RISING ANTI-ABORTION SENTIMENT IN TURKEY:

DETERMINANTS OF ABORTION ATTITUDES FROM 1990 TO 2018

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DECLARATION OF ORIGINALITY

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- I am the sole author of this thesis and that I have fully acknowledged and documented in my thesis all sources of ideas and words, including digital resources, which have been produced or published by another person or institution;
- this thesis contains no material that has been submitted or accepted for a degree or diploma in any other educational institution;
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ABSTRACT

Rising Anti-Abortion Sentiment in Turkey:

Determinants of Abortion Attitudes from 1990 to 2018

Although abortion has been legal in Turkey since 1983, increasing conservative political rhetoric and de facto restrictions in recent years have made it less accessible and more stigmatized. This mixed-methods thesis examines how attitudes toward abortion have changed in Turkey between 1990 and 2018 and the role of factors such as religious beliefs, political views, income, and education in this change. In this context, the thesis uses World Values Survey data to analyze the determinants of abortion attitudes using ordered logistic regression models. In addition, in-depth interviews with ob-gyns who have over 20 years of experience were used to investigate the implications of changing attitudes toward abortion and stigmatization in the healthcare settings. Quantitative findings show that anti-abortion attitudes have increased significantly from 1990 to 2018, and that religious beliefs and political conservatism are the strongest and most persistent determinants of attitudes toward abortion. In contrast, the effects of income and education have weakened over time. Qualitative findings reveal that the politicization of anti-abortion discourse and institutional restrictions have led to the marginalization of abortion services in public hospitals and weakened the capacity and motivation of healthcare workers to provide these services. The thesis demonstrates how attitudes toward abortion in Turkey have been influenced by ideological polarization and an increasingly conservative political atmosphere, and how this has resulted in negative consequences for access to abortion services.

ÖZET

Türkiye'de Yükselen Kürtaj Karşıtlığı:
1990'dan 2018'e Kürtaja Yönelik Tutumların Belirleyicileri

Türkiye'de kürtajın 1983'ten bu yana yasal olmasına rağmen, son yıllarda artan muhafazakâr politik söylem ve fiili kısıtlamalar kürtaja erişimi güçleştirmiştir ve kürtaj giderek daha stigmatize hale gelmiştir. Bu tez, Türkiye'de 1990-2018 yılları arasında kürtaja yönelik toplumsal tutumların nasıl değiştiğini ve bu değişimde dini inanç, siyasi görüş, gelir ve eğitim gibi faktörlerin rolünü incelemektedir. Bu bağlamda, tezde Dünya Değerler Araştırması verileri kullanılarak sıralı lojistik regresyon modelleri ile kürtaja yönelik tutumların belirleyicileri analiz edilmiştir. Ayrıca, 20 yılı aşkın deneyime sahip kadın doğum uzmanları ile yapılan derinlemesine görüşmeler aracılığıyla kürtaja yönelik tutumlardaki değişimin ve stigmatizasyonun sağlık alanındaki yansımaları araştırılmıştır. Nicel bulgular, kürtaj karşıtı tutumların 1990'dan 2018'e belirgin şekilde arttığını ve dini inanç ile siyasi muhafazakarlığın kürtaja yönelik en güçlü ve kalıcı belirleyiciler olduğunu göstermektedir. Buna karşılık, gelir ve eğitimin etkisinin zamanla zayıfladığı gözlemlenmiştir. Nitel bulgular ise, politikleşen kürtaj karşıtı söylemin ve kurumsal kısıtlamaların kamu hastanelerinde kürtaj hizmetlerinin marjinalleşmesine ve sağlık çalışanlarının bu hizmetleri sunma kapasite ve motivasyonunun zayıflamasına yol açtığını ortaya koymaktadır. Tez, Türkiye'de kürtaja yönelik tutumların ideolojik kutuplaşma ve artan muhafazakar politik atmosferden nasıl etkilendiğini ve bunun kürtaj hizmetlerine erişim üzerindeki olumsuz sonuçlarını ortaya koymaktadır.

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CHAPTER 1

INTRODUCTION

The infamous 2012 utterance of the then-Turkish Prime Minister Recep Tayyip Erdoğan: "Every abortion is an Uludere. Abortion is an insidious plan to eliminate a nation from the world stage"[1] (Bianet, 2012a) was simply the beginning of a still-ongoing abortion rights issue in Turkey. Just a few days after this statement, Erdoğan announced official plans for an abortion ban (Al Jazeera Turk, 2012), which never ended up being enacted but is now a de facto regulation in public hospitals across Turkey.

Erdoğan's words and the announcement of a potential abortion ban sparked two completely different reactions in Turkish society. While some opposed the ban, arguing that it could potentially cause a surge in maternal mortality rates, and that access to abortion is crucial for protecting women's freedom, bodily autonomy, and agency; others showed their support, insisting that abortion is inherently unethical and against the religious beliefs of Islam, and that the ban would prevent women from making immoral decisions they might regret in the future (Uras & Sudagezer, 2012).

The coexistence of such polarized views in contemporary Turkish society reveals the multifaceted nature of the abortion debate, involving religious beliefs, socio-economic inequalities, and the growing state control over reproduction. Although abortion has been legal in Turkey since 1983, de facto restrictions on access to abortion services, the hostile rhetoric created by political leaders and

[1] Erdoğan's controversial statement was analogy between abortion and the 2011 Uludere Massacre, which involved the killing of 34 Kurdish civilians by a military strike in Uludere, a Kurdish majority town situated by the Iraqi-Turkish border.

supported by religious institutions, and changes in the healthcare system have made it difficult for women to exercise this right in practice. Considering the growing conservatism in Turkish politics and society under the rule of AKP, this thesis focuses on the shifting demographic determinants of abortion attitudes between 1990 and 2018 in Turkey. Furthermore, it explores the impact of these attitudinal changes and the current hostile political climate on the experiences of health professionals who provide abortion services.

Using a mixed methodology, the thesis consists of two parts: I first examine the four strongest indicators of attitudes toward abortion, namely religiosity, political stance, education, and income (Adamczyk et al., 2020) using Ordered Logistic Regression models based on data collected in Turkey in 1990, 2007, 2011, and 2018 from the World Values Survey and compute interaction models to investigate how they changed. Following the data analysis, I examine how changing social attitudes and the political atmosphere are reflected in the experiences of healthcare professionals providing abortion services through in-depth interviews with seven obstetrician-gynecologists who has at least 20 years of professional experience. Combining data analysis with real-life narratives, the use of mixed methods will help build a more comprehensive interpretation of the findings, especially when studying complex or sensitive social phenomena (Condomines & Hennequin, 2013) such as abortion. This way, the thesis aims to contribute to the literature not only through its findings but also through its methodological choices.

Abortion attitudes have been studied extensively worldwide yet less is known about the shifting abortion attitudes and their reflections on abortion services in Turkey. Existing research either focuses on the abortion attitudes among a specific group (see Özmen et al., 2019; Ayraler, 2023; Yanikkerem et al., 2018), failing to

capture nationally representative trends, or disregards the political dimension of the issue (see Fidan et al., 2021; Hatun & Yılmaz, 2020). However, in countries where pronatalist policies and conservative discourse around abortion prevail, such as Turkey, the effect of political stance could indeed reveal a different dimension of the abortion debate.

Much of the research on abortion in Turkey approaches abortion from legal and moral perspectives (see Kansu, 2016; Sayar & Öztürk, 2018; Özaltuğ, 2018). However, these approaches are insufficient because legality or moral perspectives are not the only factors determining women's access to safe abortions; social norms and attitudes also play a major role (Jelen & Wilcox, 2003). Leading to abortion stigma, anti-abortion attitudes can create a sense of shame and guilt on individuals who choose to have an abortion and may push them to seek abortion through unsafe means and discourage them from seeking follow-up care when needed (Kumar et al., 2009). In such context, the reproductive justice approach underlines the importance of ensuring that individuals can access these services not only legally, but also safely, with support, and without judgment.

Reproductive justice framework analyzes different policies and practices as part of an interconnected system, especially in light of unequal power relations created by the state, identifying and addressing intersectional inequalities within the system to support reproductive rights and access (Luna & Luker, 2013). Women have decreased access to safe abortions and an increased risk of suffering the economic and emotional consequences of forced childbearing in countries where abortion is highly stigmatized (Ostrach, 2016), depriving them of their reproductive autonomy. Hence, within this framework, studying anti-abortion attitudes and abortion stigma in Turkey is particularly crucial. To address this critical issue, this thesis asks the

following questions: How did attitudes toward abortion change in Turkey between 1990 and 2018, and what role did religiosity, political stance, education, and income play in this change? How did the changes in attitudes and the increasingly conservative political atmosphere shape the experiences of doctors who provide abortion services?

The thesis consists of 6 chapters: In Chapter 1 (Introduction), I introduce the topic and present my research questions, with a specific focus on how the research will contribute to the literature on attitudes toward abortion and the experiences of healthcare workers. In Chapter 2 (Literature review), I introduce the literature on both abortion policies in Turkey and the broader literature on determinants of abortion attitudes. This chapter includes 6 subsections: In the first subsection, Background: History of Abortion Policies in Turkey, I provide a background on abortion policies in the late Ottoman Empire, pronatalist policies of the early Turkish Republic, and legalization of abortion in Turkey. In the second subsection, Politicization of Abortion in Contemporary Turkey, I examine the current political discourse around abortion. In the third subsection, Determinants of Abortion Attitudes, I present the literature on the predictors of attitudes toward abortion around the world. In the fourth subsection, Second Demographic Transition and Value Change in Turkey, I provide a brief background on my theoretical framework and how it relates to Turkey. In the fifth subsection, Abortion Stigma and the Role of Abortion Providers, I discuss abortion stigma and the importance of incorporating experiences of abortion providers to this research, while also touching upon the relevant literature. In the last subsection, I present and explain my hypotheses. Chapter 3, Determinants of Abortion Attitudes, is all about the quantitative part of my mixed-methods research. In this chapter, I first provide information about my

dataset, the relevant variables, and the statistical methods I will be using; afterwards, I present and interpret the results of the data analysis. In the next chapter, Chapter 4, Experiences of Abortion Providers, I move on to the qualitative part. In this chapter, I first explain the in-depth interviews I have conducted and provide information about the participants and then move on to the analysis of the key themes that came up in the interviews. In Chapter 5, Discussion, I bring together the results of the quantitative and qualitative analyses, contextualizing the findings of the quantitative data analysis using the insights from the in-depth interviews. In the final chapter, Conclusion, I summarize the findings and present the contribution of the research to the literature and its implications.

CHAPTER 2

LITERATURE REVIEW

The literature review of my thesis consists of six subsections. In the first subsection, I review the literature on the abortion policies in Turkey from the late Ottoman period to 2025 in order to summarize and discuss how abortion policies have shifted at different periods. In the second subsection, I discuss how abortion has been increasingly politicized under the rule of the Justice and Development Party. In the third subsection, I explore the existing literature about the determinants of attitudes toward abortion both in Turkey and globally. In the fourth subsection, I introduce the theoretical framework. In the fifth subsection, I discuss the relevant literature on abortion stigma and the experiences of abortion providers, and finally, in the last subsection, I formulate and explain my hypotheses.

2.1 Background: History of the abortion policies in Turkey

2.1.1 Abortion in the late Ottoman Empire

The Ottoman Empire was largely governed by Islamic law, and the criminal law system was based on the Hanafi school of Islamic jurisprudence (Demirsoy, 2018). According to the Hanafi sect, abortion was considered *makruh* in the first 120 days of pregnancy when the mother's life was in danger, that is, it was not recommended, but it was also neither considered a sin nor prohibited (Balsoy, 2012). Although the Hanafi sect permitted abortion within certain limits, the Empire began to limit abortion in the 18th century onwards, as it started to view reproduction as a means of population control (Esengen, 2021).

The main reason why the Empire valued demographic information was that it allowed the state to obtain data on taxation, military enlistment and minorities like non-Muslims (Özbay, 2010). For instance, the first census conducted in 1831 only included men, since the sole purpose of this census was to obtain data on military service and taxation. Starting from the 19th century, together with the rise of modernization, the disciplines of medicine and law became the core pillars of power, and the state began to prioritize public health, reproductive health, fertility, and women's bodies started to become subjects of state intervention (Erkmen, 2020). In other words, in an era of new public health regulations, abortion became a tool for the state to "manage and interfere in women's bodies and lives"[2] (Erkmen, 2020, p. 29).

Foucault's concept of biopolitical power, which he observed emerging in 18th-century Europe, also began to emerge in the Ottoman Empire during the same century, as the empire implemented population policies that made biopolitical governance visible within its own administrative structure (Atay, 2017). One of the first explicit manifestations of these policies and one of the first attempts of the state to limit abortions was an edict prepared by Meclis-i Umûr-u Nâfia in 1838, which explicitly emphasized that a nation's wellbeing depended on the size of its population (Ertem, 2011). This edict required doulas, pharmacists and doctors to take an oath not to provide women with medications that induce abortion (Balsoy, 2012) and anyone who provided such medications were exiled (Erkmen, 2020). The rationale behind this document was that the state derived its power from the size of its population, a view shared commonly across Europe at the time. In addition to such administrative restrictions, abortion was first criminalized with the Penal Code of

[2] "Kadın bedenini ve hayatını yönetme ve müdahaleye açma" in Turkish.

1858. Articles 192 and 193 of this Penal Code indicate that whoever causes a pregnant woman to abort her child by administering to her, with or without her consent, a drug would be sentenced to imprisonment (Atay, 2017).

During this period, although abortion was criminalized, women continued to have abortions through illegal practices. As a result, to further discourage people from getting abortions, Abdulhamid II, who was the caliph at that time, announced that abortion was considered a sinful act by the Quran and Muhammad (Ertem, 2011). Starting in 1904, various financial incentives were introduced to discourage women from having abortions and encourage childbirth (Erkmen, 2020). All in all, the criminalization of abortion and the increasing state regulation of reproduction in the late Ottoman Empire reflected a broader shift toward biopolitical governance, where the government's way of seeing society shifted from "a scattered entity" to a population that "needed to be observed, controlled and disciplined" (p. 52), and public health policies served not merely to modernize society, but to discipline and control women's bodies by reinforcing their role as childbearers within a newly politicized concept of family (Ertem, 2011).

2.1.2 Abortion in the early Turkish Republic: Pronatalist policies

For approximately 15 years prior to the founding of the Turkish Republic, the population declined due to wars including the Balkan Wars, World War I, and the War of Independence. In addition to the deaths directly caused by these wars, war conditions led to increased health problems, economic deterioration, and, consequently, higher infant mortality rates. However, there was a need for labor in agriculture and industry to ensure the country's economic development (Akın & Aykut, 2011). This led to the implementation of pro-natalist policies, as reflected in

words of Mustafa Kemal Atatürk: "The protection and improvement of the health of our nation, the reduction of mortality rates, the promotion of population growth, the eradication of epidemics to improve public health, and thereby ensuring that the individuals of the nation are vigorous and capable of work, are our objectives" (Akın & Aykut, 2011, p. 4). Atatürk's words serve as evidence that the state pursued population policies aimed at increasing the population.

Several restrictions were imposed to support pronatalist population policies. In the Early Republican Period, starting in the 1920s, birth control methods were highly restricted. In addition, providing education on birth control and promoting birth control were also prohibited (Ertem, 2011). Abortion was initially addressed under the heading "Crimes Against Persons"[3] in the 1926 Turkish Penal Code, but with the 1936 amendment, it was moved to the heading "Crimes Against the Integrity and Health of the Race"[4] (Konan, 2008). At the same time, the 1926 law prohibited intentional abortions performed using drugs or instruments on the grounds of "the right to life and bodily integrity" (Karaömerlioğlu, 2012). These policies reflect the importance attached by the new Turkish state to the power that population growth would bring: Population, in a sense, meant wealth, power, and greatness. In fact, the transfer of abortion to the heading "Crimes Against the Integrity and Health of the Race" shows that abortion was perceived as a crime and a threat against the nation. Women's reproductive and sexual behaviors were brought under state control, and the state viewed the right to abortion as a threat to the nation's integrity and health; as a result, "reproduction became the cornerstone of the nation's integrity"[5] (Erkmen, 2020, p. 52).

[3] "Kişilere Karşı İşlenen Cürümler" in Turkish.
[4] "Irkın Bütünlüğüne ve Sağlığına Karşı İşlenen Cürümler" in Turkish.
[5] "Üreme, ulusun bütünlüğünün yapıtaşı olmuştur" in Turkish.

Another indicator of pronatalist policies, alongside restrictions on abortion and birth control, is the 1930 General Public Health Law, which encouraged women to give birth. This law tasked the Ministry of Health with encouraging childbirth by providing various material and moral rewards to women with six or more children (Akın & Aykut, 2011). During this period, courses on childcare and motherhood were introduced into the education curriculum to increase the birth rate, thereby teaching girls the values of motherhood (Erkmen, 2020). Leading political actors of the time emphasized that social concepts such as family, children, and marriage were of direct concern to the state. The state also made its anti-abortion stance clear through articles shared with the general public. For instance, abortion was defined as "an open betrayal against the Turkish world for nations and countries like ours that need to multiply in a short time..."[6] in the magazine Ülkü, which was part of the propaganda apparatus of the period (Karaömerlioğlu, 2012).

The pronatalist policies implemented during the early Republican period proved effective. Conducted in 1927, the first census of the Turkish Republic revealed that the population was 13,648,270. This number rose to 16,188,767 in 1935, indicating a growth of 21.1% (Bostan & Doğan, 2019). Alongside population growth, there was also a significant increase in migration from rural areas to cities due to industrialization. However, the level of industrialization in major cities and their infrastructure were not sufficient to accommodate such a large influx of migrants and the high population that came with it (Toksöz, 2011). As a result, by the 1960s, the population, which had previously been regarded as a national resource, began to be seen as a source of social and economic problems (Gürsoy, 1996), leading to a shift toward anti-natalist policies.

[6] "bizim gibi az zaman içinde çoğalmaya muhtaç olan millet ve memleketler için... Türk dünyasına karşı açık bir ihanet" in Turkish.

2.1.3 Toward legalization from the 1950s to the Population Planning Law of 1983

As in many historical contexts where abortion was banned, the prohibition of abortion in Turkey did not stop the practice of clandestine, illegal abortions. Despite being classified as a crime by law and subject to penalties, the number of women who terminated their pregnancies using various objects or abortifacient drugs/foods under unhealthy conditions increased alongside population growth. This situation drew the attention of many doctors, who prepared reports on deaths caused by unsafe abortions.

The first of these reports was prepared by Dr. Zekai Tahir Burak, who conducted a study on 5,000 women at the Ankara Maternity Hospital. He determined that 30% of the 5,000 women had previously terminated their pregnancies through induced abortions. He also found that the maternal mortality rate among women who had undergone abortions was four times higher than among those who had not, and that 27% of the surviving women became infertile after the abortion (Kaleci et al., 2013). Dr. Zekai Tahir Burak, who submitted the report to the Ministry of Health, emphasized the need to take necessary measures to prevent deaths caused by unsafe abortions and to legalize birth control (Akın & Aykut, 2011, p. 4).

Another valuable report was prepared by Dr. Nusret Fişek. Prof. Dr. Ayşe Akın summarized Dr. Nusret Fişek's report, which was based on his study of 137 villages, in an interview as follows: "At that time, Nusret Fişek (my mentor) found that 53% of maternal deaths were due to induced abortions based on his research in 137 villages... one in two maternal deaths was due to abortion."[7] (Kaleci et al., 2013, p. 17). These two reports revealed how unsafe abortions pose a serious threat to women's health.

[7] "O sırada Nusret Fişek (benim hocam) 137 köyde yaptığı araştırmaya göre anne ölümlerinin %53'ünün isteyerek düşüğe bağlı olduğunu ortaya çıkardı" in Turkish.

