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COVID-19 PANDEMIC: HEALTH CRISIS AND CITIZENSHIP

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Contents

The global health crisis triggered by the COVID-19 pandemic is phenomenal and is likely to have a radical impact on the definition of citizenship and state-society relations. It may not be possible to predict today the direction the world, which is currently going through a deep and multi-dimensional (economic, political and ecological) crisis, will follow after the shock caused by the pandemic. However, undoubtedly the days we go through will have long-term consequences. Likewise, the past year has generated striking and even destructive effects in several areas varying from the economy to social policy, from social gender relations to the environment, from international politics to security technologies. The magnitude of unemployment and income reduction caused by the measures taken in the name of public health has reached a level that cannot be easily overcome in a wide part of the geography, except for a limited number of countries. It remains uncertain how long the economic recovery will take for the countries that have managed to compensate for this shock with programs such as temporary income support. Simultaneously, economic uncertainties have uncovered the problems due to the structural reforms that have been implemented almost all over the world in the last four decades. The first-hand results of the pandemic, which emerged under the circumstances where unemployment increased, the phenomenon of working poverty became permanent, and welfare state practices were undermined, are experienced much heavily precisely due to these very reforms.

On the other hand, all of this may result in questioning and a reaction to the dominant policies of the last decades. The pandemic can deepen the discomfort with neoliberal globalization, which has already lost much of its glory. However, whether this will give way to more freedom and equality or not is still a question mark. At one end of the spectrum are authoritarian populist movements' promises of autarky, and at the other are demands such as the right to universal basic income or progressive taxation. Briefly, both the results of the pandemic conditions and the transformations that can be experienced after the acute shock caused by the pandemic are the subject of the political struggles. The course of these struggles will also determine how the content of the notion of citizenship will be redefined. If we consider citizenship not only with its normative dimension of rights and duties but also as an amalgam of practices, we can state that the meaning of citizenship in the post-pandemic period will be reconstructed through these tough questionings and struggles. Whether they will lead to a more securitised, restrictive and controlling state-society relation or not will depend on how effective the reactions from below will be.

In this issue of **saha** we focus on the landscape occurring with the pandemic and its projections in the context of Turkey. We deal with Turkey's adventure, which has undergone dramatic transformations in the last twenty years, together with the global developments. We seek to survey the traces of the pandemic in a wider range, thus questioning how the health crisis is interacting with the existing political economic context. In this sense, the focus of this issue is the question of the consequences we face under the current circumstances, especially in terms of the segments whose voices are not heard enough. Ultimately, we wish to contribute to the rethinking of the practice of citizenship in Turkey in a more egalitarian and libertarian manner.

Interview by Fırat Genç

State and citizenship in the mirror of the pandemic

What will be the political and social effects of the unusual conditions and practices occurred due to the COVID-19 pandemic? How are we to comprehend this state of acute crisis that simultaneously engulfs the whole world in the historical phase where the boundaries of citizenship that we are familiar with are getting blurred? We discussed these challenging questions with Özyeğin University Faculty of Social Sciences faculty member Evren Balta, based on her book recently published in Turkish.

In your book, titled *Age of Uncertainty: On Violence, Belonging and Politics,* you argue that we live in an age of unrest and that the widespread state of uncertainty we are in is what lies behind it. How do you define this generalized state of being? Moreover, since uncertainty is not specific to the present, what is new or different today?
Evren Balta: Uncertainty is actually something inherent to human experience, that is, it is not something that applies only to today. If we go back 500 years or 1000 years, we find much greater uncertainties. You don't know when the earthquake will happen, you don't know why the earth is shaking, you don't know when there will be a storm. Today we have many more tools to reduce all these uncertainties. But I think this is one of the most fundamental parts of the problem. With all these developments, our desire and possibility of controlling uncertainty has increased

You are the cause of anything that happens to you, and you can control life. Now think about the 30 years ahead, plan everything, put down all the risks on a piece of paper, take some precautions for almost all of them, if you can't, you're to blame for it, you're unsuccessful!

Photo: Kamile Kurt

Photo: Özcan Yaman

enormously. For almost all of us, all these risks have become things to be controlled. So we no longer define them by referring to external factors, for example to fate or god. We actually want to control everything. We have a very serious desire for control. On the other hand, our capacity to control our own lives has decreased, especially in our personal lives. This is a little bit about neoliberalism. The world is no longer a world of collective mechanisms and permanent bonds. So the gap between our desire and our capacity to control makes uncertainty something much more intolerable. Perhaps the most important thing here is that uncertainty has become something intolerable for us.

After the Second World War, we at least tried to deal with the uncertainty all over the world, albeit with different forms and mechanisms. There were certain constants in our lives, such as the welfare state. Or the family for example, family is something that can be perceived as a constant. Sometimes your family provides the welfare mechanism for you. We have seen that such mechanisms are either broken down, rotten or disappear all over the world simultaneously. On the one hand, neoliberalism has eroded all welfare-making collective security systems, from healthcare to education. For instance, you cannot have a life-long career today. You constantly have to re-invent yourself, re-actuate yourself, invest in new careers. Therefore, our relationship with work has changed. There is no longer a person who says, "I have a career, I will retire from here, I will work there all my life". Accordingly, rights, retirement rights or unemployment guarantees have also disappeared for all of us, although at different levels. Let's add the loss of some jobs to this. Second, collective mechanisms for us to take risks are also disappearing. What were these? Unemployment insurance, for example, or the right to send my child to a good school or the right to good health care free of charge when I am sick. Third, as I have mentioned earlier, our personal ties have also eroded. Undoubtedly, there are many reasons for this from social media to the change of urban life. Finally, the thinking system that what happens to us is beyond our control has also weakened. These are actually the kind of systems that comfort people. This feeling of loss has been strengthened not only in seculars, but also in religious groups: You are the reason for anything that happens to you and you can control life. Now think about the 30 years ahead, plan everything, put down all the risks on a piece of paper, take some precautions for almost all of them, if you can't, you're to blame for it, you're unsuccessful! In other words, a kind of investor individual who is over-investing in herself/himself and her/his children, who is responsible to think about everything, in my opinion, is very hegemonic all over the world, and this is also the case among religious groups. After all, there is an individual who has a very high desire for control, but this individual has a very low capacity to control what (s)he should actually control in life. It seems to me that this gap has made the uncertainty intolerable.

We have seen that a particular type of leadership and style of politics – authoritarian populism as the most common phrase– react similarly around the world in a moment that acutely reinforces the uncertainty you speak of like the pandemic. How do you evaluate the motivations behind these responses to the crisis?

E.B.: Although the style is similar, we should not omit that the reasons for this may vary. For instance, the ground for the problem being neglected in Turkey is largely the system remaining helpless or weak against the magnitude of the crisis, other reasons came to the fore elsewhere. But in fact, the main common feature of all these leaders is that they pretend that there actually is no problem and claim that the problem is greatly exaggerated by others, by outsiders. Almost all of these leaders are actors that create a crisis themselves, even if there isn't any and feed off the crisis. They create a crisis even if there isn't one, and claim that they are the only one to solve it. However, the corona crisis is not created by them, it's an external crisis in terms of size and functioning; so a kind of surprise and astonishment factor is very strong here.

Second, it's not a crisis they can easily resolve; in fact it's a crisis that requires other tools than the tools these leaders normally use to resolve crises, requiring the mobilization of another kind of state or institutional mind, such as expertise, consultation, coordination, cooperation, strengthening institutions, transparency of the state-citizen relationship, actually calling the lost governing features back. Those who have come up with more successful solutions are the ones who could do these. Calling them back means that all of these come back to politics, perhaps permanently. This in return may mean that you won't exist. Because fighting them is exactly the essence of your existence. It is very difficult to recall the things you fight with, because you can take politics to another course with your own hands. This is the case especially in Trump's style of politics. Let's call it the desire not to call back things he is constantly fighting, like expertise, scientific opinion, etc.

Besides, these leaders have a conspiratorial, in fact highly conspiratorial way of thinking. So at least some of them actually believe it's exaggerated. Donald Trump or Brazil's president Bolsonaro is saying this openly. It was harder to do this at first, but now, as society gets used to it, the death rates and the disease itself, it becomes easier to say that it is exaggerated or to fight with experts on media.

If we consider Turkey within this context, how do you think we should interpret the way the epidemic is managed?

E.B.: I think the first period should be seen as a phase of confusion. Thus, at least in the first 3-4 months, that is, in the first wave of the epidemic, a parenthesis was opened in the negligence I just mentioned. At that point, the opinions of the Scientific Board or experts were at the forefront. Turkey might not be one of the countries with the hardest implementation of the measures, but it surely was not like it is now in the first months. So I think the confusion factor at that stage opened up some space for experts in Turkey, the monitoring of global developments and the implementation of the rules a bit harder.

But I think this ended for two reasons. First, the obvious economic situation of Turkey. If you are to implement such measures, you need to do them with some protection packages. A plan needs to be developed both for the protection of those who lost their jobs and the protection of the sectors economically. In order for such mechanisms to exist, your economy should contain at least some of these priorities. Or you need to have a stronger economic system. The economic crisis Turkey is already going through, the military interventions I don't know in how many different places, that is, the circumstances did not allow equal distribution of social wealth. Apparently, the main priority today is to manage the situation with small precautions, take precautions to save the day.

Secondly, and I think more importantly, they saw that with the disappearance of the surprise factor, not an excessive number of people in Turkey died and these deaths did not create great resentment. Socially we got a little used to it, and there is no social opposition to challenge it. On the contrary, there are a lot of groups that say, "If you lock it down, we will lose our jobs. Oh, don't lockdown." Including the lower classes to the very rich. The very rich would not want their profit rate to decrease, the lower would not want to lose their jobs, so there is actually some kind of coalition that demands to focus on the economy.

> The strengthening of the notion of health citizenship, the state starting to provide some aid during the isolation periods, the fact that unemployment etc. are to increase due to this crisis, may lead to the formation of a new citizenship consensus within the framework of welfare citizenship.

Since the first days of the epidemic, some observers have stated that this crisis can reverse the loss of reputation experienced by notions such as reason, rationality and scientific thought in recent years. What would your comment be?

E.B.: We have a very complex picture. On the one hand, there is a very serious expectation, desire, and therefore respect for the solution of this issue with the vaccine. Even Trump has this expectation because he sees it as the definitive solution. There are some groups in Turkey working on the vaccine that are cherished on social media as well as by the governors. Science is politically reconstructed here. On the one hand, there is this kind of consensus about the vaccine; the importance of the vaccine has been realized, so the vaccine issue has become seen as a matter of national pride, something that will greatly increase your power in the global system. Everyone is in such a national race that scientists have turned into the country's Olympic racers. This is one side. On the other hand, there is a lot of confusion, such as the mask issue. The recommendations on that issue were not the same in the first period of the epidemic. Or, there were serious debates about how big the threat was, whether there should be a quarantine, what the travel restrictions would be, which drugs and which treatment protocol would be better to use, and the reflection of this below was actually a huge confusion. Discussions such as how much our social distance should be, whether a specific drug helps or not, manifests largely as

scientific uncertainty and I think it creates a serious problem of trust. Yes, science has come to the fore and we do whatever doctors say, but there are still those who believe that the coronavirus emerged due to 5G, that this virus was created by Bill Gates, that wearing a mask does not mean anything, and that this is nothing but restricting our freedom; hence the sense of social conspiracy around scientific knowledge continues.

When we say pandemic, we are talking about a truly global phenomenon in terms of its emergence, spread or consequences. On the other hand, when we look at it from a political perspective, the pandemic emerged in a conjuncture where liberal globalization movements lost their position and prestige. What kind of results do you think these experiences will produce regarding the idea of nation-state? How about pondering the basic axes of such speculation.

E.B.: Of course, the short-term effect has been largely the introversion of the nation. Strengthening the nation has been the main issue, from economic nationalism to closing borders. In this sense, this means reversing the globalization process. However I'm not so sure about how persistent this will be. First of all, looking at global supply chains, there was an ongoing tendency to converge, localize, regionalize supply chains, especially due to the US-China conflict, and the crisis accelerated this trend. Therefore, for example, it is possible to say that this trend will be permanent, at least in the medium term. Apart from that, the fact that health is provided as a national service, and the fact that it will continue to be so will actually strengthen a sense of 'health citizenship'. In other words, the floating ideas such as I can live anywhere will be undermined, the desire to have fixed territory-based rights and the belief that this can be provided by nation-states will be strengthened. I think it will increase the desire to be a kind of a health citizen, at least at the individual level. Moreover, it is said that the corona has some long-term effects. Discussions such as how to overcome the burden on health systems will continue on a national scale, and in this respect, we may be entering a period in which the welfare leg of the nation-state is a little stronger. There are many reasons for this, this crisis is just one of them.

The strengthening of the notion of health citizenship, the state's initiation to provide some aid during the isolation periods, and the expected increase in unemployment due to this crisis may lead to the formation of a new citizenship agreement within the framework of the understanding of welfare citizenship. Moreover, the relative success of actors such as Biden or the Green parties in both Europe and the US will now lead to the strengthening of a new consensus and coalition, with capital's desire to balance rising right-wing populism. Maybe not every layer of capital, but such a coalition exists now and this coalition expresses the need for a new consensus. Global threats such as the climate crisis also reinforce this search. New mechanisms such as the regulation of carbon emissions to jointly address such global threats are shaping, which will ultimately depend heavily on the nation-state. This will be a national consensus.

Photo: Burcu Yürüyen

Photo: Özcan Yaman

On the other hand, unlike in the past, this consensus has a global dimension. Because the consensus is based on a number of new threats, and these are truly global, as in the climate crisis or pandemic. It doesn't matter how much you strengthen your health system, you need them to be strong everywhere, and you need the blocking mechanisms to be global. In time, this discussion will definitely come to this point. It has to come because the things regulated by the national system that we see as a threat are global.

So, paradoxically, the crisis caused by the pandemic may have caused the possibility to end the phase of the last 10-15 years.

E.B.: Yes, it may be so. When Naomi Klein says, for example, 'disaster capitalism', she reads it entirely on capital basis. To put it very roughly: A very bad crisis is happening to the capital, they want to do some bad things as they always do, they want to suppress the movements or they want to pass some rules, for example, so they see the crisis as an opportunity. There is no doubt that some of it is correct. But that doesn't mean that it will always be the case. Times of crisis actually mean that ideas that are not preferable to capital may as well become popular. It also allows popularized ideas below to actually create a consensus with the top. For example, the Second World War is a period of such an example. After all, it's a major crisis for capital or for the ruling class; you have lost a significant portion of your male population. There are women who have to work; orphans, and you have to take care of them. You are forced to create a kind of welfare system in a way you never wanted, because you have to accept the demand that arises from below. The world you are familiar with will be lost if you don't accept it. So you can't just think of your own profit at that point. Somehow you have to keep it going. It may be the case for today, because such crises can mean the end of capitalism after a while. Of course, it is hard to say that this definitely is the case, but it opens a door. You either choose that door or not. Such crises always open a door for you, and behind that door there are always discussions going on for years. For example, we have been discussing basic income for years. Or improving health systems, providing broad health systems for everyone, democratizing education, Green Deal... These are ideas that have already existed for years but have not been popular among the upper classes or the ruling classes. One day, that door opens and they realize that the realization of these ideas actually mean their own liberation.

If one aspect of the nation-state is welfare practices, the other is control and surveillance. As expected, there is a wide debate that the pandemic will expand this second area. Undoubtedly, this is an incomplete process. But, based on the developments so far, in what direction do you think we are heading?

E.B.: This is the dangerous aspect of

the issue. On the one hand, it has a positive dimension, on the other hand, that positive dimension can go together with the strengthening of the state. After all, this is a trend we've seen for a while already; the punitive state, that is the monitoring, tracking, punishing side of the state grows over the years. Now, unfortunately, this period and this situation seem to lead to the strengthening of this dimension of the state, which has already happened for many states. I don't know if these will be permanent.

But let's also consider the fact that certain violations of rights become a part of politics is possible only by violating them and the mass realization that they are violated. That certainly was the case before, but since 9/11, state technological surveillance devices have evolved significantly. However, the issue of violation of privacy rights has entered the agenda of social opposition more seriously. As an individual, how do I protect my privacy rights not only against governments but also against other individuals or companies? What are these rights? How are these rights protected in the age of social media, how much of them can be collected and shared by companies, how can I give or withdraw consent, when I get on a plane is my information private or public, a series of questions such as such came to the fore more.

This is a challenge, of course, and it wears out more and more each time. I think one of the fundamental rights issues of the next period will be related to privacy rights. It is one of the most fundamental issues that the existing national and international institutions, national or international agreements do not fully regulate. Moreover, we do not know

I think one of the fundamental rights issues in the next period will be about privacy rights. This is one of the most fundamental issues that the existing national and international institutions, national or international agreements do not fully regulate. Moreover, we do not know exactly what privacy and the rights related to it might be.

If we do not fight against this, then of course all these surveillance and monitoring practices specific to the current crisis will be permanent. In fact, the desire of the rulers to monitor and gather all the information about you, to manage you through that information, to have the privilege of guessing your desire without you even knowing what your desire is, is very strong.

exactly what privacy and the related rights are. In terms of activists, it is actually an area that is not fully codified and its boundaries are not clear. If we do not fight against this, then of course all these surveillance and monitoring practices specific to the current crisis will be permanent. In fact, the desire of the rulers to monitor and gather all the information about you, to manage you through that information, to have the privilege of guessing your desire without you even knowing what your desire is, is very strong.

Photo: Hülya Avdan

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We witnessed conflicts between local governments and central government institutions, especially in the first months of the epidemic. This, of course, was the result of a political conflict in the narrow sense. Taking a step further, this may be considered as the reaction of Turkey's highly centralized structure of the public system it has become today. In your opinion, what can be said about the meaning and content of the local scale in the context of the epidemic?

E.B.: I think this crisis is essentially the crisis of the big cities, at least the way it emerged in the first wave. When I look at it from the new risks and threats perspective, from the epidemic to terrorism, the world of cities and smaller settlements is not the same world anymore. There is a big rupture in terms of affect or threats. So I think one of the most important things that this latest crisis has brought into our lives is the question of "how should urban life be?" Just as health citizenship has been put on our agenda, the reorganization of the city and urban life should be rethought. Of course, the crisis did not remain simply the crisis of the cities afterwards, but it emerged and spread in a network of largely globalized cities.

It is quite possible that this will lead to reactionary views that we can call anti-urban or anti-metropolitan.

E.B.: That is already the case. For example, if we look at who voted for Trump, of course there are other actors in that coalition, but this is largely based on a city-provincial division, that is, right-wing populism actually emerges from the conflict between the urban and educated population benefiting from this globalization and the rural groups outside it, where industrialization receded, agriculture lost its former power with industrial agriculture. First of all there is already anger towards the cities and the urban population. Second, once upon a time the nation-state itself was actually able to compensate for this division with practices such as conscription. However, the newly rising state of locality and discourse, that is, the state of big cities increasingly detached from the nation-state structure and articulated with each other, has the potential to increase the tension between the city and the provinces. There is already serious anger from below against the elite networks in the metropolis and their non-national tendencies, and such tendencies can also mean the emergence of political units of that anger. I am aware that I am speculating, but there is no doubt that we should consider and talk about how the increasingly idle provincial population can be reintroduced into development, new types of development models, how the blessings of globalization can be distributed more symmetrically to the national population, not just in the big cities. This ultimately means rethinking the notion of citizenship universally in today's conditions. It means establishing a new consensus on the one hand morally, that will make society a society again and make us feel that we are responsible to each other, and on the other, it has an economic and political dimension.

PATENTING THE SUN: OUR HUMAN (IN)SECURITY AND HEALTH

How can the universality of the right to health be achieved in a world dominated by states and multinational corporations? The conditions of the pandemic have once again raised this compelling question in all its simplicity. In this article, Hakan Ataman discusses the normative content of the right to health from a human security perspective, and points out the tension revealed by the pandemic and emphasizes the vitality of the demands and interventions developed from below.

As a global health problem, the COVID-19 pandemic continues to adversely affect almost all of our daily life practices, with increasing severity. The only thing we can understand from the daily numbers of cases and deaths reflected on media is that the scale of the problem is enormous. When we look behind the numbers reflected on us, it is possible to face much more terrifying facts: With different dimensions of our human (in) security. Elderly people left to die in nursing homes, the increasing dose of physical and sexual domestic violence against women and children, people who have to deal with unemployment and poverty, or those who risk their lives and hit the road rather than being unemployed! All these circumstances of human (in)security reminded us once again of the vital role of health. As a matter of fact, 'health' has not been off the agenda from the ancient Homeric epics to the present day. Health was an issue that the representatives of the ancient Greek civilization always kept somewhere in their minds. There were gods and goddesses of health. Before it was adapted to its present form, the Hippocratic oath began by addressing Apollo, Asclepius, Hygieia and Panacea.[1]

After being sentenced to death, and couldn't be convinced by his students and close friends to escape, Socrates' last words to Crito in the *Phaidon* dialogue were: "Crito, we owe a cock to Asclepius; pay it and don't forget."[2] The last words of Socrates were not merely a simple vow. Socrates called for "a healing ethos in civil life," as James E Bailey put it: "Socrates' last words prevented the attempts of the Athenian authorities to silence him, called for Asclepius's ideals to rule in the city of (polis) Athens, and described self-sacrifice towards others as exemplified by Asclepius as the greatest duty for all humans."[3] These ideals, which we can summarize as accepting to be mortal but living in 'healing', we define today as "the right to have the highest standards of physical and mental health". How close we come to this ideal is indeed open to question under the conditions. I think that the most and perhaps the latest person to come close to this ideal is Jonas Salk, who is the founder of bio-philosophy, and received the Nobel Prize for Science in 1954 for developing the first successful vaccine against polio. Edward R. Murrow asked him on a television show, "Who has the patent for the vaccine?" In response to the question, Dr. Salk replied, "I can say it belongs to the people. There is no such thing as a patent. Can you patent the sun?"[4] According to *Forbes* magazine in 2012, with this attitude, Dr. Salk has forfeited 7 billion dollars.[5] As the pharmaceutical industry today talks about Dr. Salk's attitude as a "myth"[6], as we will mention in a short while, the discussions about the distribution of the vaccine against COVID-19 cannot go beyond being embarrassing. Moreover, this is not the first time.

UN Universal Declaration of Human Rights begins by articulating "the freedom of human beings from fear and want" and "human dignity". These expressions constitute the essence of the definition of human security, which is defined as "the right to be free from fear and want and to live in dignity".

When we approach the issue from a human security perspective, we can go back to the introduction of the UN Universal Declaration of Human Rights. The UN Universal Declaration of Human Rights begins by articulating "people's freedom from fear and want" and "human dignity". These expressions constitute the essence of the definition of human security, which is defined as "the right to be free from fear and want and to live in dignity". However, a comprehensive definition of the concept of human security was included

Photo: Özcan Yaman

for the first time in the 1994 Human Security Report of the UN Development Organization (UNDP). When we go over the report, we see that the human security approach is positioned on a general critique of the conventional understanding of 'security': "The concept of security has long been considered with a narrowing interpretation: It has been limited to the security of a territory against external attacks, the defending of national interests against international or the threat of a nuclear holocaust as a global security. It applies to nation-states rather than individuals."[7]

The conventional security approach criticized by UNDP in its 1994 report is unfortunately still valid today. Most apparently, Health Minister Dr. Fahrettin Koca's statement from his social media account regarding the criticisms that the COVID-19 data announced by the Turkish Republic Ministry of Health do not reflect the truth, that the actual numbers are much higher than the data announced by the Ministry was as follows: "The state is protecting not only public health but also national interests because the outbreak impacts the whole life. The criticism levelled by those who are not accountable is no different than trying to find a stain by focusing with a lens on a single spot in a whole picture."[8] By the way, it should be stated that the expression "not accountable" corresponds to the Turkish Medical Association.[9] However, as we have stated above, physicians have had the greatest 'accountability' since ancient times.

Whereas UNDP in its 1994 Human Security report, defines human security with seven interdependent and interrelated components unlike the conventional understanding: economic security, food security, health security, environmental security, personal security, community security and political security. These seven components are accompanied by five basic principles.[10] To put it briefly, the human security approach:

- *is people-centred.* It tries to produce the solution of human insecurity locally and to meet the expectations of the society by considering social peace with an inclusive and participatory method.
- *focuses on producing comprehensive solutions.* For this reason, it develops solutions on a multi-sectoral and common basis by developing a dialogue between different sectors and communities. It tries to strengthen resilience by providing consistency and coordination between sectors. While doing all this, it takes into account internal and external factors.
- *aims to produce context-specific solutions.* With an in-depth analysis, it focuses on the rights and freedoms under threat. It activates the locally existing potential for a solution. It

Photo: Özcan Yaman

takes into account all local, national, regional and international dimensions and their impact on the targeted situation.

- *is proactive.* It develops preventive rather than reactive strategies by analysing risks and threats in depth.
- *is protective and empowering.*

The seven basic components of human security combine personal and political rights with economic, social and cultural rights. Furthermore, it takes into account to live in peace and free from conflict as an obligation. Thus, social development ceases to be an economic development alone. It offers a holistic approach that combines human rights, democracy, the rule of law and economic development:[11]

- *Economic security* requires an assured basic income for individuals to sustain their lives. When necessary, the state finances the social security network.
- *Food security* requires that all people at all times have both physical and economic access to basic food. Food security also includes the ability of people to obtain their own food by growing or producing it themselves, or by purchasing or a public food distribution system.
- *Health security* includes protection from diseases and unhealthy lifestyles and access to basic health care and services for this purpose. Risk sharing systems and community-based social insurance programs are part of this topic. It requires the establishment of interconnected control systems to detect outbreaks at all levels.
- *Environmental security* is to prevent the destruction of nature. For this purpose, it includes sustainable practices that take into account natural resources and prevention of environmental degradation (such as deforestation, desertification). It is the development of early warning and response mechanisms for natural and / or human-induced disasters at all levels.
- *Personal security* is the protection of an individual from physical violence whether by the state, non-state actors or other individuals. It requires explicit and obligatory protection of the rule of law and human rights and freedoms.
- *Community security* means protecting people from loss of traditions and values and ethnic violence. It requires explicit and obligatory protection of the identity of ethnic groups and communities. It is the prevention of traditional oppressive practices and violence against women or discrimination against ethnic / indigenous / refugee groups.
- *Political security* means making full use of human rights. It is also the protection of democracy from military dictatorships and other violations. So, it is protection of individuals from political or state repression, torture and ill treatment, illegal detention and imprisonment.

Efforts to improve the human security approach were not limited to the UNDP's Human Development Report of 1994. The UN Trust Fund for Human Security was established in March 1999 at the initiative of the Government of Japan and the UN Secretariat. In May 2004, the UN Human Security Unit got involved.

Yukio Takasu, appointed Special Adviser to the UN Secretary-General in 2017, is working on the mainstreaming of the human security approach, including the implementation of the UN Development Goals.[12] On the other hand, at the European level, the Human Security Working Group that came together with the call from Prof. Mary Kaldor in 2007 also has efforts[13] to mainstream human security in the European Union since the Madrid Report.[14]

Now, if we go back to the health issue, which is our main topic, the definition of health provided by the Constitution of the World Health Organization (WHO) is in full compliance with what we have stated above. The introduction to the WHO constitution of 7 April 1948 describes health through nine basic principles:

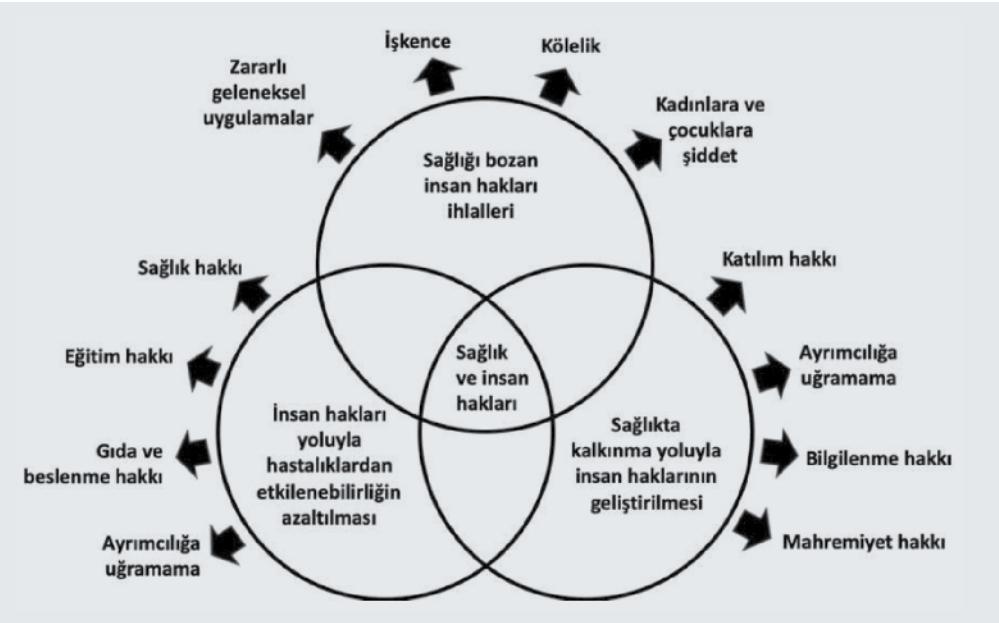
- Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.
- The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.
- The health of all peoples is fundamental to the attainment of peace and security, and is dependent on the fullest cooperation of individuals and states.
- The achievement of any State in the promotion and protection of health is of value to all.
- Unequal development in different countries in the promotion of health and control of diseases, especially communicable disease, is a common danger.
- Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development.
- The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health.
- Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people.
- Governments have a responsibility for the health of their peoples, which can be fulfilled only by the provision of adequate health and social measures.

