# ABORTION IN TURKEY:

# IMPACTS OF PRONATALISM AND ETHICS OF MEDICAL PROFESSIONALS ON WOMEN'S PREGNANCY LOSS EXPERIENCES

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and have found that it is complete and satisfactory in all respects,

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Burcu Pehlivan

This thesis aims to explore women's voluntary and involuntary abortion experiences in Turkey. Based on participant observation in a private clinic for over six months and 13 interviews with medical professionals and women who experienced spontaneous abortion, this study aims to shed light on the political and social factors that inform pregnancy loss process. To reveal the political factors, I analyse the population policies, legal amendments on reproduction in Turkey, and pro-natal discourses of Justice and Development Party *(Adalet ve Kalkınma Partisi)* in contemporary Turkey. In addition to this, I explore how medical professionals' ethical approach towards abortion inform this process. Although legal code in Turkey allows women to have voluntary abortion in ten weeks of gestation, a great majority of the clinicians avoid performing voluntary abortion because of their moral stance towards abortion. Therefore, secondly, through an ethnographic research in a private hospital, I investigate how personal position of the obstetricians, delivery midwives and nurses can inform their medical practices. Lastly, I analyse women's narratives of pregnancy loss, their perceptions on motherhood and reproduction, and their relations with their bodies during post-pregnancy loss period.

**Keywords:** Pronatalist policies, voluntary abortion, miscarriage, reproductivity, medical authority, sexuality, bodily experience, Turkey.

# TÜRKİYE'DE KÜRTAJ: GEBELİK KAYBI SÜRECİNE DOĞUM-TEŞVİK POLİTİKALARI VE SAĞLIK ÇALIŞANLARI ÜZERİNDEN BAKMAK

Burcu Pehlivan

Bu tez Türkiye'de kadınların gönüllü ve zorunlu kürtaj deneyimlerini incelemektedir. Araştırma, özel bir klinikte altı aydan fazla bir süre devam eden katılımcı gözlemi, 13 sağlık çalışanı ve gebelik kaybı yaşamış kadınla yapılan mülakatları temel alarak gebelik kaybı sürecini etkileyen sosyal ve siyasi unsurlara ışık tutmayı amaçlamıştır. Siyasi unsurları incelemek adına nüfus politikaları, Türkiye'de üreme üzerine yapılmış yasal düzenlemeler ve Adalet ve Kalkınma Partisi'nin doğum teşvik söylemlerine odaklanıyorum. Bunun yanında sağlık çalışanlarının kürtaja karşı ahlaki duruşunun sürece nasıl katkı sağladığını inceliyorum. Türkiye'de kanun, kadınlara gebeliğin onuncu haftası doluncaya kadar isteğe bağlı kürtaj hakkı tanısa da, hekimlerin büyük bir çoğunluğu isteğe bağlı kürtaj yapmaktan kaçınmaktadır. Buna bağlı olarak özel bir hastanede yürüttüğüm etnografik araştırmayla kadın doğum uzmanlarının, ebelerin ve hemşirelerin şahsi değerlendirmelerinin tıbbi operasyonları nasıl etkilediğini aktarıyorum. Son olarak, gebelik kaybı tecrübe etmiş kadınların anlatılarını çözümleyerek, onların annelik ve doğurganlık algılarına, ve süreç sonrası kendi bedenleriyle ilişkilerine açıklık getiriyorum.

**Anahtar Sözcükler:** Doğum teşvik siyaseti, isteğe bağlı kürtaj, düşük, üreme, tıbbi otorite, cinsellik, bedensel tecrübe, Türkiye.

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# CHAPTER 1
# INTRODUCTION

Pregnancy loss -voluntary or involuntary- is widely encountered during the first trimester of the pregnancy[1]. However, women often refrain from talking about their pregnancy loss experiences in public spaces in Turkey. In contrast with this situation, politicians and state officials engage in discussions on reproduction, fertility and abortion very frequently in the public space. For instance, in his speech at the Fifth International Parliament conference, the Prime Minister of Turkey, the then Recep Tayyip Erdoğan, declared abortion to be murder (Badamchi 2014, 45). Right after this statement, the then Minister of Health, Recep Akdağ stated that every baby must be given the right to live. In response, main opposition party leader, Kemal Kılıçdaroğlu, asserted that abortion is a matter between women and the doctor and no one should make a comment this issue (Unal and Cindoglu 2013, 26). While political figures constantly produce statements regarding abortion and women's bodies, women's experiences on reproduction remain mostly invisible. It is thus important to understand how women experience abortion in an environment where their reproductive identity is frequently brought to the centre of political agenda. To this end, in my thesis I decided to investigate pregnancy loss experiences of women in a private clinic in Turkey, more specifically how socio-cultural and political dynamics impact women's subjective experiences of abortion.

In medical terms, abortion has several classifications, yet I focused on two types of abortion in this study; spontaneous and voluntary. Spontaneous abortion, or miscarriage refers to uterine evacuation after having noninduced pregnancy loss. In other words, when pregnancy is over due to foetal or embryonic death, doctors might undertake spontaneous abortion to clear out intra uterine of the woman. Voluntary abortion is elective abortion, performed upon the

[1] Miscarriage Probability Chart
https://datayze.com/miscarriage-chart.php

request of the woman for non-medical reasons. Since both operations have different motives, they contain different actors and social processes which often contribute to the silencing of women's abortion experiences in diverse ways.

My main purpose is to reveal how political discourses on abortion and attitudes of medical actors inform women's pregnancy loss experiences. Women's experiences of abortion are informed by women's perceptions of their body, their understanding of motherhood, and reproductive capacity as well as gender roles in the family.

**Anthropology of Sex and Reproduction**

This research contributes to our understanding of how political, social, legal and economic factors can influence women's experiences of abortion. Recent scholarships on pregnancy loss have approached this topic from various vantage points, for instance, how cultural expectations of 'mothering' affects pregnancy loss experiences (Kilshaw, Miller , et al. 2016), how "suffering" discourse which circulates among women can imply agency over pregnancy interruptions (van der Sijpt 2014), how cultural difference impacts discursive stance after pregnancy loss (Murphy and Philpin 2010), and how moral beliefs, reproductive politics shape women's pregnancy and abortion experiences (Ellison 2003). However, while these studies focus merely on women's inner circle (e.g. family, neighbour) and cultural expectations of the society they live in, this thesis also considers the moral judgement of local actors specifically -doctors and midwives- as well as political debates on abortion.

In considering the morality of medical professionals, a study asserts that discursive division regarding abortion as spontaneous and voluntary is associated with moral judgement of "first being guilt free, second deserving of blame" (Erviti, Castro, & Collado, 2004, 1062). This division affects ethical approach of medical professionals, and therefore, the quality of medical care that women receive after the abortion is influenced by medical professional's personal judgement on the issue (McCallum, dos Reis, & Menezes, 2009). Similarly, in this

thesis I investigate whether ethical approaches of medical professionals reflects to the medical care they provide, and influence patient's feelings in the post-abortion period. Additionally, Browner's (2007) study asserts that health service providers may create alliances between male partners of women, and therefore undermine the women's autonomy while making medical decisions regarding their reproductivity of their body (161). Likewise, in this thesis, I explore whether women are autonomous in making decisions with regard to their reproductivity of their body.