At this point, the government had already initiated measures to limit population growth. In the First Five-Year Development Plan prepared in 1963, population growth was identified as one of the main obstacles to development (Gürsoy, 1996). During this period, Turkey abandoned its pronatalist policies and began to implement antinatalist policies. As part of these policies, the reports that documented the consequences and risks of abortions performed under unsanitary conditions also served to support the decision-making process. In 1965, Law No. 557 on Population Planning, prepared in line with the development plan, legalized the use of birth control methods (Erkmen, 2020). As mentioned earlier, before this law, it was illegal to provide education on birth control or to promote birth control. With this law, these restrictions were lifted, and the state began educational activities to raise public awareness about birth control (Karaömerlioğlu, 2012). The Justice Party government continued this objective with the Second Five-Year Development Plan prepared in 1967.

The fact that birth control methods were only made available by the state when population growth began to create economic and social problems, and that access to birth control methods was only granted at this point, indicates that the state viewed birth control as a population control tool rather than a human right (Keskin, 2014). During this period, the ban on abortion was not fully lifted; abortion was only permitted if the health of the mother or the fetus was at risk.

In the 1970s, the abortion debate resurfaced. During this period, the issue of abortion was raised by various civil society organizations as well as professional organizations such as the Turkish Medical Association. Dr. Erdal Atabek, the President of the Turkish Medical Association, advocated that the state should provide abortion as a free service to the public, and a survey conducted by the Turkish

Medical Association found that 94% of doctors supported the legalization of abortion (Karaömerlioğlu, 2012). In 1979, 2% of all abortions performed worldwide occurred in Turkey; when comparing the populations, the rate of illegal abortions in Turkey was found to be twice the global average (Kaleci et al., 2013).

After the 1980 coup, the legalization of abortion was placed on the agenda of the Consultative Assembly, and a bill on the legalization of abortion was submitted to parliament. Upon reviewing this bill[8], I can highlight the following points: First, the bill draws attention to the increasing infant mortality rates and maternal deaths and disabilities resulting from illegal abortions. Second, the bill notes that abortion is expensive because it is performed in secret, meaning that only families with a certain income can afford it, while women who cannot afford it are victimized. The bill emphasizes that women resort to tools such as matchsticks, soap, and nails as a last resort, which leads to very poor health outcomes. The fact that illegal abortions were not prosecuted legally and that only a small number of abortions were prosecuted had also drawn attention; it has been argued that this situation led to a decline in respect for the law.

Following this proposal, the Health and Social Affairs Committee announced that abortions performed within the first 10 weeks of pregnancy would be permitted (Atay, 2017). Finally, with the Population Planning Law adopted on March 26, 1983, abortion was legalized within the first ten weeks of pregnancy. Article 2 of the law states that abortion shall be performed entirely "under state supervision and control"[9] and that "pregnancy shall not be terminated except in cases provided for by law."[10] (Erkmen, 2020, p. 58). The language of the law and the limited freedom it granted

[8] The bill prepared by the Advisory Council of TBMM can be accessed online at https://www.tbmm.gov.tr/tutanaklar/TUTANAK/DM__/d02/c016/dm__02016083ss0347.pdf
[9] "Devletin gözetimi ve denetimi altında yapılır" in Turkish.
[10] "Bu kanunun öngördüğü haller dışında gebelik sona erdirilemez" in Turkish.

women were criticized by scholars who asserted that abortion was not recognized as a human right for women but served as a tool for implementing antinatalist population policies by placing women's bodies under state control (Erkmen, 2020). The legalization of abortion was not considered a human right given to women to enhance their conditions, but rather a strategy to be used to reduce birth rates (Keskin, 2014).

The abortion law is also criticized for the spousal consent requirement. According to this requirement, married women should obtain the consent of their husbands to be able to get an abortion. "Supporting a patriarchal society even on an issue such as abortion, which primarily affects women,"[11] this law legitimizes male authority over the bodies of married women, creates troubling circumstances in cases of marital rape, and undermines women's ability to make decisions about their own bodies (Komut, 2011, p. 93). Spousal consent may also discourage women from exercising their right to abortion if they believe that they will be subjected to physical violence or psychological abuse by their spouse, lose financial security, or be forced to stay at home if their spouse finds out about their intention to have an abortion (Sayar & Öztürk, 2018).

The legalization of abortion in 1983 is part of the broader antinatalist policies that had been implemented by the state since 1960s. As outlined in the first nine Development Plans, population growth was considered one of the major social problems that hindered the nation's quality of life: Despite significant increases in national income, it has been noted in the Development Plans that this increase has not been sufficiently reflected in national income per capita due to rapid population growth (Özdemir, 2017). With the 9th Development Plan, laws aimed at population

[11] "[Yasalar da] erkek egemen toplumu destekler nitelikte. Hem de öznesi sadece bir kadının olduğu kürtaj konusunda bile" in Turkish.

planning were directed toward maintaining population growth at a certain level (Özdemir, 2017), and with this Development Plan, which came into effect in 2007, antinatalist policies were abandoned.

2.2 Politicization of abortion in Turkey

Abortion has been legal since 1983 in Turkey under the Population Planning Law. Yet it remains highly politicized in contemporary Turkey, especially since the early 2000s under the rule of the Justice and Development Party (AKP). The social policies outlined in the AKP's party program when it won the 2002 election explicitly state that women are important not only because they make up half of society, but above all because they play a key role in raising healthy generations (AKP Kalkınma ve Demokratikleşme Programı, 2002, as cited in Erkmen, 2020). This framing of women's value primarily through their role as mothers has been reflected in the party's broader discourse on reproductive rights and abortion, particularly since 2012. Within this pronatalist agenda, women's bodies have become part of the political sphere (Ergeç, 2015), and abortion became an increasingly politicized issue with a politically- and religiously charged hostile rhetoric built around it.

One of the most telling examples of the politicization of abortion occurred in 2012 during the International Conference on Population and Development. During his speech, the then-Turkish Prime Minister Recep Tayyip Erdoğan said:

> I consider abortion an act of murder. No one should have the right to make this decision. Killing a child in the womb is no different than killing it after birth. There is no difference. We must be more sensitive to this issue. We must stand together against it. (Bianet, 2012b) (Appendix A, 1)

The day after his statement, Erdoğan continued to talk about abortion at the Congress of Justice and Development Party's Women Branches:

> I am a Prime Minister who is against cesarean births. I know that these are planned, and I know that they are steps taken to prevent the population of this country from growing. I also know that these steps are taken to generate financial resources for themselves [referring to foreign states]. This keeps the population of a country from growing. I view abortion as murder... I say every abortion is an Uludere. I ask you, what is the difference between killing a baby in the womb and killing it after birth? We must fight this battle together. We know that there is a sinister plan to wipe this nation off the face of the earth. (Hürriyet, 2012) (Appendix A, 2)

Erdoğan's anti-abortion rhetoric revolves around three main themes: (1) There is a clear emphasis on the fetus, while women are relegated to the background, (2) abortion is framed as a national security threat tied to foreign conspiracies instead of a matter of healthcare, individual rights or reproductive justice, (3) perhaps in parallel to the second theme, abortion is transformed into a symbol of collective trauma, reframing women's reproductive choices as acts of betrayal against the nation. The third point is most clearly reflected in Erdoğan's analogy between abortion and the Uludere massacre, during which 34 Kurdish civilians were killed by a military strike. A few days after he made these statements, Erdoğan announced that he had held a meeting with the then-Minister of Health and that they had begun preparations for an abortion ban (Al Jazeera Turk, 2012).

Since then, the prominent discourse of AKP consistently linked abortion, birth control and family planning to national strength and *yerli ve milli*[12] Turkish family values. At a wedding he officiated in 2018, Erdoğan criticized birth control, arguing that strong nations are built upon strong families and claiming that Turkey had been deceived for years through the promotion of birth control policies (Evrensel, 2018). He also reinforced this stance through religious rhetoric, declaring that having more children is a duty, and that no Muslim family should engage in birth

[12] "Yerli ve milli" is a Turkish political phrase that literally translates to "local and national." It is frequently used by conservative and nationalist politicians to define values that are in line with the cultural and moral traditions of the Turkish nation, in contrast to foreign or Western influences.

control or population planning, in line with his emphasis on the importance of having at least three children, which he has maintained since 2008. He further emphasized that the women should bear the primary responsibility in this matter and avoid using birth control. This narrative blends nationalism with religious conservatism, framing women's reproductive choices not as personal rights, but as moral obligations tied to the strength of the nation (Ekmek ve Gül, 2018).

Erdoğan's attempt to justify the abortion ban on religious grounds was widely supported by religious figures such as the President of Religious Affairs:

> A pregnant mother does not have the right or authority to say, "My body is mine, I can use it as I wish, I can have a baby, and if I want, I can throw it away." This is because she is not the true owner of the baby in her womb. She cannot abandon or kill it arbitrarily. She is a trustee responsible for caring for it, protecting it, and ensuring its survival. (Yeni Şafak, 2012) (Appendix A, 3)

Through statements like this, the Presidency of Religious Affairs rejects women's bodily autonomy by reducing the female body to merely a "carrier" of the fetus and framing pregnancy as a divine responsibility rather than a personal choice. Moreover, this discourse places the responsibility solely on women, reinforcing Erdoğan's repeated claim that women are primarily responsible for childbearing and avoiding contraception. Such statements exemplify how religion goes beyond being a belief system and becomes a tool that justifies conservative governance and control over reproduction.

Although abortion remains legal in Turkey and no formal ban has been enacted, it has become de facto inaccessible in practice. One of the leading causes of the decline in accessibility is the granting of conscientious objection rights to doctors, along with the inclusion of information in medical school curricula stating that abortion can be considered a matter of conscientious objection and that doctors may refuse to perform abortions (Köklü, 2022). In addition to conscientious

objection, doctors began to feel reluctant to provide abortion services due to fear of being blacklisted (Erkmen, 2020) as a result of statements made by state leaders and religious leaders.

Another policy that restricts access to abortion is the performance system implemented by the government as part of its Health Transformation Program[13]. The performance system is a program implemented by the Ministry of Health, where healthcare workers receive additional payments from revolving funds based on their performance scores in exchange for the services they provide. Within the performance system, abortion scores very low compared to surgical procedures known as "easy and low risk" such as cataract and appendectomy. Since abortion is already a risky procedure, this low score means that doctors may not want to perform a risky procedure that will earn them few points, leading to a decrease in abortion rates (Tıp Dünyası, n.d.). During her field research, Saluk (2014) proves through conversations with doctors that they do not want to perform abortions due to their low performance scores, and argues that this practice, like other neoliberal practices, serves to complement the government's pronatalist policies.

As a result of these de facto restrictions, abortion became largely inaccessible in Turkey. Perhaps the empirical study that best illustrates this inaccessibility is the Abortion Services Research Report published in 2020 by the Gender and Women's Studies Research Center at Kadir Has University. As part of this study, 295 state hospitals were surveyed using a confidential telephone survey. Out of the 295 hospitals, only 10 stated that they provided abortion services on demand (O'Neil et al., 2020).

[13] "Sağlıkta Dönüşüm Programı" in Turkish.

From restrictive policies and increasing accessibility to the anti-abortion political discourse, the history and politics of abortion in Turkey do not stand on their own; they shape and are shaped by public attitudes (Adair et al., 2024). The current politicization of abortion and its framing as a tool for moral and demographic control strengthen the existing stigma and lead to further polarization of opinions in Turkish society, where attitudes toward abortion become closely related to people's religious and political views. In the next section, I will review the existing literature on determinants of abortion attitudes.

2.3 Determinants of abortion attitudes

Attitudes toward abortion have been extensively studied by scholars in different parts of the world. Although these studies were conducted in a wide variety of contexts with different abortion laws and cultural backgrounds, they consistently identify a number of determinants that play a major role in shaping attitudes toward abortion. Religiosity, political stance, education, and income are the strongest determinants of abortion attitudes according to this body of literature (Adamczyk et al., 2020). Hence, in my thesis, I investigate the extent to which these determinants shape abortion attitudes in Turkey and how the relationship between these determinants and anti-abortion attitudes has changed over the years.

In the global literature, religiosity is accepted as one of the strongest determinants of abortion attitudes (Adamczyk et al., 2020; Jelen & Wilcox, 2003). Most religions support traditional family structures and gender roles (Adamczyk, 2013). Accordingly, the literature shows that religious people are more likely to adopt patriarchal norms (Engin & Pals, 2018) and conservative values (Yuchtman-Yaar & Alkalay, 2007); thus, those who are more religious tend to be less tolerant of

abortion (Osborne et al., 2022; Jozkowski et al., 2018). Furthermore, Osborne et al. (2022) find that both women and men with religious romantic partners are less supportive of elective abortion, compared to their peers whose partners did not define themselves as religious. Abortion attitudes also differ by religious affiliation and studies find that Muslims tend to be more pro-life than Catholics, Jews, and Buddhists (Adamczyk, 2013).

Among key religiosity measurements, attendance to religious services is one of the strongest predictors in countries with a Christian majority (Hess & Rueb, 2005; Adamczyk & Valdimarsdóttir, 2018). However, in countries with a Muslim majority, attendance to religious services is not a reliable measure. Unlike many Christian-majority settings where religious service attendance is expected of all believers, Friday prayers in Islam are obligatory only for men, and mosque attendance among women is uncommon (Utaberta et al., 2018). Therefore, attendance to religious services is a weak and/or unreliable predictor of abortion attitudes, as it might exclude or underrepresent women's religiosity.

Studies also use private religiosity (i.e., frequency of prayer), the importance of God and the importance of religion to measure the effect of religiosity on abortion attitudes. All of these variables have a negative effect on abortion attitudes, as participants who pray more often (Ogland & Verona, 2011) and who consider God and/or religion more important in their lives have more negative feelings toward abortion (Wilcox & Riches, 2002; Adamczyk, 2013; Pavić, 2024). Notably, studies show that the importance of God variable is the strongest predictor of abortion attitudes both in the United States (Nevitte et al., 1993) and in Turkey (Hatun & Yılmaz, 2020).

Regarding the relationship between religiosity and abortion attitudes in Turkey, a study by Fidan et al. (2021), using data from the fourth wave of the European Values Survey, suggests that a higher frequency of praying significantly leads to more negative attitudes toward abortion both when the woman is not married, and a married couple does not want any more children. In contrast, attendance at religious services had no significant effect in either scenario. In a similar study that uses the same dataset, the authors found that importance of God and importance of religion also significantly predict anti-abortion attitudes in both scenarios, as well as frequency of prayer (Hatun & Yılmaz, 2020). Similarly, using World Values Survey data and structural equation modeling, Yorulmaz (2023) found that religiosity consistently and significantly predicts abortion attitudes in both Wave 5 and Wave 7, and that higher religiosity is linked to less tolerance toward abortion.

In addition to survey-based nationally representative studies, there are also small-scale non-representative studies conducted in healthcare centers in different cities of Turkey. For example, in Manisa, Özmen et al. (2019) found that even though higher levels of religiosity were associated with more negative abortion attitudes, and many of the participants considered abortion a sin and/or murder, they also expressed more flexible attitudes toward abortion when the woman's life was in danger and/or the woman was mentally ill.

In addition to religiosity, political ideology is also considered an important determinant of abortion attitudes, especially in highly polarized political contexts. People with liberal views tend to be more tolerant towards abortion (Scoglio & Nayak, 2023), while more conservative respondents are generally less supportive (Osborne et al., 2022; Jozkowski et al., 2018). Studies that examine the relationship between party affiliation and abortion attitudes also support this pattern, as

Democrats consistently express pro-choice sentiments compared to Republicans in the United States (Hess & Rueb, 2005). Strickler and Danigelis (2002) suggest that the connection between positive abortion attitudes and political liberalism in the United States may be linked to "the rise of the Christian Right and the pro-choice response of the Democratic Party" (p. 199), which polarized abortion attitudes along ideological lines. Recent research also suggests that sexism may mediate the relationship between political conservatism and anti-abortion attitudes and that a significant portion of the relationship between anti-abortion attitudes and conservatism can be explained by individuals' levels of sexist beliefs (Merlici et al., 2025).

Considering that abortion has become highly politicized over the past 20 years in Turkey, it is surprising that most studies on abortion attitudes do not include political stance as a variable. To my knowledge, only two studies using nationally representative data account for political stance: In a study that focuses on the relationship between gender roles, religiosity, education, and abortion attitudes, Yorulmaz (2023) finds that political stance, measured on a left-right scale, significantly predicts abortion attitudes in both 2009 and 2019 and that those who place themselves on the left tend to find abortion more justifiable. Moreover, examining the differences between people who vote for religiously-oriented political parties and secular-oriented political parties Kaya & Sunar (2015) find that those who vote for religiously-oriented political parties tend to be more pro-life. In sum, the literature suggests that ideological predictors such as religiosity and political stance play an important role in determining attitudes toward abortion.

Attitudes toward abortion also significantly differ by social class and income. Higher household income, self-reported income and satisfaction with the income

level are associated with positive attitudes toward abortion (Misra, 1998; Cannedy & Lee, 2022), and there is also a significant negative relationship between higher levels of respondent reported income and disapproval of abortion (Adamczyk, 2022). In addition, Patrick (2013) finds a positive relationship between self-reported social class and abortion attitudes. One explanation for this pattern is that people with higher incomes tend to be liberal, which increases their support for reproductive rights (Fernández & Adamczyk, 2025). When we look at support for the legality of abortion rather than its justifiability, we can also see that having a lower income is a significant determinant of believing that abortion should be illegal in all or most cases (Thomas et al., 2017). Similarly, focusing on the circumstances under which people believe abortion should be legal, such as rape, health risks, and disabilities, Fernández and Adamczyk (2025) recently found that respondents who have a higher income are more likely to support legal abortion in a greater number of situations and at later stages of pregnancy than those with lower incomes.

Studies on the relationship between income and abortion attitudes in Turkey yield results consistent with global studies. Higher annual income is associated with a higher support for abortion both when the woman is not married or a couple does not want any more children (Hatun & Yılmaz, 2020; Fidan et al., 2021). Moreover, in a non-representative study conducted in Giresun, Ayraler (2023) found that women whose household income is above the minimum wage have more positive attitudes toward abortion than women whose household income is below the minimum wage.

Another factor that significantly influences people's attitudes toward abortion is education. Higher levels of education are consistently associated with greater acceptance of abortion (Osborne et al., 2022; Misra, 1998) across different circumstances such as birth defects, health risks for the woman, and for "any reason"

(Smith & Son, 2013). Dutta et al. (2024) suggests that education shapes individuals' attitudes by fostering open-mindedness and reducing prejudice, which in turn strengthens values like trust and respect, making educated people more likely to support abortion on demand compared to their less educated counterparts. Hence, individuals tend to find abortion more acceptable as they complete more years of education and transition to higher education (Granberg & Granberg, 1980; Scoglio & Nayak, 2023; Adamczyk, 2022), while those with primary or less education hold negative abortion attitudes (Mosley et al. 2017; Tuman et al., 2013). On the other hand, some studies underline that the statistically significant relationship between education attainment and acceptance of abortion has become weaker over time (Jelen & Wilcox, 2003).

Ayraler (2023) found that women with a university education held less stigmatizing attitudes toward abortion compared to their less educated counterparts in Giresun and Özmen et al. (2019) found that married women with higher education had more positive abortion attitudes in Manisa. Similarly, in their study involving students who pursue degrees in health sciences, Yanikkerem et al. (2018) concluded that midwifery and nursing students with a lower family income held more negative attitudes toward abortion. Lastly, attitudes toward abortion are not only influenced by participants' own educational levels; their mothers' educational levels also play a role in determining their attitudes. Students whose mothers had only completed elementary school were significantly more likely to oppose abortion than students whose mothers had a university degree (Kesen et al., 2015).

The determinants of attitudes toward abortion, such as religiosity, political stance, income, and education, have been clearly established. Scholars generally study these trends within broader theoretical frameworks, such as the Second

Demographic Transition (SDT) theory, which link modernization and changes in social values to increased tolerance within society and growing support for reproductive rights (Lesthaeghe, 2014; Brzozowska, 2021). However, this expectation may not hold true consistently across all contexts. It is therefore important to assess whether modernization in Turkey has led to more liberal attitudes toward abortion or whether these effects have been overridden by the political and religious climate. To this end, SDT theory offers a useful but somewhat controversial lens for examining the relationship between modernization and value change in Turkey.