Thus, health is assured under numerous international conventions as "the right to enjoy the highest attainable standard of health of every human."[16]

The "Ottawa Charter" adopted at the first international conference on Health Promotion in 1986, in order to realize the right to health or our health security, describes health as "a resource for everyday life", not "the objective of living". Stating that health means "well-being beyond a healthy lifestyle", the Ottawa Charter requires the safe establishment of eight basic preconditions for health improvement: peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity.[17] The UN Economic, Social and Cultural Rights Committee, in its general interpretation of the right to health, pointed out that the right to health should be considered together with "many socio-economic factors, nutrition, food, housing, safe drinking water and adequate sanitation, safe working conditions", "and its occurrence at each stage and based on the conditions in a particular country" describes health through four basic elements:[18]

- *Availability:* Means that there is a sufficient number of functional health and health-care facilities. This means having a sufficient number of trained healthcare personnel, adequate numbers of health supplies, provision of services, public health and services and programs for health care.
- *Accessibility:* Accessibility regarding health basically includes four issues: (i) Equal access of everyone to the right to health without discrimination; (ii) Easy physical access to health services, including rural areas; (iii) Financial access is that everyone can afford the health care. Wealthy households should be prevented from using healthcare services disproportionately compared to poor households, and it is essential to provide the necessary guarantees for everyone to enjoy their right to health. (iv) Accessibility also implies the right to seek, receive and impart health-related information in an accessible format, but does not impair the right to have personal health data treated confidentially.
- *Acceptability:* The facilities, goods and services should also respect medical ethics, and be gender-sensitive and culturally appropriate. It is important that services are provided in a way that increases privacy and standards.
- *Quality:* In addition to being acceptable, the materials and services used by healthcare institutions should be scientifically and medically appropriate and of high quality.

With this point of view, it is possible to summarize the general framework of the health issue on a chart as follows. WHO has been making an effort for a



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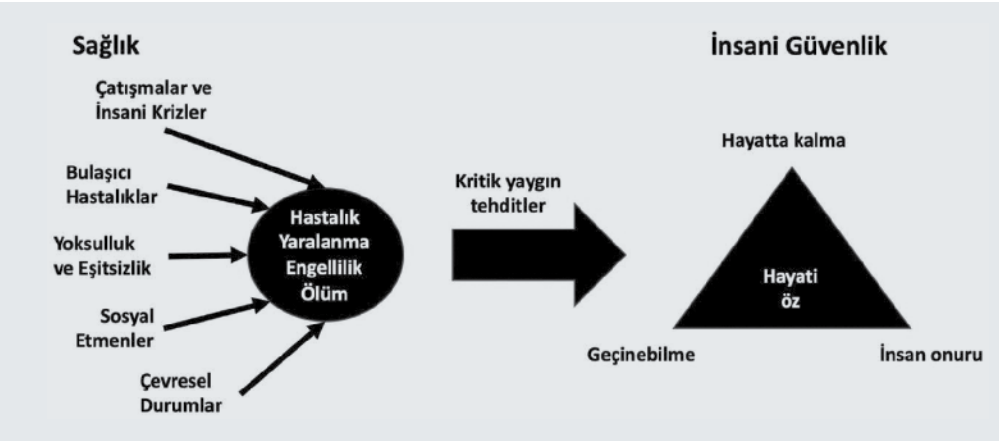

Source: World Health Organization

long time to practice the human security approach in the field of public health.[19] WHO's Regional Office for the Americas on the other hand, pointed out the insecurities that negatively affect the health and the vital essence of the human security approach in the technical document[20] prepared on this issue, by updating the definition in the document prepared by the Human Security Commission in 2003:

In fact, we can say that the chart above shows how pathetic the situation is. In its latest report announced on December 2, 2020, The UN World Meteorological Organization (WMO), which keeps temperature records from 1850 up to today, stated that 2020 is a candidate to be the warmest year in the last six years. 2016 remains to be the warmest year ever on WMO's records.[21] In short, our world is warming up. Human-induced climate change continues. There is no decrease in conflicts and humanitarian crises. Due to armed conflicts emerged in neighbouring Syria in March 2011 alone, 13.1 million people are in need of help, 6.6 million people are displaced within the country while 5.58 million people are in refugee status outside the country, 2.98 million are under siege and are trying to live in areas extremely difficult to reach.[22] According to estimates, more than 400 thousand people were killed, many more were injured.[23] According to the Organization for Economic Cooperation and Development (OECD) 2019 data, income equality range among OECD countries is very wide; Turkey is associated synonymously with South America and USA in terms of highest income inequality. Turkey is below the average of OECD countries (4000 USD) on health expenses. While Turkey is positioned with the OECD members in Central Europe and Latin American countries regarding healthcare, it ranks last in terms of the share of OECD countries' health expenditures within the Gross Domestic Product (GDP).[24] I think it would be sufficient enough to remind you of the negative impacts of COVID-19 pandemic in all around the world as well as in Turkey.

In another study where WHO points out the link between human safety and health with good practices, it states that the main purpose is to strengthen the resilience of people living in vulnerable conditions and to ensure that they benefit from the right to good healthcare. The organization categorized what needs to be done to achieve this goal under four headings: (i) Maximizing a preventive and supportive approach; (ii) improving sensitivity and accountability; (iii) minimizing avoidable differences between people; (iv) encouraging synergy between efforts to protect and strengthen communities. In order to do all of these, it is useful to underline two points. First of all, governments must play an active role in providing services and setting up the necessary facilities. Secondly, community skills need to be developed so that people can make conscious decisions and protect themselves.[25]

Our world is warming up. Human-induced climate change continues. There is no decline in conflicts and humanitarian crises. In neighbouring Syria alone, due to the armed conflict that broke out in March 2011, 13.1 million people required aid, 6.6 million were internally displaced, while 5.58 million people are refugees outside the country, 2.98 million are under siege and live in extremely difficult places to be reached.

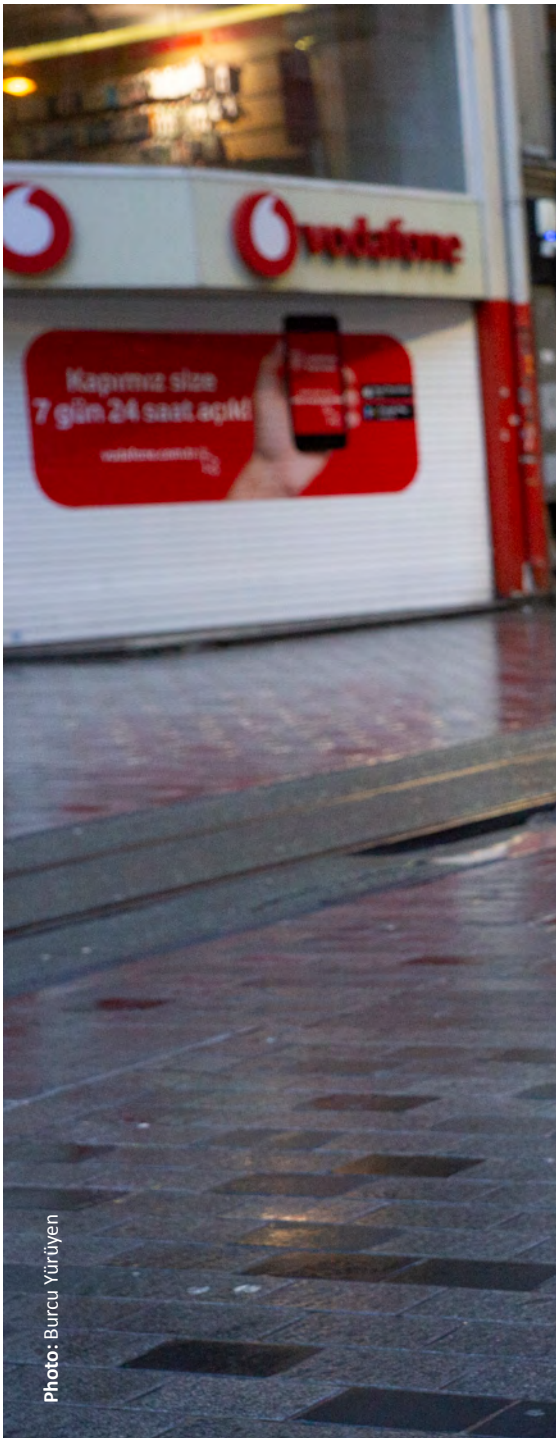

Photo: Burcu Yürtiyen

In short, the concept of human security offers us a highly integrated approach. However, there is a fundamental question to be asked at this very instance: What will happen if governments do not fulfil their duty? Or who will reverse the situation if wealthy social groups unfairly want to use their resources only for their own benefit? Trump, an extreme right-wing populist leader losing the presidency of a superpower like the United States seems to be a relief for now. However, we could have faced the opposite situation. Besides, many presidents like Trump are still active in the rest of the world. Even further, multinational companies seeking to patent the sun continue to plunder the globe and there seems to be almost no mechanism to stop them. Institutions such as WHO which struggle for the fair distribution of the COVID-19 vaccine have almost no sanction power.

Not very long ago, as we may recall The Republic of South Africa struggled with pharmaceutical companies in the early 2000s, being the country most affected by the HIV-AIDS pandemic. South Africa, where 7 million people still live with HIV today, found a way to

We are faced with a fundamental question: What will happen if governments do not do their part? Or who will reverse the situation if wealthy social groups unfairly want to use their resources only to their advantage?

Multinational companies seeking to patent the sun continue to plunder the globe, and there is almost no mechanism to stop them yet. Institutions such as WHO, which strive for the fair distribution of the COVID-19 vaccine, have almost no sanctioning power.

provide a cheaper drug to its 4.5 million HIV-infected citizens back then. They took action to obtain drugs at much cheaper prices from countries such as Brazil and India. However, The South African Pharmaceutical Manufacturers Association filed a lawsuit to prevent this. With the intervention of the Treatment Orientation Campaign (TOC) and other non-governmental organizations which got involved with the case in court very last minute, the South African Constitutional Court found the drug manufacturers unjust in the case by emphasizing human dignity and the right to live and paved the way for South African citizens to be treated for HIV and to access cheap medicine.[26] So, what will we do if a similar problem occurs in the distribution of the COVID-19 vaccine? General Director of WHO, Tedros Adhanom Ghebreyesus said, "rich and powerful nations must not trample the poor and marginalized in the stampede for vaccines" at the press conference held on December 4, 2020 and added such: "There is no vaccine for poverty and hunger, no vaccine for inequality and climate change. When the pandemic ends, we will face greater challenges than before it started."[27] At this stage, there seems to be no alternative but to demand our human security from the bottom up[28] without leaving it to the initiative of states, pharmaceutical companies, patent firms and even intergovernmental organizations. I suppose it is particularly important that this demand is literally 'glocal', in other words, expresses the unique conditions of the local at the global level and taking action accordingly. Maybe that's why the human security approach is the best fit for this case.

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PANDEMIC, SOCIAL INEQUALITIES AND THE RIGHT TO HEALTHCARE

In this article, Tuğba Zeynep Şen, researcher from Boğaziçi University Social Policies Forum, discusses the conditions for establishing the right to healthcare as a fundamental right, emphasizing how critical the political choices are regarding the increasing inequalities.

The devastating Izmir-based earthquake that took place on October 30 caused the phrase "building kills, not earthquake" to be heard frequently again. Although the language of the media and the politicians mostly sound like they evoke war and conflict (struggle, conflict, etc.), it would be more correct to think of the ongoing pandemic as an earthquake-like disaster. As social scientists working on disasters have long pointed out, even though disasters are triggered by factors beyond human will, they are systems established and maintained by humans as much, if not more so, that caused the crisis – that is, the actual disaster.[1] In the case of COVID-19 pandemic, it does not mean that deaths are caused entirely by social and political conditions. Of course, even with the most ideal systems and policies, it would not be realistic to expect that a considerably fatal disease without drugs and vaccines could cause no deaths; modern medicine and all systems have certain limits. But the change between epidemic and pandemic, pandemic and disaster is in most cases is determined by systems and policies.

With the current pandemic, the right to healthcare and the systems surrounding it became the agenda in a more striking and urgent way than ever before. The right to healthcare is a fundamental right due to its importance for satisfaction of human rights, constitutional rights and others. So what do we understand from right to healthcare? Expressing it as a right gives the state some responsibilities regarding the health of its own citizens and those living within the borders of the country. This is a fairly undisputed phenomenon, but the scope of this responsibility is a more complicated issue. It can be argued in the narrowest sense that, the duty of the state is limited to a health service accessible to the public: Even if the state does not provide services itself, it can realize the right to healthcare through the existence of such a service. However, this reading is as narrow as it is unrealistic. Neither the existence of healthcare services does guarantee access to that service, nor the access to healthcare may bring about being healthy or gaining health. The offering of healthcare is of course a vital issue, but it is not enough to think that the responsibility of the state is as simple as ensuring the offer and access to these services.

Health policies and pandemic

There are many socioeconomic factors that determine the health of individuals before they apply for medical treatment.[2] Access to healthcare and the ability to use them efficiently is part of this relationship, but not all. Many factors such as access to clean and healthy water and food, working conditions, housing conditions, and the acquisition of behaviours to improve and maintain personal health are determined by socioeconomic conditions. People in lower income groups are more prone to having health problems and they have more difficulty in reaching the solutions to health problems as they face more obstacles in using the healthcare system which affects them negatively. This close relationship of the right to healthcare with other social rights points out the importance of protective and preventive public healthcare policies that aim to restrain diseases rather than cure them, as well as medical treatment.

> In most cases it is the systems and policies that determine the difference between epidemic and pandemic, pandemic and disaster.

Since the start of the pandemic, political authorities have two main goals in front of them to be achieved in general: slowing the spread of the disease, and preventing the diseases and deaths associated with the SARS-COV-2 virus.[3] These goals did not change from the time the disease started to spread until November when this article was written, and it is unlikely that they will change until widespread vaccination becomes possible. Guiding document published by the World Health Organization (WHO) on November 4[4] aiming development of vaccines and treatments can be added to these two goals. Although vaccine and medicine production generally do not come to the forefront in discussions on healthcare policies and systems, it can be said that these three goals generally point to three different areas of healthcare systems. Avoiding the

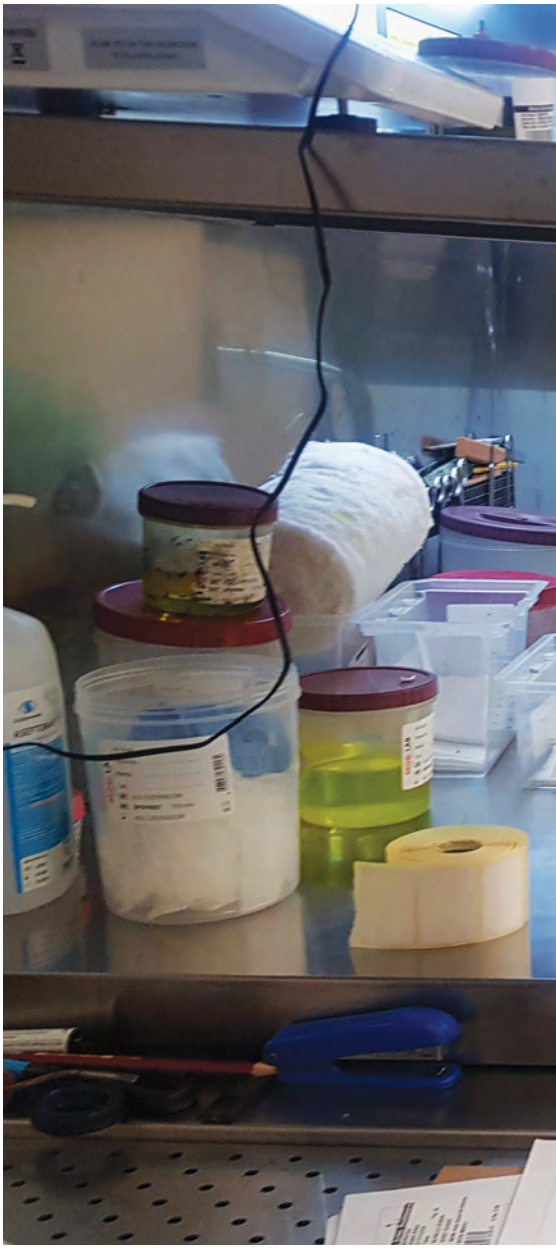
spread of the diseases is in the field of preventive medicine or public health, whereas prevention of related diseases and death in those infected with the virus is in the field of therapeutic medicine, development of vaccines and treatments. All three of these areas are governed by a country's health policy.[5] In very general terms, healthcare policies are the planning, regulation, supervision and implementation of a state regarding the regulation and presentation of health services. Providing healthcare services includes decisions and practices regarding to who (for example, a private or public hospital) and how (for example, the existence of different types of healthcare institutions such as health centres and research hospitals) they will be presented. At the same time, as far as public health is concerned, healthcare policy determines which services will be provided (e.g. for which diseases there will be mandatory vaccination). The financing covers the decisions to be made in the manner of the payments of these services, and by whom (e.g. through taxes, the public health insurance, with the private health insurance or out of pocket payments) and which actions of this insurance, especially in countries with public healthcare insurance such as Turkey. In other words, the kind of treatment a person should receive in case of illness is the field of medical science, while the way of diagnosis and access to treatment is determined by the healthcare policy. These policies can be based on science to some extent, but are largely subject to political decisions. In addition, designing the correct policy is not necessarily enough for any policy to be successful; the capacity of the state and its institutions to implement the designed policy becomes an important factor here. In the context of healthcare policy, these types of capacity include functional capacities such as the number of hospitals and healthcare workers, as well as the communicative capacity to persuade the public to comply with public health measures, the financial capacity to make the necessary expenditures, but not limited to these examples.

An important part of the interventions made during the pandemic was public health measures. It can be said that there are two prominent and closely related reasons for this. Since there is no current treatment method or drug for the new type of coronavirus, therapeutic medicine cannot do anything other than managing the course of the disease after the person is sick and trying to prevent the emergence of related and potentially fatal diseases such as pneumonia. This situation, combined with the spreading rate of the disease, naturally leads to the conclusion that the most beneficial method to deal with the epidemic would be to prevent the spread of the disease.

While what treatment a person should receive in case of illness is the field of medical science, the way of access to diagnosis and treatment is determined by the health policy. These policies are based on science to some extent, but are largely subject to political decisions.

Crisis management and the rights

COVID-19 pandemic is unusual, and experts say that extraordinary practices are necessary, especially in the field of public health, to contain the pandemic. In this process, most of the measures taken to protect the right to healthcare restrict other rights and freedoms. Some measures such as curfews, restrict everyone's freedoms, while implementations such as resignation of healthcare workers and day off of work bans affect only certain groups. At the same time, tracking and monitoring practices such as the HES code, which exist in many countries, have caused discussions about privacy. Especially in crisis, it may be necessary to take such restrictive measures and, in some cases, violating measures, but this does not mean that every measure taken against the crisis is directly acceptable. In order for such measures to be acceptable, the



It may be necessary to take restrictive precautions in case of a crisis, and in some cases, measures violating rights, but it does not mean that every measure taken in case of a crisis is directly acceptable. In order for such measures to be acceptable, the measure taken must have a valid objective, the measure should be able to achieve that objective effectively, and the measure to be implemented should be the most effective option among alternatives and the one causing the least violation of rights.

Photo: Kamile Kurt

target of the measure must be valid, the measure must be able to achieve the target effectively, and the measure to be implemented must be the most effective and least violating option among alternatives.[6]

The obligation to make compromises for public health measures is not limited to choices made between rights. These measures lock people up into their homes and slow down the economic process to the extent that they require social distance. For many people, this potentially means job and income losses for longer periods than the pandemic, and also has an impact on the country's economy that should be taken seriously. Concerns about the economy are no small issues; poor economic conditions are just by themselves a risk to public health. However, in the current situation, the measures that will prevent the spread of the virus and the practices that will stop the deterioration of the economy contradict each other. Which one should be given priority is as much a political issue as it is scientific, and perhaps even more so.

Balance sheet of managing the epidemic in Turkey

When we examine Turkey's response to pandemic, we come across a mixed picture. Public health measures were quickly taken after the first official COVID-19 case was announced on March 11. These included measures such as pausing education in schools, closing entertainment venues, travel restrictions and lockdowns. In addition to public health measures, interventions such as the suspension of the day off and resignation rights of healthcare workers and the acceptance of all hospitals, including private hospitals with COVID-19-related expertise or intensive care beds, as 'pandemic hospitals', were carried out to increase the capacity of therapeutic medical services. In June, the 'normalization plan' was announced and these measures gradually loosened up and removed.[7] At the time when this article was written, although the obligation to wear a mask continued on a provincial basis, almost all public health measures were now abolished. According to official numbers, the course of the disease could be slowed down in the spring months, when strict measures

were taken, but the numbers started to increase rapidly again since the measures were lifted and a kind of herd immunity approach was adopted.

Measures such as social distance, wearing a mask and self-isolation in case of symptoms of illness, which have been considered basic and vital from the very beginning of the pandemic, require the public to comply with these measures. Ensuring this is closely related to the state having an effective communicative capacity to persuade the public to follow these rules. However, if the state explains why these practices are necessary to its citizens in a transparent and realistic way and shares the necessary information in an appropriate language, it can enable the citizens to accept these restrictions of their own accord. Especially in the early stages of the pandemic, Health Minister Fahrettin Koca's regular statements regarding the number of cases and practices, the style he uses in these statements and his active use of social media can be considered successful in this respect. However, as of the end of July, the number of 'patients' is announced, not the number of cases, so people who are asymptomatic are not included in the numbers announced, even if the test results are positive. As a result of this, the fact that the current data not fully reflecting the extensity of the disease may have shaken the trust between the state and its citizens.

The success and feasibility of such restrictions of human mobility is closely related not only to the public acceptance of the necessity of these measures, but also to the ability to live with the conditions created by these measures. Employees losing income or jobs were direct results of public health measures such as suspension of work in places like cafes, restaurants, shopping malls and the lockdowns. Layoffs were tried to be prevented with lay off bans, short-time work allowance and cash wages, thus possible income loss by both the employee and the employer were turned over to some extent.[8] These supports were the means to ensure that the citizens expected to stay at home could stay at home. The functionality of these tools has been made possible by the administrative and economic capacities of existing institutions such as İŞKUR (Turkish Employment Organisation), SGK (Social Security Institution) and the unemployment fund. However, although the existing social and economic policy infrastructure came into use to make these public health measures feasible, the fact that this infrastructure was not designed for this purpose caused some problems. Turkey's undeclared work ratio is high for a ban on layoffs. Therefore Turkey not only could not maintain the employment of a significant portion of the community, also support programs for this revenue exclude these people. It was not announced until June that the cash wage support would also include undeclared workers, No information was shared regarding to what extent unregistered workers can be included as a result of this statement in June. In addition, the amount of support given to registered employees was not sufficient for those living in cities such as Istanbul and Ankara to continue their lives without leaving their homes. These problems related to the way the social and economic policy infrastructure was operated during the pandemic period had significant effects on public health measures and their feasibility.

Pandemic and social inequalities

However, the COVID-19 pandemic has revealed the power of social characteristics of health. Although some social figures at the beginning of the pandemic said the pandemic would be the 'great equalizer', the data showed that this was not the case at all. People with low socioeconomic status or who are marginalized are more affected by both the SARS-CoV-2 disease itself and the negative effects of the measures taken for the pandemic. These people are more likely to have concurrent diseases that will

Photo: Hülya Avdan

Photo: Burcu Yürüyen

> Turkey's ban on layoffs from work not only could maintain the employment of a significant portion of society due to high undeclared work rate, it also excluded these people from income support programs.

have negative consequences in the event of contracting the virus, and it is more difficult for them to keep their immune systems strong, as they have less access to healthy and balanced nutrition options and supplements when necessary. According to many studies, low-income group or undeclared workers are less likely to perform their jobs from home.[9] This means that they have higher risks of being unemployed during the pandemic process, as well as the risks of contacting the virus, as they cannot work from home if their job continues. A significant portion of the employees, such as market workers and cargo couriers who continued to work with low wages due to the necessity of work during the restriction periods, were also at higher risk. In addition to all these, although the mask use in public seems like an extremely simple measure, it should be noted that the economic burden of regular and correct use of masks in households is a substantial amount, especially for the low-income group. Although reusable fabric masks are recommended, the effectiveness of the mask can vary greatly depending on the type of fabric used.[10] It is predictable that most people will not be able to distinguish between useful and useless masks, and there seems to be no effective oversight of the production and sale of such items. The failure of the state to provide free and effective masks regularly to its citizens makes it difficult to comply with public health measures and also creates a separate risk factor for those who cannot constantly purchase medical masks.

Testing large sections of the public and identifying people with positive results and others that have come into contact with them become prominent as one of the most effective methods in this process. Widespread testing requires a serious capacity. In addition to having a sufficient number of test kits, the implementation and evaluation of these tests require both personnel with the necessary expertise and laboratory technology. Several countries including Turkey don't have necessary means, therefore who should be tested is determined in different ways depending on the symptoms and risk status in these countries. Many national and international health institutions, including WHO, recommend that those with mild symptoms should isolate themselves, monitor their symptoms, and get tested when the symptoms are serious. It can be said that such prioritization is necessary and valid for the most efficient and rational use of limited opportunities. However, in order for people with suspected COVID to be able to isolate themselves without losing work or income, it is essential to take necessary measures for job and income security in both public and private sectors. On the other hand, the fact that private hospitals can perform tests for a fee is a very vivid example of how privatization leads to inequality in healthcare systems and a sign that private hospitals do not use their full capacity for public health or cannot be used to their full extent despite the state's practice of 'pandemic hospitals'. Considering access to healthcare services as a civil right, associating access to testing services with money, especially in an uncertain and insecure situation, such as a pandemic, is a phenomenon that strikes the sense of equal citizenship.

It can be predicted that similar problems will occur in providing therapeutic services to patients if the virus spread rapidly. Decisions had to be made as to who could and should not receive treatment among serious patients, as Italy was unable to bear the burden placed on the healthcare system during the peak of the pandemic. Despite the mention of above usual density in intensive care units at the time of writing this article, it seems such a situation has not yet been formed in Turkey. However,

it is not certain that such circumstances will not occur, especially as the situation is worsening in cities such as Istanbul.

Problems associated with both testing and treatment are related to the functional capacity of the healthcare system. Similar and even more serious problems have been experienced in countries such as Italy and England where healthcare systems are considered among the best in the world. This draws attention to both preventive public health measures and shows that the capacity of healthcare systems that are considered sufficient and strong under normal conditions may be insufficient during an extraordinary situation such as a pandemic. As in the UK and Italy examples, even the world's most powerful healthcare systems could not respond well to the pandemic. Singapore, on the other hand, is an example of a country with a significantly low mortality rate, although the number of cases is high, as it has greatly expanded its capacity after the 2003 SARS epidemic. At this point the question arises, according to which criteria the state should make its decisions while planning the number of hospitals and employees, the resources and possibilities of the healthcare system. In general, healthcare systems are expected to have a slightly higher capacity than would normally be used, and planning is made accordingly. However, since this excess capacity is not determined by predicting an event at the size of COVID-19, it is seen that the necessary tools such as the number of employees, physical infrastructure and personal protective equipment are insufficient in such extraordinary conditions. The extent to which surplus to be included in planning is a highly political and economic issue; a healthcare system with substantial overcapacity would be a huge burden on government resources that could and should be used in other areas. In addition, it may not be fair to expect governments to plan their healthcare systems for a situation such as the COVID-19 pandemic that caught the whole world unprepared.

Of course, healthcare systems and their capacity play a vital role in a pandemic situation. However, the ability of these systems to respond to such a crisis does not depend solely on therapeutic medicine and its policies. What we saw globally during the pandemic was how important the function of public health and preventive policies was. One's health does not depend solely on access to medical treatment. Health outcomes are the result of many social factors that shape the process leading to illness. For example, concurrent health problems such as obesity and heart disease, which increase the risk of death due to COVID-19, and the relationship of behaviours such as smoking with socioeconomic status and marginalization show that the disease does not catch us all under equal conditions. This relationship between health outcomes and social identifiers becomes even more

> The fact that private hospitals can perform tests for a fee is a very vivid example of how privatization leads to inequality in healthcare systems and a sign that private hospitals do not use their full capacity for public health or cannot be used to their full extent despite the state's practice of 'pandemic hospitals'

Photo: Ayşegül Yılmaz

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important when it comes to public health crises such as the pandemic. Because the success of preventive practices marks changes in a person's lifestyle and daily practices, and is shaped by whether or not we have the means to make these changes possible. In this context, calls for "stay home" showed us all how important job security, social security and income guarantee are to overcome this pandemic with health. One of the important lessons to be learned this year is that the success of the healthcare system is organically linked to the success of other policies and systems. The right to healthcare is both a human right and the right to citizenship and protection of this right is very important for every individual. Having healthcare systems accessible and viable for everyone is vitally important for protecting this right. However, the steps to be taken to protect the right to healthcare cannot be limited to providing access to health services. In order to realize the right to healthcare both under normal conditions and in crisis situations, it is necessary to have holistic health policies that take into account the social identifiers of healthcare and address these problems.

[1] E.L. Quarantelli (der.), *What is a Disaster? A Dozen Perspectives on the Question.* Routledge, 1998.

[2] M. Marmot ve R.G. Wilkinson (eds.), *Social Determinants of Health.* İlker Kayı (trans.) İnsev Publications, 2006.

[3] WHO, *Responding to community spread of COVID-19,* Geneva: World Health Organization, 7 March 2020; WHO, *Critical preparedness, readiness and response actions.* World Health Organization, 4 November 2020.

[4] WHO, *Critical preparedness, readiness and response actions,* World Health Organization, November 4, 2020.

[5] It should also be taken into account that the drug and vaccine development activities are generally related to the research and development activities carried out by the government and the private sector, and due to their commercialized and technology-intensive nature, they are related to industrial policies and international trade regime that exceed national health policies.

[6] L.O. Gostin and Z. Lazzarini, *Human Rights and Public Health in the AIDS Pandemic.* Oxford University Press, 1997.

[7] For a list of decisions and measures taken by mid-May, see. F. Budak and Ş. Korkmaz, "COVID-19 Pandemi Sürecine Yönelik Genel Bir Değerlendirme: Türkiye Örneği", *Sosyal Araştırmalar ve Yönetim* 1, 2020: 62-79.

[8] For a list of applications made until June regarding employment, see. V. Yılmaz et al., *COVID-19 Salgınında İstanbul'da Çalışan Deneyimleri,* Boğaziçi Üniversitesi Sosyal Politika Forumu, August 2020.

