

IMPACT OF SOCIAL SOLIDARITY NETWORKS ON ILLEGAL  
ABORTION EXPERIENCES OF YOUNG ADULTS IN TURKEY: A MIXED METHODS  
STUDY

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ABORTION EXPERIENCES OF YOUNG ADULTS IN TURKEY: A MIXED  
METHODS STUDY**

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## ABSTRACT

### IMPACT OF SOCIAL SOLIDARITY NETWORKS ON ILLEGAL ABORTION EXPERIENCES OF YOUNG ADULTS IN TURKEY: A MIXED METHODS STUDY

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This thesis aims to investigate young adults' experiences of abortion. Based on a mixed-methods research, this study will have a quantitative section where the data from the Turkish Demographic and Health Survey 2018 (TDHS-2018) will be aggregated and analyzed, and a qualitative section that will interview young adults about their induced abortion experiences. The focus of the study is to explore the effects of young adults' social bonds during their experiences of induced abortion. First, as the thesis will adopt a feminist standpoint, it will problematize general discourses and policies on abortion and the reaction to it by the feminist movement. Then, it will elaborate on the importance of social solidarity bonds' critical position in building solidarity around reproduction politics and its role in informing young adults on reproductive health. The quantitative part of the thesis analyzes the relationship between women's social bonds and whether they had an abortion via analyzing the TDHS data. In the light of the quantitative results, the qualitative part will reveal the marginalized abortion experiences of young adults based on the legal status of their operations. Overall, the thesis aims to highlight whether solidarity impacts young adults' experiences of induced abortion as a stressful life event in their reproductive lives.

**Keywords:** induced abortion, feminist solidarity, social bonds, mixed-methods, illegal abortion

## ÖZ

### TÜRKİYE’DEKİ GENÇLERİN YASA DIŞI KÜRTAJ DENEYİMLERİNDE SOSYAL DAYANIŞMA AĞLARININ ETKİSİ: BİR KARMA YÖNTEM ÇALIŞMASI

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Bu tez, genç yetişkinlerin istemli düşük deneyimlerini araştırmayı amaçlamaktadır. Karma yöntemli bir araştırmaya dayalı olan bu çalışma, 2018 Türkiye Nüfus ve Sağlık Araştırması'ndan (TNSA - 2018) elde edilen verilerin toplanıp analiz edileceği nicel bir bölüm ve genç yetişkinlerle istemli kürtaj deneyimleri hakkında görüşme yapılan bir niteliksel bölümden oluşmaktadır. Çalışmanın odak noktası, genç yetişkinlerin isteyerek kürtaj deneyimlerinde sosyal bağlarının etkilerini araştırmaktır. Birincisi, tez feminist bir bakış açısı benimseyeceğinden, kürtaj konusundaki genel söylemleri, politikaları, ve feminist hareketin buna tepkisini sorunsallaştıracaktır. Ardından, toplumsal dayanışma bağlarının üreme politikaları etrafında dayanışma inşa etmedeki kritik konumu ve genç yetişkinleri üreme sağlığı konusunda bilgilendirmedeki rolleri üzerinde durulacaktır. Tezin nicel kısmı, TNSA verilerinin analizi yoluyla kadınların sosyal çevresi ile kürtaj yaptırıp yaptırmadıkları arasındaki ilişkiyi incelemektedir. Nicel sonuçlar ışığında gelişen nitel kısım ise, genç yetişkinlerin operasyonlarının yasal statüsüne dayalı olarak yasa dışı ve yasal kürtaj deneyimlerini ortaya çıkaracaktır. Genel olarak, tez, dayanışmanın genç yetişkinlerin üreme hayatlarındaki stresli bir yaşam olayı olarak kürtaj deneyimlerini etkileyip etkilemediğini vurgulamayı amaçlamaktadır.

**Anahtar Kelimeler:** istemli düşük, feminist dayanışma, sosyal ağlar, karma-yöntem, yasa dışı kürtaj



*To my grandmother Ayşe.*

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## TABLE OF CONTENTS

|                                                  |      |
|--------------------------------------------------|------|
| PLAGIARISM.....                                  | iii  |
| ABSTRACT.....                                    | iv   |
| ÖZ.....                                          | v    |
| DEDICATION.....                                  | vi   |
| ACKNOWLEDGMENTS.....                             | vii  |
| TABLE OF CONTENTS.....                           | viii |
| LIST OF TABLES.....                              | xi   |
| LIST OF FIGURES.....                             | xii  |
| LIST OF ABBREVIATIONS.....                       | xiii |
| CHAPTERS                                         |      |
| 1. INTRODUCTION.....                             | 1    |
| 1.1. Motivation and Problem Statement.....       | 2    |
| 1.2. Background and context.....                 | 3    |
| 1.2.1. The Abortion Debate.....                  | 3    |
| 1.2.2. The Turkish Case.....                     | 4    |
| 1.3. Methodology.....                            | 6    |
| 1.3.1. Adaptation of a Feminist Methodology..... | 6    |
| 1.3.2. Data and Methods.....                     | 7    |
| 1.3.3. Quantitative data.....                    | 8    |
| 1.3.4. Qualitative data.....                     | 8    |
| 1.4. Significance.....                           | 9    |
| 1.5. Structure of the Thesis.....                | 10   |
| 2. LITERATURE REVIEW.....                        | 12   |
| 2.1. Abortion.....                               | 13   |
| 2.1.1. Abortion as a Medical Procedure.....      | 13   |
| 2.1.2. A Historical Overview of Abortion.....    | 14   |
| 2.1.3. Population Control and Abortion.....      | 16   |
| 2.1.4. Politics of Abortion.....                 | 19   |

|                                                                  |    |
|------------------------------------------------------------------|----|
| 2.1.4.1. Gendering Abortion.....                                 | 22 |
| 2.1.5. The Abortion Stigma.....                                  | 22 |
| 2.1.6. Feminist Perspectives on Abortion.....                    | 23 |
| 2.2. Solidarity and Social Support.....                          | 27 |
| 2.2.1. Defining feminist solidarity, sisterhood, or network..... | 27 |
| 2.2.2. Role of Social Support on Abortion.....                   | 30 |
| 2.2.3. Abortion Networks.....                                    | 32 |
| 2.2.3.1. Feminist Abortion Providers.....                        | 32 |
| 2.2.3.2. Self-Managed Abortion.....                              | 35 |
| 2.3. Abortion in The Turkish Context.....                        | 36 |
| 2.3.1. The practice of Abortion in Turkey.....                   | 36 |
| 2.3.1.1. Abortion during the Ottoman Empire.....                 | 36 |
| 2.3.1.2. Abortion in the Early Republic.....                     | 37 |
| 2.3.1.3. Pronatalist Policies.....                               | 38 |
| 2.3.1.4. Antinatalist Policies.....                              | 38 |
| 2.3.1.5. Today's Abortion Law.....                               | 39 |
| 2.3.2. Demographics of Abortion.....                             | 42 |
| 2.3.3. Attitudes towards abortion.....                           | 44 |
| 2.3.4. Backlash on Abortion.....                                 | 46 |
| 2.3.5. Feminist Reactions to the Abortion Debate.....            | 47 |
| 2.3.5.1. The abortion campaign in 2012.....                      | 47 |
| 2.3.5.2. Reaction of pious feminists.....                        | 47 |
| 2.3.5.3. Gendered discourses.....                                | 48 |
| 2.3.5.4. Medical Abortion in Turkey.....                         | 48 |
| 2.4. Conclusion.....                                             | 48 |
| 3. METHODOLOGY.....                                              | 52 |
| 3.1. Background on Feminist Methodology.....                     | 52 |
| 3.2. Data and Methods.....                                       | 54 |
| 3.3. Research Design: Qualitative Mixed Methods.....             | 55 |
| 3.3.1. Quantitative Component.....                               | 56 |
| 3.3.1.1. Description of quantitative data.....                   | 56 |
| 3.3.1.2. Sampling Frame.....                                     | 57 |
| 3.3.1.3. Empirical Strategy and Variables.....                   | 58 |
| 3.3.2. Qualitative Component.....                                | 59 |
| 3.3.2.1. Qualitative data.....                                   | 60 |
| 3.3.2.2. Sampling Frame.....                                     | 61 |

|                                                                 |     |
|-----------------------------------------------------------------|-----|
| 3.3.2.3. Interview Technique and Qualitative Data Analysis..... | 62  |
| 3.1.1. Limitations.....                                         | 63  |
| 3.4. Conclusion.....                                            | 63  |
| 4. QUANTITATIVE RESULTS.....                                    | 65  |
| 4.1. Descriptive Analysis.....                                  | 65  |
| 4.2. Correlation Results.....                                   | 69  |
| 4.3. Chi-square results.....                                    | 70  |
| 4.4. Logistic Regression Results.....                           | 72  |
| 4.5. Conclusion.....                                            | 74  |
| 5. QUALITATIVE RESULTS.....                                     | 76  |
| 5.1. Learning about the pregnancy.....                          | 78  |
| 5.1.1. Perceptions on abortion.....                             | 78  |
| 5.1.2. Consulting to the experienced.....                       | 79  |
| 5.1.3. Involvement of People.....                               | 81  |
| 5.1.3.1. Family.....                                            | 81  |
| 5.1.3.2. Friends.....                                           | 83  |
| 5.1.3.3. Partner.....                                           | 85  |
| 5.1.3.4. Excluded People.....                                   | 86  |
| 5.2. The Operation.....                                         | 88  |
| 5.2.1. Medicalization and criminalization of abortion.....      | 88  |
| 5.2.2. Legal or illegal status of the operation.....            | 91  |
| 5.2.3. The practitioner.....                                    | 94  |
| 5.3. Aftermath of the operation.....                            | 96  |
| 5.3.1. Silence as a coping strategy.....                        | 96  |
| 5.3.2. Loneliness.....                                          | 98  |
| 5.3.3. Outspokenness.....                                       | 99  |
| 5.4. Conclusion.....                                            | 101 |
| 6. CONCLUSION.....                                              | 103 |
| REFERENCES.....                                                 | 111 |
| APPENDICES                                                      |     |
| A. APPROVAL OF THE METU HUMAN SUBJECTS ETHICS COMMITTEE.....    | 127 |
| B. CORRELATION TABLE.....                                       | 128 |
| C. CHI- SQUARE TABLES.....                                      | 129 |
| D. QUESTION LIST.....                                           | 131 |
| E. TURKISH SUMMARY / TÜRKÇE ÖZET.....                           | 132 |
| F. THESIS PERMISSION FORM / TEZ İZİN FORMU.....                 | 143 |

## LIST OF TABLES

|                                                                               |    |
|-------------------------------------------------------------------------------|----|
| Table 1: Variable List.....                                                   | 59 |
| Table 2: Demographic Characteristics Table.....                               | 66 |
| Table 3: Reproductive Choices Table.....                                      | 68 |
| Table 4: Binary Logistic Regression: Abortion and Social Characteristics..... | 73 |
| Table 5: Respondent characteristics.....                                      | 77 |

## LIST OF FIGURES

|                                         |    |
|-----------------------------------------|----|
| Figure 1: Overview of the Research..... | 55 |
|-----------------------------------------|----|



## LIST OF ABBREVIATIONS

|              |                                                                                                                                    |
|--------------|------------------------------------------------------------------------------------------------------------------------------------|
| <b>TDHS</b>  | Turkish Demographic and Health Survey                                                                                              |
| <b>HUIPS</b> | Hacettepe University Institute of Population Studies                                                                               |
| <b>GWS</b>   | Gender and Women's Studies                                                                                                         |
| <b>CEDAW</b> | Convention on the Elimination of all forms of Discrimination Against Women                                                         |
| <b>ICDP</b>  | International Conference on Population and Development                                                                             |
| <b>womxn</b> | women and queer                                                                                                                    |
| <b>MLAC</b>  | Mouvement Pour La Libération De l'Avortement Et De La Contraception<br>(Movement For The Liberation of Abortion and Contraception) |
| <b>AHA</b>   | Abortion Health Activism                                                                                                           |
| <b>SMA</b>   | Self-Managed Abortion                                                                                                              |
| <b>quan</b>  | Quantitative                                                                                                                       |
| <b>QUAL</b>  | Qualitative                                                                                                                        |
| <b>TUIK</b>  | Turkish Statistical Institute                                                                                                      |
| <b>FP</b>    | Family Planning                                                                                                                    |
| <b>CO</b>    | Conscientious Objection                                                                                                            |

## CHAPTER 1

### INTRODUCTION

In 1971 in California, the U.S. a group of women comes together, with a single speculum on the table. They learn and try using the speculum and as they say ‘on that day, they emancipate an area of their bodies that has so far only been the specialization of the gynecologists’ (Seaman & Eldridge, 2012, p. 81). Then and after as those women kept on discovering their bodies through the speculum, one of them Lorraine Rothman develops a device called the ‘Del Em’ that can initiate the menstrual bleeding, meaning that through a vacuuming system women can clear out their uteri. Del Em can be used with the help of only three women, one that puts in and out the device, one that controls the process, and one that undergoes it (Seaman & Eldridge, 2012, p. 85). At the time of its invention, the device, not only served as a method for abortion, but it also criticized the governments’, medicine’s and patriarchy’s reckless trials of controlling women's bodies. It rebels to the dominant patriarchal discourses and highlights the importance of women's solidarity and women's bonding over their reproductive capacities.

The distance between womxn<sup>1</sup> and their bodies has been a prominent and universal one that has been developed and constituted constantly by the dominant forces of the patriarchal understandings. Therefore, womxn always had to find alternative ways out to discover what is their own. Rosalind Petchesky (1990, p.1) introduces her work on women's reproductive freedom by stating from the beginning that ‘recurrent moral or legal prohibitions against

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<sup>1</sup> The word womxn refers to women and queer people. It is preferred to be used throughout this thesis in order to be more inclusive towards gender identities. In cases of quotations or references to other scholars their use of the word ‘women’ is kept.

such practices [abortion and birth control] merely forced women underground their research for reproductive control'. Petchesky (1990, p.29) argues that throughout time abortion has always been a widely accepted and performed practice despite the development of contraceptives. She relates this to the fact that abortion intervenes with the pregnancy itself not women's reproductive cycle, sexuality, or else. Abortion, therefore, with all its risks, both social and biological, will continue to exist and be practiced.

### **1.1. Motivation and Problem Statement**

The notion that abortion is a way for womxn to control their own lives brings me to the motivation of this research. My research is interested in how womxn receive knowledge on abortion and whether womxn's circumstances have an impact on their reproductive decisions. As mentioned, womxn practice abortion even when it is not publicly available, and womxn had been using methods ranging from emmenagogues to abortifacients even when modern birth control was inexistent. As it can be intuitively understood, not all womxn can find these methods on their own, therefore there must be a path that they learn about these strategies. I suggest, womxn learn about those strategies from each other, therefore as womxn share their experiences and knowledge on reproduction, these methods become widespread. If womxn encounter such practices, they can normalize and adapt them to their lives. Social ties and womxn's solidarity networks serve as an area to share and create knowledge on womxn's lives.

The concept of social ties is kept as broad as possible, in this research, ranging from one's neighbors to sisters, from university friends to family members. Moreover, I argue that sociability and the strength of those social ties also matter. As womxn get more involved and active in different networks and spheres, their knowledge of different living strategies and self-defense mechanisms can flourish. From this point, I speculate that the knowledge and practice of abortion would also follow a similar path. As womxn enlarge their social bonds they would have possibilities of engaging in such conversations and as they learn about it their opinions on abortion and their experiences of it would evolve accordingly.

The main research interest of this thesis is to understand the relationship between young womxn's ways to have an abortion in a restricted context and how their social bonds are utilized in the process. This thesis aims argues that despite abortion is now legal in many places of the world, it is not a simple right to be given to womxn. As abortion and reproductive operations are defined in terms of rights, these regulations put boundaries on what womxn can do with their bodies. Furthermore, as the limits of these laws and rights are not bounded by womxn themselves these rights may not be liberating at all.

As a case at hand, this thesis investigates the situation in Turkey. In Turkey, abortion has been legal since 1983 as a part of the antinatalist turn in population policies. However, the law only passed for allowing abortion up to 10 weeks, only if a practitioner performs and with consent requirements. As such, despite its legality, the abortion law in Turkey restricts access by itself. Even before, discussing how hard it is to reach out to abortion providers, the law by itself is an obstacle to reach for the services due to its time, practitioner and consent requirements.

However, despite restrictions abortions take place. In the Turkish context, women not only deal with the restrictive structure of law or the stigmatization on abortion but they also face its criminalization. In cases where abortion is performed in circumstances that do not align with the law, sanctions can be faced. However, women still do continue to take the risks or utilize their networks in order to go beyond the restrictions. In order to analyze women's ways of doing that, this thesis first tries to understand who gets abortions and who reports them, and the conditions under which that increase abortion prevalence in women. Then, the research will shift its focus to the experiences of women who had abortions under conditions in which that do not align with the law.

## **1.2. Background and context**

### **1.2.1. The Abortion Debate**

Stenton (2006), posits the issue of abortion as a gendered issue that is under the reproductive dimension of gender conflict. First, it points out women's reproductive rights and of these rights being held by women themselves. Secondly, it is a concept regarding women's body fully and thus relates to body politics and sexuality. Thirdly, as many radical feminists argue, abortion rights are a part of the sexual revolution. Fourth, the restrictions and reformist laws on abortion, all highlight the power dynamics and mentality of patriarchy. For all these reasons and more, abortion has been a crucial topic in the feminist agenda.

To begin with, not all feminists agree on a single position on the topic of abortion. Notably, there have been controversies among the first and second-wave feminists. From a broad view, first-wave feminists argued that abortion was equitable to murder (Petchesky, 1990, p.45). As Farganis (1994) states most of them even had the opportunity to have housemaids for the care of children and housework. Thus, the literature on liberal feminism does not problematize abortion as a women's right but mostly treats women as patriot mothers of the next generation.

On the other hand, second-wave feminists stood in opposition to these arguments. They initiated discussions on freedom of sexuality, reproductive rights, and women's choice. For them, abortion was a reproductive right and it should be performed by women's choice. Women's Liberation Movement activists insisted that women should have complete reproductive freedom, including access to contraception (Napikoski, 2019). They argued that women must take control of their bodies and the means of reproduction.

Second-wave feminists, especially in the U.S. kept abortion on their agenda through consistent demands. In 1965 family planning council in the U.S. gave the rights for using contraceptives and in 1971, the Roe v. Wade law on abortion passed. Opposition argued that if there is an unwanted pregnancy then women should have decided before it happened and focused on the rights of the fetus (Stetson, 2006).

Even though Roe was a huge achievement it was criticized in many dimensions. Roe allowed for abortion however it was based on conditions, such as week limits or insurance limits, leaving behind poor women, rural women, and those in the so-called "flyover zone" and others without easy access to abortion (Hanisch, 2014). This situation later was marked by another bill, which was called the Hyde Amendment that restricted the payment of abortions. The main argument on the Hyde amendment was to equate mother's and fetus' right to live at the same level (Stetson, 2006). It was considered a failure in the women's movement. However, it had highlighted the underlying power dynamics of the abortion debate, that it must take into account the diversity of women, economic conditions, access to abortion, and moral considerations.

### **1.2.2. The Turkish Case**

The Turkish Republic began its population planning history with legacies or residuals of the Ottoman Empire. While coming to an end the population increase in the Ottoman Empire had become static. Reasons such as low birth rates due to an increased number of wars, causing a decrease in the male population, and an increase of diseases due to a rejection of Western medicine, increased contact with foreign lands could be listed for the low population increase in the late Ottoman period. After the foundation of the Turkish republic, the first census was counted in 1927 and was found to be 13.6 million, when compared to the last census in the Ottoman Empire, there was a noticeable decrease from 15 million in 1914 (Mutlu, 2003, p.12). This decrease is mostly attributed to the loss of land after the foundation and the casualties at the war. The fact that the republic was built after a long period of wars had impacted its population dynamics. According to the 1927 census, there were 9.27 men for every ten women and for the women of reproductive ages the ratio was 8.24. More than

half of the population was younger than 20 and almost 84% of the population had reported living in the rural areas (Gürsoy, 1996, p.532).

With rising discussions on nation-states and with the new country's competitors in the world arena, Turkey followed Ottoman's legacy of pronatalist policies, to increase human resources for rebuilding military and agricultural bases (Gürsoy, 1996, p.532). The idea behind this was to balance the high death rates with increased birth rates. As Özbay (2015) narrates during that era the policies planning the families were mostly aiming at women and interfering with their life choices. Tax incentives for more children were brought (1929), having illegitimate children was encouraged (1926) and contraceptive devices and abortion-inducing pills were banned (1930). However, with such restrictive pronatalist policies until 1965, the country faced an overpopulation problem that hindered economic growth. Thus, the first five-year development plan (FYDP) was introduced (Gursoy, 1996, p.532). In this plan, the approach of 'population planning' was dropped and instead 'family planning' was adopted, claiming to enable families to have as few as or much as children, as they desired, with this aim in 1965 contraceptives and birth control methods, were legalized.

However, these policies were ineffective in increasing maternal mortality, decreasing malnutrition, and child mortality. Moreover, there was a 6.3% increase in the proportion of women who underwent illegal abortions (Pehlivan, 2019, p.18). Therefore, in 1983, with the population law, abortion was legalized under restrictive conditions. The 1983 law requires spousal or parental consent for married women and under 18 forces doctors to explain the health risks of induced abortion and only allows the procedure to be performed until the 10th week (Gürsoy, 1996, p. 536). Even though with these law women are legally allowed to terminate their pregnancies at their will, its restrictions are bounding and prohibitive.

Even though the mentioned law is still in effect, the discourses around abortion have fluctuated in Turkey. As in the 2000s, the country's political atmosphere moved to center-right when AKP came to power and neoconservative policies and discourses started (Türker, 2014; Toksöz, 2019; Erkmen, 2020). The modernization meta-narrative had gone far enough, and now there was a need to go back to traditional ties, and similar to the secular governments the policies prohibitive sides aimed at women. In 2012, the Prime Minister of AKP stated in a meeting that he perceived abortion as murder. After that point, he and his allies started discourses ranging from equating abortion with a national massacre 'Uludere' or advising women who got pregnant after getting raped to give birth. Then, the government signaled its intention to enforce a new amendment banning abortion (Pehlivan, 2019, p.20). At the time being, there were no coalitions for the abortion movement in Turkey, however,

after that point, women's organizations and individual women, not only from secular fields but also from elaborates on, from religious spheres started to organize (Özcan, 2015). As Turkish women were unexpectedly driven into the abortion debate at that time, their reactions were impulsive, and therefore criticisms among different fractions also held the women's movement's defense back (Keskin, 2014, p.74).

Currently, the pronatalist discourses of the government continue as women's coalitions among a possible ban on abortion. Even though abortion is still legal in Turkey, access to abortion and the conditions under which one can go through the operation is highly unequal. As Pehlivan (2019) reveals in her study, still the majority of public hospitals refuse to perform abortions, and private hospitals offer different prices based on personal moral judgments, i.e. charging less for spontaneous abortion while charging more for induced abortion to single women.

### **1.3. Methodology**

#### **1.3.1. Adaptation of a Feminist Methodology**

As a Gender and Women's Studies thesis, this thesis will claim to make use of the feminist standpoint theory. However, rather than following a single path or a theory, this thesis will take into consideration the common values of the feminist methodology. The rest of the section will touch upon several significant points of feminist research and connect them to the components of this thesis.

To begin with, the main point that will be highlighted in this thesis is that feminist methodology calls for the investigation of feminist epistemologies, women's different ways of knowing. It highlights the diversity and multivocality of truths and criticizes the modernist approach from its rigidity of the claim for a single universal truth (Ramazanoglu & Holland, 2002, p.56). This notion brought by feminist scholars also shatters the idea of a single subject in modernity. Multiple truths rise from multiple identities and voices. Therefore, feminists suggest that as women they are not a united group either. They have commonalities that unite them in a group but also they have differences in terms of class, sexuality, sex, race, and else. Therefore, one of the core components of this thesis is to uncover the underlying ways of knowing women and their strength to gain an understanding of how women learn about their reproductive choices.

Secondly, feminist methodology criticizes the generalizability and calculability of common scientific understanding. It aims to open the field for knowledge coming from individual experiences and how they affect individuals in their relationship to the structure

(Ramazanoglu & Holland, 2002, p.48). Even though the common feminist methodologies in social sciences may stand against quantitative projects for valuable reasons, such as being against reducing women into numbers, this thesis will aim to provide a feminist quantitative analysis with the data, to show that treating the data with a feminist lens is also possible.

Thirdly, feminist methodology problematizes position of the researcher and requires her to eliminate the hierarchies in the knowledge process and make the research self-reflective. It enables the researcher to self-discover and continues the research process knowing the inner self herself. It redefines objectivity with its relationship and opposition to subjectivity (Ramazanoglu & Holland, 2002, p.48). In order to ensure that especially for the qualitative part of this research, and in order to strengthen the reliability and smoothness of the interviews, the method will be chosen to be semi-structured interviews. So, I would not have an upper hand in leading the conversation. Moreover, as the sample choice is preferred to be women of 'young' ages which is a group I also belong to, the interviews would also have a self-reflexive component.

Last to mention for this section but not the least, is to adopt the feminist methodology in both its quantitative and qualitative parts. This would be a strength of the thesis as I suppose, since the thesis aims to highlight the multivocality of women while emphasizing the common life paths they may have gone through.

### **1.3.2. Data and Methods**

As suggested in the earlier sections the main interest of this research is to see the relationship between the decision for abortion and the social ties of young womxn, using a feminist methodology. In order to accomplish that, this thesis claims to design and conduct a mixed-method research. The quantitative data that will be used for this analysis is already collected thus, I do not have a position to alter the questions, probing, etc. of the data. However, for the qualitative part, field research will take place. Therefore, the most applicable research design for mixed-method research is chosen to be an explanatory sequential design as outlined in Creswell and Clark (2011, p.22). Therefore, the qualitative results will be used to explain further, and understand the quantitative results via snowball sampling. The questions asked for the qualitative framework will thus, be arranged in a manner that the variables would overlap and even go beyond the questions in the quantitative survey to understand the inner dynamics of the social ties of womxn that are not asked or cannot be easily discovered via quantitative techniques. For that reason, this section will first discuss the nature of the quantitative data, then explain the data collection methodology for the qualitative data.

Lastly, it will provide a brief discussion on the advantages and the shortcomings of the data sources.

### **1.3.3. Quantitative data**

The quantitative data used will be the 2018 Turkish Demographic and Health Survey (TDHS-2018) which is collected both on individual and on the household level, by the Hacettepe University Institute of Population Studies (HUIPS) every five years since 1968. The data provides the most reliable and extensive information on the socioeconomic characteristics of households and reproductive experiences of women at reproductive ages (15-49). TDHS collects data by two types of questionnaires, household and women's questionnaires, which are standard modules from the Demographic and Health Surveys (DHS) program. The surveys seek to gather information on ranging topics such as migration patterns, marriage history, knowledge, and usage of contraceptives, work history and status, birth history, abortion and fertility preferences of women and households.

On a broader level, this thesis aims to uncover the underlying solidarity networks and conditions of young womxn while having an abortion in Turkey. Therefore, the subjects of this research can be broadly stated as young womxn in Turkey. However, this statement would immediately bring a question on how to define young. For the purposes of this thesis the cut off age for 'young' will be 30. Existing literature, on gerontology and demography, has contrasting approaches for a cut-off age for being young, which will be elaborated further in the thesis. Yet, as this study adopts a mixed-method strategy and therefore uses quantitative survey data, the cut-off age can be altered according to the availability of data – as will be explained further-, through replicating similar strategies of prior works.

### **1.3.4. Qualitative data**

As this thesis, aims to adopt a mixed methodology, qualitative data collection will take place. For the qualitative fieldwork, the application of a feminist standpoint theory in line with the aforementioned criteria will be cared for.

One of the interests of this research is the characteristics of and the factors leading young womxn to come up with the decision of having an abortion. Therefore, intuitively, womxn of reproductive ages who are classified as 'young' for the quantitative sample come to mind. However, for ethical ease, the sample should be above 18. Moreover, even though in the quantitative sample there are considerations for whether 24-30 should be considered young or not, for the qualitative sample this condition would be dropped. Therefore, the sample of

womxn this section will take at hand will be womxn above 18 who have experiences related to abortion.

The qualitative fieldwork for this thesis was planned to be conducted as anonymous third-party interviews. As Rossier (2003, p.88) outlines in her paper 'Estimating Induced Abortion Rates', anonymous third-party interviews ask the respondents about the abortion cases they have heard within their social networks, either in the community they belong to or among their circles of womxn who confide them. This method is specifically chosen for the fieldwork related to this thesis for several reasons. First of all, considering the importance of feminist methodology gives to not re-creating womxn's traumas for the purposes of research, this methodology would contact not with the womxn who have gone through abortion but with their friends. Secondly, using such a strategy would show the 'sisterhood' connections among womxn, meaning that such a methodology can highlight to whom womxn consult in such cases. For example, a university student may be sharing her need for an abortion with her peers but womxn from a rural area may be sharing it with her relatives. Thirdly, such a strategy may reveal ways through which womxn find abortion clinics or under which conditions they go through the operation. Lastly, this methodology would allow commenting on womxn's conditions after abortion from an outsider's eye.

The nature of the interviews is planned to be semi-structured. So, the interview would not have the upper hand of knowing the next question but rather the interviewer would be a mediator in the conversation. During the interviews, the respondents will be acknowledged about the thesis project and the aim of this research. Then, they will be asked whether they consent to conduct an interview or not. If they do, then they will be asked whether they consent to the interview being tape-recorded or not. According to their answers, I will record the interview or take notes. After both parties are informed on the aim and method of the project, then the interview will take place.

#### **1.4. Significance**

This thesis contributes to Gender and Women's Studies literature and is a contribution to abortion studies on three levels. Firstly, in terms of what this thesis investigates, it is taking the topic at hand for the context it is researching. Up to my knowledge, there has not been any research on womxn's relationships and social bonds and how they have experienced abortion in Turkey. Furthermore, as the qualitative component of this thesis will delve deeper into illegal abortion, there has not been any academic literature found on illegal abortion experiences in Turkey after the 2000s. Secondly, this thesis is significant for the literature based on the subsample of the population it has selected. The main group of

womxn investigated in this thesis are womxn at the age of 30 and under. Most studies in the field of abortion and womxn's reproductive experiences focus on married womxn who are most open about their sexual activeness. However, in contemporary Turkey, not only single young adults but also teenagers undergo an abortion. womxn do not start to experience their reproductive existence after marriage but they start long before. However, the stigma surrounding sex before marriage is still intact, which is making single womxn's experiences harder. Thirdly, this thesis contributes to the method it uses. The research is a feminist mixed methods study, implying that it will enlarge upon its quantitative results via bringing qualitative life stories, experiences of womxn. A mixed-methods study is argued to have been a contribution to Gender and Women's Studies literature in Turkey as the field is mostly built upon qualitative research and mixed-methods applications in Turkey are not applied much to the field. While it is mostly believed that feminist studies take a step back from quantitative research, having a feminist perspective in quantitative research can increase the explanatory and policy-making power of feminist studies. Furthermore, the feminist methodology can contribute to mixed-methods research especially in terms of highlighting the outliers and marginalized points of the data.

### **1.5. Structure of the Thesis**

The thesis is made up of six chapters, the first one being the introduction. The second chapter begins with a literature review. The literature review is kept extended in order to cover the main points of discussion for the rest of the thesis. It consists of three key parts. Part 1, analyzes abortion as a procedure. It begins with an overview of how abortion is conducted and approached medically. This part is important because the medicalization of abortion is closely related to how it is performed in contemporary gynecology practice. Then, the literature regarding the history of abortion is analyzed in order to analyze how the procedure was practiced before its medicalization. Following the history of abortion, how abortion is utilized as a population policy and how it is used as political leverage is analyzed. Lastly, Part 1 discusses the abortion stigma and feminist perspectives on the abortion debate. Part 2 of the literature review, introduces the second key literature of the thesis, which is the solidarity literature. This section outlines how the concepts of sisterhood, social solidarity, and social bonds are approached in literature and points the discussion into the direction in which this thesis will follow. Furthermore, specifically, Part 2 introduces the feminist abortion networks in different places of the world. Lastly, Part 3 of the literature review, discussed the above-mentioned points in the context of Turkey and Turkish politics and the feminist movement.

Chapter 3, introduces the methodology and the mixed-methods approach for the thesis. It outlines the key concepts of feminist methodology emphasized in the approach of this thesis and then introduces the mixed-methods approach which extends from a descriptive quantitative part to a larger and explanatory qualitative part. The methodology section introduces both quantitative and qualitative data sources and analysis techniques and leads to results chapters.

Chapter 4, introduces and analyzes the results from the quantitative part of the research. It introduces the subsample used from the TDHS-2018 data. It begins with an analysis of descriptive statistics and outlines the characteristics of the subsample. Then, it continues with non-parametric tests. First, it outlines a correlation matrix to investigate for multi collinearity and then, continues with chi-square tests. Lastly, Chapter 4, analyzes binomial logistic regression results and highlights what has been the limitation for purely quantitative analysis of this research, and lead to the qualitative part of the thesis.

Chapter 5, showcases the qualitative results. It begins with how the data is analyzed and gives a brief outline of the characteristics of the respondents and the key themes. Analysis of qualitative results is developed in a timeline of how womxn experience abortion. It begins with the themes they have witnessed when they first learn about the situation. Then, analyzes their experiences of the abortion operation and lastly, discussed how they coped up with this experience in its aftermath.

Lastly, Chapter 6, which is a conclusion chapter overviews the results from the previous two chapters and related them to the briefed literature. Then, this section showcases the contribution and significance of the results and conclusions.

## **CHAPTER 2**

### **LITERATURE REVIEW**

This literature review will briefly and analytically evaluate the international and regional literature provided on the topic of abortion. The research question this thesis aims to explore is how womxn experience induced abortion and through which bonds they get access to it. Therefore, the first part of the literature review will describe abortion as a medical procedure and put it in its historical context via discussing its applications over time. Firstly, Part 1 will explain how abortion is carried out as a medical procedure. Secondly, it will describe its applications in antiquity. Thirdly, it will critically evaluate the use of abortion as a population control policy. Fourth, it will discuss the political journey of the abortion law, and fifth, analyze its social reflection of the abortion stigma. Lastly, Part 1 will briefly discuss the feminist perspectives in terms of the application of abortion and its laws.

The second part of the literature review will focus on the solidarity networks of feminists. First, it will introduce the theoretical framework for feminist solidarity. Second, it will discuss how social support is utilized while coping with abortion. Third, it will showcase historical examples of feminist abortion networks.

Lastly, Part 3 will delve deeper into the region at hand for this study. Firstly, it will provide a historical development of abortion in terms of its application, criminalization, and law in Turkey. Secondly, it will discuss the demographical background for abortion studies conducted thus far. Thirdly, it will evaluate the backlash on legal abortion in 2000s and lastly, mention the feminist reactions towards the backlash.

## **2.1. Abortion**

### **2.1.1. Abortion as a Medical Procedure**

For the purposes of this study and in order to understand the level of the medicalization of abortion as a procedure, comprehending it on medical terms and in its historical context gives important insights. Medical literature provides several general definitions of abortion. Widely used medical definition of World Health Organization refer to abortion as “pregnancy termination prior to 20 weeks’ gestation or when pregnancy duration is unknown, a fetus born weighing less than 500 g” (Cunningham et al., 2010, p.215). Expected pregnancy for humans’ averages around 40 weeks. The first three months is referred to as the first trimester, and uterus evacuations take place in these first 12 weeks referred to as early abortions. Uterus evacuation in the second trimester, which is between weeks 13-20 is referred as late abortion. If uterine evacuation takes place in the third trimester which is after 20 weeks of gestation, it is referred to as stillbirth.