In another ethnographic study on kidney-disease patients in Egypt, Hamdy (2008, 563) indicates that patients' mistrust to medical system changes the view on their bodies and shapes their bodily experiences of health and illness. Therefore, social, economic and political structure contribute to biological meanings such as illness, survival etc. (Hamdy 2008). Following this thread, as in Hamdy's research, I observed that many women who experienced pregnancy loss did not receive any reasonable explanation from the health professionals regarding their miscarriages. Because of the mistrust women had towards doctors' diagnosis of miscarriage, they kept visiting different hospitals while they are having a miscarriage. Therefore, collecting different views from the doctors until they find trustworthy explanations became a part of women's pregnancy loss experiences.

**Abortion studies in Turkey**

There are a few studies that elaborate abortion practices in Turkish hospitals. The General Assembly of Women's Shelter and Solidarity Centers' report (2015, p.1) elicits that there is a de facto prohibition of voluntary abortion in most of the state hospitals in Turkey. In this regard, Mor Çatı Women's Shelter Foundation have previously reported that only 9

out of 184 state hospitals perform voluntary abortion in accordance with the law[2]. While these studies focus merely on statistical analysis, in this thesis, I offered a qualitative data that could demonstrate abortion experience in practice.

Some other scholarships have concentrated on political and ethical attitudes toward abortion in Tukey. While Gürsoy (1996) presents historical outlook of legalization of abortion from late Ottoman period to modern days, Ekmekçi (2017) elaborates the fundamentals of Islamic view on abortion, and investigates how Islamic ethics can give reasoning to social and political attitudes towards abortion in Turkey. Unal and Cindoglu (2013) offers a prosperous analysis on political discourses by Turkish public figures on abortion debate, emphasising how abortion is medicalized, and became a public issue. Aydın (2000) demonstrates the evolution path of abortion laws in Turkey since the late Ottoman period, affirming that abortion policies have transformed by the following social and political developments in Turkey. Additionally, Hessini (2007) investigates the abortion practices and policies in Middle East and North African (MENA) countries, noting that Turkey and Tunisia as the only two countries where abortion is legally and socially acceptable among other MENA countries. While these studies theoretically contributed to my study, Toksöz's (2011) data that shows the global trend on pronatalism and the influence of Justice and Development Party – current ruling party in Turkey – on this issue, provided me with a starting point on analysing political climate on pronatalism.

Above studies have been crucial in contributing to abortion issue theoretically, however, so far, the studies focused merely on political and religious agenda by locating politicians and Islamic discourses into their centre. However, I locate women's experiences into the centre of

[2] Mor Çatı Women's Shelter Foundation (2014). *Do you practice abortion? "No, we don't"* (Kürtaj yapıyor musunuz? "Hayır yapmıyoruz") https://www.morcati.org.tr/tr/290-kurtaj-yapiyor-musunuz-hayir-yapmiyoruz
*See also: https://www.morcati.org.tr/tr/yayinlarimiz/izleme-raporlari/371-kamu-hastaneleri-ku-rtaj-uygulamalari-arastirma-raporu*

this research and tracked the impacts of public discussions at the microlevel. By eliciting women's standpoint on abortion, I provided a different site for abortion scholarship in Turkey. In this regard, I focused not only on political and religious framework, but also on how diverse actors (e.g. hospitals, obstetricians, delivery midwives) and concepts (e.g. motherhood, family, marriage) may play major role on abortion experience.

## 1.1 Methodology

I conducted an ethnographic research in a delivery room of private clinic in Istanbul for over six months. My research data includes participant observation and in-depth interviews with five delivery midwives, and eight pregnant women who experienced pregnancy loss. I also use discourse analysis to explore the current political debates on abortion in Turkey.

### Discourse Analysis

I used discursive analysis to examine the contemporary political outlook towards abortion in Turkey. I have collected and analysed variety of written materials such as legal documents and media reports on abortion. Through the media channels, I collected the most popular declarations of the political figures regarding abortion and fertility. The main legal document I used was The Turkish Population Planning Legislation, which was amended in 1983. In addition to this, I used Turkish newspaper channels such as HaberTurk, CNNTurk, Haber7, Sabah, Hürriyet to collect official declarations of politicians on abortion. In these newspapers I focused on some of the key terms such as "family, child delivery, caesarean delivery, multiple births, motherhood, womanhood", which I find relevant to pronatalist discourses.

**Participant observation**

I visited the private clinic two times a week and spent three to four hours in the delivery room. The clinic was located in one of the low-income neighbourhoods of Istanbul. Because this clinic offered decent prices compare to many other private clinics, it receives lots of patients in a day. Thanks to this situation, I was able to observe and meet many patients who go there for abortion purposes.

In the delivery room, I observed midwives' daily interaction with pregnant women and the medical care they provided to them. In her ethnographic research on pregnancy and reproduction in a gynaecologic unit of a hospital Bridges (2011, 5) offers a small sketch from daily interactions between hospital members and patients, which provides a hint about regular atmosphere of the hospital. In a similar fashion, I tried to grasp the daily routine of medical professionals including their interactions, colloquial expressions. By this means I could see the regular hospital procedure and midwives' general approach to women's reproductivity. I was in presence not only at times abortion is performed, but also in their regular working hours to observe regular climate in the delivery room. Therefore, I was able to distinguish the attitudes of hospital staff towards pregnant women who come for prenatal care, and women who come for voluntary abortion purpose. Moreover, I observed the general look of pregnant women who visit the delivery room for prenatal care, and how their feelings change depending on the operation – abortion, vaginal examination, ultrasound check – that they undergo.

Additionally, I spent a considerable amount of time with delivery midwives and ancillary staff during the lunch breaks and chatted with them in the waiting room of the delivery room. This made easier to build mutual trust between each other. During the times we spent together, I got to know delivery midwives, nurses and staff members better, became aware of their considerations about womanhood, mothering, reproduction and fertility. I focused on their

personal observations of the patients, and how it has impacts on patients' reactions i.e. whether they grieve, get pleased or silenced after the operation. This inquiry also revealed midwives' moral approach on abortion, unplanned pregnancy, and reproductivity planning. Specifically, I analysed if their personal position affects to post-abortion medical care, and feelings of pregnant women.

**In depth interviews**

I conducted semi-structured interviews with delivery midwives, ancillary staff and the pregnant women who had experienced pregnancy loss before. During the interviews, to gain insights about women's perspective on pregnancy losses, I asked open-ended questions to get the interlocutors to talk as comprehensive and flexible as possible about their experiences. The questions I asked were about the post-abortion experiences including medical and social care they receive from their surroundings. How did they feel about their body after having pregnancy loss? How did this process inform women's relations to their body and their configurations about womanhood, motherhood? How did they manage to cope with this process?