[9] U. Aytun, and C. Özgüzel, *COVID-19 Sonucunda Evden Çalışabilirlik ve Eşitsizliğe Etkileri,* ISTANPOL and Friedrich Ebert Stiftung, 2020; JL Dingel and B. Neiman, "How many jobs can be done at home?" *NBER Working Paper 26948,* National Bureau of Economic Research, 2020; F. Saltiel, "Who Can Work From Home in Developing Countries?" *COVID Economics,* 7, 2020: 104-118.

[10] E. Fischer et al., "Low-cost measurement of facemask efficacy for filtering expelled droplets during speech", *Science Advances,* August 2020.

A MORE FAIR LIFE IS POSSIBLE: THE PANDEMIC FROM THE PUBLIC HEALTH PERSPECTIVE

The epidemic has unveiled the existing social inequalities and vulnerabilities very clearly. All optimistic beliefs that the virus had no specific targeting or that each of us shared a common destiny quickly vanished facing the current social reality. Yeşim Yasin, who is a faculty member of Acıbadem University, Faculty of Medicine, Department of Public Health, discusses in her article, in which she formed the balance sheet of the epidemic, that the path to a genuine change from the perspective of public health is not only an economic or institutional transformation, but also a mental transformation.

Since the moment COVID-19 entered our lives, there has not been a single day that we have not talked about public health. This is the clearest proof that something is wrong. Because we know with reference to the 'invisibility rule' that the more public health is mentioned anywhere, the worse the things are.

So what is this public health?

Of course, it is possible to define it in many different ways, but the definition I find most clear is: The discipline that deals with health at the population or community level. Public health focuses on services that will provide the greatest benefit to the widest segments of the society. It deals with the groups, communities, or ultimately society, not with the individuals one by one as in clinical medicine. While clinical medicine focuses on treatment, public health prioritizes preventive health practices. Their interventions are centred on a triple trivet: prevention, enhancing and preserving health. Preventing epidemics or removing waste that may pose a threat to human health from the environment can serve as an example for the first group. Programs such as "smoke-free air zone" to reduce the consumption of tobacco products or "10 thousand steps every day" to keep people away from a sedentary lifestyle can be included in the second group. Supporting the widespread use of masks against respiratory viruses can also be a current example of protection. More specifically, while a cardiologist works to treat a patient's coronary heart disease, a public health practitioner tries to plan interventions that limit the use of trans-fat, for example, or develop age-friendly urban policies to reduce the burden of coronary heart disease on the community. As an individual, you cannot direct or change a public health issue by yourself; a collective and organized effort is required. Public health cannot be considered independent of politics, especially public policy; it is essential that the services are run by the public, as the recipient does not offer an attractive menu for those with an appetite for profit. In addition, policy is essential so that the planned intervention can be strengthened with sanctions when necessary. Therefore, the ministry of health or the highest level public health authority in the country is responsible for the planning and execution of public health services. Often it also requires cooperation with other government institutions and relevant civil society.

In clinical medicine, laboratory tests and imaging methods are used for diagnosis and medicine or surgery comes to the fore in treatment, while public health uses epidemiology and biostatistics in diagnosis, and health education, health promotion programs and facilities of health systems in treatment. It takes a holistic view to human health. Beyond seeing health together with its bio-psycho-social components, it focuses on the concept of 'single health', the importance of which we understand much better today, that human health cannot be considered apart from the environment/planet and animal health. Let's not forget, the health of our planet has never been more endangered than it is today; the global climate crisis and the dramatic increase in zoonoses are the two main indicators.

It is worth underlining that it has a deep philosophy that makes this discipline discrete and special from other fields. It is shaped on a philosophical basis that prioritizes social equality, evaluates the individual with one's environment, understands life in its entirety, takes into account social factors, prioritizes risk groups, creates channels for the participation of stakeholders in decisions related to him/herself, believes in integrated service/team service in healthcare services. The list

Photo: Özcan Yaman

can be extended further. Therefore, it is almost impossible to find a subject that cannot be under the responsibility of public health, and this opens up a great intellectual space for a thinking person. It emphasizes the social aspect of health. In fact, it is precisely for this reason that German pathologist Virchow, who with great insight stated that the main cause of the typhus epidemic that emerged in the region where he studied in the mid-1800s was the widespread poverty, unemployment and unhealthy environmental conditions, and said "medicine is a social science, and politics is majorly nothing but medicine" is considered to be one of the founders of public health. Being open to not only multi-disciplinary but also inter-disciplinary collaborations for the solutions of multi-layered health problems is an important part of its ethos.

> The bad break of public health is that if there is no natural or political disaster, if the sewage system is working properly, if there is no air or environmental pollution problem, if access to clean drinking water is OK, or the mother/infant/child death numbers are within acceptable limits, no one will even notice its existence, it will never be mentioned.

Everything seems fine so far; but not quite. The fate or great misfortune of public health is that if there is no natural or political disaster, if the sewage system is working, if there is no air or environmental pollution problem, if access to clean drinking water is unproblematic, or if mother/infant/child deaths are within acceptable limits nobody notices its existence, it is never mentioned. Public health becomes visible and talked about only when a concrete problem is encountered. It is most remembered in disease pandemics. And the main reason for this is epidemiology.

What is meant by epidemiology?

Epidemiology is the basic science field of public health. Although there was a special emphasis on epidemics/pandemics in its old definition, it is not limited to infectious diseases in its current definition, and it became a branch of science that examines the distribution and determinants of disease, accidents or any health problem in a society and practices for the control of health problems. To this end, it pursues, analyses, interprets continuous and systematic information (primarily surveillance data) and shares the result with the parties. Although chronic and degenerative diseases are becoming more and more prominent in terms of disease burden, the control of infectious diseases, especially their epidemics, is one of the problems that still remains to be important in terms of epidemiology.

Four elements in epidemic control

As can be easily predicted, public health has the most important expertise in methods to control the epidemic. There is a simple fact consistently underlined since March 11, 2020, when the first Covid-19 case was reported in Turkey: The pandemic can only be controlled in the field. Of course, the country's

Photo: Burcu Yürüyen

hospital and laboratory infrastructure, health manpower, intensive care bed capacity and the number of ventilators, medical imaging technologies and clinical expertise are critical in terms of rapid diagnosis and treatment of patients. However, in order to control the epidemic without pushing the limits of the health system by reducing the number of new cases, public health prescription that can be summarized as foursome prescription is needed: Testing, Contact Tracking, Isolation and Treatment (even recently, attention has been drawn to the need to add a fifth element to this list, in line with the nature of the situation: Basic income support). In countries that have managed to control the epidemic at the national level, widespread testing practices supported by mobile test centres, contact tracing requiring the use of electronic codes when necessary, strict isolation measures/mobility restrictions that sometimes reach the level of quarantine and starting treatment as early as possible are the determining factors.

Where did we go wrong?

If we are to evaluate the pros and cons critically, it would be much better to start with the pros, that is, what we did right. The first thing that comes to mind in this case is: Turkey had an influenza pandemic plan before the Covid-19 pandemic. Therefore, we can say that the country was 'relatively' prepared for the pandemic. Moreover, at the beginning of the outbreak of the new type of coronavirus, in the days it started to be mentioned, when there was no case yet in Turkey, a Scientific Advisory Board was formed. Although it is mainly composed of clinicians and there is only one public health professional among them, the existence of a scientific board gave confidence to the society. Especially at the beginning of the pandemic, the cool-down attitude and decisive statements of the Minister of Health are also to be mentioned.

The country's health services organization, health institutions serving both in primary, secondary and tertiary levels, hospital and intensive care bed capacity, technology and laboratory infrastructure, especially advanced imaging methods, and health manpower were sufficient. And on top of all these, if we add the healthcare staff who are already accustomed to working overtime (even superhuman) in their daily routine, we can say that they were strong against the pandemic. It is quite ironic, but just remembering that we are the only country in the world that has almost twice as many emergency service applications of its population every year, medical ER staff working in hospitals that have been declared as the pandemic hospitals, may have even felt themselves in a boutique holiday environment in the first months.

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Although there were difficulties in accessing pneumonia and influenza

vaccines that were recommended especially for risk groups, the medications used in treatment were always adequate and accessible. Protocols and algorithms for diagnosis-treatment and contact tracking have been updated in line with scientific developments. It was expressed in many different media, especially mass communication channels, that masks, distance and hand hygiene are critical in individual protection. These are the things that are done well.

Unfortunately, many mistakes were made during this period. We can start with the ones that became controversial over time, although they were included in the list of what we did well at the beginning: the existence of a pandemic preparedness plan, the establishment of a scientific advisory board and the attitude of the Minister of Health. If we were truly prepared for the pandemic, we would not have to wait and waste time for all PCR results of a country of 80 million from the only one reference laboratory in Ankara at the beginning and only six reference laboratories at the end of the first month. First of all, it should not be so difficult to procure the most basic personal protective equipment (PPE) to protect healthcare staff, so dozens of healthcare staff would not get infected or die simply because of the lack of PPE. At this point, the mask deserves a special emphasis. You remember, for the first few months, accessing a simple surgical mask was difficult enough to deserve to be covered in a separate article, complex and sometimes absurd, and was subject to a social black humour.

Over time, the Scientific Board became the Scientific Advisory Board, and then different boards emerged, some of which the purpose they served for was not fully understood. Although the executive institution is the ministry of health, we could not learn how decisions were made in the Scientific Board, which members agreed with which decisions, which decisions were taken with the recommendation and/or agreement of the scientific board. However, as time passed, we were able to learn that many decisions taken were also a 'surprise' to the board members. Of course, the fact that no resignation has been recorded from a board with such great influence is quite informative in terms of showing how sociology of science is intertwined with political sociology.

A similar situation is valid for the Minister of Health. The minister, whose name was mentioned among the most trusted politicians at the beginning of the pandemic, came to the agenda with a series of statements that made public think that his power was 'only to a certain extent'. We understood that the claims of the Turkish Medical Association since the beginning of the pandemic that "the official cases and death numbers do not reflect the truth" were correct, both from the 'case/patient' distinction he himself expressed, and from published international articles, including the Ministry of Health bureaucrats. These articles were hurriedly withdrawn from the magazines on the grounds that they were published 'erroneously'.

Despite the persistent calls from both public health professionals and different professional organizations and chambers, the Ministry of Health continued its determination not to disclose basic epidemiological data on the state of the epidemic in the country. Even worse, it subjected any research on COVID-19 to the ministry's authorization, totally against the principle of scientific autonomy; and scientists who wanted to conduct research could not even apply for an ethics committee without this permission. The scientists objected to this situation with an article on The Lancet, and the health minister

Photo: Ayşegül Yılmaz

Photo: Yahya Koçaoğlu

personally responded to this objection with a letter again on The Lancet, and in fact claimed that the country's lands were very libertarian and fertile for science. Obviously, there was a big difference in country perceptions just like it was the case in the patient/case distinction.

Filiation, contact tracking to be more precise, started late. As the number of cases increased beyond the officially reported figures, the teams could not reach the patients and their contacts, and therefore more and more manpower was needed every day. The news spread that employees from irrelevant sectors such as tea makers or tin workers were also employed in the filiation teams. Provincial pandemic boards were also formed late and were ineffective in prioritizing specific cities. Meanwhile, local governments formed their own pandemic monitoring boards and published their data on a regular basis. It was noticed that the number of deaths announced by the municipalities were much higher than the official data announced. On the other hand, an investigation has been launched against scientists who are critical of the official data, are the only source of information available and try to explain on the basis of evidence that the data in the 'turquoise table', which has been changed several times to make it even more difficult to understand, do not reflect the true extent of the situation and warn the public. The most basic social responsibility of the scientist was interpreted as 'not to provoke the public into panic'. Today we are still far from understanding where we are in the epidemic.

While various measures were taken to limit mass mobility in the beginning, the

total abolition of all public measures on June 1, 2020 as if an effective vaccine or medicine was found or the epidemic was brought under control, created a great relaxation on the society. Each individual was expected to fill the void of public authority by taking responsibility. With this emphasis, calls were made constantly. And the uncontrolled growth of the epidemic has been reduced to individual irresponsibility; it was described as thoughtlessness or imprudence, it was condemned. The responsibility was on 'oh those ignorant people'!

Individuals were expected to fill the gap of public authority by taking the responsibility. With this emphasis, calls were made constantly. And the uncontrolled growth of the epidemic has been reduced to individual irresponsibility; it was described as thoughtlessness or imprudence, and it was condemned. The responsibility was on 'oh those ignorant people'!

Healthcare staff paid the most for the pandemic getting out of control. The applause and respect they received at the beginning of the pandemic gave way to indifference at best. They were afraid of infecting both themselves and their loved ones. They tried to stay away from their relatives, to isolate themselves. Moreover, although they were among the main risk groups, they did not have the chance to access the tests as much as legislators, employees of the palace or football players. They have been blamed for mismanagement. They had to work continuously without rest. Staff in the field faced with resistance, the filiation teams extended their shifts until midnight to catch up with patients, those who had contact with patients were faced with discrimination, most of the promised supplementary payments were not made, their right to leave and resign was taken away. They became sick, they died, they said "you cannot manage, we are exhausted", they were not heard. COVID-19 was not considered an occupational disease for healthcare workers. Every day, news of a new patient or death comes from medical staff; they are getting more and more exhausted.

These are roughly the first to come to mind. The list can be extended, but the summary is: The pandemic management started relatively well, but currently, things are out of control. As this text was being put down on paper, Turkey seemed to move to the strategy of de *facto* herd immunity. Unfortunately, we will see the results together.

The invisibility of fragile groups

There is also this 'virus romance' issue; in other words, the myth that SARS-CoV-2 is democratic or equidistant to everyone without any discrimination. However, let alone that the virus affects everyone in the same way, it has clarified existing inequalities and increased vulnerabilities. The epidemic created new fault lines in social life, and the elderly, women and girls, labourers and LGBTI+ suffered the most from it. New problems intertwined with existing inequalities and became deeper. Moreover, the effect of the epidemic on these groups seems to last much longer than the pandemic itself.

Undoubtedly, the most vulnerable group in the epidemic was the elderly, and it continues to be so. As the only country in the world that has secluded the population over the age of 65 for months and reset their social interactions, we risked both their physical health and their mental and emotional health. Due to the ratio to the total population and cultural characteristics of the population such issues like nursing homes becoming almost like a morgue, or 'peaceful death protocols' did not come up for the 65+ group in Turkey. However, the perception that causes them to be seen as a source of infection rather than the risk group and their exclusion from the public sphere paved the way for ageist discourses, they were coded as dependent and needy, they were ridiculed, abused, discriminated, and felt worthless. They were confused even about continuing their existing treatments for a long time, and they could not apply to health institutions out of fear, although they needed it. Disconnection from the outside life, has set the basis for a range of health problems especially sarcopenia (decrease in muscle function, strength and mass) leading to falls and home accidents; social isolation resulting in increased stress, anxiety and depression; the decrease in external stimuli paving the way to dementia, impaired cognitive functions, sleep problems and, in more advanced cases, suicidal tendencies. Some people went so far as to compare them with "vintage cars" or to say "most of those who died from the corona had one foot in a grave." These

Photo: Özcan Yaman

marginalizing practices aimed at elderly people, who we can see as the carriers of the collective memory of societies, will undoubtedly be subject to more discussion in the future.

Women and girls had to undertake a double or even triple burden throughout the epidemic. Unpaid domestic labour increased dramatically, especially during periods of lockdown. With the closure of nursing institutions, day care centres and schools, they had to undertake all care work: children, the elderly, the disabled, and sick care. Apart from being unpaid labour, patient care also brought the risk of domestic contamination. Girls also had to do the household work, their education was interrupted. Women in business life were among the first to lose their jobs because they worked more in unrecorded jobs without even the most basic social security. The home and professional lives of those working in formal jobs were intertwined, especially the healthcare professionals working both non-stop and on the front lines. Life squeezed into homes increased male violence and abuse on the one hand, legal remedies and legal mechanisms were operated less on the other hand, and the situation of shelter homes became uncertain. Hospitals' turning to priority services only and the fear of applying created problems in accessing sexual and reproductive health services; contraceptive methods, termination of unwanted pregnancies, pregnancy care services and treatment services for problems arising from the reproductive system were disrupted. On top of that, let alone special 'support' programs, the women of this country have struggled not to lose their acquired rights even while going through such a period. In a country where violence against women reached a level of *femicide* women did not give up on the Istanbul Convention, despite the government that seemed to have already given up on them.

While teleworking is a luxury limited to certain sectors and certain occupational groups, such an option has never existed for the majority of the working population, especially blue-collar workers. As the country's administration kept economic priorities above public health, it was claimed that the 'class immunity' strategy was actually adopted in the fight against the epidemic. We have witnessed the news about those who became ill collectively in large workplaces, those who were forced to continue working sickly, those who continued to work without the simplest personal protective equipment, those who were imprisoned in the factories they worked, and those who were dismissed because they were sick even though they were dismissed illegally. When considering the geographical distribution of the cases, it turns out that the regions with the highest number of cases are the districts where the workers live the most. In short, hundreds of thousands of workers were forced to make a choice between their health and their jobs in order to survive.

LGBTI+, who were already among the first vulnerable groups that came to mind before the epidemic, had to survive increasingly difficult living and working conditions, diseases that weaken the immune system and make them more vulnerable to COVID-19, since many health services they need were postponed and restricted or stopped because they were not considered 'necessary'. They were scapegoated about the epidemic, became the subject of hate speech statements, and were stigmatized. Cohabitation at home became difficult, they were subject to pressure, violence and abuse, and their access to support mechanisms became difficult. The budgets of a handful of non-governmental organizations working in line with the needs of these groups by breaking the heteronormativity moulds have shrunk, and their chances of accessing the already limited few health services that are offered considering LGBTI+ priorities have weakened. This community, which has already limited options in terms of participation in economic life, was disproportionately affected by the fluctuations in employment during the pandemic, and was among first to lose their jobs. As the epidemic progressed without touching

the small lucky few, the existence of groups that were not 'welcome' and their needs were unseen.

Will this epidemic end one day?

The answer to the question is 'yes, this epidemic will surely end one day', but the epidemics will never end. We are in a period in which we can talk about an effective vaccine, even vaccines. It will soon be widely implemented. Specific treatment options that target the virus are also promising. However, the global capitalism paradigm that made these epidemics possible will not change from today to tomorrow. William H. Stewart said in 1967, "It is time to close the infectious diseases book, declare victory over the epidemics [...] More than 40 new pathogens have entered our lives since the day" (even causing the SARS and MERS pandemics of our recent past, are also from the coronavirus family). Old diseases reappeared or appeared in new forms; some diseases also began to affect regions where they never existed before. In short, dozens of disease epidemics have occurred since that day. The reasons are various: The global climate crisis, the speed of globalization, the rapidly increasing and aging population of the world, crowded cities, unplanned urbanization, deforestation, unplanned dam construction, natural and political disasters, increasing antibiotic resistance, the spread of industrial agriculture are among the top ones. But there is another reason that is even more critical: increased human-animal interaction. The more destroying and damaging nature, the more animals are beginning to live outside of their natural habitats. Every day, humans come into contact with more and more wild or domesticated animals.

Considering that approximately 75 per cent of new and re-emerging infections in the world, like COVID-19, are of zoonotic origin (passing from animals to humans), we can say that the relationship we establish with animals determines our health. As is known, coronaviruses have been in our lives before; in fact, SARS-CoV-2 is the seventh coronavirus passed from animal to human. This new type of virus passed on to humans from bats (the intermediate host is thought to be an anteater). The source is a wild animal market in Wuhan, China. The Chinese culturally consume animals such as snakes, dogs, bamboo rats, as well as many wild game animals. Likewise, many different animals are included in the culinary culture of many different geographies. In a world where there are people who have broken the skull of a living monkey and whose brains do not see a problem in eating the animal while it is alive, the country names are not very distinctive. I feel like I can see you grimace. How a person eats dog meat, right? Live monkey? What about a bat? Oh my God!

Adorno, one of the most important thinkers of not only the Frankfurt School, but of all times, said, "Auschwitz begins when a person looks at a slaughterhouse and thinks, 'but they are animals.' Adorno is referred to in many subjects, but his awesome aphorism is hardly known. Do you know why? Because we tend to deny the issues we are afraid of confronting. What we hear is immediately erased from memories. And it takes courage to face it. So let's face it. As long as we say "but they are animals," we will continue to go out on the streets saying "black lives matter." Because for white people "But they are…" Men will go on killing women as long as we say "But they are animals." Because for men, as long as we say "but they…" "But they are animals", those with different sexual orientations will continue to be the subject of hate speech. "But they…" As long as we say "But they are animals," the refugees will continue to do the dirtiest work, to the fullest, because for the local people "but they..." That 'but' means so much.

Let's not lose our focus and go back to our main issue. For one reason or another, we kill animals for food, but be sure they are killing us too. Moreover, not only with acute disease epidemics like today, but also with chronic diseases that we see the effects over time. We harm animals today, but the damage they cause often spreads over time. We are dying slowly. Plaques clogging our heart vessels, cancer in our intestines, uric acid accumulating in our joints and kidneys…

Not only do we end the lives of animals, we often torture them to kill, but we never confront with this brutality. In fact, by alienating them, we call dead animals 'carcasses', not corpses, and we define their deaths as 'destroyed' in order to ease our consciences. Let's not forget, we establish our connection with the outside world and things through language. The language we use determines our symbolic universe, who we are and where we stand. There is even more to it; we are not only killing animals, but nature also dies around the farms where animals live collectively as well as the people living around. In short, we destroy an entire ecosystem, our own future, with industrial animal farming. If we go back to the beginning, we create our own hell in this world, we start Auschwitz.

> There's also the 'virus romance' issue. In other words, the myth that SARS-CoV-2 is democratic or equidistant to everyone without any discrimination. However, let alone that the virus affects everyone in the same way, it has clarified the existing inequalities and increased vulnerabilities.

'Discard your old normals' or is another world possible?

Honestly, I'm not too optimistic. However, if there is another way, it is certain that the starting point will occur in our collective minds one by one. If we can tidy up our own micro-universes before we become followers of grand narratives and self-evident ideologies, if we can initiate change from ourselves...

If another world is possible, I believe we should start by confronting our speciesism, our hypocritical love of animals, what we bring to the table for the sake of food, what we put on our plate. If this happens, our souls will be healed first. A fairer, more compassionate existence will be possible. And over time, our bodies, environment, nature and societies will improve.

We will definitely control COVID-19 one day; the main thing is to be able to control our 'appetite'.

MINISTRIES OF EDUCATION, HEALTH AND INTERIOR, AND THE DIRECTORATE OF RELIGIOUS AFFAIRS DURING THE COVID-19 PANDEMIC

The conditions of the pandemic lead to a stronger questioning of the state giving priority to the basic needs of the citizens in Turkey, just like in other countries around the world. Cafer Solgun is looking for the answer to this question with reference to the data of the comprehensive report he wrote on behalf of the Citizens' Assembly, which will be published in March 2021. Eventually he demonstrates in detail that the political and ideological priorities of the governing executives in Turkey are ahead of the citizens' genuine needs and demands.

In the summer of 2020, as the COVID-19 pandemic and the discussions of "will there be a second wave?" continued, the Minister of Education, Ziya Selçuk, made statements in the press conference he held on issues about education. One issue came to the fore in Selçuk's statements: According to Minister Selçuk, teachers' salaries were a 'burden' and it was for this reason that they could not invest. Selçuk's statement on the issue that sparked a debate at the press conference held on 29 August 2020 was as follows:

> The real burden on the education budget is related to the salary of the teachers. When you consider the budget of the Ministry of Education, you will find out that the invested budget is very little. When compared to what? To the staff salary. This is the case for all schools. In other words, the real burden is rent when rent is the case, and the salary of the teachers.[1]

Selçuk's statements reminded Emrullah Efendi's statement, who was the Minister of Education during the reign of Abdülhamit II: "How well I would manage education if there were no schools." Following the reactions, the Minister of Education made a new statement on 31 August 2020, two days after this statement, "I cannot have any other goal but the improvement of our teachers' reputation and personal rights. "If such a conclusion is drawn here, it is a strained interpretation," he said.[2] However, it could not be understood which criticism he saw as 'strained' instead of correcting his words, where Selçuk pointed out the "burden" of teachers' salaries as the "justification" of their inability to make new investments in education.

Taking this opportunity to understand the issues of the Ministry of Education better and more accurately, looking at some data and comparing it with the data of the Ministry of Health, the Ministry of Interior and the Directorate of Religious Affairs may allow us to see the current picture from a wider perspective. Undoubtedly, these ministries and the Religious Affairs did not come to the fore accidentally. Apparently, the Ministry of National Education (MEB), as it is called, is a ministry directly related and responsible for a basic field such as education. The Ministry of Health is a ministry whose work becomes even more important due to the COVID-19 epidemic and we listen to its statements and warnings almost every day, we wonder about its work with criticism, we follow it, and we remember that it has a vital responsibility like public health. The Ministry of Interior is a ministry that has responsibility in a fundamental area such as security. The Directorate of Religious Affairs (DIB), on the other hand, is an institution that works as a public institution and its budget is growing exponentially every year, especially with the AKP governments, and it is an institution that attracts attention once again during the pandemic period.

All four institutions have 'common' features that directly affect our daily lives. We will have the opportunity to make an objective and healthier comparison with the results derived in the light of the data obtained from official sources on how they fulfil their duties and responsibilities with what they do, responsibilities and aspects affecting the society, to what extent they form a "weight" in our daily lives with their budget, personnel and investments, the results obtained when compared with the real situation in other countries.

National Education statistics and the issues they revealed

National Education Statistics announced by the Ministry of National Education: According to the Formal Education 2019-2020 data, there are 18,241,881 students in total in Turkey, including pre-school,

Photo: Burcu Yürüyen

primary and secondary levels in all public and private schools. The total number of teachers is 1,117,686. Educational activities are held in 68,589 schools. There are a total of 18,241,881 students in Turkey, at preschool, primary and the secondary level education. 15,189,878 of them study at public, 1,468,198 at private and 1,583,805 study at open education institutions. 7,781,791 of those studying at public schools are male and 7,408,087 are female students. 804,170 boys and 664,028 girls are educated in private schools. 849,039 of the active students enrolled in open education are boys, 734,766 are girls.

1,629,720 of the students in public education are in preschool, 5,279,945 in primary school, 5,701,564 in secondary school, 5,630,652 in secondary education. Of the 5,630,652 students in secondary education, 3,412,564 are educated in common high schools, 1,608,081 in vocational and technical high schools, and 610,007 in imam hatip high schools. According to the Ministry of National Education data, the rate of students in private education institutions in total formal education is 8.8 per cent. This rate is 17.7 per cent for preschool education, 5.2 per cent for primary school, 6.3 per cent for secondary school, and 13.1 per cent for secondary education. Schooling rates for the 2019-2020 academic year are also included in the statistics. The net enrolment rate at age 5 in preschool education is 71.22 per cent. Net enrolment rates were recorded as 93.62 per cent in primary school, 95.90 per cent in secondary school and 85.01 per cent in secondary education.[3]

While the number of teachers working in formal education institutions was 1,117,686 in the 2019-2020 academic year, 942,936 of these teachers were employed in public schools and 174,750 in private schools. 56,218 of the teachers are employed in preschool education, 309,247 in primary school, 371,590 in secondary school, 380,631 in secondary education. In formal education, there are a total of 68,589 schools, of which 54,715 are public schools, 13,870 private schools and 4 open education schools. 11,485 of these schools are in pre-school education, 24,790 in primary school, 19,268 in secondary school and 13,046 in secondary education. There are 588,010 classrooms in public schools and 139,337 in private schools, with a total of 727,347 classrooms in formal education.

A closer look at the data of the Ministry of National Education reveals many thought-provoking negativities in this area. While the net enrolment rate in pre-school education is 71 per cent, this rate is 93 per cent in primary school, 95 per cent in secondary school, and 85 per cent in secondary education. These rates show that although primary, secondary and high schools are within the scope of compulsory education, thousands of children are excluded from the educational course. Where and what they are doing is unknown.

Another thought-provoking data is about the number of students in open education. While the number of students in vocational and technical education of open high schools is decreasing, the number of students in open secondary schools has increased. The number of those studying in open secondary schools seems to have increased by 32,884 in 2020 compared to the previous year. The exclusion of these children from formal education is a problem that ministry officials should seriously think about and find solutions.

The rate of students in private education institutions in total formal education is 8.8 per cent. This rate is 17.7 per cent for pre-primary education, 5.2 per cent for primary school, 6.3 per cent for secondary school, and 13.1 per cent for secondary education. The striking thing about it is that the number of private secondary education institutions, which is 3,176, surpasses the number of "formal general secondary education", which is 3,065. The criticisms of "commercialization" and "marketization" of education, which are among the basic responsibilities of being a state, gain a more serious meaning with these data. On the other hand, although the number of private schools has increased as a result of the Ministry's policy of incentives for private schools, there is a decrease in the number of students. While the data reveals that the number of students studying in private high schools has decreased by 25,911, the most obvious result of this situation is that private schools are in a difficult turn in terms of economy, with the effect of pandemic conditions.

Of the 1,117,686 teachers employed in formal education institutions in the 2019-2020 academic year 942,936 are employed in public schools and 174,750 in private schools. The number of contracted teachers employed within the ministry increased to 101,730. This became a matter of criticism and anxiety for permanent teachers.

Another data that needs to be recorded is that despite all the encouragement of the ruling party and the Ministry of National Education, the number of students in imam hatip high schools continued to decrease in the 2019-2020 academic year. While the number of students in imam hatip high schools decreased by 2,343 compared to the previous year, the increase in general high schools was 198,530. With 27 new imam hatip high schools opened in a year, the number of students per imam hatip high school decreased to 153, while the number of students per general high school was 525.