Originally, the word abortion derives from the Latin *aboriri*, meaning to miscarry. Although, the medical definition for abortion do include miscarriages as well, lay persons use of the word usually only refer to induced abortions (Cunningham et al., 2010, p.215). Medically, abortion is classified as spontaneous and induced abortion. Spontaneous abortion (miscarriage) refers to pregnancy termination that takes place without an external effort. They are classified as ‘threatened abortion’, which is when vaginal discharge or bleeding appears through a closed cervix, ‘inevitable abortion’ when membranes rupture and amniotic fluid leaks with cervical dilatation, ‘missed abortions’ when dead products of conception remain in the uterus with a closed cervix, and ‘incomplete abortions’ when whole or parts of the fetus or related tissue detaches from the uterus. Lastly, the term ‘septic abortions’ refer when complications take place during the procedure. On the other hand, induced abortions, also known as provoked abortions, are classified as therapeutic abortions when take place after an incomplete abortion or elective (voluntary) abortions when pregnancy termination takes place on request rather than medical reasons (Çokar, 2008, p.20; Cunningham et al., 2010, p.227).

While performing an induced abortion there are three major techniques. Firstly, surgical abortion techniques which are hysterotomy, surgically cutting out the uterus for evacuation, and hysterectomy, removal of uterus, are practiced in cases of late abortions, where further complications are possible or a risk on women’s mortality exists. Secondly, trans cervical approaches which are evacuation of uterus through the vagina are the most known and widely used methods for first trimester abortions. Currently, the most practiced methods in

the developing world are known as menstrual aspiration (menstrual extraction, menstrual induction, mini-abortion) and manual vacuum aspiration. For the prior a Karman cannula attached to a syringe is inserted into the cervical canal and produce suction for extraction, for the latter a syringe is attached to a cannula and inserted into the uterus, the reverse pressure is produced manually. Another widely known first trimester method is vacuum aspiration, in which a similar operation to manual vacuum aspiration takes place but with the use of a device. The last trans cervical method is the widely believed method used for all abortions, even though its usually practiced between weeks 12-14. This method is known as dilatation and curettage (D&C) and includes dilatation of the cervix and then mechanically scraping out its contents (Cunningham et al., 2010, p.228). According to 'Safe abortion' guidelines by the WHO, curettage is an outdated method and should be replaced by vacuum aspiration or medical methods (Say, 2012). Lastly the third technique for abortion is medical abortion, where abortifacient drugs such as mifepristone, misoprostol are used either orally or vaginally.

Induced abortions are categorized in two as safe abortion and unsafe abortion. This distinction is different than legal or illegal abortions as some legal abortions can be unsafe while some illegal abortions can be safe. While the legal status of abortion differ by country and legislation, unsafe abortions are considered to be procedures for terminating a pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both (WHO, 2012). Typical conditions that indicate an unsafe abortion are when abortion is carried out by unskilled provider, in unhygienic conditions, when it is self-induced by traditional medication or insertion of objects, when it takes place without pre-abortion counselling or when a medical abortion is prescribed without instructions or follow-up (WHO, 2012). (Grimes et al., 2006) refers to unsafe abortion as 'the preventable pandemic' and reports that nearly 19-20 millions of unsafe abortions take place every year in the world with 90% of them taking place in developing countries. Authors, argue that legalization of abortion is a necessary but insufficient condition to end this pandemic but it must be supported with access to modern contraception, and a breaking down of the stigma surrounding it (Grimes et al., 2006, p.7).

### **2.1.2. A Historical Overview of Abortion**

Abortions were available all the time. The earliest prescription regarding abortion dates back to 5000 years ago in China, where the emperor Shen Nung describes the use of mercury for abortion (Grimes et al., 2006, p.4). Furthermore, it is known that Chinese women believed that eating 25 turtles in spring would prevent births for 5 years (Çokar, 2008). In ancient

Egypt, around B.C. 865-925, Al-Razi, prescribed crocodile and elephant feces which work as a spermicide to prevent pregnancies (Riddle, 1992).

Though abortion existed it was not accepted everywhere and criminalized in many ancient cultures. In Mesopotamian sources, abortion is widely criminalized. For example, in the Hammurabi Laws the punishment for abortion is just a penalty fine, while sources from Assyrians (B.C. 1450) indicate that abortion was punished by death (Çokar, 2008, p.55). On the other hand, in ancient Greek law, abortion was not criminalized however, social stigma was put on women who had abortions. They could be exempted from some rituals or perceived as immoral (Çokar, 2008, p.60). Greek had different versions of soul and therefore, the soul of the fetus would not be considered human until birth. For Greeks, the fetus was not considered a human and therefore had limited rights. The male fetus would not be ensouled before 30 days according to Hippocrates and 40 days according to Aristoteles. Therefore, the moral stigma on abortion was not related to the rights of the fetus but rather related to the morality of the women. Furthermore, in ancient Greek understanding of male authority bodied in consent laws existed as well. While married women were to have abortions in ancient Greek they would be required to have the permission of their husbands otherwise the abortion would be viewed as immoral (Çokar, 2008, p.61).

Ancient Greek physicians, therefore, preferred the use of birth control measures and made differentiations among suppositories, oral contraceptives, emmenagogues, regime, and abortifacients (Riddle, 1992, p.27). In the second century B.C., Soranus highlighted the importance of coitus interruptus, the calendar method and suppositories like pomegranate peel, and oral contraceptives like Cyrenaic juice. In the first century B.C., Dioscorides recommended oral contraceptives such as white willow, cabbage leaves, and barrenwort, and certain plants for miscarriages (Riddle, 1992, p.34). Also in 421 B.C, Aristophanes mentions the use of pennyroyal in his play 'Peace'. Furthermore, some of these traditional methods survive long after. Angela Davis (1983) notes that a book named "The United States Practical Receipt Book" published in 1844 included 'birth-prevention lotions' with ingredients such as potassium carbonate, mercuries chloride, alcohol, and almond milk.

During antiquity, the fetus was mostly considered as a part of the female body and the status given to the family was an abstract status given to the institution rather than its diversity and multitude. In ancient Jewish belief, the fetus was also perceived as a part of the mother. Therefore, crimes against the fetus such as abortion would be considered crimes against the mother. However, the redemption of such a case would be given to the husband of the women (Çokar, 2008, p.65; Riddle, 1992, p.20). Contrastingly, in Christianity, virginity was

seen as sacred and thus the ultimate explanation for marriage could be to give birth. Approaches towards sexuality had been strict and sexuality for pleasure was also considered as sin. Through such a rigid understanding, the status of the fetus, in Christianity is also straightforward that life begins with conception therefore, abortion is murder (Çokar, 2008, p.66). In Greek and Latin churches both, a distinction between a formed and an unformed fetus is remarkable. If the fetus is unformed it is thought to be senseless therefore abortion in those cases is not considered a homicide. This point highlights the distinction between late-term and early abortion.

On the other hand, in Islam and Arabic Medicine, the approach towards the ensoulment of the fetus is completely different. While in Christianity and Eastern perception, the soul comes with conception, in Islam it comes after a certain time. Even though there is no agreement on when the ensoulment of the fetus takes place according to different sects and interpretations it is either at 40, 80, or 120 days (Riddle, 1992, p.127; Erkmen, 2020).

Through the Middle ages, anti-abortion arguments surmounted. Even when population control was in need, instead of birth control measures or abortion, abstinence was advised. Around the 17th and 18th centuries, however, with the rise of diseases and illness, a population policy focused on women's medicine and health care surmounted. Knowledge on reproductive systems and birth control methods got medicalized and by 1827 it was scientifically proven that conception took place as sperm and egg met each other. According to Çokar (2005, p.79) physicians had used this discovery to condemn abortion and draw a strict differentiation between abortion and birth control measures.

### **2.1.3. Population Control and Abortion**

Historically varying methods of abortion always existed and it was performed either by individuals themselves or by varying providers according to restrictions and limitations on their use and distribution. Those limitations and restrictions had to be explained on legitimate grounds for the people, or at least a major part of the public to accept it. In ancient times, these explanations were grounded on the moral values of the public and then on religions' inclinations. After the 1800s, however, fertility patterns of individuals started to become a concern for states which required their quantification and scientific explanations. Initially, starting from explorations of clergymen a need to control population growth had emerged. One of the first prominent names is Thomas Malthus. Despite his antinatalist perspective, the Malthusian take on demography condemns the use of birth control methods and views abortion as a sin. Instead, this view proposes the postponement of marriage,

abstinence during the marriage, and abandonment of intercourse except for reproductive purposes (Anderson, 2015). Later on, scholars from different fields ranging from economics to sociology started to think about the position of fertility in population planning, leading to the emergence of a new domain of population studies.

Studies tried to explain individuals' preferences for fertility, such as having children, aborting, or limiting their fertility on various grounds. Mainstream literature initially did not articulate abortion as a fertility limitation method but mostly focused on the reasons and consequences of the decline in fertility. A groundbreaking argument in economics suggested that the demand for children goes parallel with individuals' demand for consumption goods. Generally, those scholars argued that children have various costs and benefits for a family, and individuals make decisions rationally based on this cost-benefit analysis. Notably, Gary Becker argues that the demand for children can be analyzed by the differences among individuals on their relative preference of children, their desire for a higher quality or quantity of children, and their expected amount of income spent on children and their expected income from them (Becker, 1960). Enlarging Becker's arguments, Leibenstein (1974, p.460) argued that the family's decision for marginal children depends on their consumption utility, work or income utility, and security utility. He firstly agrees that the utility of a marginal child is less than the prior. Therefore, he suggests that as the number of children in a family increases the utilities for the marginal children decreases as income increases (Leibenstein, 1974). Besides income, work and consumption-related factors were also added into these early analyses. It has been established that fertility preferences were related to the cost of contraceptives (Easterlin, 1975), religion (Westoff & Jones, 1979), education (Becker, 1960), and opportunity cost of children for women (Calhoun & Espenshade, 1988).

Over time, literature searching for explanations to fertility-related decision making expanded with the inclusion of specific fertility limitation methods, such as contraceptive prevalence, sex-selective abortion, unintended pregnancies, and impacts of reproductive policies. Furthermore, while searching for its determinants, social measures were also included in the analysis, such as migration history, circumstances of pregnancy, technology, and marital history.

To begin with, recent literature continues to emphasize economically grounded reasons for fertility limitation decisions. Bose and Trent (2006), suggest that the type of employment of women also impacts their likelihood for abortion. As they find Indian women in non-agricultural sectors are more likely to have abortions, and less likely to have sex-selective

abortions. In addition, in another region, in Finland, Väisänen (2016) finds that unemployed women are more likely to have abortions compared to women in the labor force. Lastly, another interesting study by Shanmugasundaram (2007) presents a case study on women from Tamil Nadu and shows that women's employment does not always serve to increase their likelihood of abortion but in some cases, they use abortion to come up to the expectations of their working conditions. If women choose to continue with their pregnancies in Tamil Nadu, they face the risk of unemployment and therefore lack of wages, thus they are forced into choosing to have abortions in order to face the harsh realities of their working conditions.

Secondly, women's social position such as their level of education, marital status, age, nationality, or ethnicity is prominent in their decisions to terminate pregnancies and their access to methods of termination. Their position of life or education levels can change their access and determinants such as their migrant status or nationality impact the abortion laws applied. For example, in their comparative research among Norwegian and Pakistani women living in Oslo, Eskild et al. (2007) find that at higher education levels Norwegian women were less likely to have abortions, Pakistani women at lower levels of education were less likely to have abortions. Another research in Chile, shows that at higher education levels, the tendency to abortion increases (Koch et al., 2012).

Thirdly, new technologies in reproductive medicine also alter women and family's abortion decisions. For example, research in Southeast Asia focusing on sex-selective abortion indicate that with the introduction of ultrasound technology that allowed for prenatal sex determination, sex imbalance in birth increased in China (Chen et al., 2013) and Taiwan (Lin et al., 2014). Another, research by Sangari (2012) shows the existence of sex-selective abortion, related to dowry costs in India, showing that economic incentives matter for the decision-making on abortion. However, technology can also impact these decisions positively as Goldin and Katz (2002) show that the adoption of oral contraceptives among young, single American women has shown an increase in their age at first marriage and a decrease in the costs of their long term education. Furthermore, growing research on telemedicine suggests medical abortion techniques improve access to abortion for especially women in vulnerable communities (Killinger et al., 2020).

Lastly, recent literature showcases the importance of exploring the extent of access to safe abortion for individuals in vulnerable situations. Erhardt-Ohren and Lewinger (2020) analyze the abortion practices of refugee women in low and middle-income countries. They highlight their vulnerable position to sexual violence, possible reduced access to

contraceptives, language barriers while reaching out to providers, and major financial burdens for supporting a child. Thus, they call for attention to their increased need for safe abortion services. Shahawy (2019) investigate the abortion access of women in occupied Palestinian territories. As abortion is illegal in Palestine, women cannot access it in their own territories, however, it is available in Israeli hospitals. Yet, Palestinian women face barriers due to the occupation. Either due to hospital policies asking for Israeli IDs or by their loyalty to their nation women may back step from reaching abortion services in Israeli.

#### **2.1.4. Politics of Abortion**

Abortion is a procedure in so many individual's reproductive lives however, it is also broken down from its corporeality in the public discourses (Purcell, 2015, p. 585). Societal and political perception of abortion is in more abstract terms a politicized, medicalized, and stigmatized notion. Therefore, literature analyzes abortion not only in terms of the individual and societal characteristics of individuals experiencing abortion or the laws covering their experiences but also on a more abstract level in terms of how abortion is stigmatized, medicalized, gendered, and embedded in the power discourses.

Throughout the 18th and 19th centuries, bodies got mechanized and started to be perceived as tools for regenerating the population, stabilizing family and nurturing children (Erkmen, 2020, p. 25). This medicalization reflected on the status of abortion as well. While in the 18th-century abortion was understood as menstrual regulation, and was considered acceptable until the women could feel the fetus inside. In the 19th-century doctors started to claim authority in the process and with the fear of a decreasing population criminalizing laws appeared in Europe and in the USA (Erkmen, 2020, p. 25).

In the first half of the 20th century increasing maternal mortality and unsafe abortions led women's rights activists to campaign on women's health and abortion rights. Initiatives such as the Boston Women's Health Movement and Jane Initiative realized projects to educate women on self-practices of abortion and making safe but illegal abortions available to women (Seaman & Eldridge, 2012). Furthermore, in 1967, abortion law in the United Kingdom extended to include social and socio-economic reasons as a ground for abortion (Çokar, 2008). The abortion movement reached its peak in 1973 when with the case of *Roe v. Wade* abortion was legalized in the USA, spreading the liberalization of abortion laws to the world in its decade. After the enactment of abortion on request in the US, Austria (1974), Denmark (1973), France (1975), Singapore (1975), Sweden (1974), and Tunisia (1973) allowed abortion on request (Cook & Dickens, 1988, p. 643). Furthermore, though abortion

on request was not available in all, many other countries extended their abortion laws. For example, 'social, socio-medical or socio-economic' reasons became grounds for abortion in Norway (1975), Zambia (1972), India (1971), and Finland (1970). As Cook and Dickens (1978, p.638) explore, even though a wave of enacting laws for abortion on request took place, these laws came with legal and administrative restrictions. For example, institutions abortion could be provided, which professionals could perform and under whose approval and consent was regulated.

In the following decade, in 1977, in the US the Hyde Amendment was enacted, withdrawing federal funds from payments of abortion on women except for the cases of incest, rape, or life-threatening situations. Hyde Amendment draws attention from legalizing abortion to making it accessible for everyone. Because as abortions would not be covered, rural, working-class, poor people would not be able to afford them, which would leave them no choice but to try illegal or unsafe ways, perhaps both. According to Cook and Dickens (1988, p.1306), further 35 countries legalized abortion after 1977, however, only 5 of them had legalized abortion at the request and only for the first trimester. This was a barrier for, especially adolescent and single women. As pregnancy was measured not since the day of conception but since the day of the last menstruation, when women realized that they are pregnant they may well have passed this limit. Furthermore, countries had their own definitions of social, psychological, and socio-economic reasons as grounds for abortion. For example, in Romania even though abortion based on socioeconomic reasons was legal it was only allowed for women over 45, or in Hungary to make use of such grounds women had to be over 35 or had at least 3 children (Cook & Dickens, 1988). Such indications suggest that even though abortion was legalized it was not to ease women's life or to give them autonomy about their bodies, it was rather implemented as population policy.

Cook et.al. (1999, p. 584) argue that by 1998, the tendency to use abortion law to punish and stigmatize remained but it was moving towards vanishing especially with the worldwide developments such as CEDAW, Cairo, and Beijing conferences. To begin with, in 1979, The Convention on the Elimination of All Forms of Discrimination against women (CEDAW) put issues ranging from women's rights to violence against women, in legal, social, economic, and private lives of women on the agenda of the globe. Furthermore, with the formation of the CEDAW committee, organized monitoring and evaluation of policies began. In 1994, International Conference on Population and Development (ICDP) in Cairo, discussed reproductive health, birth control measures, maternal mortality, family planning, etc. in terms of population planning policies and urged attending nations to take measures on

those points. Cook et.al. (1999, p.580) note that Cairo conference participants committed to tackling the health impact of unsafe abortions. Thirdly, in 1995, The United Nations Fourth World Conference on Women, in Beijing, problematized the punitive laws for abortion. They argued over the case of Yugoslavia, where politically and ethnically motivated rape cases' requests for abortion were denied. They referred to those as forced maternity or forced pregnancy and counted as a violation of women's rights and as a war crime (Cook et al., 1999)

Currently, in 24 countries abortion is prohibited altogether (5% of women of reproductive ages), in 42 it is provided only to save a woman's life (22%), in 51 to prevent a woman's health (13%), in 13 based on socioeconomic reasons (23%) and in 73 on request with gestational limits between 8 to 24 weeks (37%) (The World's Abortion Laws | Center for Reproductive Rights, n.d.).

Even in countries with liberalized abortion laws, the fact that it is still seen as a right to be given, and law to be regulated are problematic as none of these policies can be considered benevolent. In almost all of the countries, these laws come with a week limit and practitioner limit. Furthermore, in some countries, even though abortion at request is allowed, mandatory waiting times or mandatory counseling sessions exist. In almost all cases gestation duration is medically counted from the day of the last menstrual period, which is not commonly known information by the public. All such regulations and necessities are possible causes for individuals to pass the week limit for a legal abortion (Aba et al., 2016, p. 1656).

Recent studies suggest that this restrictive side of laws opens up a need for illegal abortion which can become unsafe if practiced under uncontrolled conditions. Drawing on her study in Morocco, Capelli (2019) suggests that the intersection of political and social policies regarding marginalized groups normalizes the risk and persistence of illegal abortion. A hospital-based study in Sudan where abortion is legally restricted unless women's life is in danger or cases of rape, investigate entries in hospitals for unsafe abortion-related complications and confirm unmet post-abortion care and contraceptive need (Kinaro et al., 2009). They find that only a small number of doctors provide safe abortion care in hospitals and mostly nurses and midwives are accessible at community levels. women usually prefer the latter to avoid stigma and complete the process in secrecy.

#### **2.1.4.1. Gendering Abortion**

In the mainstream literature, abortion is usually discussed as a women's reproductive health issue. However, in the light of the developing discourses on gender, our language and understanding of abortion should also be expanded. Abortion is not simply an operation women undergo but anyone with the capacity to gestate can undergo an abortion. As the experiences of abortion differ by age, race, and class which are mainly studied in the literature, abortion experiences depending on gender are rather understudied. Sutton and Borland (2018) evaluate the abortion rights movement in Argentina in the light of its 2010 legalization of same-sex marriage and 2012 Gender Identity Law which recognized rights for several gender identities. As they argue Argentina serves as a unique example in terms of its inclusion of everyone in its abortion rights activism.

#### **2.1.5. The Abortion Stigma**

Kumar et.al. (2009, p.7) conceptualize abortion stigma on several levels. Firstly, on the discursive level, authors argue that abortion is usually referred as a 'missed', 'delayed', 'lost' "pregnancy". Therefore, abortion is not taken as an event in itself but it is rather as an event for the termination of a pregnancy. Secondly, the authors also mention the reproduction of the stigma through ideological means via abortion policies and laws. Thirdly, the stigma takes place at community and individual levels as well. On the community level women can fear being labeled, or fear community rejection, while on both levels they can feel guilt, shame, or isolation (Kumar et al, 2009, p.8). Cockrill et al. (2013, p.80) suggest that as a concealed stigma, in order to stay nonstigmatized or due to the fear of the stigma individuals with an abortion experience can chose to stay in secrecy and isolation due to internalized stigma.

The stigmatization not only takes place on the community level of women but can also come from abortion providers. Research in Kenya by Izugbara et al. (2017) interviews post-abortion care providers, and show that although they find abortion acceptable and common in Kenya, in cases of young unmarried women who seek an abortion, they blame young women for the challenges they report while seeking for abortion care. Providers find premarital pregnancy objectionable, and against the proper ideal of femininity. As such stigmatization does not occur the same for everyone. Izugbara et al. (2017) suggest that this attitude also reinforces the abortion stigma and increases the challenges for young single women seeking abortion care. Ellison (2003, p. 323) argues that married women can pass the stigma as they are legally married, while single women are left more vulnerable. Her results

show that single women recall the experience of unintended pregnancy as a 'traumatic event', and remember they feared being stigmatized as 'easy' or 'loose' women (Ellison, 2003, p.329).

On the other hand, another study by Koster-Oyekan (1998) analyzes the vulnerabilities and the stigmatization faced by different groups in Zambia between 1990 and 1993. The study conducts a community-based survey on schoolgirls, home interviews with women, and focus group interviews with both and men. As authors suggest schoolgirls end up as the most vulnerable group as they are in multiple dependency relations. They rely on their parents financially, they depend on school and teachers for education, on their peers and partners for social wellbeing. Furthermore, they lack sexual education and are not given contraceptives (Koster-Oyekan, 1998, p.1307). Secondly, unmarried women also stated that they feared their bride price would be low for unmarried sex, desired to continue with their education and some feared 'malili' which refers to malnutrition of second child as the prior is already in need. Lastly, married women also feared the stigma of having broken abstinence (Koster-Oyekan 1998, p.1309).

The persistence of the abortion stigma can be best observed in the recent rise of telemedicine where women can terminate their pregnancies without notifying anyone. Telemedicine services, usually, work outside the formal health system. It is technically illegal in many countries that require a consultation period or that ban advertisement related to birth control, however it is loosely controlled. In terms of a conceptualization of illegal abortion and self-managed abortion, telemedicine falls in a position in-between. Telemedicine services exist online therefore technically they can be reached from anywhere in the world via a VPN service, however, countries with stricter regulations fail to provide the pills. A mixed-methods study conducted in Germany by Killinger et al (2020) find that even in countries where abortion is legal and accessible telemedicine can be preferred over a legal abortion as it provides autonomy and lets women be in control of the process, and it can lessen the stress and fear of stigma. Furthermore, it is a plausible option for people in marginalized conditions such as migrants who are not provided with sufficient health care.

#### **2.1.6. Feminist Perspectives on Abortion**

Rosalind Polland Petchesky (1990, p. 2) briefly outlines the two essential ideas in a feminist perspective of reproductive freedom, the individual dimension which is the biological connection between women and their body, and the social dimension which is the social

position of women and the expectations from that position. Reproductive freedom, therefore, is not only a singular individual decision-making process but is also social.

Feminists arguing for abortion have not always been on the same side. Petchesky (1990, p.7) notes that instead of arguing as a material inside women's body, pro-choice feminists mostly viewed unwanted pregnancies as bodily invasions, during the abortion rights struggle. However, feminists have not been pro-choice always. In the nineteenth century, feminists who are also known as the suffragettes or the first wave feminists, are known for their opposition to abortion. While they evangelize pregnancy and motherhood, their understandings of sexuality fall within the normative lines. One of the pioneers of the suffragette movement Dr. Alice Bunker Stockham stated that:

When the female germ and the male sperm unite, then is the inception of a new life ... Is it not plain that the violent or forcible deprivation of existence of this embryo, the removal of it from the citadel of life, is its premature death, and hence the act can be denominated by no more mild term than murder, and whoever performs the act, or is accessory to it, is guilty of the crime of all crimes? (Bunker Stockham, 1887 as cited in Naranjo-Huebl et al., 2006, p. 101).

As she relates abortion to murder, she also criminalizes the operation of abortion. Later on, second-wave feminists such as Oaks (2000, p. 64), stated that for first-wave feminists' abortion was equitable to murder and they blamed the 'to-be mothers' with the murder of their 'fetal persons'.

However, Petchesky (1990, p.45) notes this harsh criticism of first-wave feminists' opposition to abortion and argues that it is understandable as they linked it closely to the degradation and exploitation of women. As Petchesky (1990, p.45) cites, Elizabeth Cady Stanton who is one of the leading figures of American first-wave feminism, saw abortion as an evil prompted by men's sexual oppression of women, and their refusal to act on their wives with respect. As she suggests the focus in the opposition was not on the abortion itself but that it was a consequence of male's exploitative and inconsiderate sexual relations with women.

In the 1920s eugenics movement rose rapidly in the west, fueling the already existing 'bettering the population' argument. Eugenicists' are classified as positive and negative eugenics. Positive eugenics believed that well-educated, upper class, white, Christians were the true race to be populated and negative eugenics saw social engineering in terms of diminishing the 'inferior' population as a measure to be taken. One of the key control

mechanisms they used for their purposes was compulsory and involuntary sterilization. Around the 1920s compulsory sterilization to the 'deviant' population, indicated by the incarceration of individuals attacked on the poor, uneducated, and black population. Furthermore, such practices continued with involuntary sterilization narratives of a similar population. Such racist and eugenic practices in order to diminish minorities were left in their collective consciousness as practices of bio power that one much takes into account while treating their position in the abortion debate.

For example, when the right to abortion in the U.S. has been won in 1973, with *Roe V. Wade*, however, as Davis (1983, p.200) notes campaigns for abortion significantly lacked black women's inclusion. Davis (1983, p. 201) criticizes the lack of understanding of the dominant white feminist groups. According to her, some white feminists did not understand black women's distance to the campaign and therefore did not worry to include them. However, underneath their distance lay the eugenic practices of birth control such as involuntary sterilization black and slave women had faced. Before the abortion, the campaigns on birth control had mostly focused on birth control as a right for white women, and as a eugenic practice for others. Davis (1983, p.209) suggests the sterilization of Relf sisters in 1973 in Montgomery, Alabama. Minnie (12 years old) and Mary (14 years old) had been involuntarily sterilized in a birth control clinic where they were attending a birth control trial for 'Depo-Provera'. After researchers found that the drug caused cancer on guinea pigs, the girls' mother, who neither read nor wrote, was told to sign a document with an 'X', and without the family's knowledge, the girls were sterilized. The Relf case exposed many other malpractices with eugenic purposes. In 1974, it was found by a federal district court that 'Over the past few years, an estimated 100,000 to 150,000 low-income persons have been sterilized annually under federally funded programs' (Petchesky, 1979, p. 31). Furthermore, in Alabama alone, more than 50 percent of the involuntary sterilizations were performed on black people (Tessler, 1976, p. 59). Davis (1983, p. 201) argues that women who were not white, middle or upper class, and teenagers also needed the right to abortion in order to control their own fertility. However, they also had a collective memory of such eugenic practices. Moreover, the abortion campaigns did not promote the abolishment of involuntary sterilization which is a practice against the arguments of the birth control and abortion movement that advocate for the right for women to decide on their own fertility.

After *Roe v. Wade*, in 1973, even though abortion was legalized and this was viewed as a win from the feminist perspective it was not widely accepted easily. Grimes et al. (1991, p.1264) state that from 1977 to 1988, 110 cases of abortion violence incidents have been

identified. The attacks ranged from arson to bombing and ended up with a total incarceration rate of %39. The attacks raised attention and awareness on the topic of abortion among the feminists as well and abortion continued to be an opinionated topic for different perspectives in feminism. To mention specifically, after the 1980s rights-theory perspective feminism shifted to care theory. This shift led to the emphasis being put on women as mothers, caregivers, and friends. Care-focused feminists such as Carol Gilligan argue that when women face conflicts they do not rationally solve them but approach them as responsibilities through their nurturing and caring side (Çevlikli, 2017, p. 161). As such Leslie Cannold, a care-focused feminist suggests that when women get abortions they do not get them thinking of the rights of themselves and the fetus but they get abortions because they think they cannot be good mothers. It is important to note that care-focused feminists are not intrinsically anti-abortion, but they approach from another perspective.

On the other hand, explicitly anti-abortion feminists also known as pro-life feminists argue that abortion harms women rather than emancipates them. Some pro-life feminists simply follow the steps of first-wave feminists and argue that termination of a pregnancy is immoral, or claim that having rights of abortion makes women look like reusable sex objects (Çevlikli, 2017, p.162). On the other hand, some criticize abortion rights on the basis that it undercuts the rights of caretakers. Ziegler (2013, p. 238) states that a lobbying group for pro-life feminism named, Feminists For Life (FFL) argued that abortion rights let men use women sexually without any liabilities and also let the state not support women undertaking career and nurturing duties. Afterward, different pro-life feminist's groups appeared such as Susan B. Anthony List (SBAL) which aimed at increasing anti-abortion coalition in the congress or Women Affirming Life (WAL) which aimed at defining a new "authentic" feminism (Ziegler, 2013, p. 257). Pro-life feminism, however, always rose attention and controversy on defining what is a feminist perspective on abortion.

Today the anti-abortion coalition has risen overall in the political arena, which in turn increased feminist coalitions for abortion rights. Worldwide organizations such as Women on Web, or national level feminist groups such as the Soccorrista aim to increase access to abortion via providing women with tools for self-help methods. Contemporary arguments for feminists for abortion shifted also from the rights-based approach. Feminists, today, have realized that the right to abortion is not emancipating but it comes with restrictions and is used by states as a tool of oppression. Therefore, the current demand in terms of abortion is not of abortion as a right given but abortion as a legal and accessible healthcare service.

## **2.2. Solidarity and Social Support**

### **2.2.1. Defining feminist solidarity, sisterhood, or network**

Ann Whitehead (1984, p. 6) proposes that women's solidarity takes place in crises as these impact the everyday lives of women. She mentions that in poor conditions when women face risks that constitute obstacles for their survival they strongly unite and build networks for their survival. These networks function as safety nets for women, as places they can count on in need. However, such networks do not always provide safety nets. Whitehead (1984, p.9) emphasizes the oppression of kinship solidarity which not only takes place among men and women but also among women, through reproductions of the dominant ideology. As hooks (1986, p. 30) argues in order to have solidarities on feminist grounds women must work harder to overcome this alienation and unlearn the given and taught hostility towards each other. Although hooks (1986) naively argues for the apprehension of diversity under the tag of solidarity, contemporary politics of difference come to agree on the impossibility that sisterhood can lead to feminist emancipation.

Steans (2007) discusses the possibility of feminist solidarity in the complex of contemporary politics of difference perspective. As she argues the ideas of solidarity among women have initiated the idea of commonness", "shared realities" and 'shared oppression' (Steans, 2007, p.729). However, as a politics of difference came to present women do not unite neither under shared realities nor under oppression. Steans (2007) states that for feminist politics gender has come to be a uniting force as it determines access to resources and control of them, among mixed groups. However, as control and access also differs among different groups of women, transnational politics of feminism have come to an understanding of diversity. Steans (2009, p.733) states that his discourse of diversity started to construct identities and boundaries sometimes through conflict and sometimes through the sense of togetherness. Conflicts over discourses have enabled feminist activists to become self-reflexive on their own privileges and start to accept different feminists as they are through dialogue. As Steans (2007) cites from hooks "confronting conflict is a necessary process in a 'sustained committed struggle' towards feminist agenda". Thus, Steans (2007, p.737) proposes inclusive solidarity that builds upon recognition, respect, and self-reflexivity. In the stage of feminist inclusive solidarity, feminists must respect the fluidity of their identities and accept that each and every person can live and experience similar events in different ways.

Another criticism of feminist solidarity based on commonness which came to be known as 'sisterhood' was developed by Tingting Qi (2010). As she argues 'sisterhood is not powerful enough' as it fails to constitute an effective political strategy for all women, it only emphasizes the voices of the privileged. Even though the idea of sisterhood has become handy in political struggles in our contemporary understanding of identity it only surpasses multiplicities. Furthermore, Qi (2010, p.330) also criticized the idea of all-inclusive sisterhood. Such a perspective focuses on building coalitions around issues of interest. However, as Qi (2010, p.331) criticizes this perspective only focuses on including women but disregards the power relations among women. For example, white feminists writing on 'Third-world women' without a reflection on their privileges is criticized for making them look like exotic objects.

At this point, it is important to define the separating views on collective action and feminist solidarity. Despite the terms being tied up, some scholars especially in the field of development try to break them apart. Sweetman (2013, p. 219) defines 'collective action involves women discussing their lives, analyzing their shared experiences of injustice and oppression, and developing common goals. Fundamentally, it is about understanding and challenging gender-specific constraints on women's options, which prevent them from achieving their true potential.' While "feminist solidarity is defined broadly as the principle of mutual support between individuals, groups, and organizations working on gender equality and women's rights." The difference in their definitions makes collective action seem like an organized movement for rights and feminist solidarity as a set of bonds among individuals. Criticizing this approach, this thesis argues that feminist collective action should be defined differently than thus far definition of male movements.

Another contribution to solidarity politics, by Jodi Dean (1995), states that the notion of solidarity has a repressive and exclusionary position as well. In the notion of solidarity questions such as why does it take place and who does it oppose are important. She introduces three types of solidarity, affectional, conventional, and reflective. Affectional solidarity comes from mutual feelings of love and friendship, it is an immediate connection that is deemed to be unique, accepting the other as she is (Dean, 1995, p. 115). On the other hand, conventional solidarity is based on common interests and concerns. It comes out of a feeling of 'we'ness. However, as Dean criticizes conventional solidarities unite people on terms, thus putting a limit in which the member can realize herself in the group. In terms of acceptance of members as who they are, members are recognized as 'members'. Thus, there is an exclusion of individuals with intersecting identities. As they start to question the

solidarity, the solidarities can dissolve. Such questioning and exclusion have been tried to be solved with several methods such as fragmentation to groups, reassertion of values, and tactical solidarities (Dean, 1995, p.122). However, as Dean (1995, p.121) none of them proposed communication, thus failed to solve the problems. As such, Dean (1995, p.123) defines reflective solidarity as a response to failing strategies in building solidarities. Reflective solidarity tries to create a “communicative we”, where the idea of us and them is overarched. She states that instead of defining each other as ‘us’ against ‘them’, trying to exclude the exclusion of them is necessary. Instead of having the terms of ‘us’ strictly stated, we can never know who we are, and thus should keep the boundaries of ‘we’ open. Furthermore, reflective solidarity recognizes the particularity of each and accepts that one cannot be fully accepted as who she is, therefore, provides the space for her to be whom she wants. In addition, reflective solidarity surpasses the idea of readiness to take responsibility in conventional solidarity. One can manifest their commitment in different forms.

However, Qi (2010, p.331) criticizes reflective solidarity as despite it sounds hopeful it fails to provide a tool for the privileged to understand the less privileged and create reciprocal dialogues. Qi (2010, p.332) states that in terms of reflective solidarity, privileged women can reflect on their position and give the stage to less privileged women, however, in those cases this would require those women from less privileged groups to come to a level in which they can communicate with the privileged, such as learning their languages or entering their spaces.

As a solution, Qi (2010, p.331) proposes all-relational solidarity. Citing from (2006) Seyla Benhabib (1992), she states that different from the idea of all-inclusive solidarity ‘all relations solidarity emphasizes receptiveness and perspective-taking, and recognizes the complex positionality of individuals. All relational solidarity suggests that feminists must understand that the knower and the known are inseparable. Each has her realities and thus a perception drawing from them. As such Qi (2010, p.333) proposes ‘enlarged empathy’ as a tool to make this solidarity possible. Instead of showing compassion and sympathy, feminists should try to engage in perspective-taking and empathy among themselves.