2.4 Second Demographic Transition theory and value change in Turkey

After most European societies completed their initial demographic transition, i.e. shifted from high fertility and mortality rates to low ones, their fertility kept unexpectedly declining and most of them eventually reached below replacement levels. To explain this phenomenon of low fertility, van de Kaa and Lesthaeghe coined the term "Second Demographic Transition" (van de Kaa & Lesthaeghe, 1968).

SDT argues that the shift to postmodern values that underline personal autonomy and agency eventually transforms people's fertility behavior and leads to changes in the family (Zaidi & Morgan, 2017). To be more specific, SDT is characterised by an increase in divorce, cohabitation and ages at first marriage, and a decrease in marriage rates and remarriage (Lesthaeghe, 2014). In parallel, countries also experience an increase in women's education and economic autonomy, sexual revolution, and tolerance as a "prime value" (Lesthaeghe, 2014). Thus, according to

this theory, people demonstrate greater tolerance toward the behavior and choices of others.

Latest data from Turkey shows that fertility rates declined to 1.48 in 2024, falling well below the replacement level (TURKSTAT, 2025). In line with SDT, declining fertility in Turkish society is often attributed to increases in women's educational attainment, improvements in public health, and increased access to birth control and family planning (Çavlin et al., 2016; Senlet et al., 2001). However, it remains unclear whether these cultural and demographic changes are accompanied by the tolerance-based value changes proposed by SDT.

In Turkey, SDT indicators such as an increase in the female education levels, divorce rates and age at first marriage (Engin et al., 2020), as well as a dramatic decline in fertility rates, coexist with an increasingly conservative political atmosphere (Engin, 2018) and a religious and political narrative around reproduction and abortion. Considering this ambiguity, this thesis questions whether the value changes predicted by SDT regarding abortion might be constrained or invalidated by political and religious discourse.

2.5 Abortion stigma and the role of abortion providers

So far, I discussed that in the literature, attitudes towards abortion are generally studied at the individual and population level, through demographic determinants such as gender, age, education, and ideological determinants such as political attitudes and religiosity. However, it is important to remember that these attitudes do not exist on their own. They are both influenced by political discourse, institutional policies and the environment in which abortion services are provided, and affect them in return. In this context, it is important to recognize that abortion providers are

not only the enforcers of abortion law, but also active agents who are impacted by this political and ethical framework in which they keep making medical decisions. Hence, as well as enforcing the law through medical decisions, abortion providers also face the politicization, de facto restrictions, anti-abortion attitudes in society and stigma mentioned in the previous sub-sections every day in their professional lives.

Especially in places where abortion is highly stigmatized, doctors may internalize this stigma and think that abortion is wrong or "dirty work" (Joffe, 1978). The moral dimension of work that is perceived and stigmatized as "dirty work" has the greatest negative impact on workers and threatens identity (Ashforth & Kreiner, 2014), and the "moral (sinful) taint" (O'Donnell et al., 2011) assigned to abortion is even more pronounced in countries where abortion is highly stigmatized. The source of this moral stigma is often the ongoing ethical debate about the right to life of the unborn child (Dempsey et al., 2024). Especially in countries where conscientious objection is normalized, abortion providers have reported feeling "morally bankrupt" (Footman, 2025). In this context, the experiences of abortion providers in societies where abortion is perceived as a "morally tainted" service help us reveal how social norms and value judgments are reflected in medical practice and how stigmatization of abortion shapes professional attitudes and service provision.

At the same time, in countries where abortion is stigmatized, providers report that abortion services are avoided or relegated to the background in the institutions where they work (Footman, 2025), and they may also face pressure not to provide abortion services, especially in institutions where abortion stigma has religious undertones (Hasselbacher et al., 2020). Doctors have frequently expressed that people's attitudes towards abortion services can also be negatively affected, especially in societies where abortion services are tried to be prevented by restrictive

policies (Dempsey et al., 2024), and they think that the characteristics of restrictive policies aim to shame women and drive them away from abortion services (Mercier et al., 2015). On a broader scale, studies have also shown that restrictive policies in different places can influence people's attitudes; where abortion is supportive and accessible, people's attitudes are more positive, and vice versa, where policies restricting abortion are prevalent, public attitudes are more negative (Scoglio & Nayak, 2023). While the literature suggests that restrictive or supportive policies can shape abortion attitudes, abortion laws in Turkey do not explicitly prohibit abortion, but rather, abortion is de facto prohibited. Therefore, in order to get an accurate picture of what restrictions have been imposed and how they have affected abortion services, and to be able to reflect on the impact of these de facto restrictions on public attitudes, it is necessary to turn to the experts who are most closely involved in this issue: abortion providers. In this thesis, the experiences of providers are sources to reveal barriers to service provision and help us understand how these policy-based barriers shape people's attitudes towards abortion.

2.6 Hypotheses

In this research, I employ a mixed-methods research design to understand how the determinants of abortion attitudes have been changing in Turkey and how healthcare workers have been experiencing this change. I first analyze nationally representative survey data from 1990 to 2018 to determine how individuals' religiosity, conservatism, income, and education have been affecting their attitudes toward abortion. Then, I conduct in-depth interviews with obstetrician gynecologists to ask them about their perception of the changing attitudes toward and policies about

abortion in Turkey. The following hypotheses have been formulated for the quantitative analysis, which is the first part of my research:

Although abortion has been legal in Turkey since 1983, a hostile discourse has been established around it, particularly since the 2000s, by political leaders and religious institutions. Previous studies in other countries argue that negative discourse around abortion and restrictive policies are effective means of reproducing stigma around abortion (Kumar et al., 2009; Cullen & Korolczuk, 2019). As a result, the politicization of abortion, the negative rhetoric surrounding it, and de facto restrictions may have led to increasingly negative attitudes toward abortion in Turkey over the years:

H1. Year is positively associated with anti-abortion attitudes, indicating a decline in support for abortion in Turkey over time.

According to the literature, religion is the strongest determinant of abortion attitudes (Adamczyk et al., 2020; Jelen & Wilcox, 2003). Almost all studies point out to the positive relationship between different measures of religiosity and anti-abortion attitudes. Firstly, I predict that this relationship will also hold true in Turkey. Secondly, due to the increasing politicization of abortion and the hostile rhetoric around it created by politicians and religious institutions with a conservative Islamist agenda, I predict that the effect of religiosity has intensified over time:

H2a. As individuals' level of religiosity increases, they are more likely to express anti-abortion attitudes.

H2b. The effect of religiosity on abortion attitudes has grown stronger over time.

Regarding political stance, the literature suggests that left-leaning individuals tend to have more positive attitudes toward abortion, while right-leaning people tend to be pro-life. This relationship will also be observed in Turkey. Moreover, similar to

religiosity, I predict that the effect of conservatism on anti-abortion attitudes has intensified over time, again due to the increasing politicization which reframes abortion as a moral and national issue tied to conservative identity:

H3a. As individuals' level of conservatism increases, they are more likely to express anti-abortion attitudes.

H3b. The effect of conservatism on abortion attitudes has grown stronger over time.

Higher income is associated with more positive attitudes toward abortion in the literature. Firstly, I expect this finding to be true for Turkey as well, as wealthier people tend to be more tolerant of liberal sexual relations, making them see abortion as more acceptable in return (Fidan et al., 2021). However, I believe that the impact of the income variable on abortion attitudes will decrease over time, particularly due to the gradual disappearance of the middle class over the last two decades as a result of the economic recession, growing poverty and the economic precarity experienced across socioeconomic groups in Turkey (Eğilmez, 2024; Soydan, 2022). Going one step further, due to both increasing economic precarity and political anti-abortion discourse, I suggest that ideological polarization may now be overriding the effect of economic status:

H4a. As individuals' income increases, they are less likely to express anti-abortion attitudes.

H4b. The effect of income on abortion attitudes has grown weaker over time.

Although education is strongly linked to support for abortion in many countries, recent studies show that this link is weakening or disappearing (Jelen & Wilcox, 2003; Yorulmaz, 2023). Nevertheless, I expect that across the full period from 1990 to 2018 in Turkey, individuals with higher levels of education will still be significantly more supportive of abortion. However, like income, the strength of this

relationship may have declined in recent years as moral and religious discourses have become more dominant in shaping public opinion.:

H5a. As individuals' education increases, they are less likely to express anti-abortion attitudes.

H5b. The effect of education on abortion attitudes has grown weaker over time.

The qualitative part of my study explores how healthcare providers perceive the shifting attitudes and institutional policies. This part of my research will remain largely exploratory due to the limited prior research on the experiences and perspectives of healthcare workers in Turkey, particularly on the topic of abortion. In this section, I will be focusing on the narratives of abortion providers in the field, which will help me contextualize the interpretation of quantitative findings.

CHAPTER 3

DETERMINANTS OF ABORTION ATTITUDES IN TURKEY

3.1 Data and methodology

In this section, I will describe the dataset and the operationalization of the variables, as well as the statistical methodology used to examine the change in abortion attitudes in Turkey over the years and the determinants associated with this change.

3.1.1 Data

In order to examine the shift in abortion attitudes from 1990 to 2018, I use World Values Survey (WVS) data. WVS collects nationally representative data from almost 100 countries, making up almost 90% of the world's population (World Values Survey, 2025). Through its common questionnaire, WVS provides information about the beliefs and values of people in different parts of the world. This common questionnaire consists of over 200 questions, which get updated by social scientists in each wave. The common themes include social values and attitudes, migration, science and technology, political interest and participation, and institutional trust.

To date, there are 7 waves of WVS collected so far: Wave 1 (1981-1984), Wave 2 (1990-1994), Wave 3 (1995-1998), Wave 4 (1999-2004), Wave 5 (2005-2009), Wave 6 (2010-2014), and Wave 7 (2017-2022). Not every wave is collected in the same year in every country, and the year intervals indicate the time it takes to collect data in all countries. In each wave, data is collected cross-sectionally, meaning that each sample includes different respondents. Currently, as of January 2024, the 8th wave is being collected and the data collection process is expected to last until 2026. In addition to annual datasets, WVS also provides a time-series

dataset covering all waves between 1981-2022. It is important to underline that since each wave is collected cross-sectionally as mentioned earlier, the time-series does not measure the change in values of a specific group of people, but how values change in a specific country.

WVS waves collected in Turkey are as follows: Wave 2 (1990), Wave 3 (1996), Wave 4 (2001), Wave 5 (2007), Wave 6 (2011), Wave 7 (2018). The data collection was supervised by Prof. Yılmaz Esmer for all of these waves. Turkish respondents were surveyed face-to-face at their home and all surveys were collected in Turkish.

WVS in Turkey used stratified multi-stage random sampling across all years, with changing levels of regional stratification. In 1990, sampling involved two stages: selecting representative locations and then individuals. By 2007, a three-stage process was introduced: Selecting statistical blocks, then addresses, and finally individuals while using NUTS-1 regions (12 in total) for stratification. In 2011 and 2018, multi-stage full probability sampling was applied. While 2011 sampling was based on NUTS-1 regions, the 2018 wave shifted to a more detailed stratification at the NUTS-2 level, which divides Turkey into 26 regions. To ensure randomness, respondents were selected using the Kish grid method in each household and quota sampling was strictly forbidden at all stages.

Though multi-stage sampling is ideal for large-scale surveys as it "produces a representative sample for a homogeneous population spread over a large geographical area" (Sharma, 2023, p. 19); however, sampling error tends to increase with each additional stage in the selection process (Ahmed, 2024). To reduce this sampling error, I used the original country weights which were provided by each participant country.

To analyze abortion attitudes in Turkey between 1990-2018, I use four waves of WVS: Wave 2 (1990), Wave 5 (2007), Wave 6 (2011), and Wave 7 (2018). Waves 3 (1996) and 4 (2001) were excluded from my analysis because my dependent variable, which measures justifiability of abortion, was not included in these waves. Since my research question focuses on the change in abortion attitudes over the years, I used the time-series dataset provided by WVS, rather than using individual annual waves. This time-series dataset includes all countries and years, so I first filtered out countries other than Turkey and years where my dependent variable is not included.

The final dataset includes 6396 respondents who were interviewed for WVS for the remaining five waves: The sample size is 1030 for 1990, 1346 for 2007, 1605 for 2011, and 2415 for 2018 (see Table 1).

Table 1. Sample Size of Each World Values Survey Wave, Turkey

Wave	Sample size
1990 (Wave 2)	1030
2007 (Wave 5)	1346
2011 (Wave 6)	1605
2018 (Wave 7)	2415
Total	6396

Source: WVS Time Series

3.1.2 Variables

In this subsection, I will describe the dependent and independent variables of my analysis and discuss how they are operationalized.

3.1.2.1 Dependent variable: Abortion attitudes

Questions measuring public opinion on abortion have been included in surveys such as the GSS, Gallup, and National Election Study for a very long time but the format and level of detail of these questions vary from survey to survey (Cook et al., 1993). In World Values Survey, respondents are asked about their attitudes towards other "controversial" topics such as sex before marriage, prostitution, divorce, and homosexuality. The question about abortion attitudes is part of this battery. Respondents' attitudes toward abortion are measured by asking them to what extent they believe abortion can be justified. For this question, respondents place their views on 10-point scale that goes from "1 - Never justifiable" to "10 - Always justifiable". In my analyses, I use a reverse-coded version of this variable, so that higher values predict more negative attitudes toward abortion.

This variable has certain limitations in terms of measuring abortion attitudes. It treats abortion as a single experience, ignoring people may hold different views depending on the specific context under which someone decides to get an abortion, such as when a pregnant woman has an abortion because her health is in danger or when a married couple decide to have an abortion because they cannot take care of more children for economic reasons (Jozkowski et al., 2018; Hans & Kimberly, 2014; Rye & Underhill, 2020). Nevertheless, it remains the longest-standing measure of abortion attitudes in Turkey and proves to be a valuable source of information about how public opinion has been shifting.

3.1.2.2 Independent variables

To analyze how the determinants of abortion attitudes have been changing since the 1990s in Turkey, I focus on four independent variables: Religion, political stance, income and education. According to the systematic reviews of abortion attitudes, these are the four most common statistically significant independent variables (Adamczyk et al., 2020).

To measure religiosity, I use the level of importance participants attribute to god. This is measured by asking the respondents how important god is in their lives on a scale from 1 to 10, where 1 means "Not at all important" and 10 means "Very important". I initially tried to create a religiosity scale out of importance of religion, importance of God and attendance to religious services to capture religiosity more comprehensively. For each survey wave, I calculated standardized Cronbach's alpha but the scale showed insufficient internal consistency in most waves (standardized $\alpha < 0.6$), except for 1990 ($\alpha = 0.6193$). Among these three variables, I decided not to choose attendance to religious services, as it has limited explanatory power over the religiosity of women in Turkey due to the fact that women do not attend Friday prayers like men do. I ended up using importance of god over importance of religion for two reasons: First, importance of god was measured with a 10-point scale, while importance of religion used a 4-point scale. Therefore, the importance of god variable enables more accurate and nuanced predictions by providing a more detailed categorization. Secondly, previous studies in Turkey suggest that importance of god is a stronger predictor of abortion attitudes than importance of religion (Hatun & Yılmaz, 2020).

The second independent variable is individuals' political stance, which was asked by the following question: "In political matters, people talk of "the left" and

"the right." How would you place your views on this scale, generally speaking?" The answers were coded on a left-right scale where 1 means "far left" and 10 means "far right".

The next independent variable, income, is measured on a scale of incomes where the respondents place themselves on a scale from 1 to 10, in which "1" indicates the lowest income group in Turkey and "10" indicates the highest income group in Turkey.

Lastly, the education variable asks the respondents about the highest level of education they have attained and has categorical response choices. I recoded these categories as years of schooling (No education = 0 years, Primary education dropout = 3 years, Primary education = 5 years, Secondary education dropout = 6 years, Secondary education = 8 years, High school dropout or currently high school student = 10 years, High school = 12 years, Currently university student = 13 years, University dropout = 14 years, University = 16).

3.1.2.3 Control variables

In my analyses, I control for a variety of socio-demographic variables as suggested by the literature. These variables are marital status, age, gender, and number of children.

Previous studies confirm that abortion attitudes can depend on individuals' marital status. Compared to unmarried people (i.e. single, cohabiting, or divorced), married people tend to hold more negative attitudes towards abortion (Loll & Hall, 2019) and married women tend to believe that abortion should be illegal more than cohabiting or single women (Thomas et al., 2017). Furthermore, Andersen et al. (2015) report that although single women felt more comfortable talking about

abortion with their friends and supporting a friend who needed an abortion compared to their married counterparts, they also felt a significantly greater risk that both their close circle and healthcare workers would treat them badly if they had an abortion. On the other hand, according to Yorulmaz (2023), marital status was a significant determinant of abortion attitudes in Turkey in earlier waves but lost its effect in the recent years. In the WVS survey, marital status is measured as married, living together as married, divorced, separated, widowed, and single. I recoded this marital status variable into a dummy variable where 0 = married, 1 = single, 2 = previously married.

Literature also suggests that people's attitudes toward abortion may differ depending on the number of children they have. People who have at least one child are less likely to be pro-choice than those with no children (Osborne et al., 2022) and there is a positive correlation between the number of children respondents have and their tendency to be pro-life (Misra, 1998). Misra (1998) further adds that those who have younger children (less than 6 years old) are significantly more pro-life compared to those who have older children. Similarly, using International Values Surveys (IVS) database 1989–2019 together with International Social Survey Programme (ISSP) database 1991–2018 that encompass 91 and 46 countries respectively, Fernández et al. (2023) prove that number of children is negatively associated with the tendency to find abortion justifiable. On the other hand, Barkan (2014) underlines that although having more children is significantly associated with decreased support for legal abortion, this association goes away once the model controls for religiosity.

Previous studies also point out that abortion attitudes can vary by gender. Men are generally less supportive of abortion than women (Loll & Hall, 2019;

Osborne et al., 2022) and women are more likely to support legal abortion (Pew Research Center, 2024; Barkan, 2014; Lizotte, 2015). Therefore, I control for gender in my analyses, which is operationalized as a binary variable where 0 = male and 1 = female. The last control variable is age, as literature shows that younger people are more pro-choice (Misra, 1998) and there is a negative correlation between age and support for abortion (Osborne et al., 2022). In the analysis, age is operationalized as a continuous variable showing years of age.

3.1.3 Statistical methods

In my analyses, I use ordered logistic regression instead of ordinary least squares to see the indicators of attitudes toward abortion and how they change over time. There are two main reasons why OLS regression is not appropriate for this part of the analysis. Firstly, the dependent variable, abortion attitudes, is an ordinal variable measured on a 10-point scale. Although the scale and the responses range from 1 to 10, it would be wrong to assume that the actual distance between the numbers (e.g., the difference between 2-3 or 8-9) is equal, as this can be perceived very differently by different participants. As the nature of this scale is not truly continuous, it violates the assumption of a continuous dependent variable with equal intervals between values of OLS. Secondly, a quick look reveals that the responses are heavily skewed, with a large proportion of the respondents choosing the lowest answers such as 1 (never justifiable), 2, and 3. It is thus not appropriate to use OLS with this variable, as OLS assumes that residuals of the dependent variable are normally distributed. Hence, by using ordered logistic regression instead of OLS, I ensure that the ordinal nature of the variable and the non-linear structure of responses are accounted for in the statistical analysis.

I estimate two sets of models in my analysis. Firstly, I construct a main effects model including survey year (1990, 2007, 2011, 2018), independent variables (religiosity, political stance, education, income), and control variables (gender, age, marital status, and number of children). This model tests the main effects of the predictors and abortion attitudes from 1990 to 2018. Secondly, I estimate a set of interaction models to test whether the effects of religiosity, political stance, income, and education on abortion attitudes changed over time. Hence, in these models, I used interaction terms between year dummies and independent variables to examine the change in their effect.