MEB's 'burden', staff salaries and education investments

As of July 2020, 'increased' teacher salaries according to their seniority and degrees are as follows:[4]

Seniority Year	Degree/ Level	Monthly Net Salary
1/1	25 and +	4,958 TL
1/4	24	4,956 TL
1/3	23	4,947 TL
1/2	22	4,939 TL
1/1	21	4,930 TL
2/3	20	4,836 TL
2/2	19	4,828 TL
2/1	18	4,820 TL
3/3	17	4,736 TL
3/2	16	4,729 TL
3/1	15	4,722 TL
4/3	14	4,662 TL
4/2	13	4,657 TL
4/1	12	4,651 TL
5/3	11	4,454 TL
5/2	10	4,449 TL
5/1	9	4,443 TL
6/3	8	4,427 TL
6/2	7	4,415 TL
6/1	6	4,417 TL
7/3	5	4,380 TL
7/2	4	4,375 TL
7/1	3	4,372 TL
8/1	3	4,361 TL
9/3	2	4,308 TL
9/2	1	4,304 TL
9/1	0	4,301 TL

While the budget of the Ministry of Education was 113 billion 813 million TL in 2019, the budget for the year 2020 was 125 billion 397 million TL. Accordingly, the share the Ministry of Education gets from the budget increases in numbers. However, the education expert writer Abbas Güçlü points out that the ratio of the MEB budget to the central government budget was 11.84 per cent in 2019, but this rate decreased to 11.45 per cent in 2020. After mentioning this in an analysis in which Abbas Güçlü examined the issue, he also came up with other remarkable findings:

- The ratio of the education budget to national income is way below the OECD average of 6 per cent.
- 73 per cent of the MEB budget goes to personnel and 11 per cent to social security state contributions.
- While the share allocated by the MEB to education investments was 17.18 per cent in 2002, this figure declined to 4.57 per cent in 2009. The budget allocated to education investments, which increased partially after 4 + 4 + 4, started to decrease again after 2014. In 2019, the share allocated to education investments by the Ministry of National Education was 4.88 per cent, in 2020, this rate was further reduced to 4.65 per cent.
- Education is an untransferable and inalienable public right. As shown by various studies in this field, as the paid education practices become widespread in public schools, the share they have to allocate to education expenditures within the income segment of the lowest 20 per cent increases. The mentioned increase can only be met by reducing food and health expenditures.[5]

With these findings, it appears that Minister Selçuk's statements are not very coincidental. However, the misconception here is that the salaries of the personnel working in a basic field such as education and the investments that need to be made are opposed to each other. Since "education" cannot be carried out without educators, it is a political preference issue that the necessary share is not allocated to the necessary investments while setting the budget. On the contrary, this share gradually decreases over the years.

Teachers' salaries and investment in education are constantly on the decline

The Education and Science Workers Union (Eğitim Sen) came up with some findings about teachers' salaries in the report announced to the public after the 2020 budget was announced.

According to this; on October 15, 2009, when US $ 1 was 1.56 TL on average, a teacher could get 898 US dollars with a monthly salary of 302 TL, while a teacher who received 3,895 TL on 15 October 2019 got US $ 660 (1 $ = 5,90 TL). Based on the last 10 years, the monthly loss on a 9/1 grade teacher's salary was $ 238. On October 15, 2009, a teacher could buy 15 quarters of gold with his salary, ten years later he can only buy 8 quarters of gold with the same teacher salary. Considering that the Turkish lira lost value during the fluctuation in exchange rates in 2020 in an unprecedented way, it should be seen in this comparison of Eğitim Sen that there is a great regression against teachers in dollars.

According to the findings of Eğitim Sen, education investments of the Ministry of Education have been declining systematically since 2002 until today. While education investments were 17.18 per cent in the MEB budget in 2002, this rate declined to 6.64 per cent in 2012 and 4.65 per cent in 2020 after 10 years. While this rate corresponds to 5 billion 830 million TL, it should be noted that the Directorate of Religious Affairs' budget is 11 billion 520 million TL.[6]

The number of teachers per person

Minister of National Education Ziya Selçuk, in his presentation at the Turkish Grand National Assembly Plan and Budget Committee, stated the following regarding this issue: "We have 946,114 teachers working in formal educational institutions affiliated to our Ministry. The number of students per teacher is 16 in primary education and 11 in secondary education." In the same speech, Minister Selçuk stated that the number of students per classroom in primary education is 24.[7]

Since 'education' cannot be carried out without educators, it is a political choice not allocating the necessary budget for the necessary investments, on the contrary decreasing this share gradually over the years.

At the beginning of the 2019-2020 academic year, Egitim Sen, in its report mentioned above which drew attention to the problems in the field of education, listed the compulsory schooling needs of students as follows:

It was stated in the report that "The ratio of spending on education in Turkey is less than half the OECD average, Turkey remains to be among the countries spending least on education among OECD countries after Mexico". It was also indicated in the same report that the average of OECD for the proportion of education spending from public sources at primary and secondary levels is 90, and that of households and private sources is 9 per cent. In Turkey the proportion of public sources is 75 per cent, and the proportion of households and private sources is 25 per cent.

Item	Monthly Inflation Rate	Annual Inflation Rate	Change in Purchasing Power
Juvenile books	0.35%	14.90%	0.09%
Exam preparation books	1.23%	16.30%	-1.12%
Writing & drawing paper	-1.71%	16.64%	-1.42%
School bag	3.43%	18.20%	-2.77%
Misc. stationery items	1.41%	30.51%	-13.48
Paints	1.80%	33.11%	-15.74%
Notebooks	1.80%	33.73%	-16.28%
Pens and pencils	1.99%	34.75%	-17.17%

The report includes the following information on the expenditures of countries per student according to the levels in the OECD's Education at a Glance Report 2018:

> The average of OECD countries is 8,759 in preschool education, 8,631 in primary education, 10,010 in secondary education and in university15,656 USD. Considering the same spending in Turkey Education Expenditures 2017 published by Turkish Statistical Institute to compare; it is 2005 USD in preschool education, 1591 in primary education, 2395 in secondary education, and 3736 USD in university. The difference between other OECD countries and Turkey regarding the expenditure according to levels is increasing further, let alone decreasing.

Another remarkable issue in the report is the General Directorate of Religious Education. According to the Eğitim Sen report, although this general directorate is affiliated with the Ministry of National Education, "it has begun to act as an institution that is largely independent from the ministry and even above MEB with some policies and practices." Continuing, it is stated that imam hatip schools have a privileged and special place among the schools affiliated to the ministry.[8]

The Ministry of Health statistics

The global COVID-19 pandemic has naturally and inevitably made the state of the health system and its functioning one of the priority agendas of people in all countries. To make a generalization based on the process experienced, it has been observed that few countries, including the countries considered 'developed' in the world, have the capacity to bear with such an epidemic.

Health Minister Fahrettin Koca, in the coronavirus information note he gave in the Turkish Grand National Assembly on March 19, 2020, referred to the data on the number of intensive care beds per 100 thousand people by countries. Minister Koca noted in his statement that there are 40 intensive care beds per 100 thousand persons in Turkey.

This data is taken from an article on *Statista,* published on March 12, 2020, however most of them are out of date.

This is how it looks on a chart when compared to other countries:

As stated in the article, the number of intensive care beds in Germany and Italy are 2012 figures; they are 2015 statistics for the USA, and 2017 data for South Korea, China and India.

According to OECD data of 2017, South Korea ranks the first in the number of hospitals per 1 million people with 77.55. Japan with 66.39 and France with 45.55 follow South Korea. Turkey ranks # 23 out of 31 countries with 19 hospitals per 1 million people.

The OECD also announces the proportion of governments of the countries' compulsory health expenditures in the gross domestic product (GDP). When the ratio of government expenditure in GDP allocated for health in Turkey is considered, it ranks second to last among the 36 countries with 3.3 per cent.[9]

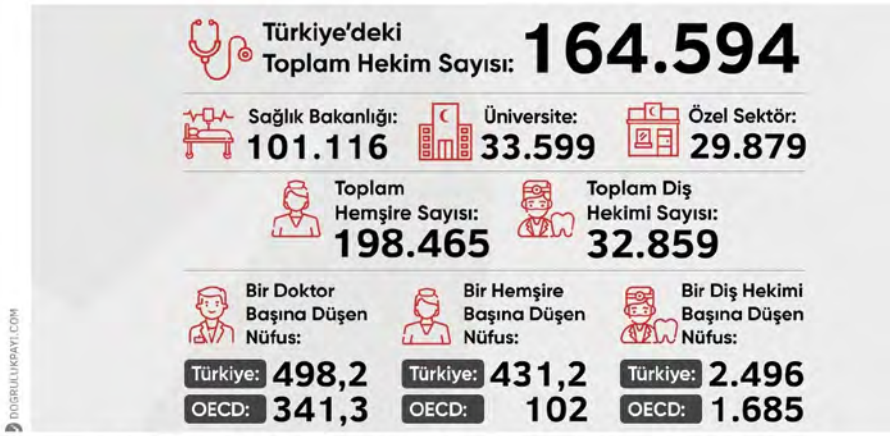
The number of healthcare workers

According to the Health Minister Fahrettin Koca's statement on January 1, 2020, responding to the question

brought up by CHP deputy Mahmut Tanal in parliament in Turkey, the number of physicians affiliated to the Ministry of Health is 101,116, while the total number of physicians is 164,594. This table contains the details of the figures as follows:

It is possible to reach the OECD healthcare data to compare with Turkey's

OECD also reports the ratio of the governments' compulsory health expenditures in the gross domestic product (GDP). When the proportion of the government expenditure allocated in health to GDP is considered in Turkey, it ranks second to last among the 36 countries with 3.3 per cent. Mexico ranks the last with 2.8 per cent.



*01.01.2020 itibarıyla (Sağlık Bakanı Fahrettin Koca'nın Mahmut Tanal'ın soru önergesine yanıtından)

data of Koca's statement. Accordingly, the number of people per doctor in Turkey is 498.2. In OECD countries, the average figure is 341.3. Turkey falls further back in the number of nurses per person: while the number of people per nurse is 431.2 in Turkey, the average of OECD is 102.

The salaries of the healthcare professionals

Doctors and nurses constitute the most important part of the healthcare personnel. The floating capital income is an important item for healthcare professionals. Healthcare personnel received a 4 per cent increase in the first six months of the year and 4 per cent in the second period of the year, effective from January 2020, within the scope of the 5th term collective agreement.

The data of *Kamu Ajansı* regarding the salaries of healthcare professionals is as follows:[10]

Undergraduate Contract Health Personnel (salary + fixed)	4,335 TL
Associate Degree Graduate Contract Health Personnel (salary + fixed)	4,150 TL
Secondary Education Graduate Contract Health Personnel (salary + fixed)	4,010 TL
Health Technician and Health Officer - Undergraduate Graduate	3,820 TL
Nurse salary	5,420 TL
Midwife salary (1/4)	5,420 TL
Midwife salary (8/1)	4,800 TL
Assistant (Health services-6/1)	6,300 TL

Is it the number of cases or the number of patients?

As known, Health Minister Fahrettin Koca has been sharing daily data and warning about the mask, distance and hygiene rules regularly since day one of the epidemic. The Scientific Board established within the Ministry also convenes regularly, and although the meeting minutes are not made public, it probably evaluates the course of the epidemic and advises the government on the measures to be taken.

The statement made by Minister Koca after the Scientific Board meeting on October 1, 2020, was greeted with astonishment by the public, unlike his previous 'routine' statements. Because what Koca said about the data announced almost supported the citizens who think that "the real numbers are not disclosed", he stated that the number of patients on the daily chart is not the total number of COVID positive cases per day, it only reflects the patients who have symptoms: "Not every case is sick. Because there are those who show no symptoms even though their test is positive. These are the vast majority. Our filiation teams predominantly detect them. " These words revealed that the daily number of cases was 20 times higher than the number of patients announced.

There was serious backlash against this approach, including some Science Board members. The fact that Minister Koca put "national interests" before public

health was quite thought-provoking in terms of revealing the understanding that the state was based on in combating the coronavirus epidemic, probably due to economic concerns.[11]

The Ministry of Interior data

The first thing that comes to mind about Ministry of Interior is 'security' and 'police organization', and this is quite natural since we are a country where 'terrorism' and 'security' issues are constantly on the agenda. It is not an exaggeration to say that it is one of the most 'active' ministries because of this feature. With the affiliation of the Gendarmerie General Command within the Turkish Armed Forces to the Ministry of Interior, the 'weight' of the ministry increased even more.

The police organization has a staff of 323,842 people according to data at the end of 2019. It serves 79 per cent of the country's population. 307,813 of the police personnel consist of security services and 16,029 of them are other service categories. Of the security services category, 6.6 per cent are police chiefs, 86.4 per cent police officers, 7 per cent are bazaar and neighbourhood guards.

Within the police organization, as 1, 2, 3 and 4 classes, 3,528 police commissioners, 596 chief of police, 402 superintendents, 1932 commissars, 13,994 deputy police officers, 2,268 senior chief police officers, 2,126 chief police officers, 261,648 police officers, 21,319 bazaar and neighbourhood guards are on duty. 93 per cent of the police are men and 7 per cent are women.[12]

The number of police and gendarmes per person

According to the EU statistical agency Eurostat data, the number of police decreased by about 3.4 per cent and went down to 1.6 million since 2009 within the Union unlike Turkey. An average of 318 police / gendarmes work for every 100 thousand people in the EU. In Turkey however, considering 2018 data of the Gendarmerie General Command and General Directorate of Security, 540 police / gendarmes are on duty per 100 thousand people. While the number of personnel of the General Directorate of Security in the "Security Services class" was recorded as 187,510 as of December 2007; this number increased to 255,974 in 2018. This indicates that in the last 10 years, the number of police in Turkey (except gendarmerie) has increased by 36 per cent.

> As of December 2007, the number of staff of the General Directorate of Security in the "Security Services" category was recorded to be 187,510; this number increased to 255,974 in 2018. This shows that the number of police (except gendarmerie) in Turkey has increased by 36 per cent in the last 10 years.

According to the United Nations Drugs and Crime Office data, the number of staff in Turkey's gendarmerie in 2007 was approximately 140 thousand. It can be seen by the announcement of the Gendarmerie General Command in March 2018 that this figure increased to 176 thousand. Regarding the number of police per 100 thousand people, Southern Cyprus is the only EU country that is ahead of Turkey with 573 police.[13]

The constant increase in the number of security guards per person is often the subject of "laudatory" statements by government spokespersons. However, this 'record' increase in the number of police and gendarmerie is considered to be the opposite of being a 'development' indicator for a country and society.

Police salaries

There is a difference of about 10-15 per cent between a new police officer and a police officer with 25 years experience on the job. Accordingly, the salary of a police officer who has just started working in the police department (8/1) is 5,233 TL, and the salary of a senior police officer (1/4) who has completed 25 years in the service is around 5,954 TL.[14]

D/K	Seniority year	Net Salary (July 15, 2020)	
		Tax rate (15 per cent)	Tax rate (20 per cent)
1/4	25 +	5,995 TL	5,868 TL
1/4	24	5,992 TL	5,866 TL
1/4	23	5,990 TL	5,864 TL
1/4	22	5,988 TL	5,862 TL
1/4	21	5,986 TL	5,860 TL
1/3	20	5,977 TL	5,851 TL
1/2	19	5,968 TL	5,843 TL
1/1	18	5,960 TL	5,835 TL
2/3	17	5,864 TL	5,745 TL
2/2	16	5,856 TL	5,737 TL
2/1	15	5,848 TL	5,730 TL
3/3	14	5,835 TL	5,718 TL
3/2	13	5,828 TL	5,711 TL
3/1	12	5,721 TL	5,610 TL
4/3	11	5,659 TL	5,552 TL
4/2	10	5,653 TL	5,546 TL
4/1	9	5,647 TL	5,540 TL
5/3	8	5,505 TL	5,399 TL
5/2	7	5,499 TL	5,394 TL
5/1	6	5,493 TL	5,388 TL
6/3	5	5,477 TL	5,373 TL
6/2	4	5,472 TL	5,368 TL
6/1	3	5,467 TL	5,364 TL
7/1	3	5,427 TL	5,326 TL
8/3	2	5,418 TL	5,317 TL
8/2	1	5,273 TL	5,172 TL
8/1	0	5,269 TL	5,168 TL

The number of staff for General Command of Gendarmerie

According to the information in the Gendarmerie General Command's Annual Report of 2018, the number of personnel in the positions of gendarmerie, officer, non-commissioned officer, specialist sergeant and officers is 189,915. The number of personnel is as follows: 4,706 gendarmerie officers, 1,465 gendarmerie reserve officers, 29,261 gendarmerie non-commissioned officers, 17,711 gendarmerie specialist gendarmes, 69,779 gendarmerie specialist sergeants and 63,372 gendarme rank and file. Apart from these, there are also personnel with employee and civil servant status within the organization; however, their number is not disclosed.[15]

Salary of a newly appointed specialist sergeant varies between 4,600 lira and 4,950 lira, and the salary of the gendarmerie specialist sergeant in the East varies between 6,000 lira and 7,500 lira. Contractual salaries vary between 3,500 TL and 4,500 TL. The reason for the difference in salary rates is that it is determined according to the region of duty. Officer salaries can vary between 4 thousand TL and 8 thousand TL depending on the area of duty and rank. The salaries of the non-commissioned personnel vary between 4 thousand TL and 5 thousand 500 TL on average.[16]

The Reinforcements Unit

The Reinforcements Unit, which was first established in Ankara Gölbaşı by the Directorate of Security Department within the General Directorate of Security, was later established in the Ankara Police Department. Following the instruction of Interior Minister Süleyman Soylu, the process of establishing the same unit within the Istanbul Police Department was initiated. After the infrastructural procedures were completed, with the decree signed by President Erdoğan, the establishment of the unit in Istanbul became official.

Prior to the 2018 general elections, the Reinforcement Police Force Unit, which was established within the headquarters of the General Directorate of Security, takes part in the countrywide meetings of senior officials, primarily President Erdoğan. The police officers working for the unit, which consists of approximately 600 personnel in two separate groups, namely the Central and Ankara Police, are specially selected and trained from within the organization.

Reinforcement Ready Police Force trained for disaster and emergency, and aircraft intervention besides weapon training, are dispatched to their duty areas by private aircraft rented from Ankara aligned with the demands of the provincial police directorates, within the framework of election security activities. Reinforcement Ready Police Force independent from the Riot Police Force Branches, which have been operating in the police force for many years, will continue their activities in Istanbul from now on.

In addition to Istanbul and its surroundings, the police will be deployed to different regions if needed, and will also contribute to the security of Istanbul "when necessary". For example, Reinforcement Ready Police Force sent from Ankara were in charge of Hagia Sophia's security which was opened for worship.[17]

"This is Turkey, not Norway!"

The existing powers of the police defined by the Police Duties and Authority Law, which was first adopted in 1934, were expanded to an almost "unlimited" extent with the Internal Security Package, which came into effect after being published in the Official Gazette on April 4, 2015. It may be useful to briefly remind what kind of powers are given to security forces with this 'package' law, which caused public debate.

- The police can virtually search anybody they 'set eyes on' for any reason.
- The police were empowered to take statements from complainants, victims and witnesses at home and workplaces.
- Authority to use weapons has been expanded. Materials such as slingshots, iron balls, even flammable molotov cocktails and fireworks were included in the scope of weaponry and the police were authorized to use their weapons against them.
- Without the need for a judicial decision, 'monitoring calls' are authorized for 48 hours.
- Regulations were made to deactivate the right to assembly and demonstration; the security forces were allowed to act with extremely subjective measures that would prevent exercising these rights (An emblem seen on a demonstrator's clothing, demonstrators covering their faces, wearing gas masks to protect them from gas, etc.).
- Citizens can be detained without any prosecutor's or judicial decision with the practice known as 'preventive detention'.
- Article 11 of the Provincial Administration Law numbered 5442 that is the judicial power and crime investigation authority belonging to prosecutors was amended and transferred to the governors and district governors.[18]

However, some decisions of the Constitutional Court (AYM) regarding the rights and freedoms secured by the constitution cause reactions in the ruling circles at a level that even pronounces the abolition of the Constitutional Court. It should be noted that Süleyman Soylu, the Minister of Interior, is one of the names that express this most clearly. Soylu, noting that they got "a counselling session on law" when they communicated their discomfort associated with Constitutional Court's (AYM) decisions states that, "This is Turkey, not Norway". With this approach, he not only puts aside that his duties and responsibilities are bound by current law, but also expresses his 'feelings' about rights and freedoms, which are universal norms in democracies.[19]

The army of personnel and salary rates for the Religious Affairs

According to Turkish Statistical Institute's declaration of June 2020's inflation rate, the salary increase ratio for government employees and retirement pensions for the second half of the year was determined as 5.75 per cent. Accordingly, the Religious Affairs staff preachers' (1/4) salary went up to 5,854 TL from 5,536 TL and imam salaries increased from 3,272 TL to 3,460 TL.[20]

The number of personnel of the Religious Affairs, which has a gigantic budget, has increased incrementally over the years. According to the official data of the presidency, the number of personnel increased to 127,000 as of 2019. Just

to compare, the number of personnel working in the central and provincial positions of The Religious Affairs is 26,000 more than the number of physicians working in state hospitals. The number of personnel of The Religious Affairs, which surpassed many executive ministries with 11.5 billion worth of funds in 2020, increased by 59 per cent from 2006 to the end of 2019.

While the number of personnel classified with the title 'religious services' in The Religious Affairs is stated as 95,087, the breakdown of this figure in sections is as follows: Imam: 60,808; Muezzin-trustee: 12,028; Preacher and prison preachers: 2,624.

The 'sensitivity' of the government to build mosques even in villages with a population of 10 caused an increase in the number of mosques in the country. According to the data of The Religious Affairs, the number of mosques increased to 88,681 in 2018 which was 83,000 in 2011.[21] The share The Religious Affairs is expected to receive from 2021 government budget has created a new dimension to the increasing graph of the recent years. According to the Medium Term Fiscal Plan (MTFP) prepared by the Ministry of Treasury and Finance covering the period 2021-2023, the budget of the institution will increase from 11.5 billion to 12.9 billion TL.[22]

What the numbers and statistics tell us

The logic of making a budget, to put it in simple terms, is essentially not different from the short, medium and long-term (e.g. daily, weekly, monthly) budget planning of a nuclear family. Although it is not possible for a family with limited income to make long-term plans, it can still be said that they have long-term goals such as buying a house if they do not have one, buying a car if they do not have one, depending on the hope and possibility of "if we have the money…" There is a certain income, and in return, expenditures are planned accordingly, especially the inevitable expenses of daily life (such as rent, bills, basic food items, education).

This is more or less the logic behind the state budget. No doubt that the state budget is handled within a more complex and large-volume framework. The expenses required for governing a country have social, political and economic dimensions. The expenses of the fields of responsibility of the public administration such as health, safety, transportation, education, as well as the expenses required by the investment planning that will ensure the fulfilment of the targets determined for the elimination of the existing deficiencies in these areas. The revenue items for which these expenses are covered are obvious and among these are direct and indirect taxes collected from citizens in various ways.

While setting a governmental budget in addition to the basic items, preferences also play an important role within the determined goals and needs. For example, ignoring the shortcomings of the Ministry of Health –whose duty became important due to the COVID-19 pandemic– would have a heavy 'cost'. These needs cannot be ignored. As another example, Turkey being a country of earthquakes, the Environmental and Urban Planning Ministry bearing the sole political responsibility for measures to be taken against an earthquake and ignoring the needs to fulfil this responsibility will also have a heavy 'cost'. As a matter of fact, serious loss of life and property is experienced in every shock. Risks arising from unplanned and improper construction in big cities become the issue. From this point of view, it can be stated that priority and contingency planning is natural and inevitable.

It is worth questioning and discussing what kind of needs analysis the Religious Affairs has, so that it has a graph growing continuously in the last 18 years, both as an organization and in terms of the budget it manages. It can be said that the answer to this question corresponds with the statement of the ruling party leader: "we will raise religious generations." And this is obviously related to the ideological and political preferences of the ruling party rather than the needs.

If we are to make a comparison, the personnel ratios of the Ministry of Health and RA can be looked into based on the figures and statistics given above, since it is the ministry on the agenda and in the limelight. The number of personnel for the Religious Affairs is

Photo: Kamile Kurt

approximately 130,000 people and the money spent for its personnel as of 2019 is 8.2 billion TL. The number of physicians under the Ministry of Health is 101,116 according to the figures of the same year.

There are about 88 thousand mosques in Turkey. Governed by Sharia, Iran with almost the same population as Turkey has 50,000 mosques according to 2018 figures. Saudi Arabia, another country ruled by Sharia with 33.7 million (2018) population has 38,000 mosques. 600 new mosques are built every year in Turkey. Compared to the money the Religious Affairs receives from the government budget, it is 130,000 TL per mosque. Considering that 35 per cent of the budget of the Ministry of National Education is allocated to religious education, it is necessary to add 44 billion TL to this amount. With this calculation, 144 TL per person is paid to the Religious Affair's budget. The compulsory contribution of a family of four to the Directorate of Religious Affairs is 576 TL.[23]

There is certainly a logic behind the country leaders to put their ideological and political preferences before real needs, and it can be stated that they have the motivation and desire to shape the society according to their own ideological preferences and to consolidate their power. It can be done by a nationalist ruling party, an ambitious leftist party or a party that adopts a blend of religion with politics. It is possible to understand this to a certain extent, whether we like it or not. Without reflecting our own ideology and sensitivities, and dealing with the problems only within the scope of "duty", "responsibility" and "needs" when in power is something that can only be dreamed of. However, asking and expecting to act with an "above-politics" sensitivity with a stereotypical expression on vital issues such as health and earthquakes that we have exemplified shouldn't be spelling out a dream. Because acting with a responsible understanding in these areas is one of the bare necessities of being in power. Obviously, the need for a deep-rooted reform in the understanding of state and administration should be the main issues on our basic agenda, and there is a need to talk and discuss this further.

[1] https://www.cumhuriyet.com.tr/haber/bakan-selcuk-ogretmen-maaslarinin-yuk-oldugunu-iddia-etti-1762030.

[2] https://www.birgun.net/haber/ziya-selcuk-tan-ogretmen-maasi-aciklamasi-niyetim-cok-acik-313910.

[3] https://www.hurriyet.com.tr/egitim/turkiyenin-egitim-ogretim-istatistiklerini-aciklandi-41603792.

[4] https://www.mebpersonel.com/meb-personeli/2020-temmuz-ayi-zamli-ogretmen-maaslari-h242188.html

[5] At the end of his analysis, Abbas Güçlü recorded the following under the heading "What is the solution?": "At this point, it is easiest to want more of everything. Well, if the share increases before the income increases, what will happen to the expenditures to be made on other areas? Certainly, education is very important, but no one can say that health, safety, agriculture, energy and other areas are not important. Great miracles were worked out on education in the first years of the Republic with scarce resources. We can do it again. Yes, the resources are very insufficient, but the effective use and increase of it is just as important. To summarize the summary: We cannot get out of it and get a better education chance by only delegating the state with this issue! The solution is for everyone to take responsibility!"

[6] https://egitimsen.org.tr/2020-meb-butcesi-temel-ihtiyaclara-yanit-vermemektedir/.

[7] https://www.bolgegundem.com/bakan-selcuk-ogretmen-basina-ogrenci-sayisi-ilkokulda-16-ortaokulda-11e-dustu-1081328h.htm.

[8] https://egitimsen.org.tr/2019-2020-egitim-ogretim-yili-basinda-egitimin-durumu/.

[9] https://www.dogrulukpayi.com/bulten/turkiye-nin-saglik-istatistikleri.

[10] http://www.kamuajans.com/maaslar/bransina-gore-2020-yili-saglik-personeli-temmuz-ayi-maasi-ne-kadar-h549660.html.

[11] https://www.birgun.net/haber/korona-verileri-ulusal-cikarlar-icin-gizlenmis-317652.

[12] https://www.aa.com.tr/tr/turkiye/emniyet-teskilati-175-yasinda/1798184#:~:text=Emniyet%20te%C5%9Fkilat%C4%B1%20b%C3%BCnyesinde%201%2C%202,ve%20mahalle%20bek%C3%A7isi%20g%C3%B6rev%20yap%C4%B1yor.%20.

[13] https://tr.euronews.com/2019/01/04/avrupa-da-314-kisiye-turkiye-de-185-kisiye-bir-polis-dusuyor-polis-sayisinda-rekor-artis.

[14] http://www.kamuajans.com/maaslar/2020-yili-temmuz-ayina-ait-kidem-ve-hizmet-yilina-gore-egm-polis-memuru-maaslari-ne-kadar-h549643.html.

[15] https://polisaskeradaylari.com/jandarma-genel-komutanligi-personel-sayisi-aciklandi/.

[16] http://www.kamuajans.com/maaslar/2020-yili-temmuz-ayina-ait-tsk-uzman-cavus-ve-jandarma-uzman-erbaslarin-maasi-ne-kadar-h549664.html.

[17] https://t24.com.tr/haber/emniyet-istanbul-a-takviye-birlik-kuruyor,898229.

[18] https://m.bianet.org/bianet/insan-haklari/163348-15-soruda-ic-guvenlik-paketi-ne-getiriyor.

[19] https://www.sabah.com.tr/gundem/2020/03/26/son-dakika-icisleri-bakani-suleyman-soyludan-canli-yayinda-aymye-sert-sozler-bizi-gonulsuzlestiriyorlar.

[20] https://www.haber7.com/guncel/haber/2991666-imam-vaiz-maaslari-kac-tl-temmuz-2020.

[21] https://www.birgun.net/haber/diyanet-saglik-bakanligi-ile-yarisiyor-personel-sayisi-130-bine-yaklasti-292932#:~:text=PERSONEL%20SAYISI%20KATLANDI&text=Diyanet%27in%20merkez%20ve%20ta%C5%9Fra,sonuna%20kadar%20y%C3%BCzde%2059%20artt%C4%B1.

[22] https://t24.com.tr/haber/diyanet-in-butcesi-7-bakanligi-solladi-12-9-milyar-liraya-yukseltildi,908353.

[23] https://www.sozcu.com.tr/2019/yazarlar/murat-muratoglu/hesap-ahirette-para-diyanette-5412111/.

Interview by Fırat Genç

The Istanbul Planning Agency: Pandemic, planning and data-oriented local government

The Istanbul Metropolitan Municipality is faced with a very critical test. On the one hand, it needs to find a solution to the cluster of social problems caused by the pandemic, on the other hand, it struggles to cope with the political obstacles that the government is tightening. At the same time, it seeks to develop a model that takes into account not only the present but also the future of urban life. We talked with Oktay Kargül, the general secretary of the Istanbul Planning Agency (IPA), a novel body of experts established by the metropolitan administration, what the acute crisis brought about and the fundamentals of the planning understanding they developed.