While acknowledging the importance of enlarged empathy as a tool for feminist coalition building, Lyshaug (2006), mentions the need for enlarged sympathy as well. She notes that while the prior functions in order to give participation to each subject, give them the opportunity in engaging in communicative action by rejecting or accepting and, defines the extent of reciprocity in feminist politics. Drawing on Barky and Scheler’s “mitgefühl” – feeling with – instead of sympathy, Lyshaug (2006, p.88) argues that a genuine fellow

feeling without falling into the trap of identifying with a disadvantaged group than ourselves can be overcome. Enlarged empathy combines the idea of *Mitgefühl* with a kind of 'egoism' or self-referencing (Lyshaug, 2006, p.90). It helps self to identify with diverse others in a way that self-projects others on itself discovering an echo of others in itself. This practice of imaginative impersonation is claimed to encourage one to experience another not from a total alien position but an understanding of the realities of others and the fluidity of otherness. Here, it is important to give attention to this othering view of sisterhood. The author suggests that there will always be others in feminist politics. Despite efforts to unite and build coalitions, unresolved conflicts will take place. During decision making enlarged empathy would only let us stay separate from each other while enlarged sympathy can bring us closer in terms of our understanding. As the author suggests it requires one to be flexible and playful, tolerate change and differences, and be generous.

### **2.2.2. Role of Social Support on Abortion**

Major et al. (1990) conceptualizes solidarity networks around abortion as social support. They define abortion as a stressful life event and mainly aim at exploring social support's impact on coping with stressful events. As they argue the majority of women seeking abortion report their unintentional pregnancy and decision to terminate as a stressful and conflictual experience (Major et al, 1990, p.453). Women tend to feel reluctant about sharing this experience with others due to the related stigma surrounding it and moral sanctions. Furthermore, unintended pregnancy is not perceived as a faulty action of the women only, therefore starting from the partners' social support, social support is also sought by women. Major et al (1990, p.454) propose that especially partner's support has been detrimental in women's post-abortion experiences. They suggest that literature proposes women's hostility towards the partner, their relation's duration, and status had positively correlated effects on post-abortion adaptation. In their model, they assess the perceived social support of women from their partner, family, and friends. As expected, higher social support before, during, and after abortion was found to be related to having a high self-efficacy while coping with abortion. Their results show that social support doesn't have a direct effect on coping with abortion but it is impacted through boosting self-efficacy. Furthermore, they find that a sample of women who disclosed their abortion and received unexpected and unsupportive reactions faced a negative buffering effect, and much stress (Major et al, 1990, p.461).

In addition, Green and Rodgers (2001) approach mastery, stress and social support among low-income mothers and argue for three components of social support; tangible support

which is concrete support, informational support such as giving advice and belongingness, or emotional support such as reassurance. They define mastery as a predictor of social support and argue that individuals who can engage in necessary behaviors to accomplish their goals can perform better under stressful conditions, and that mastery can also be related to asking for the necessary help (Green & Rodgers, 2001, p. 421). Secondly, they also propose that social support as a predictor of mastery as people who can have social support can develop mastery, making the two reinforcing variables. Furthermore, they take stress as a factor impacting social support similar to other studies. They find that individuals' level of mastery enables them to ask for instrumental assistance, meaning that individuals' feeling in control can help them ask for concrete advice. Secondly, individuals who initially had tangible support felt more comfortable in terms of re-asking for support and in terms of their levels of mastery. Thirdly, they found that belongingness support had a reducing impact on stress levels.

Furthermore, Sandler and Barrera (1984, p. 48) measure different aspects of social support, namely, the content of support, satisfaction with support, and networks' characteristics. They find support satisfaction to serve as stress-buffering, while when the supportive behaviors were combined with upsetting interactions, this conflicted network served as a negative buffer. Authors noted that this suggested the interactive effect of social support.

Another, qualitative study by Fathallah (2019) investigates the social solidarity networks on abortion in Lebanon. As the study shows abortion is accessible in the country, however, women are required to have access to social capital, networks, and bargaining power on physicians and partners. Firstly, women have to negotiate with their partners before a termination. While a group of women try to make the partner agree on marriage and when they fail to persuade, consult to abortion services, another group were forced to terminate by their family and partner. This second group consisted of women who already had a child, who was not expecting, and who got pregnant from extramarital relations. Secondly, in order to be able to find a gynecologist who will perform an abortion, women need to have gatekeepers. Fathallah (2019, p.27) states that even though married women and women who had their partner's approval may have access to gynecologists single women with low socioeconomic status were much more deprived. In addition, women's social networks usually rely on kinship and friendship. As noted, they trust the physicians or decide to terminate their pregnancies based on their trust in the gatekeeper. Thirdly, financial constraints also determined women's access to safe abortion services. While women from the upper classes had access to abortion in hospitals, despite they would be recorded as

miscarriages, single women from disadvantaged classes would consult for clandestine abortion services (Fathallah, 2019, p.30).

### **2.2.3. Abortion Networks**

As such abortion is not viewed as a single bodily experience of a women but it can involve several parties. Individuals' can make use of others in terms of coping with this experience, learning about it, or even operating it. Firstly, abortion can be a traumatic or stressful experience for some. Therefore, social support while coping with abortion can ease its negative effects. Secondly, knowledge on abortion methods and how to prevent pregnancy is also diffused through social networks. Petchesky (1990, p.49) calls this 'cultural diffusion'. Besides medical knowledge on abortion, such as ancient techniques, or potions, through midwives or by generations different methods were generated and carried on. For example, an outbreak of lead poisoning due to contamination in the water, in Sheffield, made working-class women in the 1890s realize the abortifacient effect of lead. This knowledge spread quickly to every working-class home making Diachylon, which is healing medicine, to be purposefully used for causing miscarriages. Thirdly, women can help each other in operating this procedure. Another study cited by Petchesky (1990, p.52) suggests that self-help groups and cross-generational or community networks were made of use during the diffusion of abortion methods and care. For example, a study in 1913 in Germany notes that where women noted an accomplice during their abortions they mostly name either a midwife, a coworker, or the wife of a coworker of their husband. Thirdly, women can help each other for operating this procedure. Historically, when there were significant barriers and obstacles in access to abortion, there was always a way to get one. In those cases, women rely on two well-known methods, illegal abortions provided by different parties or self-managed abortion (SMA).

#### **2.2.3.1. Feminist Abortion Providers**

The most known feminist abortion self-care network has been the Jane collective. It was established in 1969 In Chicago, by a group of women to provide illegal abortions for women in need. They would be referred and reached on the phone. Each call would be taken by the name Jane and then referred to illegal abortionists whom the members initially knew as a physician (Joffe et al., 2004, p. 786). Once members find out that this person was not a physician, some members learned how to perform and become 'abortion counselors' themselves (Kaplan, 2016). The Jane collective notes one of the key events in self-care health activism. As women get to learn their bodies and gather around this movement, a

health movement emerges and publishes their influential book 'Our Bodies, Ourselves: Boston Women's Health Movement' in 1973. Joffe et al (2004, p.787) note that initially, feminist activists had the power of their bodies' medical care. Even after abortion was legalized 'abortion counselors' of self-help groups assisted doctors in the clinic. Unfortunately, as authors suggest after the 1980s, this active and on-site activism was discontinued, and instead, women joined pro-choice groups that were active in political and social arenas rather than on their bodies or in clinics.

Abortion movements have coincided with self-care or self-management groups in other parts of the world as well. In Europe, a well-known abortion rights activist group from France was *Mouvement de liberation des femmes* (MLF). In 1971, MLF initiated a petition that was signed by mostly famous women such as Simone de Beauvoir, confirming that they have had an abortion, in France, while abortion was a criminal act (Stewart, 1980, p. 351). Around the 1970s, abortion and contraceptives thus became widely discussed at all levels of French politics and society. In 1972 after a trial that sentenced a minor who obtained an abortion and her mother, a new movement emerged: *Mouvement pour la libération de l'avortement et de la contraception* (Movement for the Liberation of Abortion and Contraception (MLAC)). Their methods were radical. They would travel collectively to England or Holland with women in need of an abortion and who can afford them (Stewart, 1980, p.351). Furthermore, in 1973, MLAC opened a center in Paris where they provided free illegal abortions (Olszynko-Gryn & Rusterholz, 2019, p. 129). After, in 1975, the law legalizing abortion passed and most MLAC activists stopped performing abortions deciding that now that state was responsible for that. Only a few continued to practice due to shortcomings of clinics. Ruault (2016) interviews later generations of MLAC activists after the law from different regions of France and reports their cultural transfer of self-help knowledge. She notes that recent members try to keep the practice of self-help and not surrender the cannula to physicians (Ruault, 2016, p.11). Their methods included self- examinations on their bodies with a speculum and home abortions. Their main understanding in self-help was to renowned the body and have collective consultations enabling women to talk about their own (Ruault, 2016, p.13). As the author notes, with the translation of the book 'Our Bodies, Ourselves' to French, MLAC members had learned new methods and they also carried on their methods. After 1980s, MLAC members who continued with self-help practices organized, united, and created solidarity bonds among them. In 1981 a convention in Geneva was organized with other feminists and MLAC activists had the opportunity to meet with their English counterparts and learned about other methods such as abortive plants. Ruault

(2016)'s analysis suggests not only the emancipative perspective on self-help groups but also the diffusion of knowledge among them.

A recent example of feminist abortion networks marks solidarity among European feminists as well. Until recently, when abortion was legalized in Ireland in 2018, support networks on abortion health activism (AHA) which helped women have abortions in neighboring countries operated. Duffy (2020, p. 76) interviews AHA's in England and notes that they provided logistic, emotional, and economic help to Irish women traveling. Furthermore, the authors stated that the activists understood that experiences of abortion for Irish women were harder than the ones from countries where abortion was legal. As they observed, Irish women had to come up with excuses, travel, and get the money together. Furthermore, activists were also aware that it was not only the illegality of abortion that Irish women suffered but also the negative attitudes of physicians. Duffy (2020, p.76) cites from an interviewee that states despite the law has changed in England, the practitioners' minds haven't, leading them to face negative attitudes as well.

Contemporary feminist abortion networks, rarely perform abortions themselves, but they provide the means for medical abortion. Walsh (2020) explores Mesoamerican feminist networks in Honduras, Guatemala, and El Salvador where abortion is still illegal, and in Mexico where the legal status of abortion changes by state. Walsh (2020) finds that overall the activists provide either misoprostol or mifepristone or a combination of them and communicates it to women in secrecy. Consulting women either meet face to face or on phone to make sure they have the space and time for the procedure. Then, they make the arrangements for the women to receive the pills, which is noted as the riskiest part for the activists, as both parties can risk prosecution.

Similar networks also perform in Latin America. Drovetta (2015, p. 53) investigates five different Safe Abortion Information Hotlines (SAIH) in Argentina, Chile, Ecuador, Peru, and Venezuela. She notes that all these hot lines provide information on contraceptive use, safe use of medical abortion, and sometimes on how to avoid to the police by the doctors if they need to consult to hospitals. Furthermore, the author draws differences among hotlines as well. For example, she notes that the case of Chile differs as it is a feminist political project that does not have a dialogue with the state but rather supports self-managed abortion with telemedicine. Another different feminist abortion network from Argentina called Socorrista also differs by providing care in person not only on call but until the abortion is complete. Furthermore, Zurbriggen et al. (2018) state that Socorrista not only provides information but they make sure women have the lead in every step of the abortion process. Their practice

named ‘socorrismo’ is the act of providing feminist care, where they reflect on their understandings of care, destigmatize and de-dramatize the abortion experience (Zurbringen et al, 2018, p.113).

### **2.2.3.2. Self-Managed Abortion**

Berro Pizzarossa and Nandagiri (2021, p. 2) define SMA as:

“a range of individual activities – a multiplicity of behaviors and navigations that surround abortion self-use (e.g. self-sourcing, potentially necessitating (unpaid) leave from work, arranging childcare, and management of symptoms or complications, confirmation of abortion), and the collective dimension that enables safe self-use through a constellation of actors and interlocutors (e.g. friends, partners, family members, community health intermediaries, pharmacists, activists, non-profit organizations, hotline operators, accompaniment networks, doulas) who undertake several activities (e.g. provision of accurate information, sourcing of pills, accompaniment through the process, childcare provision) to support peoples’ SMA trajectories.”

Their definition shows that SMA highlights that it is not always a one-person experience. There can be a constellation of actors that carry out different parts of the process. For example, as explored feminist groups or a person’s friend network can become an intermediary in sourcing necessary equipment or the aftercare. Therefore, laws jeopardizing providers of abortion pills or abortifacients have also been criminalized in the past and now. As such, historically, despite abortion is one person’s experience it doesn’t always take place on one’s own. There are outside sources of information, helpers, medical providers, pharmacists, or other parties that take place in women’s stories of their abortion. As Assis and Larrea (2020, p. 38) note feminist initiatives’ experiences or narrations of women’s circles on abortion include stories of solidarity and non-judgmental support, in opposition to narrations of negative experiences in physician’s offices.

Juarez et al. (2019, p. 7) conduct a research in Mexico on women’s trials of SMA due to inaccessibility of abortion or their misinformation on abortion laws and find that even though misoprostol was the most widely used method, in most cases it was taken together with herbs and/or home remedies. Women who was provided with guidance on how to safely use the pills usually narrated positive stories while others such as the ones guided by midwives narrate stories of unsafe experiences, such as the midwives giving unknown drinks and then inserting their hands inside women’s uterus to pull out clots (Juarez et al., 2019, p.13).

Another qualitative research with 14 in-depth interviews by Raifman et al. (2021, p. 5) in the U.S. also report that despite women were aware of the legality of abortion they chose SMA methods as they were unsure about gestational limits, whether the operation would be covered by insurance or worried about the stigma surrounding it and thus chose to “deal with this on [their] own”. Different from other research on SMA, no one in their sample report using pills but they refer to using herbs, vitamin C, parsley, ginger root, chamomile, black cohosh.

### **2.3. Abortion in The Turkish Context**

#### **2.3.1. The practice of Abortion in Turkey**

##### **2.3.1.1. Abortion during the Ottoman Empire**

In the region of contemporary Turkey, during the 18th century, Ottoman Empire was ruled by a partially implemented sharia law and the dominant religious sect was the Hanafi sect. Islam highly tolerated and advised birth control methods, while interpretations on abortion are various. Though abortion is not implicitly condemned, it is not also explicitly advised. Although Islamic comments on abortion differ by sect, the Hanafi sect allowed abortions for 120 days. In Islam abortion is not considered a sin but is referred to as *mekruh*, meaning that it is not advised but also not condemned. However, due to considerations about population, laws in the Ottoman Empire were aiming at limiting abortions. In 1789, it was said that health personnel were supposed to take a vow depending on their religion, in front of the rabbi, patriarch, or the Istanbul Kadi, not to administer abortifacients to women\_ (Erkmen, 2020, p. 47)

The first law criminalizing abortion was decreed in 1858 in the Criminal Law which was inspired by the Napoleonic Penal Code. Interestingly, the law did not take the act of abortion as a crime but it took the act of causing an abortion as the crime. Therefore, providing abortifacients or causing a woman to lose a child through battering her would be punished but the women who had the procedure would be not (Balsoy, 2012, p. 24). In the Ottoman society midwives who assisted with abortion were called out as ‘bloodstained midwives’ (kanli ebe) (Demirci & Somel, 2008, p. 386). Gürsoy (1996, p.532) states that in the late 19th-century abortion was common among Ottoman women, and it was not morally condemned. Therefore, she comments that the prohibition was based on the European value system rather than an Anatolian one. However, by the late 19th century the pronatalist policies of the Ottoman Empire hit abortion as well. As Akile Gürsoy (1996, p.532) cites

from Sabah newspaper from 1889, “abortion is perhaps not the most important reason for population decline, but it is surely the most terrible’.

Gürsoy (1996, p.535) lays down three positions in abortion decision-making. The first one gives man control over reproductive decisions. Second, give women but only because they would make better mothers or as household matters were their responsibility. Third, allowed women to give their own decisions. The allowance of contraception in Islam is explained by two reasons (Gürsoy, 1996, p.535). The first is to ensure the spacing and the second was to prevent pregnancy in case the men do not consider the women fit enough to bear his children. The main focus in Quran and hadith was not on childbearing but rather was on child-rearing. Instead of having many children, having children carrying on proper Islamic values was rather much appreciated.

#### **2.3.1.2. Abortion in the Early Republic**

Following the downfall of the Ottoman Empire, the newly founded Turkish Republic was in great demand for population growth. Due to long going wars, immigration, and illnesses, population growth had slowed down and the ratio of men compared to women had dropped. Özbay (2015, p. 309) notes that this discrepancy encouraged the intellectuals of the time to support women's employment, simultaneously stressing that it can only be temporary. In the initial phases, upper and middle-class women working in senior positions were considered important and rose constantly while women's employment as workers or public servants was not encouraged (Özbay, 2015, p. 309).

However, it was as a given that women's place was home and until the male to female ratio was replaced it was acceptable for some women to work. Especially for the rural women it was articulated that the first and foremost duty was giving birth to increase the population. As Neset Halil Bey had stated the implication of Turkish women was that they ‘are the most fertile creatures on earth’ (as cited in Özbay 2015, p.311). As families were supported to have more children, precautions to give inertia to population growth were taken. These included the criminalization of selling and distributing birth control pills and devices, and criminalization of abortion, and a ban on commercials and public education about contraceptive methods (Akin, 2012, p. 45). Furthermore, the dominant eugenic discourses were also carried out in Turkish population policies as intellectuals defended the reproduction of ‘superior people’ (Türker et al., 2014). In the 1926 Turkish Penal Code, abortion was treated under ‘crimes against individuals’ and in 1936, this law was stricken by envisioning penalizing the women who undergoes the operation, her husband, and the

practitioner who operates with large sums of penalty fines (Tezcan & Akadli Ergöçmen, 2012, p. 37).

#### **2.3.1.3. Pronatalist Policies**

The pronatalist discourses and policies continued until the 1960s, leading the fertility rate to rise to 6,6 in 1927, reach a peak at 7.1 in 1930-35 and then fluctuate around 6,4 during 1960-65 (Akin, 2012, p. 65). In 1963, the first survey on fertility and family planning took place and revealed that women wanted to limit their fertility. According to the results, while the desired number of children was 3, the actualized number was 6.5 (Tezcan & Akadli Ergöçmen, 2012, p. 38). Furthermore, 63% of rural women and 84% of urban women stated that they wanted to learn about birth control techniques and, 1 in every 5 couples were making use of birth control methods. There was demand from the population on limiting fertility. Moreover, besides the demand, there was need. In 1953, Dr. Zekai Tahir Burak revealed in his analysis of hospital records of 5000 women that, despite its illegality, 30% of these women have had induced or spontaneous abortions, and among them, the rate of maternal mortality was 4 times higher and 27% of them had gone infertile. Secondly, in 1953-57 Dr. Ahmet Şükrü Esendal, observed that among women who applied to his clinic around 39% of them had started that they had an abortion once and 13% stated that had an abortion more than once (Tezcan & Akadlı Ergöçmen, 2012, p. 39). Research suggested that a change in the population planning laws was not only demanded by women, but was a need.

#### **2.3.1.4. Antinatalist Policies**

By the 1960s however, pronatalist discourses reached their ends and in 1965 Turkey was officially recognized with an overpopulation problem. The first concern with overpopulation was the economy. The economy was not able to support the population, employ and feed them. Secondly, with the popular use of contraceptives and the modernization ideal of Europe, having a larger population was perceived as backwardness. In 1963, the first Five Year Development Plan (FYDP) officially noted the rising population problem and highlighted the importance of maternal mortality (Gürsoy, 1996, p.532).

In 1965, Turkey's population planning policies took an antinatalist turn. However, as Özbay (2015) argues, attributing this turn to women's health considerations and fertility preferences would be rather naive. She attributes it more to the speculation that rapid population growth would slow down economic growth. The State Planning Organization and Ministry of Health and Social Welfare agreed upon taking birth control measures with the agreement that

instead of a large, unemployed, uneducated, and unqualified population, a qualified population was preferred (Tezcan & Akadlı Ergöçmen, 2012, p. 38). Therefore, in 1965 “Law on Population Planning” was made. While the law for population planning was drafted the word “birth control” was not preferred as it would be entering into people’s private sphere, instead ‘population planning’ was preferred (Özbay, 2015, p. 306). It allowed for selling and distributing birth control devices and pills, educating families on family planning methods, and practicing abortion in cases of a threat to a mother’s health. However, abortion at request was kept illegal since 1983. Though initially, it can be understood as a religious concern, Özbay (2015, p.317) relates this specific decision on the criminalization of abortion to the concerns of gynecologists as they were worried that with these new policies both the number of births and number of patients requiring illegal abortions for large sums of money would fall (Özbay, 2015, p.317). Furthermore, this opinion is supported by Ayse Akin, who is a gynecologist who has been effective during the abortion law was drafted (Kaleci et al., 2013). However, while upper-and middle-class women could acquire abortion by paying for it, especially women from rural places and low-class women would provoke their own abortion and then attend to the hospital. In one of his reports, Dr. Zekai Tahir Burak states that so many women with terminal status due to self-provoked abortions had applied to his hospital and most of them had lost their lives (Akin, 2012, p. 47).

In 1983 through lobbies of the women's movement and campaigns for abortion, Law No.2827 on “Population Planning” also known as ‘the Abortion Law’ and its bylaws Law No.508 on “Education, Authority, Responsibility of the Enforcing Personnel for Population Planning Services”, Law No.509 named “Code of Conduct of Enforcement of Population Planning Services”, and Law no.510 on “Enforcement and Audition of Uterus Evacuation and Sterilization Services” were enacted, legalizing abortion until the tenth week upon request. However, this law required spousal and parental consent, a gynecologist as the operator and a hospital or clinic for the abortion to be performed. Later on, an additional condition to the doctors to explain the health risks of abortion to counseling women was also introduced.

#### **2.3.1.5. Today’s Abortion Law**

Today, abortion and family planning practices are still realized under the same law. According to Law No. 2827, abortion is referred as ‘uterus evacuation’. As it is stated ‘in pregnancies which have not passed 10 weeks’ uterus evacuation can take place at request’. The procedure can be performed by gynecologists or by practicing physicians who have completed the necessary training to perform the procedure. The procedure can take place

where gynecologists are practicing in their clinics or hospitals, or in public hospital or maternity houses when practitioner physicians with certificates are performing menstrual regulation techniques. In case the pregnancy has passed beyond its 10th week, uterus evacuation cannot take place. It can only take place unless there is a condition that may risk women's life. In such cases, this condition must be reported by the gynecologist and the physician who has specialized in the area of the illness threatening the women's life and this should be reported to Health and Social Welfare management institutions. However, after 10 weeks if there is an urgent situation such as if there is excessive bleeding or if vaginal discharge had already taken place or if there are fetal abnormalities, then uterus evacuation can take place with the decision of the gynecologist. However, in such cases, this has to be reported in 24 hours.

Even though induced abortions can take place according to such law, there are consent requirements. According to the law “if the pregnant women is of full legal age from herself, if not, from her and her parent, and if married from her husband, lastly, if the person is not of legal age and under guardian then the consent of the person, guardian, and the magistrate's consent is required” The consent forms are signed by the parties when they come for uterus evacuation.

The law also regulates the manufacture and advertisements of birth control methods. This section of the law allows for production and advertisement of abortion services and birth control methods however, it also mentions that if anyone provides abortifacients or birth control related drugs that are not approved by this law and sells it for commercial reasons would be punished with short term prison time or with up to 150.000 Turkish liras penalty fine. Moreover, the law envisions penalties for persons operating abortions without being authorized by the law. These persons face 2 to 4 years of a prison sentence even when they perform with consent under 10 weeks. Furthermore, if these persons without the authority, provide a woman with abortifacients or act upon her in order to induce abortion without her consent, the person faces penalties.

The current condition of law seems to be decriminalizing abortion, allowing it, and supporting it. However, with a close look at the law, its restrictions jeopardize the access of many people to abortion and reproductive health services. First and foremost, the law only allows abortion up to 10 weeks of gestation. This gets more problematic as medically the number of days of gestation is counted from the last menstrual cycle instead of what lay people usually think as since the day of conception. Therefore, pregnant people may fail to recognize their situation within the legal limit, or even when they do, they may not realize

their need to act quickly and consult a doctor immediately. It is noted by gynecologists that women can tend to have another period after conception, therefore they can realize in the 6th and 7th week. At that point, if by any reasons, such as not being able to find the money, transportation means, consent of a parent, they may pass the legal gestational limit for abortions.

Secondly, the law specifies the institutions and personnel who can perform the procedure. This jeopardizes especially individuals living in rural areas, or who need to commute in order to reach a health institution. As the law specifies only gynecologists or trained practicing physicians can legally perform abortions, however, in rural areas, this authorized person may not readily exist and therefore women may need to commute or try illegal and perhaps unsafe methods. Furthermore, even if the authorized personnel exists or a person who can perform menstrual regulation is found, the institutional requirement stands by.

Thirdly, the law explicitly requires consent by several parties. The consent requirements other than the individuals' own consent, serve as obstacles while obtaining abortions. To begin with, due to parental consent requirements, young adolescents are forced to share this information with their parents. These situations can be risky for some family structures, or adolescents may not want to share this information. Sharing such information may threaten their lives, health, or psychosocial development. Secondly, adolescents living under guardianship require the consent of their guardian and a justice to consent for their abortion. Such a requirement further involves the state as a party in deciding on the future of an adolescent. Thirdly, married women are required to receive consent from their husbands. Such a requirement oversteps an individuals' agency and presupposes that in marriage her bodily activities are controlled by the marriage contract.

Fourth, the law presupposes and allows the advertisement of birth control methods and services. However, mostly these services are accessed in the private health sector. This is attributed to mismanagement or disinterestedness in advertising and educating people on family planning. In contrast, in the Turkish health care system even though birth control methods and abortion are freely available in the public sector, the private sector is much more preferred yet, private health insurances are not allowed to cover these measures. Forcing individuals to either pay for these operations in the private sector.

Lastly, the law constantly refers to 'pregnant women'. Such a language puts the law gender blind, as it makes other individuals with uterus invisible, such as transmen, intersexual, etc. The law is especially problematic with a gender lens. Even though it seems to be liberal it

restricts individuals in terms of their access. It medicalizes abortion and refers to it as a surgical operation. It does not allow for medical abortion, contrastingly it paves the way for penalizing its providers. It specifically criminalizes abortion after 10 weeks which is not medically grounded. It privileges and provides abortion services only to women who can reach them, which can be educated, middle class, urban who can have access to health institutions, transportation, and economic means to have an abortion.

Overall, The Abortion Law is restrictive on several grounds. Firstly, when the law passed it used the term ‘family planning’ rather than ‘population planning’ or ‘birth control’. Such wording proposes an implicit equation of women with family. This, in return, attacks women's agency in decision-making about their own body and also legitimizes sexuality only for reproduction in a family. Secondly, the spousal and parental consent requirement overrides a women's autonomy over her body and gives a saying to her family. Such a requirement not only jeopardizes access to abortion services but also threatens the health of especially young womxn from vulnerable groups. Thirdly, the law allows legal abortion only up to 10 weeks of gestation without any medical or scientific grounds. Usually, in the first trimester, which is the first 12 weeks, the risks of abortion are minimal and at the same level for the whole period. Having an abortion in the 12th week or the 10th week does not have any scientifically proven medical difference in terms of risks. The law, however, only allows for 10 weeks. This situation causes a great tendency to consult for illegal abortions as most womxn cannot realize or make the decision to get an abortion in 10 weeks. Moreover, contrasting to the commonsensical thought that gestation starts at conception, medically gestation is counted from the day of the last menstrual period as such, even though womxn think they are in the legal period, as they consult to the doctor they may have well passed the legal limit. Such discrepancies in the law also make it harder for womxn to apprehend it. In their qualitative survey, McFarlane et al (2016), authors find that even though informants were in command of the political discourses on abortion, they were vague about its legality. Even though slightly above half of their respondents correctly explained the laws, their results suggest that women's knowledge about the law is dependent on their individual experiences

### **2.3.2. Demographics of Abortion**

Demographics literature on abortion in Turkey focuses on the characteristics of individuals getting abortions, such as migration history, work history, age, education; misreporting levels; relations between abortion and abortion laws, contraceptive use; and its providers. As Özbay (2015, p. 5) reflects, demography accepts a positivist language. It lays out the data

and exempts itself from commenting on them. Therefore, the underlying social explanations such as social stigmatization or social networks are usually delved deeper into studies mostly conducted in domains such as politics, sociology, psychology, and women's studies.

Studies suggest that women's education, employment, and urban residence are significant determinants of their use of contraceptives (Karaoğlu & Saraçoğlu, 2018; Kirdar et al., 2011). Especially, Özbay (2015, p.64) emphasizes the importance of schooling for rural families in their fertility preferences. Decreasing fertility, access to contraceptives, and abortion in rural areas have been major concerns. These regions' resistance to antinatalist policies can be attributed to the emphasis given to them during the pronatalist phase. Quoting from *Ülkü Halkevleri* magazine in 1933, Türker (2014, p.45) notes that writer Zeki Nazir claimed that "the initial source for the population in Turkey was villages. Village mothers give birth without spacing and they neither have concerns on not making children nor search for its cure".

However, the data on abortion studies face the risks of misreporting and underreporting. Tezcan and Omran (1981) compare data collected by randomized response technique (RRT) and direct questioning (DQ) to subsamples of TDHS. While the DQ technique directly asks for women's abortion history, RRT asks them to respond using a tool. Their results show the existence of misreporting of abortion, as in the RRT sample around 33% of women have had stated to have induced abortions while in the DQ sample it stayed at 13% which is much less. Furthermore, recent research by Saraç and Koç (2020), showed that from 1993 to 2013, misreporting of induced abortions increased from 18% to 53%. They related this increase largely to increasing social stigmatization against abortion and sexuality. Özyeğin (2009) approaches the changing norms of social stigma through its transformation in the understanding of virginity. She notes that the physical norms for virginity have been surpassed however, it did not transform into the articulation of sexuality and pleasure but as she calls builds up 'virginal facades'. Even though people experience sexuality, instead of discussing it they abide by the social norms and moral expressions of virginity. Furthermore, in their study conducted in Izmir, Aras et al. (2007) discuss the gender discrepancy of these norms. They administer a questionnaire to evaluate the sexual attitudes of both male and female students. Their research suggested an imbalance in opposing premarital sex and engaging it. Male students opposed to premarital sex for both genders more than females, despite the fact that among male students 61% of them were engaging in premarital sex, while the rate for female students was 18%.

According to the latest results of TDHS-2018, %22 of all married women have had at least one spontaneous abortion, and %15 of them have had at least one induced abortion (HUIPS, 2019, p.155). As age and number of children given birth increases number of induced abortions also increases. While %19 of women who have had five or more children have had induced abortions for women who have never had children the ratio is %7. According to dispersion per region, the number of induced abortions per 100 pregnancies is 8 for İstanbul while it is 2 for the Black Sea region. In terms of education, induced abortion rates are the highest for women with primary schooling education, while it is the lowest in secondary school graduates by %10 (HUIPS, 2019, p.155).

Furthermore, according to TDHS-2018, both before and after abortion women largely do not use contraception despite after abortion rates are lower (respectively %64 and %60). Percentages of using withdrawal drop after abortion (HUIPS, 2019, p.157). While before abortion withdrawal use is reported as %20, after abortion, it becomes %10, while the use of IUD increases from %2 to %11, pill increases from %5 to %6, and female sterilization increases to %1 (HUIPS, 2019, p.157). As seen, after abortion a change from male-controlled methods to female-controlled methods takes place.

Overall, the literature suggests that while searching for abortion incidences contraceptive use and method serve as a mediator. Use of modern contraceptives increase with age, education, urban residence, employment for a majority of the population. Furthermore, in order to decrease report abortions post-abortion family planning programmes have been found useful. Lastly, in the light of recent research on abortion misreporting, it must be kept in mind that vulnerable groups can end up misreporting or underreporting their abortions or have unwanted pregnancies.

### **2.3.3. Attitudes towards abortion**

Despite its historical commonality abortion is and has been highly stigmatized and received with negative reactions in Turkey. Causes of these reactions can be regarded on several domains. Firstly, the religious understanding does not support the idea of abortion, even though it doesn't condemn it. Ekmekçi (2017) discuss the religious tendencies in approaching abortion law. She notes that despite regular standard for first trimester abortions are up to 12 weeks, in Turkey this cut off is left at 10 weeks, which is acceptable to the 120-day limit in the Sunni Hanafi belief that finds abortion as mekruh. Furthermore, Hatun and Yılmaz (2020) find that an increase in one's religiosity leads to an increase in that person's attitudes towards abortion.

Secondly, life course characteristics of women also change the reactions they face and reactions they give for abortions. Yıldız et al. (2020) show in their study in Iğdır to women aged 15-24 that according to advancement of age negative attitudes based on stigma increases.

Third, despite the existence of the stigmatization of medical professionals in a global context these findings were less compared to the one's found for the Turkish context. As found, literature review suggests that when searched for the stigmatization of abortion, international research focus on the internalized, accepted or perceived stigma of individuals while, research in the Turkish context focus more on the stigma faced by the medical professionals and abortion providers. Toksöz (2011) conducts interviews with 8 hospitals with family planning units, and her results show that the providers do not abide by the law but rather they improvise it on their terms. As her interviews suggest practitioners claim to operate between 6 to 10 weeks, and some of them suggest they do not perform with anesthesia at all, even the law is clear on that. The legal definitions, according to Toksöz (2011, p.65), are arbitrarily decided by the personnel rather than medically defined. Furthermore, her results show that in some of the centers' spousal consents are also taken from single women even though it is not required by law. Toksöz (2011,68) states that the personal justifies this requirement as due to their wish to protect themselves from getting beaten by an angry partner afterwards.

Another reflection of the differences in stigma appears in the pricing of abortion. Pehlivan (2019) conducts a study on midwife's perceptions on abortion in a private clinic in Istanbul. She finds that in private clinics pricing for abortion also changes based on the medical professionals' moral evaluation (Pehlivan, 2019, p. 36). As a respondent narrates in cases of married women the pricing is less compared to single women, or if the women explains her situation to the doctor such as whether her partners' beating her or her economic situation etc. as the midwife narrates, discounts are applied. Moreover, Pehlivan (2019, p.32) finds that even when doctors themselves are willing to perform abortion other personnel can make the women face the stigma, as in her study midwives tend to find abortion as murder, state they wouldn't have taken on the procedure if they were the doctor, and in general put the blame and shame on women.

Lastly, besides providers' lack of abiding by the law Toksöz (2011, p.76) also mentions the marketization of public hospitals which leads to a decrease in operating abortions. In Turkey, public hospitals' salaries are changed based on a score for interventional operations, where the scores are set by the Ministry for different operations. As such politicization of

healthcare takes place. The ministry can set scores based on its preferences for different operations, which will give incentives to the personnel to prefer patients with high-scored needs rather than patients with low-scored needs. In this system, abortion procedures are uncounseled, while seeing new patients are. This can lead the operators to quickly refuse abortion seekers in order to have other appointments. As Saluk (2014) shows the performance system for doctors and nurses in public hospitals impacts their decisions in which patients to prioritize.

#### **2.3.4. Backlash on Abortion**

The backlash on abortion rights can be perceived as an historical amnesia of its decriminalized years. It was always known and accepted that abortion is universal and women take the risks for unsafe abortion. Even though abortion had been legal in Turkey since 1983, access to it has been much deprived. Government discourses focusing on family planning rather than birth control, had been reproduced since the 1990s and policies on family and placing women as reproducers of citizens were implicitly articulated in the 2000s.

In 2000s, discourses started to explicitly disapproved abortion and birth control measures together with women's agency and education. In 2008, in Trabzon, Prime Minister Erdogan advised for at least 3 children. On May 2012, the President of Turkey, Erdogan, compared abortion to the massacre in Uludere, where Kurdish civilians had been murdered. For him, and therefore for his coalition, abortion was equalized with murder, which opened up a space for criminalizing abortion. After such discourse by the head of government, a cloud of fear and opposition for abortion started. Soon after in 2012, when a women applied to court for allowance on an abortion due to rape in the 12th week, the prosecutor replied as 'give birth and the state will take care' (*'Sen Doğur, Devlet Bakar,'* 2012)

In 2014, Erdogan had advised young women he was addressing in a iftar in a women's dorm, to not to postpone marriage and not be too picky'. In 2015, with the Action Plan on protecting family and dynamic population structure, several practices for encouraging women to have more children and join the workforce were implemented. These included programmes for family education, education programmes before marriage and flexible working hours for women until their children reach primary school age.(Erkmen, 2020, p. 91).