I estimate six interaction models in total. All models include survey year and control variables (gender, age, marital status, and number of children). Model 1 tests the impact of survey year (year dummies) and control variables (gender, age, marital status, and number of children) on abortion attitudes. Model 2 tests the impact of religiosity on abortion attitudes and how it has changed over time with control variables. Model 3 tests the impact of political stance on abortion attitudes and how it has changed over time with control variables. Model 4 tests the impact of education abortion attitudes and how it has changed over time with control variables. Model 5 tests the impact of income on abortion attitudes and how it has changed over time with control variables. Lastly, Model 6 is the full model, where I include all of the independent variables, religiosity, political stance, income, and education, along with their interactions with survey year and control variables.

In all of these models, I added survey year as a categorical variable rather than as a continuous one. This allowed me to build a model that captures non-linear changes in abortion attitudes over time, avoiding the assumption that there was a gradual or linear change in attitudes or how attitudes were affected by the

independent variables. Additionally, in all of the models, I use the original weights provided by the participant country itself.

3.2 Results

In this section, I will present the results of my analysis on the determinants of attitudes toward abortion in Turkey and how these determinants have been changing from 1990 to 2018. I will begin with the descriptive results to explain how abortion attitudes and independent variables have changed over time across the four survey waves (1990, 2007, 2011, and 2018) in Turkey. Then, I will interpret the results of the ordered logistic regression analyses, starting with a model of main effects and then introducing a series of interaction models to examine how the influence of religiosity, political stance, income, and education on abortion attitudes has shifted over time. To better explain the results of the interaction effects, I will calculate and visualize predicted probabilities, plotting how the probability of believing that abortion is "never justifiable" varies by wave and across different levels (−2 SD to +2 SD) of each independent variable.

3.2.1 Descriptive results

Tables 2, 3, 4 and 5 show the descriptive statistics for each survey wave (1990, 2007, 2011, and 2018), based on the final analysis sample obtained after listwise deletion. The variables include abortion attitudes (measured on a 10-point justifiability scale), religiosity (importance of God), political stance (left-right), income (scale of incomes), education (years of schooling), gender, age, marital status, and number of children. The total sample size is 1030 for 1990, 1346 for 2007, 1605 for 2011, and 2415 for 2018. After applying listwise deletion based on the variables included in the

final regression model, the analysis samples are reduced to 815 (1990), 1113 (2007), 1385 (2011), and 2068 (2018) due to the missing data. The left-right scale, which measures respondents' political stance, had the most missing values: 132 missing values in the 1990 wave, 203 missing values in the 2007 wave, 152 missing values in the 2011 wave and 264 missing values in the 2018 wave.

Table 2. Descriptive Statistics - Wave 2 (1990)

	Mean	SD	Min	Max
Dependent variable				
Abortion attitudes	6.71	3.01	1	10
Independent variables				
Importance of God	8.86	2.33	1	10
Political stance (left-right)	5.44	2.14	1	10
Education	5.86	3.76	0	14
Income	4.01	1.32	1	10
Control variables				
Female	0.48		0	1
Age	36.96	13.72	18	84
Marital status				
Married (ref)				
Single	0.20		0	1
Previously married	0.05		0	1
Number of children	2.11	1.68	0	5

Source: World Values Survey, 1990 Valid N: 815

Table 3. Descriptive Statistics - Wave 5 (2007)

	Mean	SD	Min	Max
Dependent variable				
Abortion attitudes	8.64	2.25	1	10
Independent variables				
Importance of God	9.33	1.56	1	10
Political stance (left-right)	6.14	2.69	1	10
Education	8.23	4.62	0	16
Income	3.45	2.38	1	10
Control variables				
Female	0.46		0	1
Age	36.59	13.87	18	82
Marital status				
Married (ref)				
Single	0.30		0	1
Previously married	0.04		0	1
Number of children	1.71	1.68	0	5

Source: World Values Survey, 2007 Valid N: 1113

Table 4. Descriptive Statistics - Wave 6 (2011)

	Mean	SD	Min	Max
Dependent variable				
Abortion attitudes	8.74	2.16	1	10
Independent variables				
Importance of God	9.17	1.53	1	10
Political stance (left-right)	6.22	2.50	1	10
Education	9.22	4.60	0	16
Income	5.70	1.88	1	10
Control variables				
Female	0.51		0	1
Age	38.40	14.43	18	86
Marital status				
Married (ref)				
Single	0.27		0	1
Previously married	0.07		0	1
Number of children	1.54	1.52	0	5

Source: World Values Survey, 2011 Valid N: 1385

Table 5. Descriptive Statistics - Wave 7 (2018)

	Mean	SD	Min	Max
Dependent variable				
Abortion attitudes	8.32	2.20	1	10
Independent variables				
Importance of God	8.08	2.19	1	10
Political stance (left-right)	6.29	2.56	1	10
Education	8.53	4.83	0	16
Income	5.34	1.71	1	10
Control variables				
Female	0.50		0	1
Age	38.89	12.67	18	95
Marital status				
Married (ref)				
Single	0.32		0	1
Previously married	0.05		0	1
Number of children	1.35	1.40	0	5

Source: World Values Survey, 2018 Valid N: 2068

To measure abortion attitudes, I use the 10-point justifiability scale variable, ranging from “1 - Always justifiable” to “10 - Never justifiable” (see Table 6). Higher scores reflect more negative abortion attitudes. The mean scores over the years show a clear rise in anti-abortion sentiment with a slight decrease in the most recent year, 2018 (See Tables 2, 3, 4, and 5). In 1990, the average justifiability score was 6.71, reflecting relatively positive attitudes. By 2007, the mean increased dramatically to 8.64 and further rose to 8.74 in 2011, indicating that anti-abortion attitudes became more prevalent in society. In 2018, there was a slight decrease to

8.32 yet overall anti-abortion sentiment remained well above what it used to be in 1990.

Table 6. Tolerance toward Abortion (%), 1990-2018, Turkey

Justifiable: Abortion	1990	2007	2011	2018
1 - Always justifiable	7.61	2.43	2.17	0.92
2	3.44	0.72	0.22	0.73
3	4.91	1.17	1.52	2.08
4	3.07	3.05	2.60	3.34
5	25.52	3.59	2.38	5.08
6	5.52	7.55	9.17	10.98
7	5.15	3.86	3.83	8.80
8	6.13	6.47	4.55	8.42
9	3.07	9.43	9.17	6.33
10 - Never justifiable	35.58	61.73	64.40	53.34
N (valid sample)	815	1113	1385	2068

Source: World Values Survey, 1990-2018

Table 6 presents the distribution of responses to the question on abortion justifiability in Turkey between 1990 and 2018. In 1990, almost 36% of the respondents stated that abortion could never be justifiable, meaning that they think abortion is “wrong” in every case. This proportion nearly doubled to 62% in 2007 and peaked at 64% in 2011. Although there was a slight decline in 2018, the percentage remained high at 53%.

To measure religiosity, I use the 10-point importance of God scale, ranging from “0 - Not important at all” to “10 - Very important” (see Table 7). Measured on this scale, the mean value of importance attributed to God peaked in 2007 with, 9.33.

This is a dramatic increase from 1990 (8.86). The mean importance of God gradually decreased from 2007 onwards, declining to 9.17 in 2011 and further decreasing to 8.08 in 2018 (See Tables 1, 2, 3, and 4). Changes in the average importance attributed to God in Turkish society is statistically significant between the years ($F(3, 5377) = 137.60$, $p < 0.001$), except for the slight decrease from 9.33 to 9.17 from 2007 to 2011.

Table 7. Importance of God (%), 1990-2018, Turkey

Importance of God	1990	2007	2011	2018
1 - Not at all important	3.68	0.99	0.79	1.11
2	0.74	0.36	0.07	1.02
3	1.96	0.45	0.58	1.26
4	1.23	0.72	0.72	2.95
5	3.68	1.35	1.30	7.93
6	1.96	2.25	2.24	10.83
7	4.05	4.13	6.06	10.44
8	4.66	5.57	11.62	12.23
9	6.01	8.98	10.11	8.70
10 - Very important	72.02	75.20	66.50	43.52
N (valid sample)	815	1113	1385	2068

Source: World Values Survey, 1990-2018

Over the years, the proportion of respondents who find God “very important” has declined gradually, decreasing from 72% in 1990 to 44% in 2018. At first glance, this suggests a sharp decline in religiosity. However, when we consider respondents who gave scores of 6 or above, we see a different pattern. In 1990, 88.7% of respondents rated the importance of God in their lives as 6 or higher. This proportion

remained relatively stable across time: 96.13% in 2007, 96.53% in 2011, and 85.72% in 2018. At the same time, the percentages of respondents selecting middle values have increased over time. For example, those giving a score of 6 increased from 2% in 1990 to over 10% in 2018, which could be interpreted as a potential shift from extreme religiosity to moderate but still significant levels of religiosity (see Table 7).

To measure political attitudes, I use the 10-point political stance scale, ranging from "1 - Left" to "10 - Right" (see Table 8). Looking at the means over the years, we can say that there is a clear shift toward the right on the political stance in Turkey between 1990 and 2018. The mean score increased gradually over the years, rising overall from 5.44 in 1990 to 6.29 in 2018, highlighting a gradual yet consistent rise in the respondents' identification with right-wing politics (See Tables 2, 3, 4, and 5). The gradual increase is statistically significant between waves ($F(3, 5377) = 23.42$, $p < 0.001$).

The percentages reported in Table 8 also prove the shift towards right-wing identification among respondents. In 1990, the mode was 5, with 41% of the respondents placing themselves in the middle. By 2007, this share dropped dramatically to 13.30%, showing greater polarization in political attitudes. The percentage of respondents who identify their political views as far-right (10) almost doubled from 7.73% in 1990 to 15.14% in 2018. In addition, categories 6 to 10, which can be considered center-right and right, together made up 34.85% of respondents in 1990 and increased to 58.56% by 2018.

Table 8. Political Stance (Left-Right) (%), 1990-2018, Turkey

Political stance	1990	2007	2011	2018
1 - Left	4.66	8.00	5.78	5.66
2	2.58	3.77	3.61	3.48
3	8.47	6.92	6.86	5.08
4	7.98	6.02	5.63	7.74
5	41.47	13.30	14.66	19.49
6	9.20	19.14	16.82	10.64
7	8.71	7.55	13.36	11.99
8	6.63	13.39	13.29	14.02
9	2.58	6.56	8.30	6.77
10 - Right	7.73	15.36	11.70	15.14
N (valid sample)	815	1113	1385	2068

Source: World Values Survey, 1990-2018

To measure income, I use a scale of incomes, where respondents specify where they would put themselves on a scale where 1 indicates the lowest income group and 10 shows the highest income group in their country (see Table 9). Over the years, the average perceived income level fluctuates as follows: It decreases from 4.01 in 1990 to 3.45 in 2007, then increases to 5.70 in 2011, and finally decreases to 5.34 in 2018. These changes in the perceived positions on the income scale are statistically significant across the four survey waves ($F(3, 5377) = 409.76$, $p < 0.001$). Post-hoc Bonferroni test also confirmed that all differences between consequent pairs of waves are statistically significant ($p < 0.001$).

Table 9 shows the distribution of answers respondents gave while placing themselves on the scale of incomes. In 1990, the most common answer was 4, followed by 3. In 2007, perceived income generally decreased and most of the

respondents placed themselves in either the 2nd or the 1st step. In 2011, there was an upward trend in perceptions of income and more than half of the population placed themselves on steps 5 to 8. In 2018, this trend continues, and the highest concentration is now on the 5th and 6th steps.

Table 9. Scale of Perceived Incomes (%), 1990-2018, Turkey

Income level	1990	2007	2011	2018
1 - Lowest step	3.80	21.02	1.59	0.87
2	5.03	25.97	2.89	3.63
3	24.54	14.20	7.65	10.30
4	35.71	15.36	15.09	17.02
5	19.88	3.32	19.28	21.71
6	8.47	7.64	16.90	19.97
7	1.23	1.35	18.34	16.20
8	0.61	6.65	12.27	7.69
9	0.49	2.25	5.13	2.22
10 - Highest step	0.25	2.25	0.87	0.39
N (valid sample)	815	1113	1385	2068

Source: World Values Survey, 1990-2018

To measure educational attainment, I use years of schooling (see Table 10). The mean values across the four waves show quite a noticeable improvement in schooling. In 1990, respondents attained an average of 5.86 years of education. This value increased somewhat steadily in the subsequent years: 8.23 years in 2007, 9.22 years in 2011, and a slight decrease to 8.53 years in 2018. The difference across the waves is statistically significant ($F(3, 5377) = 97.68$, $p < 0.001$) and this is further proven by the post-hoc Bonferroni test which shows that there are significant

differences in terms of the average years of education between all of the consequent survey years.

Table 10 further breaks down the distribution of educational attainment over the waves. Years of schooling ranged from 0 to 14 in 1990 and from 0 to 16 in the rest of the years. In 1990, the majority of respondents (42.9%) had completed only primary school (5 years), and 13.7% had no formal education at all. Secondary and tertiary education levels remained low. Over time, higher levels of education became more common: By 2011, over 30.1% had completed high school (12 years), and 14.4% held a university degree (16 years). In 2018, this share increased to 16.5%.

Table 10. Years of Education (%), 1990-2018, Turkey

Years of schooling	1990	2007	2011	2018
0 (No education)	13.74	7.64	4.84	7.01
3 (Primary school dropout)	5.77	3.59	3.90	4.26
5 (Primary school graduate)	42.94	35.58	28.09	34.86
6 (Secondary school dropout)	11.53	2.52	2.89	1.21
8 (Secondary school graduate)	11.17	7.55	8.01	10.06
10 (High school student/dropout)	0.98	3.59	2.96	0.53
12 (High school graduate)	4.42	26.86	30.11	24.23
13 (University student)	0.00	0.00	0.00	0.77
14 (University dropout)	9.45	1.08	4.77	0.53
16 (University graduate)	0.00	11.59	14.44	16.54
N (valid sample)	815	1113	1385	2068

Source: World Values Survey, 1990-2018

I control for respondents' gender, age, marital status and number of children (See Tables 2, 3, 4, and 5). The gender distribution is balanced for all of the waves:

Women made up 48% of the respondents in 1990, 46% in 2007, 51% in 2011 and 50% in 2018. Age ranged from 18 to 84 in 1990, 18 to 82 in 2007, 18 to 86 in 2011, and 18 to 95 in 2018, with a mean age of 36.96, 36.59, 38.40, and 38.89, respectively. About 75% of the respondents were married and 20% were single in 1990. The percentage of married respondents declined to 66% in 2007 and to 65% in 2011; it recently further dropped to 63% in 2018. The percentage of single people increased in parallel, increasing to 30% in 2007 and decreasing slightly to 27% in 2011 before finally rising to 32%. In each year, the rest of the respondents belong to the previously married category, meaning they are either divorced, widowed, or separated. The last control variable is the number of children, which is measured by asking the respondents' how many children they have. One thing to underline about this variable is that, in the time-series data, WVS categorizes those who have more than 5 children together under the last category. Over the years, there is a downward trend in the number of children, with the average decreasing from 2.11 in 1990 to 1.71 in 2007 and 1.54 in 2011. In the last wave, it further decreased to 1.35.

3.2.2 Predictors of abortion attitudes

In this section, I will first present and interpret the baseline analysis using a main effects model that combines all four survey waves (see Table 11). The dependent variable is acceptance of abortion, measured on a 10-point scale ranging from 1 ("always justifiable") to 10 ("never justifiable"). Estimated via ordered logistic regression, this model examines how religiosity, political stance, income, and education are associated with anti-abortion attitudes, while controlling for gender, age, marital status, and number of children. The purpose of this initial main effects model is to assess the average effect of each predictor across time.

Table 11. Odds Ratios from Ordered Logistic Regression: Main Effects of Religiosity, Political Stance, Income and Education on Abortion Attitudes in Turkey (1990-2018)

	Anti-abortion attitudes				
	Model 1	Model 2	Model 3	Model 4	Model 5
Year					
2007	4.17***	4.13***	4.18***	5.23***	4.22***
2011	5.45***	5.20***	7.09***	6.86***	6.68***
2018	4.03***	3.11***	4.07***	4.14***	4.47***
Independent variables					
Religiosity	1.20***				1.15***
Political stance		1.16***			1.13***
Income			0.88***		0.90***
Education				0.93***	0.96***
Control variables					
Female	0.84**	0.87*	0.86**	0.80***	0.82***
Age	1.00	1.00	1.00	1.00	1.00
Marital status					
Single	1.14	1.16	1.12	1.13	1.14
Previously married	0.96	1.01	0.90	0.94	0.97
Number of children	1.18***	1.19***	1.19***	1.15***	1.10***
Likelihood Ratio $\chi 2$	578.88***	545.13***	483.06***	496.03***	764.63***
Degrees of freedom	9	9	15	9	12
Pseudo R2	0.04	0.04	0.03	0.04	0.05
N (valid sample)	5381	5381	5381	5381	5381

*** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$
Source: World Values Survey, 1990-2018
Notes: (1) Reference category for year is 1990. (2) Reference category for marital status is married.

According to the final model (see Table 11), there is a drastic increase in anti-abortion attitudes in Turkish society. In 2007, respondents were 4.2 times more likely to express anti-abortion attitudes compared to 1990, indicating a statistically significant shift toward more negative attitudes in society. The strongest increase in anti-abortion sentiment among all years happened in 2011 as respondents were almost 6.7 times more likely to find abortion unacceptable compared to 1990. In 2018, the odds ratio is slightly lower compared to 2011 but still indicates respondents were 4.5 times more likely to oppose abortion compared to 1990. Hence, all three years indicate a statistically significant increase in the likelihood of people finding abortion unjustifiable when compared to the attitudes in 1990.

In addition to the increasing anti-abortion attitudes over the years, Table 11 also shows the main effects of the independent variables and control variables on attitudes toward abortion. Religiosity is one of the factors that significantly determine attitudes toward abortion. The odds of finding abortion unjustifiable increases by 15% with every one-unit increase in religiosity, controlling for other variables. This effect is highly significant ($p < 0.001$); more religious individuals tend to be more anti-abortion. Political stance is another significant predictor of abortion attitudes. With every additional increase in political stance, meaning each one-unit shift from left to right, the odds of holding anti-abortion attitudes increases by 13%, holding other variables constant. This effect is also highly significant ($p < 0.001$), showing that conservatives are more restrictive when it comes to abortion attitudes.

Years of schooling is slightly associated with abortion attitudes: Each unit of increase in educational attainment decreases the odds of finding abortion unacceptable by 4%, net of other variables. Moreover, those with higher perceived

income are less likely to be anti-abortion: Every step up the income scale is associated with a 10% decrease in being less tolerant towards abortion, controlling for other variables. This relationship is also statistically significant, making income a significant predictor of abortion attitudes.

Among the control variables, only gender and number of children statistically predict abortion attitudes. Women are about 18% less likely than men to believe that abortion is unjustifiable, holding other variables constant. Each additional child increases the odds of anti-abortion attitudes by 10%, suggesting that people with more children are more likely to find abortion unacceptable. The other control variables, namely age and marital status, do not seem to predict abortion attitudes significantly.

Table 12 shows if the effect of the independent variables has changed over time. I test four interaction effects between survey year and each independent variable (religiosity, political stance, income, and education). I adopt a step-by-step approach, where I first introduce interaction terms between survey year dummies and each independent variable separately, while controlling for other covariates. In the final model, I include all interaction effects simultaneously to examine their combined effects.

Model 1 introduces an interaction between survey year and religiosity to assess whether the influence of religiosity on abortion attitudes has shifted across the four survey waves. Model 2 tests the interaction between survey year and political stance for an evaluation of how the association between political conservatism and abortion attitudes has shifted. Model 3 includes an interaction between survey year and income, exploring whether income-based differences in abortion attitudes have changed over time. Model 4 examines the interaction between year and education

level to determine if the effect of education on abortion attitudes has become stronger or weaker. In each of these first four models, the respective interaction term is added separately, while all control variables and the remaining independent variables are included as main effects. Finally, Model 5 combines all four interaction terms in a single model to assess their joint contributions and examine whether the observed trends persist when controlling for each other.

