An assessment of women's abortion experiences in Istanbul, Turkey

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Abstract

Abortion upon request has been legal in Turkey since 1983. In 2012 the Prime Minister of Turkey announced his intent to restrict or ban abortion. The public protested in response and the Turkish government did not amend the abortion law. However, recent anecdotal evidence suggests that the provision of abortion in public hospitals has diminished significantly. The purpose of this qualitative study was to explore women's experiences obtaining abortion care in Istanbul, Turkey. We also documented key informants' perspectives about abortion and reproductive health service availability in Istanbul. According to women and key informants, abortion availability has decreased remarkably and is now only available in one public hospital in Istanbul. Abortion care remains available in the private sector but there are nonetheless barriers to obtaining timely abortion care in Turkey. To improve abortion services, future efforts should focus on re-integrating abortion services in the public sector and making medication abortion available to Turkish women.

Résumé

L'avortement sur simple demande est légal en Turquie depuis 1983. En 2012, le premier ministre de Turquie a annoncé son plan de changer ou d'abolir la loi qui autorise l'avortement. Le public avait protesté en grand nombre et le gouvernement n'a pas modifié la loi. Toutefois, des évidences anecdotiques suggèrent que l'accès aux services d'avortement a diminué dans le secteur public. Le but de cette étude qualitative était d'explorer les expériences des femmes en obtenant les services d'avortement à Istanbul, Turquie. De plus, nous avons documenté les perspectives des informateurs clés au sujet des services d'avortement et de santé reproductive disponibles en Istanbul. Selon les femmes et les informateurs clés, la disponibilité de l'avortement a diminué et les services sont disponibles à un seul hôpital public dans Istanbul. L'avortement est encore disponible dans le secteur privé, mais il existe quand même les barrières en obtenant les services d'avortement en Turquie. Pour améliorer les services d'avortement dans le futur, les efforts devraient se concentrer sur la réintégration des services d'avortement dans le secteur public et sur l'accessibilité accrue à l'avortement médical pour les femmes turques.

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Acronyms and Abbreviations

AÇSAP	Mother-child health and family planning
AKP	Justice and Development Party
ANAP	Motherland Party
CHP	People's Republic Party
DP	Democratic Party
EC	Emergency contraception
ECPs	Emergency contraceptive pills
FP	Family planning
IUD	Intrauterine device
MAB	Medication abortion
MMR	Maternal mortality ratio
NGO	Non-governmental organization
OCPs	Oral contraceptive pills
PKK	Kurdistan Worker's Party
PM	Prime Minister
SGK	Turkish Social Security
SRH	Sexual and reproductive health
TAR	Total abortion rate
UPA	Ulipristal acetate

Chapter 1: Introduction

1.1 Background

1.1.1 Historical and political background

Following World War I and the Turkish War of Independence, the Ottoman Empire was officially dissolved and the Republic of Turkey was founded in 1923. Turkey was established as a secular nation; the sultanate and caliphate were abolished in 1922 and 1924, respectively, and a constitutional democracy was installed (Başkan, 2010). The first President of the Republic, Mustafa Kemal Atatürk, promoted large-scale political, social, and economic reforms throughout the 1920s and 1930s. Largely modeled after European principles, these reforms included the abolishment of sharia law with the subsequent adoption of European legal jurisprudence, the restriction of religious dress in public, and the introduction of the Latin alphabet (Başkan, 2010). Women's rights were also highly emphasized during this period; Atatürk modified the civil code in 1926 to guarantee women equal rights. By 1934, Turkish women had achieved full suffrage and could be elected to the Grand National Assembly (Baltaeva, 2015).

Even at this remarkable pace of modernization, Turkey has endured a long and tumultuous trajectory toward achieving democracy. In the first half of the twentieth century, the goal was secularism, not democratization (Arat, 2010). The first hint of realizing any resonant democratic identity was initiated when Atatürk's successor, Ismet Inönü, led the transition from a single party to a multi-party political system in 1947 (Unver, 2013). By allowing the participation of other political parties, the state also paved the way for Islam to be introduced into Turkish

politics. The military perceived this shift as inherently problematic, and increased political Islamisation was a major contributor to the series of coup d'états and memorandums in Turkey during the latter half of the twentieth century.

In 1950, the *Cumhuriyet Halk Partisi* (CHP), the People's Republic Party, lost an election for the first time to the newly founded *Demokrat Parti* (DP). Under the leadership of Adnan Menderes, Turkey thrived economically throughout the 1950s. However the DP also increased censorship measures and systematically oppressed the CHP opposition party and its members (Pelt, 2014). By the end of his decade-long tenure as Prime Minister (PM), Menderes was charged with embezzlement of state funds and violation of the Turkish constitution. In 1960, a military coup d'état removed Menderes from power and executed him in 1961. The military junta ceded control thereafter to a civilian government led once again by Inönü. Free elections were called in 1965 and Süleyman Demirel was elected as Prime Minister; however the military maintained significant influence over the Turkish political arena throughout the next two decades.

The 1960s and 1970s were characterized by widespread political movements, both nationalist and socialist in nature. In particular, the Kurdish cause gained momentum. The minority Shi'ite Alevis also mobilized, threatened by the increasing nationalism that was emerging among the majority Sunni Muslim population (Orlow, 1982). Islam became further politicized and was highlighted as a prevailing force in the fight against communism (Orlow, 1982). The legacy of Islam as a political tool remains entrenched within Turkish politics to this day.

Amid major economic instability, political violence, and social unrest, power transitioned back and forth between Prime Ministers Demirel and Ecevit throughout the 1970s. At the same time, increased polarization of the left and right movements and public disillusionment with unstable coalition governments led to heightened violence. By 1980, over 5,000 people had died as a result (Schmid & Jongman, 1988). In response, the military carried out another coup d'état in 1980. This coup was a major turning point. While the coup aimed to minimize the rampant political violence, it was also meant to crush any hint of socialist uprising. The manner in which the military handed back civilian power was also very deliberate. The junta banned several major political players and parties from running in the elections, thereby directing the political outcomes of the 1980s.

In 1980 to 1983, Turkey did stabilize under military rule. The country experienced a dramatic economic recovery and the military led efforts to draft a new constitution, which went into effect in November 1982. The same constitution remains in effect today. Under the leadership of Turgut Özal and the newly formed *Anavatan Partisi* (ANAP), the Motherland Party, the 1980s and early 1990s proved to be a significant time for Turkey. Turkey emerged from this tumultuous period a significant player in international politics, and the government focused on building strong relationships with central Asian and Balkan countries. Turkey also took a vested interest in the outcomes of regional conflicts, and played an active role in the coalition against Iraq during the first Gulf War (Çandar, 2013). Özal was also the first political leader to confront two resounding issues facing 20th century Turkey. First, he wanted to recognize the 1915 Armenian genocide and re-establish relations

with Armenia. Second, he aimed to negotiate a peace agreement with the *Partiya Karkerên Kurdistanê* (PKK) also known as the Kurdistan Worker's Party (Çandar, 2013). Early steps were incredibly promising: the PKK called for its first ever ceasefire on March 16th, 1993. However, the promise of a resolution to the Kurdish question was incredibly short-lived: Özal died on March 17th, 1993, just one day after the ceasefire, and was ultimately unsuccessful in realizing his vision of peace with Armenia or the Kurds.

After Özal's untimely death, Necmettin Erbakan was elected Prime Minister, but by 1997 the military put forth a memorandum calling for his resignation. He complied and yet another coalition government took power. In 2002, this cyclical power hand-off between unstable, short-lived coalition governments and the military finally came to an end. The newly formed *Adalet ve Kalkınma Partisi* (AKP), the Justice and Development Party, won a majority government that they have maintained ever since. In the mid-2000s the AKP was wildly popular. Turkey finally had relative political and economic stability, and the AKP was taking a more decisive approach to advancing Turkey's accession into the European Union. The public's support was reflected when the AKP won the 2007 general elections with an even higher vote count.

However, there has been a notable transition in political rhetoric since the late 2000s. Turkey has seen a resurgence of pro-Islamist, conservative political values in the past decade. The political leadership has overwhelmingly promoted religious values, especially those pertaining to a traditional model of family and marriage, and thereby altered public perceptions of and attitudes toward sexual and

reproductive health in a Muslim-majority state that has traditionally held relatively liberal views toward reproductive and sexual health.

1.1.2 Reproductive rights in the Ottoman and Turkish contexts

The cultural and religious acceptability of family planning (FP) and abortion has shifted throughout Ottoman and Turkish history. Islam offers a wide range of interpretations around abortion permissibility, depending on the school of Islamic jurisprudence. Within the Hanafi school, abortion has long been considered acceptable until 120 days gestation when ensoulment is believed to occur (Bowen, 1997). Consequently, Gürsoy (1996) suggests that abortion was socially acceptable and widely practiced during the Ottoman Empire. In 1848, however, abortion was banned. This change is generally attributed to a rise in pronatalist ideology among the Ottomans, aimed at preserving the Muslim population in a declining empire (Gürsoy, 1996). After the fall of the Ottoman Empire, the Republic of Turkey also enforced strict limitations on FP, banning both abortion and contraception in 1930. The Republic had similar motivations as the Ottomans and hoped to encourage nationalistic population growth following major losses in World War I and the Turkish War of Independence. The bans were highly effective – the Turkish population grew at an unprecedented pace for the next thirty years.

By the early 1960s, Turkish leaders realized the economic implications associated with rapid population growth and introduced family planning measures and contraceptive education across the country. By 1965, a law banning the use of oral contraceptives was lifted, the Ministry of Health distributed intrauterine

devices (IUDs) free of charge, and abortion was permitted for medical reasons (Özbay & Shorter, 1970). Knowledge and use of both traditional and modern methods of birth control increased significantly from 1963 to 1968. Abortion, still criminalized for social and economic reasons, remained commonplace despite harsh penalties for providers and women alike. The Turkish penal code imposed sentences ranging from two to five years imprisonment for providers and one to four year imprisonment for women (United Nations, 2002). By the early 1980s, illegal and unsafe abortion was recognized as a major contributor to the high rate of maternal mortality in Turkey and the abortion law was subsequently liberalized in 1983.

In 1983, the Turkish government passed the Population Planning Law No. 2827 and it remains the current abortion law in effect today. The law stipulates that abortion is legally permitted without restriction as to reason, but with spousal consent, through the 10th week of pregnancy. Single adult women and minors with parental consent can also legally obtain abortion care. Notably, Turkish feminist groups condemned the legalization of abortion for two reasons. First, the law propagated traditional patriarchal values because it required women to obtain spousal consent for abortion (Gürsoy, 1996). Second, the law did not advocate for women's rights but was instead motivated by demographic and population planning objectives. This can be contrasted with the motivation for liberalization in other countries. In the Canadian context, for example, it was ruled that abortion restriction was unconstitutional because by "forcing a woman, by threat of criminal sanction, to carry a foetus to term unless she meets certain criteria unrelated to her

own priorities and aspirations, is a profound interference with a woman's body and thus a violation of security of the person." (R v. Morgentaler 1998). No such observations have been integral to decision-making around abortion and reproductive rights in Turkey.

Indeed, the historical record suggests that Ottoman and Turkish family planning policies have generally been enacted to further the political and economic agenda of the empire or state (Gürsoy, 1996). I would argue that this legacy continues today, and has become ever more apparent in the recent debates around reproductive rights in Turkey. Indeed, the AKP seem to disregard a woman's right to autonomy and security of person, and focus instead on larger population planning objectives.

1.1.3 Recent political discourse

Recep Tayyip Erdoğan has been the enduring face of modern Turkish politics, acting as both Prime Minister from 2003-2014 and as the elected President since August 2014. As leader of the AKP, Erdoğan's rule has been characterized by successful economic reforms while increasingly targeting human rights guaranteed by the constitution, such as freedom of speech and freedom of assembly. For example, the government was harshly criticized for its use of excessive force against peaceful protesters during the Gezi Park protests of 2013. Amnesty International (2013) denounced this as a "brutal denial of the right to peaceful assembly in Turkey" (p. 1).

Erdoğan has also been accused of targeting gender equality rights. This is

not surprising given that at a recent convention, Erdoğan stated "You cannot make women and men equal; this is against nature." (Dearden, 2014, para. 3). Advocates have noted that violence against women has increased in the last decade. Erdoğan and other AKP leaders have also spoken out against abortion, contraception, and Cesarean sections. This attack against reproductive rights is most notably linked to Erdoğan's open support of pronatalist population policy. He has consistently urged all Turkish women to have a minimum of three children (Hürriyet Daily News, 2008, 2013). Some academics and women's rights advocates believe that the pronatalist objectives of the government are a primary motivation for the restriction of FP services including abortion.

The abortion debate in Turkey, one that had remained relatively quiet, if non-existent, during the last thirty years, was suddenly re-opened in 2012. During a speech on May 25, 2012, Erdoğan openly condemned abortion as murder:

> We are very sensitive about children in Turkey. I love children. In my country I want at least three children for each family. Because I know that we need a young and dynamic population . . . I declare openly that I am a prime minister who is against delivery by caesarean section. I consider abortion as murder. Killing a child in the body of a woman is no different than killing him after the birth. We should stay together to oppose this. (Badamchi, 2014, p. 50-51)[1]

In his ongoing rhetoric, Erdoğan frequently equates population growth with the prosperity of a nation. Abortion is not only unacceptable based on moral and religious grounds, but also because it limits the ability of the nation to achieve growth and success. Shortly following his public anti-abortion statements, Erdoğan shared his ultimate goal with the public: to pass a law that would severely limit or

[1] Translations by the author of the work cited unless otherwise noted.

completely ban abortion, even in cases of rape (Green, 2012). A bill was drafted in mid-2012 but later discarded after widespread protests from women's rights activists. A later draft in early 2013 aimed to uphold abortion as a legal medical service but impose severe restrictions on access. Proposed limitations included requiring that abortion be performed by obstetrician/gynaecologists (Ob/Gyns) in a hospital setting, imposing mandatory wait times, and granting doctors the right to refuse to provide abortion care on moral grounds (Letsch, 2013). Women's rights advocates argued this would impede access so significantly that many women would in fact not be able to obtain abortions. After backlash from the media and women's rights organizations, the bill was dropped in 2013.

The abortion law has not actually been amended; however, access to abortion services may have decreased following the proposed abortion restriction in 2012. There is a substantial amount of anecdotal evidence and media reports that suggest Turkish women have recently faced more obstacles when seeking pregnancy termination. Women have reported hostile and aggressive treatment from doctors when requesting abortions and diminished medical care during the procedure, including a lack of anesthesia (Jones, 2013). That is assuming that women can even obtain an abortion; women have also reported being turned away from hospitals and being falsely informed by hospitals that abortion is illegal (Letsch, 2013). Single women, due to discrimination and cultural stigma, have also reportedly been denied abortions at public hospitals in Istanbul (Songun, 2008). A quote from Deniz Bayram, a lawyer at the Purple Roof women's shelter in Istanbul, highlighted the emerging problem in Turkey:

> Women call us and ask: 'We were told [in the hospital] that abortion is illegal in Turkey. Is that true?' These women then often don't know where to go. We realised that even without a legal abortion ban, it is already largely unavailable in Turkey (Letsch, 2013, para. 12).

Indeed, other barriers to reproductive services have been reported following Erdoğan's anti-abortion speech. In 2012, the medication abortion (MAB) drug misoprostol was removed from pharmacies across Turkey (Moral, 2012). Misoprostol alone is a highly acceptable regimen for pregnancy termination through the second trimester (Borgatta & Kapp, 2011), and misoprostol was the primary MAB drug available in Turkey. A survey of Turkish Ob/Gyns found that 60 percent had provided MAB, most commonly with misoprostol alone (Akin, Doğan, Özvaris, & Mihçiokur (2012). Mifepristone, a component of the gold standard regimen for early MAB, has not yet been licensed for use in Turkey, however mifepristone-misoprostol regimens have been permitted in clinical trials. Because of the clinical trials, one-quarter of Ob/Gyns surveyed had used mifepristone to provide MAB (Akin et al., 2012). An earlier trial with two hundred Turkish women showed that the majority of women (94 percent) reported high levels of satisfaction with this method of pregnancy termination (Akin et al., 2005), and seventy-one percent of Ob/Gyns believed that MAB should be made widely available to Turkish women (Akin et al., 2012). Based on widespread acceptance among providers and women, Akin et al. have consistently recommended that advocacy efforts to license mifepristone should be a priority. The removal of misoprostol may limit reproductive options for some Turkish women and it certainly signifies a shift away from MAB and the licensing of mifepristone, a movement that had been gaining momentum in Turkey.