Currently, the law banning abortion has not passed, however, discourses replacing women in the family as producers of children still continue. Even though abortion was kept legal, according to a report by Kadir Has University (2020), access to abortion services was left

inaccessible. Their report suggests an analysis over public hospitals, and show that in many regions there are either none of just a few public hospitals providing abortion services, leaving women from rural areas or lower socio economic status especially vulnerable.

### **2.3.5. Feminist Reactions to the Abortion Debate**

#### **2.3.5.1. The abortion campaign in 2012**

Initially, a campaign was started by bianet, which is an independent news agency upon calls they have received from the public encouraging them to lead a campaign (Özgüler & Yazar, 2017, p. 144). Throughout the campaign women wrote 'My Body My Decision' on their bellies or on papers and hold them at their bellies and took pictures. As these pictures were circulated international support also came. Another campaign took place under the slogan "abortion is a right and the decision is up to women". This campaign collected abortion stories of women and published them under 'womb stories'. Lastly, another group of women's rights and feminist activists created another campaign a "Say No to Abortion Ban" and started a public petition over their website (Negron-Gonzales, 2016, p. 205). The petition was signed by 55000 people and 900 organizations. Furthermore, there was international support to the campaign as well. Over 200 international organizations declared their support and it was publicly reminded to the government that a ban on abortion would contravene with CEDAW, and lead to tensions between Turkey and the EU.

#### **2.3.5.2. Reaction of pious feminists**

Despite the international support on the abortion campaign by feminist coalitions, there was also arguments in opposition to the way campaign was held. The main arguments had started and revolved around the idea of 'my body my decision', which clearly states that corporeal body belongs to women. Even though secular feminists adopted the global campaign on the idea of owning the body and women's agency to make decisions over it, a localized opposition came from pious feminists. In her analysis of the discussions among secular and pious feminists during the abortion debate Unal (2018, p. 16) notes that pious feminists received these arguments as 'elitist and isolationist'. Pious feminists were also in favor of legal and safe abortion rights however, the discourse revolved around it were criticized as discursively making local understandings of feminism in Turkey invisible. In their understanding of Islam abortion is not unacceptable as body is perceived as a vessel through which soul is carried out, however, even if it is a sin they argue that it is in women's pious critical agency to commit it or not (Özcan, 2015, p. 86).

### **2.3.5.3. Gendered discourses**

Up to my knowledge there has not been literature on the gendered discourses of abortion in Turkey. However, an analysis of news during the campaigns clearly highlights a binary language. It is mostly articulated that ‘abortion is a right for women’ (Avci, 2010), or and ‘the preference of the mother is important’ (KAOS GL, 2012). Furthermore, the campaigns all state and agree upon that abortion is a right (Alpar, 2012). Several news, interviews and feminist blog posts mention the gendered discourses on abortion (Alpar, 2012), and several mention the binary language however, up to my research no academic papers, research or data has been found. After this initial lack I have found in the literature, I have tried to reach out to several trans rights activists however, I have received two prominent rejections. Firstly, one of my gatekeepers suggested that especially trans men were thought to be performing their masculinity therefore they may be reluctant to talk on the issue, while another stated that even if there are people who may have this knowledge they may not want to share it in an academic research as they do not want to be taken as ‘subjects’.

### **2.3.5.4. Medical Abortion in Turkey**

In 2012, after the highly criticized discourses on abortion the Ministry of health banned use of Misoprostol, which was initially approved as an ulcer medicine. They argued it was used ‘out of its aim’ (Atay, 2017, p. 11). As such their distribution was denied to pharmacies. Medically it is accepted that medical abortion is a less traumatic method with high user satisfaction (Akin, 2013). Today, it can be found in the hospital pharmacies however, it can only be used under doctor’s consultation. As the law dictates distribution of such medicine is also illegal in Turkey and criminalized. Despite some research, and illegal distributors of misoprostol and mifepristone exist, they are not legally available.

## **2.4. Conclusion**

The literature review part aimed to bring about an outline and overview for the analysis of the data gathered. First of all, it has mentioned the important distinctions and definitions among terms of abortion. As mentioned, when abortions take place through an external effort they are referred to as induced abortions. Induced abortions are also referred to as curettage in the Turkish context despite their medical inaccuracy. When they take place on their own via bodily activities they are referred to as spontaneous abortions or miscarriages. Furthermore, in terms of uterine evacuation through different methods of abort, three were highlighted. The first method is the D&C method, where the uterus is evacuated through the

use of a curette via scraping it out. The second method, which is contemporarily widely used is the menstrual aspiration method, where the uterine evacuation takes place by creating reverse pressure and suction either manually or through a vacuum aspiration device. Thirdly highlighted method, which is not as widespread as the rest is medical abortion. It refers to when an individual orally or vaginally takes a pill and through the pills effect uterine evacuation starts. Medical abortion can also become a method of self-managed abortion when it is practiced without a practitioner.

Another key distinction made through this literature review is on the terminological approaches. The literature overviews the political development of the abortion laws as given rights, not as taken. Therefore, it also emphasizes the restrictions of the laws. For example, the historical struggle that led to the legalization of abortion rights through *Roe v. Wade* enabled women to have abortions legally however it did not guarantee access to abortion. Furthermore, through the Hyde Amendment, the law got further restrictive as it blocked access for young, rural, and financially restrained women. Today, in the U.S. legal status of abortion and access to it differs by state and by person's conditions.

This thesis makes use of the difference between legality, safety, and access to abortion through a similar perspective. The Turkish Abortion law explored above legalized abortion on restrictive conditions. It allows abortion on request only when it is practiced by specified institutions and by specified practitioners, only up to the 10th week. Furthermore, it has consent requirements from husbands if a woman is married or under 18. Moreover, if the woman is under 18 it has to be reported. This suggests that law restricts abortion if a woman does not get consent from her husband or parents if an underage abortion is not reported if the abortion is not undertaken in a medical environment, if it takes place after the 10th week or if it is practiced by someone who is not authorized. As such this thesis defines legal and illegal abortion based on this distinction. Any types of abortion experiences that do not align with the specified regulations of the law are defined as illegal. However, while defining illegal and legal procedures its overlapping distinction from safe and unsafe abortion is also important. While the legal status of abortion is explained via the Turkish Abortion Law, safe and unsafe status is bordered by the definitions of the WHO. As the WHO states, abortions are referred unsafe when it is undertaken by an unskilled provider, under unhygienic conditions, take place via traditional methods such as inserting objects, without post or pre-counseling. While some illegal abortions can be safe, some legal abortions can be unsafe. For this thesis, while analyzing abortions experiences the focus will be upon their legal status rather than their safety. To clarify, in some cases where a practitioner practices an abortion under the 10th week for a single woman over the age of 18, the practitioner may

operate in an unhygienic environment which can lead the woman to end up with an infection. This operation would be legal but unsafe. On the other hand, a woman in a rural area can have an abortion at her house, operated by a skilled midwife under the 10th week. This operation would be illegal in the Turkish context but would be considered safe.

After building up the distinctions among types of abortion, this literature review also outlines how this thesis approaches feminist solidarity and social support. To begin with, mainstream literature comes up with terms such as solidarity, sisterhood, coalition, network, and such to define this relation. All these words refer to when people need others. Some scholars such as Whitehead (1984), therefore, argued that women would build solidarities in times of crises and named them as 'networks for survival. However, she also notes that these can also work negatively and exemplify kinship solidarity, which can have negative results when crises pass. While conflict and resolution are viewed as a part of a struggle in many solidarity networks, bell hooks (1984) and Sweetman (2013) argue that basic collective action dynamics only suggest toleration for others for a common goal while feminist solidarity aims at unlearning hostility overall. Steans (2007) explains this as inclusive solidarity, on three pillars, recognition, self-reflexivity, and respect. However, her notion is criticized as inclusive solidarity and unlearning hostility would still have power dynamics and hierarchical relations inside of it. Therefore, Qi (2010) proposes all-relational solidarity which would highlight one's reflection on her position through tools of enlarged empathy and enlarged sympathy. Another overlapping typology by Dean (1995) categorize three types of solidarity. First, she notes affectional solidarity which comes through positive emotions but can also turn negative easily. Second, she notes conventional solidarity which rises through struggling for a common goal. Third, she reflective solidarity where women can build up relations openly through being self-reflective and reflecting on their position and others'.

The importance of social support while coping up with stressful life events and utilization of abortion networks has been studied in the psychology literature and Gender Studies literature before however both kinds of literature have had different approaches. Psychology literature uses abortion as a proxy for stressful events and finds out that while coping with stressful events people make use of their social bonds and these bonds work as stress buffering. Moreover, the find out that the agency to ask for help increases the potential for searching for help when one encounters such an event. On the other hand, Gender Studies literature focuses on the cultural diffusion of knowledge through networks, the informative side of those networks and groups, and how they can be utilized as self-help groups. Overall, abortion networks, regardless of whether they are built up of one's family, friends or

whether it is an organized one can work as a way to access abortion, as a stress buffer from other negative comments or stigmatization, and as a safe space to discuss and learn about reproduction.

In the case of Turkey, such networks have not been found or survey data do not measure for significant bonds for such diffusion of knowledge, which is why this thesis will take over the literature from here and aim to connect social solidarity networks and abortion.



## **CHAPTER 3**

### **METHODOLOGY**

#### **3.1. Background on Feminist Methodology**

Greene (2006, p. 93) specifies four distinct domains that build up a methodology. The first domain is philosophical assumptions and stances constitute the backbone of the study. This domain includes assumptions on the ontology of things and epistemology, the relation between the knower and the known, objectivity/ subjectivity debate, and the role of context and contingency. The second domain is 'inquiry logics', which includes the strategies for operationalization, measurement, sampling, and methods. The third domain is the guidelines of practice, where particular and solid analytical tools and processes are defined to realize the parameters defined in the second domain. The fourth and last domain is the sociopolitical commitments the study makes. These include the ethics of the study, its beneficiaries, supporters, whether it produces new knowledge or urges for action. Greene (2006, p. 94) states that the credibility and persuasiveness of a methodology come as all these domains act in harmony altogether.

As a Gender and Women's Studies thesis, this thesis approaches the social phenomena of abortion and access to medical services from a feminist lens. Therefore, rather than focusing on the overall patterns of abortion, such as its commonality and inaccessibility, as highlighted in the literature review, this thesis will first look for the invisible cases and then explore their experiences of abortion. The assumptions and philosophical stance of the first domain can be explained by the feminist methodology.

I strongly advocate voicing the silence. women's culture, history, and lives have remained 'underground and invisible, relegated to the 'underside' of men's culture, history, and lives (Nielsen, 1990, as cited in Brooks, 2007, p.55). Humankind's adopted way of living is

androcentric that puts the interests and comfort of the patriarchal male among all others. Complex and disparate areas ranging from rule of law to medicine, science to household labor are organized around the authoritative patriarchal structures. The 'othering' of what is not male is not a newly emerged phenomenon but has been constructed. Humankind's ways of learning and understanding have also been illusioned with such dominance of patriarchal structures in order to imagine a new way of being, living, understanding, and knowing the need for an alternative way of observing, investigating, and researching was utterly necessary.

A feminist way of research and investigation has risen from the mismatch between what was being thought in the scientific domains and the way it was experienced by 'others' of the society. Therefore, while acknowledging the stance of a feminist methodology, it is important to put this process of othering in the center. This suggests a dualistic understanding of the society in opposition. Here, however, the opposition is not simply between men and women but rather between what is patriarchal and all-other.

Drawing upon feminists' criticisms of mainstream methodologies, feminist methodology stood against the dogmatic knowledge production by an authoritative scientific community and targeted at including the participant in the research process, in order to break down the researcher and researched hierarchy along with other dualist and oppositional contrasts in the research process. Therefore, methods used, focused on initiating interactions and communication among the researcher and the participants to create a feeling of solidarity and understanding. This study adopts and forwards these interactive methods and backlash to authoritative approaches aiming for singular and universalizing truths.

The idea of a fragmented and multifaceted understanding is necessary to understand intersecting realities of women such as ethnicity, age, class, race, nationality, religion, which combined would define a women's position. Even though individuals' knowledge and experiences serve as truth and listening to their stories is a way of knowing, it is also important to interpret them in relative terms. As Patricia Hill Collins puts it, 'each woman spoke from their standpoint, sharing her own partial and situated knowledge', therefore all knowledge was partial (as cited in Brooks, 2007, p. 75).

Overall, the feminist methodology does not adopt a single path of research methods but brings up a way of conducting research regardless of the method. Ultimately, it is concerned with the empowerment of the 'others', improvement of their lives, and voicing of their marginalization which aims for initiating social change (Apodaca, 2009, p.419). With such a

goal, feminist methodology claimed its principles as being collaborative and participatory, transformative, accountable, accessible, ethical, and intersectional (Leung et al., 2019, p. 413).

### **3.2. Data and Methods**

The second domain of inquiry logistics includes the components of a methodology that builds up its methods, design, and analysis. In the light of feminist methodology, this study prioritizes knowledge coming through individuals before stories, aims to integrate them into the process interactively, and aims to have concrete action-oriented results. Building upon such a logic, this study makes use of both quantitative and qualitative research methods as complementary to each other, employing a qualitative explanatory sequential mixed methods research strategy.

As Hesse-Biber (2010, p.106) outlines sequential mixed methods designs do not explicitly state whether they prioritize qualitative or quantitative parts, the prioritization depends on the research question. This thesis aims to shed light on the paths through which individuals access abortion in Turkey, therefore, due to the nature of the data, the qualitative (QUAL) part will have primacy in analysis over the quantitative (quan) part even though the sequence of analysis is the opposite way. The interaction between the quantitative and qualitative components is sequential, as the prior identifies the sample for the latter. This specific integration between the methods makes mixed methods study purposeful in order to interpret the social reality at hand. Besides this integration at the data analysis stage, the mixed-methods design will triangulate the analysis from both components at the inference level as well.

What is specific about the sequential mixed methods design of this research is that the quantitative component is utilized to understand the structure of the general population and from the general population the quantitative part directed the research for the qualitative sample. As the marginalized groups in the quantitative analysis revealed themselves the qualitative part focused on uncovering their experiences. This sequence aligns with the highlighted notions of feminist methodology. As mentioned, feminist methodology suggested voicing the silenced, and in terms of data analysis underrepresented groups are the ones in silence. As such the quantitative analysis aims for finding these groups.

### 3.3. Research Design: Qualitative Mixed Methods

In order to discuss access to reproductive healthcare systems, this study will use abortion at request as an operationalization for several reasons. Firstly, abortion as an operation has a specific position in the gynecologist's job description. Even though as a service to better one's overall health they are required to perform abortions, they have the right to personally deny it on moral grounds. Secondly, both in Turkey and over the globe the debates on abortion upon legalizing or criminalizing it are used as clamps in the political agenda.

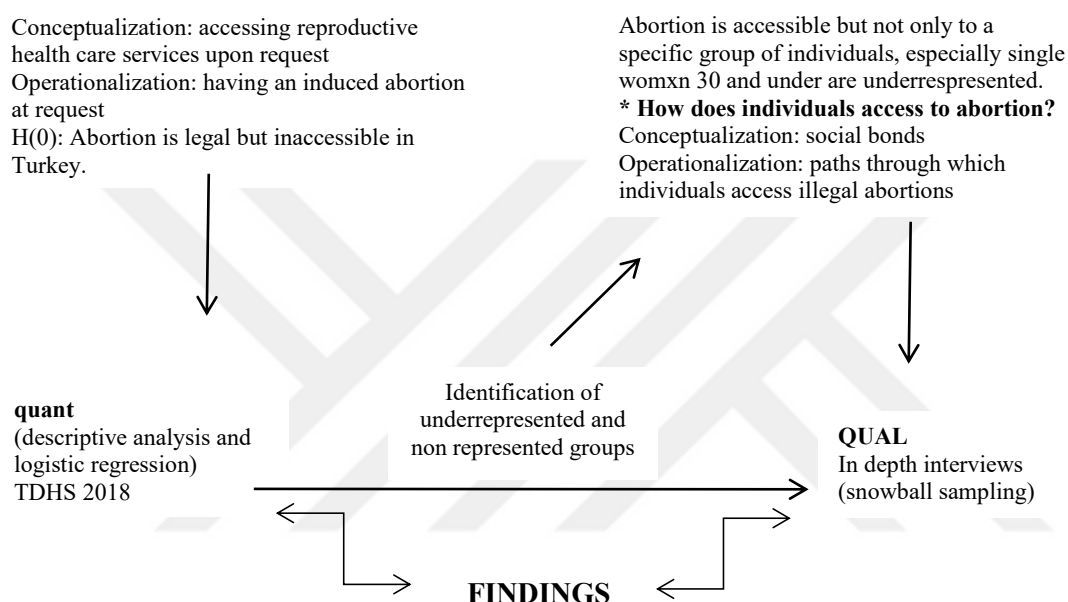


Figure 1: Overview of the Research

As shown in the figure above, the starting point is the claim that ‘abortion is legal but inaccessible in Turkey. Firstly, the quantitative part of this study conducted a statistical analysis using the data from TDHS-2018, to determine who had access to abortion and their characteristics compared to women who had not. The results of the quantitative analysis will identify the underrepresented and non-represented groups in terms of their access to such services. As the results of the initial phase suggest, abortion is accessible but only to a specific segment of the population, who are mostly married women with children. However, as women's experiences suggest, individuals who are single without a child also get abortions. At this secondary phase, the study will hypothesize that individuals access abortion via their social environments, which are conceptualized as social bonds. In order to adequately determine the importance of social bonds, the study will employ snowball

sampling to reach out to single people, 30 and under who had abortions and have semi-structured in-depth interviews. The second phase of this study will interview individuals who had legal or illegal abortions in order to investigate the unique characteristics of their experiences and the various paths they make use of to access these services. As explained in the literature review, the abortion law in Turkey restricts women on its own. Because of its short time frame of 10-weeks, consent requirements, and limiting the operation only to gynecologists, the law itself closes off access to many women. Therefore, it is important to highlight the existence and accessibility of illegal abortions despite the restrictions. Lastly, the results from both the quantitative and qualitative analysis cumulatively propose an overall condition for access to reproductive services in Turkey.

### **3.3.1. Quantitative Component**

#### **3.3.1.1. Description of quantitative data**

The data used for the quantitative part is the 2018 Turkish Demographic and Health Survey (TDHS – 2018). Hacettepe University Institute of Population Studies (HUIPS) conducted the survey both on an individual and on a household level. It is a representative survey whose data is collected every five years since 1993 as a part of The Demographic and Health Surveys Program. As a part of a larger program, the TDHS data is collected and can be compared to other countries that are a part of the program. Besides these comparison measures, DHS also employs country-specific questions depending on the structural realities of countries.

TDHS surveys are conducted on women of reproductive ages (15-49) in each household. The neighborhoods in each THDS region are chosen randomly by the Turkish Statistical Institute (TUIK) and then stratified for block selection using the information on population sizes from the Address Based Population Registration System. As such, the survey has several contributing partnering organizations. From a feminist standpoint, it is important to note the contributors and benefactors of the TDHS - 2018. The survey is conducted fully by HUIPS and it is funded fully from the national budget, by The Scientific and Technological Research Council of Turkey (TÜBİTAK) and its beneficiary institution is T.R. Presidency of Turkey Directorate of Strategy and Budget. However, as stated in the main report of the project, the report only reflects the opinions of HUIPS and was conducted solely by staff employed by HUIPS. Lastly, prior to the fieldwork of TDHS, the Ethics Committee of Hacettepe University evaluates the data collection phases and the questionnaires. During interviews, respondents were briefed about the survey and their informed consent are taken.

Thus the academic honesty and transparency of the data make it a reliable and representative source.

TDHS provides cross-sectional data which is collected from 12 different regions in Turkey on the NUTS-1 level. All women at fertile ages (15-49), living at selected households, or were staying at the house the night before the survey are counted as eligible respondents. Overall, the survey is conducted in 11,056 households, with 9,056 eligible women. The survey has interviewed 7,346 of these women with an 81.1% response rate, which suggests a decline from the response rate of the previous 2013 survey which was 89.9%.

The survey includes two questionnaires, household questionnaire where the equipment inside the house and its residents are asked and the women's questionnaire which delves deeper into individual women's fertility preferences, birth history, contraceptive knowledge, and use, vaccination, early childhood, marriage history, work history, information on her partner and family and, her opinion on women's status.

#### **3.3.1.2. Sampling Frame**

The quantitative phase of this study aims to understand the characteristics of women who access abortion services at the request and specifically analyze young women's access to those services. Therefore, initially, the descriptive analysis of the whole women sample is made and a general pattern on women from which segments had an abortion is analyzed.

Then, as this thesis mainly problematizes youth's access to reproductive services, the data is be split and only the 'young women sample' is be used for further analysis. Defining an age group as 'young' is cumbersome, as the literature does not suggest a strict age group. Özbay (2015, p.259) argues that the aim is not to define the youth as a group but to define their social problems. According to the research question on 'youth,' their definition is subject to change. Özbay (2015, p.258) gives the example of the well-established age limit of 18 for accounting for someone as a child. However, exemptions to this rule include marriages allowed after the age of 16. In terms of daily responsibilities, these people are not referred to as children.

At this stage, it is important to note that this thesis focuses on young women because of this group's specific intersecting characteristics. Firstly, as mentioned, the law defines different regulations for abortions of married and single women, thus it is important to include single women in the 'youth' sample. Secondly, some argue knowledge and use of contraceptives increase via education, therefore when defining youth, this study needs to include university

graduates. Thirdly, as the qualitative phase of this study makes comparisons between abortions under legal and illegal conditions and it is known that illegal abortions, especially self-induced or illegal abortions are the last resorts for married women, the sample should include married women as well. Based on this criterion and for comparative reasons and given the limitations of data, the cut-off age for this study is chosen as 30.

### 3.3.1.3. Empirical Strategy and Variables

The sampling frame includes all women at the age of 30 and under, regardless of their other characteristics, and this data is first analyzed via its overall patterns. Then, to make a difference among women's tendency to access abortion at request, a binary logistic regression analysis is conducted with the equations shown below. For the statistical analysis of the data, SPSS 25.0 and Stata software is used.

$$\ln\left(\frac{P}{1-P}\right) = y = \beta_0 + \beta_1\chi_1 + \beta_2\chi_2 + \beta_3\chi_3 + \beta_4\chi_4 + \beta_5\chi_5 + \varepsilon$$

$$\ln\left(\frac{P}{1-P}\right) = p(\text{abortion})$$

$$= \beta_0 + \beta_1\text{talked\_FP} + \beta_2\text{age} + \beta_3\text{educ} + \beta_4\text{urban} + \beta_5\text{ethnicity} + \beta_6\text{internet} + \beta_7\text{work} + \beta_8\text{opinion} + \beta_8\text{partner} + \varepsilon$$

The null hypothesis for this part is that access to abortion at request does not show any significant differences among different women. To measure that, this thesis employs a binary logistic regression analysis using the dichotomous variable of whether the respondent had an abortion as the dependent variable and the rest as independent variables. ‘Abortion’ stands for whether or not the individual had an induced abortion. This variable only includes women who reported being at the age of 30 and under and had experienced induced abortion. It is important to note that the sample does not differentiate women based on whether they were ever married or not. Regardless of their marital experiences, the data is aggregated based on whether the woman had an abortion or not. Secondly, ‘talked\_FP’ signifies the main independent variable of whether the individual which is whether the individual had spoken about family planning to someone. This variable takes 0 if the person has not spoken to anyone before and 1 if the person has. Thirdly, ‘social bonds’ stands for the group of variables that note individual had entered relationships with others, ‘educ’ signifies the educational status of the individual, ‘urban’ signifies the type of residence of the individual, ‘ethnicity’ measured by the mother tongue of the individual suggests her ethnic group, and ‘family’, ‘work’ and ‘partner’ variables signify individual’s characteristics of her family, work and partner’s situation. These control variables are implemented as dummy variables.

As the analysis is a logistic regression the tests measure each variable and their contribution to the model and the dependent variable singularly.

Table 1: Variable List

| Type                             | Name                           | Question                                                                       |
|----------------------------------|--------------------------------|--------------------------------------------------------------------------------|
| <b>Dependent variable</b>        | Experience of induced abortion | Whether the respondent had an induced abortion                                 |
| <b>Main Independent variable</b> | Social bonds                   | Who have you talked to about reproductive health in the last couple of months? |

Table 2: Variable List (continued)

|                              |                                |                                                                |
|------------------------------|--------------------------------|----------------------------------------------------------------|
| <b>Explanatory variables</b> | Education                      | education (years of education)                                 |
|                              | Rural/urban                    | type of place of residence (rural/urban)                       |
|                              | Ethnicity                      | mother tongue and parent's (mother and fathers') mother tongue |
|                              | Migration                      | Number of migrations                                           |
|                              | Family type                    | number of siblings alive                                       |
|                              |                                | whether parents are relatives                                  |
|                              |                                | whether the respondent and her partner were related            |
|                              | Work history of the respondent | Number of jobs                                                 |
|                              |                                | takes care of the child when the respondent is at work         |
|                              | Money                          | Have money to spend on her own                                 |
|                              | Opinion                        | Women should be virgin at wedding night                        |
|                              |                                | Approve abortion                                               |
|                              | Partner's status               | partners education                                             |
|                              |                                | respondents opinions on acting independently                   |

### 3.3.2. Qualitative Component

The third domain stated by Greene (2008, p.18) was 'Guidelines for Practice', which enables the researcher to specify how to mix the methods strategically. The mixing initially takes

place at the sampling level in this study as the results of the quantitative component suggested the underrepresented groups that are to be investigated in the qualitative component. The results of the qualitative component interactively impact the variables of the quantitative component. Eventually, the results are to be interpreted altogether.

Feminist scholars argue that quantitative measures work specially to convince the nonbelievers of women's realities about the validity of the results (Apodaca, 2009, p.419). As Spierings (2012) outlines, quantitative methods can formulate the patterns, construct a common language for all to examine the degrees of diversity and change, and can help researchers formulate additional research questions. However, the mainstream approach in feminist theoreticians was to criticize the use of quantitative methods, especially its connection with positivism as they distance the participants and reduce them to numbers. Even though by the 1990s, the debate among research methods concluded that none of which would be bias-free or more feminist, as both are required to interpret social phenomena (Campbell & Wasco, 2000, p.784), the inclination towards qualitative methods in the feminist methodology developed them and adopted their application in feminist studies.

The major focus of feminist researchers was overhauling silence above women. They wanted to break this silence and collaboratively conduct the research with all its participants. (Belenky, 1986, p.24) narrates that in silent women's lives 'words were perceived as weapons. Words were used to separate and diminish people, not to connect and empower them. As such, feminist methodology focused on breaking down the separative and dualistic nature of words and adopted qualitative methods that would give the agency and credibility to its participants and make them be heard. Qualitative methods such as in-depth interviews, oral histories, focus groups or conducting fieldwork stand out with their hands-on approach to the field. In qualitative methods, the observer usually integrates into the field, takes notes, talks to the participants individually, and shares about herself (Flick, 2018, p.2).

### **3.3.2.1. Qualitative data**

As this is a qualitative mixed-method research, the qualitative data analysis comprises a priority in the study as the sample reached out through this phase is rather unique. The quantitative analysis suggested that according to the statistics young, single women or women who had abortions after the legal limit of 10 weeks or under the age of 18 were non-represented or underrepresented. Even though during data collection, women with such experiences had come through, it was likely that they have misreported (Saraç & Koç, 2020).

Therefore, the qualitative part of this study targeted uncovering these underrepresented individual's experiences.

Up to my knowledge, no other research on an academic level on illegal abortions exists in Turkey. Therefore, the method selection began by questioning the reasons for which researchers may have avoided such a topic. Possible causes can be the risks of recalling traumas or the difficulty in accessing such a group. Taking the risk of having a small sample, I had interviews with young women of my age that I can also connect over my experiences to have smooth interviews.

Legal abortions carried out in a public institution are recorded in the hospital information and included in the government's statistical database however, as induced abortions can take place in private clinics, these can stay undocumented or mis-documented. As in the case here, illegal or non-statutory procedures were mostly undocumented. Firstly, self-reports of induced abortion in population surveys can yield under-reporting because of stigmatization or criminalization of abortion or women may report induced abortions as spontaneous (Rossier, 2003). Secondly, because of the presence of others, individuals may misreport the instances. For such cases, indirect questioning such as asking whether the respondents' last pregnancy was planned, or use randomized response techniques especially in regions where abortion is highly stigmatized is advised (Tezcan & Omran, 1981).

To overcome these pitfalls and minimize the risk of recalling traumas, I initially began by searching individuals who had known people who had illegal abortions. At this stage, anonymous third-party reporting (ATPR) was used. Respondents were asked to report on the instances of abortion they have witnessed among their social networks. This method, as proposed by Rossier (2003, p.97) is claimed to work efficiently in social settings where women solidarity networks exist and where abortion policies are restrictive. According to Rossier (2003, p.97) however, one obstacle of this method was that women's possibility to have access to abortion may be dependent on their social network, which may bias the estimates upward. As this was a qualitative study, this limitation was overcome. Secondly, as interviews continued, women who had abortions themselves contacted me, and self-reports of abortion were taken as well. Having a qualitative phase of such a stigmatized topic enabled me to observe clearly and partially overcome the pitfalls of survey data.

### **3.3.2.2. Sampling Frame**

The quantitative part of this thesis conducted semi-structured in-depth interviews with individuals who have had abortion experiences at the age of 30 and under or with individuals

who have accompanied individuals going through an abortion. I reached the respondents through snowball sampling and purposive sampling. I initially reached them through personal networks. The initial phase of interviews adopted a purposive sampling strategy to reach out to individuals who have had illegal abortion experiences and then, in order to have a comparative basis and expand the sample, individuals or their friends during legal abortion operations was reached out to as well.

### **3.3.2.3. Interview Technique and Qualitative Data Analysis**

As the respondents responded to the call, we arranged interview dates for online meetings. Before the interviews, I briefed the respondents about the purpose of the study and their contributions. Furthermore, I received their informed consent beforehand. Due to the specific conditions of the time in which this study is conducted, online interviews were preferred to reduce the risk of the COVID-19 spread. This strategy had its positive and negative impacts together. Positively, it enabled me to reach out to women's experiences from different cities and regions of Turkey. Second, it allowed the respondents to have the interview in places they felt comfortable in. Third, it eased the recording process and financial restraints of traveling. Negatively, as expected, drawbacks because of the internet quality have taken place in several interviews. Second, even though it was not the case here, it was possible for the respondents of individuals to not agree to the interview as they would not want to discuss this issue in their houses, instead, some may have preferred a private space. Third, having the interviews from the screen has blocked off the possibility for me to observe individuals' gestures and environment.

The interviews took place as follows. Firstly, in each interview, a small talk for both parties to introduce themselves was given. The first part of the interview comprised questions regarding the witnessed abortion, such as why was it necessary, or where and how it took place. Then, its aftermath for the experiencing individual was asked. The first part ended by asking the respondent's opinion on the condition of access to and education about abortion, contraceptive and reproductive care services. The second part of the interview focused on the social environment of the experiencing individual. The questions were prompted according to the status of the respondent. For example, if the respondent was the one who had experienced abortion, their perceived views on the social environment and the help she received were asked, and if the respondent was a friend of the experienced individual, then their opinion on the individuals' social environment was asked. Firstly, they described their relationship to the individual who had an abortion/ the closest person who helped them. Secondly, the social support individuals received from different sources were asked to be

elaborated upon and prompted as the social support individual expected but could not receive. Lastly, the degree of social support received and its aftermath was asked. Afterward, interviews were transcribed and decoded by me, and the data analysis is completed using MAXQDA software.

### **3.1.1. Limitations**

Even though preventive measures to minimize limitations throughout the study have been taken, significant limitations of this study still exist. First of all, the quantitative component of this study used a representative sample. However, this study aims to find the specificities of underrepresented groups which is beyond the aim of a quantitative sample. Secondly, as a general limitation of quantitative studies, this study also forwards the limitations of the TDHS study, in terms of its systematic errors. Data collection for survey data is prone to misreporting. As TDHS collects data on stigmatized reproductive health matters, misreporting or underreporting is also at stake. Thirdly, in the qualitative component, at the data collection stage the narrations collected were on individuals' experiences of abortion, therefore individuals or their companions were the respondents. This approach creates a difference between received, given, and perceived levels of social support in between the networks. Fourth, I did not restrict the qualitative sample to a single gender, both in terms of the gender of the person who had the abortion and the gender of the respondent. The data collection stage encouraged and purposely searched for individuals of different genders to join as well however, this was not reached as all experiences told belonged to women. Furthermore, sampling was open for experiences from all over the country however, because my networks mostly resided in Ankara, the sample ended up being composed of a large proportion of respondents from Ankara. For further research, the data collection stage can be conducted with purposive sampling and via queer networks or through expert interviews.

### **3.4. Conclusion**

Greene (2008, p.20) views mixed-methods inquiry as 'challenging the taken-for-granted methods and actively inviting all to take part in the dialogue built over the study. As such, the fourth domain that should also be in harmony with the whole methodology is the 'sociopolitical commitments' of the design. In terms of the sociopolitical vision of this study, it is important to note that the mixed-method strategy contributes to the diversity of the sample as the sequential component aims to fill the misses of the quantitative component. Secondary, this design provides new answers to an unexplored topic of illegal abortions and

aims to start a conversation on several topics such as the abortion law, our discourses on abortion, and medical abortion.



## CHAPTER 4

### QUANTITATIVE RESULTS

#### 4.1. Descriptive Analysis

As explained in the methodology section, the data used for this thesis is the TDHS-2018. The data consists of information on 7346 women's reproductive lives, opinions, and attitudes. The survey is a nationally representative survey, conducted with cluster sampling. Therefore, the data has high explanatory power on a national and regional level.

The first table of this section (Table 2) shows the demographic characteristics of the women included in the whole survey. For the purposes of this research, the table below shows three subpopulations among the sample, which are women who are 30 and under, women in the whole sample who have had an abortion, and women who are 30 and under and had abortion, and in the last column reports the data for the whole sample. The purpose of this table is to have a broad overview of the sample and realize the underrepresented groups. As a survey data TDHS-2018 is representative in its full sample however, despite their accuracy and strength its subsamples are not. Table 2 shows the dispersion among categories of variables for the full sample, for the subsample 30 and under, for the subsample who had an abortion of all ages, and for the subsample who have had an abortion and is 30 and under. As the last column reads, the population splits almost evenly among age groups around 12-15% for each.

Secondly, as is common in all groups a large proportion of the population lives in urban areas. 78.2% of the whole sample lives in urban areas, while only 21.8% lives in rural areas. For the group who had an abortion and were 30 and under, proportion living in urban is higher than the other subgroups. For this group, almost 82% of the women live in urban.