Table 12. Odds Ratios from Ordered Logistic Regression: Interactions Effects of Religiosity, Political Stance, Income and Education on Abortion Attitudes in Turkey Over Time (1990-2018)

	Anti-abortion attitudes				
	Model 1	Model 2	Model 3	Model 4	Model 5
Year					
2007	4.19***	4.17***	4.63***	5.00***	5.08***
2011	6.76***	6.67***	7.00***	7.70***	7.63***
2018	4.45***	4.47***	4.99***	4.97***	5.30***
Independent variables					
Religiosity	1.18***	1.15***	1.15***	1.15***	1.15***
Political stance	1.12***	1.14***	1.13***	1.12***	1.14***
Income	0.90***	0.90***	0.76***	0.91***	0.79***
Education	0.96***	0.96***	0.96***	0.90***	0.91***
Religiosity x year					
2007	1.00				1.03
2011	0.95				0.98
2018	0.97				1.00
Political stance x year					
2007		0.97			0.96
2011		0.95			0.95
2018		1.01			1.01
Income x year					
2007			1.15*		1.13
2011			1.29***		1.25***
2018			1.21**		1.13
Education x year					
2007				1.04	1.02
2011				1.05*	1.02
2018				1.10***	1.08***
Control variables					
Female	0.82***	0.82***	0.82***	0.81***	0.81***
Age	1.00	1.00	1.00	1.00	1.00
Marital status					
Single	1.14	1.14	1.13	1.11	1.10
Previously married	0.98	0.98	0.98	0.95	0.96
Number of children	1.10***	1.10***	1.09***	1.07*	1.07**
Likelihood Ratio $\chi 2$	770.73***	775.98***	798.50***	790.23***	827.65***
Degrees of freedom	15	15	15	15	24
Pseudo R2	0.05	0.05	0.06	0.06	0.06
N (valid sample)	5381	5381	5381	5381	5381

*** $p < 0.001$, ** $p < 0.01$, * $p < 0.05$

Source: World Values Survey, 1990-2018

Notes: (1) Reference category for year is 1990. (2) Reference category for marital status is married.

Model 1 analyzes whether the effect of religiosity on anti-abortion attitudes changed over time. The interaction terms between religiosity and year dummies

(2007, 2011, 2018) are not statistically significant, indicating that the strength of the relationship between religiosity and anti-abortion attitudes did not significantly change over time. The model also has a likelihood ratio chi-square of 770.73 ($df = 15$, $p < 0.001$), indicating a strong model fit.

Model 2 focuses on the interaction between political stance and year. Similar to religiosity, the interaction terms between political stance and year dummies are not statistically significant, which shows that the correlation between political stance and anti-abortion attitudes has remained consistent over the years. In Model 2, religiosity remains a significant predictor ($OR = 1.15$, $p < 0.001$), showing its robust influence. This model also shows a good fit, with a likelihood ratio chi-square of 775.98 ($p < 0.001$). The first two models suggest that the influence of both religiosity and political conservatism on anti-abortion attitudes remained stable.

Model 3 examines whether the effect of income on anti-abortion attitudes changed over time. The interaction terms show that this relationship became significantly weaker over time. The coefficients for 2007 ($OR = 1.15$, $p < 0.05$), 2011 ($OR = 1.29$, $p < 0.001$), and 2018 ($OR = 1.21$, $p < 0.01$) are all significant, suggesting that the negative association between income and anti-abortion attitudes has decreased significantly compared to 1990 and income has become a weaker predictor. The model has a likelihood ratio chi-square of 798.50 ($p < 0.001$).

Model 4 tests whether the effect of education on anti-abortion attitudes changed over time. The year interactions for 2011 ($OR = 1.05$, $p < 0.05$) and 2018 ($OR = 1.10$, $p < 0.001$) are statistically significant, indicating that the negative association between education and anti-abortion attitudes has diminished over time and education has become less strongly associated with anti-abortion attitudes. The

2007 interaction is not significant. The model has a likelihood ratio chi-square of 790.23 ($p < 0.001$).

Model 5 includes all interaction terms simultaneously to test their joint effect and robustness. Only the interactions between income and year 2011 (OR = 1.25, $p < 0.001$), and education and year 2018 (OR = 1.08, $p < 0.001$) remain statistically significant. This suggests that the declining influence of income and education on anti-abortion attitudes is robust even when accounting for other variables. Model 5 has the highest model fit ($\chi^2 = 827.65$, df = 24, $p < 0.001$).

Across all models, the control variables remain mostly stable. Female respondents are significantly less likely to report anti-abortion attitudes across all models (OR = 0.81-0.82, $p < 0.001$), and pro-life tendencies are more common among those who have more children (OR = 1.07-1.10, $p < 0.001$). Age and marital status do not show significant effects in any of the models.

To check the goodness-of-it of the models, as well as assessing the likelihood ratios and reporting robust standard errors, I also checked for multicollinearity using VIF (Variance Inflation Factor) in the main effects model with centered variables, based on an OLS regression model using the same predictors as the main effects model. According to the results, there are no concerns regarding multicollinearity, as all VIF values are below the commonly-accepted threshold of 5 (Menard, 2001). The mean VIF was 1.67. The variables which had the highest VIF values were the dummy variables for the year 2018 (VIF = 2.53) and 2011 (VIF = 2.25), and number of children (VIF = 2.22). All in all, the VIF values suggest that the independent variables are sufficiently independent of each other.

After running the ordered logistic regression analyses, I also calculated and plotted predicted possibilities of finding abortion “never justifiable” to better

understand and visualize how the interactions effects between each independent variable and year dummies (Figures 1, 2, 3, and 4).

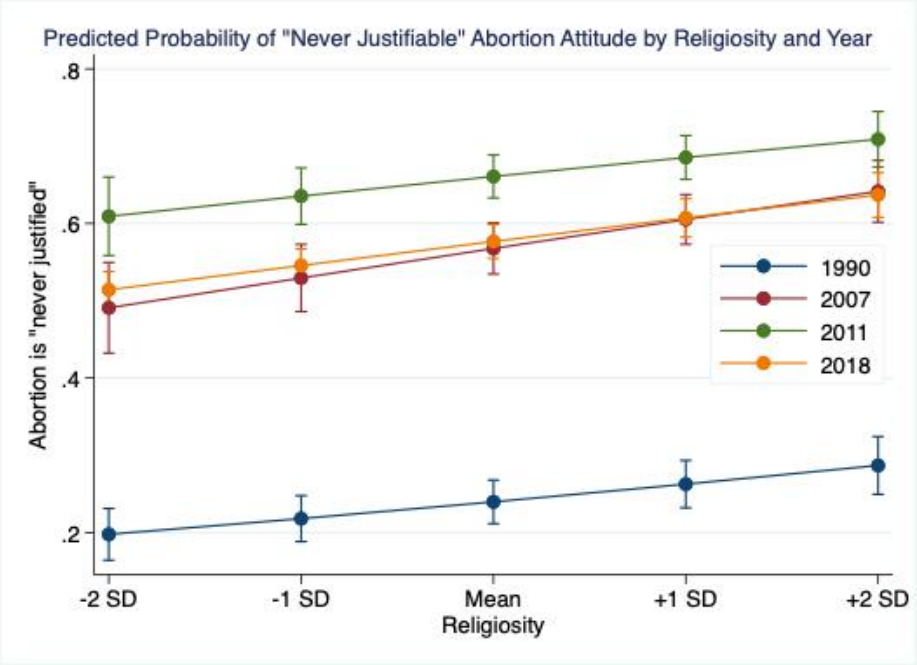

Figure 1. Predicted probability of "never justifiable" abortion attitudes by religiosity across time (1990-2018)

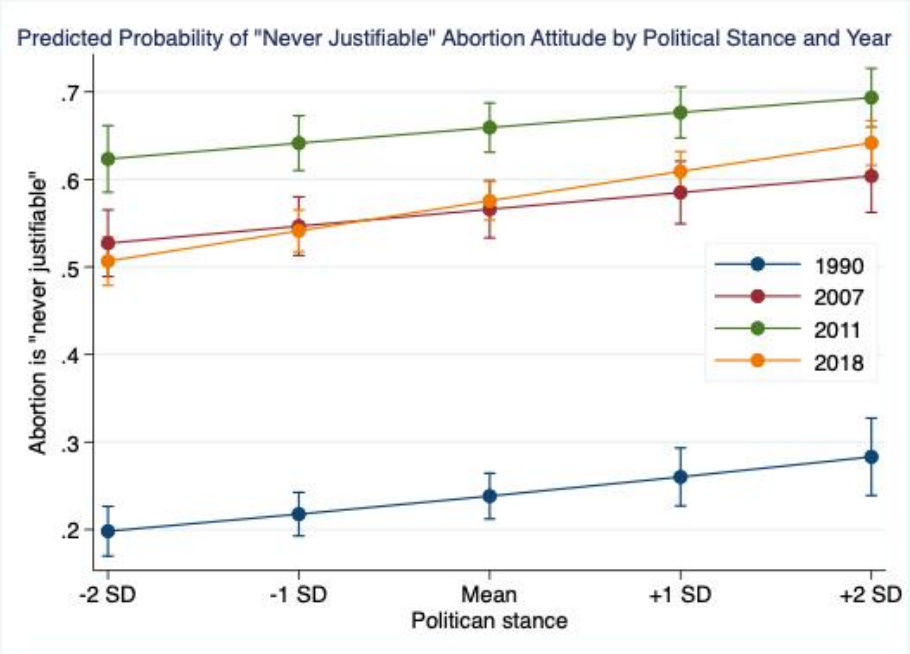

Figure 2. Predicted probability of "never justifiable" abortion attitudes by political stance across time (1990-2018)

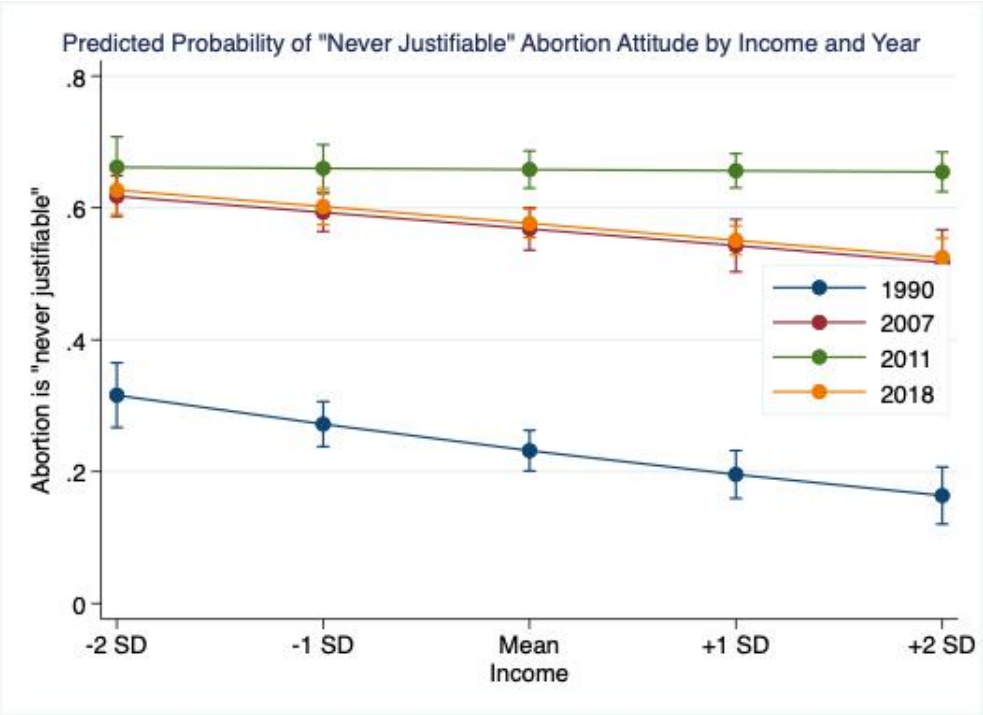

Figure 3. Predicted probability of "never justifiable" abortion attitudes by income across time (1990-2018)

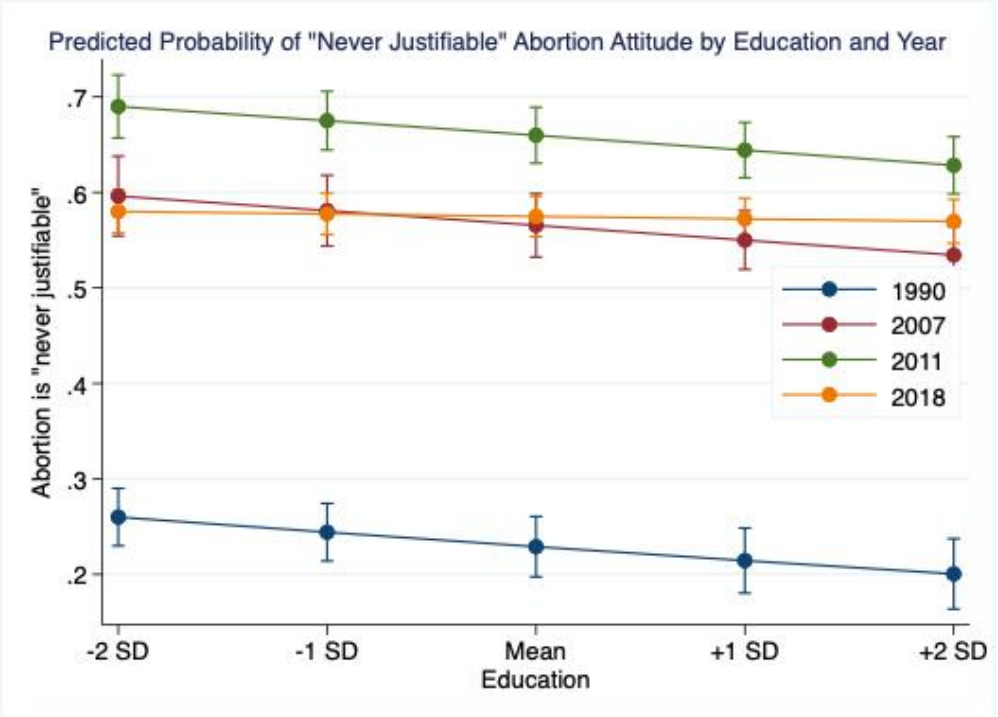

Figure 4. Predicted probability of "never justifiable" abortion attitudes by education across time (1990-2018)

Figure 1 shows the predicted probabilities of the option “Never justifiable” on the abortion attitudes scale. These predicted probabilities are calculated based on Model 5, the final ordered logistic regression model which includes all interaction effects. Each graph shows the relationship between a predictor and anti-abortion attitudes across four survey waves (1990, 2007, 2011, 2018). In all of the plots, the X-axis includes values from -2 to +2 standard deviations from the mean of the centered predictor variable. Y-axis represents the predicted probability of choosing the most extreme score on the abortion scale, namely that abortion is “never justifiable”. All graphs are plotted based on 95% confidence intervals.

The first figure visualizes the predicted probabilities of believing that abortion is “never justifiable”, plotted by the interaction between religiosity and survey waves. All trend lines have a positive and consistent slope, meaning that those who attribute more importance to God have a significantly higher likelihood of finding abortion unacceptable and that religiosity’s effect on anti-abortion attitudes is stable. Most importantly, the trend lines do not get steeper or flatter over time, remaining similar across 1990, 2007, 2011, and 2018. Hence, the plot overall confirms the results of Model 5: Religiosity is a stable and significant predictor of anti-abortion attitudes across time, with no significant interaction effects. Its impact does not significantly increase or decrease across years.

The second figure plots the predicted probabilities of believing that abortion can never be justified by the interaction between conservatism and year. Similar to religiosity, all trend lines have a positive slope, meaning that those who identify with the far-right have a significantly higher likelihood of finding abortion unacceptable. It is important to note that people at the far-left (-2 SD) express a more tolerant attitude toward abortion in 2018 compared to 2007 and 2011; moreover, people at the

far-right (+2 SD) in the same year hold more anti-abortion attitudes compared to their counterparts in 2007. Hence, there is a widening ideological gap in abortion attitudes, suggesting that political stance may be playing an increasingly polarizing role. Just like religiosity, the predicted probabilities of political stance and the similarity between steepness of the slopes across all waves confirm the results of Model 5: Political stance, too, is a significant independent variable that keeps predicting abortion attitudes strongly in a stable way, with no significant interaction effects. The strength of its effect on abortion attitudes remains stable over time.

In contrast to religiosity and conservatism, there is a negative slope in the predicted probabilities of the income variable: Individuals that place themselves on the higher steps of the scale of incomes are more tolerant toward abortion. Though not significant, the slope gets flatter in 2007 and 2018 compared to 1990, and almost disappears in 2011, reflecting the significant interaction effect between income and year in that wave: In 1990, there was a steep negative association between income and opposition to abortion. Respondents with income levels -2 SD had a predicted probability of almost 0.60 of saying abortion is never justifiable, whereas those +2 SD had a probability closer to 0.30, showing that lower-income individuals were significantly more likely to oppose abortion than their higher-income counterparts. In 2007, the slope remained negative but flattened, suggesting a weaker income effect on abortion attitudes. By 2011, the line became almost completely flat, indicating that income had no meaningful effect on whether respondents viewed abortion as "never justifiable". Thus, all income groups had similar predicted probabilities of saying abortion was never justifiable. In 2018, the slope appears to steepen again slightly. While not as steep as in 1990, there is a modest return, with lower-income respondents still more likely to oppose abortion than higher-income ones. However,

the overall difference between extremes is much smaller than in 1990, similar to 2007. All in all, the plot supports the findings of Model, showing that the influence of income significantly declined in 2011, as confirmed by a significant interaction term, and only partially re-emerged in 2018.

Similar to income, the predicted probabilities of the interaction between year and education also have a negative slope. In 1990, there was a clear and strong negative association between education level and anti-abortion attitudes. This sharp slope suggests that in 1990, education was a powerful predictor: Higher educational attainment was associated with more liberal abortion attitudes, while lower education correlated with stronger opposition. The steepness of the slope does not seem to change in 2007 and 2011, as education remains a strong predictor of abortion attitudes. In 2018, the line becomes almost completely flat, proving the results of Model 5: Education loses its significant effect on abortion attitudes and is no longer a strong predictor. Respondents across all education levels had a predicted probability around 0.55-0.60 of saying abortion is never justifiable. Hence, opposition to abortion became similarly high, regardless of educational attainment.

CHAPTER 4

EXPERIENCES OF ABORTION PROVIDERS

In this section, I will describe the qualitative component of my research. I will explain the sample, the structure of the interviews, and the data collection in detail. Afterwards, I will provide the results of my analysis, where I identify and interpret the key themes that came up during the interviews, with a specific focus on the impact of attitudinal shifts and the political atmosphere on the experiences of healthcare workers.

4.1 Data and methodology

In the qualitative part of my study, my primary goal was to contextualize the quantitative results and further explore how healthcare workers in Turkey were affected by the abortion attitudes that are becoming increasingly negative in society, as well as the political and religious discourses surrounding abortion. To understand the doctors' experiences, I conducted semi-structured in-depth interviews with 7 obstetrician gynecologists.

4.1.1 Participants

Interviewees were selected using purposive sampling. Since my quantitative analysis covers the period from the 1990s to the present, I only interviewed obstetrician gynecologists who had been working at hospitals during this period, i.e., who had been working for at least 20 years. I contacted most of the interviewees via email and initially sent them a brief summary of my research topic. Afterwards, I contacted the participants who expressed interest in participating and sent them a follow-up email

that included detailed information about the research position and the informed consent form. All interviews were conducted via Zoom, except for one doctor who works in Istanbul. The interviews were conducted in Turkish and lasted approximately half an hour.

The final sample included 3 male and 4 female doctors (see Table 13 for detailed information about the doctors and their careers). Throughout their professional lives, the interviewees had worked in a wide range of cities, including Adana, Adıyaman, Afyon, Ankara, Bursa, Çankırı, Çorum, Eskişehir, İstanbul, İzmir, Konya, Manisa, Muğla, Sivas. In order to ensure the anonymity and security of doctors, a general list of provinces has been provided, and the provinces where each doctor has worked are not listed individually in the table below.