MAB has not been the only target. As of 2014, dedicated levonorgestrel emergency contraceptive pills (LNG-ECPs) have not been on the market in Turkey (Emergency Consortium for Emergency Contraception, 2016). It appears that LNG-ECPs have been replaced with the dedicated ulipristal acetate (UPA) emergency contraceptive; however UPA is two and half times the price of LNG-ECPs. It remains unclear whether or not this price difference has had any impact on emergency contraception (EC) access for women in Turkey.

The restriction on MAB and EC options for women, while not the focus of this study, is nonetheless important because it reiterates that Turkish women's reproductive health options have likely become more restricted. The reduced access to MAB and EC also emphasizes the need for continued access to safe surgical induced abortion in Turkey. Yet the Turkish Society of Obstetrics and Gynecology reported another obstruction to abortion provision in 2014. In March 2014, they released a statement that the service code for abortion had been removed from the billing software in public hospitals throughout the country, effectively rendering the service impossible to provide (Hürriyet Daily News, 2014). Dr. Cansun Demir, an obstetrician in Istanbul, explained in an interview:

> The option to click on 'Abortion' is removed from our Web page…The right to choose to terminate a pregnancy based on the woman's decision is legal, but we cannot provide the service. What is left to medical doctors is either classifying any abortion as a medical necessity or redirecting the woman to seek private care to terminate the pregnancy (Tremblay, 2014, para. 5-6).

1.1.4. Sexual and reproductive health in Turkey

Most sexual and reproductive health (SRH) indicators in Turkey have improved significantly within the last two decades. However, disparities in SRH

indicators across geographic region, education level, and socioeconomic status persist. Poor SRH outcomes are most common in the rural regions of the country, typically central and southeastern Anatolia. On the other hand, outcomes tend to be better in the Marmara and Aegean regions (refer to the map in Appendix A). Women with a secondary school education or higher also tend to have better health outcomes, as well as those who belong to a higher wealth quintile.

The majority of women in Turkey (97 percent) received at least one antenatal care appointment during their most recent pregnancy. The prevalence of postnatal care is almost as high as that of antenatal care; 93.7 percent of women obtained a postnatal check-up within forty-one days of delivery. Almost all women reported giving birth in a medical facility. Given these advances in perinatal care, Turkey has made tremendous progress with respect to its maternal mortality ratio (MMR). In 1989, the MMR was estimated at 132 deaths per 100,000 live births (SIS, 1993); by 2009, the MMR was reported at 29 (Türkyılmaz, Koç, Schumacher, & Campbell, 2009). With respect to mode of delivery, the prevalence of births by C-section in Turkey is relatively high; nearly half of all deliveries (48.1 percent) are via Cesarean (Hacettepe University Institute of Population Studies [HIPS], 2014).

In addition to the notable progress in maternal health outcomes, family planning has also improved dramatically in Turkey. Since the legalization of contraception in the 1960s, knowledge and use of traditional and modern methods of contraception have steadily increased. Currently, 99 percent of Turkish women are familiar with at least one modern method of contraception (HIPS, 2014). The oral contraceptive pill and the IUD are the most well known methods of modern

contraception. Despite nearly universal knowledge of modern contraceptives, the most common form of contraception remains withdrawal. Nearly half (45.8 percent) of all women reported ever-use of withdrawal. With the exception of the male condom, the IUD is the most common modern method ever-used among married and unmarried Turkish women (HIPS, 2014). Turkish women tend to find the IUD highly acceptable and seek this as a preferred modern method, however the reliance on traditional FP methods, specifically withdrawal, remains significant in the context of Turkish sexual and reproductive health.

Another important indicator of family planning education and availability is the unmet need for family planning. This is defined as the percentage of currently married fertile women who want to space or limit their births but are not using a form of contraception. The most recent demographic survey indicates that six percent of Turkish women have an unmet need for family planning, which is remarkable. However, it should be noted that this measure does not address unmet contraceptive needs among single people and contraceptive use may not be as prevalent as indicated by the unmet need measure. For instance, when women seeking induced abortion in Izmir were questioned about their use of contraceptive methods in the month that they became pregnant, 38 percent of women reported using no form of contraception (Atan, Kavlak, Kulak, & Bozkaya, 2011). In a study of sexually active university students who did not always use contraception, 61.4 percent reported 'no reason' or 'the idea that pregnancy will not occur' as their reasoning (Erenel & Golbasi, 2011).

In addition, knowledge of emergency contraception remains fairly low; the

most recent data suggests that less than half of all women (42 percent) had any knowledge of EC (HIPS, 2014). In the study by Atan et al. (2011), only seven percent of women seeking abortion reported using emergency contraception after sexual intercourse. Knowledge and usage of both traditional and modern methods tends to be higher among married women than unmarried women. In Turkey, there is still a disproportionate focus on FP services for married couples. Premarital sex remains highly stigmatized and some of the literature suggests that this could pose a barrier for young, unmarried people to obtain contraceptive services. In a survey of Turkish university students, 8.6 percent of sexually active respondents had experienced unplanned pregnancy; all participants had either miscarried or sought induced abortion (Erenel & Golbasi, 2011).

Since the early 1990s, the abortion rate in Turkey has steadily declined, but a significant proportion of pregnancies in Turkey, up to 28.7 percent, are unplanned or unwanted (Özkan & Mete, 2010), a percentage that has remained steady for some time. While it is difficult to establish an accurate value for abortion ratio, the HIPS (2009) indicated that one out of ten pregnancies in Turkey ends in induced abortion. More recent but smaller studies suggest that as many as 21.7 percent of all pregnancies are terminated (Nur, 2012). The majority of women (62 percent) are obtaining this abortion care through the private sector (HIPS, 2014) and, as with other SRH services, abortion prevalence tends to vary significantly across the different geographic regions of Turkey. For instance, Istanbul has the highest total abortion rate (TAR) of the country at 0.20, which is twice the rate reported in central Anatolia (HIPS, 2014).

Post-abortion contraception counseling represents an important area of intervention for enhancing sexual and reproductive health education and increasing the uptake of modern contraceptives. Günyeli, Abike, Bingöl, & Ornek (2012) demonstrated that, even with post-abortion contraceptive counseling, the uptake of modern methods by Turkish women following induced abortion is relatively low (14.3 percent). However, other studies have demonstrated more success with post-abortion interventions. Ceylan, Ertem, Saka, & Akdeniz (2009) found that among a group of 237 women presenting for induced abortion, not one had an IUD prior to her unplanned pregnancy; however one year post-intervention, over half (52.3 percent) were using an IUD as their method of contraception. The authors emphasized in this study the importance of introducing the modern method immediately following an abortion.

1.2 Rationale

The rationale for this study is twofold. First, there is minimal literature about women's abortion experiences in Turkey. A 1996 study of Turkish public hospitals reported that less than 10% of women are provided information about possible side effects of the abortion and approximately half of all women received no pain medication during the procedure (Huntington, Dervisoğlu, Pile, Bumin, & Menach, 1996). The same study showed that post abortion contraceptive counseling was limited. However, these findings were published twenty years ago and there have been no qualitative studies exploring women's experiences or key informant

perspectives on abortion care. We therefore wanted to address this existing gap in knowledge.

Second, the political rhetoric and media reports suggest that abortion care in Turkey may have changed dramatically in the last five years. Despite the lack of scientific literature, there have been dozens of newspaper articles, blogs, and reports from professional organizations such as the Turkish Society for Obstetrics and Gynaecology in the last four years indicating that abortion access has become increasingly restricted. The anecdotal reports suggest a need for a rigorous study to investigate these dynamics. Some literature has documented the political abortion debate since 2012 and analyzed the various arguments put forth by Turkish politicians. However, there is still little understanding of how the political rhetoric around abortion has impacted access and quality of abortion care in practice. This research study will aim to address some of these gaps. Liberal legislation does not necessarily guarantee accessible, safe, and judgment-free reproductive health care. This study will shed light on the dynamic relationship between political rhetoric and abortion access, from the perspectives of multiple stakeholders. The findings will likely be of value to researchers and activists both inside and outside of Turkey.

1.3 Objectives

My thesis aims to explore two central research questions.

1) What are the experiences of women who have obtained an induced abortion in Istanbul on or after January 1, 2009? Are there significant differences in

the experiences of women who obtained their abortion after the proposed abortion restriction in mid 2012?

2) What are the perspectives of key informants toward current abortion availability and accessibility in Turkey?

1.4 Thesis outline

My manuscript is a thesis by articles. Chapter one offers a general introduction to the background of Turkey and provides a review of the relevant sexual and reproductive health literature. The introduction also provides the rationale for the project, the main study objectives, and an outline for the thesis. Chapter two describes the methodology of my thesis and includes a detailed description of the study location and the data collection and analytic approach.

Chapter three is the first of three articles that have been submitted for publication. My first article focuses on the current political and social dynamics surrounding Cesarean section (C-section) provision in Turkey. Entitled, "C-Section as a nefarious plot: The politics of pronatalism in Turkey" this article will be published in a forthcoming edited volume entitled *Abortion pills, test tube babies, and sex toys: Emerging sexual and reproductive technologies in the Middle East and North Africa* (Vanderbilt University Press). This article explores how the recent restriction on C-section provision is motivated by a broader pronatalist agenda that aims to increase the Turkish population at the expense of women's reproductive rights.

Chapter four is dedicated to my second article, entitled ""It was as if society didn't want a woman to get an abortion": A qualitative study in Istanbul, Turkey." This article focuses on women's lived experiences obtaining abortion services in Istanbul. We provide insights into multiple aspects of abortion care including the wait time, cost, quality of care, and experiences with stigma. This article has been formatted for and was submitted to the peer-reviewed journal *Contraception* in May 2016.

Chapter five, my third and final article, is an integrated piece about the findings from both the in-depth and key informant components of the study. It is titled "Politics, policies, pronatalism, and practice: Availability and accessibility of abortion and reproductive health services in Turkey". The final article has been formatted for and was submitted to the peer-reviewed journal *Reproductive Health Matters* in May 2016.

In Chapter six, I integrate the results of the three articles and discuss the significance of the findings. I also include a section about the important of positionality and reflexivity in my work and a discussion of how reproductive justice informed the overall project. Next, I outline the limitations of the study and provide a statement of contribution describing the key contributors to this project. The discussion ends with a conclusion section, and the references and appendices follow.

Chapter 2: Methods

2.1 Study population

Turkey has a population of 75 million and the living conditions of its population vary dramatically across the country. The coastal regions along the Aegean, Mediterranean, and Black Sea tend to be more developed; inland Anatolia has a largely rural and generally more politically and religiously conservative population. This particular study aimed to understand better the experiences around obtaining abortion and reproductive health services in Istanbul.

We decided to centralize our study efforts in Istanbul for a number of reasons. First, Istanbul is the largest city in Turkey and provided ample recruitment opportunity for eligible participants and key informants. It has the highest abortion rate of anywhere in the country, and public and private health institutions are prevalent throughout the city. There are also a number of relevant organizations based in Istanbul including local offices for the Ministry of Health and the Turkish Society of Obstetrics and Gynaecology. Second, the residents of Istanbul are representative of a wide range of educational, socioeconomic, cultural, ethnic, and religious backgrounds. We hoped to recruit a diverse set of participants and capture a wide range of women's experiences. Finally, we anticipated that Istanbul would probably be one of the easiest places in the country for women to obtain abortion. It is highly urbanized, health care service providers are plentiful, and it is arguably one of the most liberal parts in the country. We believed that in studying women's experiences in Istanbul, we would likely illustrate one of the best case scenarios for

abortion access in Turkey. Thus, this study offesr a good starting point to identify current challenges and barriers, and highlight the need for further research in different regions of the country.

2.2 Methodology

Given the scope and aims of the study, this research project utilized a qualitative methodological approach. Our primary objective was to understand better women's lived experiences obtaining SRH services and abortion care; in-depth interviews allowed us to capture a rich range of experiences. We used a semi-structured interview guide to allow for flexibility thereby creating a more organic discussion that was responsive to participants. In doing so, new themes that we had not necessarily anticipated emerged over the course of the data collection process.

It is also common to apply a qualitative approach when studying human experiences that have not previously been studied in-depth. When we undertook this study, there was little to no existing scientific literature exploring women's experiences obtaining abortion care in the Turkish context. A qualitative approach meant that we could enter our data collection process without any preconceived hypotheses and would allow women's experiences to speak for themselves.

The qualitative study consisted of two major components. First, I completed in-depth interviews (IDIs) with eligible women who obtained abortion services in Istanbul anytime on or after January 1, 2009. Second, I carried out key informant (KI) interviews with individuals who were well positioned to discuss SRH and abortion services in Istanbul. These informants held a range of professional

backgrounds and included obstetrician/gynaecologists, women's rights advocates, nongovernmental organization (NGO) representatives, academics, and pharmacists.

A fundamental tenet of good qualitative research is consideration of one's own positionality within the context of a study. That is, I had to actively consider what unique dynamic I contributed to the study, both as an outsider and a woman. I engaged in memoing throughout the data collection process to reflect on how my positionality may have affected the interviewing and data analysis processes. In addition to considerations of positionality, memoing also serves as a useful analytic tool. Through memoing, the researcher will reflect on elements from interviews that are surprising or come up repeatedly, thus allowing the researcher to begin identifying emergent findings from the data.

2.3 Data collection

I carried out data collection in Istanbul between May and August 2015. The following section details the data collection process for the in-depth and key informant interviews.

2.3.1 In-depth interviews

I conducted in-depth interviews with 14 eligible women during the data collection period. We used purposive sampling in order to reach out to eligible women. In order to be eligible, women had to be over the age of 18 and must have obtained an abortion in Istanbul on or after January 1, 2009. We recruited participants using a variety of strategies. I reached out to several women's rights,

gender research, and abortion advocacy organizations based in Turkey. A number of these organizations disseminated information about the study, mostly through online platforms such as Facebook and Twitter. I also worked closely with a reproductive health NGO in Istanbul; they directly approached eligible women on my behalf and invited them to participate in the study.

Before beginning the interview process, we explained to participants the purpose of the study and provided them with a detailed consent form. We provided this information via e-mail and/or in person prior to the interview. We provided consent forms in either Turkish or English according to the preference of the participant. At the start of the interview, we went through the consent form together and I obtained verbal consent. Upon obtaining consent, I also provided 20 Turkish Lira to each participant as a token of our appreciation. All but one participant consented to audio-recording. In the instance where I was unable to audio-record, I took extremely detailed notes throughout the duration of the interview and completed a memo immediately following the interview.

I conducted the majority of the interviews face-to-face in a location chosen by the participant. I interviewed several women in their own homes, while other women chose to complete the interview in another comfortable location such as a local tea garden. I conducted two interviews over the phone for the convenience of the participant. Interviews typically lasted between sixty and ninety minutes and were conducted in English or in Turkish with the assistance of an interpreter. Interview questions centered around the woman's general background, her reproductive health history, the circumstances surrounding the unplanned

pregnancy/pregnancies, the process of obtaining the abortion, ways of improving abortion care in Istanbul, and her perspectives about the current political dialogue towards women's reproductive rights in Turkey.

Upon completion of the interview, I uploaded the audio files onto a password-protected Dropbox and wrote a short memo reflecting on the interview. Memoing allowed me to consider my own influence on the data collection process while simultaneously identifying content and themes that were frequently arising during the course of the interviews. The audio files were later used to transcribe and translate the interviews.

2.3.2 Key informant interviews

I conducted 11 key informant interviews with relevant professionals working in Istanbul. Informants came from a wide range of educational and professional backgrounds and included obstetrician/gynaecologists, NGO representatives, human rights lawyers, academics, and pharmacists. I purposively identified and recruited potential key informants prior to my travel to Istanbul. I did so primarily by searching online for various organizations and health service providers. I also reached out to personal contacts I had established while living in Istanbul. In addition, Dr. Mary Lou O'Neil, my collaborator at the Kadir Has Gender and Women's Studies Research Center, provided valuable insight about possible stakeholders to approach. I also recruited several of my key informants through early participant referral (snowball sampling).