Table 3: Demographic Characteristics Table

*Sociodemographic Characteristics of Respondents (weighted)*

| Baseline characteristic        | 30 and under      |      | Had abortion     |      | 30 and under and had abortion |      | Full sample       |      |
|--------------------------------|-------------------|------|------------------|------|-------------------------------|------|-------------------|------|
|                                | <i>n</i>          | %    | <i>n</i>         | %    | <i>n</i>                      | %    | <i>n</i>          | %    |
| Age group                      |                   |      |                  |      |                               |      |                   |      |
| 15-19                          | 1163              | 34   | 2                | 0.2  | 2                             | 2.2  | 1163              | 15.8 |
| 20-24                          | 1034              | 30.3 | 20               | 2.5  | 20                            | 25.4 | 1034              | 14.1 |
| 25-29                          | 1035              | 30.3 | 43               | 5.5  | 43                            | 55.5 | 1035              | 14.1 |
| 30-34                          | 184               | 5.4  | 107              | 13.7 | 107                           | 17.0 | 1065              | 14.5 |
| 35-39                          |                   |      | 161              | 20.6 |                               |      | 1105              | 15.0 |
| 40-44                          |                   |      | 213              | 27.4 |                               |      | 1025              | 14.0 |
| 45-49                          |                   |      | 234              | 30.0 |                               |      | 918               | 12.5 |
| Type of place of residence     |                   |      |                  |      |                               |      |                   |      |
| Urban                          | 2645              | 77.4 | 615              | 79   | 63                            | 81.7 | 5744              | 78.2 |
| Rural                          | 772               | 22.6 | 163              | 21   | 14                            | 18.3 | 1602              | 21.8 |
| Mother tongue                  |                   |      |                  |      |                               |      |                   |      |
| Turkish                        | 2649              | 77.5 | 620              | 79.6 | 48                            | 62.4 | 5836              | 79.4 |
| Kurdish                        | 605               | 17.7 | 119              | 15.3 | 21                            | 27.6 | 1157              | 15.7 |
| Arabic                         | 107               | 3.1  | 22               | 2.9  | 4                             | 5.7  | 193               | 2.6  |
| Other                          | 55                | 1.6  | 17               | 2.2  | 3                             | 4.2  | 160               | 2.2  |
| Have money <sup>a</sup>        | 1230              | 36   | 264              | 34   | 22                            | 28.4 | 2776              | 32.4 |
| Partner's ever attended school | 1392 <sup>b</sup> | 98.3 | 758 <sup>c</sup> | 97.6 | 74 <sup>d</sup>               | 96   | 5031 <sup>e</sup> | 98.1 |
| Partner's occupation           |                   |      |                  |      |                               |      |                   |      |
| Agriculture                    | 126 <sup>f</sup>  | 9.7  | 60 <sup>g</sup>  | 9.6  | 4 <sup>h</sup>                | 6.5  | 430 <sup>i</sup>  | 9.7  |
| Industry                       | 271 <sup>f</sup>  | 20.9 | 131 <sup>g</sup> | 21   | 15 <sup>h</sup>               | 23.4 | 920 <sup>i</sup>  | 20.8 |
| Service                        | 902 <sup>f</sup>  | 69.4 | 434 <sup>g</sup> | 69.4 | 46 <sup>h</sup>               | 70   | 3080 <sup>i</sup> | 69.5 |
| N                              | 3417              |      | 779              |      | 77                            |      | 7346              |      |

Note: Valid percentages are reported.

<sup>a</sup> Reflects the number and percentage of participants answering "yes" to this question.<sup>b</sup> n= 1416, <sup>c</sup> n= 777, <sup>d</sup> n= 77, <sup>e</sup> n= 5130, <sup>f</sup> n= 1300, <sup>g</sup> n= 625, <sup>h</sup> n= 65, <sup>i</sup> n= 4430

Thirdly, in terms of the dispersion of ethnicities of the sample, the survey asks the question of an individual's mother tongue. Previous research by Ergöçmen et al. (2004) had shown that ethnicity and work status serve as important factors in determining contraceptive use. As expected Turkish as a mother tongue has the most percentage of all. 79.4% of the respondent's state that they speak Turkish as their mother tongue, while 15.7% state Kurdish, and 2.6% Arabic.

Fourth, the survey also collects information on women's economic level and independence. Among the whole population, only 32.4% of women claim that they have money to spend on

their own. Unexpectedly, for the subpopulations, higher percentages of women state they have money to spend on their own. 36% of women 30 and under and 28.4% of women 30 and under who had an abortion state that they have economic independence while spending money. Selim and Bilgin (2020) also find that according to TDHS-2008 and 2013 data, they find that in both sample women with migration history tend to have higher fertility rates, while women's employment, education, infant mortality and ethnicity has been found as significant determinants.

The TDHS-2018 survey also makes a distinction among ever married and never married samples. The survey collects data on the partners of the ever-married sample. While the meaning of ever married does not only mean legal marriage it refers to having been in a partnership before. The last part of Table 2 refers to the ever-married sample. As the last column shows, among 7346 women 5031 of them who have been in a union stated that their husband/ partner has attended school, while the proportions for school attendance is similar in other groups as well. Lastly, the table also shows the occupations of women's partners. As expected, most partners' are working in the service sector, followed by industry and agriculture. Here, it should be highlighted that for the non-parametric analysis and regression, the ever married subsample is not preferred instead the sample is aggregated specifically for women who have had an abortion. Ever married sample would include women who have not had an abortion as well however the main interest of this quantitative part is to look for underrepresented abortion experiences.

As one of the aims of the DHS surveys is to collect information not only on respondents' demographics but also on their reproductive lives, the survey also provides information on individuals' reproductive choices and lives. Table 3 aims to showcase women's opinions on abortion, their choice of methods whether they would prefer another method, and whether they have talked to anyone about family planning. For this table it is important to realize that the time frame for variables is not specified therefore, one cannot comment on whether talking to someone leads to any difference among the groups or one cannot understand whether the individual started to approve abortion before or after the experience. The table only aims for giving an understanding of the general population. To begin with, individuals' attitude towards abortion while among the whole proportion only 696 of 7346 women approve it, in the subsample of 3417 women 30 and under, 346 of them approve (Table 3). Interestingly, among the 779 women who had abortions and 77 who are 30 and under and had abortions respectively on 138 and 7 of them state that they approve. As this description suggests women undergo abortions despite they may not approve of it.

Table 4: Reproductive Choices Table

| Baseline characteristic                       | 30 and under     |      | Had abortion    |      | 30 and under<br>and had<br>abortion |      | Full sample      |      |
|-----------------------------------------------|------------------|------|-----------------|------|-------------------------------------|------|------------------|------|
|                                               | <i>n</i>         | %    | <i>n</i>        | %    | <i>n</i>                            | %    | <i>n</i>         | %    |
| Approve abortion <sup>a</sup>                 | 346              | 10.1 | 138             | 17.8 | 7                                   | 8.9  | 696              | 9.5  |
| Current use by method type                    |                  |      |                 |      |                                     |      |                  |      |
| None                                          | 2540             | 74.3 | 247             | 31.8 | 34                                  | 43.4 | 3901             | 53.1 |
| Folkloric                                     | 4                | 0.1  | 1               | 0.2  |                                     |      | 8                | 0.1  |
| Traditional                                   | 299              | 8.8  | 132             | 16.9 | 10                                  | 13.2 | 1011             | 13.8 |
| Modern                                        | 573              | 16.8 | 398             | 51.1 | 34                                  | 43.4 | 2425             | 33   |
| Prefer to use a different method <sup>a</sup> | 187 <sup>b</sup> | 25.7 | 95 <sup>b</sup> | 17.9 | 7 <sup>d</sup>                      | 16.8 | 594 <sup>c</sup> | 17.3 |
| Talked about FP with someone                  | 889              | 26   | 197             | 26   | 25                                  | 32.8 | 1792             | 24.4 |
| Partner                                       | 180              | 5.3  | 43              | 5.5  | 10                                  | 12.5 | 386              | 5.2  |
| Mother                                        | 182              | 5.3  | 15              | 2    | 3                                   | 4.1  | 250              | 3.4  |
| Father                                        | 4                | 0.1  | 1               | 0.1  | 1                                   | 1.2  | 5                | 0.1  |
| Sister                                        | 183              | 5.4  | 48              | 6.1  | 6                                   | 7.1  | 396              | 5.4  |
| Brother                                       | 4                | 0.1  | 3               | 0.4  | -                                   |      | 11               | 0.2  |
| Daughter                                      | -                | -    | 10              | 1.3  | -                                   |      | 44               | 0.6  |
| Son                                           | 3                | 0.1  | -               |      | -                                   |      | 7                | 0.1  |
| Mother in law                                 | 28               | 0.8  | -               |      | -                                   |      | 40               | 0.5  |
| Friends                                       | 554              | 16.2 | 114             | 14.6 | 14                                  | 17.8 | 1092             | 14.9 |
| Neighbors                                     | 25               | 0.7  | 11              | 1.5  | 3                                   | 3.9  | 103              | 1.4  |
| Teacher                                       | 26               | 0.7  | -               |      | -                                   |      | 26               | 0.4  |
| Family Doctor                                 | 33               | 1    | 20              | 2.5  | 2                                   | 2.9  | 79               | 1.1  |
| Health Personnel                              | 12               | 0.3  | 8               | 1    | -                                   |      | 39               | 0.5  |
| Other                                         | 49               | 1.4  | 18              | 2.3  | 3                                   | 3.5  | 109              | 1.5  |
| N                                             | 3417             |      | 779             |      | 77                                  |      | 7346             |      |

Note: Valid percentages are reported.

<sup>a</sup> Reflects the number and percentage of participants answering “yes” to this question.

<sup>b</sup> n= 877, <sup>c</sup> n= 531, <sup>d</sup> n= 44, <sup>e</sup> n= 3445

In terms of the methods currently used by women, the survey classifies the methods as none, folkloric, traditional, and modern. Folkloric methods are ones such as believing that milk protects from conception, while traditional ones are calendar or withdrawal methods. More than half of the whole sample state is not using any method currently, while the ones using modern methods the most. In the subsamples that are 30 and under, women mostly state not using any method as they may not be sexually active. The proportions for currently using modern methods are the highest among the subpopulations that had an abortion, respectively 51.1% and 43.4% for all and 30 and under subsamples. This finding is consistent with Erfani & Yüksel-Kaptanoğlu (2012) where they make a comparison over the DHS data for Iran

(2000) and Turkey (2003) and find that in both countries use of withdrawal is prevalent especially among older cohorts and a largely related to incidences of abortion and unwanted pregnancies.

Similar to international results, use of contraceptives is found to be increasing with education and over the life courses of women. Moreover, use of contraceptives decrease by abortion incidence. Şenlet et al. (2001), attribute this decline in abortion incidences to the rise in the use of modern contraceptives. Besides, use of contraceptives research also highlights the importance of family planning services. Bulut (1984) and Şenlet et al. (2001) investigate the link between family planning services and abortion incidence. They find that inadequacy of family planning services which can lead into contraceptive failure is a major reason for the need for abortion, and considering the country's situation they propose for the further implementation of post abortion services. Research shows that post abortion planning implemented through 1990s has led to a decrease in repeat abortions and a change from tradition to modern methods of contraceptives.

The key indicator which is also altered as the independent variable for this research, whether the respondent talked about FP with others has also been shown in detail in Table 3. In all groups fathers and brothers are not preferred to talk about FP, while most friends, sisters, and partners are preferred respectively. Specifically, for the group 30 and under and had an abortion, despite their low count percentages for having talked about FP are the highest. For this subpopulation, as the third column shows, mostly partners and friends are preferred to talk about this issue. On the other hand, among the whole sample without the age limit women who have had abortion state having talked with their friends, sisters, and then partners about family planning, suggesting a change in preferences among age groups.

#### **4.2. Correlation Results**

Before the regression analysis to explain this tendency, correlation matrix to rule out multicollinearity among variables is given in Appendix B. The correlation matrix considers respondents 30 and under who are the main sample for the quantitative part of this research. The sample includes all women 30 and under, regardless of their marital status and whether they had an abortion. The main interest of the correlation table is to which characteristics of women 30 and under align together. The correlations among their stated characteristics are shown in the table and the significant relations at alpha-level 0.05 are signified with a star next to them. The characteristics are chosen as possible measurements that can indicate the sociability of the individuals. Firstly, with the age variable, it is assumed that as the

respondent's age increases the people she could have met with would increase, accordingly increasing her social environment. This aligns with the literature for the purposes of this research. For example, Edmeades et al. (2010), show using a life-course model on a sample of Indian women, show that their use of contraceptives and therefore tendency to apply for abortion services is affected by their age and accumulated experiences.

Secondly, variables indicating education status, financial status, or use of the internet of the individual would indicate the different social groups they entered and their possible sources of information. Thirdly, variables such as whether respondents' parents are related, whether they attended school or whether they belong to the Turkish ethnicity are assumed to reflect their family type. Fourth, their opinion on abortion, women's status, or smoking behavior is assumed to indicate the strength of their attitudes and position on a political scale.

Except for the ethnicity variable, age is significantly correlated with all other characteristics. Notably, it is strongly positively correlated with whether the partner has attended school. However, as the value is at 0.6 it does not indicate multicollinearity. Moreover, as expected age is negatively correlated with whether an individual's mother attends school, uses the internet, and approve of abortion. Strikingly, the variable of whether the respondent has money to spend on her own is negatively correlated with variables about her family status and partner. If respondents' parents are related, her command of money is decreasing.

Lastly, the correlations of whether respondents have talked to someone about family planning are most notable for the purposes of this thesis. The variable is significantly positively correlated with age, having money, whether mother and partner attended school, use of the internet, approval of abortion, and smoking while it is significantly negatively correlated with education and opinion on whether the husband should do housework. As all correlations are low, the results do not indicate multicollinearity but it does indicate a possible link to be investigated with social networks of individuals and their speaking of family planning.

#### **4.3. Chi-square results**

After inspecting for correlations, chi-square test results for different variables are taken in order to investigate their associations with whether the individual has had an induced abortion. The results are given in Appendix C. The subsample used for the chi-square tests includes all women at the age of 30 and under and categorizes them into two groups as women who have had an abortion and those who have not. The purpose of this test is to see the significant differences between the two groups. Women 30 and under who have not had

an abortion also include sexually inactive women, while women 30 and under who had an abortion suggest to women who are both sexually active and had an abortion, regardless of marital status or number of children. Sexually inactive women are included because the main aim of the test is not to see the difference between the decision to have an abortion or not but to see the differences among women who experienced abortion and not. Chi-square results do not indicate significant associations between work status and financial independence, type of residence, approval of abortion, or women's opinion on women's status. About the association between individuals' abortion experience and whether the individual talked about Family Planning (FP), the results only indicate an association with talking to a health professional and abortion. It is expected as usually after abortion health professionals inform individuals on family planning,  $X^2 (1, N = 3418) = 4.505, p < .05$ . Talking to females, males, or others such as friends or neighbors is not found to be significantly associated.

Similar to the correlation results, use of the internet, smoking, and education are also found to be associated with the chi-square results. For education, the sample includes 8 women who had abortions without any education, 11 who had primary, 55 who had secondary, and 3 who had higher education. Regardless of whether they had an abortion or not, the percentage of secondary school graduates is the highest in the sample and these frequencies are significantly different from each other,  $X^2 (3, N = 3417) = 35.085, p < .05$ . Use of internet is significantly associated to having an abortion,  $X^2 (2, N = 3418) = 26.094, p < .01$ . Lastly, smoking regularly has the highest percentage of individuals who had abortions, and the frequencies among smoking regularly, irregularly or not at all differ significantly,  $X^2 (2, N = 3418) = 26.094, p < 0.01$ .

Furthermore, the results also indicate association between contraceptive method and having an abortion,  $X^2 (3, N = 3417) = 45.862, p < .01$ . The sample mostly prefers the modern method and the ones who use the modern method among the ones using any method have the highest percentage. On the other hand, among the ones having an abortion not currently using any method has the highest percentage of an abortion experience.

Overall, chi-square tests only direct us into building a better model than planned initially. As the non-parametric results suggest living in urban or rural does not have an effect at all. Furthermore, the effect of the mother tongue is very small. However, they highlight that there is a strong association between having an abortion and talking to a health professional, while others people affect it in smaller or insignificant amounts. Moreover, both correlation and chi-square results suggest that education, smoking, and the use of modern contraceptive methods have associations.

#### 4.4. Logistic Regression Results

Based on the information from the previous non-parametric tests in order to observe the direction of relations and their strength a binary logistic regression has been constructed. The subsample used includes all women at the age of 30 and under and the binary restriction is whether they have experienced an induced abortion or not. The regression analysis with the highest explanatory power with a Nagelkerke  $R^2$  of 0.23, is included in this section (Table 4). The regression analysis is a rare events regression with a total number of observations of 3287, who are all women in the TDHS at the age of 30 and under, and a number of observed events of 74. As such the explanatory power of the model is limited due to a rarity of events. The low number of events is related to two facts, one of which is underreporting while the other is the low reach for young women. As TDHS is a survey conducted via home visits during the daytime, working women and students can be absent from the residence. Moreover, in cases where young women are reached, they can have the fear of being listened to by the other members of the residence and thus tend to misreport.

Even still, a Nagelkerke value which explains 23% of the variation in young women's abortion prevalence is acceptable for a study in social sciences as in social sciences it is almost impossible to have full explanatory models due to a high number of variations in events and measurement. Moksony (1999, p. 5) especially highlights the acceptability of a low  $R^2$  in social sciences, especially in cases of rare events. As exemplifies of suicide victims, he notes,

People who attempted to take their life usually comprise but a minor portion of the sample, resulting in a highly skewed distribution, with the great bulk of the cases falling in one of the two categories. And this, in turn, implies small variance, since the variance of a dichotomy is simply the product of the two relative frequencies. If we are interested in the effects of rare events, then, we should be aware that a low value of  $R^2$  does not necessarily indicate that the impact is small and negligible (Moksony, 1999, p.5).

The model has an intercept value of -5.431, suggesting that without any variable abortion prevalence would be negatively counted. The main independent variable of the model was whether the individual has talked to anyone about family planning. This variable was chosen to understand whether individuals' openness about the topic would have any impact on their abortion tendency. While models with variables such as whether the individual talked to a female, male, or health professionals came out to be insignificant, a model using talking to "others" had the highest significant relation. "Talked to others about FP" is a variable that

takes the value 1 if the individual has spoken to her friends' relative' neighbors or stated that she spoke to others about family planning. This variable is of interest because the main aim of this component was to dig out to which group individuals talk to about FP. As shown talking to others who are friends, relatives and neighbors about FP is negatively associated by -0.669 units with having had an abortion.

Table 5: Binary Logistic Regression: Abortion and Social Characteristics

| Effect                                               | Estimate | SE     | Odds ratios | 95% CI |        | p      |
|------------------------------------------------------|----------|--------|-------------|--------|--------|--------|
|                                                      |          |        |             | LL     | UL     |        |
| Intercept                                            | -5.431   | 1.323  | 0.004       |        |        | 0.000  |
| Talked about FP: other <sup>a</sup>                  | -0.669   | 0.295  | 0.512       | 0.288  | 0.912  | 0.023* |
| Age                                                  | 0.098    | 0.039  | 1.102       | 1.021  | 1.190  | 0.013* |
| Modern_method                                        | -0.304   | -0.304 | 0.738       | 0.447  | 1.217  | 0.233  |
| Higher education <sup>b</sup>                        | 2.396    | 0.648  | 10.979      | 10.979 | 39.070 | 0.000* |
| Turkish <sup>c</sup>                                 | 0.248    | 0.271  | 1.281       | 0.753  | 2.180  | 0.361  |
| Women should be virgin at wedding night <sup>a</sup> | -2.166   | 0.535  | 0.115       | 0.040  | 0.327  | 0.000* |
| Have money <sup>a</sup>                              | -0.218   | 0.299  | 0.804       | 0.447  | 1.446  | 0.467  |
| Uses internet <sup>a</sup>                           | 0.432    | 0.284  | 1.541       | 0.883  | 2.687  | 0.128  |
| Approve abortion <sup>a</sup>                        | -0.892   | 0.451  | 0.410       | 0.169  | 0.993  | 0.048* |
| Smoke <sup>a</sup>                                   | -0.881   | 0.264  | 0.414       | 0.247  | 0.695  | 0.001* |

Note. Respondents at the age of 30 and under who have had an induced abortion are included in the binary variable.

Number of events = 74, total N = 3287. CI = confidence interval; LL = lower limit; UL = upper limit.

Nagelkerke R<sup>2</sup> = 0.23

<sup>a</sup>0 = no, 1 = yes. <sup>b</sup>1 = had higher education, 0 = else. <sup>c</sup>1=Turkish, 0= not Turkish.

Besides talking to 'others' the model shows significant relations between age, having had higher education, opinion on women's status, approving abortion, and smoking. Having had higher education shows to increase the tendency for abortion by 2.396, while opinion on whether women should be virgin shows to decrease by -2.166. While higher education has a

significant effect, other levels of education have shown insignificant effects when added to the model.

Another point is that women's opinion on whether women should be virgins on their wedding night has a significant negative effect on the probability of abortion. These intuitively expected results are worth mentioning as an outcome of this analysis because it highlights a major reality which is that women do not mostly engage in sexual relations before marriage based on this opinion. Therefore, in a sample 30 and under, this result suggests that despite women who believe women should not have extramarital relations, there are also women who have had abortions or miscarriages before marriage or who have had abortions during their early pregnancies.

Lastly, on the other hand, approval of abortion, ethnicity, and financial status of women do not show significant effects on the tendency for abortion similar to non-parametric results. While mainstream literature mostly suggests that ethnicity and work would have significant effects both have yielded insignificant results in this analysis.

Overall, the quantitative results outlined a direction towards women's characteristics. Descriptive statistics have shown who had been marginalized in the population and which experiences of abortion are not reflected in the general population. The non-parametric results showed, which differences among groups in our subpopulation are meaningful associations and directed us to interpret which factors can have an impact on the probability of abortion. Lastly, logistic models with binary independent variables of talking to females, males, or health professionals did not have significant and explanatory results while talking to others who are friends, relatives and neighbors about family planning had shown strong effects. However, these models do not allow for us to test for time-specific effects, for example, we cannot look for when females or males are involved, we can only see the cases in which utilized these individuals. These results also showed that while the education level of the partner significantly decreases the probability of abortion, higher education of women increases. However, the model does not explain why. A possible explanation can be that when women's educational level increases their tendency to approve and accept abortion may increase.

#### **4.5. Conclusion**

The purpose of the quantitative analysis was to understand the general nature of the survey data, population, and its subsamples. Analysis showed the trends in the overall population and subsamples and showcased the realities of the majority. As such, it also highlighted the

minority. As mentioned the main aim of the descriptive analysis was to find out the silenced data and delve deeper into it in the sequential qualitative component. Descriptive statistics showed that the age distribution among age groups for the full sample was even however in terms of characteristics younger groups do not reflect all types of women but only highlight the general trend. Overall, abortions take place later in women's lives. As the ages increase the possibility of women had abortions increases. This is not only intuitive but also shows women's tendency to not having an abortion early in their lives. However, women who have an abortion early in their lives are also in the data. In the 15-19 age group out of 1163 women 2 women stated they had abortions. This supports the overall trend of not having early abortions but also shows that women who do not fall in the general trend exist as well. Moreover, descriptive statistics show that overall women do not approve of abortion. Even in subsamples where women state they had abortions they still mostly do not approve. Also, in terms of their methods, types women 30 and under mostly state not using any method as it is not customary to have relations before marriage and most of them 30 and under group is never married. However, 30 and under and had abortion subsample suggests that they either use no method or the modern method. Lastly, descriptives show that in all samples women mostly talk about family planning with their friends, and then sisters, partners, and mothers, while at the least they talk to their fathers, sons, and brothers.

On top of descriptives, non-parametric tests are also conducted to overview whether differences among groups are significant. Chi-square tests showed that only talking to a health professional leads to a significant difference while talking to females or males is not significant. Moreover, chi-square tests also highlighted smoking, use of the internet, and having secondary school education leading to significant differences among groups.

Despite its limitations and low explanatory power, the quantitative component has shown that capturing the experiences and realities of sexually active women is beyond the scope of survey data. For showing the abortion experiences of women the data highlighted that for women 30 and under talking to 'others' had a decreasing effect on their probability of abortion. This directed this research to its qualitative component. Quantitative results it falls short on showcasing women's experiences of abortion. Therefore, the next component of the research delves deeper into the qualitative experiences of women 30 and under who have had an abortion. As such the purpose and the integral necessity of the quantitative part becomes its leading role for the construction of the qualitative sample.

## CHAPTER 5

### QUALITATIVE RESULTS

To collect the data for the qualitative part of this research I searched for individuals with experiences of illegal abortion. Out of 25 individuals, one canceled after making an appointment saying that her trauma has been triggered. Semi-structured interviews with the other 24 women have been conducted. The interviews have a mean of 32 minutes with the shortest being 12 minutes and the longest being 52 minutes. While 13 of my respondents have had the experience themselves, the rest 11 of them narrated the abortion experience of someone they knew. The mean age of abortion for the narrations is 23 with a range of 15 to 30 and all abortions have taken place between the period 2002- 2018. Except for two of them, all of the respondents stated that they were never married, single women.

The data collected from the interviews have been transcribed and coded thematically on MAXQDA. During the analysis several important themes and comparisons came up, thus this section of the analysis of the data is organized according to those themes. As this is a Gender and Women's Studies thesis having a chronological order in terms of years or a categorical organization that divides women based on their characteristics has not been preferred, rather I chose to combine the themes based on the order they were experienced in every narration.

As expected, the narration follows as such, women realize a delayed period or get suspicious that they got pregnant and learn about the pregnancy. Except for one of the cases, women have not considered giving birth at all, but directly start searching for a place to have an abortion. In most cases, they inform someone about the situation. That person is utilized while finding a practitioner, in the aftermath or during the process, etc. Afterwards, they go through the operation and have a recovery period.

Table 6: Respondent characteristics

| No | Name    | Relation               | Status       | City          | Place                      | Age | Year | Education/ work        |
|----|---------|------------------------|--------------|---------------|----------------------------|-----|------|------------------------|
| 1  | Güneş   | Friend                 | Semi-illegal | Mersin        | Private hospital           | 28  | 2009 | Working private sector |
| 2  | Dilara  | Herself                | Under 18     | Bursa         | Private clinic clandestine | 18  | 2002 | High school student    |
| 3  | Begüm   | Friend of her daughter | Under 18     | Istanbul      | Private hospital           | 17  | 2015 | High school student    |
| 4  | Ceren   | Herself                | Unsafe       | Manisa/Ankara | Private hospital           | 21  | 2011 | Student                |
| 5  | Ceyda   | Friend                 | Legal        | Kibris        | Private clinic             | 26  |      | Student                |
| 6  | Deniz   | Herself                | Under 18     | Ankara        | Private clinic/hospital    | 15  | 2011 | Graduate engineer      |
| 7  | Evrin   | Herself                | Legal        | Ankara        | Public hospital            |     | 2018 | Master student         |
| 8  | Cansu   | Friend                 | Unsafe       | Istanbul      | Clandestine                | 21  | 2014 | Student                |
| 9  | Gamze   | Friend                 | Legal        | Ankara        | Private clinic             | -   | -    | Student                |
| 10 | Ecem    | Herself                | Semi-illegal | Ankara        | Private hospital           | 22  | 2013 | Working private sector |
| 11 | Irmak   | Herself                | Legal        | Antalya       | Private hospital           | 29  | 2018 | Working private sector |
| 12 | Sibel   | Herself                | Legal        | Ankara        | Private clinic             | 26  | 2016 | Working private sector |
| 13 | Yaren   | Expert                 | Illegal      | Ankara        |                            |     |      | Working private sector |
| 14 | Emre    | Friend                 | Legal        | Ankara        | Private clinic             | 23  | 2017 | Student                |
| 15 | Berfin  | Friend                 | Legal        | Ankara        | Private clinic             | 29  | 2020 | Working private sector |
| 16 | Betül   | Herself                | Legal        | Mugla         | Private clinic             | 20  | 2015 | Student                |
| 17 | Yağmur  | Herself                | Legal        | Ankara        | Private clinic             | 30  |      | Working private sector |
| 18 | Tuğçe   | Herself                | Under 18     | Mersin        | Private clinic             | 17  | 2013 | Student                |
| 19 | Tutku   | Friend                 | Illegal      | Ankara        | Private clinic             | 30  | 2020 | Working private sector |
| 20 | Necla   | Friend                 | Semi-illegal | Istanbul      | Private hospital           | 24  | 2017 | Working private sector |
| 21 | Berivan | Herself                | Semi-illegal | Ankara        | Private clinic             | 21  | 2019 | Working private sector |
| 22 | Jiyan   | Friend                 | Illegal      | Balikesir     | Home                       | 23  | 2016 | Student                |
| 23 | İrem    | Herself                | Legal        | Denizli       | Public hospital            | 27  | 2010 | Working public sector  |
| 24 | Melike  | Friend                 | Legal        | Istanbul      | Private hospitals          | 19  | 2012 | Student                |
| 25 | Pelin   | Herself                | Illegal      | Ankara        | Home                       | 21  | 2018 | Student                |

## **5.1. Learning about the pregnancy**

The first thing womxn narrated as I began with the interview was how they learned about the pregnancy, their first feelings and thoughts, and whom they have informed on the process. At this stage, they usually mentioned their friends, partner, and family. Moreover, they noted to whom they specifically did not mention about the pregnancy. Then, they explained how they reached out to a practitioner.

### **5.1.1. Perceptions on abortion**

One of the most important elements that are related to womxn's narration of abortion is embedded into their attitudes, perception, and knowledge towards abortion. All of the womxn have narrated to be pro-choice. They were not thinking of it as a sin or as wrong. This contradicts the general direction given by the quantitative results. Quantitative results had suggested that a larger proportion of the population either didn't approve or approved abortion based on the circumstances. They argued that it was something preventable and thus they could not have gone through such an experience. Only one of my respondents narrated to have perceived abortion as 'murder', however, she still knew that she did not want to carry forward with the pregnancy, yet, she felt the guilt.

As I said, she was a spiritual person with faith in God. And she had the belief that having her child in a grave would make her feel better psychologically, I was with her during that process. Like we dug the ground, and it's a purely symbolic thing, she stood there solely talking to it. [She said] "I will never hold you in my arms". This friend of mine took a perspective that thought she had destroyed a living thing. after this attempt [of grave digging] she felt a little more comfortable (Ceyda, 26, legal).

Despite the overall acceptance of abortion, all of the respondents carried forward with it as they did not want to have a 'baby' at that point in their life. Even one of the respondents who was already married with children suggested that her decision to abort was related to the fact that 'it was too soon. Thus, abortion can be understood in its relation to pregnancy. It is not perceived simply as an induced period but is perceived as a rejected pregnancy. When respondents were asked their reasons for their preference of abortion, they all referred to reasons why they could not have a child.

Regardless of their attitude towards abortion womxn's knowledge of the law also impacted their experience. As explored, in Turkey, there is a stigma towards abortion and a vagueness about the law. As MacFarlane et al. (2016) also noted women's knowledge of the legality of the law changes by their individual experiences. Depending on the circumstances under

which they know that abortion is legal their search for a practitioner or how they conceive the process they go under differs.

One respondent who was totally in command of the law stated that she chose to have an abortion in a public hospital as she knew it was a legal right.

To be honest, this is our legal right, we have the right to have an abortion using the means of the state, and I insisted on using it. I wasn't bothered by the fact that this is going under record and that no one should hear about it. I didn't want to prefer such a way. As this is our legal right, I preferred to go through this operation in a state hospital without paying a lot of money. Thus, I did not get examined privately or by anyone else. Because, since it is not a critical operation, I did not feel the need to find the best doctor. I went public hospital and get examined (Evrin, legal).

Among all of the respondents, only Evrin stated that she did not hesitate at all and had a non-traumatic experience of the operation. Her experience of the state hospital was narrated as a regular visit. However, it is possible to argue that her experience can be an outlier to the overall narrations. As noted in the 'Legal but Inaccessible' report by Kadir Has University (2020), the overall abortion in state hospitals is not accessible. For example, Berivan noted that she had tried calling state hospitals; however, all of the ones she reached stated that they did not perform the operation and thus she asked her friend whom she knew has a girlfriend that had the operation

### **5.1.2. Consulting to the experienced**

Most of the womxn facing an unwanted pregnancy know about it from narrations of other people, thus the initial action taken was to ask for someone who might know something about it. womxn's search for someone who knows about a practitioner or who knows a way can work in different ways. Firstly, womxn search for someone who had an abortion to find out a practitioner because they feel like they cannot just call any practitioner and go through the operation, but they are searching for someone who would not judge them as a doctor and do the operation. This is the main use of a social solidarity network. A major part of the respondents stated that they already were having a gynecology visit and they asked their own doctors whether they could direct them to another doctor who can operate. In all of those cases, their routine doctor had rejected them as despite morally they would do the operation, their institution would not allow them. Furthermore, the knowledge of the practitioner does not always come from a person who has experienced it personally, but it can come from the diffusion of knowledge, such as 'someone who knows someone'. The diffusion of numbers

or addresses of practitioners is similar to what Petchesky (1979, p. 49) calls 'cultural diffusion. Through social support networks or personal relationships womxn receive knowledge of practitioners.

There is one gynecologist at my university. [A close friend of mine directed me to him and] said that you will not be able to get examined because you have graduated but go at a time when no people are waiting and have a talk. He is someone who knows these issues and he helps. Her close friend has had the same operation. That's how she knew. Then, I hurried and got into a taxi and went to school. [I found the doctor.] There were several people. I waited for them to leave. When they went and the atmosphere calmed down, I said I needed help, went inside, and explained the situation. Then, he gave me the name of a doctor. He also did an ultrasound check to look for how long into the pregnancy I was. He did the initial control and, gave me the contact information of a reliable doctor so that I could go without delay. I went to that doctor over the weekend (Sibel, 26, legal).

A second way to utilize consulting other people's experiences works as a method to relieve oneself. Sillence (2013, p. 483) analyzes receiving and giving peer advice in a support group of people going through another stressful health situation, breast cancer. She argues that in such cases seeking advice takes a different form as 'looking for someone in the same boat'.

I have had already experienced something like this: "I was in the second grade and a friend of mine had experienced something like this, his girlfriend has had experienced this". I learned this very accidentally. It was like a message of the universe. Yes, I was receiving psychological support, but it was like having a friend with me and holding my hand. I learned that this friend of mine and his girlfriend went through something similar a year ago at about the same time. She was 19 when that happened. But I was told that his girlfriend's family was very supportive. I had very much enjoyed listening to this (Ceren, 21, unsafe).

In her research Silence (2013, p. 481) underlines that asking for advice shows the advice seeker incompetent. For my research, this was only the case when the advice-givers and advice seekers had socially different characteristics, namely age gap or gender differences. Other characteristics such as differences in ethnicity or education level were not in effect. Interaction with other people and learning about their experiences can also come in the form of unsolicited advice. Other womxn may give unsolicited advice to relieve the individual or to connect with her.

His mother did not like me at all, she hated me. His parents were separated and I had never met his father. I was very bad with his mother, she was very grumpy and aggressive towards her child

as well, thus, I also felt bad. Naturally, we had a very tense relationship. But there was no tension initiated by this event, the existing tension had continued. In fact, on that day, she told me that she had a similar experience, to support me. [She said to me] her child also happened to be an accident. [She said] she couldn't have had an abortion due to health reasons. Therefore, she said I was lucky. It was something between a little jealousy, a little of giving advice, a little of giving morale... mixed feelings (Deniz, 15, illegal).

Vasquez-Tokos (2017, p. 16) mentions the use of preaction information creating social categories before interaction. As the author cites from Blumer (1969, p.8) "human beings interacting with one another...direct their conduct or handle their situations in terms of what they take into account". Giving advice and taking advice on the experiences of especially stressful events depends on the conditions of the two people. As noted in the research, the age gap, gender differences, and status among the person who had the abortion and the person counseling her. As in the given quote despite their unfine relationship the mother of Deniz's partner advises her and tries to comfort stating that 'there are worse conditions and that these will pass'. Her inferences depend on her own experiences. In many of the cases, what is notable is that despite the person consulted for help were not chosen deliberately, however, the help and advice received during that time and the ones remembered and comforted the individuals the most are the ones that come from who have witnessed a similar situation.

### **5.1.3. Involvement of People**

#### **5.1.3.1. Family**

Nauck and Arránz Becker (2013, p. 580) show that kinship solidarity can become fragile according to economic status, and lineage. Despite feeling affectionate, womxn may feel obliged to have bonds with relatives in cases of economic crisis or cases of marriage. While kinship is only one type of solidarity, the hostile relations that can take place in kinship relations among womxn can serve as an example of alienation from one another's sexist oppression.

My respondents' experiences towards sharing the situation with their parents differ strikingly. In cases of illegal abortion experiences, womxn are found to have let their family, at least their mothers know. However, in cases of legal operations families are never involved during the process, only in some cases, mothers are told in the aftermath of abortion. For example, Betül's case of her legal abortion is an important example. Even though she deliberately kept

her abortion a secret from her mother. She felt the urge to talk to her to overcome the post-abortion stress.