If you wish, let's start by describing the general scenery within the context of Istanbul. What do we know about the consequences of the pandemic so far?
Oktay Kargül: Since the first day of the pandemic, not only a single field or a single institution/organization but also the whole municipality in general, even the related affiliates were tied up. The main reason for the tie-up is that we are faced with an unknown crisis. Disasters, undoubtedly are always on the agenda, Disaster Management Plans are always talked about. Instant, daily or three-days scenarios are ready and available regarding this. But we had never experienced such a health crisis. Undoubtedly, this has brought difficulties. There are many factors to take into account. The first is to ensure the health safety of people. The second is while providing this, at the same time to come up with solutions for people to maintain their daily lives. Third, think about how we can minimize the burdens on the economy. Mobilization was declared based on these basic items. So all issues were put aside and the focus was on what can be done. Certainly, a scientific committee has been established. We started to examine field hospitals. We started to recommend field hospitals for the moment of possible intervention, especially for regions where the disease is intense.

On the one hand, we tried to determine the ones to get social assistance. This part of the task was easy in practice, the current staff was able to organize it quickly. The real story started after that, as it wasn't a matter of three to five weeks. As the days passed and weeks passed, families reached the point where they could not meet their daily needs, let alone quality in maintaining their lives. There are many people in Istanbul trying to get along with what they earn daily. When interaction decreased, the income channels of those people disappeared. We had to identify these people and reach them. This was not easy; we had to get reliable information from the locals. We tried to organize this as much as possible. There were online applications, but as you can imagine, there are people without access to the Internet at home or others who cannot use mobile phones. For this reason, we asked for lists from mukhtars and opinion leaders of the neighbourhoods. We phoned them, registered their applications, and then quickly sent help. We're talking about 1.1 million households, that is, a quarter of the urban population. But our approach has never been only to reach/touch these people. We will save the day today and tomorrow, but the real story is how we will intervene if the pandemic continues a year later.

We can save the day today, maybe tomorrow too, but the real story is how we will intervene if the pandemic is still to continue a year later.

What is the content of the aids you mentioned? How are these different from the aid provided by the central government?
O.K.: The aids were either as parcels or as a shopping aid card. These aids were intended to ensure those people at least to save that month when they couldn't go on the streets even for grocery shopping. Apart from that, a lot of housing problems and rent problems started to occur. This was very clear in our analysis. Looking at the breakdown of the data we could determine the vulnerabilities there. We started to study their transportation-related fragility, spatial spreading risk or risks related to urban overcrowding.

Who is obliged to go out to survive? Who does not live in a healthy eco-system? Who doesn't have a sufficient income level for that house because of the size of the household? We looked for the answers to such questions. Thanks to these findings we will know if there is a neighbourhood that we didn't access or reach, and will be able to intensify

If we are going to follow a road map, if we are going to work accordingly, we definitely should build it based on data, and realistic and future-oriented basis.

the permanent services of the Istanbul Metropolitan Municipality (IMM) in those areas. For example, the cheapest, most affordable and most accessible bread in Istanbul is now produced by Istanbul Halk Ekmek. Previously, Halk Ekmek buffets were located in places with higher sales potential, easy access, and heavy transfers. But places that are in need the most are neighbourhoods like Esenler, Sultangazi or Sancaktepe. Buffet availability is very low in these districts. After determining this, we immediately talked to our affiliate, Istanbul Halk Ekmek, and said, “These are the districts that lack buffets, and these should be the points we will serve.” We may forward the aid boxes or shopping cards in the immediate first moment of a crisis. We are practising the concept of the social municipality only when the services that the IMM is obliged to provide to that neighbourhood are provided in a permanent and accessible manner.

Then, we looked at where ISADEMs (Istanbul Family Counselling and Education Centres) are concentrated. These are the units where social aid goes to. However, we continue to work on our Public Market concept based on data. When we combined the data we have, we were able to determine the fragile neighbourhoods regionally. In other words, if we are going to follow a road map, if we are going to work accordingly, we definitely should build it based on data, and a realistic and future-oriented basis. We shouldn’t act by rote anymore. In the past it was as such: As a municipality, I own land here, I own land there. I can raise a building here. This should not be the case anymore. This is what the pandemic taught us. With the pandemic, we clearly could see the highly fragile regions. We tried to do it as punctually as possible, with data in front of us, and we did not consider any administrative boundaries during this process. There are neighbourhoods such that the average household income level is 500 TL on one side of the street, especially after the policies followed in urban transformation, while on the other side it is 5000 TL or 10,000 TL. When considered by the neighbourhood boundaries, that area looks completely fragile. Instead, we created hexagonal systems that we call Honeycomb System, so we could make more accurate and to the point determinations.
Kindergartens are another important issue. We know that the return on investment of $ 1 on a child is 7-10 dollars to the economy in the long run. In many places, we have seen that families cannot send their children to school due to economic reasons. To overcome this, we said that we will open day-care centres in 150 neighbourhoods and we will establish them in areas with high child population and low income. Based on these two parameters, we selected the regions and started opening them. I would like to point out that the first kindergartens to be opened were in Sultangazi, Sancaktepe, Pendik, Esenyurt, Küçükçekmece and Beyoğlu. We focused on these regions. The main reason why we did this is: We never want to serve only in populist movements of the present. Istanbul is our issue. Our concern is the wellbeing of those who live in this city. We are happy when they are happy. There is no point in this career as long as we cannot touch those living in Istanbul. If we can impose this state of mind, this systematic on the IMM and settle it from the top management to the smallest unit at the bottom, then it will be possible to account transparently for what, where and why was made in a possible strategic plan, a possible budget, a possible investment.

Photo: Istanbul Planning Agency

The IMM should be able to alleviate the problems caused by the gaps between income levels. Social policies and poverty were therefore the most central topics during the election period. Now we are emphasizing the concept of deprivation a little more. The IMM could have done many things otherwise. It could do this in the areas where the daily traffic is 2 million and create great word of mouth. But that's not our concern. Our concern is to reach everyone equally and to provide services. Therefore, we determine our priorities for all assistance, services and activities to be carried out in the future based on data. For example, as the municipality, we developed the concept of regional employment offices. They get a serious amount of applications. Approximately 12 thousand people have been employed so far. Respectively, we decide on the locations to open them based on data. In short, we have basically developed all our working principles, especially our practice-related working principles, to be data-oriented and concentrated accordingly.

Two things stand out from what you said. First, the pandemic has revealed how unequal a city Istanbul is. Second, the policies pursued until today, largely being not data-driven. On the other hand, the change in perspective you mentioned requires a bureaucratic renewal, both within and between institutions. How successful have you been in this?

O.K.: It wasn't easy, it was a bit like an organ transplant. Some accepted the new texture, some had difficulty accepting it. But at the end of the day, especially when the outputs of IPA's work became visible, we started seeing invitations instead of difficulties. This made collaboration easier. Therefore, the general structure of IPA is not in the form of a company or a subsidiary, but a foundation. Currently it is in progress to become a legal entity, and the organization consists of an executive board. The executive board consists of the general secretary, assistant general secretaries and related departments of the IMM, such as the Department of Survey, the Department of Science, the Department of Information Technology, the Department of Transportation, the Social Services Department, the Department of Parks and Gardens. The fact that such a large table was set up prevented the risk of disintegration.

Photo: Istanbul Planning Agency

IPA reveals why and how to create a vision/strategy based on data, research and studies in different fields. Thinking this is not enough, we also state our suggestions and commitments to create a road map. With the current bureaucracy, it is not always easy to know what's happening currently and determine policies for the future. This is what IPA provides. For example, we are working together with the Statistics Office to make all data communicating with each other. Istanbul Institute details how different issues are dealt with in international settings, institutions and organizations. For instance, the institute conducted many studies on the pandemic and reported on how the 'new normal process' should be. Nearly five hundred sources were scanned and numerous articles were translated for this study. Thus, we had the chance to watch how international organizations such as UNDP, OECD countries or metropolitan administrations within the C40 are handling the pandemic. What are they doing? What are the concrete suggestions? They can come up with a road map for us and show us the points to refer to with all the data at hand.

As I said earlier, benefitting from such international experiences makes the data-driven approach possible. Inspired by these, for example, the Statistics Office compiled very striking economic data regarding the pandemic period. Most predictable of all, the number of tourists has declined by 98 per cent. The second is data on employment. For example, the number of employed through İŞKUR (Turkish Employment Agency) has decreased by 85 per cent in those months. Indebtedness increased by 78 per cent in low-income families. These striking numbers show us the direction to go and the areas to concentrate on.

Undoubtedly, these are very critical issues, however, on the other hand, they are the type of issues beyond local governments. In this regard, what is the prioritization of the Istanbul Metropolitan Municipality (IMM) recently?
O.K.: The Strategic Plan is being revised now. There was a right of revision and we are doing it according to the conditions created by the pandemic. We are preparing the Vision Plan, which we call the Istanbul Constitution. This was a study already in progress, now we are reconsidering it in pandemic conditions. We directly take into account what the pandemic taught. For example, covered markets are being built underground. We started to meet with the relevant municipalities as much as possible to prevent this. We started to explain the importance of outdoors. In addition, we try to touch everyone we can touch in the city. Many issues that coincide with the Ministry. For example, we may not be able to create that employment as a municipality. But with Employment Offices, we can direct people to the right employment resources. An Industrial Platform Desk is being established together with Organized Industrial Zones. We can direct the blue-collar personnel in need according to the data that will emerge from here. At the same time, the Tourism Platform is also currently working.

Most decisions are indeed beyond us. But if we are in Istanbul, if we are in the administration of Istanbul, if we want to consolidate the steps towards making Istanbul a liveable city, we need to be at the same table with all the stakeholders here. With its industrialists, artists, hospitals and hotels, the Tourism Platform (ITP) was able to do that. Yes, financial aid or support may not be given to anyone. In fact, it is not always enough and not the right thing to do. The ITP provided accommodation for all healthcare personnel. As the IMM, we mediated this and talked to the hotels. We requested them to allocate some space, sometimes paid for and sometimes for free. With such a compromise, we provided accommodation to all healthcare personnel. Besides, we also tried to provide morning/evening meals in line with the working hours. So sometimes we tried to be a facilitator instead of one-on-one intervention. Emphasised working as versatile as possible. We introduced the concept of pending invoices. Although the IMM cannot pay all of the debts of people, we tried to be an intermediary between the people who can pay them and the bill holders. Of course, it is not possible for us to keep up with everything, but we strive to establish a common action mechanism and work in cooperation as much as possible.

With the first months of the pandemic, we saw that the relationship between the IMM and the government evolved into an open conflict. In this respect, what were the most painful issues?

It is very clear where the aid will be allocated. It is very simple and easy to show the account movements of the donations collected. However, it is extremely irrational to create a bureaucratic obstacle stating that the local municipality does not have such authority and permission.

O.K.: The first was undoubtedly the blocking of accounts reserved for donations. It is very clear where the aid will go to. It is very simple to show the account movements of the donations collected. However, it is extremely irrational to create a bureaucratic obstacle stating that the local municipality does not have such authority and permission. Istanbul or Ankara doesn't belong to A Party, or the B Party but the people living there. It is necessary to meet the needs of those people, and for this, everyone needs to be mobilized. Especially in times of disaster such as earthquakes, pandemic, flood. This was striking. This of course was not enough to stop us. Alternatively, we organized parcel aid and the pending invoice.

The second was the field hospital issue. We were ready to mobilize all the means of the municipality in this regard. We have also done our part from the location organization to the needs of the hospital. At this point, they again pushed aside the needs of local governments. Frankly, I can't help thinking: Wouldn't it be better to expand services through field hospitals both in terms of access to healthcare services and improving the quality of the existing ones instead of so much accumulation in hospitals? Access has become more and more difficult, especially with city hospitals. Accessibility, public transportation, the need for people to go from one place to another and the overcapacity of the places they go to are among the most fundamental problems that caused the pandemic to increase. Couldn't there be cooperation here?

It will be useful to repeat that we have a supra-political administration. The Istanbul Planning Agency (IPA) is the most concrete example of this. Certain organizations and structures could be

Photo: Istanbul Planning Agency

Photo: Istanbul Planning Agency

established within the municipality without the existence of such a structure. However, the IPA works for the future of Istanbul with what it does today. It includes minds that worked for Istanbul all their lives but have been left out for years. It brings its designs to life in a participatory way. We exist today, but nobody knows whether we will be here in the next election or not. But the IPA should continue to serve Istanbul. That's the reason for this set up. Changes in policies with every new administration also disrupt the flow of the work.

What is the scope of the Vision 2050 Plan that you mentioned, how does it proceed?

O.K.: Vision 2050 has two years to go. We claim to create the constitution of the entire city. The main reason for this is that every new administration sways Istanbul from side to side with their own truths and facts. The current Environmental Plan was made in 2009. The management/administration who prepared that plan specifically is violating the red lines of the plan. There are very clear statements in the plan: The projected population of Istanbul is 16 million; the settlement should not spread to the north and should be on the east-west axis. There are location recommendations for airports for instance, or highways or metro networks. But they put forward projects, disregarding these recommendations, and the Third Bridge was built, the Marmara Highway was built. Now there is the reality of Kanal Istanbul. As long as it goes on like this, the city can never add on. The city ends nature and its own living areas. It consumes all and causes the emergence of an unhappy habitat. Nature always takes back what belongs to it. We may occupy as much as we like. But it needs to be done holistically, compatible with nature.

Vision 2050 will in fact provide that. There are 17 topics and these topics touch every part of the city. We do this not only from our own perspective but by looking at the world. The Vision 2050 study started in line with the sustainable development goals of the United Nations. Studies are carried out based on 17 main topics and more than two hundred sub-divisions. We are trying to understand how managers and experts from metropolises, which are similar to Istanbul, such as Barcelona, Berlin, London and New York, deal with these issues. We leave these meetings with both happy and sad feelings. Because, while we are more advanced than them in many areas such as resources, geography, *know-how* they are revising such plans for the second or the third time, whereas we have not even started.

Of course, the development process of the plan is another critical issue. It will

be fully participatory. We have built a structure coordinated by experts of their own field, but the Plan will not be written by experts of that topic. There is an advisory board related to

We are managing a supra-political rule. The IPA is the most concrete example of this. There could have been certain organizations and structures within the municipality without the establishment of such a structure. However, the IPA works for the future of Istanbul with what it does today. It includes people who have worked for Istanbul throughout their life but have been excluded for years.

Photo: Istanbul Planning Agency

that expert and also a list of over 200 stakeholders. We have a stakeholder list of nearly 4 thousand in total. More than 100 academics and stakeholders from the sectors attended the first search conference. We are including that intelligence to the work we carry out. The vision work can be realized not by the team of 20-30 people within the institution, but by transferring the experience, knowledge and mind from outside.

Moreover, our stakeholders include not only European cities but also metropolises such as Sao Paulo, Cairo, Johannesburg and Seoul. In these meetings, we mainly try to understand how they operate the process, how they use the tools, where they have difficulties, and to what they pay attention to. All these are undoubtedly world cities. In time, the number of cities we meet and communicate with will increase. If there was no pandemic, we had the idea of increasing

Now there is the reality of Kanal Istanbul. As long as it goes on like this, the city can never add on. The city ends nature and its living areas. It consumes all and causes the emergence of an unhappy habitat.

the number of cities and creating a common international table with these collaborations. We also have a goal of bringing together the representatives of these cities, project executives and teams preparing vision plans at a conference in Istanbul, and transferring our experiences to the whole world. Because such practices ensure that the work done is more permanent, adopted and cared for. We want it to be systematic so that constantly repeats/renews itself, not to realize the work and be thrown aside after four years. This is all we aim for.

Photo: Istanbul Planning Agency

THE EXCEPTIONAL STATE OF THE PANDEMIC POLICIES: WORKING CITIZENS

One of the most crucial pillars of the political agenda shaped around the pandemic is the reliability and accessibility of data. Aslı Odman, an instructor at Mimar Sinan Fine Arts University and a member of the Istanbul Occupational Health and Safety Council, discusses this caustic topic that directly affects the nature of the relationship between citizens and the state.

Workplace COVID-19 clusters made invisible in the pandemic policy

The policies regarding labour during the pandemic period are in line with the pre-pandemic social policies. There is no work-oriented social policy during the pandemic as it was the case in the pre-pandemic period. The paradigms of official social policy are structured on bodies in need, not on working bodies. Workplaces and the working state of the citizen are not included in the field as both the object of protection against the pandemic and the subject who demands the right to healthcare and life. The first exclusion is regarding data, knowledge and memory, the second one regarding concrete policy steps which are recognized in different ways; exclusion from general public health bans, generic definitions, ensuring the continuation of conditions that would compel people to work with economic enforcement despite all risks and condoning the implementation of protective legislation on the workplace – for example, by completely suspending labour inspections. All of this happens in our societies that constitute 'working societies', although workplaces are –in parallel with the unquestioned production priority of the system– known as primary transmission sites of the

Photo: Özcan Yaman

pandemic. The concept of workplace COVID-19 clusters[1] and the policies centred on this concept stand out with their absence in all areas of analysis and action in the country.[2] This proves that the class based policy choices are imposed on the locals by the Ministry of Health and the Ministry of Internal Affairs at the central level and by the governorships at the local level in the pandemic management. The knowledge of 'work life' being local of the local cannot become a disaggregated data entry even in the case of a pandemic. Up until now, no distinction between essential/non-essential business sectors was made referring to the central class policy preferences, production in non-essential business sectors has not been stopped, 'the most protection to the most vulnerable' as the principle of social justice has not been guarded, ultimately the priority of production and capital accumulation continuity has not been stretched under these extraordinary conditions. In any case, it could not be expected of any public health policy being effective by disregarding the health of the working population.

However, considering our current structure of production and lifestyle, workplaces and schools stand out among the spatial and temporal clusters that allow the pandemic to spread rapidly – when places providing healthcare services are excluded. It is clear that both schools and hospitals are yet another workplace from a point of view of the service providers, not in terms of those on the receiving end. Regardless of a social benefit of the commodities produced in the production system and depending on the importance attributed to the continuity of production without the distinction of 'essential jobs', it is quite understandable that the primary spreading sites of the pandemic are workplaces (and public transportation used to reach these workplaces). What is not understandable is the extremely low production of concept, data, interest about COVID-19 clusters at workplaces in Turkey.

In English-speaking countries, we see that the concept of 'COVID-19 workplace clusters' is frequently used in the information, news and campaigns of independent and central government/ state/local government institutions which

It is necessary to acknowledge that no precaution individualizing the risk of a pandemic can replace social and labour policies that provide egalitarian social protection, and to underline monitoring workplace clusters, sharing their data and developing a pandemic policy at the scale of the workplace as one of the most important deficiencies of the public healthcare policies of the period.

are in the field of press, trade unions, worker's health and public health. For example, Hazards Campaign, a senior grassroots platform for networking between unions and local organizations in the UK, and the magazine of the network *Hazards Magazine* draw attention to the 'workplace COVID-19 clusters' with the slogans #ShutTheSites, #KillerWorkplaces, #StopThePandemicAtWork, #WeAreNotDisposable since the beginning of the pandemic.[3] Hazards Campaign's video in the viral protest launched in November suggests a hierarchy of measures to prevent the spread of the pandemic caused by workplace clusters (Figure 1).[4]
In the hierarchy of measures signed by the Canadian National Centre for Occupational Health and Safety (CCOHS),[5] steps regarding social and labour policies were in the lead as the most effective ones, while the use of individual personal protective equipment and non-medical masks (based on the slogans like "Mask-Distance-Hygiene=OK") has been defined as the least effective measure. It is necessary to acknowledge that no precaution individualizing the risk of a pandemic can replace social and labour policies that provide egalitarian social protection and to underline monitoring workplace clusters, sharing their data and developing a pandemic policy at the scale of the workplace as one of the most important deficiencies of the public healthcare policies of the period.

However, with the hegemonic perspective imposed by the existing power relations that existed before the pandemic and led to the pandemic, private properties such as factories, plazas, offices, mines, organized industrial zones, small industrial zones, warehouses, shipyards, free zones, construction sites, call centres, hospitals, schools, universities have never been of interest as workplaces, whereas the residences and public areas were always of interest. This alone is one of the most important reasons for the failure of the pandemic policies where protecting the weakest link is essential to prevent or slow down the spreading of the disease. Because where workers' healthcare is not provided, public health policies are doomed to fail.

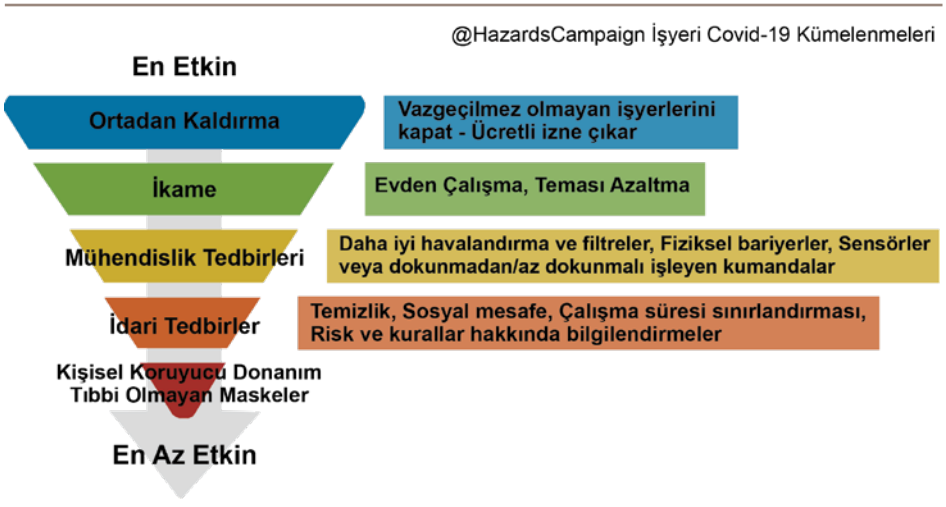


Figure 1. Diagram adapted by @ HazardsCampaign from CCOHS (Canadian Centre for Occupational Health and Safety).

Photo: Özcan Yaman

Istanbul: Invisibility of a working city

This contrast becomes even more visible when we look at Istanbul alone as the capital of the pandemic without taking a look at Turkey in general. Istanbul, like any other metropolis, is primarily a working city. A significant part of the identity and practice of citizenship or urban citizenship –including unemployment experience– is built on belonging to working life. Here we are not talking about a 'working class belonging' valid only for the manufacturing industry that is distinctly separated from consumption and housing spaces. A location, which is a place to consume for one urban citizen (shopping mall, art institutions, etc.) or public services (transportation, education, health), is another urban citizen's workplace. They are workplaces, moments and conditions of a city, which is associated with abstractions such as 'Capital of Culture' and 'Capital of Finance' and covered by the glittering 'Cool Istanbul' images which were popular until recently.

Let's talk about a few obvious indicators of the face of Istanbul that is working and getting sick while working: The city –within its borders– accommodates millions of employees working in nearly fifteen thousand businesses registered only with the Istanbul Chamber of Industry such as The Tuzla shipyards district, Ümraniye, Küçükçekmece, Büyükçekmece, nearly twenty OSB (Organized Industrial Zone) and Small Industrial Areas, three Free Zones where thousands of people have to come side by side in their work environment.[6] Thousands of poorly ventilated, sometimes windowless formal, informal or semi-formal ateliers, apartments, under the counter businesses in the various neighbourhoods of Zeytinburnu, Ümraniye, Esenler, Bağcılar, Güngören, Bahçelievler, Avcılar, Esenyurt and many other districts form the important part of the urban landscape.[7] Workplaces in Istanbul –where workers have to work side by side, in coordination with the pace of commerce in hundreds of ports, depots, warehouses and logistics centres established continuously to feed, clothe and supply raw materials to Istanbul which is a huge production and consumption location– constitute serious COVID-19 clusters.

Constituting only two per cent of a total of 544,000 active and registered workplaces from all kinds of businesses in Istanbul, with a total number of around 10,000 workplaces with more than 50 workers (declared), however stating that the number of these workers is nearly 1,720,000 and exceeded 40 per cent of the employment in the city shows the magnitude of the risk. More than 50 workers working side by side seriously increases the spreading speed of the pandemic. The number of people working formally only within the scope of SGK (Social Security Institution) in Istanbul is 5.5 million people, 350,000 of which are public servants and 600,000 of them are self-employed. The overall rate of working from home for Turkey[8] is calculated as 25 per cent the highest, even if we think of this rate to be slightly higher for Istanbul, this makes more than 4 million people working 'without the luxury of staying at home' and a significant number of them working at such scales that cause the pandemic to spread faster. Healthcare professionals who had to fight the pandemic on the frontline at work; other employees not being able to stay home due to employer's instructions, using public transportation/private company buses, remaining in common areas at work are primarily exposed to contamination. Besides, in a city where the official unemployment rate is not below 15 per cent, having the chance to be able to work by the employer's instructions may sometimes indicate a privilege. Still another critical category that is not included in this picture, not recorded and openly exposed to the pandemic, are the informally or illegally

employed and the wageworkers. When, those who are unemployed, those with no prospect of finding a job, those working precariously and under risky situations disadvantageously because insufficient retirement benefits or invalidity pension, formerly self-employed tradesmen, craftsmen or workers in the service sector in small businesses that are closed, unable to pay their rents or whose financial turnover is below the minimum of subsistence limit, female domestic workers with decreasing cleaning, maintenance work and almost all precarious, seasonal agricultural workers and farmers who keep up the food chain that has no place in this metropolitan map, refugees/immigrants without a reliable residence address, not even citizenship are added to this table, it will become obvious that it is impossible to implement an effective public healthcare policy when various kinds of working life are excluded.[9]

It is necessary to add the employees who cross Istanbul and flow to their workplaces in neighbouring Kocaeli and Tekirdağ provinces by public transportation and shuttles to this 'map of working Istanbul' within the context of employment-housing correlation.[10] The mobility created by many workers living and working in Istanbul is possibly the reason why Gebze, Kocaeli and Tekirdağ stand out in the exit activity out of Istanbul in the analysis of the IMM's (Istanbul Metropolitan Municipality) transportation data of 2-8 April (Figure 2). Also in the Istanbul Vulnerability Map that was recently prepared under the umbrella of Bimtaş, a subsidiary firm of the IMM, neighbourhoods that indicate 'vulnerability due to transportation' are located on the workplace-housing mobility lines.[11] On the same map, it is striking that many neighbourhoods that are 'vulnerable due to urban population density' are neighbourhoods that are 'among the social class which cannot be isolated –i.e. safe site islets–intertwined with scattered workplace areas and cross main transportation lines in transit.

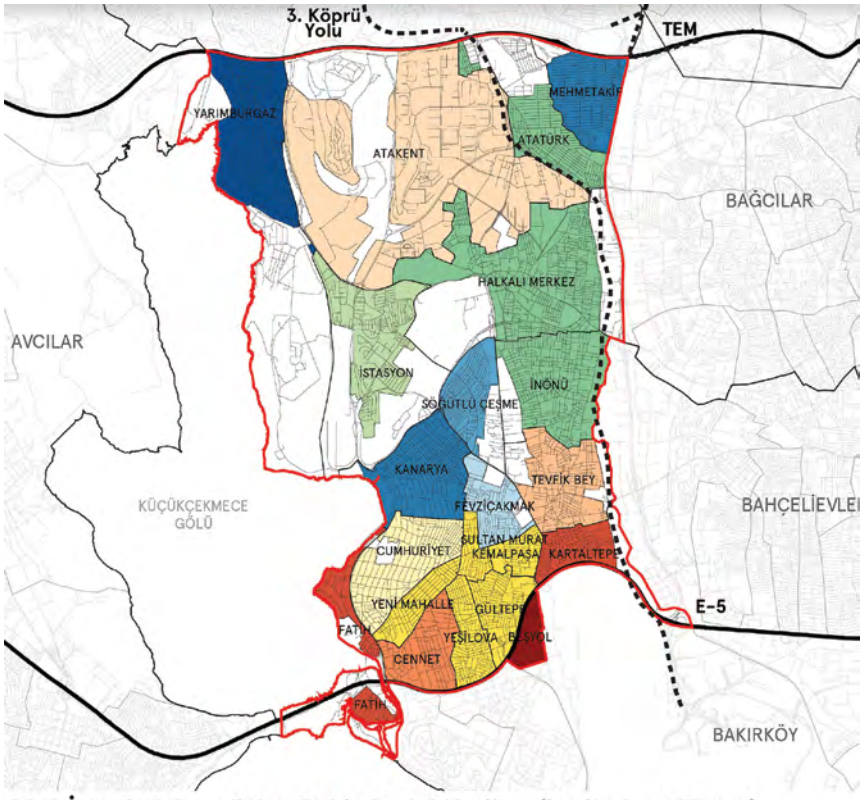
In summary, employees, who are out of sight of public interest and policies with their working conditions, death under working conditions and workplaces even in the 'normal state' exclusive of the pandemic appear to be a prominent group in COVID-19-related deaths, but they are still not visible.

Figure 2. Sefer Selvi, *Leman.*

Employees, who are out of sight of public interest and policies with their working conditions, death under working conditions and workplaces even in the 'normal state' exclusive of the pandemic appear to be a prominent group in COVID-19-related deaths, but they are still not visible.