Most of the women whom I interviewed had gained various experiences by visiting different state and private hospitals. By listening their narratives, I gained insights about how Turkish medical professionals and hospitals approach to reproductivity-related matters. Among the pregnant women I talked to, I paid specific attention to those who have had spontaneous abortion before, since their narratives would reveal whether medical professionals consider the motivations behind the abortions. For instance, do medical professionals provide different care if the requested abortion is spontaneous, not voluntary?

### 1.2. Permission Process

Before I started my research in this private clinic, I visited several other health clinics in Istanbul. My main purpose was to gain insight about the pregnancy loss process, via collecting narratives either from the health professionals or the women who experienced miscarriage. With that purpose in mind, the first site that I considered to be my field was a Family Health Centre (FHC)[3] which was located in a low-income neighbourhood of Istanbul. FHC only had three delivery midwives who were dealing with reproductivity-related matters. Therefore, a very few pregnant women were visiting the centre daily. Those who came to the FHC, were therefore to consult midwives whether everything is alright about their pregnancy. Because of these reasons, I realized that the data I could collect in the FHC would be too limited for my research. Therefore, I began to look for a larger health facility which includes an obstetrician.

In the meantime, I kept sharing ideas about my research to my close friends telling them that I was trying to gain access to the gynaecological unit of a hospital to explore pregnancy loss experiences. Luckily, one of our family friends, Ali, was a brain surgeon and advised me to proceed my research in his workplace. Next day, I went to the hospital where Dr Ali works. He directed me to the office of one of the gynaecologists, Dr Zeynep, in the clinic. I explained her my research, that I needed to conduct the study in a health facility to reach out the women who experienced this process. She told me that speaking with the medical staff in the delivery room, a section that receives many pregnant women daily would be more beneficial for me. As a result of this conversation, I could enter the delivery room of the clinic, and conducted the rest of my research there.

[3] FHC health centres are staffed by general practitioners, nurses, delivery midwives and health officers.

Lastly, I asked Dr Ali if he could help me to get the approval of the head doctor of the hospital. On the same week, me and Dr Ali went to head physicians' office. I introduced myself to the head doctor, and explained that I was a graduate student, and was doing a research on women with pregnancy loss experiences for my master thesis. I also assured him that all of the names and the location of the hospital would be anonymized. The head doctor seemed convinced that I would be harmless, yet asked me to bring the ethics committee approval, so I did. After I got the oral approval of the head doctor, I felt more confident blending into the hospital community, roaming around the hospital and I could easily speak to the delivery midwives, asked whether we could have an interview.

### 1.3. Limitations

The significant limitation of my study is its one-sided examination for Turkish hospitals and medical professionals. Due to the time limitations and difficult accessibility of health sites in Turkey, I focus on the operations and experiences in only one private clinic in Istanbul. This situation inevitably restricts the discussions on general abortion practices of Turkish health services.

Another limitation of this study was the lack of obstetricians' narratives about the abortion practice. In the following chapters I mention obstetricians' discriminatory attitudes towards women through the midwives' narratives. However, because the two obstetricians in the clinic kept avoid from the interviews by saying that they were too busy for this, I limited the discussions of abortion practices with my own personal observations and midwives' narratives. Therefore, throughout the chapters, I avoid making assertive claims about doctors' personal evaluations on women.

### 1.4. The Organization of Chapters

The thesis consists of five chapters. The first chapter elaborates the pronatalist policies, anti-abortion discourses and laws in Turkey. I traced the roots of medicalization of reproductivity-related activities such as pregnancy, contraception, induced abortion, since the late Ottoman era. There were various legal regulations concerning abortion in Turkey since 1850s. The original article that legalized abortion, "Law Concerning Population Planning", law no 2827, was issued in May 27, 1983. First article clearly states that the termination of pregnancy is one of the key components of population planning and therefore must be under the control of the state. According to article five, voluntary abortion is allowed during first ten weeks of the pregnancy; after ten weeks, pregnancy can only be terminated on the condition that if there is threat to woman's life. Here, I borrow Foucauldian term of "biopolitics" and problematize Turkish pronatalist politics as a modern state surveillance over biological processes and individual body through "series of interventions and regulatory controls" (Foucault, 1978, 139). To that end, I evaluate the legal amendments on abortion as the instrument of biopower.

In addition to these legal regulations, political figures' negative statements regarding abortion create political surveillance over women's body in Turkey. Therefore, anti-abortion discourses and laws in Turkey have reproduced a very specific imagery about women's responsibilities regarding their reproductive capacities and mothering. In this environment, state's pronatalist and anti-abortion policies become part of abortion process, and they influence women's abortion experiences. Hence, I explore the political discourses on abortion through media channels. In doing so, I seek to answer the following questions: How are pronatalist discourses manifested by the politicians in media channels? How political debates are revolved around reproductivity-related topics? Which notions are highlighted in anti-abortion discourses (e.g. family, motherhood, womanhood)?

In the second chapter, I focus on the role of Turkish health services and medical personnel on abortion process. Here, the questions I asked; how do private and public hospitals approach to voluntary vs. spontaneous abortion? How do medical professionals (obstetricians, midwives, nurses) feel about this procedure? How do their personal opinions inform their medical practices? How do their personal and ethical positions affect women's experiences of abortion?

Based on the data I collected during my fieldwork in a private clinic in Istanbul, I divide this chapter into three sections. The first section introduces the field, and the medical personnel whom I interviewed. Later, I show the differences between private and state hospitals regarding practicing abortion[4], and discuss the discrepancies between the written code and medical practices. Therefore, most of the time, women in Istanbul prefer private clinics for abortion[5].

In the second section of this chapter, I present the interviews that I had with delivery midwives. I focus on midwives' personal opinions about voluntary abortion, contraception, and their judgements over the women who requests voluntary abortion.

In the third section of this chapter, I show the arbitrary decisions of the obstetricians. For instance, doctor may give a discount for voluntary abortion according to women's economic or marital status. Or if pregnancy occurs as a result of an act of violence (e.g. marital or extramarital rape), doctor may bend the ten-week-gestation code and perform the voluntary abortion with his/her own initiative. Therefore, personal judgement of doctors on abortion may have direct influence on this process. In this regard, I evaluated hospitals and medical

[4] O'Neil, M. L. (2017). Abortion services at hospitals in Istanbul. The European Journal of Contraception & Reproductive Health Care, 22(2), 88-93.
[5] Serap, H. (2005). *The examination of the causes of induced abortion and distribution of family planning method postabortion.* MA Thesis. Retrieved from Ulusal Tez Merkezi Database (Accession no 194784)

professionals as important actors that deeply influence women's reproductivity-related experiences

Additionally, marital status of women determines the actors that involve into this process. For instance, if a married woman wants to undergo voluntary abortion, legislation requires the consent of her spouse for the operation. On the other hand, a single woman who is over eighteen years old, does not need such consent from anyone else. Single women under eighteen needs parental consent to get abortion. If you're married, your husband i.e. your family has a say about the termination of pregnancy. Hence, voluntary abortion ceases to be problem between woman and her body; rather it becomes greater deal that involves multiple actors.