At that time, my housemates were very supportive, but then I realized that I would not be able to get through this healthily without telling my family about it. I knew it somewhere inside of me all the time, but I had not dared it. It was 1-2 months after the abortion, I went in front of my mother and told her about the whole thing. After my mother learned, the healing process started for me. Perhaps the healing process of abortion is still not completed for me because sometimes I wonder if I am pregnant [and] I can't take this stress and I take a test. I am constantly taking a pregnancy test whenever I have a regular relationship (Betul, 20, legal).

In most cases of legal or semi- legal abortion experiences respondents deliberately kept this as a secret from their families. In those cases, the main reason women chose to go through with semi-illegal practices was to exclude their families from the process. This tendency of women related to what Ann Whitehead named as “kindship solidarity”, which can work as a safety net but is also fragile. Each respondent who stated they did not share this experience with one or more members of their families also noted that this member or members of their family would not understand this necessity or would not approach to it positively, which may lead to a fracture in their relationship.

I told the [doctor]; I was very scared that I don't want my family to learn. That was my major worry, I never really thought about the health side. My only concern was that there was a creature inside of me and I had to get rid of it. At that time, I had a gynecologist in a private hospital. And that was the time that the social security institution started to send “Congratulations, your daughter is pregnant” messages to your family. The doctor said that the hospital I was regularly going to was not sending messages, but if I do a blood test, the social security institution could send a message as the result goes to the institution. I couldn't take the risk. Both my doctor and I searched for alternatives (Ecem, 22, semi-illegal).

However, in cases of illegal experience, the respondents noted that the families had been notified. The cases that families got notified usually highlight that they were notified because they had to, not because they were wanted to. One of the respondents noted that she talked to her mother because she was underage and therefore, needed their help to seek for safe abortion. Another one, who was past the legal week limit let the family learn to have financial aid from them as an unsafe and illegal abortion cost too much for her. In another striking case, of an illegal underage abortion, the respondent had only let her grandmother learn about the situation however, as the practitioners' office got raided her mother was

informed by the police. There was only one illegal case where the family was not involved. In that case, the womxn was also underage, however, she was facing the risk to be harmed if her family learned about it thus, in this case, the family of her school friend were the key actors in seeking an abortion.

She was a very young woman... girl. She was under the age of 18. She had one month left before her 18. It was the year she was going to take the university exam. She became pregnant when she was a senior in high school. It wasn't a case of harassment or abuse. It wasn't rape. She got pregnant because they had sex with her boyfriend. She was crying a lot until she came to me. They were my daughter's friends. They could not find a solution. They were very depressed and panicked. There was an exam, and if she did not have an abortion until the exam, she might have had to continue with the pregnancy. If her family had heard about this, they would have killed her. I do not know whether they would actually kill but she was experiencing that feeling. You know, there are macho men... both her father and mother were like that (Begum, 17, illegal).

The relationship between letting the family know and the abortion experiences of womxn is prevalent. womxn especially seek their mothers to be there however, in cases where respondents expect a rejection from the mother this was not possible. Not letting the family learn to lead to incidences of illegal and even unsafe abortion experiences. Especially for womxn under 18, this causes a major problem. The abortion law in Turkey requires the consent of both parents in case of abortion of an underage person. However, when womxn cannot reach out to their parents their abortion experiences can end up being traumatic.

The type of solidarity constructed with parents and the social support received from them shows alterations among womxn's relationships with their parents. However, all patterns do lead to a way of affectional solidarity as Dean (1995) suggested. Bonds with families are based on mutual positive feelings and womxn fear they can easily be broken as if they break their heart or disappoint them there would be fewer points of connection between them and the family.

#### **5.1.3.2. Friends**

Betül who had her abortion at the age of 20 in a private clinic narrated that when she first learned about her abortion, her friends checked the stick and then they helped and carried her all along the way. She stated this by saying that "It was as if the four of us had that abortion." Her narration highlights at most that how much of a help friends can be during this experience.

Due to the nature of my interviews, I had the chance to collect comments on both womxn's perception of how they received help from their friends and their friends' perception of how they helped. The key types of qualities highlighted by both parties refer to the characteristics of the friends chosen: being non-judgmental and working as a buffer zone for the individual to not feel lonely.

Even if I hadn't been there, the events would take the same course. Maybe the family would think long and for a while, but in the end, I think that the child would not be born. Again, money would be found, something would be done. But she could have been left much more alone. [with her friends around] she was not alone. Apart from her family, we acted as her chosen family. We didn't do much for a long time, we tried to solve it without judgment, but we were always there, and we were there after the operation (Cansu, 21, illegal).

As stated in the quote above friends were mostly aware that the process would have been handled without them however, they were also aware of how they were helpful in the process. While the friends themselves stated that they helped the individual by not making her feel lonely, the individuals referred to this situation as having their friends serve as a buffer zone against all else. For example, in Cansu's case friends were a buffer zone against the parents of the womxn, who at some point even considered making her give birth as the gestation was very late. On the other hand, as Tuğçe, who was at high school back then noted that her friends worked as a buffer zone against any teenager who may gossip about this situation.

As common in the literature, the other key characteristic both parties highlighted was being non-judgmental towards the situation. All respondents specifically noted that this was their prior concern while sharing about abortion with anyone. This concept should be thought of about the overall stigma applied to the concept of abortion. As womxn are aware of the stigma that is surrounding them among their family or social network, they try to find people whom they know are not going to label them or hurt their feelings while helping them. At this point, friends not only serve as a buffer zone but the solidarity they build rely on their positive feelings of understanding towards the individual. In most cases, friends did not mention they were putting themselves in the position of that individual but they were trying to help.

Solidarity patterns observed among friends relate to the typologies of Dean (1995, p.115) Female friendships mostly help the women go through the experience in a way they wish they would be helped. Female friends are not forced into or are not fallen into the situation

but mostly they are invited, and their help is deliberately asked. In narrations, while solidarity with female friends was told the focus was on not being judged. Judgments take place when a relation of “us” and “them” is formed among parties, however as in those narrations women did not feel the judgment from those female friends what they were searching for was reflective solidarity. As in, both parties were aware the other could also have been in the same situation.

#### **5.1.3.3. Partner**

Various research states that involvement of the partner during the process of abortion has positive effects on women's perception of their abortion experiences (Freeman et al., 2017; Kimport et al., 2011; Makenzius et al., 2012; Robbins & DeLamater, 1985). Pregnancy itself is perceived as something done with two people, as such men are expected to be there as they are also involved in the picture. Moreover, in many cases contraception use is understood as men's duty, thus in some cases, women put further blame on the counterpart for not being there. Freeman et.al.(2017, p. 93) state that men's absence and presence have different causes and consequences. Firstly, their interviews show that some women who did not have their partners during the process mentioned their absence. Those women stated that men were absent as after learning about the pregnancy they rejected the relationship or the abortion. Secondly, the women who stated they had men involved during their abortion process had positive experiences. They stated that partners were mostly utilized during abortion seeking and post-abortion care. Furthermore, the involvement of men other than women's partners was also existent. In those cases, they were told to be effective in decision-making and financial aid. Freeman et.al. (2017, p.95) argue that men's involvement had positive effects on women's abortion experiences due to persisting gender inequalities that led to the fact that they had rather much access to healthcare systems and jobs opportunities.

In my interviews partners have been mentioned by the sole fact that they were informed about the situation. Only in two cases, the partner was not informed as the womxn feared he may reject the abortion or give a reaction that would make her feel worse. Furthermore, none of the womxn consulted them for decision making, they were all certain with the decision for the abortion. These findings suggest that partners do not usually become a part of the social solidarity network of the individuals but they are mostly informed as they are an involved party.

In cases where the relationship took place on equal power relations among men and womxn, partner's tried to be included in the process by their effort however, they were not integral to the process.

He was not my boyfriend; from a boy I was with occasionally. I talked to him and he was very supportive. He was one of the types that we could call a jerk, but he was as supportive as he could be (Tuğçe, 17, illegal).

In the cases where there was an obvious power relationship between the womxn and the partner, partners were told to have fled when they learned about it. In the case of Cansu's narration, the womxn were a waitress at the partner's restaurant, and in Dilara's case the partner was older in terms of his age. Both partners were told to have fled after learning about the pregnancy.

The man had not wanted to use contraception, and the girl was secretly taking pills to avoid getting pregnant. She gets pregnant to the point where she misses her pills. Also, she was getting moody due to the pills. You know, some birth control pills can drive you crazy, and that's why they broke up [as she told]. According to her, they broke up because of her behavior and her weight gain. She said that the effect of the pills pushed them to break up. She didn't tell the man that she was using contraceptives (Cansu, 21, illegal).

Despite the literature, my research shows the minimal need for a partner during an abortion. Partners were either deliberately not included in the process, did not join the process themselves, or were not effective even when they were included. This finding suggests that the sample I had was rather informed, empowered, and had social support systems they could reach out to without the help of a partner. Furthermore, this highlights that when social support networks exist, womxn prefer to go through the experience with the help of their networks rather than the partner or family.

#### **5.1.3.4. Excluded People**

When specifically asked about who was deliberately not involved during the process the answers varied but consolidated on four common points; family, partner, male members of the family, and political organizations. The reasons for not involving the family and partners have been discussed in the previous parts of this section. Therefore, now I will continue with womxn's hesitation while sharing this life experience with male members of their family and people they call "comrades".

As conceptualized in the literature review of this thesis, womxn fear stigmatization and being labeled by their community, family, or social environment. Therefore, they can hesitate in sharing this experience with some. While with whom they share is important to understand their social support networks, whom they do not share with also indicates several points.

As mentioned, they can tend not to share with their family or partners due to their fear of their reaction. However, even in cases when womxn share this experience with them at some point they indicate that they always hide it from the male members of their family. For example, one of my respondents Berfin said that she could not remember who was involved in the process but she was sure that the womxn's brother was kept out of it. Moreover, Irmak, also notes that despite sharing the process with her family it was kept as a secret from her father due to her concerns that her fathers' religiosity might be hurtful.

On the other hand, respondents noted that they hesitated to share their experience with people from their political organizations. Their main concern in hesitating was that they failed to trust their comrades for their issues. When they reflect upon why they did not share this with womxn from organizations they Ceren noted that;

I knew about women's associations and organizations because I was already a politically organized person. I was in the women's branch of a party as a young woman, but I didn't even trust them or I couldn't get that feeling of trust from them. Now, when I look at it, there are many platforms, ...that comes to mind when talking about women's associations, [this] gives me confidence because I feel like I can talk to them because of their age and political background, but at that time I did not have enough confidence to talk to the party I was organized in. Or it had never felt like I could contact them about it. I felt so worn out and in a hole. I felt like I could get out of that hole only by myself. Telling someone seemed like it would spread the news to my family at some point (Ceren, 21, unsafe).

Women's relation to their political organizations indicates the characteristics of conventional solidarity, as named by Dean (1995). Women share a common goal and an agenda with those organizations, especially with women's organizations however the aim of the type of solidarity they have built is still collective action.

Güneş who was herself also a member shared that she and her friend did deliberately try for this information not to reach out to members of their organization as they were afraid that the people in the organization would stigmatize the womxn, may hurt her partner or lay off the womxn from the organization.

Living in a small city is a huge problem. Although people say that they are socialists and intellectuals, unfortunately, there is patriarchy among all men in Turkey. Unfortunately, this is also common in the leftist community. My friend didn't want to deal with them. That's why she went to another city to have an abortion (Güneş, 28, semi-illegal).

While individuals did not want to involve males or organizations the fact that they kept this as a secret is also important. In most, cases, they utilize their social network whom they had included in the process as a buffer zone between them and others. As Sandler and Barrera (1984, p.48) also showed support satisfaction of individuals was related to how their social networks worked as a buffer in front of what they wanted to avoid. In most of the narrations families, organizational ties, or partners were not included in the processes, and friendship ties were used as either stress buffering for those factors or they were deliberately utilized not to include those others.

Only one single case narrated by Tutku noted that the womxn who was having an abortion did not find it problematic to share this with her womxn's organization. However, as Tutku noted, this act of her friend made her question whether she would have done the same.

On the first day, when it became certain, we started to think about solutions with a group of women. I or another friend of ours suggested that we could write to a group of women [from the organization] without giving her name that she needs solidarity. She said there was no need to hide her name. [I remember thinking] if I was there, would I hide it? I thought of what I would do if it was happening to me. It made me empathize (Tutku, 30, illegal).

The individuals usually recalled whom they deliberately did not share with more strongly than whom they shared with. These findings that suggest they do not include their organizations and families in such a life event suggest who are excluded from their solidarity network. Despite on a collective level or a lifelong level individuals are tied to their organizations and families, in such stressful life events which are stigmatized and can be possibly judged they exclude these people from their support networks.

## **5.2. The Operation**

After womxn are certain of the pregnancy and they agree on getting an abortion, they reach out to a practitioner and the process of operation begins. Narrations of the operation built up a large part of my interviews. In those narrations, they used medical terms and explained the operation as a complete medical one. Moreover, their narrations differed based on whether the operation was legal or illegal.

### **5.2.1. Medicalization and criminalization of abortion**

Medicalization of abortion refers to the general conception in society that views abortion as a medical procedure. When information about abortion is gathered online or when

individuals learn about it in the doctor's office the operation is defined with technical terms and made harder for the layperson to understand. On the other hand, as abortion is medicalized in the biomedical research realm, it is demedicalized in social scientific research and media. There, when abortion is discussed, policies were criticized or abortion-related news were shared, and the medical and procedural details of the operation are uncovered.

Siegel (2020) argues that abortion research has been conducted in two camps, namely biomedical research and social scientific research. As such he argues that common research usually suggests a singular type of abortion experience, either from its medical definitions or socio-cultural construction. Medical definitions and research refer to abortion in categories. For example, they define a category for “normal”, “unsafe”, “natural” abortions. Social scientific research, on the other hand, argues that those are constructed by individuals as they are interpreted. However, building upon Haraway’s account on naturecultural perspective Siegel (2020) argues that an experience cannot be innately biological or innately social only. Medicalization and naturalization of abortion not only take place in the social realm but also in the natural. On top of his research, my interviews suggested that besides naturecultural perspective political and legal perspectives should also be taken as the criminalization of abortion aligns with its medicalization., latter being a cause for the prior.

As explored in the previous sections the Abortion Law in Turkey define many categories, include and exclude specific groups and introduce different regulations for individuals with the same need. Furthermore, the law restricts the practice only to gynecologists and doctors with menstrual regulation certificate, excluding other health personnel or individuals. As such the law restricts abortion practice only to a specific group of people making all other practices theoretically illegal. This suggests a link between the medicalization of abortion and its criminalization. Although abortion is legal in Turkey, under some conditions it is still criminalized.

One of my respondents, Yaren, who joined the study as she has witnessed many abortions as a social worker stated that she had a doctor friend who had been performing safe abortions after 10 weeks for a long period. Eventually, as he was reported to the police, he was jailed. When released, he stopped operating. As Yaren commented;

For instance, I had a doctor friend who was making operations past 10 weeks. He went through a lot of trouble. He does not do it now but has done it for many years. [and] I think he did a great favor because he was not doing it at expensive prices. I think it was very beneficial for women. He even got a prison sentence, I do not know how long he was imprisoned (Yaren, expert).

As exemplified by Yaren's doctor friend such cases that link criminalization with medicalization lead practitioners to reject performing abortions and led individuals to believe that unless it is a gynecologist who performs the abortion under clinical conditions it should have been unsafe. This brings another point that besides how the operation and individuals are categorized according to their characteristics, their categorization of illegal and unsafe also overlap.

Siegel (2020, p.14) argues that "when people internalize medical and anti-medical ideologies, expecting to have a "normal" or a "natural abortion," anything else can provoke anxiety and frustration". His comment aligns with the results from my interviews. My respondent's general idea of abortion was one made by a gynecologist in a private clinic or hospital. Thus, any operation they went through that did not align with their expectations was defined as both illegal and unsafe. While some of my respondents noted illegal and unsafe experiences some defined their safe abortion as illegal and unsafe as it did not meet their expectations. Their abortion experiences were thus coded as semi-illegal. For example, one of my respondents, Ecem, suggested that they entered her into the records under a fake name and she had anesthesia. Thus she said, "I was lucky I got off that anesthesia".

On the other hand, the reactions received by others are another element contributing to the medicalization of the operation. As abortion is medicalized, criminalized, and stigmatized, when individuals learn someone they know will go through this operation they contribute to its medicalization. Tutku, one of my respondents whose friend had a safe illegal abortion after 10 weeks stated that:

She was very comfortable; she could share it easily. ...however, everybody treated her like she was sick like they approached her as if a cancer patient. They had attitudes such as 'let's not talk about the disease', 'let's make her happy', 'let's not upset her'. It would be a bad analogy, but they behaved as if she was going to die and should have a good time in her last days (Tutku, 30, illegal).

As such medicalization, demedicalization, criminalization, and legalization of abortion are all related concepts to one another. As abortion is medicalized in one area and demedicalized in another individuals' categorization also differ. Despite most of the womxn I have talked to were culturally and socially approving abortion and had positive ideas on it, as they were experiencing it or talking about the operation they discussed it from a medicalized perspective. They talked about the anesthesia, healthcare sides, the pills, and such. On the other hand, as womxn are mostly aware that abortion is legal but inaccessible they cite their experiences referring to the law, especially the 10-week limit, and that the operation should

be performed by a gynecologist. As they realize anything that does not go as the law reads, they view this malpractice as both illegal and unsafe.

### **5.2.2. Legal or illegal status of the operation**

While narrating their experiences of abortion a striking pattern among the interviews was how legal and illegal experiences differ in terms of the narration. Having an illegal abortion changes the nature of the experience on three important points. Firstly, womxn feel the stress of engaging in something illegal. Secondly, besides their initial stress, they get anxious about the malpractices during the process. Thirdly, they may end up not getting the proper consultancy for the aftermath.

Despite its risks and insecurity towards illegally practiced abortion, individuals still get those abortions mostly because they end up in conditions that are out of the legally defined boundaries. Most of the respondents I have met have had illegal abortions either because they were under 18 or because they have passed the 10-week limit. Also, one of them reported having witnessed one due to financial reasons. On the other hand, individuals who had their abortions in semi-illegal conditions all noted that they chose this to avoid their families learning about it.

A study by Chemlal and Russo (2019) conduct a qualitative literature review on unsafe and clandestine abortion experiences of women in countries where abortion is legal, ranging from Ghana to Northern Ireland. They find that women usually stated that they sought informal sector abortions due to privacy, costs, misinformation on abortion laws, and women's social network (Chemlal and Russo, 2019, p.6). Social networks serve as a determinant in women's journey to seek services as friends, social workers or neighbors or even strangers can inform women on their opportunities of abortion.

Despite both legal and illegal abortions, womxn seek a practitioner through their social network in illegal abortions utilization of gatekeepers is significant. In cases of illegal abortions, it is not a simple referral that leads individuals to a practitioner but it is rather a gatekeeper that the practitioner also trusts.

Begüm narrates how she has helped her daughters' friend from high school to obtain an abortion under 18. She notes that they have searched for a practitioner who would do the operation without parental consent for a very long time as the girl who had the abortion was facing threats to her life if she had let her parents know. She emphasizes that the whole event was an attraction as they were doing it undercover.

At the end of a busy and deep week, the hospital said that they couldn't because they would get a bad reputation. So, I said to him "give me the hospital's name with a bad reputation" and [I asked] "what would you do if it was your daughter". The doctor gave us the name of another doctor, the one who had a bad reputation. We went to the doctor 15 days later. It was like in the James Bond movies. Before the doctor took us, he told us to come at a time to a hospital. After that, he went in his car. He didn't take us with him. Then we went to that hospital by taxi. We opened another registration there. A second registration for some other person. We tried to ensure that the nurse taking the blood would not be the same at the operation so that she would not realize. It was like an adventure. [I mean] what was the need for all this? The government makes people do this (Begum, 17, illegal).

A striking pattern with cases where the individual is under 18 during the time of the abortion, is the involvement of parents in each case. Only in the cases of Begüm and Güneş, the family involved is not the family of the person having the abortion, but in all others, individuals were left without any other option than informing their parents. Dilara's story is a good example of the regular pattern with the involvement of families. She narrates that initially, she did not want to let them know and even went to a gynecologist by herself. Then as she was rejected by the gynecologist, they asked her for clandestine abortion clinics and she visited one. However, at some point, her mother realizes that she is missing her period and asks her. From then on her family takes care of the operation. In Tuğçe's case, events happen similarly except that the breaking point of the family to learn is initiated by Tuğçe as she realizes she can go through the process without their help. Another case by Deniz has the most interesting breaking point. She enters the clinic for the abortion and during an abortion, the clinic gets raided by the police and thus her mother learns about it. Family involvement in all those cases shows that due to desperation parents are included in the solidarity networks to find a practitioner however, in all cases, after the operation parents are excluded from the support networks.

The narrations where the individual receives an illegal abortion as she passes the 10 weeks' limit differ according to where and how they choose to get the abortion. If they manage to get in contact with a practitioner, womxn usually prefer the practitioner and thus have a safe procedure. However, when individuals are financially restrained to pay for a gynecologist to perform the abortion they consult different illegal abortion techniques.

Jiyan narrates that her friend who was financially restrained, chose to have a medical abortion rather than a legal one.

[in her second abortion] we arranged an illegal abortion through another friend. She couldn't have a legal abortion because we could not arrange the money and she couldn't go to the state hospital because it gets recorded. Her cousin lived in the same city and he was a doctor. Since her cousin is a doctor, she was afraid that her information would reach her cousin somehow, so she couldn't have the operation legally. She was tied up and we couldn't force her, she already had financial problems. I do not know exactly how they found it, but they found a woman in another city. Maybe it's an acquaintance of her friend, I don't know. This woman was buying pills from the gynecologist and selling them to those in need (Jiyan, 23, illegal).

Another case Cansu narrated, is similar in terms of the monetary limits. Her friend learns about the pregnancy however could not get an abortion due to her financial restraints. As such she ends up telling this to her parents. However, when she informed them, then she was over 10 weeks and thus they had to go with an unsafe and illegal option that required them to get a loan to pay. These align with the results of Capelli (2019). As her study from Morocco, shows legal abortions do exist however they are inaccessible especially for womxn in marginalized conditions.

She had to work in a restaurant as her family forced her into. It was a place that serves alcohol. And she had a relationship with the owner of the place after a while. Then, when they fell apart, the man fires her straight away. When she said to the man that she was pregnant, the man said that it is not from him, and asked how could he know that it is from him, as such he does not give any support and money. And there is no chance of getting an abortion in a state hospital in the city where she lived. As the 10th week approached, she realizes that she had to give up and she tells her family. By the way, at that time she was unaware of the legal time limit. She tells her family... then when they went to the clinic for the first time, I did not go inside, but I waited for them outside and drank tea at the door. Then, she came crying. I was surprised. They couldn't get an abortion, as it was past the legal time limit.... At last, we found a place, it was an uncanny clandestine place... The man said, "because it is going to be illegal, the price was going to be a little more, around 10 thousand liras". When she heard about 10 thousand liras, she said something like that, "there is no money anyway" ... My friend also thought that she should give birth. Then... we sat down and made some calculations... Her family took a bank loan. After taking the loan, they started with the operation immediately (Cansu, 21, illegal).

On the other hand, individuals who have had legal abortion experiences all narrate it as a simple procedure that did not affect them much. Evrim states that she chose to have the abortion in a public hospital as she thinks "it is our legal right".

During the interviews, while womxn who had legal abortions did not stand on the operation and mostly narrated it in a few minutes, womxn who had illegal experiences gave deep details on the operation. Overall, legal abortions are not noted as scary, womxn perceive the operation as a simple medical procedure and see a doctor who can help them. However, in illegal cases, womxn narrate the experience as stressful, scary, and detailed. Both groups of womxn medicalize abortion in their perception at the stage of the operation. They argue the operation should be done under properly defined conditions.

### **5.2.3. The practitioner**

The practitioner and her attitude is also a contributing factor to womxn's narration of abortion. As the literature suggests both over the globe and in Turkey, practitioners' and health professional's attitudes towards abortion impact women's experiences. Stewart (1978, p. 1036) collects the response of gynecologists in three mid-Atlantic states and comes up with a typology of abortion attitudes of doctors. He categorizes doctors as conservatives, liberals, and moderates based on whether they accept performing an abortion and/or repeat abortions. He finds that physicians early life and childhood impacts their perspective towards abortion while their workplace of pressures from colleagues does not. Moreover, he finds that towards the liberal end of the scale doctors perform more abortion which increases their abortion performance, and comments on this as a sharing of tasks in the practice. Another research in Chile by Casas et al. (2020, p. 25) also relates the refusal of doctors to their religious affiliations and shows that religious practitioners supported conscientious objection (CO) rights while seculars believed that it should have been regulated.

The conscientious objection right given to doctors while performing abortions has been criticized on many levels. American College of Obstetricians and Gynecologists (ACOG) Ethics Committee (2007, p. 2) evaluates the conscientious objection right of physicians and without completely rejecting it they note that it should be done with scientific integrity, its consequences for the patients' health should be considered and the potential for discrimination it creates must be discussed. On the other hand, some scholars such as Savulescu & Schuklenk (2017, p. 170) strongly criticize this right and argue that medical procedures should not be left to the moral values of individuals and that everyone should have access to decent healthcare services.

Recent fieldwork by Erkmen (2020, p. 125) about abortion practice in public hospitals in Ankara questions practitioners on whether they refuse to perform abortions, and by two of her respondents she notes that she was told that in some hospitals some doctors refused to perform abortions on moral grounds and those were accepted as other doctors in the same

hospital was providing the service. This outcome of her again relates to Stewart's typology and comment of a division of work among physicians.

In my interviews, the respondents did not come across any doctor who would reject the service due to moral values, but they noted that the physicians reached had refused the procedure because of political or institutional conditions. For example, when Şilan was searching for a practitioner she noted that in public hospitals she was refused, while Ecem noted that her regular gynecologist at a private hospital refused to perform for institutional reasons, i.e. her institution would not allow her to operate. Ecem also notes that when searching for a practitioner who would do the operation she sought referrals.

Ecem recalls that her main concern was for her parents to learn and during that time she recalls that the Social Security Institution was sending messages to families after women's blood test results reading "Congratulations, your daughter is pregnant" Thus, she refused to give blood tests and chose to go under a fake name.

You're being directly labeled that you are having illegal sex by the doctor. I don't know if social security institutions' "congratulations, your daughter is pregnant" message still exists. It was incredibly scary. Even if you care about your health, the state is doing its best to make sure you can't care (Ecem, 22, semi-illegal).

Literature does show that the attitudes of health professionals matter for women's experiences of abortion (Demir et al., 2021; Higgins et al., 2021; Maxwell et al., 2021). When doctors' treat patients without consideration or engage in malpractice patients may end up refusing to go for a check-up after abortion.

When I went for the first ultrasound control, I couldn't look because I was so humiliated. They held my head and made me look. They did this to me. But when I went with a man, he didn't do such a thing. He put my female friend in the operating room as an assistant, my friend had no idea about the operation. For instance, when I was given anesthesia, she told me I passed out and I took the serum out. It was a bloodbath everywhere and women had no idea. When we came out, she told me "I will never look at a strawberry jam again". The man forced her in, he said: "someone had to stand here and you will stand". He took my friend because she was a woman and put her in the operating room. By the time I woke up, they were looking at me with a cotton ball to see if it was bleeding a lot. I was under anesthesia anyway, so I cried, it hurt so much. Then he told me that "if I didn't want the pain I shouldn't have gotten pregnant in the first place". ...Normally I was supposed to go for a check-up but I refused to go (Berivan, 21, semi-illegal).

Womxn who had experiences in legal and safe settings, however, do not even recall the practitioner well. For example, Irmak notes that she did not even see the practitioner as she was sedated before the doctor entered. Moreover, Irmak notes that her experiences with the nurses were very positive. As the nurses were motherly and comforting to her.

Not only, the practitioners' attitudes but also the other health professionals' attitudes matter for abortion care. Based on the attitude of midwives and nurses womxn can feel stigmatized, wrong or they may feel their comfort. Maxwell et al. (2021, p. 35) find that healthcare professionals' attitudes towards abortion and abortion patients can contribute to normalizing the procedure as routine. Furthermore, they note that positive attitudes of the nurses can be welcomed by the patients with the expectancy of stigma. They state that the patients “think that the staff is going to be horrible to them, and that’s especially true of younger people, they think the staff is going to be judging them. So the comments would normally be along the lines of “I wasn’t expecting people to be as nice as they were” (Maxwell et.al., 2021, p.34).

### **5.3. Aftermath of the operation**

In the aftermath of the abortion operation, individuals are usually sent home unless there are not any complications and then they are asked to come back for a consultation after one week. In all of the narrations, the aftermath of the abortion revolved around three themes. Firstly, women mentioned they felt lonely no matter what. Secondly, they stated that especially in cases where parents were involved silence was utilized as a coping strategy. Thirdly, after some time women note that they made it a mission for them to speak about the process and inform other women about it.

#### **5.3.1. Silence as a coping strategy**

Belenky et.al. (1986, p.34) argue that culturally and socially women have limited experience with language and dialogue to the norms of silence put on them and the position as a listener given to them. As such, authors argue that women receive knowledge based on listening to others. They suggest that women associate themselves less with the authoritative position of men as they fail to see themselves included in their “we” (Belenky et al., 1997, p. 44). Hitherto, they associate themselves with “others” and start listening to them. Authors explain this process of listening and silence as the power of inward watching and listening. women are taught to turn into themselves to cope up with problems and use silence as a strategy to cope with events.

In the interviews, womxn were not ashamed of their experience of abortion but they did not want the public to learn about it. Cockrill et al. (2013, p.80) conceptualizes this hiding in secrecy as concealed or internalized stigma. Despite people do not hesitate going through with abortion, their fear of stigma and wish to stay nonstigmatized can lead them to stay in silence. In those cases, they utilized two different strategies of silence. Firstly, some told their friends to deny any rumors if they heard. In such a way, they could avoid their larger network to learn about it. In one case, the individual notes that her mother suggested that she should not tell any of her friends that she has missed her period. Moreover, she also prepped her before the operation and said that in case any of the nurses ask her about her age she should just say she is over 18 and re preparing for the exam.

A second strategy related to silence is for womxn to turn into themselves which can end up in feelings of loneliness. Emre who has witnessed his friends turning into herself and distancing narrate it in his own words, blaming himself.

Normally, she was one of my very close friends who shared and told everything to me, and I was one of her close friends. But after all that, she put me in a position where she left me out of it all. It was like when you tell someone something very special, then it dawns on you like “why I did this, or if he uses it against me, in case he judges me differently” .... Also, I guess I also made her feel ordinary because I’m on good terms with everyone. Maybe if I isolated myself a little from school and that environment, it would be different for her (Emre, 23, legal).

Besides the individuals' use of silence as a coping strategy, it was highlighted that especially in cases of under 18 abortions, families used silence as a strategy to forget and cover up the abortion. When I asked Deniz how was the healing after abortion, she simply said, “Only my mother knew and she never talked so it was like covered and thus I had to heal”. While in most cases families were deliberately kept out of the experience, in cases where they were asked for their help they refused to re-open the subject afterward and chose silence as a coping mechanism for them.

One evening, while my mother was cooking, I approached her. I said, “I’m pregnant”. She said very calmly, “okay, let your father come, we’ll decide what to do”. We talked to my father when he came home. One day, they said, “get ready, we will take you to the doctor”. They took me to a doctor very close to our house. When we got in, he said “what is done here today, will be discussed here and will end from now on”. We went to the doctor. I had my abortion and got out (Dilara, 18, illegal).

It is striking that parent preference for silence has taken place in all cases of teen abortions. Griffin-Carlson and Schwanenflugel (1998, p. 549) state that before requirements for

parental notification in the U.S. most teens preferred to not involve their parents, which is a similar case for my study. In all cases, parental involvement took place because there was no other choice. Even when parents were involved in all cases the parents also moved forward with illegal or semi-illegal abortions. In none of the narrations of teen abortions, there was a mention of the parental consent form, parents mostly chose practitioners who would not take the abortion under record. While they do help out their children for moving on with the process the stigma they fear to face is visible also in their preference for such types of abortions.

### **5.3.2. Loneliness**

A group of individuals stated that the abortion experience made them feel lonely. Despite having people around such as their parents or partners, they noted that they could not feel the support. Dilara, who reached the doctor with the help of her parents, and whose partner had left her after learning about the pregnancy, recalls that time stating that she had no one.

I was completely alone. At that time, I was studying at high school abroad, so I was disconnected from my old friends. And I couldn't get support from my partner, as he just took off (Dilara, 18, illegal).

Furthermore, even though individuals usually reach out for help from their friends or parents, the ones' they could not inform or the ones who did not care about the process, are recalled to have broken their trust and make them feel insecure. Ceren who got help from her two close friends felt the loneliness through the fact that she could not inform her parents. She states that despite her mother and sister being feminists, she still felt that they could be judgmental and decided not to inform them.

In particular, when I had the abortion and couldn't go to my family, I felt very lonely. It felt like there was no one to support me if something had happened to me. I was very frightened. Feeling like no one was going to be there for me If something happened to me made me turn into myself (Ceren, 21, unsafe).

Individuals who have felt the loneliness in the aftermath of the abortion always had someone in their solidarity network who helped them closely before and during the abortion such as their parents in the case of Dilara, or their friends in the case of Ceren, however, these people have either disappeared in the aftermath, chosen not to speak about it or as they were not the people whom the individual needed attention from in the aftermath the individuals felt loneliness. Furthermore, the feeling of loneliness does not only come through

not having anyone to talk to in the aftermath but it can also come through other people's inconsiderate actions.

I don't remember what he said, but my boyfriend said something stupid to me on the morning of that day. It was something that implied that the operation I was having was not so important. He made me feel like I was insignificant, worthless, and as if I brought him trouble. Also, my friend was planning to come, but she canceled at the last moment, I was very hurt. I felt very lonely even though I had a boyfriend (Sibel, 26, legal).

As explored in the previous section where people's use of silence as a coping strategy is very much linked to the feeling of loneliness. The silence of the person who goes through the experience can be attributed to a running away but it can also be attributed to a lack of people who would not judge her. Moreover, the silence of families and their closed perspectives on the topic can also lead to the individuals feeling threatened or judged by them and make them feel lonely in the aftermath of the operation.

Research on women's psychological and mental state after an abortion shows that women do not necessarily experience psychological problems after an abortion but some do (Major et al., 2000, p. 777). However, research mostly suggests that they can face existential or emotional crises due to several factors such as feelings of shame, loneliness, stigma, or how they perceive the pregnancy (Zareba et al., 2020, p. 478). During the interviews, I have specifically asked whether women received psychological counseling after abortion. Most of them stated that they did not seek counseling, however, when later in life they received counseling they realized and solved complications about their experience of the abortion. For example, Sibel, narrates that after the abortion she did not receive any counseling however, due to piling up of events she had a panic attack, and then was referred to a psychologist.

When I had a panic attack, we thought it was a physical thing. After doing all the physical examinations, the doctors sent me to psychiatry. That's when I learned. It was specifically, because of the abortion (Sibel, 26, legal).

### **5.3.3. Outspokenness**

The last theme that appeared in my interviews about the aftermath of abortion is how womxn made this experience a tool for empowerment. Even though initially abortion was an experience they only felt safe to share with their close friends who would not judge them later on they utilize it to break the silence surrounding it.

I used to be more inclined to hide it, I would never want this to be heard. But then something happened, I guess I tried to get

over it myself and in my own way. I also attributed a political mission to it. I'm very comfortable telling it to everyone. For instance, there were times when I talked about this unnecessarily to people I do not know (Pelin, 21, illegal).

Normalizing abortion as such in public discourse, in one's social environment is one of the empowering solutions advised by Norris et.al. (2011, p. 8). Authors argue that individuals choose to silence this experience to avoid the stigma however, talking about it would normalize the experience in the public discourse. Furthermore, they suggest that while discussing this experience binary and polarizing terms such as a "good" or "bad" experience should be avoided.