Recruiting specific demographics of key informants proved to be very challenging. Despite repeated efforts, I was unable to procure interviews with municipal political figures and government employees such as those employed by the Ministry of Health or the Sosyal Güvenlik Kurumu (SGK), the Turkish Social Security Institution. Public sector doctors were also very difficult to contact and schedule times to speak.

I conducted the majority of the interviews at the interviewee's place of work during regular business hours. Interviews lasted an average of forty-five minutes. I provided informants with a copy of the consent form via email prior to the interview and obtained verbal consent at the beginning of the meeting. All informants consented to audio-recording. Eight interviews were completed in English, while three interviews were conducted in Turkish with the assistance of an interpreter.

The key informant interviews included questions about educational and professional background, knowledge about reproductive health services available in Turkey, knowledge about the current abortion law, opinions about the acceptability of the current abortion law, and opinions about whether access to abortion and other reproductive health services has changed in the last five years. Where relevant, informants were also asked about the availability of other reproductive health services, including contraception, emergency contraception, medication abortion, and C-sections. Finally, I asked informants to provide recommendations about how reproductive health and abortion services in Istanbul could be improved.

I took detailed notes while conducting each interview and upon completion of the interview, I wrote a brief memo reflecting on the interaction. Memoing also

served as a starting point to identify recurring content and emerging themes. Finally, I transcribed the English key informant interviews verbatim, while the interpreter transcribed and translated the Turkish interviews into English.

2.4 Data analysis

I conducted content and thematic analysis of my qualitative data. I began the analytical process by conducting an initial review of all of my data, including notes, memos, and transcripts. As I completed this preliminary overview, I took additional notes and developed a codebook of *a priori* codes based on the interview guide and the general content of the transcripts. I used ATLAS.ti software to manage and code all of my qualitative data throughout the analytic process. I coded the interviews using an iterative approach, developing new codes as I analyzed the data. As new codes emerged, I went back to earlier transcripts and recoded them accordingly. Once the first level of coding was complete, I engaged in second and third level data analysis. Second level analysis involved grouping smaller units of data into categories and identifying recurring content that emerged throughout the interviews. During the third level of analysis, I used the codes and categories to identify major themes that were representative of the data. In the final stage of analysis, I aimed to determine concordance and discordance of findings. Specifically, I reviewed themes to establish any similarities or differences between women's experiences based on marital status and whether they had obtained their abortion before or after May 2012 (the proposed abortion restriction). I also compared my in-depth interview and key informant findings to look for any

concordant or discordant themes. Throughout the iterative process, I determined that thematic saturation had not been achieved on all aspects of the interview guide.

Discussions with members of the study team took place throughout the study and influenced my interpretation. When I was in the field, I regularly debriefed with my research assistants, a process that helped refine future interviews and served as an initial step in identifying themes and establishing thematic saturation within the in-depth interviews. In Turkey, I also met regularly with Dr. O'Neil, which helped place some of my early findings, particularly with key informants, in context.

I also debriefed regularly with my supervisor while I was in the field. These discussions resulted in some early changes to the interview guide and aided in the overall analytic process. These discussions continued when I returned to Ottawa and I received feedback on the various phases of my analysis. Regular meetings guided my interpretation and we resolved differences through discussion.

2.5 Research ethics

This study received ethics approval (File #02-15-05) from the Social Sciences Research Ethics Board (REB) at the University of Ottawa. The REB letter of approval can be found in Appendix B. There are no research ethics boards for social sciences research at Turkish institutions, however we obtained written approval from Kadir Has University, our local affiliate in Istanbul, that the study adhered to local ethics protocols. In order to protect the confidentiality of our participants, full names were never recorded on the consent forms and any and all identifying information is removed or masked in this thesis and other publications.

Chapter 3: Article #1
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Chapter 9

C-Sections as a Nefarious Plot

The Politics of Pronatalism in Turkey

Katrina MacFarlane

The Rise of the Cesarean

Since the advent of its use in the nineteenth century, the Cesarean section (C-section) has been a cornerstone of maternal and neonatal health. Although the origins of the Cesarean date back well before the 1800s, the procedure became largely successful at decreasing maternal and infant mortality only toward the latter half of the nineteenth century, with the onset of medical techniques such as stitching the uterine incision and providing anesthesia during the procedure (Van Dongen 2009). As physicians developed new strategies to limit sepsis during surgery, maternal mortality associated with the C-section continued to drop in the early twentieth century. The common thread during its early historical use was that the C-section was a last resort, medically indicated only when the dangers of a traditional vaginal delivery far exceeded the risk of a Cesarean. To this day, C-section remains the optimal mode of delivery in cases where vaginal delivery is risky or not possible, as in cases of abnormal fetal position, fetal distress, or prolonged labor (World Health Organization 2015a).

What originally emerged as a life-saving procedure has evolved a complex and multifaceted social, cultural, and political identity in the twenty-first century. The Cesarean is considered underutilized in some regions, most notably in sub-Saharan Africa, where it often represents less than 5 percent of all deliveries (Gibbons et al. 2010). Simultaneously, Cesareans represent half or more of all deliveries in countries such as Brazil and Turkey. Italy, China, and Iran have also reported significant overuse of the medical procedure. By the mid 2000s, the C-section was the most commonly performed surgery among women in the United States (DeFrances and Hall 2007). The resulting dichotomy of provision suggests that Cesareans are no longer deemed an

emergent medical procedure by much of the world, and in some contexts they are used electively, on the basis of the physician's preference, the woman's preference, or both. The use of the procedure, which still represented a minority of deliveries internationally into the early 1990s, has grown at an unprecedented pace across many developed and developing nations in the last two decades.

Although a C-section can be medically indicated for a number of reasons, increased maternal and neonatal health risks are associated with Cesarean provision; neonatal respiratory problems, for example, are more common after a C-section delivery (Ramachandrappa and Jain 2008). Further, complications tend to increase with multiple pregnancies; complications increase in vaginal birth after Cesarean section (VBAC), and repeat C-sections come with increased incidence of uterine rupture, placenta accreta, and placenta previa (Boutsikou and Malamitsi-Puchner 2011). As a result, clinicians and policy makers around the world have called for countries with a high C-section prevalence to decrease Cesarean provision and have discouraged the performance of elective—that is, not medically indicated—C-sections (World Health Organization 2015a). Until recently the World Health Organization (WHO) recommended a Cesarean prevalence of 5 percent to 10 percent, with an upper limit of 15 percent, to optimize maternal and child health (World Health Organization 1985).

Another vital consideration is cost. C-sections are generally more expensive to provide than vaginal delivery; therefore nations that provide substantial numbers of Cesareans require additional funding for a medical procedure that, in many cases, is not needed (Gibbons et al. 2010). Although some researchers argued that the 10 percent to 15 percent target is not optimal, or even realistic, to achieve, recent studies with an emphasis on maternal and neonatal health outcomes have supported these findings and suggest that international public health programs should aim to lower C-section provision to below 15 percent or to maintain it below that level (Althabe and Belizán 2006).

Countries have tried to combat the increasing trend in a variety of ways. As new findings demonstrate that the majority of women can have successful and safe vaginal deliveries even with a previous C-section delivery, some countries, such as the United States, have revised obstetrical guidelines to encourage more women to pursue VBAC (O'Callaghan 2010). There are also educational measures in place for physicians and patients to decrease the incidence of first-birth C-section in low-risk pregnancies. Once a

woman has a primary C-section delivery, she is more likely to have a C-section for subsequent deliveries, so this represents an important area of intervention to decrease the overall Cesarean rate (American College of Obstetricians and Gynecologists 2014a).

Some nations, like Brazil and Turkey, have faced major cultural, medical, and systematic challenges while trying to curb the rising Cesarean trend. Cultural attitudes toward C-section have shifted and become deeply ingrained, particularly in the private sectors of health care. In Brazil, for example, vaginal delivery is looked down on as a mode of delivery for the poor; Cesareans are associated with wealth and privilege (Nolen 2015; Raifman, Cunha, and Castro 2014). Turkish and Brazilian physicians alike reportedly do not want to deal with the inconvenience of spontaneous vaginal deliveries and often pressure women into C-sections. While these two countries have experienced similar trends and challenges in Cesarean provision, the political landscape surrounding C-section in Turkey has created a unique set of challenges mirrored nowhere else in the world.

I lived in Istanbul from 2011 to 2014, when public perceptions around C-sections became openly contentious. During that time there was a complex interplay between national pronatalist goals and the preservation of women's reproductive autonomy. Scientific literature and media accounts over the last decade suggest that Turkey has been propelled by a deeply rooted ideology in support of nationalistic population growth. Turkish politicians have strongly petitioned their public for an increased birth rate, claiming it necessary in order to ensure a thriving economy and resilient national identity well into the twenty-first century. What is fascinating is how these politically minded goals have directly and specifically affected women's reproductive autonomy, including the right to obtain a C-section.

C-section deliveries, which accounted for only 8 percent of all births in Turkey in 1993 (TDHS 1993), have increased astronomically over the last two decades. By 2011, 48 percent of all deliveries in Turkey were via C-section (Yinanç 2012), with some private hospitals reporting rates of 70 percent (Üzüm 2012). This rapid increase has caused concern among Turkish leaders, although not for any of the reasons raised by WHO or maternal-child health advocates. Since 2012, C-sections have nearly been likened to abortion by Turkish political figures. They are seen as a serious threat to the pronatalist political endeavors of the governing party because they seemingly limit the

number of children a woman can bear, and legal restrictions have since been imposed on their provision. The Turkish minister of health also publicly stated at the end of 2014 that women do not have the right to request a Cesarean delivery, calling into serious question the rights to individual decision-making that women have in Turkey. C-sections are far from a novel medical procedure, but the twenty-first–century Turkish dialogue about them is entirely new.

The Cesarean Section in Turkey

Turkey has been one of the most extreme examples of a dramatic upward trend in C-section prevalence. In 1990 Cesareans accounted for 7.1 percent of all births in Turkey, and by 2001 reports indicated that C-section prevalence was 27.7 percent (Koç 2003). According to the Turkish Demographic and Health Survey, the rate reached 36.7 percent in 2008 (TDHS 2008). By 2012, *Sosyal Güvenlik Kurum*, the Turkish social security system, reported that more women were giving birth via Cesarean than not (Today's Zaman 2013), with C-sections accounting for just shy of 51 percent of all publicly funded births.

It is also noteworthy that there are significant disparities in Cesarean provision in Turkey, both geographically and between the private and public health sectors. By 2013, 66.3 percent of all deliveries in the West Marmara region were via C-section, whereas more rural southeast Turkey had a prevalence of 32.1 percent (TDHS 2013). Cesarean delivery is associated with higher levels of education and higher socioeconomic status (TDHS 2008); it follows, then, that the highest prevalence of Cesareans recorded in Turkey is along the more developed Marmara, Black Sea, Mediterranean, and Aegean coasts. Not only does provision vary enormously across the country, but one study demonstrated that the prevalence of C-section is up to 1.7 times higher in private than in state hospitals (Akarsu and Mucuk 2014). The Ministry of Health has also reported that up to 70 percent of births in some private and university hospitals are via Cesarean (Letsch 2012).

The rapid growth in C-section prevalence in Turkey has been attributed to many factors, including the growth of the private health sector within the last ten years under the Adalet ve Kalkina Partisi (AKP)—the Justice and Development political party, which

currently holds a majority in the parliamentary government. Although the literature is not sufficient to determine whether Turkish privatization has had any causal impact on C-section prevalence, similar trends have been noted in other countries. In Peru, health-care reform in the private sector was associated with an increase in C-section prevalence from 28 percent to 53 percent, theoretically because it created financial incentives to provide C-section instead of vaginal delivery (Arrieta 2011). Many speculate that shifting attitudes and perspectives of Turkish clinicians are also driving the increase. In a 2007 study by Koken and colleagues, 51.9 percent of Turkish female clinicians surveyed preferred to provide C-section delivery, but reasons for the preference were not determined in this study. Later studies by Atan and colleagues (2013) have revealed even more significant physician preference, with 72 percent of clinicians favoring C-section delivery. In line with these findings, Akarsu and Mucuk (2014) more recently found that 68.6 percent of women revealed that Cesarean was their doctor's preference, while only 13.4 percent of women indicated it as a personal preference.

This all suggests that regardless of motivation, there is a strong inclination for Turkish practitioners to preferentially employ Cesarean delivery. Researchers and government officials have speculated it may be because it is more convenient and time-effective for a clinician to provide a scheduled C-section than to oversee a spontaneous vaginal delivery. There may also be financial motivations for physicians; historically, it has been more lucrative for Turkish practitioners to perform a Cesarean rather than a vaginal delivery, and Turkish health officials have openly expressed their concerns that physicians may pressure women into Cesarean delivery to increase their own earnings (Hacaoğlu 2012). Liability is also a concern among Turkish clinicians, as there have been costly lawsuits in cases where vaginal births did not have optimal maternal or child health outcomes (Üzüm 2012). Decision-making around mode of delivery should also be considered. Although some countries like Italy guarantee the woman the right to take part in all decisions regarding her own pregnancy and delivery, Turkish regulations state that it is the obstetrician or midwife, not the woman, who holds decision-making power with respect to mode of delivery (Atan et al. 2013). Many women delivering in a private Turkish hospital said that they had a preference for vaginal delivery, and they had to actively dissuade their obstetricians from performing a Cesarean. Some women receive a C-section despite repeated insistence on vaginal delivery.

This is not to underestimate the role that women's decision-making has contributed to the upward trend of Cesarean provision. Certainly as Turkey has developed economically, a larger proportion of women are seeking a C-section when one is not medically indicated. One study in 2003 found that 7.8 percent of women indicated that a C-section was their personal preference (Koç 2003). More recent studies suggest that the rate of Turkish women seeking elective C-sections is upward of 10 percent (Akarsu and Mucuk 2014; Atan et al. 2013).

There are a host of factors associated with the increased use of C-sections in recent years, including health-care reform and privatization, clinician training and preference, and patient preference. As the Cesarean rate in most developed countries either stabilizes or continues to climb, nongovernmental organizations, governments, and health-care providers are collectively supporting measures to lower C-section prevalence in countries that exceed the WHO recommendation. Turkey has been no exception. However, the Turkish government's efforts to curb C-section provision have had little to do with health equity or public-health outcomes and more to do with demographic aspirations. To fully contextualize the modern-day conversation around C-section provision in Turkey, it is necessary to consider Turkey's historical policies toward family planning and population growth.

A Historical Pronatalist Tradition

The Ottoman and Turkish states have a long-standing tradition of using women's reproductive rights and freedoms as pawns in their pursuit of a desired political agenda. This can be seen in overarching historical attitudes toward family planning. A prime example involves abortion in the Ottoman context. Although abortion had long been considered permissible under Hanafi Islamic jurisprudence and was practiced widely when the Ottoman Empire was powerful, the Ottomans banned abortion in 1848. This shift is most commonly attributed not to any religious motivations, but to a rise in pronatalist ideology, which aimed to preserve Muslim population growth in a declining empire (Gürsoy 1996).

Similar motivations inspired the early Republic of Turkey, established in 1923. On the heels of a collapsing Ottoman Empire and the catastrophic loss of Turkish lives in

World War I and the Turkish War of Independence, the Republic enforced strict limitations on family planning, banning both abortion and contraception in 1930. In the Atatürk era, encouraging Turkish population growth stood at the forefront of efforts to establish and preserve a national identity.

When the 1960s brought a massive and systematic introduction of family planning and contraception throughout the nation, the women's rights movement had little to do with it. Rather, the Turkish government was concerned that excessive population growth would hinder sustainable economic development, so the intrauterine device was distributed free of charge, and oral contraceptives were legalized (Özbay and Shorter 1970). In 1983 abortion without restriction as to reason, with spousal consent, was legalized in Turkey through the tenth week of pregnancy.