Acknowledging that only 3% of public hospitals in Turkey offer elective abortion services (O'Neil et al., 2020), I prioritized interviewing doctors who have spent a significant portion of their professional careers in public hospitals. I initially aimed to complete the interviews at public hospitals while also doing participant observation; however, obtaining permission from the Ministry of Health to conduct such research is nearly impossible due to the current political climate (Can, 2020). Therefore, the interview sample consists of doctors who have worked in public hospitals throughout their careers and have recently retired, or who have been working in private hospitals or their own clinics for the past 4-5 years and currently have no affiliation with public hospitals.

Table 13. Gender and Work Experience of the Interviewed Doctors

Participant identifier	Gender	Years of experience	Years in public sector	Years in private sector
G1	Male	28	22	6
N2	Female	32	19	13
M3	Male	31	31	0
M4	Female	20	18	2
M5	Male	22	17	5
I6	Female	30	5	25
N7	Female	32	18	14

4.1.2 Interview questions

The interview consisted of 8 questions (see Appendix C for the questions and Appendix D for their English translation). The first two questions asked the participants about their professional careers, particularly how many years they worked for, which cities they worked in, and how many years they spent working at public hospitals and private hospitals. The second was about their perception of how abortion attitudes have been changing in Turkey in the last 30 years. If the participants believed that the attitudes have been changing, they were asked about the potential explanations of this change and how it affected their own experiences.

Afterwards, the participants were asked about the accessibility of abortion services, especially whether they observed any changes regarding accessibility in the last 30 years, whether their geographical location affected their ability to perform abortions, and whether they developed any strategies to continue providing abortion services. This was followed by a question about the changes that occurred in the

legal and administrative processes related to the provision of abortion services over the past 30 years.

Lastly, the participants were asked about their personal and moral belief about abortion, and whether this belief ever had an impact on their professional life. I chose to ask this question last since it directly concerns the personal opinions of the participants.

4.2 Key themes

4.2.1 Doctors' perceptions of social change

Even though quantitative data analysis has revealed a significant rise in anti-abortion sentiments over the past 30 years in Turkey, the majority of doctors I interviewed stated that they had not observed any change in this regard. Instead, they said that abortion attitudes have remained relatively stable over time in society and emphasized that the decision to have an abortion is generally based on individual needs rather than ideological views:

> I don't think attitudes toward abortion have changed. I provide services to people who are slightly below middle class. Although they are religiously opposed to abortion, they take a more practical approach when they have no other choice. No matter how much they fear committing a sin, if they can't take care of the child, they have an abortion. (Appendix A, 4)

As suggested by this quote, most of the doctors thought that their patients were behaving pragmatically. In other words, they said that people may not generally approve of abortion, but when faced with an unwanted pregnancy, they may act differently than their values:

> Emotionally, people may say they are against abortion when they are not in that situation. But when it happens to them, things change completely. Even the imam at the mosque sees things differently when it happens to him. When it happens to him, he seeks help. (Appendix A, 5)

It is important to note that the observations of doctors in this regard might have certain limitations. Doctors primarily interact with individuals who already want to or decided to have an abortion. However, in fact, there is no reason to assume that the views and decisions of this group reflect broader perceptions among society. As a result, abortion providers may develop a filtered understanding of public opinion, relying on repeated encounters with women who have already made their choice.

One important point to underline here is that doctors play an important role in the development, understanding, and implementation of abortion policies. They are not only medical experts but are also often treated as informants for policy-building. However, what these interviews reveal is that many doctors do not really notice the shift in social attitudes toward abortion that we observe in survey data. Most believe that people's views "have not changed much"[14] or that "the country has always been conservative"[15]. As a result, there is a discrepancy between what doctors observe and what is actually changing in society in terms of the rise in opposition to abortion.

This discrepancy is important because doctors often help shape how laws are interpreted in practice. If their understanding of public attitudes is wrong or limited, their responses to policy, and even how they will implement or resist certain regulations, may be missing a critical perspective. Therefore, a discrepancy between social reality and the doctors' perception can have adverse consequences for access to abortion and how abortion is managed on the ground.

When asked about abortion attitudes in society, doctors shifted the conversation toward issues of access, infrastructure, and policy. Rather than addressing the possibility of changing cultural values, which they generally did not perceive, they emphasized changes in how abortion was provided and regulated,

[14] "pek de değişmedi" in Turkish.
[15] "Ülke zaten başından beri muhafazakar bir ülkeydi" in Turkish.

saying “I don’t think people’s opinions have changed. My opinion is that there is more of a change in government policy than in people’s opinions.”[16] or “rather than public opinion, government policies have changed.”[17]. One interviewee underlined that while people’s perception of abortion itself has remained stable, their perception of its legal status has become distorted due to increasing inaccessibility, leading many to believe it is now illegal:

> I don’t think society’s view of abortion or the need for it has changed. Those who were against it before are still against it. I don’t think more people seem opposed to it, but there is a problem with access. People even think that abortion is illegal, because it is so inaccessible. This accessibility issue has increased significantly since 2012, along with changes in political discourse. (Appendix A, 6)

The fact that most of the discussion changed so consistently during the interviews and shifted towards policy and administrative change shows that doctors are well aware of the barriers to accessing abortion, which leads directly to the next theme: Policy and institutional change.

4.2.2 Policy and institutional change

During the interviews, the topic that all doctors consistently emphasized the most was changes in policies and institutional aspects, as well as the consequences of these changes. Doctors emphasized that access to abortion in Turkey is being restricted not through legal changes, but through changes in public health infrastructure, the lack of state support, and administrative pressure on abortion providers. Some doctors linked these changes specifically to the period after 2000, while others linked them to the period after 2010, but all of them attributed them directly to the rise of the AKP, underlining how “in the current political climate,

[16] “Bence insanların düşünceleri değişmedi. Kendi düşüncem, toplumdaki düşüncededen ziyade devlet politikasında değişiklik olması” in Turkish.
[17] “Toplumdaki düşünceden ziyade devlet politikaları değişti” in Turkish.

there are serious difficulties in providing abortion services; this situation began particularly during the second and third terms of the AKP"[18]. A frequently mentioned institutional change was the disappearance of sanctions for doctors who refuse abortion services, as illustrated in the following narrative:

> Previously, when a patient came in for an abortion and you did not perform it for some reason, the patient could complain about you. As a doctor, you could be punished in such a case. However, after the political atmosphere in the country changed, even if complaints were made, no sanctions or pressure were imposed on doctors. (Appendix A, 7)

An important milestone repeatedly highlighted by doctors is the closure of family planning clinics and the transition to a more uncertain reproductive health care system. Previously, these clinics were operating as facilities that provided counseling about family planning, distributed free contraception, and performed abortions. The closure of these clinics was a sign that the government was pulling back from providing reproductive health services:

> Normally, there used to be Family Planning Clinics at public hospitals. Women would receive counseling, have abortions, and get IUDs inserted. These clinics were closed down. It wasn't really an official closure, but rather they prevented them from operating by not replacing doctors who retired, for example. They didn't ban them or remove them by regulation; they simply rendered them inoperable. (Appendix A, 8)

Several participants also described how administrative and financial policies created de facto restrictions on abortion access. One of the most frequently mentioned de facto restrictions by doctors was how the implementation of the law has become increasingly discretionary and the increase in conscientious objection. Unlike in 1990s, when refusing to perform an abortion could result in administrative sanctions, today's providers often face no consequences for refusing: "In the past, no one working at public hospitals could say, 'I'm not doing it.' Now almost everyone says,

[18] "Mevcut siyasi atmosferde, kürtaj hizmetinin sağlanmasında ciddi sıkıntılar var. Bu durum, özellikle AKP'nin ikinci ve üçüncü dönemlerinde başladı" in Turkish.

'I'm not doing it' and they face no repercussions. This situation emerged with the change in government."[19]

The interviewees also underlined how the state's formal complaint mechanisms no longer work, highlighting that "even if the patient applies to CİMER after being denied an abortion by the doctor today, nothing will happen to the doctor. Because the government is protecting the doctor in this regard"[20]. This normalization of non-provision is also reflected in institutional culture: "When I started working at a public hospital in Manisa, they told us that if we wanted to perform abortions, we could; and if we didn't want to, that was okay."[21]

Several participants also pointed to financial policies that further limit abortion access. SGK (state health insurance) no longer covers elective abortion procedures, and hospitals are not reimbursed for them, meaning that institutions must either absorb the cost or refuse to offer the service altogether. As a result, even when legally permitted, abortion is not prioritized or not even offered in some cases:

> Abortion now falls under categories such as cosmetic surgery. The state has stopped contributing to the cost of abortion. Patients pay out of their own pockets, and it has become entirely a private matter. Citizens pay the entire cost, as if they had no social security coverage. (Appendix A, 9)

Doctors attribute these administrative changes to the politicization of the abortion discourse during the AKP era. In most of the interviews, participants referred to then-Prime Minister Erdoğan's statement that "every abortion is an Uludere," associating abortion with murder and betrayal to the nation. Doctors described how this rhetoric was reflected in practice; just days after Erdoğan's statement, hospitals started to

[19] "Önceden kimse devlette çalışırken 'Ben yapmıyorum' diyemezdi. Artık neredeyse herkes 'Ben yapmıyorum' der oldu, hiçbir yaptırımla da karşılaşmıyorlar. Bu durum iktidarın değişmesiyle oldu" in Turkish.
[20] "Artık doktor reddedince hasta CİMER'e başvursa bile doktora bir şey olmaz. Çünkü iktidar doktorun arkasında" in Turkish.
[21] "Ben Manisa'da devlet hastanesinde çalışmaya başladığımda bize 'Kürtaj isterseniz yaparsınız, istemezeniz yapmazsınız' dendi" in Turkish.

receive calls from the Ministry of Health: "Political pressure was exerted on chief physicians, who were called and told not to allow abortions to be performed"[22]. Others highlighted the moral tone used by administrators: "The chief physician said, 'Don't do abortions, it's a sin,' and so on."[23] Even though abortion remains legal to this day, this rhetoric created an environment in hospitals in which administrators felt either encouraged or obliged to restrict access and physicians felt increasingly unsupported for performing the procedure. In some cases, doctors were even deliberately denied the necessary environment and materials:

> There has been a strange change in administrators, especially since 2010. It's as if they have been instructed to say, "We do not support abortion." They make it difficult for us to obtain materials. They make everything as difficult as possible. (Appendix A, 10)

Many doctors emphasized that these institutional changes were implemented without any official legal changes, making it difficult to fight back or resist them. They specifically underlined how the government restricts access not through legislation but through indirect means such as administrative pressure, denial of resources, the performance system designed to discourage doctors, and attempts to get them to sign informal commitments not to perform abortions in their clinics. Built on indirect restrictions, this model of governance deems abortion services inaccessible without officially banning them. In the words of one doctor, "It [abortion] is not banned, but it's become inaccessible. It is perceived as if it's banned."[24] Another said, "They [the government] realize that if they banned it [abortion], there would be a bigger reaction, so they're trying to prevent access in practice without banning it."[25]

[22] "Ayrıca politik olarak başhekimlere baskı yapıldı, başhekimler arandı, kürtaj yapılmasına müsaade etmemeleri söylendi" in Turkish.
[23] "Başhekim bunu diyen, "Doktor hanım, yapmayın günah" falan dedi" in Turkish.
[24] "sanki yasakmış gibi, çünkü ulaşılamaz bir halde. Ama sanki yasaklanmış gibi bir algı var" in Turkish.
[25] "Yasaklasalar daha büyük bir tepki alacaklarını farkındalar, bu yüzden böyle fiili olarak erişimin önünü kesmeye çalışıyorlar" in Turkish.

Political and institutional practices that restrict access to abortion do not affect all segments of society equally. Here, socio-economic inequalities become particularly salient, with socioeconomic status becoming a determining factor in access to services.

4.2.3 Economic and regional barriers to abortion access

Almost all of the doctors interviewed stated that abortion is increasingly becoming a service available only in private hospitals and clinics, and that public hospitals either provide abortions under very limited conditions or they stopped providing the procedure altogether. This situation makes safe abortion accessible only to women who can afford it:

> Citizens used to be able to talk freely and receive services under better conditions both in terms of birth control and abortion, but now they can no longer do so in public hospitals. They have to go to a private hospital, not everyone has the financial means to do that. (Appendix A, 11)

Not only do low-income women have less access to abortion services, but they also have limited access to birth control, specifically due to the closure of Family Planning Clinics, which used to provide contraception free of charge: "A package of birth control pills costs 400 TL. How many people can afford that? And if you want to have an IUD inserted, you have to go to a private clinic. Who can afford that?"[26]

Access not only to legal abortion but also to safe and healthy abortion has become a class privilege. This inequality increases the risk of resorting to unsafe and clandestine abortion practices in cases of unwanted pregnancy, directly threatening women's health. Many doctors have highlighted that unsafe abortion practices in the past have led to maternal deaths and that the risk of returning to such practices poses

[26] "Şu anda doğum kontrol hapı almaya gidiyorsun, paketi olmuş 400 tl. Buna kaç kişi ulaşabilir?" in Turkish.

a serious public health issue: “Many people who could not access services at private hospitals, who could not afford to pay, are forced to resort to illegal abortions”[27]. One interviewee explicitly reminded that abortion was legalized precisely to prevent the kinds of life-threatening outcomes that are now at risk of returning:

> Abortion was practiced before, but it caused women to lose their lives: the use of skewers, soap, and other things. It was unhygienic. These things caused maternal deaths. That was one of the reasons it was legalized in the first place. (Appendix A, 12)

This inequality in access to abortion is not solely linked to economic constraints. During interviews, doctors frequently emphasized that access varied significantly depending on geographical location and the sociocultural characteristics of the province in question. In particular, it was noted that access to abortion is much more difficult for women living in smaller, more conservative cities: “While this [abortion] is easier in large cities, it has become more difficult in Anatolia”[28]. One story shared by a doctor vividly illustrates the barriers women face in smaller, more conservative provinces:

> Once, a medical student contacted me. She was from Kayseri, if I am not mistaken. She was unable to get an abortion there. I was working at the Family Planning Clinic at the time, so I assisted her. She said she went to the maternity hospital, and also went to the university hospital, and they both said, “We don’t do that here.” They also asked for a lot of money at the private hospital. (Appendix A, 13)

This means that women who live in rural or conservative areas and also have low incomes face way more obstacles because of both economic and regional reasons. This situation reveals that, despite being legal, abortion is not an equal health service but it is indeed intertwined with inequalities stemming from both geographical

[27] “Bir sürü kişi, özel hastanelerde hizmete ulaşamayan yani ücretini veremeyen bir sürü kişi, karşılayamayınca merdiven altı kürtaj olmaya zorlanıyor” in Turkish.
[28] “Büyük şehirlerde bu iş daha kolayken Anadolu’da daha zor hale gelmeye başladı” in Turkish.

differences and socioeconomic class. However, inequality in access to abortion is not limited to these two factors; it also has a gender dimension.

4.2.4 Abortion from a gender perspective and spousal consent

Many of the participants stated that spousal consent, i.e., the requirement for married women to obtain their husbands' consent in order to have an abortion, has become a mechanism that legitimizes male control over women's bodies. Doctors also noted that this practice is problematic not only in practice but also from an ethical standpoint, as it limits women's decision-making and causes serious harm in situations like marital rape: "[Spousal consent] is often exploited by husbands. The situation becomes very difficult for women who are victims of violence or marital rape"[29]. Another interviewee further mentioned how spousal consent can directly push women toward unsafe abortion practices:

> Spousal consent is a very problematic issue. There are cases where a couple is about to get divorced, but the woman cannot have an abortion because the man refuses to sign the consent form. In such cases, women are forced to resort to illegal abortion. (Appendix A, 14)

Some doctors pointed out that the legal basis for this practice is also controversial. According to international agreements to which Turkey is a part of, the right to make decisions about their own body belongs solely to the person herself. Therefore, the requirement for spousal consent is considered a contradictory practice from a legal perspective as well:

> According to Law No. 2857, spousal consent is required. However, in Turkey, international agreements actually take precedence over domestic law. In 2001, Turkey signed the Bioethics Convention. According to this convention, "A person has the right to decide on any intervention on their body if they are of sound mind." In fact, in this case, spousal consent becomes invalid. (Appendix A, 15)

[29] "Bu, eşler tarafından kullanılabiliyor. Şiddet gören kadınlar, evlilik içi tecavüze uğrayan kadınlar için durum çok zor bir hal alıyor" in Turkish.

Some doctors also see this practice as a reflection of gender inequality in society and consider it a tool of the patriarchal system. According to those who share this view, the fact that unmarried women can make decisions on their own, but married women need their husband's signature shows that women's individual autonomy is not recognized within the institution of marriage:

> Women do not need spousal consent when they are single, but they do when they are married. This is very discriminatory and unequal. Women are already in an unequal position in society, and this inequality is being reproduced once again, leaving women exposed to it. (Appendix A, 16)

All in all, spousal consent exemplifies how access to abortion goes hand in hand with gender-based inequalities and how women's right to decide over their own bodies is still so often restricted by male authority: "It is terrible that abortion is dependent on a signature. It becomes a means of oppression and a tool for violence against women."[30] In this context, where abortion is restricted on both institutional and patriarchal grounds, women's access to abortion often depends on the initiative of doctors, who have developed different strategies to make abortion available to women who want it.

4.2.5 Strategies adopted by doctors

Some of the participants stated that they and other doctors around them developed strategies to enable women to have abortions within legal limits. These strategies include conducting medical assessments to justify the patient's request and emphasizing the risks of a miscarriage to overcome obstacles such as the need for spousal consent or helping the patients avoid stigma/judgement from their own families:

[30] "Bunun bir imzaya bağlanması çok kötü. Bu bir eziyet aracına dönüşüyor, eril şiddete bir aracı oluyor" in Turkish.

> I try to make abortion easier for women as long as they want it. For example, a woman has just had a c-section and is pregnant again. Her husband says, "If it's risky, she should have an abortion." It may or may not be risky. If the woman wants to have an abortion, I explain that there may be risks. I try to prioritize her wishes. (Appendix A, 17)

> Afyon is a small, particularly conservative city. One day, a couple who wanted to have an abortion told me, "We will come tomorrow with my mother. Please tell her that the baby has already died and that an abortion is necessary." I would do it if both spouses agreed. This is an innocent secret between the doctor, the patient, and the spouse. (Appendix A, 18)

Some doctors further stated that they try to justify and meet the patient's demand to have an abortion on medical grounds by telling the authorities that the woman already had a miscarriage or by using phrases such as "no heartbeat" in ultrasound reports. This situation shows that doctors feel obliged to exploit the gray areas of the system in order to meet women's demands: "If a woman wants to have an abortion, some doctors I know would say 'she came in bleeding, she was having a miscarriage'. Some said they looked at the fetus with an ultrasound and there was no heartbeat."[31]

All in all, doctors are not only static agents of medical decision-making, but also ethical actors with their own agency. Some doctors have directly described this process as a form of social responsibility or solidarity with women. These acts may be considered a response to the existing oppressive system and a way of resisting it. However, the existence of such strategies also highlights a deeper problem: The fact that abortion, despite being a legal health service, is left to the discretion of doctors, leading to both marginalization and stigma.

[31] "Kadın aldırmak istiyorsa, tanıdığım bazı doktorlar kanamayla geldi, düşük yapıyor diyip aldı. Bunların hiçbiri ispatalanamaz. Ultrasonla baktım, kalp atışı yoktu diyenler de oldu" in Turkish.