Lack of spatiality in data: Individualizing public responsibility by numerical covers

So, what kind of data is visible data, and how and what does it show? Sixteen days after the announcement of the first official COVID-19 case in Turkey, The Ministry of Health's information website on the COVID-19 pandemic was opened.[12] On the same day, we met with the turquoise-coloured Turkey Coronavirus Daily Chart. Widespread public communication area of this chart, which resembled a mixture of the *saatli maarif takvimi* (a traditional calendar based on customs and beliefs, more of an encyclopaedia and basic reference tool rather than a calendar) leaf and the Ministry of Tourism's logo in terms of its design, which was shared on the personal twitter account of the Minister of Health –rapidly increasing the number of followers by a crowd of concerned citizens[13]– at the same hour in the evenings (Until 1 December 2020), expanded day by day. The use of a personal, not corporate social media account in data sharing on this acute issue concerning public health deserves to be analysed separately in terms of social risk/crisis/disaster communication and public understanding. The reliability of these data was seriously damaged in three stages. First, on July 29, data categories were replaced by 'intensive care' and 'intubated patient', 'number of severe patients' and 'rate of pneumonia'. Then, on September 30, it was officially announced that the definitions of 'case' and 'patient' with international validity were tampered with.[14] Finally, on November 26, going back to the internationally accepted figures without any justification. It would not be wrong to say that the scientific



2018 İstanbul Geneli Yaş-Rahiç Bedel Haritası (harita.kent95.org)

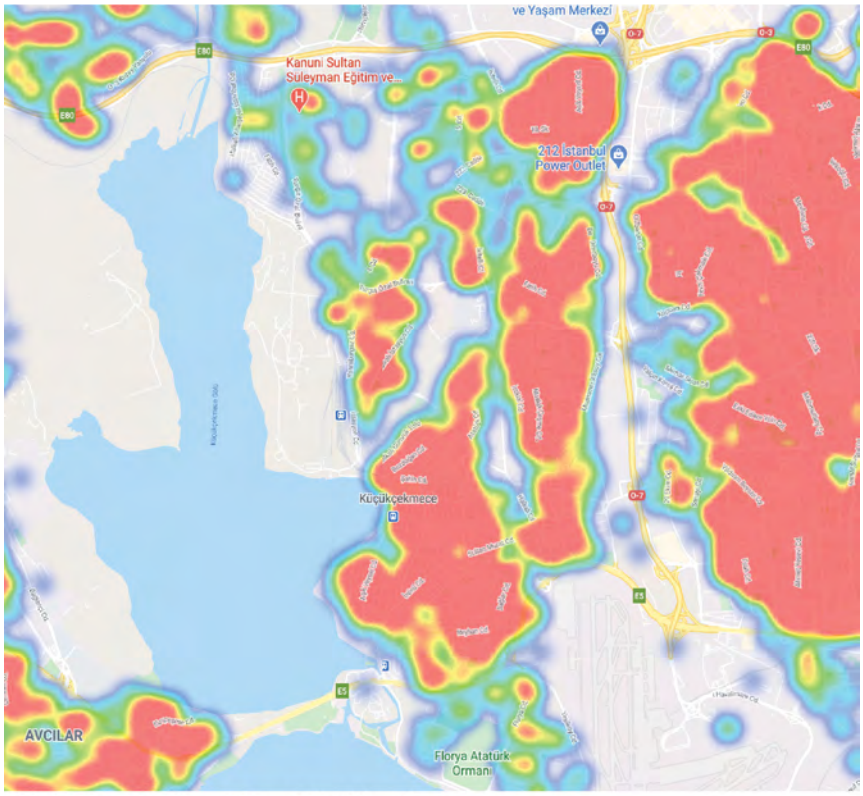


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Figure 3. Socio-Spatial Differentiation and spread of COVID-19 in Küçükçekmece district. **Map:** Murat Tülek. (The difference in infection risk ratio between Atakent neighbourhood, which has high-mid-market value, where secure compounds are concentrated, and Halkalı, İnönü, Atatürk and Mehmet Akif neighbourhoods, which constitute the industrial lane to the south of İkitelli Small-scale Industrial Site, and which host large and small outsourced workplaces, is striking. this map[17] can also be read taking into account many other factors.)

scepticism about 'official data' formed by the statements of 'deaths due to contagious diseases' obtained from the Cemetery Directorates of Metropolitan Municipalities, or the calculations of TTB (Turkish Medical Association), independent data scientists and investigative journalists is now extended to the general public.[15]

The point we want to make here is the kind of opportunities missed in terms of intervening of the pandemic in the name of public health, with data that appears in this chart that is published every day and loses its reliability day by day which has no breakdowns and is non-spatialized – as in the example of 'workplace COVID-19 clusters' that have not become a data category. When referring to non-disaggregated/non-spatialized data, we are talking about the breakdown and distribution of the cases and deaths individually and according to administrative scales such as regions, provinces, districts and neighbourhoods, gender, age, income groups, occupational groups/sectors, educational opportunities obtained, accompanying diseases, disease symptoms and risk groups. In the absence of tools that will enable us to question the social differences the effects of the pandemic make visible in the environment,[16] we cannot have the knowledge of the differentiating criteria for appropriate health and social policies to be implemented (Figure 3).

Failing to see and analyse the differentiated prevalence of a contagious disease that progresses along ancient social fault lines and deepens them, also brings along the inability to determine the correct scales of intervention for concrete risk groups. The central public authorities' approach to data in this regard reminds us of the same approach in the issues of workplace homicides, femicides and human rights violations. The authority to assign names/concepts and diagnose, collection and sharing of data units are centralized. Moving away from transparency and accountability, it becomes the information of ignoring and custody. In particular, the fact that data is not socialized and spatialized specific to the pandemic acutely and 'crucially' reveals the weaknesses of the central organization, which extends to the gigantic City Hospitals that replaced the spatial organization of primary care/ preventive medicine.[18]

The HES (*Hayat Eve Sığar* – Life Fits Into Home) code application, the second type of data shared with the 'citizen' in the process, uses a central system that opens the data to the direct access and control of government institutions, and millions of people already[19] have downloaded this application and acquired a HES code. The use of the HES code is required in intercity public transport buses, airplanes and trains, and more and more public institutions (and access to central exams, some private institutions, fairs, even other events such as astroturf matches), and started to be used as a kind of more common 'health GBT' (Criminal Record Check). Furthermore, with the "Turn in" *(İhbarda Bulun)* application added later[20] a very dangerous approach in terms of society, which popularises risk, security and police measures among individuals, has been 'technologized' and placed on individual smartphones that are carried everywhere. The care and investment spared on worker's health and security were once again directed towards public sphere security, which would further legitimize police-like measures.

At the same time, a more minor social weakness of this static representation based on address (ADNKS) is that for those who are obliged to work using public transport and continue to move in the city, it is the misleading impression of 'low risk' about areas where many infected patients come together, such as hospitals, transfer points, excluding housing. Generating such a misleading 'low risk' perception contradicts the purpose of this application which was explained at the beginning.

Counter-data or data of the loss: COVID-19 as an occupational disease, occupational accident or invalidity of official

That's why it becomes even more important to keep and share data from the ground on the fault lines that the pandemic has proceeded and deepened. Within this article, it would be appropriate to mention the picture drawn regarding the pandemic period by the Istanbul Occupational Health and Safety Council (İSİG) which fights against making workplaces and working life invisible.

Since May 2011, the İSİG Council has been publishing workplace homicide reports on a monthly and annual basis, with breakdowns according to age, gender, province, citizenship status, industry and reasons for workplace homicide.[21] COVID-19 appeared as the cause of a workplace homicide in the April 2020 report for the first time. Rapidly overtaking the two prominent causes of workplace homicides, such as falling from a height, which was the cause of repeated deaths on construction sites, and the mass death of seasonal workers in the agricultural sector, with the increasing traffic accidents, maintained this position uninterruptedly every month until the end of the year. COVID-19 became the cause of more than half of the deaths on the job according to the most recent November 2020 report (Figure 4). Even from this simple data retention process, the causal link between work and death can be established, while the pandemic is not recognized as an occupational disease even for healthcare workers. There is even a circular of the Social Security Institution, whose legality is questionable, stating that the situation of 'those who are exposed to a contagious disease on the job' is not recognized as a work accident/occupational disease.[22]

In the third and last COVID-19-related work homicide report of the ISIG Council dated 13 November, it has been revealed that at least 368 people died from being infected while working actively during the pandemic, based on national and local media coverage, as well as reliable local sources (health organizations, colleagues of workers) on deaths that are not reported on media (Figure 5).[23] Accordingly, at least 108 of those who died on the job lived and worked in Istanbul, which continues to be the centre of the pandemic in the number of cumulative cases. Eighty-five per cent of the dead were wage earners (workers and civil servants), the remainder were self-employed. The sectors with the highest number of deaths were: 141 workers health, 90 workers trade/office/education/cinema, 25 workers municipality, 20 workers textile/leather, 17 workers security, 15 workers metal, 14 workers transportation (driver and pilot), 10 workers accommodation. The average age of the deceased was 51. The death rate for 65 years and over in Turkey is much lower than the rate of the World Health Organization European Region, meaning a higher death rate for the young,[24] which is an indicator

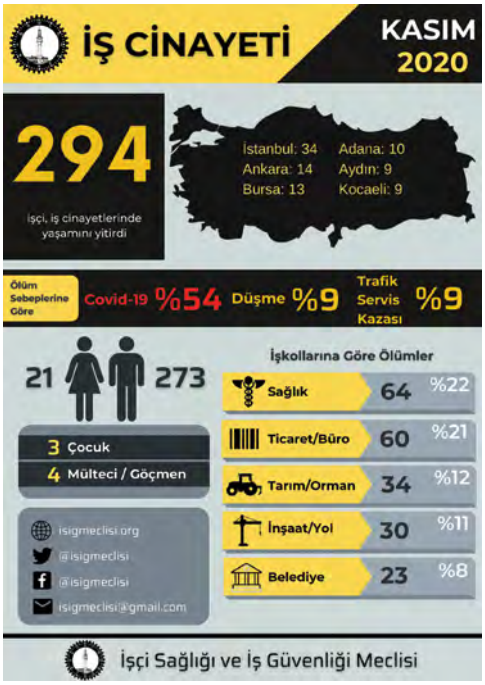

Figure 4. From the report of the Istanbul Occupational Health and Safety Council dated November 2020.

of the inequalities experienced by the actively working population during the pandemic.[25]

Health workers (TTB and SES) and metal workers (Birleşik Metal İş Union) from the lines of business, which bear the life cost of social disaster unequally, kept pandemic data specific to their business lines. This period turns out to be a complete slaughter for healthcare

Figure 5. From the report of the Istanbul Occupational Health and Safety Council dated 13 November 2020.

Photo: Özcan Yaman

professionals. The number of healthcare workers who have lost their lives since the beginning of the pandemic increased to 221 as of December 6.[26] Likewise, the report that Birleşik Metal-İş Union, whose six of nine branches are located in Istanbul and its close vicinity where the industry of Istanbul is spreading, shared on November 20, with the data compiled from the beginning of the pandemic in the workplaces where it is organized, is striking.[27] In the workplaces where the union is organized, the number of active cases reached 771 in the week of 9-16 November 2020, approximately 9 times more than it was five weeks ago. In the report, the high rate of increase in the number of active cases during this period was stated to be based on the increase in workplaces in Gebze and Istanbul Asian side. It was stated that in these regions, this number jumped from 39 to 347 and that there are workplaces with the number of diagnosed workers reaching 30 per cent. Three-quarters of the workplaces where the union is organized had active cases diagnosed with COVID-19, and the number of workers who have been sick since the beginning of the pandemic corresponds to 7.3 per cent of the total number of workers in the workplaces covered by the union's collective agreement. These suggest the presence of an 'actively-working-out-of-home sickness' with case rates higher than Turkey's average and the rate of the working population in Turkey.

We believe that if similar data could be collected at Istanbul scale in other business lines, the disproportionate cost of life and health in the workplaces that did not stop production, on the contrary, which made working conditions more difficult for those who remained healthy, with overtime and concentrated work to compensate for the ill workers, would become more visible. High rates of illness of those who have to work actively and out-of-home, whose data are not kept or shared and are pushed into an invisible area for a broader public, continue to increase the rate at which the pandemic spreads not only among the working class but also in the whole society.

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[1] Turkish Medical Association COVID-19 Monitoring Board, 8th Month Evaluation Report, p 10. We see that this concept was not mentioned in any of the institutional publications on the Turkish language epidemic policy before the first reference in this document (last accessed December 12, 2020).

[2] For the report of the European Centre for Disease Prevention and Control, the official institution of the European Union, with the same title, see "COVID-19 clusters and outbreaks in occupational settings in the EU / EEA and the UK", 11 August 2020, (last accessed December 11, 2020). In this report, we understand that 15 EU member states and the UK have recorded workplace COVID-19 clusters since the beginning of the pandemic (1376 clusters are mentioned between March and early July).

[3] http://www.hazardscampaign.org.uk/.

[4] https://twitter.com/ReelNewsLondon/status/1323969689467441153?s=20.

[5] https://www.ccohs.ca/products/posters/covid-hierarchy/.

[6] See, TUIK Statistics September 2020.

[7] Temerçin and Aldırmaz conducted a study with 2014 data, and only the following17 neighbourhoods accommodate 33.3% of Istanbul's industry as the number of workplaces and 29.1% of employment. Aydınlı and Tepeören in Tuzla, Yukarı Dudullu, Esenkent and Esenşehir in Ümraniye, Maltepe in Zeytinburnu, Topçular in Eyüp, Yenidoğan in Bayrampaşa, Mahmutbey, Evren and Bağlar in Bağcılar, Yenibosna in Bahçelievler, Ziya Gökalp in Başakşehir, Hadımköy in Arnavutköy, Akçaburgaz in Esenyurt, Cihangir in Avcular and Yakuplu in Beylikdüzü are areas where industrial activities are concentrated on a neighbourhood scale. Kadir Temerç and Yolcu Aldırmaz, 2017,"İstanbul İlinde Sanayi: Tarihsel Gelişim, Yapısal Değişim, Mekânsal Dönüşüm", Kadir Temurçin ve Murat Ali Dulupçu (ed.), in *Türkiye'de Mekânsal ve Bölgesel Dönüşümler,* Süleyman Demirel Üniversitesi Yayınları, p. 8.

[8] Uğur Aydın ve Cem Özgüzel, *Türkiye'nin Evden Çalışması Mümkün Mü?,* https://sarkac.org/2020/04/turkiyenin-evden-calismasi-mumkun-mu/, 12 April 2020.

[9] For a good journalistic work that compiles what cannot be represented as data during the pandemic as narratives from the field, see Pınar Öğünç's series of articles on working life published in 36 episodes between March 22-May 22, 2020 on Gazeteduvar. https://www.gazeteduvar.com.tr/yazarlar/2020/05/22/son-soz-niyetine-pandemi-zayiati/.

[10] According to the report, "Verilerle İstanbul Profili-Kovid-19 İstanbul", written by Nilüfer Aykaç, a member of the Istanbul Metropolitan Municipality's Scientific Advisory Board, mobility in the industrial zones of Istanbul have led to a sharp increase in the number of incidents, and the risk of contamination is higher in districts such as Avcılar, Bağcılar, Bahçelievler, Esenyurt, Ümraniye, Çekmeköy and Küçükçekmece on the European side and Kurtköy, Pendik, Samandıra, Ümraniye and Tuzla on the Asian side. See also, Nilüfer Aykaç and Osman Elbek, "İstanbul COVID-19", *Birikim Dergisi,* 2 November 2020; *Son Dakika: İstanbul'da Mavi Alarm Verildi,* 16 November 2020, Milliyet Gazetesi, *https://www.milliyet.com.tr/galeri/son-dakika-mavi-alarm-verildi-istanbulun-5-ilcesinde-6355569/3,* last accessed: 4 December 2020.

[11] https://kirilganlik.istanbul/.

[12] https://covid19.saglik.gov.tr/.

[13] Health Minister Fahrettin Koca's personal twitter account had 390 thousand followers on March 11, while this number reached 6 million 400 thousand as of December 1, 2020, see. https://medyascope.tv/2020/04/30/saglik-bakani-fahrettin-kocanin-twitter-analizi-takipci-sayisi-391-binden-5-milyona-cikti-yaklasik-4-milyon-kez-retweet-edildi/.

[14] https://www.aa.com.tr/tr/koronavirus/saglik-bakani-koca-her-vaka-hasta-degildir/1991187.

[15] In this regard, it would be appropriate to mention the monthly assessment reports of TTB COVID-19 Monitoring Committee issued since the first month of the pandemic, the data scientific studies which they openly shared by Mesut Erzurumluoğlu (@mesuturkiye), Defne Uçer Şeylan (@DefneUcer), Zeki Berk (@zekib), Güçlü Yaman (@gucluyaman) and Fatih Tank (@fatihtank) from Sarkaç which is the publication of Bilim Akademisi, and the Financial Times and New York Times, with their news on 'extra deaths' in the early stages of the pandemic.

[16] We carried out a preliminary study to ask concrete questions about the social determinants of health by matching the socio-economic profile of 959 neighbourhoods in Istanbul with the riskiness of the HES application, with urban researcher Murat Tülek, within the framework of the 6th Month Evaluation Report of the TTB COVID-19 Monitoring Board: Aslı Odman and Murat Tülek, "COVID-19 Pandemisi döneminde sosyo-mekânsal eşitsizlikler ve veri/halk sağlığı ilişkisi", https://www.ttb.org.tr/kutuphane/covid19-rapor_6/covid19-rapor_6_Part60.pdf. For the interactive map covering all of Istanbul here, see: https://cdn.knightlab.com/libs/juxtapose/latest/embed/index.html?uid=5967edae-f052-11ea-bf88-a15b6c7adf9a.

[17] https://cdn.knightlab.com/libs/juxtapose/latest/embed/index.html?uid=45f703b4-3c0f-11eb-83c8-ebb5d6f907df.

[18] Turkish Medical Association, *Kentlerde Sağlık Hizmetlerinin Örgütlenmesi. Çok Sektörlü Yaklaşım,* 2007, Ankara, p. 39.

[19] Ali Taha Koç, President of Presidential Digital Conversion Office, May 6 in the video conference organized by the website Digital Agenda said that as of May 6 about 5 million people downloaded the HES app developed in Turkey. See, https://siberbulten.com/sektorel/trky/hayat-eve-sigar-uygulamasininda-daveriler-kolluk-kuvvetiyle-paylasluluk/. It would not be wrong to think that this figure has increased several times as of December 2020, considering that it also includes repeated downloads and deletions.

[20] Gazi University Faculty of Medicine Dean and Ministry of Health Social Scientific Committee Member Prof. Dr. Mustafa Necmi İlhan explains the "Turn in" section, which was newly added, to the AA correspondent, as follows: "Citizens will be able to report here if they think there is a suspicious situation. In other words, citizens will be voluntary auditors with the "Turn in" application. Warming those who do not follow the rules can sometimes be a problem. If this is the case in a location, it is a correct approach to report that place. Because it will be a coronavirus threat for everyone. "Https://www.aa.com.tr/tr/koronavirus/adan-zye-hayat-eve-sigar-uygulamasi-/1963779, 5 September 2020.

[21] http: / /www.isigmeclisi.org.//www.evimanı.net/haber/420985/is-kazasi-meslek-hastaligi-vazife

[22] Şeref Özcan, "İş kazası, meslek hastalığı, vazife malullüğü", *Evrensel,* 13 December 2020, https://www.evrensel.net/haber/420985/is-kazasi-meslek-hastaligi-vazife-malullugu.

[23] http://isigmeclisi.org/20577-salgina-issizlige-acliga-ve-guvencesiz-calistirmaya-karsi-mucade.

[24] Kayıhan Pala, "Türkiye'de COVID-19 Pandemisi", in TMA Covid -19 *Follow-up Group 6 Month Review* Report, p. 109.

[25] Additionally, DİSK compiled a survey (http://disk.org.tr/2020/04/covid-19-disk-raporunun-ucuncusu-yayinlandi/) by reaching seventy per cent of its members (130,000 people in total) on 24 April 2020, and found that at least 535 workers were positive for COVID-19. Compared to those diagnosed positive with both Turkey's general population and positive results per 1000 in Turkey's working population, the rates are (respectively 1.3 / 1.6 / 4.1) is at least two to three times. DİSK's reports published during the pandemic period on 16 April, 20 April, 27 April and 8 July are available at www.disk.org.tr.

[26] The site of TTB that keeps instant data on the loss of healthcare workers: https://siyahkurdele.com/.

[27] Birleşik Metal İş, *Metal Sector Epidemic Report,* 20 November 2020, http://www.birlesikmetalis.org/index.php/tr/guncel/basin-aciklamasi/1603-metal-sektorunde-salgin-ciddi-boyutlara-ulasti.

ARTICLE » Hacer Foggo

SOLIDARITY IN PANDEMIC DAYS: FROM DEEP POVERTY TO DEEP INEQUALITY

The pandemic has created much more devastating consequences for those at the bottom of society. From the threat of daily hunger to the possibility of children being completely excluded from the education system, a series of hot topics are on the table. Deep Poverty Network, with continuous solidarity activities in all nooks and crannies of Istanbul, is a civil initiative established to raise these issues and to generate solutions. Hacer Foggo, one of the founding participants of the initiative highlights the responsibilities of the public administration and local governments in this article in which she summarizes the findings of a recently published research report.

According to the latest data of the World Bank, conflict, climate change and COVID-19 could push 176 million people into extreme poverty by the end of 2022, contrary to the progress made in the last two decades in terms of improving the living standards of those with the lowest income. In the upcoming period, the number of people defined as poor in general may increase by 1.2 million in Turkey according to the report released by The World Bank's Turkey desk a few months ago. On the other hand, the COVID-19 pandemic has also revealed various solidarity networks operating

Photo: Özge Ergin

Unfortunately authorities did not take those who live in deep poverty – that is, those who have irregular income, who do not have social security, who work daily or on daily wages, those who live in boxy room houses with 7-8 people, who cannot eat healthy and balanced nutrition, who do not have a television, tablet, internet– into consideration while making the pandemic measures public.

Photo: Hacer Foggo

to support those who lost their jobs, became incapacitated and aiming to increase the visibility of the ones who could not take adequate measures against the pandemic. Solidarity networks gave hope to 'impoverished' families during the pandemic. The most important feature of these solidarity networks was that they provided solidarity not as benevolence or philanthropy, but with a rights-based perspective and got the message across "we are here" against the weakness, future anxiety and anger caused by poverty. In other words, solidarities were organized to stand against inequality and aim to recognize, reduce and eventually eliminate permanent inequality. One of the solidarity networks was the Deep Poverty Network which we established to support precarious and daily workers who became even more impoverished with the pandemic.

"Change from Home" Campaign for the Deep Poor

The Ministry of Health called for 'stay home' on 11 March 2020 and we all returned to our homes. A few days later, "There is no food left at home" outcry of the people living in the back streets of the city –where we worked before– was an indication that there was also nothing left at their neighbour. In other words, basic food in these houses like flour and oil were also finished. The only thing to do was to respond to this cry with solidarity and we established the Deep Poverty Network (DPN) with the slogan #ChangeFromHome on March 18, 2020. The DPN developed a model aiming solidarity with families from their homes without giving supporters an IBAN. According to this model, DPN matched supporters with families and enabled supporters to shop for families through online shopping channels.

So what is deep poverty? We define deep poverty as a chronic state of social exclusion and inequality as well as income level indicators. Deep poverty primarily means being severely deprived of basic needs such as food, shelter, health, education as well as access to public services. The most important circumstance of those who experience deep poverty is that their children inherit poverty and no future. While the authorities announcing the pandemic measures, they, unfortunately, did not take into account those who live in deep poverty, that is, those who have precarious income, who do not have social security, who work daily or daily wage basis, those who live in a boxy room houses with 7-8 people and children who cannot eat let alone healthy and balanced nutrition, who do not have a television, tablet, internet. In brief, those with deep poverty trying to earn a living were workers with precarious professions such as waiters, recycling workers, daily workers, florists, peddlers, musicians, tailors, textile workers, construction workers, welders, house workers, waste paper workers, electricians, hotel workers and barbers. That is to say, they were the ones who had no savings, regular and sufficient income for hard times before the pandemic. They were the families who had to stay crowded in 50 square meter single-room houses where calls for 'social distance', 'distance education', '65+ stay at home' were meaningless during this period. Mothers who could not feed their children regularly had difficulty getting baby food and diapers. Education for children without the Internet and 'municipal police going shopping' for the elderly (65+) without savings did not matter.

Should s/he stay home or starve?

During the four hours when they were allowed to go out, these walks of life were collecting paper or peddling in the street to bring home some money. DPN has supported and continues to support more than 2,500 families by bringing together the most vulnerable and insecure segments of the society with those who want to support them with their situation, where all the institutions in the world were caught unprepared. It supported 34 districts of Istanbul, however interesting enough, most intensive demand for support

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came from the people in Şişli, Beyoğlu, Fatih, Çekmeköy and Ataşehir districts. Interestingly, these are the most central districts of Istanbul with a socio-economic level above the average in terms of real estate prices. In other words, deep poverty was at the top level in the back streets of these districts in the heart of the city.

The Deep Poverty Network sponsored by the Heinrich Böll Stiftung Foundation and via the Open Space Association *(Açık Alan Derneği)* started a new study titled *Deep Poverty and Access to Rights in the Period of Pandemic Research* as soon as the quarantine was over.[1] Field interviews were held face-to-face with 103 participants in Avcılar, Esenyurt, Üsküdar, Sancaktepe, Sultangazi and Sultanbeyli districts with main focus on Istanbul Ataşehir, Beyoğlu, Çekmeköy, Fatih, Şişli and Ümraniye between July and September 2020. In in-depth interviews, the demographic information of the families in the region, to what extent they had access to basic rights such as education, health, social life, working life, security, nutrition and care before and during the pandemic; the difficulties they faced in these areas and solution suggestions from their point of view were discussed.

The research pointed out that during the pandemic period, children specifically experienced serious problems with their basic needs such as nutrition, health and shelter, as well as education. According to the research, only children were working in 6 per cent of the households. In other words, children started to support the household, especially with the pandemic. The main reason for this was that adults working in the family were unable to work due to illness or other reasons, or that the income they provide was not sufficient enough to meet the needs. Working children naturally, neither could continue with their education nor have access to devices such as computers, tablets and the Internet which are essential for online education.

While 42 per cent of the population working in daily and precarious jobs were paper, scrap and nylon collectors: textile workers with 15 per cent, cleaning workers with 8 per cent, peddlers and florists with 7 per cent and musicians with 3 per cent followed them. Average earnings were between 700 and 800 TL per month. Since none of the interviewees had the chance to 'work remotely', they had to face 'starvation' when 'stay at home' was called out. Once they started going out again, factors such as people's fear of shopping from peddlers during the pandemic period and not asking services of daily cleaning workers were the leading causes of unemployment and income loss in these segments. Despite all this, people working illegally or with the fear of the virus stated that they were caught between the dilemma of "staying at home or going out and taking a risk". For example, a person named Cengiz said in the report: "I tried to go to work illegally so that I could earn 5-10 liras and buy bread. It scares me to be served with fine this time, afraid of a virus infection when I just want to buy some bread for the house."

In-depth interviews within the framework of the study revealed that many families faced hunger. It is observed that households, especially those working in daily jobs, living under the conditions of deep poverty before the pandemic and having difficulty in accessing food, lost their jobs and started to fail access to food. Families who had a hard time accessing food during the pandemic were talking about having to collect it from the garbage in order to have something to eat and the risk of consuming what they have collected from the garbage. Out of

It has been observed that households, especially who work in daily jobs, living under deep poverty conditions even before the pandemic and had difficulty in accessing food failed to access food as a result of losing their jobs.

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Photo: Hacer Foggo

the 100 people interviewed, 14 stated that they had no access to food, 49 per cent was only able to reach certain food groups and 53 per cent skipped more meals than in the past. A paper collector living in Ataşehir expressed this situation with the following words: "When hungry, people get angry with everything, with their own self, why their situation, society, system, order, everything…"

One of the most striking examples of the research and the pandemic period was that families with babies could not provide their infants with baby formula and diapers, they said that they give them sugared water instead of baby food and that they used bags instead of diapers. That is to say, only 4 per cent of 103 households participating in the research stated that they could buy diapers and food without any problems while 74 per cent had great difficulty in obtaining them and 21 per cent emphasized they could not buy them at all. The situation of women in terms of hygiene also revealed a dire picture. During the pandemic period, only 2 out of 10 women stated that they could fulfil their need for a hygienic pad without support.

Digital inequality will break a generation off from education

The transition to distance education together with the pandemic also prevented the education of many children with precariously employed families could not have access to the Internet. As supported by the quantitative data, the most prominent reason for children not being able to participate in distance education is that technological facilities were not sufficient. While some families stated that their children could not attend because they did not have the Internet even though their teachers were organizing online classes, some families said that they did not have any digital means at all to access distance education from home. The risk of children being cut off from education emerged as an important theme in in-depth interviews. While some of the families interviewed told that their children dropped out of school before completing their education for various reasons, some families expressed their concerns about whether their children could continue with their education. When we asked the children we interviewed or their parents if they could follow the classes in distance education, their answers showed the severity of the situation. The results are as follows: 57 per cent cannot follow the classes because they do not have tablets, computers or televisions, the biggest obstacle for 54 per cent of the 60 per cent group is not having an internet connection, for 45 per cent not having adult supervision, not having enough information for 39 per cent, unwillingness for 18 per cent and having to work for 7 per cent and other obstacles. One mother said in the field interview: "He went to the neighbour's house because he said our TV does not have a reception for Eba TV. So there is a pandemic, people are afraid, I am afraid of both sending and disturbing the neighbours. They could never attend the live classes. Sometimes they had homework and they tried to do it with their father's phone. When their father comes home, they cling to the phone for the lesson."

So what needs to be done?

According to research results, there are three important issues for families: their basic nutritional needs to be supplied, social support for those who lost their jobs to be provided and discounts on

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The pandemic showed that local governments' social work legislation and academic reports regarding poverty are not sufficient, applicable measures should be taken in the field and sustainable solutions are needed, not temporary.

bill payments. Based on this, we can list the following suggestions for local governments and public administration:

- In terms of employment, providing social security in situations like unemployment, illness, etc.;
- Ensuring equal opportunities in new employment possibilities after the crisis;
- Establishing temporary accommodation centres by local governments;
- Renovating the idle and worn-out houses and renting them out to the needy for a small fee;
- Establishing social market applications or stores in control of local governments to ensure access to basic food, clean water and hygiene supplies;
- Preparing budgets for similar situations by local governments beforehand;
- Providing basic care and nutritional support to people who are infected / under quarantine;
- Providing protective equipment such as masks for free;
- Providing uninterrupted healthcare services during the pandemic period regardless of Green Card debts.

Pandemi süreci yoksullukla ilgili olarak Regarding poverty, the pandemic period showed that local governments' social service regulations and academic reports are not sufficient, applicable measures should be taken in the field and sustainable solutions are needed, not temporary. For this reason, bringing the fact of poverty before and after the pandemic to the table in-depth is the duty of both the state, local governments and non-governmental organizations working on this issue. Conditions for permanent work, not temporary, socially secure jobs must be created for those who experience deep poverty. In short, both the state and local governments need to take urgent measures for families living in deep poverty.