Speaking out such experiences can also help to build solidarities among womxn. As mentioned, Seyla Benhabib had emphasized the importance of receptiveness and perspective-taking, especially to not marginalize or other women's experiences. Having reflective solidarity only, and aiming only for emphasizing would not enable us to understand each other's differences. Lyshaug (2006, p.90) suggests that only listening to people and trying to empathize with them can lead people to fall into the trap of considering each as one, however, as all individuals and experiences are different. Lyshaug (2006, p. 90) suggests that while enlarged empathy combines the idea of 'feeling with' with 'self-referencing'; 'enlarged sympathy' would introduce playfulness, toleration, flexibility, and generosity in our understanding of others' experiences. Outspokenness as a coping strategy would let womxn listen to other womxn's experiences, and sympathize with what they have gone through. While we had noted reaching out to other womxn who had abortions would help individuals emphasize, as they talk they can make others sympathize.

Moreover, targeted abortion education groups are also suggested by researchers to overcome the stigma and make space for fostering dialogue on abortion. Bloomer et.al. (2017, p. 716) find that there is a silenced pro-choice majority among adults in Northern Ireland, where abortion was recently legalized. In the adult abortion education group, they make room for pro-choice and anti-abortion individuals and observe how they change their positions. According to their results as individuals engaged in dialogue, some of them changed their opinions from anti-abortion to pro-choice.

McReynolds-Perez (2017, p. 100) also states that creating dialogue can be useful for health professionals as well. In their research where they observe an activist-run abortion counseling clinic in Argentina which shifts from counseling on harm reduction level to legal pregnancy termination. Their activists engaged in conversations and listened to women's lived experiences of abortion and shifted to a more radical solution-oriented activism. The

author suggests that from this experience, health professionals can learn that engaging in conversations with one another can collectively strengthen the institution and make changes.

#### **5.4. Conclusion**

Analysis of the qualitative results has taken place in the chronological order in which women have narrated their experiences. During the analysis of the results, solidarity literature was utilized to understand to whom women reach out and whom they include or exclude deliberately during the process. Furthermore, social support literature was used to understand their attitude and felt stigma. Then, women's narrations of the operation and their comments on the legal or illegal status of the operation were analyzed with the help of medicalization literature and via analyzing the law. Lastly, women's reactions in the aftermath of the operation are analyzed via using both social support and solidarity literature.

Firstly, women learn about their pregnancy and as common in the literature, their perceptions on abortion and attitude towards it impact their initial reactions. None of my respondents had a disapproving position towards abortion and all could rationalize the reason in which abortions have taken place. The only one noted the impact of religiosity while coping with this experience, and one other noted having felt nothing in the aftermath and was viewing this as a basic operation only. After learning about the pregnancy and deciding to continue with abortion women seek experienced people. Experienced people are utilized as cultural diffusion networks. They can help women find a practitioner, or simply share their experiences and initiate a bond of empathy. Besides reaching out to experienced, womxn also involve and inform other parties of their situation. Overall, womxn include their close family-mostly mothers and sisters-, partners and friends and exclude their family-mostly male members-, partners and comrades. In terms of women's relation to their families, there are two patterns. Firstly, as Whitehead (1984) proposed kinship solidarity is a fragile one. womxn may prefer not to include their families to not to break their safety network. Secondly, as Dean (1995) proposes families serve as sources of affectional solidarity, and therefore when women need help families are there for them and help them despite how it goes in the afterward. Especially in cases where womxn under 18 get an abortion the powerful support of family is visible. In terms of the inclusion and exclusion of the partner, the literature suggests that partner support or partner's disengagement of the process changes the course of experience of women. However, in none of the cases, partner support was highlighted. In almost all cases partners knew about the situation but they either left women after learning about the pregnancy or they were only collateral to the process. Women did not mention partner support having a positive or negative impact. In cases where

partners did not flee, their support was similar to a conventional type of support. They either provided the financial means, helped with the transportation or medical process. However, as explained partners' support was mostly to achieve the common goal of abortion. Lastly, the inclusion of friends and their solidarity was especially the closest to reflective solidarity within Dean's typology. However, on top of it, narrations of how female friends were utilized during the process included enlarged empathy and enlarged sympathy. Some respondents noted to have felt like they have had the abortion altogether with their female friends, some narrated how they put each other in the other's shoes and others told the positive buffering effect of friends.

When women continue with the operation their experiences differ via the legal status of the operation. womxn narrating legal experiences note the least traumatic and troubling experiences while women narrating illegal or unsafe experiences suggest their fear of doing something illegal, their anxiety for any malpractices, and their lack of asking for post-abortion care. On the other hand, women who had semi-illegal experiences such as malpractices of the practitioner note their experience as an illegal and/or unsafe one as they have a 'natural' and 'normal' abortion experience in mind. During the narrations of the operation, anything that falls out of women's notion of legal and natural abortion, they tend to define as unsafe, which increases their anxiety about the operation. Furthermore, the approach of the health personnel is also impactful in women's narrations. If women have received rejections from doctors or got to have negative conversations with the person, they narrate these as negative experiences.

Lastly, in the aftermath of the operation women note three strategies which are silence, loneliness, and outspokenness. As Belenky et.al.(1986, p.34) states women have limited experience with expressing themselves therefore they can tend to stay in silence and process. In the interviews, women noted that initially they felt loneliness, feelings of shame, and guilt, however after a period of coping up and progress women noted to transfer their silence into a mission and become outspoken on the issue.

## **CHAPTER 6**

### **CONCLUSION**

This research aimed to answer the question of ‘to whom young adults consult to for coping up with stressful events in their reproductive lives such as abortion and to what extent they utilize their social solidarity networks’. Besides, this thesis also investigated how womxn make up such social networks.

The main motivation to explore the topic was to investigate the impact of social solidarity networks of young adults while they are coping up with stressful bodily events. Abortion was chosen as a major stressful event in young adults' lives due to its medicalization, stigmatization, and relation to womxn's reproductive lives. Throughout their reproductive lives, womxn go through many events ranging from menstruation to pregnancy, illnesses to menopause. All these stages and experiences are agreed to be different experiences for womxn in varying degrees. However, as literature also pointed out abortion as a result of an unwanted pregnancy is a major stressful event where womxn need the company of others. Beyond that, abortions that take under illegal or unsafe conditions necessitate social support networks in much more ways. Via choosing abortion as a stressful life event in womxn's reproductive lives this research aimed to figure out which support networks womxn rely on the most and through which they learn about their reproductive experiences.

Furthermore, this research was also motivated through the medicalized notions over abortion. As argued, abortion itself can be taken care of with self-help, however, today's biopolitics medicalizes discourses around it and force it to be perceived as an operation. This reality leads womxn to view their experience as a harsher one.

By starting with this motivation and such research questions, I aimed to find out how womxn learned about reproductive health-related issues, and whether they were utilizing their social

environment by making use of solidarity groups. Womxn's connections that they make throughout their lives, whom they have considered close, and whom they have avoided especially in matters of trust was examined.

Looking at abortion and womxn's decision to whom they discuss abortion was important as abortion and sexual contact are both stigmatized in the context the research took place. Especially, in cases of young or unmarried womxn sexual contact and abortion are mostly stigmatized or covered. As such when womxn face problems concerning their reproductive lives or sex life, womxn can stand back from sharing it openly.

While conducting this research use of feminist methodology was integral not only in terms of the perspective it brought to methods but also it was integral in choosing the topic or in approaching the sample. As feminist methodology claims womxn who have been marginalized and who are not heard of are problematized. Furthermore, among those womxn outliers who are not always easy to reach had been chosen as a subsample for the thesis. While the thesis initially addressed young womxn as a subsample later on after an analysis of outliers this subsample was focused on womxn who had an illegal abortion. Thanks to the feminist methodology, a look at the outliers constructed the most important part of the thesis. Furthermore, feminist methodology gave the perspective of breaking down hierarchies and introduced the importance of womxnly conversation in the thesis.

Besides the feminist perspective taken in this research, the use of a quant to QUAL mixed sequential method is also applied. As delved deeper in the methodology section, Gender and Women's Studies literature makes use of qualitative methods rather much as it is widely argued that methods-wise qualitative approaches align much with feminist methodology. However, methods are only a way to investigate the larger social issue at hand and therefore it cannot be argued that any single method can be intrinsically feminist. Furthermore, the use of empirical approaches through a feminist lens can have wider policy impacts and can have transformative power in the fields they are applied the most. The use of mixed methods in this research has visibly shown the power of data and its lack. The data used for the thesis gave an outline and direction about characteristics of women and highlighted the marginalized narratives. On the other hand, the sequential QUAL part delved deeper into the subjective experiences of womxn and how their experiences differed on structural terms.

The mixed-methods strategy was necessary for the realization of this research as the qualitative part took place as a sequence of the quantitative part. Without the quantitative analysis and realizing the marginalized women in the data and the outliers of the data, the qualitative sample would not focus on the illegal experiences of young women. Furthermore,

after observing the inadequacy of the survey data in terms of reflecting characteristics of women 30 and under, single but sexually active women, and women who had abortions early in their lives, the mixed methods design was directed to showcase those experiences and introduce those women into the literature. As such the qualitative part was necessary as it did not only discuss the experiences of womxn and their solidarity networks but also it highlighted their marginalization in data, and how to aggregate data and general trends that can fail to yield tailored results or policies for different subsamples. For example, a general trend of abortion shows that women have abortions later in their lives after having at least a child. However, policymaking solely based on such a general trend restrain the access of young women under 18 to get access to abortion services on their own.

The initial quantitative results of the research, the descriptive analysis shows that the number of women at the age of 30 and under is less compared to women over 40. Despite an outlook on the population of Turkey, based on the DHS sampling, this proportion is accurate, still, the subjective experiences of younger women are not visible in the data. Still, as women's lives are not discrete but as a process having the possibility to view women's lifelong experiences through the data gives an idea of the structural changes over generations. For example, viewing that women over 30 have had more experiences of abortion or seeing they are mostly uneducated suggests structural changes in women's lives.

Overall, the quantitative results suggest three main conclusions. Firstly, as chi-square results had suggested women mostly prefer talking to health professionals when they discuss family planning which is expected as women receive counselling after abortion. However, logistic regression results showed a significant decreasing effect of talking to others such as friends and having abortion which was despite its low explanatory power promising for the qualitative component.

Secondly, in terms of education, only high school education has been found to have a significant relation while secondary and primary were insignificant. Furthermore, women's ethnicity and financial status were also insignificant in the logistic regression analysis. This shows that women's background characteristics do not have an impact on differences in their experiences of their reproductive lives. Despite their background, women can go through similar experiences.

Thirdly, women's on whether women should be virgins on the wedding night is significant. This directs us to the position that rather than women's opinion towards abortion their practices of sexuality is in effect. This result also aligns with the chi-square results which

shows a significant relationship among the changes in groups in terms of their use of contraceptive methods.

The quantitative results showed the overall directions and the outliers. One of the key outliers in the quantitative results was the low subsample of women 30 and under. Another was the information on women who had an abortion before 18, and under illegal or unsafe situations. The data did include some second-trimester abortions however; it did not specify any abortions under unsafe or illegal conditions despite it is a known reality of the country. However, it is also known that collecting data on illegal abortions or operations has many limitations, especially in survey sampling. Therefore, for the sequential qualitative part of the thesis, I have decided to focus on this group. When looked at the data a visible downfall in the number of abortions especially illegal abortions are shown and a visible rise in the use of contraceptives is shown. However, there are still cases of illegal abortion practices in Turkey.

Qualitative interviews conducted for this section of the thesis were conducted with 24 women who had abortions at the age of 30 and under. womxn varied in terms of their ages, ethnicities, and conditions under which they had the operation. A comparative analysis of the narrations suggested similarities and differences among their subjective narrations. Comparisons among narrations have been mostly done based on the axis of the legality and safety of their abortions.

Firstly, in terms of whom they include during this experience varies for the conditions under which they face the operation. Mostly, womxn acknowledge their partner and female friends while trying to keep their families out of this experience. In cases of illegal experiences, families are mostly informed due to obligation. womxn under illegal conditions may need parents' support either financially or while getting medical care. On the other hand, in cases where abortions are counted as semi-illegal, where malpractices or misreporting of operations exist, the main concern of womxn is for their families not to learn.

Secondly, womxn's narrations of the operation are highly dependent on their approach to abortion as a medical procedure and their experiences with the health personnel. In cases where womxn, especially young womxn are aware of the medicalized discourses on abortion and the law their expectancy for a "safe" or "natural" abortion exists. The results suggested that womxn mostly equate unsafe and illegal abortion. As such, any practice that does not align with what was on their mind is argued to be clandestine or unsafe. Most of the situations categorized as semi-illegal do not fit the following definitions of unsafe or illegal abortions however, womxn's narrations of them classify them as unsafe or illegal.

Furthermore, when discussing how they felt womxn always mentioned the reaction they faced from health professionals in detail. In most cases, they narrated facing unexpected reactions from the personnel. Regardless of whether they received positive or negative reactions, in all cases they narrated being surprised.

Thirdly, the only all-common result was how they felt in the aftermath of the operation. Regardless of how the operation went, all womxn narrated having felt lonely after the operation. Although they noted they felt supported, still when they remembered that time, they suggested they always remembered it with a feeling of loneliness. Furthermore, in terms of how the womxn or their acquaintances reacted to the event in the aftermath of the operation two coping strategies had been highlighted. First of which is silence. Silence is used as a strategy both by the person who experiences the operation or by her family. Especially in cases of unsafe or under 18 abortions, families have helped the girls go through the abortion however, in the aftermath they are characterized by totally covering up the events and prefer not to talk about them. While on the other hand, womxn who experience abortion also can tend to keep it in themselves for a while. However, as the results suggest, after a while of silence they change their coping strategy to a rather empowering one which is outspokenness. After a while, regardless of whether they think they overcame it, they start to become open about this experience and try to share it with other people around them as a tool to emancipate others via sharing their own experiences.

The results are shown in the thesis, especially concerning womxn's experiences and reactions towards, during, and after illegal abortion stands as a contribution for literature as up to my knowledge no such research have been conducted on the topic. Academic literature focusing on Turkish womxn's illegal abortion experiences investigate womxn before the 1983 Abortion Law. However, unfortunately, no research on its persistence up today has been conducted. Furthermore, this research not only exposes its persistence but also uncovers that abortion is accessible. Despite womxn's circumstances and the media coverage that argues abortion is inaccessible, abortion is accessible however legal and safe abortion is not. womxn can reach out to abortion services or self-help methods by making use of their social bonds however, womxn without any access to social solidarity may have trouble reaching out to those services. As this research showed, all womxn in the sample despite their legal status of abortion have reached those services through making use of their networks.

Furthermore, the use of feminist methodology and a mixed-methods strategy in this thesis also serves as a contribution to academic literature. The feminist standpoint used in the literature is not from the viewpoint of someone who has experienced it but from someone

who has witnessed the process. As such I believe my point in conducting this research was not an objectively academic one but a subjectively feminist one. This position that I took has helped me construct considerate interviews and follow-ups. Furthermore, this position also encouraged me into reaching out to respondents not only as interviewees but also as fellow womxn. As such it would be more appropriate to call my interviews conversations. In most of the interviews, womxn got the upper hand to follow me through their experiences which impacted positively on the way interviews were conducted.

Besides, making use of the feminist methodology also made this thesis adopt a feminist sequential quan to QUAL mixed methods approach. A sequential mixed-methods approach that begins with a quantitative direction and then continues with an analysis of outliers was also encouraged by feminist methodologies dictation of making the invisible visible and making the silent speak. womxn with illegal abortion experiences do exist as much as womxn single womxn 30 and under who undergo abortions however in larger sums of data they can stand as outliers or they can simply not be as effective as a larger subpopulation. As such, making use of this methodological strategy has helped this research to include both the larger subpopulation and its marginalized corners.

Despite its contribution and significance, however, as a master's thesis, this research also had various limitations. To begin with the limitations regarding the quantitative section, firstly, despite its explanatory power the subsample I have selected from the TDHS-2018 was not large in proportion. Furthermore, it was the case of a rare event that made the predictions harder to measure. Secondly, the data itself includes fewer women 30 and under or single. This limitation is due to the data collection method. TDHS is usually collected from households in a selected neighborhood during the daytime. This makes it harder to reach out to younger women who may be at work or school at that time. Moreover, young women sample also included sexually inactive women and most probably most of the women in younger age groups were sexually inactive. Thirdly, abortion is a stigmatized event in Turkish culture, therefore, women, especially younger women may be reluctant to disclose this experience. Especially in cases where young women are interviewed, they may fear being listened to by other household members, which would increase misreporting especially for this subsample. Lastly, for the qualitative part, the binary logistic regression analysis had an acceptable explanatory power for social sciences however, for a general statistical analysis it has low explanatory power. For further research, the analysis can be re-conducted with further statistical measures.

Besides data related limitations, the qualitative section also had limitations. As this was a master's thesis the duration for conducting all interviews was kept short. The interviews could have been conducted in a larger duration which would make it possible for me to reach out to a larger sample. Furthermore, as qualitative research is prone to researcher-related bias, they could have been biased regarding me while reaching out to me. For example, womxn who were in contact with my social environment may not have reached out to me, or as this is a study from a feminist perspective womxn may have felt insecure to be commented on such a perspective. One visible bias due to the structure of the qualitative part is the lack of male respondents. The call for participants has been made regardless of gender as such males could contact as well. As most womxn noted they did share this with their partners or close male friends. However, in my sample, only one person defined himself as a male and as a friend of the womxn. Perhaps further research can structure the call for participants and aim to reach out to even numbers of respondents of different genders.

Last to mention for the limitations of the thesis is the limitations caused by using different samples for quantitative and qualitative sections. The sections made use of different datasets. Although this integration of different data sets is also a contribution, it can also be viewed as a limitation. Making use of a single sample for both would have enriched the integration of the sequential design.

Hitherto mentioned limitations are advised to be considered for future work. A larger sample for the quantitative part would be useful as it would give more outlined results. For a redesign of this study, the quantitative part could be enlarged. This research only looked at the differences among women who had an abortion or not regardless of whether they are sexually active or not. In a further redesign, the ever married sample can be used however, in such a case the number of occurred events would be even lower which would require further statistical measures or a deeper analysis of nonparametric tests. Furthermore, using the same sample for both sections would make the integration of the sequential design much more conclusive. A redesign of the research collection of the quantitative data by the researcher would help the researcher to tailor the questions and the sample. A sample with a higher proportion of sexually active women or only a larger sample of young women could yield a better matching of the results of the mixed methods. However, a larger sample for the qualitative section may not be useful as I do believe the sample reached in the thesis showed prone directions for categories of experiences. I believe for the qualitative section having more respondents would not be useful for making results stronger but instead would only make more womxn discuss their experiences for the research and possibly trigger their traumatic experiences. However, in a redesign of the qualitative component, a rather much-

dispersed sample through purposive sampling would enable us to view the experiences of womxn from different backgrounds.

As the next step of this research, besides tailoring the sample the problem of gendered approaches on abortion can be delved deeper. Including this research's sample, queer experiences of abortion are not discussed in the literature. Queer samples are not easy to be reached from surveys such as the DHS but through specific designs tailored for these samples, their experiences can be observed. Furthermore, as this research also highlighted the reaction of families and partners is very effective in the ways women cope up with abortion. Therefore, the next research question can be taking an approach from their point of view. Their support and disengagement from the process can be taken at hand from their point. Lastly, another question this research directed is the underreporting and misreporting of abortions in surveys. Further research using different proxies on experiences about the reproductive lives of women can be conducted to analyze the impact of social support and solidarity networks in womxn's lives.

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## APPENDICES

### A. APPROVAL OF THE METU HUMAN SUBJECTS ETHICS COMMITTEE

UYGULAMALI ETİK ARAŞTIRMA MERKEZİ  
APPLIED ETHICS RESEARCH CENTER



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29 OCAK 2021

Konu : Değerlendirme Sonucu

Gönderen: ODTÜ İnsan Araştırmaları Etik Kurulu (İAEK)

İlgi : İnsan Araştırmaları Etik Kurulu Başvurusu

Sayın Prof.Dr. Ayşe Gündüz HOŞGÖR

*Danışmanlığımı yaptığınız Sinem ESENGEN'in "Gençlerin Üreme Tercihlerine Yönelik Kararlarında Sosyal Dayanışmanın Etkisi: Türkiye'de yasadışı istemli düşükler" başlıklı araştırması İnsan Araştırmaları Etik Kurulu tarafından uygun görülmüş ve 035-ODTU-2021 protokol numarası ile onaylanmıştır.*

Saygılarımızla bilgilerinize sunarız.

  
Prof. Dr. Mine MİSİRLİSOY  
İAEK Başkanı

## B. CORRELATION TABLE

Table C 1: Correlations Results (for sample 30 and under)

| Variable                                | <i>n</i> | <i>M</i> | <i>SD</i> | 1       | 2       | 3       | 4       | 5       | 6       | 7       | 8       | 9       | 10      | 11      | 12 |
|-----------------------------------------|----------|----------|-----------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|---------|----|
| 1. Talked someone about family planning | 3,031    | 0.252722 | 0.434645  | —       |         |         |         |         |         |         |         |         |         |         |    |
| 2. Age                                  | 3,032    | 22.07652 | 4.286746  | 0.0728* | —       |         |         |         |         |         |         |         |         |         |    |
| 3. Education                            | 2,907    | 2.771242 | 1.323315  | 0.0138* | 0.2403* | —       |         |         |         |         |         |         |         |         |    |
| 4. Have money                           | 3,032    | 0.315303 | 0.464713  | 0.1101* | 0.0177* | 0.0467* | —       |         |         |         |         |         |         |         |    |
| 5. Mother attended school               | 2,997    | 1.576243 | 1.317418  | 0.0579* | 0.1777* | 0.1201* | 0.2937* | —       |         |         |         |         |         |         |    |
| 6. Parents related                      | 3,032    | 0.28628  | 0.452096  | 0.0275* | 0.0142* | 0.0424* | 0.0906* | 0.1616* | —       |         |         |         |         |         |    |
| 7. Speaks Turkish                       | 2,971    | 0.750926 | 0.43255   | -0.0011 | 0.0036  | 0.1263* | 0.2269* | 0.4560* | 0.1828* | —       |         |         |         |         |    |
| 8. Partner attended school              | 3,032    | 0.437995 | 0.496222  | 0.0847* | 0.6049* | 0.1486* | 0.1370* | 0.2330* | -0.0032 | 0.0705* | —       |         |         |         |    |
| 9. Uses internet                        | 3,032    | 0.819591 | 0.384591  | 0.0617* | 0.0467* | 0.1070* | 0.2316* | 0.3418* | 0.0994* | 0.3262* | 0.1442* | —       |         |         |    |
| 10. Husband should do housework         | 3,004    | 0.601864 | 0.489595  | 0.0910* | 0.0123* | 0.0276* | 0.2111* | 0.1920* | 0.0771* | 0.1509* | 0.1378* | 0.1835* | —       |         |    |
| 11. Approve abortion                    | 3,032    | 0.080145 | 0.271563  | 0.0799* | 0.0186* | 0.0294* | 0.1945* | 0.2181* | 0.0580* | 0.0833* | 0.1284* | 0.1037* | 0.1990* | —       |    |
| 12. Smoke                               | 3,032    | 0.16161  | 0.368153  | 0.0663* | 0.0837* | 0.0316* | 0.0858* | 0.1159* | 0.0640* | 0.0858* | 0.0639* | 0.0895* | 0.0930* | 0.0585* | —  |

\* $p < .05$ .

### C. CHI- SQUARE TABLES

| Table C 2 : Crosstabulations and Chi-Square Results |       |                           |      |      |      |            |         |      |    |
|-----------------------------------------------------|-------|---------------------------|------|------|------|------------|---------|------|----|
|                                                     |       | Ever had induced abortion |      |      |      | Chi-square | p-value | N    | df |
|                                                     |       | Yes                       | %    | No   | %    |            |         |      |    |
| Currently working                                   | Yes   | 11                        | 14.3 | 732  | 21.9 | 2.575      | 0.109   | 3414 | 1  |
|                                                     | No    | 66                        | 85.7 | 2608 | 78.1 |            |         |      |    |
| Type of place of residence                          | Urban | 63                        | 81.8 | 2581 | 77.3 | 0.879      | 0.349   | 3416 | 1  |
|                                                     | Rural | 14                        | 18.2 | 758  | 22.7 |            |         |      |    |
| Attended Quran course                               | Yes   | 40                        | 51.3 | 2251 | 67.4 | 8.979      | 0.003*  | 3417 | 1  |
|                                                     | No    | 38                        | 48.7 | 1088 | 32.6 |            |         |      |    |
| Migrated                                            | Yes   | 40                        | 51.9 | 1300 | 38.9 | 5.347      | 0.021*  | 3416 | 1  |
|                                                     | No    | 37                        | 48.1 | 2039 | 61.1 |            |         |      |    |
| Have money                                          | Yes   | 22                        | 28.6 | 1208 | 36.2 | 1.885      | 0.170   | 3417 | 1  |
|                                                     | No    | 55                        | 71.4 | 2132 | 63.8 |            |         |      |    |
| Talked about FP: female                             | Yes   | 6                         | 7.7  | 202  | 6    | 0.361      | 0.548   | 3418 | 1  |
|                                                     | No    | 72                        | 92.3 | 3138 | 94   |            |         |      |    |
| Talked about FP: Male                               | Yes   | 1                         | 1.3  | 9    | 0.3  | 2.678      | 0.102   | 3417 | 1  |
|                                                     | No    | 77                        | 98.7 | 3330 | 99.7 |            |         |      |    |
| Talked about FP: Health professional                | Yes   | 3                         | 3.8  | 39   | 1.2  | 4.505      | 0.034*  | 3418 | 1  |
|                                                     | No    | 75                        | 96.2 | 3301 | 98.8 |            |         |      |    |
| Talked about FP: Other                              | Yes   | 19                        | 24.4 | 606  | 18.1 | 1.967      | 0.161   | 3417 | 1  |
|                                                     | No    | 59                        | 75.6 | 2733 | 81.9 |            |         |      |    |

Table C1 (continued)

|                                         |                    |     |      |      |      |        |        |      |   |
|-----------------------------------------|--------------------|-----|------|------|------|--------|--------|------|---|
| Mother tongue                           | Turkish            | 48  | 65.8 | 2601 | 79.1 | 7.656  | 0.022* | 3361 | 2 |
|                                         | Kurdish            | 21  | 28.8 | 584  | 17.8 |        |        |      |   |
|                                         | Arabic             | 4   | 5.5  | 103  | 3.1  |        |        |      |   |
| Education                               | No education       | 8   | 10.4 | 112  | 3.4  | 35.085 | 0.000* | 3417 | 3 |
|                                         | Primary            | 11  | 14.3 | 247  | 7.4  |        |        |      |   |
|                                         | Secondary          | 55  | 71.4 | 1966 | 58.9 |        |        |      |   |
|                                         | Higher education   | 3   | 3.9  | 1015 | 30.4 |        |        |      |   |
| Method currently used                   | No Method          | 34  | 75.1 | 34   | 43.6 | 45.862 | 0.000* | 3417 | 3 |
|                                         | Folkloric method   | 4   | 0.1  | 0    | 0    |        |        |      |   |
|                                         | Traditional method | 289 | 8.7  | 10   | 12.8 |        |        |      |   |
|                                         | Modern method      | 540 | 16.2 | 34   | 43.6 |        |        |      |   |
| Use internet                            | No                 | 23  | 29.9 | 500  | 15   | 25.774 | 0.000* | 3417 | 2 |
|                                         | Irregularly        | 20  | 26.0 | 474  | 14.2 |        |        |      |   |
|                                         | Regularly          | 34  | 44.2 | 2366 | 70.8 |        |        |      |   |
| Smoke                                   | No                 | 49  | 62.8 | 2768 | 82.9 | 26.094 | 0.000* | 3418 | 2 |
|                                         | Irregularly        | 5   | 6.4  | 1776 | 5.3  |        |        |      |   |
|                                         | Regularly          | 24  | 30.8 | 396  | 11.9 |        |        |      |   |
| Approve abortion                        | Approve            | 7   | 9.1  | 339  | 10.1 | 4.430  | 0.219  | 3417 | 3 |
|                                         | Disapprove         | 57  | 74   | 2614 | 78.3 |        |        |      |   |
|                                         | Depends            | 13  | 16.9 | 343  | 10.3 |        |        |      |   |
| Women should be virgin at wedding night | Disagree           | 37  | 49.3 | 1380 | 43.3 | 1.075  | 0.300  | 3260 | 1 |
|                                         | Agree              | 38  | 50.7 | 1805 | 56.7 |        |        |      |   |

\*p &lt; 0.1.

## D. QUESTION LIST

### SORU LİSTESİ

Tanıklık ettiğiniz istemli düşük (kürtaj) sürecine yönelik bazı sorular soracağım. **Ancak lütfen sürecine tanık olduğunuz kişinin gizliliğini korumak adına kişinin kimlik bilgilerini benimle paylaşmayın.** Bu sürecin doğasını, neden bu yöntemin tercih edildiğini, bu yönteme nasıl erişildiği gibi konuları değerlendirmenizi isteyeceğim.

#### A. İstemli düşük (Kürtaj)

İlk önce, tanıklık ettiğiniz kürtaj/ istemli düşük sürecine yönelik bazı sorular soracağım. Bu sürecin doğasını, neden bu yöntemin tercih edildiğini, bu yönteme nasıl erişildiği gibi konuları değerlendirmenizi isteyeceğim.

##### a) Deneyim ve nedeni

- (1) Tanıklık ettiğiniz kürtaj deneyimini açıklayabilir misiniz?
- (2) Neden kürtaja ihtiyaç duyulmuştu?

##### b) Yöntem ve Durum

- (3) Nerede ve nasıl bu istekli düşük gerçekleşti ve neden bu yöntem tercih edildi?
- (4) Düşük sonrası bütünsel (fiziksel ve psikolojik) yeniden iyileşme süreci nasıl geçti?
- (5) Kişinin bu süreçteki çevresine dair bilginiz var mı? Örneğin, nasıl bir yerde yaşıyordu, kaçmıcı sınıftaydı, eğitim durumu neydi gibi sosyal çevresine dair neler paylaşabilirsiniz?
- (6) Sizce bu süreçte arkadaşınız sosyal çevreden nasıl tepkiler aldı? Sosyal çevre ile ilişkisi ne şekildeydi? Öncesinde ve sonrasında destek alabildi mi?

##### c) İmkanlar ve Sınırlılıklar

- (7) Başka bir korunma yöntemine veya istemli düşük yöntemine erişimi kısıtlayan ne gibi faktörler vardı?
- (8) Psikolojik destek, sağlık hizmetlerine erişimde genç kadınlara özgün engeller olduğunu düşünüyor musunuz? Engeller olduğunu düşünüyorsanız, nelerdir?
- (9) Genç kadınlara sağlanan cinsel sağlık/ üreme sağlığı gibi konularda başvurabilecekleri kurumsal destek mekanizmalarına dair bilginiz var mı? Örneğin, okulunuzda cinsel sağlığa dair herhangi bir eğitim aldınız mı? Psikolojik destek birimi var mıydı?

#### B. Sosyal bağlar ve dayanışma

Bildiğiniz üzere ben sizin bireysel bir deneyiminiz değil tanıklığınız üzerine bazı sorular soruyorum. Bunun temel sebebi, sizin bireysel olarak bir kişi tarafından neden böyle bir olayda güvenilir tercih edilmiş olduğunuzu anlamak üzere. Bu sebeple kişiyle ilişkiniz, yakınlığınız, benzerlik ve farklılıklarınız üzerine bazı sorular sormak istiyorum.

##### a) Deneyim sahibi ile yakınlık

- (10) Nereden tanışıyordunuz?
- (11) Tanışıklığınızı nasıl değerlendirirsiniz?

##### b) Sosyal destek mekanizmaları

- (12) İçinde bulunduğu durumu sizin dışınızda kimlerle paylaştığını biliyor musunuz? Bu süreçte partnerinden, ailesinden veya başka yerlerden destek alıp almadığına dair bilginiz var mı?
- (13) Sizce bu destek kaynaklarına başvurulmasındaki temel sebep nedir? Başka destek kaynaklarına olan bir eksiklik kaynaklı mı? Veya neden başka bir arkadaşı veya ailesi yerine bu kişi/kişilerle görüştüğünü düşünüyorsunuz?

##### c) Dayanışmanın boyutları

- (14) Böyle bir deneyimi beraber atlatmak için neden sizden destek aldığımız düşünüyorsunuz? Desteğinizin ona ne boyutlarda katkı sunduğunu düşünüyorsunuz?
- (15) (14.sorunun cevabına göre) Bunun dışında günlük hayat deneyimlerinde birlik olabileceğinizi, ortaklaşabildiğinizi düşünüyor musunuz?

## E. TURKISH SUMMARY / TRKE ZET

İsteyerek dřk veya Trkiye halkları arasında daha ok kullanılan adı ile krtaj konusu ele alındığında hangi literatr ekseninde yaklaşıldığı arařtırmanın gidiřatına gre ok fazla ipucu sunmaktadır. Krtaj konusu felsefi bir akıř aısı ile etik kaygılar erevesinde, ilahiyat literatrnde dini kaygılarla ele alınırken, iktisat ve demografi literatrnde bir nfus kontrol veya remeyi engelleyici yntem olarak ele alınabilir. Bu arařtırmada krtaja demografi, sosyoloji ve toplumsal cinsiyet ve kadın alıřmaları literatr ekseninde yaklaşılmaktadır. Tezin ana arařtırma konusu krtaj deneyimi geirenin genlerin sosyal dayanıřma mekanizmalarını incelemektir. Krtaj Trkiye toplumunda yasal ancak yasaklanan, kusurlanılan ve gizlenmeye alıřan bir olgudur. zellikle gen ve bekr insanların hayatında ise evlilik dıřı iliřki bile ngrlmezken krtaj deneyimi, travmatik veya daha ok marjinalleřtirilmeye ve yalnızlařtırılmaya aık bir deneyim halini alabilir. Bu varsayımlarla yola ıkarak bu arařtırma Trkiye'deki genlerin krtajla bařa ıkarken sosyal dayanıřma ađlarını nasıl kullandığını arařtırmayı grev edinmiřtir. Bu biimde amalanan yalnızca krtaj ve sosyal bađlar arasında bir iliřki iddia etmek deđil, kiřilerin sosyal dayanıřma mekanizmalarının cinsel hayatlarına dair bilgi edinme ve olaylarla bařa ıkmada ne kadar etkili olabileceğine dair de bir fikir edinmektir. Bu amata operasjonalizasyon iin krtaj olgusunun seilmesi krtajın literatrde bařa ıkılması g ve stres verici bir olay olarak tanımlanması ve bire bir kiřilerin cinsel hayatı ile ilgili olmasıdır (Major et.al., 1990).

İsteyerek dřk veya daha ok kullanılan adı ile krtajdan bahsederken literatrde en sık karřılařılan tanım, Dnya Sađlık rgt'nn (WHO) tıbbi tanımı, "gebeliđin 20. haftasından nce veya gebelik sresi bilinmediğinde, 500 g'dan az dođan bir fets" dr (Cunningham ve ark. 2010, s.215). Ne kadar Trkiye toplumunda isteyerek dřk kavramı yerine krtaj edilse de aslında literatrde bu iki kavram birbirinden ayrılmaktadır. Krtaj, *curretage*, kelimesinden gelmekte olup tıbbi bir isteyerek dřk ynteminin adıdır. *Curettage* bir yntem olarak rahim ađzının geniřletilmesi ve rahim duvarının bořaltılması anlamına gelmektedir, gnmz modern tıp pratikleri iinde artık neredeyse uygulanmayan bir

metottur. İsteyerek düşük ise rahim içinde gelişme olan herhangi ürünün rahim sahibi tarafından istemli bir şekilde alınması için kullanılan her yöntemi kapsar.