The primary motivations for abortion liberalization were twofold. First, Turkey reportedly had ongoing population control objectives. Second, the minister of health and social welfare was gravely concerned about the high maternal mortality ratio (MMR), much of which was attributed to unsafe and illegal abortion. Gürsoy (1996) points to studies estimating that prior to 1983 some 25,000 Turkish women were dying annually from unsafe abortions and inadequate miscarriage management. The estimated MMR of Turkey was 251 per 100,000 live births in 1980. Legalization of abortion was an easy way to tackle an otherwise complex public health problem. By 1990 the MMR had fallen to 121 (Hogan et al. 2010). Yet the legalization of abortion without restriction in 1983 was not cause for celebration among women's activists. Instead, feminist groups condemned the policy change, arguing that decision makers had not liberalized abortion because of any intrinsic concern for women's autonomy and reproductive justice, but were motivated by demographic and population planning objectives (Gürsoy 1996). They worried that the ideological motivations behind liberalization set a dangerous precedent for the ongoing negotiation of women's reproductive health for the sake of larger demographic, social, and political motives.

Modern-day Turkey has upheld this historical tradition. Perhaps more than ever, population planning policy has been used to promote the political and economic ambitions of the state. The current governing political party has systematically targeted women's reproductive freedoms while espousing the importance of pronatalism for the future of Turkey, and Cesarean sections have been just one piece of the puzzle. The

current president of Turkey, Recep Tayyip Erdoğan, has repeatedly shared his belief that C-section delivery diminishes the reproductive capacity of each woman and therefore interferes with his future political and economic ambitions for the nation. With that in mind, Turkey started taking a decidedly political approach to this public health dilemma in 2012.

Politicization of the Cesarean in Turkey

President Erdoğan, elected in 2014 after serving as prime minister from 2003 to 2014, has been the most influential and enduring political voice of Turkey in the twenty-first century. As the political leader of the AKP, Erdoğan has undertaken striking policy reform in virtually all sectors, including health, education, and the economy. One of his more vocal aspirations has been for an ever more economically and politically powerful Turkey. During his decade-plus in power, Erdoğan has preached the significance of procreation and, on multiple occasions, has publicly encouraged women to have a minimum of three children (Hürriyet Daily News 2013), in the hopes of solidifying Turkey's place as one of the top ten world economies by 2023. As Evangelia Axiarlis, a specialist in Turkish politics, explained:

> As a conservative democratic party, the AKP has emphasised the importance of traditional family values and its support for a higher birth rate. In fact, the party espouses a pronatalist policy at the highest level; Prime Minister Erdoğan has repeated his call for Turkish couples to have at least three children, in order to boost the economy and offset the effects of an ageing population. (2014, 87)

The effect of the AKP's pronatalist platform has primarily revealed itself via increasing infringement on Turkish women's reproductive rights, all with the overarching aim to increase the fertility rate in Turkey and ensure continued population growth.

In 2012, the AKP leadership initiated a multidimensional and concentrated strategy to support their pronatalist ideology. At a rally on the afternoon of May 25, 2012, Erdoğan openly condemned both abortion and Cesarean sections:

> We are very sensitive about children in Turkey. I love children. In my country I want at least three children for each family. Because I know that we need a young and dynamic population. . . . I declare openly that I am a prime minister who is against delivery by caesarean section. I consider abortion as murder. Killing a child in the body of a woman is no different than killing him after the birth. We should stay together to oppose this. (Arsu 2012)

Minister of Health Recep Akdağ also emphasized in his public discourse that Cesareans would limit the overall reproductive capacity of women: "A woman who gives birth by caesarean method should benefit from the same method for the second and third deliveries. In most cases, doctors do not even recommend a third child" (Badamchi 2014). Akdağ also revealed his belief that the increased rate of C-section was due to "the existence of avaricious doctors and the tendency among women to take the easy way out when giving birth" (Üzüm 2012). On May 29, 2012, just days following Erdoğan's public proclamation equating abortion with murder, Erdoğan and Akdağ announced their ultimate goal of severely restricting access to both abortion and Cesareans. Two bills were drafted to limit both medical procedures, with very different eventual outcomes. Thousands of women protested the anti-abortion bill in major cities across Turkey, including Istanbul, Izmir, and Ankara; ultimately, the government succumbed to immense public pressure and the proposed legislation was dropped. The amendment to limit Cesarean provision, however, was passed by the Turkish parliament and signed into law on July 4, 2012.

It is fairly intuitive that a political leader like Erdoğan who preaches familial abundance would take issue with abortion. Sure enough, Erdoğan explicitly linked abortion to his pronatalist and economic policies, stating that abortion was a "sneaky plan to wipe the nation off the world stage." (Hacaoğlu 2012). What was perhaps more surprising about the AKP's initiative was the political affront against Cesareans, a delivery procedure that is often vital for preserving the health of both mother and child. Atil Yüksel, head of the Istanbul branch of the Turkish Society for Obstetrics and Gynecology in 2012, highlighted a key concern with the AKP rhetoric around Cesareans: "A politician or a leader responsible for the country's administration has the right to be troubled by the 48-percent rate of births by Cesarean section and question it. But the language he used is important: He said Cesarean sections were 'murder'" (Yinanç 2012). Furthermore, Erdoğan never made any indications that his efforts to curb C-section

provision were motivated by public health concerns. His public rhetoric has overwhelmingly revolved around the concern that women delivering via C-section would have fewer children. In 2013, Erdoğan spoke at a "To Be a Family" convention in Ankara and reiterated his perceptions about the implications of a lower birth rate:

> They operated birth-control mechanisms for years in this country. They nearly castrated our citizens, our people going as far as using medical procedures. This is what cesarean section is all about. While they were doing that, it was like committing murder. They fooled people. . . . But their goal was different. Their objective was to reduce the population of this nation and for this nation to lag behind in the competition of nations. (Gursel 2013)

Rather than being the subject of a dialogue about increased health equity or improved outcomes, C-sections have become a political flashpoint in a greater Turkish debate.

The Cesarean Restriction and Its Aftermath

In July 2012, the General Public Health Law No: 6354, article 153 was amended to include the following: "Birth by C-section can be performed in case it is determined to be medically required for the mother or the baby." (İstanbul Tabip Odası 2012). According to the Turkish Society for Obstetrics and Gynecology, clinicians are no longer supposed to perform elective C-sections, and the law stipulates that doctors can be fined up to 1,000 TL (US$370) for providing a Cesarean when it is not medically indicated (Letsch 2012). Turkey is the first and only country in the world to have introduced a legal restriction of any kind on C-section provision. Shortly after the law passed, Yüksel remarked in an interview with the *Hürriyet Daily News* "I am not in favor of a law. It is unheard of in the world to regulate medical operations like Caesarean sections by law. This is not seen elsewhere in the world and it is not right. We could have come together to devise other models to decrease the rate." (Yinanç 2012).

Yüksel's sentiments were echoed by other clinicians, women's rights organizations, and the opposition political party. In October 2013 the Cumhuriyet Halk Partisi, Turkey's main political opposition party, requested that the C-section law be struck down on the grounds that it was unconstitutional. The high court ruled that it does not violate constitutional rights, and as of mid-2015, the law remains in place (Hürriyet

Daily News 2013). And although legal enforcement of this legislation is challenging, the political dialogue around C-sections is more prominent than ever. In December 2014 Minister of Health Mehmet Müezzinoğlu sparked controversy when he announced that a woman has the right to request vaginal childbirth, but she has no right to request an elective Cesarean: "The doctors' job is to fulfill their medical responsibilities, not to follow the patients' demands. Doctors must give the medical services that the patients have right to, the C-section is not one of those rights" (Yılmaz 2014). Müezzinoğlu also highlighted that increased monitoring of Cesarean provision would be a priority in 2015. The Ministry of Health contacted individual doctors who provide a high proportion of Cesarean deliveries, and reports suggest that the government intends to enforce sanctions against clinicians who provide a substantial number of C-section deliveries (Yılmaz 2014).

Despite the fact that the law has not yet been rigorously enforced, many other simultaneous measures have been employed to reduce C-section rates. Alongside new legislation, Turkey has carried out ongoing media campaigns to promote vaginal delivery to women (Today's Zaman 2012). One study about Turkish women's perspectives of vaginal birth and Cesarean found that of participants who had followed news and media about pregnancy, 92 percent had seen news or media that advised spontaneous vaginal delivery (Atan et al. 2013). The same study also found that other avenues for pregnancy and perinatal information, including family, media, and health practitioners, also overwhelmingly (70 percent) advised vaginal delivery compared to C-section (21 percent).

The Turkish Ministry of Health has also modified the funding scheme for both types of deliveries in the hopes of providing an added incentive for physicians to oversee vaginal deliveries rather than perform C-sections. In 2012 the Turkish social security system decreased state funding per Cesarean to 475 TL (US$176) while simultaneously raising the funding for vaginal delivery to 400 TL (US$148) (*Today's Zaman* 2012).

The Future of Pronatalist Turkey

It is difficult to fully ascertain the implications of the C-section law passed in 2012. Although anecdotal evidence suggests that Turkish women are still able to procure C-

sections fairly readily, particularly in private hospitals, the rhetoric surrounding the policy remains alarming. This law, along with several other moves by the AKP administration, suggests that a Turkish woman's reproductive autonomy is always under negotiation and rarely prioritized.

Since 2008, the AKP has unabashedly and repeatedly supported a pronatalist agenda. Most recently Erdoğan, while attending a notable Turkish wedding, publicly advised the young newlywed couple against using any form of contraception, claiming that it would be considered treason to the nation (Hürriyet Daily News 2014). Erdoğan's administration has made clear its disapproval of contraception of any kind and has imposed a number of barriers to family planning and abortion services since 2012. First, the medication abortion drug misoprostol was removed from pharmacies across Turkey (Moraitis 2012). This was particularly concerning, as misoprostol is not used exclusively to induce abortion but has several other indications for use. Misoprostol is listed as a World Health Organization essential medicine, and its uses include the prevention and treatment of postpartum bleeding, management of miscarriages, and induction of labor (WHO 2015b). Misoprostol can still be dispensed in a hospital setting, but the removal of the drug from pharmacies is troubling. Misoprostol was the primary medication abortion drug available in Turkey, and more than half of ob-gyns surveyed in one study had provided abortion care using this medication (Akin et al. 2012). Although most women in Turkey do not opt for medication abortion, the removal of misoprostol nonetheless signaled the government's plan to gradually curtail women's reproductive options. Erdoğan had also previously spoken out against the use of emergency contraception (Banco 2014), and in 2014, dedicated levonorgestrel emergency contraception pills were removed from Turkish pharmacies (European Consortium for Emergency Contraception 2015). Ulipristal acetate (UPA), an alternative emergency contraception pill, has since been introduced in Turkey; however UPA is sold for 49 TL compared to the previously available Norlevo®, which was available for only 17 TL.

The increasingly restrictive environment toward abortion is also indicative of the government's pronatalist policies. Although the proposed abortion-restrictive legislation was not passed by the Turkish parliament, the government has nonetheless applied informal measures to limit women's access to pregnancy termination. As of February 2015, only three out of thirty-seven state hospitals in Istanbul were willing to provide an

abortion upon request in cases where it was not medically indicated (Letsch 2015). Devrim Badamchi, an expert in political science at Izmir University, conducted a discourse analysis of 2012 Turkish public rhetoric around C-section and abortion. She highlights how Erdoğan has inextricably linked abortion, C-section, and pronatalist values:

> Erdoğan invokes two main arguments. . . . The first is concerned with the reproduction of political society over time, in his reference to the importance of a young population for Turkey. In this sense, he also brings in the issue of caesarean delivery as a bad practice for a society that is in need of a young population. In Turkey, opposition to caesarean deliveries is part of the abortion debate due to the heavy emphasis that is put on the need to reproduce as a society. There is a common belief among some in the pro-ban camp that caesarean sections lead to fewer children being born. (Badamchi, 2014)

Although the government's approaches toward restricting contraception, abortion, and Cesareans have been varied, there is a shared motivation underlying the consecutive assaults on reproductive choice, and pronatalism has been emphasized above all other values.

Conclusion

Turkish women feel strongly about the preservation of their rights. In 2012 they took to the streets across the country to protest proposed legislation and safeguard their abortion rights. Turkish women also feel strongly about their right to decision-making around pregnancy and delivery. The vast majority of women (88 percent) in one study agreed that women deserve the legal right to decide on the mode of delivery (Atan et al. 2013). The core ethical question raised by the Cesarean debate is this: should public policy prioritize individual choice or population-level intervention? What is considered an elective C-section, and should a woman's preference alone be sufficient for a C-section delivery? Thus far there is no global consensus. Despite high rates in Cesarean provision, some countries, like Italy, guarantee by law that women have the right to choose their mode of delivery (Muula 2007). The American College of Obstetricians and Gynecologists (2013) advises vaginal birth in the absence of maternal or fetal health indications but does maintain that women may request C-sections after thirty-nine weeks

gestation. A study with obstetricians across Western Europe showed that when given a fictional case study, 79 percent to 97 percent of clinicians who agreed to perform a C-section upon maternal request cited respect for autonomy as their primary reason (Nilstun et al. 2008).

Yet the ongoing conversation about the 15 percent optimal rate of C-section deliveries tends to undermine the fundamental ideal that women should have the right to make their own decisions about mode of delivery, regardless of population-level interventions aimed at lowering the C-section rate. It is also questionable whether the 15 percent upper limit on Cesareans makes sense for every country when there are rapidly changing social, political, and cultural values at play that collectively determine whether a woman or clinician may prefer a C-section delivery. Universal targets like the 15 percent limit can also be misinterpreted or misused. In 2012 Turkish Minister of Health Akdağ cited this statistic from the World Health Organization to garner support for the movement for Cesarean restrictions, a movement that was motivated by many factors other than women's health. Minister of Health Müezzinoğlu's 2014 statement that women do not have the right to request Cesareans is particularly troubling. It highlights the AKP's blatant disregard for a woman's right to autonomy around reproductive decision-making, not only when it comes to pregnancy prevention or termination, but during her pregnancy and delivery as well.

While most governments and international organizations continue to engage in a dialogue that revolves around a careful balance of benefit and risk to both mother and child, Turkey has openly prioritized state values above women's reproductive health. The AKP have made their case: a woman's right to reproductive autonomy is exceeded by her duties and responsibilities toward the state and its population ideologies.

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Chapter 4: Article #2

"It was as if society didn't want a woman to get an abortion": A qualitative study in Istanbul, Turkey

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"It was as if society didn't want a woman to get an abortion"
A qualitative study in Istanbul, Turkey

Abstract

Introduction: In 1983, abortion without restriction as to reason was legalized in Turkey. However, at an international conference in 2012 the Prime Minister condemned abortion and announced his intent to draft restrictive abortion legislation. As a result of public outcry and protests, the law was not enacted but media reports suggest that barriers to abortion access have since worsened.

Objectives: We aimed to conduct a qualitative study exploring women's recent abortion experiences in Istanbul, Turkey.

Study design: In 2015, we conducted 14 semi-structured in-depth interviews with women aged 18 or older who had obtained abortion care in Istanbul on/after January 1, 2009. We employed a multi-modal recruitment strategy and analyzed these interviews for content and themes using deductive and inductive techniques.

Results: Women reported on a total of 19 abortions. Although abortion is available in private facilities, only one public hospital provides abortion care which women found difficult to obtain. Women who had multiple abortions in different facility types described quality of care more positively in the private sector. Unmarried women considered their marital status when making the decision to seek an abortion and reported challenges obtaining comprehensive sexual and reproductive health services. All participants were familiar with the Turkish government's anti-abortion discourse and believed this was reflective of an overarching desire to restrict women's rights.

Conclusion: Public abortion services in Istanbul are currently limited and private abortion services are accessible but relatively expensive to obtain. Recent anti-abortion political rhetoric appears to have negatively impacted access and service quality.

Implications: This is the first qualitative study exploring women's experiences obtaining abortion services in Turkey since the proposed abortion restriction in 2012. Further research exploring the experiences of unmarried women and abortion accessibility in other regions of the country is warranted.