The third chapter presents women's accounts of non-induced pregnancy losses. I present the interviews I conducted with women who experienced miscarriages and spontaneous abortions. In women's narratives, I focus on their reactions when they found about the miscarriage, how the attitudes of clinicians influence their feelings and how they experience post-pregnancy loss process. This chapter consists three themes. In the first section, I discuss women's distrust to doctors' diagnosis of miscarriage and the attitudes of medical staff towards pregnancy loss incidents. Second section focuses on women's self-blame for miscarriage, and their strategies to prevent it. In the final section, through the reproductivity medications, I discuss women's belief in fertility medicines and desires of becoming a mother.

In the conclusion, I summarize the main chapter of the thesis and make an overall analysis of each of the components which contributes women's pregnancy loss experiences.

# CHAPTER II

# PRONATALIST POLITICAL CULTURE AND ANTI-ABORTION DISCOURSES IN CONTEMPORARY TURKEY

This chapter aims to shed light on the pronatalist political agenda on abortion practices through the analysis of legislative regulations and political debates on abortion. In doing so, I divide this chapter into two sections, the historical overview of the legal regulations on abortion, and the recent political debates among Justice and Development Party (JDP) – current ruling party in Turkey – members regarding abortion practices. In the first section, I discuss how state engages with reproductivity-related issues through brief historical analysis on the medicalization of pregnancy in Turkey. I focus on the legal regulations on abortion via Population Planning Legislation 1983, and the socio-political concerns behind these limitations such as religious motivations or population growth.

For the second facet of this chapter, using discursive method, I present some major political statements on abortion which I collected through online newspapers. To elucidate the pronatalist approach of the current government, I analyse popular statements that occupied media channels for a considerable amount of time. Considering pronatalist discourses as the indicators of cultural ideas about normative reproductive behaviour (Brown and Ferree 2005), I discuss how pronatalist discourses might have influence on re-defining some social concepts such as motherhood, womanhood, role of the women, family.

## 2.1 Historical background of abortion policies

In the context of politicizing of reproduction in Turkey, it is necessary to elaborate how reproductivity-related practices transformed from individuals to state institutions. Foucault (1978) claims that the modern state took over the management of population through the institutions which monitor the body, childbirth, health, and sexuality. In considering the reproduction management, Federici (2012, 67), who focuses on the bodily experiences of

women employees, argues that in the capitalist structure, women were subjected to body search and were compelled to use birth control pills to prevent the disruption of economic production with pregnancy. Therefore, with the economic transformation, the modern state has established surveillance over the individual, targeting mainly women's body through reproduction and sexuality.

For Turkish case, social and political transformation of reproduction goes back to late Ottoman era, when the modernization process began to emerge. The data gathered by Balsoy (2012, 24) indicates that in early 1800s, it was very common for women to use natural herbs such as ergot of rye in performing self-induced abortion with the help of some midwives, pharmacists or doctors. Towards the end of nineteenth century however, Ottoman state saw population as important source of national health and decided to balance declining Muslim population against non-Muslims. In their meticulous analysis on abortion in the late Ottoman era, Somel and Demirci (2008) underscores that the ruling elite believed in the power of the population in strengthening the economic and military power of the state. Hence, they began to perceive abortion as a serious threat for the future of the Ottoman state (Somel and Demirci 2008, 378) Therefore, state began intervening reproductivity-related activities through monitoring pregnancy, childbirth, birth control and abortion practices via establishing health institutions, medical schools, anti-abortion laws and discourses (Balsoy 2013, 66-68). These reforms were part of western modernization which was later followed by Republic of Turkey.

The Ottoman Criminal Code issued in 1858 was a major attempt to address abortion practices in the legal realm for the first time. The code clearly stated that anyone who deliberately provides an abortion-inducing herb or similar medication to a pregnant woman, will be imprisoned from six months to two years, even if it is done with pregnant woman's consent. Moreover, the central administration kept proclaiming an edict to doctors and pharmacists not to provide any medications that might cause miscarriage (Konan 2008, 328).

Considering these accounts, Balsoy (2012, 26) affirms that experiences like maternity, induced abortion, pregnancy and miscarriage in late Ottoman society were not merely biological, they are also the embodiment of political concerns of the period.

In a similar fashion, Miller (2007) analysed Ottoman and Turkish abortion laws and how state elaborated reproduction matters in both eras. She argues that along with criminalization of abortion, the womb ceases to be an individual space and becomes a possession where the state can regulate women's sexuality in accordance with its own political objectives. In this regard, Ottoman state addressed women who practice induced abortion as the perpetrators of the crime against the modern state. Therefore, abortion ban becomes an instrument to guard the biopolitical right of the modern state (Miller 2007, 361). According to Foucault (1978), biopower;

> "… focuses on the species body, the body imbued with the mechanics of life and serving as the basis of the biological processes: propagation, births and mortality, the level of health, life expectancy and longevity, with all the conditions that can cause these to vary Their supervision was effected through an entire series of interventions and regulatory controls: a biopolitics of the population." (139)

In this regard, health institutions and medical schools aimed to control the reproduction of the Ottoman society. The establishment of these institutions and legislation of the abortion-ban paved the way for taking over the control of reproductivity-related matters from women. In Foucauldian sense, these reforms are considered as the instruments of biopolitical power of the state.

### 2.2. Population Policies in Early Republican era (1930 - 1965)

The pronatalist culture of Turkish politics showed continuity during the Early Republican period. After the Independence War was over in 1923, Turkish state more radically invested in pronatalist policies to balance the population decline during the war. Therefore, family, multiple births and motherhood became trend notions for pronatalist culture.

Özbay (2015) who elaborates population policies in the Republican Turkey asserts that from 1930s onwards Turkish intellectuals began to praise high fertility on their writings and put the entire responsibility of being fertile on Turkish women. In this regard, many famous Turkish writers explicate their concerns about the population growth in influential magazines of that era. For instance, Şevket Süreyya Aydemir (1932), a popular Turkish writer stated that "We want to have large population, it is a national issue. Unless we reduplicate our population, we would risk our nation's eternity (…). Turkish woman is the fertility power and likes to reproduce" (p. 34-35). Another influential writer, Yaşar Nabi Nayır, asserted that Turkish nation is the most fertile nation among all others (Özbay 2015, 312). Similar to these writers, the efforts of many other intellectuals paved the way for biopolitical discourses to disseminate in the society.