Tıbbi olarak düşük kendiliğinden ve isteyerek düşük olarak sınıflandırılır. Kendiliğinden düşük harici bir çaba olmadan gerçekleşen gebeliğin sonlandırılması anlamına gelir, herhangi bir dışsal çaba olduğunda ise istemli veya isteyerek düşük gerçekleşmiş olur. (Çokar, 2008, s. 20; Cunningham ve diğerleri, 2010, s.227). Günlük hayatta düşük ve kürtaj arasında bir ayrım çizilmeye çalışılsa da aslında tıbbi anlamda birbirinden çok farklı olgular değillerdir.

İsteyerek düşüklerden bahsettiğimizde, bunlar güvenli ve güvenli olmayan olarak ikiye ayrılır. Bu ayrım yasal veya yasa dışı kürtajlardan farklıdır çünkü bazı yasal kürtajlar güvenli olmayabilirken bazı yasa dışı kürtajlar güvenli olabilir. Örneğin, kürtajın yasal olmadığı çoğu ülkede pratisyenler kendi kliniklerinde yasal olmayan yollarla kürtaj yapmaktadır, ancak bunlar güvenli olmayan kürtaj olarak sınıflandırılmazlar. Güvenli olmayan kürtajlara örnek olarak ise rahim içine çeşitli sivri cisimlerin yerleştirilmesi örnek verilebilir.

Bu tez, bu ayrım üzerinden şekillenmektedir ve kürtajın dünyanın birçok yerinde yasal olmasına rağmen, bir hak olarak değerlendirilmesinin erişiminin önünde ve ona yönelik tutumlarda olumsuz sonuçlara yol açtığını savunmaktadır. Kürtaj ve üremeye dair olgular haklar kapsamında tanımlandığında, bu düzenlemeler kişilerin kendi bedenleri ile yapabileceklerine sınır koymaktadır. Ayrıca bu yasaların ve hakların sınırları kişilerin kendileri tarafından sınırlandırılmadığından, bu haklar hiç de özgürleştirici olmayabilir. Ne var ki, haklar adı altında verilen ve aynı zamanda kısıtlanan bu olgular insanların kendi bedenleri ile ilgilidir ve insan her zaman kendi bedeni ile ilgili otonom kararlar verebilir. Bunun için de gerektiği takdirde insanlar kanunlar dışına çıkabilmektedir. Bu tezde bahsedilen ise, kürtaj ne kadar hak olarak tanımlanmış olsa da kürtajın hak olarak tanımlanması kürtaj özgürlüğü önünde ve insanların üremeye dair özgürlükleri önünde kısıtlamalara sebep olmakta olduğu ve bu durumlarda insanların takdirde kanunların dışına çıkmasıdır. Bu bağlamda, bu tezde Türkiye’de yaşayan gençlerin yasal ve yasal olmayan kürtaj deneyimleri ele alınmıştır.

Tezin birincil araştırma alanı, gençlerin kürtaj olasılığı ile karşılaştıklarında kişisel, çevresel veya toplumsal bağlarını nasıl kullandığını anlamaktır. Kürtaj yasal olmadan önce de kadınlar legal olmayan biçimlerde kürtaj yaptırmak için sosyal ağlarını kullanıyorlardı. Yasa dışılığına ve toplumsal olarak damgalanmasına rağmen, kadınlar kürtaj olmak için risk almayı tercih ediyorlardı. Yalnızca kürtaj değil, nüfus kontrol adı altında yapılan doğum kontrol yöntemlerinin engellendiği takdirlerde de insanlar başka yöntemler buluyordu.

Tezin literatür taraması kısmı üç kısımda ele alınmakta ve birden çok literatürden faydalanmaktadır. İlk kısımda kürtajdan, ikinci kısımda feministlerin ve kadınların sosyal dayanışma ağlarına yönelik kavramsallaştırmalardan ve son kısımda Türkiye gerçekliğinde kürtaj ve feminist dayanışmadan bahsedilmektedir. İlk kısmın ilk bölümü, kürtajın tıbbi tanımlarına değinir. İkinci bölümü ise, tarihsel olarak varlığını, yasaklanmasını ve yöntemlerini anlatarak başlar. Kürtajla ilgili en eski reçete, 5000 yıl öncesine Çin'de imparator Shen Nung'un kürtaj için cıva kullanımını tarif edişine dayanmaktadır (Grimes ve diğerleri, 2006, s.4). Kürtaj var olmasına rağmen, her yerde kabul edilmedi ve birçok eski kültürde suç sayıldı. Mezopotamya kaynaklarında kürtaj yaygın olarak suç sayılmaktadır. Hammurabi Kanunlarında kürtajın cezası sadece bir para cezası iken, Asurlulardan (M.Ö. 1450) kaynaklar kürtajın ölümle cezalandırıldığını belirtmektedir (Çokar, 2008, s.55). Antik çağda fetüs çoğunlukla kadın bedeninin bir parçası olarak kabul edildi ve aileye verilen statü, kurumun çeşitliliği ve çokluğundan ziyade kuruma verilen soyut bir statüydü. Nüfus kontrolüne ihtiyaç duyulduğunda bile, doğum kontrol önlemleri veya kürtaj yerine, perhiz tavsiye edildi.

İlk kısmın üçüncü bölümü, kürtajın demografi ve iktisat literatüründeki yerine ve bir nüfus kontrol yöntemi olarak kullanılışına bakar. Gary Becker, Leibenstein, Easterlin gibi bilim insanları nüfus teorileri üzerine çalışırken ve insanların doğurganlık ve üreme kararlarını ekonomik ve sosyal bir çerçeveye oturtmaya çalışırken kürtaja da değinmişlerdir. Bu araştırmalar, çoğunlukla bireylerin çocuk sahibi olma, kürtaj yapma veya doğurganlıklarını çeşitli gerekçelerle sınırlandırma gibi doğurganlık konusundaki tercihlerini açıklamaya çalışmıştır. Zamanla, doğurganlıkla ilgili karar vermeyle ilgili açıklamaları araştıran literatür, doğum kontrol, cinsiyet seçici kürtaj, istenmeyen gebelikler ve üreme politikalarının etkileri gibi belirli doğurganlık sınırlama yöntemlerinin dâhil edilmesiyle genişledi. İlerleyen dönemlerde, belirleyicilerin arasında, göç geçmişi, teknoloji ve evlilik tarihi gibi sosyal ölçütler de analize dâhil edilmiştir.

İlk kısmın dördüncü bölümü, kürtaj etrafında dönen siyasi ve politik gelişmeleri kuş bakışı ile küresel hatlarında ele alır. Bu kapsamda kürtajın medikalize edilmesinden, bir hak olarak görülmeye başlanması sürecinden ve kriminalize edilmesinden bahseder. 18. ve 19. yüzyıllar boyunca bedenler mekanize olmuş ve kadınlar nüfusu yenileme, aileyi istikrara kavuşturma ve çocuk yetiştirme araçları olarak algılanmaya başlamıştır (Erkmen, 2020, s. 25). 18. yüzyılda kürtaj menstrüasyonu düzenlemek olarak anlaşılır ve kadın cenini içeride hissedene kadar kabul edilebilir kabul edilirken, 19. yüzyılda doktorlar süreçte otorite talep etmeye başlamış ve azalan nüfus korkusuyla birlikte kriminalize eden yasalar ortaya çıkmıştır.

20. yüzyılın ilk yarısında artan anne ölümleri ve güvenli olmayan kürtajlar, kadın hakları aktivistlerini kadın sağlığı ve kürtaj hakları konusunda kampanya yürütmeye yöneltti. En çok ses getiren gelişmeler Amerika'daki kadın sağlığı hareketi ve kürtaj hakkı üzerinden yürütülen kampanyalardır. Sonunda Roe v. Wade isimli ünlü davanın kazanılmasıyla Amerika'da federal boyutta kürtaj yasallaşır. Ne kadar ki Roe bir kazanım olarak görülse ve olumlu karşılansa da, kısa bir süre sonrasında yürürlüğe eklenen Hyde anlaşması kürtaja haklar kapsamında yaklaşmanın eleştirilir yönünü ortaya koyar. Bu anlaşma dâhilinde kürtaja özellikle marjinalize edilmiş durumlardaki, yoksul ve kırsal bölgelerde yaşayan kadınların erişimi iyice kısıtlanır. Yine de kürtaj, etrafında verilen bu mücadele ve küreselde artan anne ölümleri kürtajın yasallaşmasının bir gereksinim olduğunu gözler önüne sermiştir. Bu bağlamda zaman içerisinde CEDAW, Kahire Konferansı, Pekin Konferansı gibi çeşitli küresel kongre ve toplantılarda kürtajın yasallaşması gereği sorunsallaştırılır ve zaman içerisinde birçok ülkede kürtaj haklar kapsamında yasallaşır.

Literatür taramasının ilk kısmının beşinci bölümü kürtajın toplumda damgalanması üzerine teorilerden bahseder. Örneğin, Kumar (2009) bu damgalamayı çeşitli düzeylerde kavramsallaştırmaktadır. İlk olarak, söylemsel düzeyde, yazarlar, kürtajın genellikle "kaçırılmış", "gecikmiş", "kayıp" "hamilelik" olarak adlandırıldığını iddia ederler. Bu nedenle kürtaj başlı başına bir olay olarak değil, daha çok gebeliğin sonlandırılması olayı olarak ele alınmaktadır. İkinci olarak yazarlar, kürtaj politikaları ve yasaları aracılığıyla ideolojik yollarla damgalanmanın yeniden üretilmesinden de bahsetmektedir. Üçüncüsü, damgalama hem topluluk düzeyinde hem de bireysel düzeyde gerçekleşir. Kişiler topluluk düzeyinde etiketlenmekten veya topluluk tarafından reddedilmekten korkabilirken, eş zamanlı olarak kendi kendilerine de bu damgalamayı uygulayabilmektedirler.

İlk kısmın son bölümü olan altıncı bölüm ise feminist tartışmalarda kürtaja yaklaşıma değinir. Kürtaj konusunda feministler her zaman aynı tarafta olmamışlardır. Örneğin, 19. yüzyılda, süfajetler veya birinci dalga feministleri olarak da bilinen feministler, kürtaja karşı olmaları ile tanınırlar. Hamilelik ve annelik tasvirleri yüceltilirken, cinsellik anlayışları normatif sınırlar içinde kalır. Bunun zıttına, ikinci kuşak ve radikal feministler kürtajı bir hak olmaktan öte görmektedirler. Onlar için, cinsel özgürlükler bir mücadele alanı olup haklar kapsamından da geniş ele alınmalıdır.

Literatür taramasının ikinci kısmı feministlerin ve kadınların dayanışma ağlarından ve sosyal bağlarından bahseder. Bu kapsamda, feminist dayanışma, kız kardeşlik, sosyal dayanışma gibi kavramları inceler. Kadın dayanışması üzerine Ann Whitehead (1984, s. 6) kötü koşullarda, kadınların hayatta kalmalarına engel teşkil eden risklerle karşı karşıya

kaldıklarında, güçlü bir şekilde birleştiklerini ve hayatta kalmaları için ağlar kurduklarını belirtiyor. Bu ağlar, kadınlar için güvenlik ağları olarak, ihtiyaç duyduklarında güvenebilecekleri yerler olarak işlevselleşiyor. Ancak, bu tür ağlar her koşulda güvenlik sağlayamıyor. Bazı durumlarda güçlenen bu ağlar, bazı durumlarda yumuşayıp kırılabilir.

Jodi Dean (1995), dayanışma kavramının da baskıcı ve dışlayıcı bir konuma sahip olduğunu belirtmektedir. Dayanışma kavramında bunun neden gerçekleştiği, kime karşı çıktığı gibi sorular önemlidir. Dean üç tür dayanışma biçimi tanımlar: şefkatli, geleneksel ve yansıtıcı. Şefkatli gördükleri karşılıklı duygular ve hisler karşısında kurulan dayanışmadır örneğin bir anne ile kızı arasındaki dayanışma örnek verilebilir. Geleneksel ise ortak amaçlara yönelik kurulan dayanışmadır, bir topluluk veya organizasyon dâhilindeki dayanışma gibi. Son olarak, yansıtıcı dayanışma kişinin hem kendi konumunu hem karşısındakinin konumunu düşünerek karşılıklı durumlarını birbirlerine yansıtarak iletişim halinde oldukları bir dayanışma biçimidir. Dean (1995) kadınlar için bu dayanışma biçimini önermektedir.

Steans (2009, s.733) ise çeşitlilik söyleminin bazen çatışma bazen de birliktelik duygusu üzerinden kimlikler ve sınırlar oluşturmaya başladığını belirtmektedir. Ona göre, söylemler üzerindeki çatışmalar, feminist aktivistlerin kendi ayrıcalıkları üzerinde özeleştirel hale gelmelerini ve diyalog yoluyla farklı feministleri olduğu gibi kabul etmeye başlamalarını sağlamıştır. Bunlar ışığında, yalnızca karşılıklı olarak kişilerin birbirini anlaması üzerinden ve birbirleri ile diyaloglarından yaptıkları çıkarımlarla dayanışma kurmaları yetersiz kalacaktır. Bu bağlamda, özellikle sınırlar ötesi diyalogların kurulması için araştırmacılar genişletilmiş empati ve genişletilmiş sempati pratiklerini önermektedir. Feministler birbirlerini yalnızca dinlemek veya yalnızca şefkat ve ilgi göstermek yerine, kendi aralarında perspektif alma ve dönüşümlü ve eleştirel diyaloglar kurmaya çalışmalıdır.

Feminist sosyal dayanışma ağlarının üzerine literatür sosyal destek kavramını da kullanmaktadır. Sosyal destek, dayanışma gibi düzenli bir bağdan ziyade anlık destek mekanizmalarına değinir. Sosyal destek, kişilerin ihtiyaç duyduğunda başvurduğu kanalların tümü olabilir. Bunlar yalnızca dayanışma ağları değil, sivil toplum örgütleri, devlete bağlı kanallar da olabilir. Sosyal destekten yardım alındığında kişiler bundan tatmin olabilir veya olmayabilir veya sosyal desteğin kimsen geldiğine göre deneyimleri çeşitlilik kazanabilir. Sandler ve Barrera (1984, s. 48) sosyal desteğin farklı yönlerini, yani desteğin içeriği, destekten memnuniyet ve ağların özelliklerini ölçer. Destek tatminini stres tamponu olarak görürlerken, destekleyici davranışlar üzücü etkileşimlerle birleştğinde bu çatışan ağ olumsuz bir tampon görevi görür. Yazarlar bunun sosyal desteğin etkileşimli etkisini gösterdiğini belirtiyorlar.

Kürtaj ile karşılaşınca kişilerin sosyal desteğe erişiminin olması bu deneyimin olumsuz etkilerini hafifletebilir. Bunun dışında sosyal destek ve dayanışma mekanizmaları, kürtaj yöntemleri ve hamileliğin nasıl önleneceği hakkındaki bilgilerin kişiye ulaşmasını da sağlayabilir. Petchesky (1990, s.49) buna “kültürel yayılma” adını verir. Kürtaj hakkında eski teknikler veya gibi bilgilerin yanı sıra, nerede ve nasıl kürtaj olunacağı gibi bilgiler de bu mekanizmalar sayesinde yayılabilir.

Feministlerin ve kadınların dayanışması ile akıllara gelen kürtaj ağları arasında ABD’deki Jane Kolektifi ve Fransa’daki *Mouvement de liberation desfemmes* (MLF) ilk akla gelenlerdendir. Jane Kolektifi ABD’de bir grup kadın tarafından kurulan ve ihtiyacı olan kadınların güvenli ancak yasal olmayan kürtaja erişimini sağlayan bir kolektiftir. MLF ise Simone de Beauvoir gibi çoğunlukla ünlü kadınlar tarafından imzalanan ve kişilerin kürtaj olduğunu deklare eden bir metin ile başlar. Kürtaj bu şekilde kamusallaştıktan sonra 1972’de kürtaj yaptıran reşit olmayan bir kadının ve annesinin mahkûm edildiği bir davadan sonra yeni bir hareket ortaya çıkar: *Mouvement pour la lib’eration de l’avortement et de la kontrasepsiyon* (Kürtaj ve Doğum Kontrolü Hareketi (MLAC)). Bu hareket kadınların güvenli kürtaja erişimini ne yol olursa olsun sağlamayı ve hatta kendi kendine kürtaj olmasına aracı olmayı görev edinir. Kürtajın ABD ve Avrupa’da yasallaşması feministlerin ve kadın kürtaj ağlarının sonlanması anlamına gelmemiştir. Feminist kürtaj ağlarının yakın tarihli bir örneği, Avrupalı feministler arasında kurulmuş ve 2018’de İrlanda’da kürtaj yasallaştırılana kadar, İrlandalı kadınların komşu ülkelerde kürtaj olmasına yardımcı olan kürtaj sağlık aktivizmi (AHA)dır. Bunun dışında Drovetta (2015, s. 53), Latin Amerika’da halen işlevsel olan Arjantin, Şili, Ekvator, Peru ve Venezuela’daki beş farklı Güvenli Kürtaj Bilgi Hattından (SAIH) bahseder. Tüm bu yardım hatları doğum kontrol yöntemi kullanımı, medikal kürtajın güvenli kullanımı ve bazen hastanelere başvurmaları gerektiğinde doktorlar tarafından polise teslim edilmekten nasıl kaçınılacağı hakkında bilgi vermektedir.

Literatür taramasının son kısmı Türkiye’de kürtaj ve sosyal dayanışma bağlarından söz eder. Anadolu’da, 18. yüzyılda Osmanlı İmparatorluğu, kısmen uygulanan bir şeriat kanunu ile yönetiliyordu. Bu bağlamda, Osmanlı’daki üreme kontrol politikaları da mezhep doktrinleri çerçevesinde şekillenmekteydi. İslam’da kürtajla ilgili yorumlar çeşitlidir. Kürtaj zımnen kınanmasa da, açıkça tavsiye de edilmeyen mekruh statüsündedir ve mezheplere göre farklılık göstermekle birlikte Osmanlı’da dominant olan Hanefilik mezhebinde 120 gün kürtaja izin verilmektedir. Bunun yanı sıra ise Osmanlı toplumunda ebeler ve sağlıkçılar tarafından kürtaj uygulandığı bilinmektedir.

Türkiye Cumhuriyeti kurulduktan sonra ise, savaş koşullarının sebebiyle nüfus kaybının önlenmesi adına nüfus artırıcı politikalar benimsenmeye başlanmıştır. Bu kapsamda doğum kontrol yöntemleri ve kürtaj yasal olarak yasaklanmış ve hatta kriminalize edilmiştir. Kürtajın yasaklanmasının ötesine geçilip kürtaj yapan kişiyi kriminalize eden yasalar bunun bir nüfus politikasından öte olduğunu düşündürmektedir. 1960'lar sonrasında ise Türkiye resmen nüfus problemi ile karşı karşıya kalmıştır. Bu bağlamda, artan nüfusun sıkıştırmasının etkisi ile doğum kontrol yöntemleri teşvik edilmeye başlanmıştır. Yakın yıllarda ise anne ölümlerinin de gösterdiği artış kapsamında kürtajın yasallaşması gündeme gelmiştir. Zekai Tahir Burak'ın yaptığı kapsamlı bir araştırma dâhilinde kadınların yasal olmamasına rağmen kürtaj olmak istediklerinde bu operasyonları güvenli olmayan şartlar altında geçirdiğini ve bunun yüksek oranlarda anne ölümüne sebebiyet verdiği ortaya konmuştur. Sonrasında süren araştırmalar ve lobi çalışmaları ile 1983 senesinde günümüzde "Kürtaj Yasası" olarak bilinen yasa yürürlüğe girmiştir. Yasa dâhilinde gebeliğin ilk 10 haftasında bir jinekolog veya sertifikalı bir hekime giderek kürtaj olmak yasallaşmıştı ancak yasanın kısıtlayıcı olduğu hayli boyut da vardı. Öncelikle yasaya göre evli veya reşit olmayan kadınlardan eş veya vasi onayı gerekmektedir. Bu durum kadınların kendi bedenleri ile ilgili bir kararda üçüncü kişilerin bilgi ve onayını aramaktadır. İkinci olarak, on haftayı geçen kürtajlar tamamen yasa dışı bırakılmıştır. Bu durumun ise tıbbi bir dayanağı yoktur zira 12 haftaya kadar birinci trimester kürtajlarında risk aynıdır. Üçüncü olarak, kürtaj yalnızca jinekologlar tarafından yapılabilecek bir operasyon haline getirilmiştir ve bu bağlamda özellikle kırsal bölgelerdeki kişilerin erişimi kısıtlanmıştır zira doktorların bulunduğu bölgelerde bile spesifik olarak jinekologlar bulunmayabilmektedir.

Kürtaj Türkiye'de yasallaşmış olsa da yasanın kısıtlayıcılığı ve kürtaja yönelik tutumlar karşısında erişilebilir hale getirilememiştir ve düzenli olarak politik bir tehdit unsuru olarak kullanılmaktadır. Örneğin, 2000'li yıllarda kürtaj ve doğum kontrol önlemlerini açıkça onaylamayan söylemler devlet mercilerince dile getirilmeye başlandı. 2008'de Trabzon'da Başbakan Erdoğan gençlere en az 3 çocuk yapmaları yönünde tavsiyede bulundu. Mayıs 2012'deyse Cumhurbaşkanı Erdoğan, kürtajı, Kürt sivillerin öldürüldüğü Uludere katliamına benzetti. Bu bağlamda kürtaj cinayetle eşit görülmüş oldu ve suç haline getirilmesi için bir alan açtı. Kısa bir süre sonra ise 2012'de bir kadın 12. haftada tecavüz nedeniyle kürtaj için mahkemeye başvurduğunda, savcı 'Sen doğur, devlet ilgilenir' cevabını verdi ('Sen Doğur, Devlet Bakar,' 2012). Bu gelişmeler toplumda ve özellikle feministlerde ciddi bir muhalefete yol açtı ve kadın gruplarının kürtaj etrafında toplandığı bir kampanya sonucunda kürtaj kriminalize edilmedi. Ancak bu gündem gösteriyor ki kürtaj üzerinde hala olumsuz ve yapılması devletçe istenmeyen bir imaj halen mevcuttur.

Toplumsal Cinsiyet ve Kadın Çalışmaları tezi olarak bu tez, feminist bir yaklaşım ile yürütülmüştür. Feminist metodolojiden faydalanyor olsa da, bu tez, tek bir yol veya teori izlemekten ziyade feminist metodolojinin ortak değerlerini dikkate alacaktır. Öncelikle feminist yöntem arayışı, kadınların farklı bilme biçimleri olan feminist epistemolojilerin araştırılması gerektiğini söyler. İkinci olarak, ortak bilimsel anlayışın genellenebilirliğini ve hesaplanabilirliğini eleştirir. Bireysel deneyimlerden gelen bilgilere ve bunların bireyleri yapıyla ilişkilerinde nasıl etkilediğine alan açmayı amaçlar. Üçüncüsü, araştırmacının konumunu sorunsallaştırır ve bilgi sürecindeki hiyerarşileri ortadan kaldırmasını ve araştırmayı öz-yansıtıcı hale getirmesini gerektirir. Araştırmacının kendini keşfetmesini sağlar ve iç benliğini bilerek araştırma sürecini sürdürür (Ramazanoglu&Holland, 2002, s.48). Bunun dışında, feminist metodoloji tek bir yöntem belirlemez veya herhangi bir yöntem dayatmaz. Yöntemleri metodolojinin ideallerine destek olacak yollar olarak kurgular.

Bu perspektif kapsamında bu tezde tek bir teori ele alınıp onun etrafında veriler incelenmeyecektir. Çeşitli metotlar ile toplanılan bilgiler ele alınacak ve değerlendirilecektir. Her kişinin kendi anlatısı doğru bilgi olarak ele alınacak ve özneliği kapsamında değerlendirilecektir. Araştırmacının konumu ile deneyimleri gözlemlenen ve dinlenen kişiler arasında bir hiyerarşi kurulmamasına özen gösterilecektir. Araştırma kapsamında hem nitel hem de nicel metotlardan yararlanılacak ve bu biçimde bir karma yöntem çalışması yapılacaktır. Bu sayede öncelikli olarak feminist metodolojinin kaygıları ele alınarak aynı zamanda metottan ziyade metodolojinin bilgiyi değerlendirirken yol gösterdiği vurgulanacaktır.

Bu tezde, karma metot uygulanırken feminist bir kaygı ve yaklaşımla uygulanacaktır. Seçilen karma yöntem biçimi ardışık nicel-nitel metot şeklindedir. Öncelikle nicel veriler incelenecek ve sonrasında nicel verinin bulgularından faydalanılarak nitel kısımda konu genişletilecektir. Bu bağlamda nitel veriler daha çok öne çıkarılacaktır. Nicel veri analizinde betimleyici istatistikler ki-kare testleri ve lojistik regresyon yöntemleri kullanılacaktır. Bu analiz için Hacettepe Üniversitesi Nüfus Etütleri Enstitüsü'nün toplamış olduğu Türkiye Nüfus ve Sağlık Araştırması (TNSA) – 2018 verileri kullanılacaktır. TNSA-2018 Türkiye'de yaşayan doğurganlık çağındaki (15-49) kadınların demografik bilgilerinin yanı sıra üreme bilgileri ve doğum tarihçelerini de toplamaktadır. Bu veri, öncelikle topyekûn olarak incelenecek sonra tezin odaklandığı otuz yaş altı kadınların ve kürtaj olan kadınların detaylı karakteristiklerine bakacaktır. Betimleyici analizde ortaya çıkan genel doğrultu kapsamında aykırı veriler araştırılacaktır. Bunun dışında korelasyon ve ki-kare testleri ile kadınların sosyo-ekonomik özellikleri ile demografik karakteristikleri arasındaki ilişkiler öne

sürülecektir. Son olarak, lojistik regresyon modelinde kadınların sosyal çevrelerinin ve sosyo ekonomik değişkenlerin kürtaj olma olasılıklarına etkisine bakılacaktır.

Nicel analiz sonrasında, nitel bir saha çalışması yürütülmüştür. Saha çalışmasında 30 yaş altında legal veya legal olmayan yollarla kürtaj olmuş veya kürtaj olmuş birine destek olmuş 25 kişiye ulaşılmıştır. Yarı- yapılandırılmış derinlemesine görüşmeler dâhilinde bu kişilerin, kürtaj deneyimi, bu süreçte kimleri yanlarında istedikleri, süreçteki sosyal destek mekanizmaları ile ilişkileri sorulmuştur.

Nicel sonuçlar genel yönleri ve aykırı değerleri gösterdi. Nicel sonuçlardaki ana aykırı değerlerden biri, 30 yaşın altındaki kadın alt örneğinin düşük olmasıydı. Bir diğeri, 18 yaşından önce ve yasa dışı veya güvenli olmayan durumlarda kürtaj yaptıran kişiler hakkındaki bilgilerdi. Veriler bazı ikinci trimester kürtajlarını içeriyordu, ancak ülkenin bilinen bir gerçeği olmasına rağmen, güvenli olmayan veya yasa dışı koşullarda yapılan kürtajlar mevcut değildi. Ancak, yasa dışı operasyonlar hakkında veri toplamanın, özellikle anket örneklemede birçok sınırlamaya sahip olduğu da bilinmektedir. Bu nedenle, tezin sıralı nitel kısmı için bu gruba odaklanmaya karar verdim. Verilere bakıldığında kürtaj sayılarında gözle görülür düşüş, özellikle yasa dışı kürtajlarda ve doğum kontrol haplarının kullanımında gözle görülür bir artış görülmektedir. Ancak, Türkiye'de halen yasa dışı kürtaj uygulamaları vakaları bulunmaktadır.

Nitel görüşmeler ise, araştırma konusu hakkında daha detaylı ve derinlemesine sonuçlar ortaya sundu. Nicel veriler kişilerin kürtaj deneyimini aktarımına sadık kalınarak kronolojik olarak değerlendirildi. Beklendiği üzere, kişiler ilk başta gebe kaldıklarını öğreniyorlar ve bununla nasıl başa çıkacakları üzerine stratejiler geliştiriyorlar. Bu aşamada kendilerinin ve çevrelerindeki insanların kürtaj ve gebelik üzerine algıları kişilerin deneyimleri arasında farklılıklar yaratıyor. Deneyimlerinin nasıl olduğundan bağımsız olarak bütün görüşmeciler ilk başta yakın arkadaşları ile sonra partnerleri ile bu bilgiyi paylaştığını belirttiler. İlk aksiyonları daha önce kürtaj olmuş birilerine ulaşmak için veya konu hakkında bilgisi olan yardımcı olacak birine ulaşmak için çevrelerini harekete geçirmek oluyor. Örneğin, yasa dışı şekilde kızının arkadaşının kürtajına destek olan bir görüşmeci kürtaj yapacak bir doktora ulaşmak için, ilk gittikleri doktordan “adı çıkan bir doktor”u tavsiye etmesini istediğini anlatırken, güvenli olmayan kürtaj deneyimi aktaran Ceren, başka bir kadının onunla aynı yaşlarda kürtaj olduğunu öğrendiğinde hissettiği ortaklaşma duygusunu anlatıyor. Daha önce deneyimlemiş kişilere ulaşmak hem ortaklaşma hissi, hem destek bulma hem de operasyonu yapacak birine ulaşmak konusunda kişilerin içini rahatlatıyor.

Deneyim sahibi kişilere ulaşmak dışında görüşmeciler kendi çevrelerinden bazı spesifik grupları da bu konuyla ilgili haberdar ediyor. Bunlar çoğunlukla aile, arkadaşlar, ve partner olurken bu süreçte özellikle uzakta tutulanlar ise yine aile, partner ve ‘yoldaşlar’ oluyor. Nauck ve Arránz Becker (2013, p. 580) aile bağları ile oluşan dayanışmanın zorunluluktan ve yakınlıktan kaynaklanabileceğinden söz ediyor. Bu dayanışma kriz anlarında çok ihtiyaç duyulan bir biçim olsa da sonrasında düşmanca hislere dönüşebiliyor. Yasa dışı kürtaj olmak durumunda kalan görüşmecilerim ailelerinin durumdan hep bir noktada haberdar olmak durumunda kaldığını belirtirken yasal yollarla kürtaj olmasına rağmen operasyonel riskler almış görüşmecilerim bu riskleri kürtajlarını ailelerinden gizlemek adına aldıklarını belirtmişlerdir. Örneğin, kürtaj olduğu dönem SGK’nın ailelere “Tebrikler, kızınız hamile” mesajı gönderdiğini hatırlayan bir görüşmeci ailesine bu mesajın gitmemesi için sahte isimle ve gerekli tetkikler yapılmadan operasyona girdiğini anlattı.

Aile dışında ise görüşmeciler her şekilde arkadaşlarının durumundan haberdar olduğunu iletir. Haber verecekleri ve sosyal destekleri beklenen arkadaşlar için ise ortaya çıkan en önemli özellik yargılayıcı olmamaktır. Kişiler özellikle kadın arkadaşlarıyla aralarındaki bağın karşılıklı ve dönüşken oluşunu vurguladı. Herhangi birinin o durumda olacağının bilincinde olmak onları yakınlaştıran bir unsur olarak ele alındı.

Genel literatürün aksine partnerler süreçte hiç etkin figürler olarak aktarılmadı. Major et.al (1990) gibi çeşitli araştırmalar partnerlerin sosyal desteğinin önemini vurgulamakta olsa da görüşmecilerim partnerlerin durumdan haberdar olsa bile süreçte hiç etkin olmadığını, aksine sürece dahil olanların da negatif etkideğini anlattı. Partnerler ve aile süreçten haberdar edilse de süreçten dışarı tutulmuş olsa da süreçten özellikle haberdar olmasının istenmediği grup ise “yoldaşlar” olarak adlandırdığım, kişilerin örgütten çevreleriydi. Kürtaj yaşayan insanlar bu kişilere yoldaş diyor olsa dahi, bu şekilde özel ve kendilerine dair bir deneyimi öğrendiklerinde yargılanacaklarını ve dışlanacaklarını düşündüklerini ilettiler.

Sonrasında görüşmeciler operasyonun nasıl olduğunu anlatırken ise üç temel noktaya değindi. Öncelikle operasyonu tamamen medikal terimler ve yaklaşımlar dâhilinde anlattılar. İkinci olarak, kendi düşündükleri güvenli ve yasal kürtaj tanımının dışına çıkan her türlü uygulamayı yasal veya güvenli olsalar bile yanlış olarak tanımladılar ve son olarak, operasyon sürecinde en çok sağlık personelinin onlara yönelik tutumundan bahsettiler. Sağlık personelinin tutumu çoğunlukla eleştirilse de olumlu tepki alan görüşmeciler bile personelin tutumunu garipsediğini bildirdi.

Görüşmelerin sonunda ise kişiler, kürtaj sonrasındaki deneyimlerini, başa çıkma stratejilerini ve hissettiklerini anlattı. Anlatılanlar arasında, ilk olarak öne çıkan bütün görüşmecilerin

süreci yalnızlıkla hatırlıyor olmasıydı. Süreçte yalnız bırakılmadıklarını belirtmeler de bu süreçte içlerine döndüklerini ve yalnız hissettiklerini aktardılar. Başa çıkma stratejileri olarak ise iki farklı veya birbirini takip eden yöntem dikkat çekti. İlk olarak görüşmecilerden ziyade ailelerin sessizliği bir başa çıkma ve belki de cezalandırma mekanizması olarak kullandıkları söylendi. Ailelerin olayın üzerini kapatma ve tekrar konuşmamaya yönelik tutumları kişilerin kendilerini de kapatmalarına yol açmış olabilir. Görüşmeciler de süreç bittikten sonra bir süre kendileri bundan bahsetmemeyi tercih ettiklerini ve bir savunma mekanizması olarak sessizliği kullandıklarını söyledi. Ancak, zaman geçtikten sonra bu süreci dışa vurmayı ve başkalarıyla paylaşmayı da bir misyon haline getirdiklerini iletiler.

Bu tez Toplumsal Cinsiyet ve Kadın Çalışmaları literatürüne ve kürtaj konusunda yapılan çalışmalara üç düzeyde katkı sağlamaktadır. İlk olarak, bu tezin araştırdığı konu ve bulguları ilk defa ortaya çıkan ve ele alınan noktalardır. Bilgin dahilinde Türkiye'de kadınların ilişkileri, sosyal bağları ve kürtajı nasıl deneyimledikleri konusunda herhangi bir araştırma bulunmamaktadır. Ayrıca, 2000'li yıllardan sonra Türkiye'de yasa dışı kürtaj deneyimlerine ilişkin herhangi bir akademik literatüre rastlanmamıştır. İkinci olarak, bu tez, seçtiği popülasyonun alt örneklemince literatür için önemlidir. Bu tezde incelenen ana grup, genç yetişkinler olan 30 yaşın altındaki gençlerdir. Kürtaj ve üreme deneyimleri alanındaki çalışmaların çoğu, cinsel aktiviteleri konusunda en açık olan evli kadınlara odaklanmaktadır. Ancak günümüz Türkiye'sinde sadece bekâr genç yetişkinler değil, gençler de kürtaj oluyor. Kadınlar cinselliklerini yalnızca evlilikten sonra yaşamaya başlamakla, çok daha önce başlayabilirler bu da kürtaj ve gebelikle karşı karşıya kalabileceklerini belirtir. Bununla birlikte, evlilik öncesi cinselliği çevreleyen sosyal damgalama bekâr kadınların veya ilk kürtajını olan kadınların deneyimlerini daha da zorlaştırabilmektedir. Üçüncüsü, bu tez kullandığı yöntemle katkı sağlamaktadır. Araştırma, feminist bir karma yöntem çalışması olup, nitel yaşam öykülerini ve kadın deneyimlerini, nicel verilerle bir araya getirmektedir. Türkiye'deki Toplumsal Cinsiyet ve Kadın Çalışmaları literatüründe daha çok nitel araştırmalar yer alması ve Türkiye'de karma yöntem uygulamalarının alanda fazla uygulanmaması nedeniyle, karma yöntemli bir çalışmanın bu literatüre katkısı olduğu ileri sürülmektedir. Tezin sonuçlarının ve gidiş yolunun gösterdiği üzere genel bir çerçeveden yola çıkarak aykırı gruplara ulaşılması görülmeyen deneyimlerin ve bu deneyimlerle kişilerin nasıl baş ettiklerini ortaya çıkarmaktadır.

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