1. Introduction

Turkey has one of the most liberal abortion laws in the Middle East and North Africa and is one of only two countries in the region to permit abortion without restriction as to reason [1]. Although family planning was restricted for decades after Turkey's independence, contraception and abortion were legalized in 1965 and 1983, respectively. Advocates petitioned for abortion liberalization in large part to address the high maternal mortality ratio (MMR) [2]; by 1959, more than half (53%) of all maternal deaths in Turkey were attributed to unsafe, illegal abortion [3]. Following abortion legalization, Turkey's MMR declined from 251 per 100,000 births in 1980 to 121 in 1990 [4].

Turkey's Population Planning Law No. 2827 governs the legal status of abortion. The Law guarantees women the right to obtain an abortion without restriction through the tenth week of gestation. Unmarried adult women can independently obtain the procedure, while married women require spousal consent and minors under the age of 18 require parental consent [5]. Abortion can also be obtained through 20 weeks' gestation in cases of life endangerment, fetal anomaly, rape or incest [5-6]. The abortion rate in Turkey has declined steadily since the early 1990s but the procedure remains common; 14% of ever-married women report having obtained at least one induced abortion [7]. Provision patterns suggest that the majority of abortions are obtained from private sector health facilities and abortion prevalence tends to be higher in urban areas and the western region of the country; Istanbul reports the highest abortion rate [7].

Despite the positive maternal health outcomes associated with abortion liberalization, the right to abortion in Turkey has recently been threatened. At the 2012 International Conference on Population and Development, then Prime Minister Recep Tayyip Erdoğan announced his belief that abortion is murder and that he planned to severely restrict the abortion law by reducing the gestational age limit [8]. A bill drafted in 2013 aimed to limit abortions exclusively to hospital settings and allow physicians the right to deny services based on moral or religious grounds [9]. In light of these proposed restrictions, women's advocacy groups mobilized and protested in major cities across the country. Ultimately, no changes in the law were enacted. Yet Turkish women have reported a host of practical barriers to abortion access since 2012; recent research indicates that only one state hospital in Istanbul provides abortion irrespective of reason through 10 weeks' gestation [10]. Access to medication abortion has also recently been limited. Mifepristone, licensed in nearly 60 countries worldwide, has never been registered in Turkey and misoprostol, previously available in Turkish pharmacies, was restricted to hospital settings in 2012 [11].

While the government has condemned abortion on moral and religious grounds, its intent to restrict abortion appears motivated by a broader pronatalist agenda [12-13]. Since 2008, Erdoğan and other members of the Justice and Development Party (AKP) have repeatedly called for women to bear at least three children in order to grow the population and drive Turkey's economic growth [12-15].

Although the Turkish media has documented barriers to abortion access [10,16-17], the results of rigorous research have not been reported. This context motivated our

study to document both married and unmarried women's experiences obtaining abortion services in Istanbul. We were especially interested in exploring women's reflections on the Turkish government's threat to restrict abortion access and determine to what extent the government's anti-abortion rhetoric has impacted women's reproductive health experiences since 2012.

2. Methods

2.1. Study site

In the summer of 2015, we conducted in-depth semi-structured interviews with women in Istanbul, Turkey. Istanbul is a city of 14.6 million people [18] that lies at the crossroads of Europe and Asia and acts as a major economic and political hub. The GDP per capita of Istanbul is higher than the Turkish average at $24,867 [19], yet significant education and wealth disparities persist among its population. We chose Istanbul as our study site for the unique context it offers as a relatively liberal and diverse community in Turkey with an abundance of both public and private health care providers.

2.1. Data collection

We employed a multi-modal recruitment strategy that included engagement with social media, outreach via gender studies and reproductive health organizations, and early participant referrals. In order to participate, women had to be aged 18 or older at the time of the interview, have obtained abortion services in Istanbul on/after

January 1, 2009, and be sufficiently fluent in Turkish or English to complete the interview.

KM, a Canadian master's student in the Interdisciplinary Health Sciences program at the University of Ottawa, conducted all interviews with the aid of an interpreter (including DT) as needed. Our interview guide began with questions related to the participant's background, demographics, and reproductive health history. We then explored the circumstances surrounding the participant's terminated pregnancy/pregnancies, the process of obtaining abortion care, and her ideas about how services could be improved. In the final section we asked women about their opinions toward the current political climate surrounding abortion and reproductive health in Turkey. Our audio-recorded interviews lasted between 60 and 90 minutes. All participants received 20 Turkish Lira (approximately USD7.5) as a thank you. KM took detailed notes during and formally memoed immediately after each interview. The process of memoing allowed us to critically reflect on participant-interviewer-interpreter dynamics and identify emerging themes [20]. We later transcribed and translated into English (if needed) all interviews.

2.2. Data analysis

Our analytic approach was iterative, such that data collection and analysis occurred simultaneously. During her fieldwork, KM debriefed frequently with her supervisor (AF), a social scientist with extensive experience conducting reproductive health research in the Middle East, and MO, a gender studies scholar based in Istanbul,

a process that contributed to our initial understanding of the data. Using English transcripts, notes, and memos, we analyzed the interviews for content and themes and managed our data using ATLAS.ti. KM developed an initial codebook using *a priori* codes and categories based on the study objectives and the interview guide. We then defined and added new codes as we progressed through the analytic process [20-21]. Based on the coded data, we identified key themes and in the final analytic phase we explored the relationship between these themes and some of the key characteristics of our participants, including nationality, ethnicity, marital status, and year of abortion. Regular meetings between KM and AF guided our final interpretation.

2.3. Ethical considerations

Our study received ethics approval (File #02-15-05) from the Social Sciences and Humanities Research Ethics Board at the University of Ottawa. Throughout this paper we use narrative vignettes to provide a picture of the women we interviewed and quote participants to showcase central themes. We have masked or redacted all personally identifying information and use pseudonyms throughout.

3. Results

3.1. Participant characteristics

We conducted 14 interviews with women who had obtained abortion care in Istanbul. Ten of our participants were Turkish citizens and four were expatriates living in Turkey. Women's ages ranged from 21 to 44 and seven of our Turkish participants and

all of our expatriate participants had completed or were completing at least a bachelor's degree. At the time of the interviews half of our participants were unmarried and half were married (n=6) or divorced (n=1).

Since January 1, 2009, our 14 participants had obtained 19 abortions in Istanbul; three women had two abortions and one woman had three abortions. Three abortions were performed in a public hospital, eight were in private hospitals, and eight were in private clinics. All abortions were obtained within the first ten weeks of gestation and in 12 cases women were able to obtain the abortion within a week of making the decision. Five abortions were obtained before the attempted abortion restriction in May 2012 and 14 were obtained afterward.

[Figure 1: Burcu's Story]

3.2 Private sector abortion care is relatively easy to obtain but expensive

> I don't know, I kinda feel like it was such an easy process, like to contact the [clinic] and three days later, you're done. (Natalie, age 38)

Consistent with Burcu's story, women who went to a private sector facility overwhelmingly described the process of obtaining abortion care in Istanbul as "easy" or "straightforward." Women reported that scheduling was generally quick; six participants were able to obtain an abortion within 24 hours of making initial contact with the facility and almost all women were able to obtain the abortion within 10 days. Only one participant reported waiting more than two weeks for an abortion at a private sector

facility. In contrast, all women who had abortions in a public hospital waited at least a week for their care.

Burcu's concern that some women might have difficulty affording care in private sector facilities was borne out by the experiences of our participants. The amount that women paid ranged tremendously, from nothing to 3000TL (USD1125), and averaged just under 1000TL (USD375). Many of the women who received their abortion in the private sector reported that they received some kind of discount, typically through personal or professional connections. As Damla, a 39-year-old woman who was referred through a non-governmental organization (NGO) explained, "And we paid 350TL [USD131]. Initially they asked for 750TL [USD281], but I paid less because of the ongoing [NGO] project."

Women who obtained abortion care at a public hospital typically did not report fees, although one did pay 150TL (USD56). Two of our participants obtained their abortions at a public hospital because private sector procedures were unaffordable.

> If you're rich in Istanbul, you have no problem. You can go to a private clinic. It's the women who can't afford private insurance, who don't have access, who can't go to a doctor alone without their husband looking over their shoulder...They don't have their own money a lot of the time, so they have to go to a state hospital and then they say, "Oh I'm sorry, you're gonna just have to have the baby. (Kathleen, age 32)

[Figure 2: Dilan's Story]

3.3 Women's assessment of quality of care varied by facility type

> In [the private clinic], everything went well. They were very attentive. But in [public hospital], it did not go that well… They didn't really care how I was feeling. I

> asked them to tell me what they were doing, but they didn't seem to care. That's the difference between a public and a private hospital. There wasn't much humane care. (Damla, age 39)

Almost all of the women who obtained abortion care in the private sector reported being satisfied with the care they received including the background information about procedure, pain management, quality and cleanliness of the facility, and interactions with medical personnel. In contrast, women who obtained their abortion care at a public hospital were generally dissatisfied. As exemplified by Dilan's story, these women described feeling judged by public health service personnel, lacking privacy, and receiving inadequate pain management.

Two of our participants had their first abortion at a public hospital and their subsequent abortion(s) in the private sector. These women were well positioned to directly compare facility types and were especially critical of the public sector, as Yasemin's story shows.

[Figure 3: Yasemin's Story]

3.4 Unmarried women face and fear judgment

> There is no law that states that women can't be in a sexual relationship before marriage, but the moral, unwritten laws [make] it difficult to seek and receive reproductive health care. These already existed, but they have gotten worse with this current government. (Melek, age 24)

Notably, some of the unmarried women in our study discussed how their marital status influenced their decision to have an abortion. In addition, Yasemin felt that she was charged a higher price and received a lower quality of care because she was

unmarried. Even though abortion care in the private sector was general described as non-judgmental, some unmarried women anticipated that they would be judged by providers, especially because of the recent negative publicity surrounding abortion in the media, and were surprised when they received non-judgmental care. As Burcu explained: "I heard a lot of bad stories about the abortion so...it was okay I think, because he [the doctor] didn't behave like I was guilty [because] I didn't marry and so I feel a little bit lucky."

The stigma surrounding abortion care for unmarried women appears to be fundamentally tied to the deep-seated sociocultural taboo surrounding premarital sex. Natalie described the phenomenon: "It [abortion] is very common [in Turkey] because premarital sex is condemned. So [unmarried] women do have sex and they do get pregnant so then they abort." The perception that single parenting is unacceptable in Turkey was a significant consideration in the decision-making process for six participants; more than one woman expressed she would have had to get married had she continued the pregnancy and two participants feared they would have to leave the country if they carried the pregnancy to term as unmarried women. Some unmarried women did not disclose their pregnancy to family members because of their family's religious or traditional values. Esin, age 30, explained: "This unexpected pregnancy would have been a problem, my family is a traditional Turkish family after all. They are not narrow-minded, but the mindset is still kind of traditional in that sense. This is why I decided to terminate."

3.5 Women feel their rights are being violated by government rhetoric and action

> I get angry [at the government] because…I know that if I were to [have given] birth, I wouldn't have [had] a chance to study or live my life by my beliefs and dreams. It would cost me something. I am angry that some women should pay for what others think. (Sevda, age 22)

All of our participants were aware of the Turkish government's desire to restrict abortion access. Although the abortion law was not changed, four participants felt that they had been personally affected by the government's stance on reproductive issues; several participants specifically referenced the unavailability of abortion in public hospitals. As Pinar explained, "In the law it says that we [can have an abortion] in public hospitals, but…sometimes they don't do it." Melek feels that the government's rhetoric has created an anti-abortion and anti-reproductive health climate that impacts access to services.

> [The political situation affects] my access to the pill, or just simply going to the Ob/Gyn. I get scared to go to the doctor. It takes away my right to access medical care…I feel like Erdoğan is lying in bed with me, because he is everywhere, saying many inappropriate things and getting so involved in personal lives…This government needs to go so that maybe…we can regain our abortion rights.

Kathleen obtained two abortions, one before and one after 2012, and described her first abortion as "ideal." Yet for her second abortion, while she had a positive interaction with her clinician, she felt like she had been affected by the government's anti-abortion discourse: "Somebody was making this hard for me, unnecessarily. Something that I needed and wanted and was willing to pay for, and they were interfering with my life in a personal way." In addition, at least one participant was

directly affected by the fact that most public hospitals have limited or stopped providing abortion services.

Overall, participants expressed frustration and anger over the government's stance on reproductive issues and the expressed pronatalist agenda. As Damla stated, "I'm just angry. They [the government] want more children, but they do not think about the children's future. How will they grow up? Nobody thinks about that."

4. Discussion

Members of the Turkish ruling party have described abortion as "murder" [12] and threatened to restrict the procedure in almost all circumstances. AKP members have stated that women pregnant as the result of rape should bear the child and the mayor of Ankara, Melih Gökçek, went so far as to say that a woman seeking abortion should "kill herself instead" [22]. The political discourse of the AKP has also defined abortion, along with Caesarean sections, as a barrier to the state's population planning objectives [12-13]. The public discourse around abortion has quieted since 2012, but pronatalist values continue to be unapologetically promoted [23]; in 2014 Erdoğan spoke at a prominent Turkish wedding and said that the use of contraception should be considered "treason" [24].

The importance of this political rhetoric cannot be understated. Legality does not guarantee access and the oppressive political discourse has coincided with recent barriers to public sector abortion care. The majority of our participants were still able to obtain high-quality abortion care after 2012, but this care was generally obtained in the

private sector and came at a significant cost. Our participants consistently commented that the main reason they could obtain an abortion was because they had sufficient financial resources to do so.

Abortion services have been more available in the Turkish private sector for decades, but this trend appears to have worsened. In the early 1990s, four public hospitals in Istanbul provided abortion and even then researchers suggested that low income women's access was limited [25]. The population of Istanbul has since more than doubled and the number of providing public hospitals has declined. As well as being more difficult to access, our participants described the quality of their public sector abortion experiences more negatively than their private sector abortions. Thus, identifying ways to expand public sector capacity for abortion provision while continuing efforts to improve the quality of services is a top priority.

Despite the acceptability of abortion among the Turkish public [26], stigma continues to play a role in women's lived experiences involving reproductive health, particularly for unmarried women. Premarital sex remains highly stigmatized in Turkish society; the 2013 Turkey Demographic Health Survey found that nearly three-quarters (73.3%) of women agree that a woman should be a virgin on her wedding night [7]. Similar views exist among clinicians [27]. Thus, unmarried women may be perceived as not requiring contraceptive services and may encounter judgment for seeking abortion care. Unmarried women in our study weighed issues of stigma: marital status affected both pregnancy disclosure and final decision to seek abortion. As the age of first marriage increases in Turkey [7,28], it is expected that the incidence of sexual activity

prior to marriage will increase and thus sexual health education and resources targeted for the needs of unmarried women appear warranted.

4.1 Limitations

As is true of all qualitative research, our findings are not generalizable or representative. Our study focused on Istanbul and does not shed light on the experiences of women accessing abortion in more conservative or rural regions of Turkey. Finally, the positionality of our study team members, including nationality, educational level, and language fluency influenced the researcher-participant encounter. We attempted to understand these influences through debriefings, team meetings, and memoing, an approach that we believe enhanced the credibility and trustworthiness of the study.

4.2 Conclusion

High-quality abortion care remains readily available in the private sector but is limited in the public sector in Istanbul. The findings from our study support Turkish media reports that abortion has become more difficult to access since 2012 and suggest that the political discourse surrounding abortion has negatively impacted women's experiences.

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Figure 1: Burcu's Story

Burcu is a university student living in a suburb about 20km outside of central Istanbul. Burcu obtains all of her health services in the private sector and was able to find a private gynecologist through a family friend. She is in a long-term relationship and has used condoms, oral contraceptive pills, and emergency contraceptive pills on several occasions.

Burcu and her partner were using withdrawal as their main method of contraception when she became pregnant in 2014. When she first suspected she was pregnant, Burcu took a home test and it came back negative. She soon did another test and the second time it came back positive. Initially, she was extremely scared because she thought she might have passed the 10-week gestational limit. She told her mother and boyfriend right away and she immediately went to her doctor. Burcu was able to obtain her abortion care that same day and learned she was only six weeks pregnant. She was not asked about her age or her marital status and she did not require consent from a parent or her partner. Normally, abortions at this clinic are 800 TL (USD300) but she paid 300 TL (USD112) because of her family's connection with the doctor.