The impact of this pronatalist discourses was not merely limited to societal level, it also extended to legal sphere. The government introduced legal regulations under the name of population planning. For instance, Turkish General Health Protection Law issued in 1930 promised to reward every woman who had more than six children with money or medals (Aydın 2000). Furthermore, while Turkish Penal Code that was issued in 1926 addressed induced abortion under the "Crimes against individuals", the law was amended in 1936 to reinforce the sanctions even harsher, placing this act under the title of "Crimes against the Integrity and Health of Race" (Ertem 2011). This regulation demonstrates that the legal tolerance for induced abortion was downscaled; it was no longer considered as a crime against an individual, but against the whole society.

As a result of these state initiatives, the population began to rise rapidly by the beginning of 1960s. However, along with the technological and industrial developments, the state realized that the economic development was not merely dependent on the population

growth. Alongside rapid population growth, there began to emerge political concerns regarding mother and child mortality, due to the underground abortion surgeries (Aydın 2000, 178)

Despite these anti-abortion regulations, in practice, abortion was widely practiced among women, either by their own, or in private clinics in exchange of high payments to doctors (Aydın 2000; Özbay 2015). These operations were mainly conducted under primitive conditions and therefore, this gave rise to political concerns regarding the health of the mother and child. Aydın (2000) asserts that, in 1960s, nearly 10,000 women lost their lives during the operations out of 400,000 abortion conducted under the counter. Another survey indicates that, between 1960-65, approximately 12,000 women in rural areas died because of self-induced abortions (Gürsoy 1996).

### 2.3. Retreating from pronatalism

By 1965, state officially recognized that Turkey was facing with the overpopulation problem (Gürsoy 1996, 532). The population growth was so rapid that there emerged political concerns whether this growth might harm economic developments. Moreover, the induced abortions continued to be performed, causing more maternal deaths. Due to the high maternal mortality of clandestine abortions, and the rapid growth of the population, state retreated from pronatalist implications and passed The Population Planning Law in 1965. This law lifted the ban on contraceptives in Turkey. In this regard, Fişek and Shorter (1968) indicate that the most common contraceptive methods that were used in Turkey between 1965-68 were Intrauterine Contraceptive Devices, condoms, oral pills and foam tablets (p. 583). Alongside these regulations on contraception, abortion ban still had not been lifted by this law. One of the main reasons why abortion was still not legalized in 1965 code, was the pressure which was put by

the gynaecologists who were concerned about the income they gain from childbearing (Özbay, 2015, 317).

Despite these developments, induced abortion continued to be performed illegally nationwide, often as a contraceptive method until the new amendment. Other contraception methods were not sufficient to prevent illegal abortions, as a matter of fact, between 1963 and 1975 there was 6.3% increase in the proportion of women who underwent induced-abortion (Tezcan, Carpenter-Yaman and Fişek 1980). Maternal and child mortality continued to increase due to insufficient medical care and malnutrition problems. The uncontrollable population increase began to impact the unemployment rate. These developments made abortion one of the prominent issues of the population planning for policy makers.

As a result of more than a decade of malnutrition problems, maternal and child mortality, and economic concerns, on May 27, 1983, the state decided to address these problems by issuing "Law Concerning Population Planning" (Law No. 2827) and declared the legalization of abortion on the Official Newspaper. The 1983 Legislation was the very first code that state officially allowed for practicing abortion. However, this allowance was subjected to certain restrictions in which state still exercise its authority over reproduction.

### 2.4. Permissions and Restrictions of the 1983 Law

First, 1983 legislation underscores that the termination of pregnancy is one of the key components of population planning and therefore must be monitored by the state. According to the law, the sterilization of both men and women was possible. In other words, one is permitted to prefer not to have a child for the rest of his/her life.

Second, the code states that the termination of pregnancy is possible until the end of ten weeks of gestation. If the gestation exceeds ten weeks, pregnancy can only be terminated if and

only if there is a threat to woman's life [6]. In that case, doctors are required to make an explanation regarding the possible health risks unless they perform the abortion. Later, they have to document the medical reasoning for abortion to the relevant state bodies.

Finally, the law extensively addresses the role of the third parties in deciding the termination of pregnancy. If woman is married, the consent of her husband is required for the abortion whereas single woman does not need such consent. In cases where woman is underage, termination of pregnancy is dependent on the consent of the parents or legal protector.

Although termination of pregnancy is no longer prohibited with this law, it is not merely dependent on women's consent, but subject to the consent of multiple actors including the state, male partners, or legal guardians. During the legalization of abortion, the state has transferred reproductivity-related activities into medical institutions where it could control reproduction and establish its authority over women's bodies.

The pronatalist policies began in late Ottoman era and persisted during the Republican period in order to regulate nation-state formation. During this period, the state evaluated women's body as a primary resource of the reproduction which needs to be intervened. Therefore, when elaborating women's experiences of abortion, one should consider that these experiences are not processing merely through the women herself and her body. They also bear the interests of the third parties, such as the state.

In next section, I discuss the neo-conservative and pronatalist policies of JDP (Justice and Development Party) by analysing the political discourses of the current president Recep Tayyip Erdoğan, and several members of parliament. I demonstrate how JDP members reinforce gender roles through the notions of motherhood, fertility, family, and how pronatalist

[6] For a comprehensive review see Article 5 in *Law Concerning Population Planning* (1983) No: 2827, p.5796.

politics have augmented state control over reproductivity-related activities such as caesarean delivery and abortion.

### 2.5 Anti- abortion discourses in public sphere

The state retreated its pronatalist stance to some degree by allowing abortion to be performed legally in 1983. Nevertheless, recent debates on abortion discussed by the prominent political figures of Justice and Development Party (JDP) have revived the tension on reproduction debates both in political and social realms.

The scholarship that investigates JDP's political stance have underscored the neoliberal-conservative attitude and its impacts on socio-cultural spheres. The politics of family became important for JDP members in integrating neoliberalism with conservative configurations (Baba 2011; Korkman 2015; Korkut and Eslen-Ziya 2011). Coşar and Yeğenoğlu (2011) argues that JDP's patriarchal stance locates women as the main pillar of the family institution (p.567). Moreover, according to Çitak and Tür (2008) JDP's conservatism overly emphasized women's care-giver role in creation of the family and mothering responsibility in raising new generations (p.464).

In considering neo-conservative politics of JDP, Acar and Altunok (2013) note that family, defined as a heterosexual and patriarchal structure, has a vital role in legitimizing sexual and reproductive activities for women, and producing the desired moral order. Therefore, any act that challenges women's reproductive roles in the family, such as abortion, becomes undesirable for JDP's neo-conservative stance, and hence, is strongly rejected. (Acar and Altunok 2013, 20)

Some scholars approach JDP's pronatalist policy from a different vantage point, considering, for example, the family to compensate economic insufficiencies. Buğra and Keyder (2006) elaborate family as a key institution for maintaining the social order, especially

in facing with financially risky environments like unemployment, poverty, economic crisis. In these circumstances, family ties can serve as a remedy of this environment and compensate the absence of social assistance (Buğra and Keyder 2006, 212). Accordingly, political figures of JDP keep producing statements that encourage people to produce multi-child family structure by praising high fertility and reproduction publicly.