The Deep Poverty Network is just one of the networks that organize rights-based solidarity; of course, solidarity networks should become widespread however these networks can't replace local governments and the public. What is essential is that local governments and the state produce permanent solutions, not temporary –as has been pointed out in the areas by these civil initiatives– so that the legacy left to children is not poverty. An elderly peddling in the streets during the pandemic period told me: "My grandchildren were looking into my eyes every morning when they woke up. I felt guilty every time they looked at me. I couldn't work and I couldn't bring anything home, not even a chocolate bar."

The story is the future of these children.

[1] For the full research results, see https://derinyoksullukagi.org.

ARTICLE » Deniz Mardin

HEALTH POLICIES FOR MIGRANTS AND 'TEMPORARINESS'

Pandemic caused the strengths and weaknesses of the health care system in Turkey to be seen more clearly. On the other hand, it would be wrong to think that access to the system creates equal results for everyone. In this respect, migrants are a group that deserves special attention. In this article, in which Deniz Mardin describes in detail the legal changes regulating the rights and conditions of migrants to access health, also makes a balance sheet of the institutional problems that have become much bitter with the pandemic.

Health policies for migrants underwent a radical change with the publication of the Law on Foreigners and International Protection (YUKK) in 2013. With this law, the rights and obligations of migrants were determined. According to UNHCR data, in April 2013 when (YUKK) was accepted, there were 35,664 refugees and asylum seekers in Turkey of which 14,688 were asylum seekers, that is their applications were at the evaluation phase.[1] Besides, there were approximately 400,000 Syrian refugees, and approximately half of them were staying in refugee camps. With YUKK, the refugees whose applications were under evaluation and the status holders were provided with access to health insurance and correspondingly to health services by legislation.

One of the most important factors affecting the access of migrants to health services is the affordability of healthcare costs. This is only possible if the person is financially able to meet their health expenses or if they have access to general health insurance. Before the publication of YUKK, Law No. 5510 on the General Health Insurance covered only "stateless and refugees".[2] However, with YUKK conditional refugees and status holders in Turkey were provided with access to health insurance and to health services. In fact, during the mass migrations, arrangements were made only for what happened at that moment and the people who migrated, with the temporary protection status, the Syrian refugees attained legal status, and health rights and access conditions were regulated. After this law, which deals with the right to health of non-citizens, namely foreigners, legislation was expanded. The way health services will be provided, the conditions of access were detailed with rules and regulations.

Since statistics on non-citizens are published after the end of the year, the available figures are usually from the previous year. According to the data of the Directorate General of Migration Management, the number of applicants for international protection was 114,537 in 2018 and 56,417 in 2019. The total number of conditional refugee applicants and status holders was approximately 400,000.[3] The number of Syrian refugees under temporary protection was approximately 3.6 million and the number of irregular migrants was approximately 450,000.[4] In 2019, the number of all refugees[5] increased approximately ten times compared to 2013 when YUKK was published. Syrian refugees coming to the cities from the camps with the increasing numbers required new regulations to be made.

The conditions for Syrian refugees' access to health services and the services to be provided are regulated by Temporary Protection Law and circulars. As the mass migration incident was handled as a state of emergency, Syrian refugees' access conditions to health services were organized by the Disaster and Emergency Management Authority (AFAD). In the first circular, it was stated that Syrian refugees could only benefit from health services in eleven cities by the borders. However, in September of the same year, refugees were given access to services in all cities as they came to big cities for work, shelter or other reasons. Up until the issuing of this legislation they were rejected many times when they had health problems. In the period when AFAD covered healthcare expenses, referrals from primary health care services were made compulsory to control hospital applications. Less than a year later, the obligation of referral was abolished. Migrant Health Centres were also put into practice during the referral process. Legislation on Migrant Health Centres was issued in 2015; physicians who were citizens of Turkey were on duty in the centres opened at the beginning. However, most of these physicians were not informed about the health, social, registration or legal status of migrant patients. Besides, although the legislation provided access to primary health care services, the communication problems due to the lack of translation support was a primary obstacle.[6]

Starting in 2016 and planned to be completed by the end of 2020, SIHHAT

project (The Development of Health Status and the Related Services Provided by the Republic of Turkey to the Syrians Under Temporary Protection Project) aimed at improving the primary and the secondary healthcare services for Syrian refugees. Within the scope of the project, Syrian healthcare professionals were trained and provided with the opportunity to work in migrant health centres, and Syrian refugees were provided with health services in their mother tongue. However, since Syrian healthcare professionals couldn't obtain the necessary documents to request equivalence, the employees could not be fully integrated into the health system. In other words, Syrian health workers had the right to work in migrant health centres within the scope of the SIHHAT project, but they were not able to work in hospitals or family health centres.[7] Furthermore, if it is considered that Migrant Health Centres started within the scope of a project and the project will be completed after a certain time, it can be understood that these employment conditions provided are 'temporary'. This situation also resulted in Syrian healthcare workers to work without job security and their personal rights were violated.

Moreover, the expectation that physicians, many of whom have different specialties, who have not provided primary health care for a long time, perhaps for years, to provide preventive health services such as pregnancy follow-up, infant vaccines, and follow-up of chronic diseases have increased professional concerns about medical errors. For example, asking a gastroenterologist to follow up on pregnancy both makes it difficult to provide qualified healthcare services and creates a problem for the healthcare worker to perform his/her profession well.[8] Apart from the scope of the project, there are clinics established by Syrian refugees. However, most of these voluntary clinics, for which permission is requested at six-month intervals, continue to serve as unregistered health centres. One of the reasons why such health centres continue is for the Syrian refugees to have the opportunity to get health services from specialist physicians in their mother tongue; another reason is that Syrian healthcare professionals have limited opportunities to practice their own profession outside of the SIHHAT project.[9]

Photo: Özcan Yaman

Migrant Health Centres, although its name suggests that it is intended for all migrants, primarily served Arabic-speaking migrants, especially Syrian refugees. For this reason, the Foreign National Polyclinics (YUP) were established by the Ministry of Health for other migrants and refugees to benefit from primary health care services. The Ministry of Health announced the establishment of these polyclinics as follows:[10]

> According to the data of the Directorate General of Migration Management, besides Syrians under temporary protection, our country also hosts migrants from different nationalities, mostly from Pakistan, Afghanistan and Iraq. In this respect, our Ministry has decided to open a Foreign Nationals Polyclinic to provide preventive healthcare services and primary healthcare services, with the priority of fighting contagious diseases, for the aforementioned persons.

The doctors working in these clinics are citizens of Turkey unlike the ones working in Migrant Health Centres, therefore language still remains to be a barrier in delivering services. Therefore, these polyclinics cause dissociation of the health services provided to different migrant groups.

Providing services in Arabic at Migrant Health Centres enabled millions of people to benefit from health services in their mother tongue, but the fact that data on the applicants' health status is not shared prevents it from knowing how much of the refugees' health needs are met. Migrant Health Centres and the Foreign National Polyclinics serve in line with the system of Family Health Centres serving the citizens of the country, and the fact that these centres do not intersect with the existing system becomes a phenomenon that dissociates the society. While these health centres provide privileged services to refugees in one respect, they also have a role in isolating/concealing the problems refugees experience in accessing health services. Migrant Health Centres is a solution method in which the services provided differ from one centre to another, their effectiveness is evaluated only quantitatively, implemented on a project basis, serving a part of the migrant community, and is put forward to solve the problems of access to health services temporarily. These centres would make more sense if they were positioned as a transition point to the existing system, with a facilitating/supportive role in accessing health services, where new migrants are informed about their health rights. There is a similar structure that only serves refugees in England. These health centres support refugees' access to health services by providing both preventive health services and translation support, as well as providing health literacy training by organizing training on the health system and certain health problems.[11] Primary healthcare services have a very critical role in access to healthcare services. Having a good preventive health service, regular follow-up of people with chronic diseases reduces migrants' application to emergency services, hospitalization and intensive care needs.[12]

> Migrant Health Centres is a solution set forth to solve the problems of access to health services temporarily, in which the services provided differ from one centre to another, their effectiveness is evaluated only quantitatively, applied on a project basis, serving a part of the migrant community.

One of the reasons for the establishment of a parallel system was the problems with accessing Family Health Centres which are a part of existing primary healthcare services. The first of these problems was the difficulties experienced in registering with the family physician in these centres. This stems from the practices introduced within the scope of the Health Transformation Program since the family practice system is primarily obliged to serve and monitor registered patients. Among these, pregnancy and vaccine follow-ups are significantly important because family physicians are subject to a 'penalty point' enforcement[13] in case of not complying with these follow-ups. Family physicians can provide services to people including Turkish citizens who are not registered with them as 'visiting patients' if there is an appointment available on that day. Family physicians prefer to service immigrant patients as 'visiting patients' rather than 'registered patients' because they have difficulty in keeping track of migrants who move frequently.[14] Only some of the migrants who encounter difficulties in the system find the opportunity to register with family physicians who act more voluntarily. The lack of translation support also makes it difficult for family physicians to understand and conduct the problems of their patients. In fact, similar problems occur in different countries. The reasons for family physicians not registering migrants in the UK are their constant mobility, being difficult to follow-up and communication barriers.[15] We can say that the current family practice system has not been structured to provide healthcare services for migrants and is not a migrant-friendly healthcare system the way it is implemented.[16]

> The current family healthcare system has not been formed to provide healthcare for migrants and is not a migrant-friendly healthcare system in the way it is implemented.

The fact that primary healthcare services are provided free of charge eliminates the financial obstacles that may arise in accessing these services. However, whether the person is registered or has health insurance continues to be one of the first issues encountered in admissions to hospitals. Until the decree-law issued in December 2019,[17] refugees' healthcare insurance was paid by the Directorate General of Migration Management. Due to the change in YUKK as a result of this legislation, it was stated that refugees living in Turkey for over a year would pay for their healthcare insurance themselves. It has been announced that only people with special needs won't

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The fact that refugees' health insurance is valid only in the cities where they are expected to reside prevents people who go to other cities for social or employment reasons from benefiting from health services.

have a time limit for healthcare insurance coverage. This change, which was put into effect immediately after it was issued, caused the cancelation of healthcare insurances for many people and not being able to benefit from healthcare services. This situation has caused people with chronic diseases such as cancer, diabetes, hypertension etc. or who are seeking emergency services, to be demanded of fees they could not pay, not being able to continue with their treatment and consequently being excluded from healthcare services. In addition, the fact that refugees' healthcare insurances being valid only in the cities they are expected to reside retrains them from the benefits of healthcare services when they move to other cities for social or employment reasons.[18]

The latest change regarding the conditions of benefiting from healthcare insurance has made access to healthcare services even more difficult during the pandemic. Although many people had doubts of having COVID-19, they delayed their admission to the hospital due to the financial problems or not being registered. First stating that the examinations and treatments for COVID-19 will be considered as an emergency, then announcing that people could access COVID-19 diagnostic tests and treatment whether they had social security or not, in April enabled migrants and refugees to apply to the hospitals for health problems related to COVID-19. However, many people with chronic diseases, who do not have healthcare insurance, are unregistered or do not live in the city where they are expected to be, are trying to survive at more risk because they have difficulty in continuing their treatment. Besides, the migrants and refugees not being able to benefit from social aids provided by the public caused more impoverishment on their part. Social and other aids in some cities were provided by local governments and non-governmental organizations.[19]

The migrant group that encounters the most problems in accessing healthcare services is the unregistered one. When they need healthcare, unregistered migrants prefer to go to private hospitals instead of public ones if they have the finances, with the fear of being reported to law enforcement. They are faced with different procedures in public hospitals due to the current legislation not regulating what services they will be provided with and the pricing of them. Especially in some hospitals, pricing is based on the Health Tourism Regulations, and an uninsured person is charged three, four or even five times more than what is requested, which makes it impossible for the unregistered migrants to access health services.

In some hospitals, pricing is based on the Health Tourism Regulations, and an uninsured person is charged three, four or even five times more than what is required, makes it impossible for the unregistered migrants to access health services.

Although this circular was issued only for foreigners who came to the country for healthcare services, the absence of legislation for unregistered migrants causes arbitrary charging in hospitals. People from this migrant group with currently limited job opportunities do not go to hospitals unless their health problems get worse since they do not have the means to afford these expenses. Another problem that causes them not to seek medical advice is being unregistered and undocumented. Although, in the healthcare legislation, the fact that the people being undocumented does not mean that they cannot receive healthcare services especially in emergencies, it is up to the medical staff in the emergency services to determine whether the patient is accepted or not. The fact that people delay seeking medical care despite their need or do not seek services

at all causes the health problems to progress further and due to the late inquiry, the illnesses that can be cured sometimes result in death.[20]

While applying to a hospital, migrants encounter different procedures in different cities or between institutions in the same city. Although the reason for encountering different procedures especially during the registry and charging stage of an individual is thought to be the initiative of the medical staff on duty, these implementations are generally based on an institutional decision. For example, a study conducted in Eskişehir in 2016 showed that there are differences in the acceptance mechanisms of refugees in hospitals in the city. Legislation issued for people with humanitarian aid status was applied to all refugees by a hospital. Ultimately, although all refugees have health insurance, this hospital requested to charge them as if they were uninsured and some departments within the hospital indicated that they could not accept the patients.[21] Lipsky calls the different procedures seen in public institutions after the legislation was issued as "street-level bureaucracy".[22] Unfortunately, the recognition of certain rights in legislation does not mean that access will be granted in practice. Right at this very point, corporate decisions of public employees come into play. In other words, after policy development, there is a need to monitor how it is put into practice and evaluate how it responds to the applicant's needs. On the other hand, when a migrant seeking healthcare services encounters variations in inter-hospital procedure, it makes it difficult for her/him to understand the health system and benefit from healthcare services.[23]

Another problem encountered is the lack of legislation regarding a system that regulates and controls translation services in the field of health and this prevents communication that forms the basis of healthcare services. In this field, where communication problems are tried to be solved in different ways, the applicants sometimes bring their children, relatives or acquaintances who speak Turkish as interpreters. Sometimes, healthcare professionals who speak different languages also act as interpreters besides their duties. This situation causes migrants to share limited information because they sometimes do not want to explain their health problems to their acquaintances and sometimes, they do not want to share their private problems with people they do not know. The applicant's inability to explain the health problem well causes the healthcare professionals to have difficulty in deciding on the diagnosis or treatment. Moreover, the language barrier creates an obstacle for the medical staff to describe the treatment. Healthcare professionals try to understand the problems and find a solution in a limited time for applicants without an interpreter, but the anxiety of misdiagnosis and malpractice is experienced more frequently with the increasing number of applicants.

Transformation in health and migrants

Although there was no clear legislation on migrants' right to healthcare and the services to be provided before the YUKK, some migrants could access health services. However, with the changes made since 2012, problems began to be encountered in admissions to hospitals. With the 'decentralization' of the health system within the scope of the Health Transformation Program, the plan was to take decisions locally and regionally, not centrally. It was thought that it would be faster to respond to the problems encountered and be easier to shape healthcare services to meet the needs this way. Also, the hospitals to control their own expenditures by becoming more autonomous structures and to reduce healthcare costs was still another goal. Shaping healthcare services with the participation of society was also among the envisaged things to be done. The fact that the control of health expenditures in institutions becoming a priority in offering healthcare services has turned into something that determines the conditions for benefiting from healthcare services. As a result, the perception that those who can afford healthcare expenses can benefit from services started to be accepted. With decentralization, some of the central decision-making mechanisms are transferred to local / regional institutions, and as a result, policy development and improving the health status of the society become the responsibility of local institutions. However, in Turkey, where there are regional socio-economic distinctions, transferring decision-making mechanisms to local governments in a country where they are not supported sufficiently causes differentiation in

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the offering of healthcare services on a national scale and an increase in healthcare inequalities.[24] Vulnerable groups such as migrants are the most exposed to inequality in this regard.

Another problem faced in evaluating healthcare policies is the inability to access data. To evaluate the results of healthcare policies, medical conditions of people need to be followed up and data need to be analysed. However, sharing only quantitative data from the healthcare records of foreigners, such as the number of outpatient services provided or the number of births in the hospital, etc. makes it impossible to evaluate how much the service provided is tailored to the community, accessible, affordable and inclusive.[25] It also makes it difficult to understand how legislative changes have caused a change in terms of accessibility to healthcare services.

Another major factor affecting the healthcare policies for the migrants in Turkey, as it is stated in YUKK is that refugees, conditional refugees, people under subsidiary and temporary protection do not have the right to apply for long-term residence.[26] This situation leads to the regulation of all legislation and practices only for people, who will be in the country for a certain period and causes the planning of project-based, temporary implementations where sudden changes are made. The handling of people with such status within the scope of a 'temporariness' policy is still the most fundamental problem. The planning of services to be provided to refugees according to the temporary period they will be in Turkey at the implementation stage of the legislation gets ahead of the institutionalization and development of many structures and services.

'Temporariness' and the state's attitude towards the 'other' cause everyone who is not a citizen to live with uncertainty in Turkey. Although the legislation is comprehensive in terms of the right to healthcare, the differences in practice show that no service is clear, precise and permanent. Implementations can be changed at any time and this is not a questionable issue. It is not disclosed

based on the data the change was made. The temporary status of migrants is also reflected on the healthcare policies practiced. This situation also prevents migrants from defending their rights, making demands on rights and services and participating in solution-generating mechanisms with problems they are experiencing. There is a need for the regulation of healthcare policies and implementation of permanent practices evaluating the healthcare data of migrants, considering their healthcare needs, ensuring the participation of the society, reviewing the effectiveness of the practices at regular intervals.

Photo: Özcan Yaman

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[2] Since 'refugee' in Turkey involves people escaping from events in Europe, refugees and asylum seekers coming from outside the European Union countries accepted in the international literature did not have the right to benefit from health insurance by legislation.

[3] https://www.unhcr.org/tr/wp-content/uploads/sites/14/2019/11/UNHCR-Turkey-One-Pager-Fact-Sheet-Oct2019.pdf.

[4] Statistics on migrants are available on the website of the Directorate General of Migration Management: https://www.goc.gov.tr/.

[5] In this article, the term 'refugee' is used to include refugee, conditional refugee, and all persons under temporary protection.

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Interview by Fırat Genç

Rethinking social services to rebuild the society from the bottom up

The COVID-19 pandemic is a historical phenomenon in which it is very difficult to predict what the social consequences will be. Many commentators state that we are still experiencing an open-ended process. On the other hand, at the end of the first year of the pandemic, we have accumulated a lot of observations to have an opinion or witnessed many valuable intellectual efforts in this direction. Rethinking Social Services conference, which was held for the eighth time this year, focusing specifically on the multidimensional effects of the pandemic, was one of the most comprehensive initiatives of this kind. We talked to faculty members Uğur Tekin of Istanbul Kent University and Neşe Şahin Taşğın of Maltepe University –from the organizing committee of the conference– about what the pandemic showed us from the social service perspective.

Photo: Özcan Yaman

Let's start with what you aimed for with this conference first. What did you have in mind when organizing such a meeting in this multi-layered state of uncertainty, what kind of approach did you have?
Uğur Tekin: We have been holding these meetings since October 2011, but it was the first time we held it online. The main objective of the conference is to discuss the fundamental problem of the social services and to bring ongoing international debates in various fields to Turkey. We selected this issue this year because the pandemic is a situation that will provide structural change in social services or affect intervention methods in a number of areas. In the context of the pandemic in conjunction with the changing social structure, we based our inquiries on how –already– expanding social services for a while will evolve in Turkey. This is a rapidly growing area in terms of both education and forms of interference, therefore it specifically requires it to be addressed to in the context of the pandemic.

Looking at how the pandemic is represented in public, we are often faced with the emphasis "we are all on the same boat". What can be said about the consequences that social differences and inequalities have created in terms of the functioning and effects of the pandemic? What do you think are the prominent axes of the debate, and what should be underlined as far as Turkey is concerned?
U.T.: As the speeches given at the conference pointed out, certain segments of the society are billed for the process. Specifically, topics such as the status of employees, unemployment, poverty and the situation of the poor stand out here. This disease doesn't affect everyone, after all. Although it initially spread among the more mobile middle class segments, it mainly spread among the poor. The poor and employees, those working in a certain field were effective in the change of social structure due to this disease. Decrease in income and unemployment are serious issues. Social funds to support the poor being very limited in Turkey is just another critical issue. Although some partial support is given for damages in European countries, it was very limited in Turkey and generally such funds were used for the sake of keeping the business structure alive. Not in a direction where the poor could expand their means. This is more obvious in Turkey, but in general those who benefit less from community opportunities have been more affected by this process all over the world.

Neşe Şahin Taşğın: There is no social service system including the entire society, reaching all segments in Turkey. There is a system only a small part of the society can benefit from and it is subject to an application system, therefore only the applicant can receive services. We do not have a social service structure where comprehensive, accessible services can be provided to those who are in need of it. Moreover, especially with the transformation of the field of social services in the last twenty years, if we consider the actions carried out by the Ministry of Family, Labour and Social Services, we see that a social aid-oriented policy is followed. What happened in the pandemic? The number of very few social aid beneficiaries increased. Very limited social aid is given to people.

Of course there is a wide range of social welfare in Turkey, I also need to say. For example, there are social aids, which were established during Özal's period in the 1980s and distributed through the Social Aid and Solidarity Encouragement Fund (SASEF), and they are provided by the central government. Again, the same ministry mainly provides social and economic support (SES) to women and children in order to support children with their families and ensure their continuity in education without taking them into institutional care. There is home care assistance given to families with disabled members, especially through women. Also as Ayşe Buğra stated for years, perhaps only sole right based social services in Turkey is the old age and disability pensions granted to people with disabilities within the scope of Law No. 2022. We can add social aid or social support provided by local governments to them; especially package deliveries, food supplement packages, food cards and like.

What happened during the pandemic? The limited number of social aid beneficiaries' needs increased incrementally. This unfolded very clearly in a field study we conducted recently. Secondly, during the pandemic especially during the lockdowns, small shopkeepers and some employees were affected directly. Who were they? Some of them were reflected on the press

In Turkey, there is no inclusive social service system involving the whole community, accessible by every segment of society. Instead, there is a system only a small part of the society can benefit from and is based on an application system, therefore only the applicant can get services. We do not have a social service structure where comprehensive, accessible services can be provided to those who have problems.

and also appeared in our field research. For example, shuttle (minibus) drivers, hairdressers and barbers, waiters, private school teachers could not get their salary. All these segments have been added to already existing dispersed beneficiaries. However, the most aid given in this process was 1000 TL, which the Ministry of Family, Labour and Social Services distributed through Social Aid and Solidarity Foundations for once. A friend who works in a social service centre in a district of Istanbul stated as: "We received 20 thousand e-government applications in a month in a district with a population of 800 thousand and it is not possible for us to meet the demand." In other words, there was an incredible overload on the already fragile and limited social service and social aid capacity.

One of the important highlights of the conference call was that the pandemic revealed how critical the social service field was. On the other hand, you state that the deficiencies of the field in terms of knowledge, implementation and approach are also visible. Is it possible for you to objectify them a little bit? Likewise, the field of social policy covering the field of social services is extremely critical for the understanding of the last 20 years, as many researchers have emphasized. When we consider this background, what can be said about the pandemic?
N.Ş.T.: Frankly, in our research, we did not get the impression of the state having such a discussion. The Ministry employees mentioned a lot, "We only

stretched the increase in socio-economic support requests a little, we gave aid to anyone who wanted them on principle of statement basis in regard to an article" in extraordinary cases, these conditions are not required "in the relevant regulation (SES Regulation). Apart from that I have not heard an argument about the expansion and increasing of the content of social services and aid by the central government in Turkey. I have not heard of it in the budget discussions held by the Ministry. Regarding the possible long-term effects of the pandemic, increasing the resource there from three units to five units. Other than that, I have not heard any minimum income discussion held at the state level for example.

U.T.: In general, there was no such discussion about different service presentations neither in the state nor in the social services community. What we want to do in this conference is to put different discussions on the agenda of the social services communities. For example, no such discussion became an agenda in municipalities. To a very limited extent, they tried to increase their means to meet every application. And of course, now there is also a lack of uncertainty issue of who exactly in Turkey is in charge of social services currently. Municipalities have recently entered this process. They, just like the central government implement a system based on a patronage relationship similar to the AKP's policy. In other words, they have evolved towards a social aid system based on the support and commitment of the segments from which they will get votes. One of the main problems in the central government is the lack of information sharing. There is also a series of problems such as the segments receiving more than single aid or not being able to determine where the support is directed due to the fact that it is a two-headed system. As reflected in the discussions, information sharing is the biggest problem of the Istanbul Metropolitan Municipality; since they were not provided with information, they had to create their own sources for it. They can be effective in this process but their fields of activity are based on the types of social aid we mentioned except for a few examples.

One of the main problems in the central government is lack of information sharing. In addition, due to the fact that it is a two-headed system, there are a number of problems such as the segments with multiple support or inability to determine where the support is directed. The biggest problem of the Istanbul Metropolitan Municipality is information sharing as well; they had to create their own sources of information because they were not provided with any.

N.Ş.T.: When we examine how different countries experienced this process, there are of course different practices depending on the historical and political conditions of these countries. From the perspective of social work academics and the perspective of international social work activists however, there is an emphasis on increasing the advocacy that the pandemic will deepen social inequalities, and that governments should be forced to carry out inclusive activities including social services and

Photo: Özcan Yaman

Photo: Özcan Yaman

providing social services should be based on rights and human rights.

The privatization of social services and withdrawal of public support, which started with the regression of the welfare state and neoliberal policies especially since the 1990s, is a process also experienced by developed welfare state countries. There was a specific reaction towards this by stating: "Look how beautifully the pandemic has shown the negative effects of neoliberal policies on social services". We see that welfare state practices are recalled again in this manner. In countries like ours where these have never happened, it is necessary to remind it again and again. In African countries for example, a little differently, community-based studies become prominent. What's happening in Turkey? Particularly employees of the central government protest as "Why don't we shut down?" Of course, differences based on the individual also stand out here. While a social worker in a kindergarten with 100 children is working hard to protect children, to organize daily life in this closed institution, another social worker, a psychologist can take administrative leave with a fake report and not show up at work for six months. In fact, the conditions of social service and residential social service organizations are heart breaking during the pandemic process. There are personnel problems, problems arising from living together. You know, we are proud that nursing homes were not closed during this period. We are actually proud of them for not closing. You know, in Italy and Spain, news came out saying "The employees left the nursing homes". As our interviewees said, this did not happen here. Because no matter how much a nursing home employee is afraid of the pandemic, s/he will go hungry when he quits his job. People continued to work in risky conditions out of fear of hunger.

U.T.: As one speaker from the USA stated at the conference, there are two different approaches in the world regarding this issue. The first one, social work being a part of the control system and the other one is that it stands by and defends the rights of the weak in society. Here, the speaker gave examples of the comparison between the USA and Brazil. In the USA, their social service is more connected to the control systems of the state. On the other hand, social workers in Brazil define themselves as a part of the workers, employees, and proletariat. Our approach to the discussion and the pandemic is in favour of the latter. In other words, not a control system but a system that stands by the vulnerable segments, builds itself with them, takes action, develops models about them while defending their rights, and is mostly based on social movements. When we look at the social work process developing in Central Europe, we can say that the approach is based more on rights. This lies at the heart of it; that is, not to fulfil the duty of the state but an approach and practice that stands by people and defends their rights. We aimed to discuss this second pillar in social work.

For example, we started a discussion in the first meeting we held after the Gezi Park resistance on a social work concept that is disconnected from control purposes, which is influenced by existing social movements such as Gezi and puts it in front of changing the structure of society by becoming a part of it and asked ourselves "What can we learn from the Gezi resistance? What did Gezi teach us while building the activities in social service?" This is the basis of what we call rights-based approach. If we connect this with the pandemic, it is important to carry the load of the process as Neşe stated before. As a method, there were

Photo: Bircan Akman

problems here during the pandemic process. First of all, social services were not ready for this, medical professionals are better prepared to work in such fields. However, there were only social workers with earthquake and disaster experience working in the field and they were able to transfer very limited experience they brought with them. Apart from that, there are experiments regarding the services carried out by the Red Crescent in some war zones in Africa. Other than that, social services had no experience of the pandemic period. What conclusions do we draw from the pandemic experience? This is very important to us. What kind of methods are we experiencing about working during the pandemic and to develop in theory and practice on how social services will be in the future? What kind of mechanisms can be established so that in such pandemic periods, social services can be more effective standing by the society? Thus, it is very important to support and strengthen local structures, solidarity groups and structures organized from below within the society that we discussed in the municipalities debate.

On the other hand, it can be said that both the financial resources and administrative structure allocated by the state for social policies and non-governmental organizations within this scope have expanded significantly in recent years.

U.T.: Yes, there has been a rapid growth recently. While there was a very limited structure both in terms of education and institutions in the 1960s, especially in recent years, this field has grown due to the legal changes in the European Union harmonization process and a number of related developing projects. For example, there was a cyclical, non-permanent period that did not develop with its own dynamics, but the emergence of very rapidly growing civil society structures due to the transfer of aid for refugees to civil society and their absorption of social service professionals. Social aids, which are partly dependent on the AKP's policy, and the social aids it provides to bind a segment of the society to itself are on the agenda. In addition, there is the patronage issue of the municipalities that we have just talked about. In a social aid system that mayors have set up to create their own voting potential, social service develops in such a fluctuating manner. Every country may have gone through a similar experience, but ultimately the system is weak in Turkey; as Neşe mentioned before, its institutional structure is weak. The number of trained and experienced staff is very limited and their experience is very little. The overall experience is minimal. All of these are handicaps facing social work and therefore subject to our discussions. An advantage of this might be that we are

talking about unformed structures. There are no strong institutional structures, no rigid structures that have clarified their functions. It is possible to interfere with them; this is what we try a little bit in these conferences. We talk about these in our meetings, we think that there is a possibility to get involved in the process of new formation. This is one aspect of it. On the other hand, as I said, about the pandemic, we are talking about a group and structure that does not have its own experience as in other fields. There is a two-headed activity, whose institutional structures are fragmented, the legal background is not clear. While the municipalities carry out their own field of activity, the same activity is carried out by the ministry; there is no joint activity. They even developed activities in a way that they stepped on each other's foot, information was not shared. A decision was taken that if you are going to help, you can help after doing social research

If we can establish an understanding that social service is not only social aid, that social service should also develop certain structures and these structures can be a step in rebuilding of the society from bottom-up with advanced staff, the way for local administrations will be cleared. It is not possible to do so with the current central government.

and writing a report. This being the case, the municipalities had to go on the field. They were obliged to put their own researchers in the field with their own staff, municipalities were obliged to do so.