Overall, Burcu described her abortion as affordable and easy to obtain. However, she felt like abortion was too expensive for other women. She felt lucky because her clinician was not judgmental about the fact that she was unmarried. She was also very satisfied with the pain management and treatment from other medical personnel. Burcu also mentioned that she felt lucky for obtaining care in the private sector, because she had heard that when a woman seeks abortion in the public hospital, personnel might notify the woman's family.

Figure 2: Dilan's story

Dilan is in her early 30s living on the outskirts of the European side of Istanbul. She is married with three small children. Dilan did not plan on having more children and had an IUD inserted after the birth of her youngest child. When she became pregnant four years later, she knew that she wanted an abortion. Private hospitals were far too expensive and Dilan was referred to the only public hospital in the city that provides abortion.

Dilan was able to make the appointment in one week's time, but the providing hospital was over an hour away and she had to have three separate appointments prior to her abortion in 2015. Her husband had to accompany her on the day of the abortion and sign a consent form. Dilan said there was a line of women waiting for the procedure: she felt like she was at a butcher and the women were like sheep being herded.

Although she was happy with her doctor, she found the overarching process to be stigmatizing and judgmental. There was very little privacy and nurses were openly shaming women for getting pregnant. Dilan had been told to wear a skirt and she was not provided with a hospital gown or a cloth for the procedure. She described feeling scared, isolated, and in pain and worried she might die.

Dilan described the process as extremely emotionally and logistically difficult. She was very worried about the possibility of a future pregnancy: "What am I going to do if this happens again? I can't afford [a private facility] and the public hospital is too far." Dilan strongly believes that every public hospital should provide abortion.

Figure 3. Yasemin's story

Yasemin is a university student living in central Istanbul. She experienced three unplanned pregnancies with her long-term partner, all within a six-month period. She had been using the oral contraceptive pill, but stopped taking it regularly when her doctor told her that smoking would make the pill less effective. When she became pregnant, she knew immediately she wanted an abortion – she was still a student and she was deeply concerned about her family's reaction because they are very conservative: "The child would have lived but [my family] would either kill me or force me to marry someone I didn't want to marry. I would have been isolated from life. So I chose abortion."

Her first abortion was at a public hospital in 2013. She had to wait three weeks to obtain her abortion because she and her partner needed to find 150 TL [USD56] to cover the costs. Yasemin explained her difficulties in obtaining the abortion: "It was difficult for me to get the appointment. They kept sending me to different places. I walked all around the hospital, even to the dental clinic because that's where they directed me. It was as if society didn't want a woman to get an abortion so everyone was sending me to a different place." When she asked questions, the staff said that she "could get up and leave, that they didn't have to answer [her] questions." She was awake during the abortion and experienced so much pain that she was unsure if they had administered the promised drug. Regarding quality of care, Yasemin explained: "I thought it was bad. There was no doctor-patient relationship. I felt like a test subject."

Yasemin also received negative treatment for being young and unmarried. Personnel at the hospital accused her of lying about her age and made her show three pieces of ID before accepting that she was over 18. The staff also publicly discussed that she was unmarried and Yasemin believes that she would not have had to pay had she been married.

For her two subsequent abortions, also in 2013, Yasemin went to a private clinic; the procedures cost her 400 TL [USD150] each. Although expensive, Yasemin reports that the service was much better: they had a shuttle service offering transportation, the pain management was superior, and the clinician was kind and supportive. She did not feel that she had sufficient knowledge to prevent her pregnancies and mentioned that she had only learned about EC six months ago.

Chapter 5: Article #3

Politics, policies, pronatalism, and practice: Availability and accessibility of abortion and reproductive health services in Turkey

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Politics, policies, pronatalism, and practice:
Assessing abortion and reproductive health services in Turkey

Abstract
Turkey has maintained liberal contraception and abortion policies since the 1980s. In 2012, the government proposed to restrict abortion; a bill limiting abortion was later drafted but never passed into law. Since the proposed restriction, women have reported difficulty accessing abortion services across Turkey. We aimed to better understand the current availability of abortion and reproductive health services in Istanbul and explore whether access to services has changed since 2012. In 2015, we completed 14 in-depth interviews with women and 11 semi-structured interviews with key informants. We transcribed all interviews and completed content and thematic analyses of the data. Key informants had good knowledge about the political discourse and the current abortion law. In contrast, women were familiar with the political discourse but had mixed information about the current status of abortion and were unsure about the legality of their own abortions. There was consensus that access to services has become more limited in the last five years due to the political climate, thus advocacy to prioritize reproductive health services, and abortion care in particular, in the public health system are needed.

Introduction

The Republic of Turkey has a longstanding legacy of progressive reproductive health policies. Despite restrictions on contraception and abortion at the outset of the Republic, Turkey implemented a robust family planning program in the 1960s that introduced reproductive health clinics, reduced pronatalist propaganda, and promoted the use of traditional and modern contraceptive methods. [1] At that time, abortion was permitted if the woman's health was at risk or in cases of foetal anomaly but remained restricted in most circumstances; [2] thus the practice of illegal, unsafe abortion was exceedingly common throughout the 1960s and 1970s. [1] In 1983, Turkey took another step in advancing maternal and women's health when the government legalized abortion without restriction as to reason. [2] As part of Population Planning Law No. 2827, abortion is permitted through 10 weeks' gestation without restriction as to reason. Married women and minors must obtain consent for the abortion from the spouse or parent, respectively. [2] Legalization of abortion was followed by a dramatic reduction in the maternal mortality ratio. [3]

The abortion ratio has steadily decreased from 1990 to 2008, when the number of induced abortions per 100 pregnancies went from 20.6 to 10.0. [4,5] The decrease in the abortion ratio has coincided with increased use of modern contraceptive methods and more effective use of traditional methods. [6] Nonetheless, abortion remains a vital component of maternal and reproductive health services in Turkey; as many as 28.7% of pregnancies are unplanned and/or unwanted [7] and an estimated 14% of ever-married women have had at least one induced abortion. [8]

Despite the essential role of abortion in comprehensive reproductive health, the current Turkish government initiated a vocal anti-abortion campaign in 2012. On May 25, 2012, then-Prime Minister Erdoğan announced his opposition to abortion and the Ministry of Health soon after publicised plans to restrict the existing abortion law. [9] Immediate public outcry stalled the proposed legislation thus leaving the 1983 law intact. However, since mid-2012 activists and women have reported that abortion has become more difficult to obtain. In 2014, the Turkish Society of Obstetrics and Gynecology reported that the code for induced abortion had been removed from the electronic record system in public hospitals across Turkey, thus preventing the scheduling of abortion procedures. [10] A 2015 report found that only three public hospitals in Istanbul provide abortion without restriction as to reason and only one of these provides through 10 weeks' gestation. [11] This lack of public sector availability has been echoed in research documenting women's experiences obtaining abortion services in Istanbul. [12] Since 2012, access to misoprostol, the only form of medication abortion available in Turkey, has also been limited [13].

The Turkish government has also endorsed pronatalist population planning to encourage women to bear a minimum of three children. [14] As a result, abortion is only one of the reproductive health services targeted. In 2012, the Turkish government equated both abortion and Caesarean sections with murder and later legally restricted the provision of Caesarean sections to cases of medical necessity. [15] Progestin-only emergency contraceptive pills were removed from pharmacies and made briefly unavailable in 2014 only to later be replaced by ulipristal acetate, which is significantly more expensive. [16] Given this politically charged context, we wanted to explore both key informants' and women's perspectives on the availability and accessibility of reproductive health services, in general, and abortion, in particular, in Turkey.

Methods

In the summer of 2015, we completed a multi-methods qualitative study that included key informant interviews and in-depth interviews with women who had obtained an abortion. For the key informant component, we aimed to elicit the perspectives of a range of professionals, [17] including academics and researchers, representatives from women's rights, human rights, and other non-governmental organizations, and clinicians. We identified participants through publicly available information, study team networks, and early participant referral. We modified our interview guide for each participant and used open-ended questions to explore the participant's career and professional activities, experiences in the sexual and reproductive health arena, knowledge of and perspectives on the changing political attitudes toward abortion and reproductive health and the consequences for service accessibility and availability, and ideas about how policies and services could be improved in Turkey. We audio-recorded interviews, which lasted 45-60 minutes.

As detailed elsewhere, [12] to be eligible for the second component of our project, women had to be aged 18 or older at the time of the interview, have obtained at least one abortion in Istanbul on/after January 1, 2009, and be sufficiently fluent in English or Turkish to answer questions. Our multi-modal recruitment strategy included social media posts, outreach through gender organizations, and participant referrals. Our interview guide began with questions about the participant's background and reproductive health history, circumstances surrounding the terminated pregnancy, and the abortion process. We then asked questions about how abortion and reproductive health services could be improved. We closed by asking women their opinions about the current government and its stance on reproductive rights and health. Audio-recorded interviews lasted 60-90 minutes.

KM conducted all in-person or telephone/Skype interviews for both components with the aid of a Turkish interpreter (including DT and EÇ) as necessary. A Canadian master's student in Interdisciplinary Health Sciences at the University of Ottawa, KM received training in qualitative research from her supervisor (AF), a medical anthropologist with extensive abortion-related research experience, and guidance during her fieldwork from gender studies specialist MO. KM took detailed notes during and debriefed with members of the study team after each interview. She also engaged in formal memoing to reflect on the interviewer-interviewee-interpreter interactions, explore her reactions to interview content, and initiate the analytic process. [18]

We transcribed and translated into English all interviews. BB, a Turkish graduate student at the University of Ottawa, reviewed and verified all translated transcripts for accuracy. We used a multi-phased, iterative analytic plan centred on content and themes and used ATLAS.ti to manage our data. In the first phase, KM led the development of a codebook of *a priori* codes based on the interview guide, notes, and memos. In the second phase, we developed and added new codes to address emergent content. [18] The third phase focused on interpretation and drawing connections between ideas, a process guided by regular meetings between KM and AF. We analysed each component of the project separately and in the final phase we combined the results paying close attention to convergence and divergence.

We received ethics approval from the Research Ethics Board at the University of Ottawa (File #02-15-05) and the Gender and Women's Studies Research Center at Kadir Has University in Istanbul reviewed the study protocol to ensure it adhered to local research standards. All participants verbally consented prior to the interview and gave us permission to use quotes. We

have masked or redacted all personally-identifying information and use pseudonyms throughout.

Results

Participant characteristics

We interviewed 11 key informants and 14 women during this study. Key informants consisted of three Ob/Gyns who were also abortion providers, three NGO representatives, two academics, two pharmacists, and one lawyer, all of whom were working in Istanbul at the time of the interview. Women ranged in age from 21 to 44; seven women were unmarried, six were married, and one was divorced. Ten women identified as Turkish citizens, while four were expatriates currently residing in Istanbul. Our participants had received 19 abortions since January 2009. Most abortions were obtained in the private sector – eight in clinics and eight in hospitals – and three were obtained in a public hospital. Five abortions took place prior to May 2012 and fourteen took place after May 2012.

Knowledge of and opinions about Turkey's abortion law

"I didn't really have very many arguments with myself about it. What I did have was a huge dose of fear because when I realized I was pregnant, I didn't know how far along I was…and I thought that I was very close to the [cut off], and that scared the shit out of me." (Mia, age 44)

Overall, our key informants evinced accurate knowledge about the legal status of abortion in Turkey. The majority (n=9) correctly described the spousal consent requirement, although only one noted that failure to obtain this consent is not a criminal offense. The majority (n=9) referenced the 10 week gestational age limit but only two participants correctly explained abortion is legally permissible through 20 weeks in cases of sexual assault, while one participant correctly noted that there is no legal gestational limit in cases of foetal anomaly or if the woman's life/health is at risk, provided state authorities are notified. Only five participants described the parental consent requirements for minors. Women's knowledge of the law at the time of the interview was highly dependent on their individual experience. Several women were unaware of the 10 week gestational age limit and others were uncertain if husband or partner consent was legally required.

Most of our key informants (n=10) raised concerns about one or more aspects of Turkey's current abortion law. A number specifically referenced that the 10-week limit was too low and that the spousal consent requirement should be eliminated. As one lawyer argued, *"We think that this time period should be extended, it is very minimal and there are examples of longer periods in other countries."* An Ob/Gyn working in Istanbul echoed this sentiment:

"[10 weeks] is not long enough. I don't think there should be any restrictions on abortion. It's a woman's body and she should be able to decide about everything herself. She shouldn't need her husband's consent either…if she decides not to have the baby, it's her choice, it's a private situation."

The issues raised by key informants were reflected in the lived experiences of half the women in the study. One woman described the age of consent as being a source of difficulty and additional women, like Mia, expressed significant concerns about exceeding the 10-week gestational limit, obtaining spousal consent, or both. As Kathleen explained, *"[My husband] wasn't gonna give me consent so I went to a private clinic and the doctor was a friend of a friend*

of mine, and he did it for me and was really nice about it and everything. But yeah...it was a problem."

Knowledge of abortion- and reproductive health-related policy changes

"I think it's about excluding women from social life and public space. It's about occupying women with three children and using that as an excuse to exclude them." (Yasemin, age 21)

Almost all of the participants in both components of the study were aware of the Turkish government's attempt to restrict abortion in 2012. In general, key informants understood that the bill had been drafted but not introduced and that no legal changes impacting abortion had been enacted. None of the informants had seen a copy of the 2012 bill or heard of any efforts to introduce new abortion legislation. In contrast, women in our study were confused as to whether or not restrictive provisions had been enacted in 2012; four women believed gestational age limits and consent provisions had been recently imposed.

All participants in both components of the project expressed awareness of the Turkish government's pronatalist efforts. Key informants and women repeatedly described the aim of the government as trying to promote a certain number of children per woman and explained that a number of incentives, including awarding money to families with multiple children and extending maternity leave, had been implemented in support of this effort. As Funda, age 28, explained:

"The government's new incentive of giving money after pregnancies and deliveries is manipulating and confusing women's minds…I see women like that in my neighborhood, just for the incentive they get pregnant. The government imposes this for women to have more children. I see women like that around me."

Participants, particularly key informants, discussed other types of policy changes, including the prohibition on non-medically indicated Caesarean sections, the upregulation of misoprostol, and the lack of mifepristone registration as part of this overarching effort. Well-positioned key informants also reported that policy efforts were underway to remove reproductive health content from textbooks and change the status of oral contraception pills such that presentation of a prescription at a pharmacy would be required and recorded.

Participants suggested a range of political and economic motivations for the pronatalist efforts. Notably, both key informants and women believe that the government's ideology revolves around conservative, often religious, values and building traditional families with the consequence of seriously compromising both women's rights and human rights. As 30-year-old Esin explained:

"[The ruling party has] this thing about making at least three children…They don't have a stand on women's rights, they are trying to implement their ideologies and ideas [which are] based on the value of family, the sacred nature of motherhood. They are trying to limit access to abortions, birth control, and free health services for women. It reflects the idea of the role they think women should have in a society. They don't want women to be independent and free, so they think by limiting all these things, they can prevent that."

The influence of the anti-abortion political climate on practices and access

"It's incredibly difficult to fight these secret, underlying restrictions which they [the government] do through health reform…There is no legal restriction, it's still the old reproductive health law…But there have been non-legal changes…Although abortion was not banned, although there was actually no written policy change, a lot of abortion was de facto *restricted."* (NGO representative)

Key informants and women consistently described the anti-abortion and pronatalist government rhetoric as far-reaching and significant. Participants in both components of the project explained that even in the absence of policy change, Erdoğan and other leaders of the Justice and Development Party (AKP) have tremendous impact at the individual, institutional, and systems levels. Jeanine, age 36, commented: *"Oh yeah my husband is very pro-Erdoğan, he's like 'We will have three children, one for us, one for the country and one for' whatever the saying is. Yeah my husband is very much that we will have three children cause that's what Erdoğan says to do."*

Most of our participants felt that access to abortion care had diminished in the previous five years. Informants and women spoke at length about how the government resorted to "secret" or "backdoor" measures to restrict service availability. The reduction in the number of public hospitals providing abortion in Istanbul has been well-documented. [11,12] However our key informants also reported that some private facilities that are financially supported by the AKP or prominent leaders within the party have also stopped providing services. One NGO representative offered an explanation for the relationship between the political rhetoric and provision,

"Erdoğan says that abortion is a crime…once he says something, even if it's very illogical or against the party, a lot of people in the state and in this government and in the party start claiming it. They just repeat it…[W]hen he says something, a lot of people, his followers, start implementing it, even if there's no law."