Recent debates on abortion have sparked with President Recep Tayyip Erdoğan's statement at the International Women's Day Conference in 2008, regarding the desired family structure in Turkey emphasizing the importance of the nation. According to him, multiple births were essential to preserve the Turkish nation:

> "I speak to you as your brother, not as a president. We have to protect our youth population. We need labor force to strengthen our economy. Others [states] are trying to exterminate the Turkish nation. To protect young population, we need to have at least three children." (Çetik and Gültekin 2008)

After this statement, Erdoğan kept encouraging men and wives to have as many children as possible in several other occasions like panels or public meetings. "At least three children" announcement was considered as a major discursive intervention to private sphere. For considerable amount of time, it circulated among the opponent groups of JDP. In this regard, the main opposition party leader, Kılıçdaroğlu noted that at-least-three-children statement of Erdoğan was pressuring women to be bound to housework and keeping them away from economic production (T24 2016).

In addition to praising multiple-child family structure, Erdoğan began to storm the medical practices that would challenge high fertility rate in the country such as voluntary abortion and caesarean delivery. As a matter of fact, voluntary abortion was the main target in many of his speech, mainly because it was not only a challenge to high fertility rate, but also challenge to neo-conservative stance of JDP, which is in favour of multiple births. The debate sparked again at the International Population and Development Conference organized by the

United Nations Population Fund and Europe Parliamentary Forum on May 2012. During his conference speech, Erdoğan stated that abortion should be considered as a crime which state should take immediate precautions against:

> "I am a president who stands against caesarean delivery. I see abortion as a murder. No one should have the right to give permission to this [abortion]. There is no difference killing a baby either inside or outside of the womb. We need to be sensitive about this matter. We have to work collaboratively against this act" (Haber7 2012).

Following day, Erdoğan reiterated his statement at JDP Women's Branch Conference by resembling abortion to a massacre:

> "I know that this [caesarean] is all part of a plan. This is a plan that would avert the population growth. Those who are against my statement on abortion, you all complain about Uludere massacre.[7] What is the difference between abortion and massacre? I say every abortion is Uludere. We know that this is a devious plan to erase this nation from the world scene. We will not let this happen" (CNNturk 2012).

In addition to his discursive offenses on abortion, Erdoğan began to signal that the party's intention to make amendments on abortion law. At the opening ceremony of a new private hospital, Erdoğan stated that the government will enact a law against abortion:

> "There are different legislations regarding abortion procedures in the West. We can't let a woman to have abortion voluntarily. Firstly because you take the life of the foetus inside the womb, and secondly it is harmful for the woman. That's why I told to my minister [of health], we're going to pass the new abortion law" (Sabah 2012)

After Erdoğan made alike statements, other politicians began to occupy media channels with their own opinions about abortion. For instance, Minister of Health, Recep Akdağ, criticized the 1983 legislation for legalizing abortion and confirmed the ongoing efforts that are made to change the current abortion law:

[7] Uludere massacre is an incident in which Turkish planes bombed Kurdish smugglers at Iraqi-Turkish border, killing 34 civilians and children. For further review please see: https://www.economist.com/europe/2012/06/09/massacre-at-uludere

> "We think that it's not right for a woman to get abortion without an excuse. Right now, a woman can get abortion in ten weeks of gestation. We are trying to change this procedure. We value baby's right to live. If the mother is in a bad condition, the state will look after the child. We are trying to enact the law that will bring restrictions on abortion" (Hürriyet 2012)

In addition to these, perhaps one of the most sensational statement came from another member of JDP, Melih Gökçek. In one of his interviews, he was asked to explain his opinions about termination of pregnancy if the pregnancy occurs in case of rape. He stated that it's the mother whose life should be terminated instead of the child:

> "You can bring the criminal [rapist] to the court of law, to sentence him. But why would we blame the child? The state will take care of the child. How can you take away one's right to live? If the woman, who happens to be the mother, is committing adultery, it is the woman who should be punished. If someone is going to die, woman should kill herself; not the child" (HaberTurk 2012)

These discourses demonstrate that the pronatalist policies began to disseminate in Turkey once again. As a result of the constant complaints regarding the low fertility rate in the country, the total fertility rate began to increase. A study by Erten (2015) indicates that in 2012, fertility rate went to 2.08 from 2.02 for the first time since 1955[8]. Along with the revival of pronatalism, reproductivity-related matters such as contraception, abortion and caesarean delivery were introduced as the prominent problems that need to be addressed by the state, for the sake of protecting the nation (Erten 2015, p.9).

In considering pro-Islamic perception on abortion, Ekmekçi (2017) asserts that Turkey's moderate position which intertwines Muslim culture and Western ethics in different spheres, creates cultural division which leads to controversial debates on abortion in Turkey. On the one hand, Islamic view values the community welfare, reproduction of the Muslim society and religious authority over the individual and therefore stands against voluntary abortion. On the other hand, Western ethics prioritize the individual autonomy, personal values

[8] TUİK. Doğum İstatistikleri. [Birth Statistics] (2012), http://www.turkstat.gov.tr/PreHaberBultenleri.do?id=13618. (accessed 30 April 2013)

and therefore support women's autonomous decision on this matter (Ekmekçi 2017, 894) Therefore, JDP politicians hold contradictory approach towards abortion, mainly because of its pro-Islamic political identity. More importantly, these political discourses strengthen the existing patriarchal culture by designating the gender roles through women's roles in the family. In this account, woman's primary duty becomes fulfilling her reproductive role in the family by becoming a mother.

Due to the backlash by the opposing views, the mentioned amendment on abortion was never put into practice by the JDP government. With the 1983 Law, the termination of pregnancy is still permitted in Turkey. However, the revival of pronatalism through political discourses has impacted public attitude towards the termination of pregnancy. Abortion practices began to be performed arbitrary, rather than regulatory in medical milieu (Topgül, Adalı, et al., Sisteme değil isteğe bağlı hizmet: Sağlık Çalışanları Gözünden İstanbul'da Kürtaj ve Aile Planlaması Hizmetlerinin Durumu 2017). In the next chapter, I present a few recent studies that were conducted on abortion in medical sites of Turkey, as well as provide evidence that I have collected in a delivery room of a private clinic.

## CHAPTER III
## DELIVERY ROOM, ENCOUNTERS WITH DELIVERY NURSES

As a result of the medicalization of pregnancy which began in the late Ottoman era, medical sites become prominent places that manifest pronatalist intervention under the state surveillance. Both public and state hospitals began to be influenced by the current political debates on body and health. Today, we observe how political discourses influence clinical professionals and health practices. For instance, it is becoming extremely difficult for women to get abortion in Turkey under the JDP rule. In many public hospitals, abortion is practiced depending on the consent of the gynaecologists or hospital administration despite the absence

of any directive or regulations to that end. Additionally, the abortion type appears as another factor in determining if the operation is performed or not.