4.2.6 Marginalization of abortion and abortion stigma

The fact that abortion is increasingly removed from the realm of public health services and is performed based on the individual initiative of doctors has made it become marginalized and increasingly fragile. The way abortion is no longer performed at public hospitals and is available at private hospitals only at very high costs not only makes it harder to access but also changes perceptions of abortion, both in the public and among doctors: "In contrast to gynecological examination, abortion is risky. Clots, bleeding... It's a hassle. It's a bit of a pain, really. Everyone started saying, 'I'm not doing it either.'"[32]

This statement reveals that abortion is viewed not as a medical procedure, but as an exceptional and "distressing" procedure. Many doctors have stated that they personally do not choose to perform abortions, describing it as an emotionally and professionally "difficult," "troublesome," or "unsatisfying" procedure: "Abortion is increasingly being viewed negatively in the medical community. It's seen as dirty work, something vulgar and lowly. Most doctors won't even do it. It wasn't like that in the 90s."[33]

Hence, under these circumstances, both the provider of the service and the woman accessing the service are marginalized, and abortion is not only difficult to access but it is also stigmatized. Excluded from the public sphere, abortion has become a service that is now only accessible through word of mouth, where it is known who will perform it and which specific doctor "to go to":

> For example, I know of an incident in Erzurum. A woman wanted to get an abortion. When I talked to a friend of mine about it, she said, "We can't do anything in Erzurum. Can she go to Malatya? We have connections there."

[32] "Jinekolojik muayendense kürtaj riskli bir şeydir. Pıhtı, kanama vs. Al başına belayı. Biraz da belalı yani. Herkes "Ben de yapmıyorum" demeye başladı" in Turkish.
[33] "Camiaya da kürtaj giderek kötü bir yere konumlandırılıyor. Düşük bir iş gibi, adi aşağı bir iş gibi. Doktorların çoğu yapmaz bile. 90'larda böyle değildi" in Turkish.

> That's really how the system works. If a woman who wants an abortion reaches out to a women's support group, the group contacts us, and we investigate. We try to find someone who can perform the procedure. (Appendix A, 19)

In conclusion, the experiences shared by the doctors suggest that abortion in Turkey is increasingly becoming a practice that is hidden, restricted, and removed from public health services. Medically and legally available but politically discouraged, abortion is experiencing a process of marginalization that is changing both its availability and its acceptance.

CHAPTER 5

DISCUSSION

In this study, I investigate how attitudes toward abortion in Turkey have changed from 1990 to 2018 and to what extent this change was influenced by religious, political, educational, and economic factors. To this end, I employ a mixed research methodology, combining nationally representative data from the World Values Survey (WVS) and in-depth interviews with seven obstetrician-gynecologists. The reason why I prefer to use such methodology is that when examining a "biosociocultural public health problem" like abortion, mixed-methods allows me to observe the underlying sociopolitical structures and the perspectives and narratives of people who are familiar with this field, enriching the statistical analyses that provide an overview of the population as a whole (Houghton & Paniagua-Avila, 2023, p. 175). By employing both quantitative and qualitative methods, I aim to understand the changes in anti-abortion attitudes as the population level and explore how the increasing anti-abortion sentiment might be shaping the experiences of abortion providers in the current political atmosphere.

This thesis argues that although Turkey is experiencing the demographic transformations associated with the Second Demographic Transition (SDT), such as declining fertility, decreasing marriage rates, and rising age at first marriage, Turkish society does not follow the SDT's core assumption of increasing tolerance towards values and others' behavior when it comes to abortion. Instead, I argue that due to an increasingly conservative political climate and the rise of pronatalist discourse and policy, public attitudes toward abortion have become more restrictive.

To investigate how the determinants of abortion attitudes have been changing in Turkey, I use four waves of WVS data from 1990, 2007, 2011 and 2018, and examine how the most common four predictors of abortion attitudes according to the literature (Adamczyk et al., 2020), namely religiosity, political stance, education, and income determine justifiability of abortion. In addition to these variables, the models control for sociodemographic characteristics such as gender, age, marital status, and number of children. Nine hypotheses are tested regarding abortion attitudes in Turkey. The first hypothesis proposes that anti-abortion attitudes increase over time. The second and third hypotheses suggest that higher religiosity predicts higher anti-abortion attitudes and that the effect of religiosity on abortion attitudes has grown stronger over time. The fourth and fifth hypotheses suggest that higher conservatism predicts higher anti-abortion attitudes and that the effect of political conservatism on abortion attitudes has grown stronger over time. The sixth and seventh hypotheses argue that higher income predicts lower anti-abortion attitudes and that the effect of income on abortion attitudes has grown weaker over time. The eighth and ninth hypotheses argue that higher education predicts lower anti-abortion attitudes and that the effect of education on abortion attitudes has grown weaker over time.

Quantitative analyses show an extreme increase in anti-abortion sentiment in Turkey over time. Supporting the first hypothesis, the findings underline that while Turkish society was relatively more tolerant toward abortion in 1990, anti-abortion attitudes increased dramatically in 2007 and 2011. Although there was a slight decrease in anti-abortion attitudes in 2018, anti-abortion sentiment was still significantly more widespread than it used to be in 1990. This finding is consistent with the literature suggesting that Islamic authoritarianism and conservatism are on the rise in Turkey (Şalgam, 2024) and that the society is becoming increasingly

patriarchal (Engin & Pals, 2018), especially under the regime and gender politics of the Justice and Development Party (Cindoglu & Unal, 2017). This finding from the data analysis is complemented by the most frequently mentioned concern raised in interviews with doctors: Despite the legal protection of reproductive rights, access to abortion has become increasingly difficult and stigmatized. Combined, these findings challenge the core assumption of the SDT theory, which suggests that increasing modernization brings a sexual revolution, along with greater tolerance and more liberal social values.

In this context, while relative progress has been observed in many dimensions of social modernization in Turkey, such as women's education and more widespread use of birth control, the divergence of attitudes toward abortion from this trend may initially seem counterintuitive. I propose two potential explanations for this difference in attitudes toward abortion: The growing influence of conservative political discourse on abortion and abortion's status as an area that can be directly regulated by the state.

One reason why abortion attitudes have been so susceptible to change may be that abortion is an issue that can be directly influenced by the state and its institutions. While other values that reflect individual lifestyles, such as homosexuality or cohabitation, cannot be directly controlled by the state, abortion is a service that the state can directly govern and regulate through its healthcare system. Most of the doctors interviewed stated that although abortion is technically legal, it is now almost never performed in public hospitals, that hospital administrations exert pressure, and that in some provinces women are forced to move to another city in order to have an abortion. Pronatalist policies such as the closure of family planning centers, the removal of free birth control methods, and the exclusion of these services

from the Social Security Institution (SGK) demonstrate how the state has not only taken a step back ideologically but also institutionally. Hence, the inaccessibility of abortion as a service also makes it more invisible and stigmatized among society.

In addition, the rise of conservative political discourse in recent years may have contributed to more negative social attitudes. As I mentioned in Chapter 2, during the AKP era, especially after 2012, politicians and religious authorities framed abortion as a moral and national threat, and their statements on this issue were widely shared in the media. This situation may have affected the social perception of abortion, leading to an increase in anti-abortion attitudes. This hostile rhetoric created around abortion also helps explain why variables like religiosity and political stance continue to have a strong and stable influence on anti-abortion attitudes.

In line with the literature on the relationship between religiosity, conservatism and anti-abortion attitudes (Osborne et al., 2022; Jozkowski et al., 2018), the main effects model shows that more religious and conservative people have a significantly higher tendency of holding anti-abortion attitudes, confirming hypotheses 2 and 4. In Turkey, the Directorate of Religious Affairs takes a public anti-abortion stance, emphasizing that protecting human life is one of the five fundamental principles of Islam and therefore arguing that abortion is prohibited (Din İşleri Yüksek Kurulu, 2017). Religious individuals may be more likely to take these statements more seriously and internalize them, making them more prone to holding anti-abortion attitudes. Furthermore, abortion is also highly stigmatized by right-wing conservative political party leaders in Turkey (Yükler, 2023), who frame it as a threat to national strength and barrier to demographic growth. Similar to religious people who internalize the statements of religious leaders and institutions, conservative individuals who identify with right-wing politics could be more likely accept and

embrace these narratives. Furthermore, both religiosity and political conservatism are strongly associated with higher acceptance of traditional gender roles (Engin & Pals, 2018; Özdemir-Sarıgil & Sarıgil, 2021), which place great importance on women's role as mothers (Delgado-Herrera et al., 2024). Abortion, according to this view, goes against women's primary role, leading more religious and conservative people to oppose abortion more strongly.

On the other hand, the interaction model provides only partial support for hypotheses 3 and 5. While the relationship between anti-abortion attitudes and religiosity or political conservatism does not significantly get stronger over time, it also does not grow weaker either, suggesting that these two factors have remained stable and kept being strong predictors throughout the years. In fact, the predicted probability estimates for 2018 further show that political polarization on abortion has grown deeper: Individuals who identify with far-left politics, meaning those who place themselves at the extreme left of the left-right scale (-2 SD), expressed more tolerant attitudes in 2018 than in 2007 and 2011, while far-right individuals, meaning those at the extreme right of the right-left scale (+2 SD), expressed more conservative abortion attitudes than in 2007. Therefore, the finding that anti-abortion attitudes are on the rise in Turkey can be interpreted as a reflection of the polarization between the political left and right in Turkish society and the increasing politicization of abortion.

One potential explanation for this polarization may be the rise of anti-abortion rhetoric in 2012 and after, as shown in Chapter 2, in connection with the rise of right-wing populist politics following Turkey's authoritarian shift after 2010 (Kutun, 2024). This new conservatism, which functions by "dividing society into two along the lines of friend and foe to every appropriate socio-political situation"

(Mollaer, 2023, p. 194), might be contributing to the formation of more polarized views on abortion in society: Combining religious and nationalist rhetoric, the ruling party and religious leaders keep framing abortion as a national threat and a sin, which might have further strengthened anti-abortion sentiment among right-wing religious voters. In conclusion, the hostile political and religious discourse surrounding abortion, particularly since 2012, and the polarization it has created, may have contributed to the increasing politicization of attitudes toward abortion, further exacerbating polarization of abortion attitudes and preventing the increase in tolerance toward abortion predicted by the SDT.

The social implications of the politicization of abortion can be better understood when taken together with the institutional changes in the health system. Erdoğan's remarks interpreting abortion and birth control as "a plan to destroy this nation," and the Directorate of Religious Affairs' simultaneous statements about how women cannot decide what to do with their own bodies have transformed abortion from a matter of women's right to health into a matter of national security and religious morality. All of the healthcare professionals interviewed are aware of the real-world implications of these statements: All of them say that, even though abortion is legal, abortion services are gradually becoming unavailable in public hospitals, and that managers and chief physicians are discouraging doctors from providing these services, either through covert pressure or overt obstacles, as a result of political pressure they are subjected to.

However, interestingly, almost all of the doctors I interviewed believe that the public's attitude toward abortion has not changed much in the last 30 years. One potential explanation of this phenomenon is the fact that doctors are in contact with only a specific group, namely those who have already decided to have an abortion.

Therefore, physicians cannot observe the value judgments that precede the decision-making process and are not in contact with individuals who choose not to have an abortion. Another potential explanation for the difference between this perception of stability in qualitative data and the shift toward anti-abortion attitudes in quantitative data may be that, despite becoming more anti-abortion in their attitudes, people may continue to resort to abortion in practice under challenging circumstances, particularly under the current economic uncertainty of Turkey. On the other hand, one should not forget that doctors' observations have the potential to be important sources of information that influence public health policies. Therefore, their perceptions of public attitudes may indirectly influence the implementation of abortion service regulations and policy-making processes. Thus, policies based on the views of doctors who believe that there has been no change in attitudes toward abortion may fail to address the growing anti-abortion sentiment in society.

Contrary to the consistent effects of religiosity and political stance, findings related to income and education remain rather inconclusive. Confirming hypotheses 6 and 8, the main effects model shows that people with higher income and higher education tend to hold significantly less anti-abortion attitudes, in line with the literature (Thomas et al., 2017; Mosley et al. 2017; Tuman et al., 2013). It is not surprising that more educated people are less likely to have anti-abortion views, as education generally encourages critical thinking and exposes people to social views that lead them to question traditional beliefs (Petersen, 2001), and helps them be more tolerant toward personal choices (Dutta et al., 2024). As for income, people with higher incomes tend to be more liberal, increasing their support for reproductive rights (Fernández & Adamczyk, 2025) and their tolerance for people's choices.

However, the interaction model and predicted probabilities support hypotheses 7 and 9, which suggest that the influence of income and education on abortion attitudes has become weaker over time. In 1990, both income and education strongly predicted more liberal attitudes: individuals with higher income or more years of schooling were significantly less likely to oppose abortion. Yet, by 2011 and especially by 2018, these effects had significantly declined. Income effects became negligible in 2011, with predicted probabilities nearly equal across all income groups, and only modestly re-emerged in 2018. Similarly, the predictive power of education declined steadily and disappeared completely by 2018, with opposition to abortion becoming equally prevalent among all educational levels.

The decline in the impact of demographic determinants such as education and income can be attributed to the increasing dominance of political and religious discourse on abortion attitudes. Especially after right-wing political leaders started to establish a hostile rhetoric around abortion in 2012, as the issue became more morally and politically charged, attitudes toward abortion may have become more closely associated with ideological positions than with socioeconomic status. Another possible explanation for the disappearance of the effect of education is the general rise in access to education in Turkey over the past few decades (TURKSTAT, 2024). Though education is usually associated with open-mindedness and reduced prejudice (Dutta et al., 2024), it might have lost its previous role as a predictor of more tolerant values as it became more and more widespread and people with both conservative and liberal backgrounds started to attain similar levels of education. Moreover, the spread of education in Turkey has also taken place within a specific ideological framework: The increase in the number of religious (*imam hatip*) schools (see Buyruk, 2021) and the more conservative nature of the curriculum in schools

(Polat, 2013) may have contributed to reducing the correlation between education and opposition to abortion.

One reason for the weakening effect of income on abortion attitudes over time may be the economic recession experienced in Turkey, particularly in the last ten to fifteen years, and the consequent gradual disappearance of the middle class. The new middle class that expanded in the early 2000s as a result of the newly-elected AKP government's economic growth policies and market expansion has shrunk significantly since 2010s due to economic stagnation, high inflation, currency crisis, and job insecurity, and many individuals began to experience economic uncertainty and precarity (Balta, 2022; Eğilmez, 2024; Soydan, 2022). With the spread of economic insecurity, liberal values previously associated with high-income individuals, such as sexual autonomy, bodily rights, or reproductive rights, which were once associated with the wealthier individuals among society (Fidan et al., 2021), may have become less distinct across income groups. Consequently, the determining influence of socioeconomic status on abortion may have diminished, and instead of socioeconomic factors, ideological variables such as religiosity and political stance may now be shaping abortion attitudes.

The models also controlled for gender, age, marital status, and number of children. The findings suggest that women express less anti-abortion attitudes compared to men. This gender difference is consistent with the literature that suggests men tend to hold more anti-abortion attitudes while women are more pro-choice, while other sociodemographic characteristics are held constant (Loll & Hall, 2019). This is not a surprising finding considering how abortion is generally perceived as a “women’s issue” (Barkan, 2014, p. 941), and, of course, women are the ones who suffer the physical and mental consequences of not having access to

abortion (Foster, 2021). Number of children is also a significant determinant of anti-abortion attitudes, as people who have more children might prioritize parenthood and feel uncomfortable with the idea of abortion (Misra, 1998).

Overall, this study shows that both access to and attitudes toward abortion and reproductive health is becoming increasingly unequal and politicized in Turkey. The fact that abortion is both legally accessible yet practically inaccessible demonstrates that reproductive rights do not solely depend on the laws and cannot be separated from cultural and political circumstances. In the current atmosphere in Turkey, access to safe abortion for women living in low-income and conservative regions is severely limited due to both service restrictions and increasing social stigma. When viewed from the perspective of "reproductive justice" this situation shows that not only are individuals' legal rights being restricted, but also their actual ability to exercise those rights. The rising inaccessibility and the intersectional nature of inequalities in access to abortion are also consistently brought up by the doctors I interviewed, who described how institutional and ideological restrictions affect the implementation of legal rights in practice. Therefore, there is a need for policies that aim to address the intersectional nature of the inequalities in women's access to abortion by carefully considering the ideological, regional, economic, and institutional barriers that impact women's ability to exercise their right.

CHAPTER 6

CONCLUSION

Even when abortion is legal, women's access to safe abortion practices may be restricted in societies where anti-abortion attitudes and abortion stigma are widespread (Kumar et al., 2009), and their ability to exercise their reproductive rights may be limited (Norris et al. 2011). Therefore, it is crucial to examine the mechanisms underlying anti-abortion attitudes, particularly in countries such as Turkey where abortion is legal but inaccessible. In my thesis, I sought to examine the changes in attitudes toward abortion in Turkey over time, identify the changing patterns in the effects of the primary determinants, and investigate the impact of the political discourse that condemns abortion.

In the literature review, I examined the history of abortion laws and policies in Turkey from the perspective of biopower and biopolitics, in parallel with the pronatalist and antinatalist policies of the respective periods. In this review, I demonstrated that abortion policies and laws were not regarded as women's rights or reproductive rights, but rather as a means of population control. I then examined the current situation in Turkey, particularly under the AKP government and the political discourse that emerged in 2012, and showed how abortion has been reframed through nationalist and religious connotations, rather than remaining a legal right or a matter of choice. In light of this background information and the global literature, I hypothesized that attitudes toward abortion in Turkey may not follow the Second Demographic Transition theory's assumption of increasing tolerance but instead may shift in the opposite direction, toward a more negative stance. I also hypothesized that due to the increasingly politicized nature of abortion debates, influenced by the

hostile rhetoric of both political leaders and religious figures, indicators such as religiosity and political stance will play an increasingly significant role in determining anti-abortion attitudes.

The quantitative findings of my mixed-methods thesis reveal that anti-abortion attitudes increased significantly in Turkey between 1990 and 2018 and that this trend is strongly associated with religiosity and conservative political views. Meanwhile, the impact of demographic determinants such as education and income has weakened over time. This suggests that individuals' views on abortion have become increasingly polarized politically, with politico-religious factors playing a more prominent role than socioeconomic status. Qualitative findings also show that the politicization of abortion has affected not only societal attitudes but also the experiences of doctors who provide abortion services. Doctors have directly associated the inaccessibility of abortion with political pressure and the institutional changes resulting from this pressure.

These findings contribute to the literature on social values and show that the Second Demographic Transition theory has limited explanatory power in the context of social values in Turkey. The Second Demographic Transition theory assumes that modernization will lead individuals to be more tolerant of others' choices and behavior. Indeed, although STD indicators such as rising age at marriage, declining fertility, and changes in family structure are observed in Turkey, social attitudes toward abortion have not become more tolerant. On the contrary, the rise of conservatism, possibly together with the rising right-wing populist discourse around abortion, has led to abortion being considered even more unacceptable, overriding the effects of factors such as education and income. This situation shows that demographic transformation does not always progress in parallel with social values

and that the political atmosphere and discourse can interrupt this transformation of values. Thus, similar to previous research in Japan (Raymo, 2022), the study contributes to discussions criticizing the ethnocentric biases of SDT (Zaidi & Morgan, 2017) and highlights how contemporary Turkey does and does not conform to trends associated with SDT in Western Europe, underlining the importance of not evaluating the assumptions of SDT independently of the political and cultural context, especially in non-Western contexts such as Turkey.

My thesis also makes a methodological contribution to the literature. The overwhelming majority of studies on reproductive health and abortion in Turkey are either limited to qualitative analysis or rely on quantitative data that are not nationally representative, such as surveys conducted via non-probability sampling. In contrast, I use a mixed-methods approach in my thesis, combining the strengths of both methods to examine abortion attitudes through population-level trends and the narratives and experiences of abortion providers. This methodology helps me reveal the reasons behind population-level trends and their interaction with the political discourse and de facto restrictions. Thus, the methodology of my thesis highlights the importance and potential of using mixed methods in studies on the multifaceted issues of reproductive health and reproductive justice in Turkey, which encompass political, cultural, gender, and women's health dimensions.