Informants also discussed how the recent overarching "health reform" initiative has curtailed sexual and reproductive health services in Turkey. First, the transition to a family medicine model of care has resulted in the closure of dedicated maternal-child health and family planning clinics (AÇSAP). These closures directly impacted at least two women in our study. Damla, age 39, explained: *"There used to be mother's health centres, that's where I learnt [information about reproductive health]. In the past, it was more accessible."* Since the closure of AÇSAP clinics key informants reported that women have had to travel greater distances to reach family planning and abortion care because family medicine clinics do not consistently provide these services.

Second, the health reform initiative removed family planning services, including abortion and contraceptive counselling, from the public sector funding scheme. As one Ob/Gyn explained:

"The Ministry of Health has said that menstrual regulation is not a disease so it should not have ICD [billing] code…but if you don't have an ICD code, you don't get paid for it. The hospital is not paid for it, neither by the government nor by the social security system…so the others [doctors] say that 'There is no code for it, so I don't provide abortion'…not because they are against abortion, because they are not paid for it. It's very simple."

Similarly, contraceptive services appear to have been removed from the performance scale for physicians, thereby impacting compensation. The same Ob/Gyn elaborated: *"To provide an IUD has less points than examining a patient. [Other reproductive health services] have no performance system scores. If you do it, you don't get any points, you don't earn anything. It is legal but it's not reimbursed."*

Women also repeatedly commented on the costs of obtaining reproductive health services. In addition to discussing the challenges with obtaining fee-for-service abortion care in the private sector, several women also specifically referenced the increased price of emergency contraception as a barrier to access. A pharmacist also described the challenge: *"[NorLevo] was 17 Lira [USD6] but this [Ella] is 50, 49 Lira [USD17.40]…it's very expensive for, especially for youth…I saw that many young lady or young man collecting from their friends some money to buy it."*

Women expressed significant concern about abortion documentation and familial notification
"I got the fear because our government doesn't want women to get an abortion…if you have an abortion in the government hospital, they may even write your name and inform your parents without your knowledge. So I didn't want [to be worried] that my mother would learn…I told my doctor at school [and] he said that maybe [I could] get a private abortion." (Sevda, age 22)

Women in our study were highly concerned about the documentation surrounding their abortion procedure. Half of our participants wanted to avoid having their abortion on their medical record, mainly because they were worried that their abortion would be disclosed to the government or their family members. As Mia explained, *"That was another reason why I went into a private clinic rather than a hospital…Because I have a feeling that the records at the private clinic are not accessible [to the government] in the same way that they are from a hospital."* Women spoke at great length about avoiding "the wrong hospital" or "conservative hospitals" because they believed their abortion could be disclosed without their consent. Further, women believed the government intentionally established this culture of fear to deter women from seeking services. Esin explained, *"And then, the issue of needing your husband's consent and sending letters to the parents stating that the daughter got an abortion. That's how they [the government] are scaring woman away and preventing it, by invading their privacy."* Notably, key informants did not raise this as an issue nor did they discuss government initiatives designed to track abortion patients or impose punitive systems of disclosure.

Although almost all of our participants had to show identification and sign a general consent form while obtaining their abortion care, some women still described the procedure as "undocumented" because it was understood that the abortion would not be recorded in their medical record. Esin's consent form did not specify the type of medical procedure: *"And my abortion wasn't registered or documented, so it was easy for me to access…Only when I left the hospital, I had to sign something. But that only stated that I had an operation with the doctor."* Consequently, several women seemed unsure of the legality of their abortions and used language that reflected this ambiguity. Women consistently described obtaining abortion as "a little bit illegal," "a legal grey area," or as "black market." Interestingly, women viewed this lack of documentation as highly desirable and several preferentially sought care in the private sector, especially private clinics, for this reason.

Discussion

Turkey's 1983 Population Planning Law guarantees that safe abortion should be available "for every woman who needed the service." [5] However, the law is not being consistently implemented. The Turkish media has reported that some public hospitals are unwilling to provide through 10 weeks' gestation [11], are disclosing a woman's pregnancy status to her family, [19] withholding anaesthesia, [20] turning away unmarried women, [21] and incorrectly informing women that abortion is illegal. [22] These profound inconsistencies are reflective of overarching changes in reproductive health policy, practice, and rhetoric in Turkey.

The political discourse appears to have impacted service delivery at the institutional and systems levels. Policy changes associated with health reform and the heightened stigma surrounding abortion have effectively shifted the practices of hospitals and clinicians. Family planning counselling and IUD insertions have been "virtually abandoned" as a result of the health reform initiative. [23] Our results confirm this shift, suggesting that public sector abortion provision has become more limited and funding for abortion and family planning has been undermined in the last five years. Future advocacy efforts from clinicians and community-based organizations to call for reform within the public sector is critical. Efforts should focus on (re)incorporating family planning and abortion services into the performance scale for physicians and the list of reimbursed services.

The negative political discourse has also created a culture around abortion-seeking in Turkey that is ambiguous and terrifying for some women to navigate. That women in our study lacked clarity regarding the abortion law is hardly surprising. Studies have demonstrated that, even when liberal abortion laws are in place, lack of knowledge among women about the abortion law creates barriers to accessing safe abortion services. [24,25] One could argue that the Turkish leadership has successfully created what the World Health Organization refers to as a "chilling effect"; that is, policies and practices that may ultimately deter women from seeking abortion care and dissuade clinicians from providing them because they are fearful of penalty. [24] Proactive approaches to disseminate accurate information to women about the abortion law appear warranted. Even if the existing law was uniformly implemented, informants commented on the unreasonable limits placed on abortion care, especially the gestational age limit and requirement for spousal consent. Such restrictions may hinder women from accessing safe abortion care, [26] therefore resources should be mobilized not only to protect the current law but to push for reform of non-evidence based regulations.

Limitations

This was a small qualitative study and therefore does not offer findings that are generalizable or representative. Although our key informants had experiences working in and/or were able to reflect on access issues throughout the country, all of the women who participated obtained their abortion care in Istanbul. Thus our project does not offer insight into the experiences of lived experiences of women in other regions. Unfortunately, despite our attempts, we were unable to interview members of the AKP, current government officials, or religious leaders and thus these perspectives are not reflected in our findings. The positionality of our research team members also influenced researcher-participant interactions and the interpretation of the data, dynamics that we reflected on through team meetings and memoing.

Conclusion

In 2014, Health Minister Müezzinoğlu defended the public defunding of abortion in Turkey by asking, “Is abortion a disease? No. Why should the government pay for it? The laws have not changed.” [27] Indeed, the unique intersection of neo-conservative and neo-liberalist values under the AKP has led to a resulting “politics of the intimate” that overemphasizes the importance of motherhood, and procreation, while undermining the importance of women’s choices and lives. [28] Although abortion remains legal, the Turkish leadership has successfully created a climate that hinders abortion provision and stigmatizes the procedure, in turn impacting women’s lived experiences obtaining services.

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Chapter 6: Discussion

6.1 Integration of findings

The collective findings of the three articles highlight the complex landscape of reproductive justice in modern day Turkey. First, our study suggests that abortion accessibility in public health institutions in Istanbul has diminished remarkably within the last several years. Second, key informants reiterated that a recent health reform in Turkey has significantly impacted access to FP services. Finally, many of our participants felt that sexual and reproductive health education should be a significant focus moving forward. Indeed, women and key informants felt that the overall ideology toward sexuality and women's rights in Turkey was one of the most notable barriers to improving abortion and reproductive health services. In particular, participants described the sociocultural stigma attached to premarital sex and parenting outside of marriage in Turkey and how this influenced their reproductive health decision-making and experiences.

6.1.1 Current availability of abortion in Turkey

Women and key informants both consistently raised the issue of abortion availability in public hospitals. Participants repeatedly described the fact that abortion is much harder to obtain in state hospitals now, and several women and key informants reported that only one public hospital out of thirty-seven in Istanbul will now provide abortion without restriction as to reason. Our findings support the February 2015 report released by the women's organization Mor Çatı, which also indicated that only one government hospital in Istanbul will now provide abortion

through the tenth week of gestation (Letsch, 2015). Interestingly, one of our participants obtained her first abortion at a different public hospital in 2013 at eight weeks gestation; it would appear that this hospital, along with several others, did not continue to offer the same range of abortion services in 2015. This offers further support that most changes in abortion availability occurred within the last three years.

While most of our participants obtained their care in the private sector and did not encounter significant barriers to abortion access, our key informants described arbitrary regulations that have been imposed at public hospitals. These are consistent with the media and grey literature stating that public hospitals have come up with their own gestational limits of eight or nine weeks and that hospitals will refuse abortion service based on moral and/or religious grounds. As described in our results, the two women in our study who did obtain abortion services at public hospitals after 2012 reported significant difficulties consistent with publicized accounts of women's abortion experiences in the media. It is worth noting that the number of induced abortions per 100 pregnancies in Istanbul dropped from 10.0 in 2008 to 4.7 in 2013 (HIPS, 2014). This may be related to decreased abortion provision in public health institutions or the fact that women are more hesitant to self-report given the political climate around abortion in the last five years.

Based on our conversations with key stakeholders in Istanbul, further mystery-client phone surveys, like the one conducted by Mor Çati in Istanbul, are currently being conducted at state hospitals in Ankara and Izmir. These surveys

represent an important next step in highlighting the current state of abortion availability in other regions of Turkey.

Our findings suggest that the single most influential factor in determining a woman's access to abortion in Istanbul is her socioeconomic status. Women who obtained care in the private sector were overwhelmingly satisfied with the quality of care received and they could reliably get their abortions on the same day as or within a few days of pregnancy confirmation. Overall, women in our study talked at great length about how easy they found obtaining private abortion care in Istanbul, even after the reported barriers introduced after 2012. Key informants supported these narratives, emphasizing that abortion remains a highly accessible service in Istanbul, but only in the private sector and therefore only for women of a certain economic and educational status.

In our study, the average cost of a private abortion was 993 Turkish Lira (350 USD). Many of our participants and key informants recognised how unrealistic this is for many Turkish families. A recent study from TurkStat indicated that the average monthly disposable income for an Istanbul household is 1520 Turkish Lira (533 USD) (Daily Sabah, 2014). Thus, the lack of abortion availability in public hospitals marks a significant barrier for women who do not have the financial means to seek private care.

Our study highlights the need for ongoing advocacy efforts in Turkey surrounding abortion provision. In 2012, the mobilization of advocacy groups was swift and effective in preventing the government from passing abortion-restrictive legislation. Ongoing pressure from women's rights organizations, NGOs, the Turkish

medical community and international stakeholders could have an impact on the re-introduction of abortion services in government hospitals across the country. In addition, the introduction of medication abortion services in Turkey could address significant geographic and economic barriers to abortion access, as well as mitigate issues of privacy and confidentiality relating to abortion care. Several participants in our study expressed a desire for an early MAB option, and one woman had reached out to her local pharmacist to request this protocol. Although mifepristone is not yet licensed in Turkey, a research team based in Izmir conducted three clinical trials during the 2000s using the mifepristone-misoprostol regimen. Overwhelmingly, the trials indicated that MAB is a highly acceptable method of pregnancy termination for Turkish women and clinicians. Yet, a recent study by Mihciokur, Akin, Dogan, & Ozvaris (2015) suggests that Turkish medical students have a limited awareness about medication abortion. Fifty-six percent of medical students were familiar with MAB; however knowledge about protocols was limited, as only twenty-seven percent of students knew of mifepristone and fourteen percent knew of misoprostol (Mihciokur et al., 2015). The intent to provide was also very limited: fifteen percent of students stated that they would be willing to provide MAB services themselves (Mihciokur et al., 2015). The education of future clinicians represents an area of focus for continued advocacy efforts to introduce MAB into the Turkish abortion-provision scheme.

6.1.2 Impact of Turkish health reform

Many of our key informants described the impact of the ongoing health reform in Turkey toward a family medicine model. The Family Medicine Programme was implemented countrywide by the end of 2010 (World Health Organization, 2013), and has altered the provision of many health services, including sexual and reproductive health services. A major outcome of the reform was the closure of Ana-Çocuk Sağlığı ve Aile Planlaması (AÇSAP) clinics, dedicated maternal health and family planning clinics, across Turkey. AÇSAP clinics were absorbed by the Aile Sağlığı Merkezi, family health centres. The family health clinics are meant to provide the same services that were previously delivered through AÇSAP, however some key informants indicated that they are unable or unwilling to consistently provide these services.

Key informants also attributed changes in abortion provision to this health reform. For example, one informant talked about how the funding structure for various health services has changed from fee per service to a lump sum budget. Abortions are now included in the lump sum budget and since hospitals can no longer bill for each individual abortion provided, there is a strong disincentive to provide. In addition, all services provided by public physicians are attached to a point value on a performance scale. Physicians earn a base salary and then additional income based on the point values for the services they perform. According to our key informants, abortion, contraceptive counseling, and IUD insertion do not "earn" a physician any points on this performance scale. This is supported by a 2014 study conducted by Öcek, Çiçeklioğlu, Yücel, & Özdemir. They

discovered that, while the health reform has highlighted a few key areas, such as immunization and maternal health, many other services have been removed from the performance scheme. Consequently, primary health care workers overwhelmingly described how services not included in the performance targets were not prioritized:

> The majority of participants reported that services not included in the performance targets system, such as family planning, monitoring of children and new mothers, chronic disease management, and the reporting of communicable diseases, had been neglected. In particular, they reported that there had been a significant decline in family planning services, and that counselling and the fitting of intrauterine devices had been virtually abandoned (p. 7).

Key informants indicated that it is unlikely that SRH services would improve unless the public health system restored physician incentives for family planning services. They felt that NGOs could help fill the gaps in service provision by providing contraceptive services at a reduced fee or free of charge.

6.1.3 Sexual and reproductive health education

In this study, women and key informants consistently raised sexual and reproductive health education as an area of concern. They both highlighted the fact that there is little to no SRH education in the curriculum of Turkish state schools. Our key informants consistently explained that curricular materials focus on biological function rather than reproductive and sexual well-being. A study by Çelik & Esin (2012) supports this finding. They conducted focus group discussions with adolescents in Ankara and found that "they cover the biology of living organisms with emphasis on sexual and asexual generation and reproduction but fall short of

meeting the needs of the young people" (p. 205). In addition, Turkish adolescents in the same study indicated that they receive the majority of their sexual and reproductive health information from friends and most did not feel comfortable addressing these topics with family members and teachers (Çelik & Esin, 2012). Even if SRH education were available at the secondary or high school level, a significant proportion of women in Turkey do not progress to this stage of education. 41.9 percent of women aged 15-49 living in Istanbul have completed primary school education or less (HIPS, 2014). This suggests that many women and girls do not access the bare minimum of reproductive health content covered in Turkish state schools. Thus, different forms of community-based SRH education should also be prioritized alongside SRH programs in state schools.

Most of our in-depth participants were using withdrawal as their primary method of contraception when they became pregnant. Others reported condom use, but upon further probing, shared that they did not use condoms consistently. This finding is reflected in the broader literature, which indicates that 26 percent of Turkish women still rely on traditional methods of contraception, most notably withdrawal (HIPS, 2014). While some women in our study felt that they had the appropriate education and knowledge to prevent their unplanned pregnancy, others were frustrated about their self-perceived lack of knowledge. One participant, for example, had no familiarity with emergency contraception and wished to learn more about it. Again, the literature suggests the prevalence of knowledge of EC among Turkish women is relatively low (42 percent) (HIPS, 2014). Given that UPA and OCPs remain readily available from Turkish pharmacies, education efforts

around both dedicated EC and the Yuzpe method of EC would contribute to the scope of available family planning resources available to Turkish women. A 2002 study by Tokuç, Eskiocak, & Saltık demonstrated that educating Turkish women about EC has the potential to reduce the induced abortion rate up to 60% (as cited in Atan et al., 2011). The women in our study also reported little to no post-abortion contraceptive counseling, which represents a significant missed opportunity to counsel women about their future family planning needs. This was echoed by the Haceteppe University Institute for Population Studies (2014): "the need for family planning counseling after an abortion is highlighted by the finding that, in the month following an induced abortion, 48 percent of women did not use any method and 14 percent used withdrawal" (p. xvii).