This chapter aims to elucidate the socio-political and moral factors that impact on abortion practices in one of the health clinics of Istanbul. Based on participant observation and in-depth interviews with delivery nurses in a private clinic, I demonstrate how medical personnel approach to the women who wants to get abortion; what kinds of social and economic factors become significant in performing abortion in the clinic; how does moral stance towards abortion become significant in abortion; and how pronatalist policies inform abortion practices in a local environment. In an environment where fertility is constantly praised and abortion is condemned, how is abortion performed in private clinics? Under which circumstances do doctors agree to perform abortion in private clinics? How do clinical professionals in private hospitals approach voluntary and spontaneous abortion?

As previously mentioned, the type of abortion is one of the factors that impact its practices in hospitals. There are two types of abortion: spontaneous (*zorunlu*) and voluntary (*isteğe bağlı*). Spontaneous abortion, or miscarriage, refers to uterine evacuation after having noninduced pregnancy loss. In other words, when pregnancy is over by foetal or embryonic death, spontaneous abortion is performed to clear out intra uterine of the woman. On the other hand, voluntary abortion could also be addressed as elective abortion, and performed by the request of the woman for the unwanted pregnancy without having a medical reason. Since both operations have different motives, they contain different actors and social process within.

Recent studies on abortion in Turkey have demonstrated that the difference between two operations become significant in shaping doctors' willingness to perform the operation (Aldanmaz, et al. 2016; O'Neil 2017). For instance, according to the report of Mor Çatı Women's Shelter Foundation, among 184 state hospitals, only nine of them perform voluntary

abortion in accordance with the law.[9] The report also indicates that out of 37 state hospitals in Istanbul, which is the most populated city in Turkey, twelve of them do not perform any type of abortion; seventeen of them perform only spontaneous abortion and only eight of them performs both type of abortion.[10]

In a similar vein, O'Neil's study on state hospitals in Istanbul, shows that while half of the 43 hospitals perform only spontaneous abortion, eleven of them do not perform any types of abortion under any circumstances (2017, 90). Although Turkish Population Planning Law (article 5, 1983) permits to terminate the pregnancy by request of the mother within ten weeks of gestation, abortion is not performed in accordance with this law in many public hospitals. It is rather accessible only in private clinics. As a result, abortion care becomes a scarce resource that is available to those who have the money to pay, whereas inaccessible to those who cannot afford the price. Because it is available only through the private clinics, there is "de facto privatization" of abortion service in Turkey (O'Neil 2017, 93).

A study carried out by Turkish Family Health and Planning Foundation (TAPV) also highlights that the hospital administration does not formally enforces doctors not to provide the abortion care (Topgül et al. 2017). In fact, the reason why abortion care is provided so rarely is rather because doctors' unwillingness to perform the operation. Therefore, in many hospitals, abortion practices are not implemented in accordance with the law, they are rather performed depending on doctors' arbitrary decisions (Topgül et al. 2017, 40).

[9] Mor Çatı Women's Shelter Foundation (2014). A report for abortion practices in state hospitals (Kamu Hastaneleri Kürtaj Uygulamaları Araştırma Raporu). https://www.morcati.org.tr/tr/yayinlarimiz/izleme-raporlari/371-kamu-hastaneleri-ku-rtaj-uygulamalari-arastirma-raporu

[10] Do you practice abortion? "No, we don't" (Kürtaj yapıyor musunuz? "Hayır yapmıyoruz") https://www.morcati.org.tr/tr/290-kurtaj-yapiyor-musunuz-hayir-yapmiyoruz

### 3.1. The Clinic

The hospital where I conducted the research is located in one of the middle-income neighbourhoods of Istanbul. Compared to many other private hospitals, the operations and examinations are relatively affordable in this clinic. During the interviews, the majority of the women who visited the gynaecological unit indicated that their reason for choosing this clinic was its decent prices. In the gynaecological unit of the hospital, there are two obstetrics, five delivery midwives and two employees from patient care team *(yardımcı personel)*.

In my first day at the clinic, I was directed to one of the gynaecologists by one of the doctors whom I had known previously and who is currently working in the clinic. Thanks to his reference, I was able to speak with the gynaecologist, Dr Zeynep, and provide a comprehensive information about my research. She directed me to the delivery room indicating that the delivery midwives who are working two floors below would more helpful for my project. Thus, I was able to access the delivery room of the hospital.

The delivery room is located in one floor below the main entrance. Before entering the room, there are two doors that is passed by password. The first door opens up to an operating room where all kind of surgeries can be conducted. Later, a different code needs to be entered to open up the second door which is directly connected to the delivery room. When the patient or her relatives want to speak with the medical personnel in the room, first, they must ring the bell and wait for them to open the door. Unless delivery nurses are willing to answer the door, it is not possible for patients or their relatives to communicate with the personnel and learn about the operation processes. This security barrier is guaranteeing that nobody is allowed to enter the room without the medical staff's surveillance or to communicate without a permission.

When I visited for the first time, an old woman who is in pink uniform with hairnets opens the door and lets me in interrogatively. I tell her that I was an acquaintance of one of doctors in the clinic and sent by Dr Zeynep to speak with the delivery midwife Selda. The moment I provided the names of the doctor she smiles and greets me hospitably. Later, midwife Selda comes in and together we enter to the waiting of the delivery room. The waiting room has one desk where delivery midwives record patients' identification, a computer which shows the upcoming patient's name and her operation, a sofa and a television for nurses to gather around for coffee breaks. At the end of the hallway, there are three operating rooms where deliveries and other gynaecological operations are performed, two non-stress test (NST) to measure the heartbeat and regular movement of the baby in the womb, and three rollaway beds for the labour sessions.

During the day shift, there are three delivery midwives and one patient-carer in the delivery room. While I was conducting this research, there was a period that midwives who were in the night shift, exchanged their working shift with dayshift personnel. Thanks to this consequence, I was able to interview with all of the midwives and patient-care team personnel.

Because all of the reproductivity-related operations are performed in the delivery room, delivery midwives witness every surgery including deliveries, C-sections, vaginal examinations, intrauterine device implanting, and both types of abortion. Therefore, they are knowledgeable with how the operations are proceeded in the delivery room, under which circumstances doctors proceed the operations, how the pricing is managed etc. Moreover, before coming to this hospital, all of the midwives worked at state hospitals as professional nurses or as interns in different cities around Turkey. Hence, they are able to make comparison between the state hospitals and private clinics.

Selda an experienced delivery midwife, was the first midwife I interviewed with in the clinic. She has been working in this hospital for two years. She is 34 years old, married and has two children. Before coming here, she worked at several state hospitals and now she is completing her eighth year as a midwife. Because of her long-term experience in this clinic, she has an informal authority over other workers in the delivery room. On my first day in the clinic, I explain her about my project, and we briefly have our first semi-formal interview. I ask her about the patient profile she observes here, and for what purposes women usually come to this clinic.