My thesis has several implications regarding abortion attitudes and accessibility in Turkey. First and foremost, it is clear that there is a need for policy interventions that address the inequalities in reproductive health services across the country. Above all, we need to ensure that all women can exercise their legal right to abortion, and to do so, the first step is to make abortion services available in all public hospitals. To increase accessibility of abortion in hospitals, we first need to

acknowledge and address the growing conservatism and its impact on values. Growing conservatism regarding abortion attitudes in public may lead to feelings of pressure among managers and doctors in public hospitals, making them reluctant to provide abortion services. Though it may not be possible to address the growing conservatism among society, policies could aim to reduce ideological pressure on health institutions and guarantee that healthcare professionals are able to perform abortions on demand. Ensuring the accessibility of abortion is important because restrictions not only jeopardize reproductive autonomy but they also have direct health consequences: Limiting women's access to safe abortion services may lead them to seek unsafe alternatives, which increase the risk of complications and maternal mortality. Evidence from recent anti-abortion measures in parts of the United States demonstrates how such restrictions can result in an increase in pregnancy-related deaths (Stevenson, 2021). Such evidence should be taken into account as a cautionary example for Turkey: Legal rights alone are insufficient unless accompanied by institutional policies that guarantee access.

On the other hand, it is also worth mentioning how Turkey's fertility rate has been declining steadily despite strong political discourse promoting early marriage and large families. The government has recently announced that 2025 will be the "Year of the Family" and introduced a series of incentive programs such as loans for newlyweds and increased birth assistance payments (Daily Sabah, 2025). However, these kinds of measures have proven largely ineffective in reversing fertility decline historically, and Turkey's fertility rate fell to 1.48 in 2024 (TURKSTAT, 2025). This failure may be partly due to the fact that the state's approach continues to overlook the actual needs of women, offering pronatalist solutions without addressing issues

such as gender inequality in caregiving, lack of affordable childcare, widespread economic precarity, and insufficient support for work-family balance.

Even though the relationship between education and anti-abortion attitudes have been getting weaker over time, there is still a negative main effect, meaning that more educated people tend to hold less anti-abortion attitudes. Hence, policies that aim to improve education levels across society could simultaneously reduce abortion stigma. Moreover, educating people about the adverse effects of not being able to get an abortion when desired and having to carry the pregnancy to term could help people understand the severity of the problem and help overcome anti-abortion attitudes. Informative educational programs of this kind should be provided especially to men, as they tend to be more anti-abortion than women.

We also need to address gaps in society's knowledge regarding abortion: In interviews, doctors frequently mentioned the confusion among the public regarding the legal status of abortion in Turkey, particularly their lack of awareness that unmarried women are allowed to have an abortion. Public awareness campaigns on the legal aspects of abortion could help solve this confusion. Such awareness campaigns can also help reduce abortion stigma in society by normalizing abortion within public discourse. Moreover, campaigns and other educational tools should not only be limited to providing information but should also focus on gender equality and bodily autonomy, which could effectively result in long-term positive change in values. This could offer a permanent fix to reduce the stigma around abortion and sexual health more broadly and enhance access to safe abortion in return. At the same time, it must be emphasized that rights-based approaches and gender equality are not obstacles to increased fertility, as the Turkish government's pro-natalist policies implicitly suggest, but rather necessary for sustainable family policies. Countries that

have successfully boosted fertility rates, have done so not by restricting reproductive rights, but by expanding them and supporting gender equality in both public and private spheres, as shown by studies that explore the relationship between gender equality and the reversal of fertility decline (Myrskylä et al., 2009).

Finally, it is critical to acknowledge the intersectional nature of the inequalities that prevent access to abortion, and to integrate such information into medical school curricula, so that the new generation of doctors are more informed about the systemic inequalities women face in reproductive healthcare. From a reproductive justice perspective, the right to access abortion is not merely a legal entitlement, but a right that women should be able to exercise regardless of their living conditions, class, religion, race, ethnicity, sexuality or cultural background; and future doctors should be well-informed about this framework.

This study also highlights the critical role that obstetrician-gynecologists play in the implementation of abortion policies. Some doctors mentioned how they resist political pressure and resort to various strategies to facilitate women's reproductive choices. Doctors are therefore actors who shape the boundaries of access to abortion services. However, my interviews with them suggest that these actors are largely unaware of the attitudinal shift that is happening in Turkish society. A plausible explanation for this may simply be that they interact with a limited group of patients who have already decided to have an abortion. This may make it difficult for them to observe the growing anti-abortion sentiment in the wider society, leading them to assume that their own experiences are representative of the general public. At the same time, as I showed in the section on the history of abortion policies in Turkey, doctors have been informants in the formulation of abortion policies throughout history. Therefore, the gap between doctors' perceptions and the values of the

population may cause them to overlook issues that need to be addressed by policies. For this reason, healthcare professionals need to be informed about the issue of growing anti-abortion sentiment, as doing so will enable them to make more informed and comprehensive decisions.

My thesis also has certain limitations. One of the most significant limitations is that there is only one very general question about abortion attitudes in World Values Survey. Yet recent studies have shown that attitudes toward abortion may vary in different scenarios, such as abortion due to economic hardship or when the woman's health is at risk (Fernández & Adamczyk, 2025). Unfortunately, there are no recent surveys that measure acceptance of abortion in such different scenarios. Another limitation is the unequal time intervals between the waves: The abortion question was excluded from the waves 3 (1997) and 4 (2001) of the survey, making it harder to track changes over time consistently. It is also important to underline that survey respondents may be inclined to give answers that are more socially acceptable rather than expressing their own beliefs when it comes to morally and politically controversial issues such as abortion. Hence, high social desirability bias may prevent abortion attitudes measured in WVS data from accurately reflecting actual beliefs. Lastly, although the dataset includes potentially important variables such as region and views on gender roles, these could not be incorporated into the current analysis due to limitations in scope. Similarly, personal or indirect experience with abortion, which could be important factor shaping attitudes, is not measured in the dataset.

As for the qualitative part, the main limitation is the sample size. Although the doctors work in diverse cities and institutions and the findings obtained from the interviews reached a certain level of saturation, the fact that only seven ob-gyns were

interviewed, and all of these doctors supported abortion at least to some extent should not be overlooked. Additionally, the sample is limited to obstetricians, although abortion providers are certainly not limited to obstetricians; thus, it is certainly a limitation that nurses, doulas or other healthcare personnel involved in abortion provision were not included in the study. That said, these interviews were not intended to be representative but rather to complement the quantitative findings by providing information about the lived experiences of abortion providers within Turkey's current political and institutional atmosphere.

Future research should analyze attitudes toward abortion not only at a general level but also in different scenarios, such as when a woman's health is at risk, in cases of economic hardship, or when the pregnancy is unwanted, in order to determine under which conditions these attitudes become more flexible or more rigid. Such scenario-based research could be useful for policymakers to better understand the values of society and develop effective health policies. Furthermore, acknowledging that this study is limited to the views of obstetricians, future research should include different groups of abortion providers, such as nurses or doulas, to reveal a more comprehensive picture of de facto restrictions. Regional differences in access to abortion and how this inequality intersects with factors such as socioeconomic status are not adequately addressed in the literature. To fill this gap, future research should focus on how such intersectional inequalities shape abortion stigma and access. Finally, abortion is a politicized issue not only at the national but also at the global level; therefore, comparative studies that examine the situation in Turkey alongside other countries undergoing similar or opposite political transformations are of great importance.

In conclusion, my aim in this thesis is not merely to conduct a value analysis, but also to question how abortion attitudes are shaped, what role political discourse plays in this process, and how a right is being denied. Abortion may be legal in Turkey, but without access, this law is nothing more than an empty promise. Reproductive justice is not only pursued in places where abortion is prohibited, but also in places where it is made invisible and inaccessible despite being legal. True reproductive justice is possible when all women are able to make decisions about their own bodies regardless of their income, ethnic origin, geography, or marital status. For the ability to make decisions about our own bodies is our right, and this right is not up for negotiation.

APPENDIX A

LONG QUOTES IN TURKISH

1. Kürtajı bir cinayet olarak görüyorum. Buna kimsenin müsaade etme hakkı olmamalı. Ha anne karnında bir çocuğu öldürürsünüz ha doğduktan sonra öldürürsünüz. Hiçbir farkı yok. Buna karşı çok daha duyarlı olmaya mecburuz. Buna karşı el birliği içinde olmak zorundayız.
2. Ben sezaryenle doğuma karşı olan bir başbakanım. Bunun özellikle planlı yapıldığını, ülke nüfusunun artmaması için atılan adımlar olduğunu biliyorum. Bunun bir taraftan da kendilerine mali kaynak teşkil etmesi için atılan adımlar olduğunu biliyorum, bununla bu ülkenin nüfusu bir yerde donduruluyor. Kürtajı bir cinayet olarak görüyorum. Bu ifademe karşı çıkan çevrelere, medya mensuplarına da sesleniyorum. Yatıyorsunuz, kalkıyorsunuz Uludere diyorsunuz, her kürtaj bir Uludere'dir diyorum. Anne karnında bir yavruyu öldürmenin doğumdan sonra öldürmeyle ne farkı var, soruyorum size. Bunun mücadelesini hep birlikte vermeye mecburuz. Bu milleti dünya sahnesinden silmek için sinsice bir plan olduğunu biliyoruz.
3. …gebe olan anne; 'beden benim değil mi, ben onu istediğim gibi kullanırım, bebek de yaparım, istersem onu da atarım' deme hak ve yetkisine sahip değildir. Çünkü karnındaki bebeğin gerçek anlamda sahibi maliki değildir. Keyfi olarak terk edemez, öldüremez. Ona bakmak, korumak ve yaşatmakla görevli bir emanetçidir.
4. Bence kürtaja karşı tutum değişmedi. Hep ortanın biraz altı gruba hizmet veriyorum. Onlar da dinen kürtaja mesafeli olsalar da mecbur kalınca daha pratik

yaklaşıyorlar. Ne kadar günah işlemekten çekinseler de çocuğa bakamayacaklarını düşündüklerinde kürtaj oluyorlar.

5. Duygusal olarak insanların kendisi o durumda değilken hepsi kürtaja karşı olduğunu söyleyebilir. Ama başlarına gelince işler o kadar değişiyor ki. Camii imamı bile başa geldiği zaman farklı bir şekilde bakıyor.Başına geldiği zaman yardım istiyor.
6. Toplumda kürtaja bakış açısının ve ihtiyacın değiştiğini düşünmüyorum. Daha önceden karşıt olanlar hala karşıt. Daha fazla insan karşıt gibi gelmiyor bana ama yapılması ile ilgili bir sıkıntı var. Çok ciddi bir algı değişimi var sanki yasakmış gibi, çünkü ulaşılamaz bir halde. Ama sanki yasaklanmış gibi bir algı var. Bu özellikle 2012'den sonra çok arttı, politik söylem değişikliğiyle birlikte.
7. Önceden hasta kürtaj olmaya geldiğinde ve sen bir şekilde yapmadığında hasta seni şikayet edebiliyordu: Ben başvurdum, uygundum, yapmadılar diye. Sen de doktor olarak ceza alabiliyordun bu durumda. Fakat sonra, devletin politik atmosferi değiştikten sonra, şikayet edilse bile hekimlere hiçbir yaptırım veya baskı yapılmamaya başlandı.
8. Normalde devlet hastanelerinde Aile Planlaması Kliniği vardı. Kadınlar danışmanlık alır, kürtaj yapılır, spiral falan takılırdı. Bu klinikler kapatıldı. Aslında resmi bir kapatma gibi de değil de önüne geçtiler mesela emekli olan hekimin yerine yenisi gelmedi, atamadılar. Yasak veya yönetmelikle kaldırmadılar yani, işlevsizleştirdiler.
9. Kürtaj tamamen estetik gibi ameliyatlar kategorisine girdi. Devlet kürtaja hiçbir katkı payı vermemeye başladı. Hasta cebinden ödüyor, olay tamamen özel müdahaleye döndü. Hiçbir sosyal güvencesi olmayan bir hasta gibi vatandaş tüm parayı ödüyor.

10. İdarecilerde, özellikle 2010'dan beri acayip bir değişik var. Sanki bir talimat almışlar gibi "Bu işi desteklemiyoruz" diyorlar. Doktorlara bu işlem için zaman bırakılmıyor, para ödenmiyor. Malzeme zorlaştırılıyor. Olabildiğince her şeyi zorlaştırıyorlar.
11. Vatandaş aslında önceden daha iyi koşullarda (hem doğum kontrol hem kürtaj açısından) rahatça konuşabilirken, hizmet alabilirken artık alamıyor. Artık polikliniktekı doktorun inisiyatifine kaldı. Olmazsa da özel hastane vs. Herkes buna ulaşamıyor, erişemiyor.
12. Ondan önce de uygulanıyordu ama kadınların hayatını kaybetmesine neden olan şeyler oluyordu: Şiş kullanımı, sabun gibi. Gayrihijyenik. Bunlar da anne ölümlerine sebep oluyordu. Kürtajın serbest bırakılmasının altında bu yatar, hem anne ölümlerinin azaltılması hem de kürtajın daha uygun koşullar altında yapılması için.
13. Bir keresinde bir tıp talebesi buldu beni. Kayseriden galiba. Orada yaptıramamış. Ben de Aile Planlaması Kliniğindeydim yaptım tabii. Orada yaptıramamış. Doğu mevine gitmiş, üniversiteye gitmiş yapmıyoruz demişler. Özelde çok para istemişler.
14. Kürtajda eş imzası çok sorunlu bir olay. Benim boşanmak isteyen ama eşi imza atmadığı için kürtaj olamayan çok hastam oldu. O zaman da bunu el altından yapan kişilere yaptırırlardı.
15. 2857 numaralı yasaya göre eş onayı gerekiyor. Ama türkiyede aslında uluslararası sözleşmeler üstte yer alıyor kanunen. Türkiye'de 2001 yılında biyotıp sözleşmesi imzalandı. Bu sözleşmeye göre "Bir insan bedenine yapılacak müdaheleye kendi karar verir eğer bilinci yerindeyse." Aslında bu durumda eş rızası boşa düşüyor.

16. Kadın bekarken izin alması gerekmiyor ama evliyken gerekiyor. Çok ayrımcı ve eşitsiz bir durum. Kadın zaten toplumda eşitsiz bir konumda, biz kez daha bu eşitsizlik yeniden üretiliyor ve kadın buna maruz bırakılıyor.
17. Kadın istediği sürece kürtaj olmasını kolaylaştırmaya çalışıyorum. Mesela kadın yeni sezaryen olmuş, tekrar hamile kalmış. Eşi hocam riskliyse alalım diyor. Riskli olabilir de, olmayabilir de. Kadın aldırmak istiyorsa riskli olabileceğine yönelik yorum yapıyorum, kadının isteğini öne çıkarmaya çalışıyorum.
18. Afyon, özellikle muhafazakar bir şehir, küçük bir şehir. Mesela karı-koca istemiyordur yasal çerçevede. "Yarın annemle geleceğiz, ona bebeğin zaten öldüğünü, kürtajın zorunlu olduğunu söyler misiniz?" derler. Onları yapıyordum, iki eş de okeyse. Bu doktor, hasta ve eşi arasındaki masum bir sırdır.
19. Mesela Erzurumda bir olay biliyorum. Özel hastanedeki başhekim yapmam dedi. Türk Tabipler Birliği olarak biz ısrarcı olup anca yaptırabildik. O zaman bir arkadaşımla konuştuğumda "Erzurumda hiçbir şey yapamayız, Malatyaya gidebilir mi? Orada tanıdık var" demişti. Gerçekten sistem böyle işliyor. Kürtaj olmak isteyen bir kadın, kadın dayanışmasına ulaşırsa kadın ağı bize ulaşıyor, biz araştırıyoruz ediyoruz. Birini bulup yaptırmaya çalışıyoruz.

APPENDIX B

ETHICS COMMITTEE APPROVAL

T.C.
BOĞAZİÇİ ÜNİVERSİTESİ REKTÖRLÜĞÜ
Sosyal ve Beşeri Bilimler İnsan Araştırmaları Etik Kurulu (Sbinarek)

Sayı : E-84391427-050.04-206441 14.11.2024
Konu : 2024-58T Kayıt Numaralı Başvurunuz Hakkında

Sayın Dr. Öğr. Üyesi Ceylan ENGİN

Tez danışmanlığını yürüttüğünüz öğrenciniz Ladin Toplu'nun "Demographic Determinants of Abortion Attitudes: A Mixed Method Analysis" başlıklı projesi ile Boğaziçi Üniversitesi Sosyal ve Beşeri Bilimler İnsan Araştırmaları Etik Kurulu (SBİNAREK)'e yaptığınız 2024-58T kayıt numaralı başvuru 30.10.2024 tarih ve 2024/08 sayılı kurul toplantısında incelenmiş ve projeye etik onay verilmesi uygun bulunmuştur.

Bu karar tüm üyelerin toplantıya on-line olarak katılımıyla ve oybirliği ile alınmıştır. Onay mektubu tüm üyeler adına Komisyon Başkanı tarafından e-imzalanmıştır. Bilgilerinizi rica ederiz.

Saygılarımızla,

Dr. Öğr. Üyesi Işıl ERDUYAN
Kurul Başkanı

Bu belge, güvenli elektronik imza ile imzalanmıştır.
Belge Doğrulama Kodu : 0BT3-9A6V-09ZU Belge Doğrulama Adresi : https://www.turkiye.gov.tr/bogazici-universitesi-ebys

APPENDIX C

INTERVIEW QUESTIONS IN TURKISH

1. Kaç yıldır doktorluk yapıyorsunuz?
2. Çalışma hayatınız boyunca hangi şehirlerde, ne kadar süreliğine bulundunuz?
3. Son 30 yılda toplumda kürtaja bakış açısının değiştiğini düşünüyor musunuz?
   a. Bu değişimin ne yönde gerçekleştiğini düşünüyorsunuz?
   b. Sizce bu değişimin nedenleri nedir?
4. Çalışma hayatınız boyunca coğrafi konumunuz kürtaj hizmeti sağlama durumunuzu etkiledi mi?
   a. Kürtaj hizmetleri konusunda kentsel ve kırsal bölgelerdeki sağlık çalışanlarının karşılaştığı zorluklar arasında herhangi bir fark görüyor musunuz?
   b. Sizce bu farklılığın nedeni nedir?
5. Son 30 yıl içinde kürtaj hizmetlerinin sunulmasına ilişkin yasal ve idari süreçlerde ne gibi değişiklikler yaşandı?
   a. Kürtaj hizmeti sunmanızı zorlaştıran belirli politikalar oldu mu?
6. Siz ve meslektaşlarınız kürtaj hizmeti sunmaya devam etmek için herhangi bir strateji geliştirdi mi?
7. Sizce son 30 yılda kürtaj hizmetlerinin erişilebilirliği nasıl değişti?
   a. Sizce bu değişikliğin nedeni nedir?
8. Kürtaj hakkındaki kişisel inançlarınız profesyonel hayatınızı nasıl etkiliyor/etkiliyordu?
   a. Kürtaj hakkındaki görüşleriniz zaman içinde değişti mi ve eğer değiştiyse bu durum çalışmalarınızı nasıl etkiledi?

APPENDIX D

INTERVIEW QUESTIONS IN ENGLISH

1. How many years have you been working as a doctor?
2. In which cities have you worked and for how long?
3. Do you think that society's view of abortion has changed over the past 30 years?
   a. In what direction do you think this change is taking place?
   b. What do you think is the reason behind this change?
4. Has your geographical location ever affected your ability to provide abortion services throughout your career?
   a. Do you see any differences between the challenges faced by healthcare workers in urban and rural areas in relation to abortion services?
   b. What do you think is the reason behind this difference?
5. Over the past 30 years, what kinds of changes occurred in the legal and administrative processes related to the provision of abortion services?
   a. Were there any specific policies that made it difficult for you to provide abortion services?
6. Have you or your colleagues developed any strategies to keep providing abortion services?
7. How do you think access to abortion has changed over the past 30 years?
   a. What do you think is the reason behind this change?
8. How do/did your personal beliefs affect your professional life?
   a. Have your views on abortion changed over time, and if so, how has this affected your work?

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