Women and key informants felt that a major barrier to improving the quality of SRH education and services was the level of stigma associated with sex in general and premarital sex in particular. FGDs with adolescents in Ankara found that students described sexual health as "indecent", "very private" and "unspeakable" (Çelik & Esin, 2012). Further, the most recent Turkey Demographic Health Survey found that "73.3% of women agreed that a woman should be a virgin on her wedding night" (HIPS, 2014). Several women in our study reported experiencing shame and embarrassment when seeking medical care relating to sexual and reproductive health, and single women tended to encounter more stigma from health care providers. Almost all of the single women in our study felt their reproductive health experiences had been negatively affected at some point due to their marital status. For instance, one participant believed that she only had to pay

for her abortion because she was single and that if she had been married, the social health care system would have covered it. Other single women encountered discrimination when seeking various reproductive health care services, including contraception and fertility treatment. Overwhelmingly, our participants felt like clinicians and pharmacists were more willing to have discussions about family planning with married women. This is not surprising given the views and attitudes of clinicians toward premarital sex. A 2010 study with Turkish medical interns found that a significant proportion of interns (42 percent) disapprove of premarital sexual experience among women (Ozan et al., 2010). Enhanced sexual and reproductive health education aimed at clinicians and the lay public, including education about gender, consent, women's rights, and sex-positivity, could mitigate some of the persisting stigma around sexual activity and in turn improve the quality of sexual and reproductive health care. Because this is a relatively understudied area, future research efforts should focus on the experiences of unmarried women in Turkey accessing contraception and abortion services, and aim to document any experiences with discrimination and stigma while seeking care.

6.2 Significance of findings

This thesis is the first known qualitative project to explore women's abortion experiences in Istanbul. It is timely given the recent shift in abortion and reproductive health care accessibility in Turkey. Although this dynamic has been reported extensively in the media and grey literature, this is the first academic study to explore noted changes in service provision. The study also shed light on access to other reproductive health services including modern contraceptive methods, emergency contraception, medication abortion, and Caesarean sections. Although the results are not generalizable, they do offer a snapshot of the reproductive health services available in Istanbul, and some of the challenges women face obtaining services.

The results highlight the current gap in abortion services, one that stands to disproportionately affect low-income women, thus we believe that our findings will inform advocacy efforts to re-introduce abortion care in the public sector. Many of our key informants are well-positioned for abortion advocacy in their respective fields of medicine, law, and health policy. We will disseminate a summary report of our findings in both English and Turkish to key stakeholders, academics, reproductive health organizations, and human rights organizations in Istanbul.

I anticipate the findings may also be informative to NGOs that provide reproductive health services to women in Istanbul. Participants and key informants alike expressed many possible avenues for improvement of health services, and these results could enhance the reproductive health education and service delivery efforts of local NGOs.

Finally, in conjunction with my fieldwork, I coordinated the Turkish translation of www.medicationabortionturkish.com. The website, developed by Ibis Reproductive Health and Cambridge Reproductive Health Consultants, provides an exhaustive educational resource for clinicians about the different medication abortion regimens including information about efficacy, dosage, indications, and contraindications. We will disseminate the website URL to key informants and other stakeholders in Istanbul and Ankara. The most recent evidence suggests that Turkish clinicians and medical students have limited knowledge about medication abortion (Mihciokur et al., 2015) and the development of a Turkish-language website represents a significant first step to address this gap in knowledge.

6.3 Positionality and reflexivity

Positionality and reflexivity are essential aspects of rigorous qualitative research. By its nature, qualitative research is inherently shaped by unique researcher-participant dynamics. Thus, the positionality of the researcher, characterized by sex, gender, race, sexual orientation, education, socioeconomic status, cultural upbringing, and political inclination among other values, can influence the data collection and analytic processes. Reflexivity, on the other hand, can be defined as the "self-critical sympathetic introspection and the self-conscious *analytical* scrutiny of the self as researcher" (England, 1994, p. 82). England goes on to argue that, "Indeed reflexivity is critical to the conduct of fieldwork; it induces self-discovery and can lead to insights and new hypotheses about the research questions," (1994, p. 82). Reflexivity calls upon the researcher to engage in a close

self-examination of the potential biases that they bring to the study. As a leftist and a feminist, for example, my own values have influenced how I developed this study, and collected and analyzed my data.

In the context of this project, I also reflected about my role as a foreign researcher. Being an outsider proved to be both an advantage and disadvantage in this study. Abortion, contraception, and sexual and reproductive health are topics that have complex cultural, religious, and social connotations in Turkey. It is often easier for women to discuss such topics with those outside of their social and cultural groups. Further, abortion has become highly politicized in Turkey within the last five years. A procedure that has long been considered widely acceptable in Turkey is now surrounded by a culture of fear. Many Turkish women are now afraid of their abortions being documented by the government and disclosed to their partners and family members. As a result, many women were seemingly more reluctant to discuss their abortion experiences; however, I think those who chose to participate may have felt more assured of their confidentiality knowing that a non-Turkish researcher was conducting the research.

That being said, there are drawbacks associated with being a white Western researcher doing international research. My racial and Global North privilege may create a power imbalance between the researcher and participants, and participants may feel their stories are not appreciated with the same nuance as they would be if revealed to someone from their own culture. We had a female interpreter assist with the Turkish-language interviews, necessary for logistical reasons but it also alleviated some of the cultural gap and helped to develop comfort with participants.

Upon completing each interview, the interpreter and I would discuss overarching dynamics that arose during the interview. Specifically, we reflected on our interviewing techniques including active listening, echoing of participant language, and non-judgemental word choice and tone, and aimed to acknowledge the ways in which we had influenced the interview process and outcomes. Through formal memoing, I also reflected on the unique dynamic I introduced to the research process as a Western researcher.

6.4 Importance of reproductive justice

The overarching design and implementation of this research project used a reproductive justice framework. I will outline the nature of reproductive justice and its relevance to this project, as well as how this influenced my positionality throughout the study. Reproductive justice is an ideology that evolved from the pro-choice movement during the 1980s. Initially, advocacy for abortion dominated the reproductive rights movement. However, this movement did not give a voice to the reproductive rights of marginalized populations, namely visible minority and low-income women, and their equal right to parenting. Thus, reproductive justice expanded to encompass the right to not have a child, the right to have a child, and the right to parent children you already have (Ross, 2006).

Reproductive justice is an important consideration in any study dealing with sexual and reproductive health, but reproductive justice is intimately tied to the Turkish context for two reasons. First, the rising state interest in women's reproductive capacity is reason enough for increased sensitivity when conducting

research relating to reproductive health in Turkey. Indeed, our participants vocalized this tension between state- and individual-level reproductive interests. Some of our participants felt that their reproductive lives were being deliberately manipulated for a greater purpose. These perceptions around reproductive justice were a vital consideration to me. A major part of my positionality has to do with my own beliefs about and experiences with reproductive justice. I possess a great deal of privilege when it comes to the amount of control I have over my own reproductive life, largely because of my race, socioeconomic status, and home country, and I carried this privilege with me into the study. During our interviews, women spoke about the many ways in which their reproductive lives are being influenced – by the state, by their husbands, by their families – and it was important for me to acknowledge my position of privilege accordingly. Namely, I aimed to reflect on whether or not my own perspectives were influencing the course of questioning and probing during interviews, and whether my position influenced the overall tone of the interviews. I memoed often about reproductive justice elements that emerged from the interviews, debriefed with my research assistant, and was very intentional about using qualitative interviewing skills such as active listening and mirroring language use of the participant.

Finally, reproductive justice was an important lens for this study due to the legacy of conflict between the Turks and the Kurds, and how the discrepancy between the Turkish and Kurdish total fertility rate (TFR) factors into this political dynamic. Koç, Hancioğlu & Cavlin (2008) recently determined that the total fertility rate (TFR) of the Turkish population was 1.88 compared to the TFR of Kurds at 4.07.

Some key informants I spoke with believe that one of the motivations behind the government's pronatalist policy stems from a nationalist and anti-Kurdish agenda. Specifically, some believe that Erdoğan may be concerned with elevating the Turkish fertility rate to keep pace with the high fertility rate among the Kurdish population. As one key informant put it: "I don't think any politician ever said 'Have three kids because the Kurds are gonna take over.' But I definitely think it's kind of one of the underlying messages is that we need to reproduce." There are several reasons, beyond the scope of this thesis, why the Turkish government may have a stake in encouraging the growth of the Turkish population while simultaneously limiting the overall reproductive capacity of the Kurdish people. As the anti-Kurdish political sentiment heightens, there is a corresponding need for reproductive justice considerations among Kurdish and Turkish populations in particular.

6.5 Limitations

There are a number of limitations associated with this study. First, I was based in Istanbul between May-August 2015; the data collection period was relatively brief given the expected scope of the project. Data collection during the month of Ramadan and Eid was particularly challenging, given that many locals were fasting and typically work fewer hours. It is not uncommon for people to leave Istanbul and travel to visit family during this time period, and we were unable to schedule interviews with two potential participants for this reason.

Second, the study was limited to the metropolitan Istanbul area and was not able to shed light on abortion access in other parts of the country. This was an

intentional decision but is also a significant limitation, especially since the availability of health care services tends to decline in rural parts of the country. Our study was also unable to capture the experiences of women who may have sought abortion services but were unable to obtain them.

Recruiting also posed a major challenge. We had originally aimed to conduct approximately 30 in-depth interviews with women. Although abortion is widely acceptable among the public and is often considered less stigmatized in Turkey than in other parts of the world, the political dynamics surrounding the topic have rendered many Turkish women reluctant to discuss the subject openly. Because we were unable to complete the anticipated number of interviews, we did not achieve thematic saturation on all aspects of the interview guide. In addition, we recruited primarily through social media and feminist organizations; therefore we tended to recruit women of a higher education level and socioeconomic status. It was difficult to access communities from a range of sociocultural backgrounds. As with all qualitative research, our findings are in no way representative of the experiences of other women in Istanbul or elsewhere, and are not generalizable to other populations. Our study was also limited in that we only captured the experiences of women who were actually able to reach abortion services. It is highly probable that some Turkish women are not able to mobilize the resources to obtain an abortion in the first place and we were unable to document their experiences and perspectives, which would have offered valuable insights into the availability of abortion care.

Another limitation associated with the study was the fluctuating political situation in Turkey. Although Turkey generally remains a safe place to live and visit,

it has been through some political unrest in the last two years. Within the last year, there have been a number of terrorist attacks in Southeastern Anatolia, Ankara, and Istanbul, beginning with a major bombing in Suruç in July 2015. Security measures were heightened countrywide and a travel advisory was imposed on all metro and public transit lines in Istanbul during my final month of data collection. While my supervisor and I monitored the situation closely and were confident that Istanbul remained a safe place to work and conduct research, the reality of these restrictions made conducting fieldwork around the city more challenging.

6.6 Statement of contribution

I conducted this project in partial fulfillment of the requirements for the Master of Science in Interdisciplinary Health Sciences at the University of Ottawa. Acting as the Principal Investigator (PI), I conceptualized the study, designed the study instruments, collected and analyzed the data, and led the drafting of the manuscripts. I also coordinated efforts to disseminate the study findings in Istanbul.

This project, however, was possible only through the collaboration of our study team. My thesis supervisor, Dr. Angel M. Foster, offered ongoing feedback to inform my study design and ensure it was a project of reasonable scope. She was involved with writing the thesis proposal, obtaining ethics approval, applying for funding opportunities, and facilitating connections with local organizations in Istanbul. We were in regular contact during my fieldwork and she also supervised the analytic process by listening to the audio recordings of my interviews, reading my transcripts and memos, and giving feedback during the coding process.

Dr. Mary Lou O'Neil, the Director of the Gender and Women's Studies at Kadir Has University, acted as a local affiliate in Istanbul for the duration of the project. She offered me a workspace at the research centre and met with me several times during my fieldwork to provide guidance on recruitment strategies and the interpretation of findings.

Deniz Tekdemir and Elvin Çetin were our local research assistants in Istanbul. They assisted with the recruitment of participants, communicated with potential participants and key informants, and interpreted and translated the Turkish-language interviews. Barış Bilgen reviewed the transcripts to verify accuracy of translation and translated Turkish-language sources and quotes throughout the research process.

As the PI of the project, I led the development of all manuscripts. All contributing authors meet the criteria for authorship as defined by each journal. The co-authors provided considerable feedback at various stages of the writing process, and have approved the final manuscripts included in this thesis.

6.7 Conclusion

Under the political leadership of the AKP, Turkey has experienced dramatic political and social change within the last decade. The AKP has unremittingly preached pronatalist rhetoric. As a party, they have emphasized the importance of the "traditional family" and openly devalued women's reproductive rights. This culminated in a direct attack on abortion rights in 2012. The findings from this thesis suggest that, despite the lack of any legislative change in 2012, the enormous

influence of the ruling political party has impacted practical access to services. Whether directly or indirectly, the government has created a culture of misinformation, fear, and uncertainty around abortion access, and they seem to have applied pressure on the Ministry of Health, hospitals, and clinics to reduce access to abortion and contraceptive services.

It appears that abortion services in the public sector of Istanbul and likely other large cities in Turkey have decreased substantially. Furthermore, the Turkish health reform has resulted in the closure of dedicated maternal and family planning clinics, creating a gap in reproductive health service delivery. Although further research is warranted, it appears that access to contraceptives under the public system has also become much more inconsistent and many women are resorting to the private sector to obtain not only abortion services, but also modern methods of contraception.

In August 2014, President Erdoğan was elected for a four-year term and in November 2015, the AKP regained their majority in the Turkish Parliament. It stands to reason that the AKP will hold key decision-making power in Turkish politics for years to come. This highlights the need for international pressure and advocacy efforts within Turkey to petition for the continued reproductive rights of Turkish women.

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Appendix A: Map of Turkey

Source: Rand McNally (La Historia Con Mapas)

Appendix B: Certificate and letter of ethics approval

File Number: 02-15-05 **Date (mm/dd/yyyy):** 03/25/2015

Université d'Ottawa University of Ottawa
Bureau d'éthique et d'intégrité de la recherche Office of Research Ethics and Integrity

Certificate of Ethics Approval

Social Science and Humanities REB

Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

First Name	Last Name	Affiliation	Role
Angel	Foster	Health Sciences / Interdisciplinary School	Supervisor
Kate	MacFarlane	Health Sciences / Interdisciplinary School	Student Researcher

File Number: 02-15-05

Type of Project: Master's Thesis

Title: An Assessment of Women's Abortion Experiences in Istanbul, Turkey

Approval Date (mm/dd/yyyy)	Expiry Date (mm/dd/yyyy)	Approval Type
03/25/2015	03/24/2016	Ia

(Ia: Approval, Ib: Approval for initial stage only)

Special Conditions / Comments:
N/A

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File Number: 02-15-05 **Date (mm/dd/yyyy):** 03/25/2015

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This is to confirm that the University of Ottawa Research Ethics Board identified above, which operates in accordance with the Tri-Council Policy Statement and other applicable laws and regulations in Ontario, has examined and approved the application for ethical approval for the above named research project as of the Ethics Approval Date indicated for the period above and subject to the conditions listed the section above entitled "Special Conditions / Comments".

During the course of the study the protocol may not be modified without prior written approval from the REB except when necessary to remove subjects from immediate endangerment or when the modification(s) pertain to only administrative or logistical components of the study (e.g. change of telephone number). Investigators must also promptly alert the REB of any changes which increase the risk to participant(s), any changes which considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project and safety of the participant(s). Modifications to the project, information/consent documentation, and/or recruitment documentation, should be submitted to this office for approval using the "Modification to research project" form available at: http://recherche.uottawa.ca/deontologie/submissions-and-reviews.

Please submit an annual status report to the Protocol Officer 4 weeks before the above-referenced expiry date to either close the file or request a renewal of ethics approval. This document can be found at: http://recherche.uottawa.ca/deontologie/submissions-and-reviews.

If you have any questions, please do not hesitate to contact the Ethics Office at extension 5387 or by e-mail at: ethics@uOttawa.ca.

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