There are structures that we call the third pillar, which are developed by the people themselves in this process to protect themselves, and these are very important for us. Central structures must support them. They must transfer resources to them; because during the pandemic aid process, the state does not conduct social investigations anyway, municipalities partially did this stating who is in need and who isn't. Only such local initiatives have established a specific system of how the needs will be distributed and met. The municipalities had to rely on information they got from these initiatives. Council members tried to establish relations with regional associations and the importance of such structures became apparent. If the central structure does not have a pillar in the local area and if the local pillar does not have a place in the community, this does not work. This is one of the important points we learned in this process.

You have just stated that the municipalities approach the social aid issue mainly through patronage relations. On the other hand, the resources and activities of the municipalities in this field are expanding. In this context, what is the role of municipalities and what are the cornerstones of a more egalitarian approach?

N.Ş.T.: I think this is very difficult via local administrations. I say it without any political prejudice; unfortunately all municipalities approach the issue in terms of patronage relations. There are several municipalities in Istanbul trying to break this. They are trying to develop a more egalitarian social service system through the mayor, through the people they appoint, but it is very difficult. The situation in the Istanbul Metropolitan Municipality (IMM) seems a little different to me. We met with three people from the IMM; it is a little different from district municipalities, as it is obliged to serve Istanbul as a whole. There is a newly developing social service structure, there is an effort; many young new graduates have been hired. Those we interviewed were very young. "What did you feel in the pandemic?" we asked. "We felt like it was just the time for us to work," they said, and told us how they worked until midnight. "Was there any discrimination with the aid?" I asked. "Even if it was the case from above, we employees did not allow it," they replied. How the system works for one individual to another, of course, is open to question. I am trying to explain that a new structure is forming there. There is an effort among the employees to establish it based on rights. It still is a question mark how much of it is present at central level. This is really hard with the municipalities, is it any easier at the central level? No, it's impossible there.

U.T.: No matter how much the municipalities operate through patronage relations if we can settle the understanding that social service is not social aid alone, that social service should develop certain structures and together with advanced staff these structures can be a step in rebuilding of the society from bottom-up, then the road for the local administrations will be open. It is not possible to do so with the current central government. Maybe we can do it in certain places locally. From women's shelters to nurseries, from child protection houses to how to build playgrounds, it is necessary to work on how the social service logic should be in urban planning. A more developed social service approach that is involved with various areas of daily life, social service personnel and their effectiveness in the field are crucial. Our aim is to have an organized social service structure that controls the functioning of institutions with its ethical values and prioritizes its

own professional ethics. We try to be a part of it and we try to direct the process like this.

We certainly have suggestions for the central system as well. It is not independent of these, the process that we consider as social service is not only a transfer of aid, a share of aid and how social policy will develop, but also to develop perspectives on how the society will be built from bottom to top, and to build on this. This is what rethinking the social services is based on. We try to carry out this discussion in each conference we hold. At every event we make, probably the least was available at this conference, non-governmental organizations are very crucial to us. Although limited, of course, non-governmental organizations turn into structures that are integrated into the functioning of the system from time to time. Their experiences are very important to us. Because the newly formed mechanism, the state, has already strained itself with the current AKP government. There is a system that has moved away from society and imposes its own understanding on society. It works bottom-up by adapting social structures, but it is hard to say that these are very successful. It is successful in certain places, but it's not a common thing. Actually today it is important to break through this and rebuild the society from below. It is important for us that social work is a factor here.

N.Ş.T.: In fact, community-based social service is important in social services literature. To work on solving problems and increasing the level of welfare by mobilizing the society, not individual-based, but community-oriented, society-oriented, not individual-oriented. I said it is difficult to achieve this locally, but the only way to achieve it is through local structures. If we can come up with good examples and good models with some local governments, this can be a hope for the future.

To what extent are all these discussions and efforts to create a new approach reflected on the public bureaucracy?
N.Ş.T: Frankly, I do not think they follow these discussions, they do not have such an agenda. Of course, there are a few who consider this as a positive thing. They follow the conferences, they say they benefit from them very much but when we look at the Ministry of Family Labour and Social Services' staff, we see people coming from areas that are not even remotely close to social services. The directors of the establishment are mainly teachers of religion and they are from the faculty of theology. Therefore, they are not worried about dealing with new discussions. Of course I am talking about the upper levels of bureaucracy. On the other hand, these conferences of ours affect some scholars very much because social services for years were always application-oriented in Turkey. In other words, the relationship between social policy and general politics could not be established very much. We are trying to establish that relationship. It attracts a lot of attention from scholars, students, and this is actually very important and promising. But of course I do not think we can reach the bureaucracy of the Ministry much.

U.T.: The Ministry staff does not stand idle, they are developing a number of models. For example, they introduced something new called "spiritual social work" into the social service community. Some of the religious teachers, religious social service experts began to develop such debates. The ministry cannot actualize this yet, there is a gap; however something on a discursive level is expressed. We will watch and see how the organizational infrastructure or development of this will proceed.

What are the cornerstones of this approach? What does it suggest normatively although it is not organized?
U.T.: The spread of the existing social understanding due to our religious relations, the understanding that a social structure can be established by building our Islamic values within the society as an Islamic country, etc. In addition, they constitute something with their own concepts such as "financial aid is holding the people's hand, helping, being a mother and a father". Actually, there's nothing implemented that corresponds to this exactly. It's nothing clear but there is a debate. This started to appear in dissertations, associate professorship discussions and published books. We watch these closely because it is within our interest, but as I said, we have not seen the involvement of this in institutional structures yet. They could not establish that connection.

N.Ş.T.: Foster family system for example. I have been in this community since the 1990s, it was a system that had been tried to be established for years but could not be completed. There has been an incredible increase in the foster family system in the last 10 years. Check the website of the Ministry and you will come across campaigns such as: "Give this orphan a hand too", "Give her/him a warm home". In fact, they are entirely through religious feelings, and gradually find their response.

Two of the most important axes of discussion at the conference were gender and international migration. How did the limited practices in the context of the pandemic respond to these areas? What do the ideological perspectives brewing in the ministerial bureaucracy that you point out mean in this regard?
U.T.: For one thing, the strength of the women's movement in Turkey makes space for us. By revealing the situation of women we can approach the problem from this strong aspect more comfortably. That is why there is always a topic from the women's perspective on the agenda in every discussion. Feminist approach methodically paves the way for us. Secondly, women's movement being the most active organised structure in Turkey and being able to organize protests and ideas from the bottom up impresses us as well.

In terms of refugees, the most developed civil society mechanism in Turkey was established in this area in recent years. For the first time, the field of social services carried out a civil society-centred social service, played and developed an important role in the process. Therefore, the issue of refugees is also important for us. To start a discussion about social service activities and type of institutional structures regarding refugees is especially important for Turkey. One of the most important social events in the world in recent years is the emergence of mobile societies and the reflections of this migration movement towards the centres in the current social and political pattern. This situation also affects us. Especially civil society's involvement in this and non-state actors being effective defines us. We prioritize this in our own conferences.

N.Ş.T.: In addition to the strength of these two areas, social groups such as

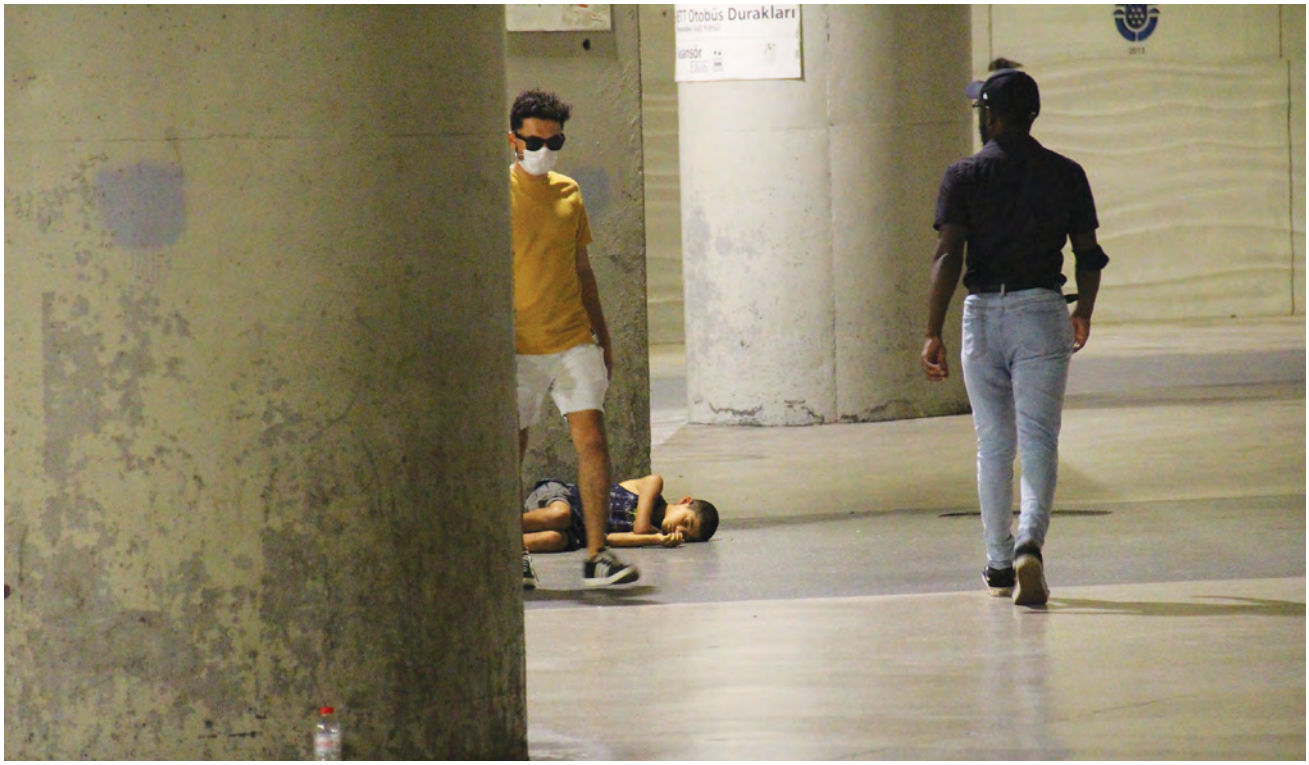

Photo: Özcan Yaman

women, LGBTIs, immigrants, refugees, ex-convicts and prisoners are actually the groups that constitute the most applicants in the field of social services in every country. Because they suffer the most from discrimination, marginalization and exclusion, these are the groups that need to be supported accordingly in order to benefit from citizenship rights. There is no doubt that citizenship rights are out of question for the refugees, but women and LGBTIs in these groups are the ones having problems in obtaining the most basic legal rights. I specifically state this about women and LGBTIs in Turkey. Awareness about women is high both in local administrations and in the central government. I say this regarding women by considering the central government specifically the Ministry of Family, Labour and Social Services, from the very beginning, there is a perspective that positions women in the family and constructs their service and social policy from there. This is very explicit and is reflected on the social services in daily life very much. When you go to a social service institution, as a woman who is a victim of violence, as a woman seeking social assistance, as a woman who has difficulties in caring for her child, you experience all the marginalization, exclusion, and positioning within the family. We always aim to position the structuring of social services from a feminist perspective, putting it in the centre. LGBTI is an issue causing serious problems especially in institutional structures. We are aware of many examples of discrimination, exclusion, especially in boarding service organizations and social service organizations where young people live, that these children are excluded, marginalized and ignored. This is not even an issue on the agenda of social services at the central government level. Because you know, "this is a disease" statement is made for LGBTIs at the highest level. The state does not generate any special social services regarding refugees. They partially benefit from the social services available. Actually, in order for immigrants and refugees to be able to survive in the country, comprehensive social services should be provided to them. Turkey handed this over to civil society. In this sense, non-governmental organizations are actually subcontractors of the state right now. In the field of refugees there are rights based organizations, there are also many organizations that are needs-based and actually manage to save the day. I believe social services do not institutionally cover the field of migrants and refugees. I think the Ministry of Family Labour and Social Services is insistently keeping this away from itself.

Segments of society such as women, LGBTI's, immigrants, refugees, ex-convicts and prisoners are actually the groups that constitute the majority of the applicants in the field of social services in every country. Because they suffer from discrimination, marginalization, and exclusion the most, they need to be supported the most in order to benefit from citizenship rights.

The state does not generate any special social services for the refugees. Refugees partially benefit from social services. Actually, comprehensive social services should be provided to immigrants and refugees in order for them to be able to survive in this country. Turkey handed this over to civil society. In this sense, non-governmental organizations are actually subcontractors of the state.

Interview by Fırat Genç

On the *Medicopolitics of the Pandemic*

Pandemic: Medicopolitics of the Pandemic / COVID-19 Chronicles is an impressive study that deals with the traumatic experience we are going through, layer by layer, with a very rich perspective, but avoiding taking an improper distance against the painful truth. We talked with Özen B. Demir about what this full-fledged crisis made visible, based on his book in which he wandered in a wide range of fields from natural sciences to humanities.

The term *chronicle* in the subtitle of your book brings to mind some kind of desire to keep the pulse of time. Moreover, in one of the footnotes, you mention the mini-ethnography practice that clinicians can undertake, and in a sense invite the physician to renounce her/his traditional position. Let's start with the claim of the book, and therefore the role you set yourself as a physician in this process.

Özen B. Demir: Probably like many other current texts, this book also deviated from what was initially designed for and shaped mostly on the road. Apart from my personal interest in the diary/journal genre, the term 'chronicle' was essentially intended to refer to the historical updates held by names witnessing the pandemics of pre-antibiotic eras; for example, to refer to examples such as Samuel Pepys, who recorded the famous plague pandemic in London in the 17th century. However, this should have gone beyond the narrow scope of an ordinary 'historiographer'. Before I was a workplace doctor here, I was working in the Emergency Service for the first six months of the pandemic, and leaving the 'clinic', which can be directly described as a 'registry clerk' institution, I imagined to generate a *kairotic* chronicle, not chronological but with the Hippocratic meaning, if you like, that permeates deep through historic readings and moved beyond the craft (inspired by Dr John Sassall). Of course, that was not what happened. After a while, as I was exposed to the cluster of texts published on the pandemic, and as I tried some of them exquisitely, I thought that someone should be dedicated to the duty of reading them systematically. So, I set out to follow many platforms daily, to 'follow up' so to speak, to take notes, and as a result of five or six months of intense labour, the book in your hand sprouted. In that respect, perhaps, if necessary, the label 'a kind of chronicle of the chronicles' can be adopted.

On the other hand, medicine, as you imply, is a word laden with strong connotations of 'status'. You may very well follow this via the memoirs of the physicians of Turkey origin penned since the early Republican period; so much so that for a while, I intended to undertake a detailed –or even *prosopographic*– excavation of the memoirs I have accumulated with *bibliophile* curiosity volume-by-volume. But I didn't have the chance. Indeed, in the West, physicians may be the most productive occupational group together with diplomats with diaries, letters, and memoirs, which belong to the category called *ego-document.* However, these are often tedious work, overflowing with bureaucratic/governmental ballast, aside from some altruistic experiences and nice/humane details. If you ask me, an 'anthropological medicine' of the kind performed by Oliver Sacks, which is passionately fond of playing around with the earth and vital splendour has not even stopped by the territorial waters of Turkey. Even if you have a plaything kaleidoscope in your eyes, it is unlikely to come across anything other than capital and power derivatives. Coming back to your question, if I have cast a 'role' for myself, I can say that it is to make the landscape in question legible and partially to aestheticize it.

Your work makes it very clear that pandemics are a very large issue that needs to be addressed in a wide range from biology to social theory. You propose the use of the term *medicopolitics* to be able to keep all this rich material together. Could you elaborate on this? What will its contribution be when compared to other approaches?

Ö.B.D.: *Medicopolitics* has not yet been conceptualized, that is, an unidentified word. Well, it doesn't have to be. My reason for using it per se is based on particular psycho-political reasons. Moreover, it stems from the fact that it has a rather *syncretic* potential rather than being 'comprehensive'. Since I put a lot of effort into the 'HIV/AIDS crisis' dating back to the 1980s, I can easily chant that, it does not seem possible to encompass and consume the pandemic issue, as a complex totality, especially to frame it within the current ontology... In that respect, I would rather *pointillistic,* fragmented, partial touches.

I just mentioned psycho-political reasons, let me elaborate on this: I chose to stay away from the concept of 'biopolitics' eviscerated by making it a *buzzword,* in order to bring a certain kind of social/human scientific perspective to trial that sees everywhere the relationship of oppressed-oppressing, a discourse producing tyranny, 'confinement' or hierarchy, moreover, within a whole *ethos* of 'political correctness' calling individuals as subjects, which makes certain questions unquestionable and certain propositions untenable, worst of all, barging into unscientific relativism

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from the critique of positivism, in short, trapped in an infinite skid of *theoreticism,* essentially because it does not have a qualitative/quantitative 'field'. In addition to the hearing in question, I found the term *medicopolitics* to be useful to bombard those 'technocratic' scientists arousing suspicion, who we can assume are positioned at the opposite-angle this time or the spontaneous ideologies. It is clear that we need to look at what kind of policies certain biomedical theses are articulated with and move beyond apparent discourses. Moreover, since we cannot reduce science to a kind of rough statistical fabric, Žižek has every right for the question: "An interesting question triggered by the coronavirus pandemic, even for a non-statistician like me is: 'Where is the point where 'data' ends and 'ideology' begins?" Now, if you will, I want to dwell on this point specifically. To scrutinize the 'technocratic' expert view that speaks for the name of science does not mean blinking at unscientific nonsense. On the contrary, a mature scientific horizon can be formulated as follows: The underlying active premise, which is the cause of COVID-19 or other new pathogens that are pending (whose names we do not yet know), is not only in the field of clinical examination as any infectious agent, but also in the area of eco-systemic relationships fixed by capital and other structural causes. Therefore, it should be admitted that: social media platforms, specifically *Twitter* that tens of scientists who are followed on are composed of actors such as virologists, molecular biologists, pathologists, microbiologists, medical doctors, who are concerned about the future of the earth and humanity and provide advice according to scientific criteria. Sufficient exposure to the posts of experts increasingly starts the feeling that something is 'missing'. The clinical guides of the World Health Organization (WHO), the Ministry of Health regarding the issue, the statements of the officials, what is reflected on the prestigious magazines and media published by the biomedical institutes, moreover, the statements of the philanthropic donors, the representatives of power, statements on the tabloids, the vocabulary floating around in the discussions on the digital platform, they all lead to a feeling that the truth has been missed. And that being: Our reference sources that define our analytical perspectives and our intellectual investments refer to a subjectivating collectivity in a way.

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Just as it is necessary to make the daily politics imprinted on the brains visible, it should be remembered (and to be reminded) that the perspective from which scientific knowledge emerged is 'neutral' to some extent only. Precisely for the sake of a healthier scientific attitude, it is necessary to abolish the mediocre beliefs that science is firmly affiliated with the 'immaterial, neutral and universal' ideal of reason. It would not be an exaggeration to say that behind the uppercase phrases such as "according to science", "science says", "science states that", there was a nostalgic and even archaic drift, a kind of pagan mythology, related to the collapse of the Humboldt type university model (1810). This form of

discourse has the connotations of 'total independence' and 'intrinsic neutrality' that bracket state and corporate (simply, dual corporation) capitalism. In particular, it performs myopia regarding the academic industry, business and the 'total quality' model, which has already broken through the medical and natural sciences institutes and now serves to meet the innovation demands of the market cost-effectively, is caught up in performance systems and in the meantime instrumentalises knowledge. It operates a kind of chair immunity, from time to time is elitist, emulates guild autonomy, and assumes that the researcher is there for the 'information for information' formulation, so much so that it excludes even industrial engineering activity.
All in all, the word *medicopolitics* thus became a mediation of a pure critical attitude, that is, my attempt to taunt the knowledge/theory agents who, by some intellectual blackmail, strengthened their limited space. Of course, in the final analysis, as an extension of friendly dialogue with the medical/scientific field.

Many commentators say that the COVID-19 pandemic is a harsh reminder of a trait that has perhaps long been forgotten, the fact that we share a common destiny as a 'species'. Although the direction to be taken is not clear, there is an implication that this will be a turning point. What do you think of these claims about 'the salvation of the species'? In this respect, what kind of a crisis are we experiencing today?
Ö.B.D.: It's not a claim; if you ask me, this is a very down-to-earth determination. Nowadays, as we tend to democratize bitter inequalities, albeit palliative, and the search for a collective 'benefit optimization' formula is tugging at our sleeves, we are in a situation where all the given (and pluralistic) values that make us different in one way or another are bracketed, and our identities stripped. With the panic wave conditioned by the pandemic, we are in the middle of a deterministic scheme in which assumptions give similar results. In our judgments, we realise a zero point, a starting point, where our social positions and even personality traits are suspended (at least expected to be suspended). We are in a *psychotic* moment in which the escape from negativity has already overwhelmed the orientation to envision the positive. Isn't it in this repertoire that our main concern as clinicians is to assume to be the guarantors of 'the salvation of the species' and, most fundamentally, to 'keep it alive'. The unexpected invasion of microbial agents threatening the human species consolidates the eternal legitimacy of the biomedical sciences, as always is the case in modernity. Public health components are present, this time in the name of an 'affirmative' biopolitical intervention in favour of the salvation of the species. Therefore, it is understandable referring to the biopolitical tool kit habitually in the face of current developments.

Let's remind ourselves before we go on. Despite various *vulgar* readings, clues to this approach that stretch the biopolitical understanding are also found in Foucault's yield itself. The French thinker, (in the final analysis) even though it is frequently witnessed that he is categorised as a *social constructivist,* does not stand apart from *naturalism,* in which

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scientific practice has achieved its own methodological maturity. Indeed, in one of his interviews, he uses a naturalistic sentence mixed with irony about the high rate of health problems associated with infectious diseases in Brazil: "Parasites exist, no matter how 'anti-medical' we are; parasites can be eliminated."

Let's go back: Medical disciplines now recall the epistemic 'positivity' by reassembling the ethos of humanity. All the measures that are taken, everything else that is interrupted, cancelled, postponed and 'distanced', trainings, competitions, events, meetings, social programs, mass tourism, international cultural activities and others are for the sake of this legitimate mobilization. Grocery stores emptied in a tearing hurry, stacked suitcases, sacked goods, masks not ever enough to hide modern anxiety, officers taking temperatures of those who go out on the streets one by one, those who are detained for not obeying the preached attitudes, those who are caught up in the ambition to turn 'mass hysteria' into opportunism, those who have locked themselves at their homes, on the other hand, those who cause altruism, those who hit to soothe the inevitable wave of 'panic', and the multiplier effect of panic-related panic... Behind the scenes, the public authority intensifies its position as per the pronounced 'shock doctrine' and provides a justification instrument for possible future unrelated political projects, and a control and optimization technology to be copied and referenced in other social crises.

From this point forth, we should acknowledge that *affirmative* biopolitics, however, regarding countries like Turkey where the state's public stand

is already crippled –and therefore the cost of weight considered– could hardly be considered a rational theoretical positioning. So, in Turkey, we can talk about the state's two other functions other than 'protecting the general interests of society', namely the functions of serving the interests of the ruling class and the ruling party (political power), far ahead of the general interests of society. In this sense, it will suffice to list some examples of opportunism and 'overlook' that are obviously revealed in the pandemic conjuncture: opening forest lands for construction, continuing to be concreted with unstopped illegal constructions, for example, the aggressive realisation of the first stage tenders of the Kanal Istanbul project, or the destruction of Salda Lake, surrender of the regions within the boundaries of

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the Environmental Protection Area and in the status of Natural Protected Area to industrial structuring, bringing nuclear reactors back on the agenda, transferring resources to the capital under the name of 'solidarity', imposing a broadcast ban on news of illegal buying/selling / leasing of authority representatives and, regulating executions as a consolidation of the 'impunity culture', more frankly, due to the risk posed by the pandemic in prisons, preparing a draft penalty reduction and putting it into effect that can be seen as a 'secret amnesty' for members of criminal organizations and persons arrested for violence against women and sexual crimes against children, however excluding journalists, just like those arrested on the allegation of 'anti-terrorism', trustees appointed to municipalities not recognizing any rules or regulations, the continuous detentions and operations in the region by the 'force apparatus', political lawsuits filed with imprisonment, censorship and advertising embargoes for publications, RTÜK penalties, some village quarantines that are obviously imposed with colonial motives...

Photo: Özcan Yaman

If we move forward from the same point, it has come to light in many places that neo-liberalization, which has caused the overall transformation of medical practice and institutional organisation, cannot respond to the conditions we face. In conjunction with this, it seems as if some of the concepts, approaches and practices discredited for some time –such as public health or preventive medicine– have become somewhat benevolent. What would you like to say about the possibility of such paradigmatic transformations?

Ö.B.D.: Paradigmatic transformations are always possible. However, I do not think so. I will call the cliché "Possible, but unlikely" to my rescue. Besides, I think paradigm shifts are moments to be determined and discussed as post hoc. We precisely come to a halt as we hit the limits of comprehensibility or *epistemic* patterns that the paradigm has provided us that cannot be diagnosed or dissected at this time and the moment. Moreover, it is utterly impossible to achieve this on behalf of subjects who are pinned down in this neoliberal 'eternal now'. If nothing else, predictions about where the main artery will curve and what course it will take won't go any further than mediocre futurism. What I am saying is that it absolutely is not possible. Most particularly, it is unthinkable that such comprehension scrutinizing the structural-historical processes makes this possible. As a matter of fact, hasn't nearly seventy per cent of the Ministry of Health budget stipulated by the Central Government Budget Law of 2021 allocated to curative services whereas twenty five per cent was allocated to protective/preventive services? Perhaps it is precisely the cyclical platform that is worth focusing on here that prompts you to ask this question. So much so that this analytical optics enables us to see that subtle parallax; to elaborate, allow me to rewind a little: In the current biomedical regime, in terms of preventive health services, according to the scheme put forward by Hugh R. Leavell and E. Gurney Clark in the *Textbook of Preventive Medicine* (1953), numerous criticisms about the 'tertiary' protection including hospital/medical treatment being common whereas 'primary' and even 'secondary' protection being postponed, are obvious –with utmost legitimacy– today. By abandoning it to the market jungle, it is clear as day that this has been settled in parallel with the profit orientation of the commodified healthcare sector. So much so that treatment is a much more costly and profitable procedure compared to prevention. Nowadays, as you have emphasized, we are witnessing that the 'public health' discourse in pandemic management embraces a whole biomedical expertise language. Mainly the view characterized by verbalizing the phrase 'herd immunity' is a highly paradoxical one. Medical treatment, contrary to the current healthcare structure, appears to be somewhat subordinated. Rather than a discussion of 'medical' solutions for the treatment and control of the disease, in this case, the pandemic has come to the fore through a *collectivity* mediation. Therefore, it is necessary to pursue the discursive analysis of the 'herd'. If reviewed quickly, it is acceptable to say that the 'herd immunity' theory refers to the capacity to create an ambiguous collective and make uncertainties manageable. So, whether it is named or not, it can be said that the current theory is strengthened as it offers the opportunity to cope and manage the virus on a national scale at no cost. Moreover, its ideological function in the context of 'national war' concept is also clear. The national war will be shifted to the biological platform. As a pure and complex system of automatic structural violence, neoliberalism attacks vulnerable groups, as we all experience or witness in one way or another.

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How would you describe the guidelines of the pandemic management specific to Turkey? How can the cornerstones of the path followed by the government be defined from a *medicopolitical* perspective?

Ö.B.D.: In simple terms, I would like to say 'bureaucratic centralism'. This point actually is an indirect expression of the so-called 'inability to manage' crisis. Because this structural impossibility is actually part of a wider problem. Turkey's crisis of the inability to manage the basic issues within the context of health, security, prosperity and freedom with which she's already bickering over; can well be attributed to 'lumpish' centralism which is scared of social dynamism, creative 'civil' policies of local governments, local solidarity networks sprouting from below. Although it is

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possible to elaborate details at length, administrative decisions made by the public authority in the management of the pandemic by de-politicizing them for so-called scientific/technical reasons were purely and simply decisions plumping the power of capital, deepening the security doctrine and to thickening the country borders with nationalism and ummah ideology by polishing them in line with an autarchic imagination.

One might question the drawback of centralization. In that case, before we finish our conversation, it is time to touch upon some of the historical points –and which I have covered extensively in the book– that I find useful to include: Going back a little further, the role of the 'centralization' advocates and their 'militarist' science historically prevailing in the settlement of the biomedical paradigm, which we curse more and more now, is very clear when it comes to the structural defects of health pedagogy. It is necessary to make the following note beforehand. It is widely known that Robert Koch's discovery of the microbe that causes tuberculosis *(Mycobacterium tuberculosis)* and the discussions related to it are highly important in the emergence and shaping of public health in the last quarter of the 19th century. Rudolf Virchow stated that the germ Koch found was 'necessary' for the development of tuberculosis in the individual, but not 'sufficient' and the qualifying condition was the social environment the individual was in. However, mainstream public health discipline took shape in the direction of the Koch postulate. However, mainstream public health discipline was shaped in the direction of the Koch postulate. Diseases have always been reduced to *biological* phenomena caused by one or more factors that can be observed when they are symptomatic. In this framework, public health, which declared 'war' against germs, also considered diseases as the sum of individual cases at the community level. The biomedical model, in which the social identifiers of health were eliminated, has been institutionalized through a network of multiple causations and multiple factors. Here, for the dynamics of political-bureaucratic centralization that are rarely emphasized, the following historical detail is very important in the name of institutionalization: The fact that the centralized, authoritarian Prussia swallowing the liberal Hamburg in the 19th century is indeed in line with the triumph of the biomedical paradigm leaning on the Koch postulate.

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CITIZENS ASSEMBLY

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