> Selda: The women who come here usually wants to get voluntary intervention *(isteğe bağlı müdahale).* Sometimes we receive a lot of patients, and sometimes we don't. In winter season we are so busy. Women usually get pregnant during the summer and come to abort in winter. (Giggles). Our prices are decent compare to other private clinics, I guess that's why they prefer here." [1]
>
> Q: What about the state hospitals? Don't they do it for free?
>
> Selda: State hospitals do not perform the voluntary intervention at all. They even avoid performing spontaneous intervention *(zorunlu müdahale)* because it takes a lot of time to anesthetize the patient. They offer regional anaesthesia, but women do not prefer that because it is painful. I don't think it is an intolerable pain, but still, it is painful. [2]

According to Selda, because of the over-crowded environment, state hospitals avoid wasting time on long-term, anaesthetized abortion surgery. Although she points out that state hospitals have a practical reason for doing this, this deters women from getting abortion in these institutions even when they have to go through abortion for medical purposes. Doctors working in state hospitals exercise in short often arbitrary power as to how they provide abortion care.

Similar account was given by another delivery nurse, Emel, as well. Emel started working in the hospital after midwife Selda transferred to a different hospital. Before coming to this clinic, Emel worked at three private hospitals before. She is 30 years old and married. In another visit, I ask her about the previous hospitals she worked, whether abortion was performed regularly as it was performed here.

Emel: No, intervention *(müdahale)* was never performed.

Question: Doctors wouldn't do it?

Emel: It was an administrational decision. They didn't find it ethical. Not every private hospital performs intervention. I worked at three hospitals before. All of them were private and none of them performed any types of intervention. Of course, they were Islamic hospitals. [3]

Question: What did you say to those who come for abortion?

Emel: We directed them to a state hospital or any hospitals that could perform the abortion. [4]

According to Emel, some private hospitals too, avoid performing the abortion. Even though a woman is aware that she cannot undergo voluntary abortion in a state clinic, it is possible that she would be turned down by some of the private clinics as well. This situation compels women to go to the doctors only via reference given by the previous patients of a specific doctor. Emel's account is important in terms of highlighting the overall scarcity of abortion practices in Turkish hospitals. Both accounts of midwives show that voluntary and even spontaneous abortion service is often inaccessible in state hospitals, it is even difficult to be obtained in private clinics.

In the next sections, I will discuss delivery midwives' ethical stance towards abortion. Focusing on the language used by doctors and midwives and personal opinions of midwives on women who gets abortion, I will show how moral beliefs can inform medical practices.

### 3.2. Pronatalist medical language

The participant observation that I conducted in the delivery room lasted for over six months. In addition to the interviews I had with the midwives, I was able to observe the women patients who visit the clinic for gynaecological operations and conduct interviews with pregnant women who come to have non-stress test (NST).

During my fieldwork, one of the most intriguing aspects of the delivery room was the medical language that is used to refer abortion among medical staff. As indicated in midwives'

narratives, delivery nurses address the abortion or any surgical process to uterus as "intervention" *(müdahale).* If a woman decides to terminate her pregnancy, the operation would be addressed as voluntary intervention *(isteğe bağlı müdahale)* whereas spontaneous abortion would be called as compulsory intervention *(zorunlu müdahale).*

The word "intervention" recalls the human interference to a natural process. In this regard, termination of pregnancy is associated with interference to a human body and to a process of giving birth. However, there were contradictory notions of maternity in the language used by doctors and midwives. For example, in the clinic, I observed the pervasiveness of the caesarean delivery which is a type of surgery to deliver a baby and performed with incision in women's body under regional anaesthesia. It is a surgery that contains human intervention to a natural birth process and to women's body with medications and surgery instruments. Yet still, medical professionals never address caesarean delivery as intervention.

I interpret this difference in use of language as an example of perception of childbirth and pregnancy in medical milieu. On the one hand, regardless of the birth method – whether it is vaginal or caesarean delivery – giving birth is considered a natural process. On the other hand, termination of pregnancy is considered unnatural, human intervention that needs to be singled out from other interventions into the uterus of women. Therefore, while giving birth and becoming mother are considered as natural, the termination of pregnancy is seen as an abnormal incident, and intervention into the natural reproduction process. The language used by doctors and midwives gives us hint about the perception of pregnancy and abortion in the medical realm. In the next section, based on the interviews with midwives, I will show the personal opinions of delivery midwives on abortion process, and women who wants to get abortion.

### 3.3. Through the midwives' eyes: woman is to blame as selfish, immoral, irresponsible

In the clinic, because delivery midwives witness every gynaecological operation, they observe all of the actors involved into this process; doctors, women, and women's relatives. Therefore, they are able to follow how doctors' reactions differ depending on the operation type, the patient profile. Because midwives are witnessing the entire abortion process, their feelings and attitudes towards abortion hints us how medical milieu approach to abortion, and why. Midwives' accounts would also help to explain why some of the doctors agree to perform the abortion while some others do not.

During out first conversation in the waiting room, Selda, the experienced delivery midwife of the delivery room, indicated that regardless of the social or economic circumstances, voluntary abortion *(isteğe bağlı müdahale)* should not be performed. To her, it was a matter of conscience *(vicdan meselesi).* Because she was willing to talk on this matter frequently, I wanted to learn more about her opinions. About a halfway through my interview with her, I explained my confusion about the inaccessibility of abortion. To me, doctors wouldn't do anything wrong by performing voluntary abortion in accordance with the law, and yet, it was surprising for me to hear that they frequently avoid performing it. In response to my reaction, she articulates abortion's inaccessibility favourably, and blames women for having unprotected intercourse.

> **Selda:** For instance, if I were a doctor, I wouldn't have done it either. The moral responsibility of the abortion is huge. You are killing a tiny living being. I wouldn't have taken the responsibility of killing that small thing. [5]
> **Question:** What if the woman is not ready to have a child?
> **S:** If she doesn't want to have a baby, she must be protected. Abortion is not a birth control. Even here, doctors prefer not to perform it in the first place. Of course. Because it is risky. There might occur [medical] complications. It is a surgery after all. It may prevent to have a child later on. [6]
> **Q:** Then, why do you think women prefer to have abortion?
> **S:** Well, sometimes they don't want it [the baby] because of the selfishness. They usually don't tell us the reason; they talk to the doctors. Sometimes woman wants to have the child, but her husband does not. In some cases, they express their regrets

> right after the abortion. I guess it's the effect of anaesthesia. Sometimes both man and woman don't want to have it. And sometimes she is married and pregnant to someone else's child, as far as we hear. [7]

Midwife Selda is concerned about the moral burden of abortion, considering abortion as murdering a living being. Moreover, while she was talking about her ethical attitude towards abortion, she mentions about the medical complications for the first time, and the harm that it could bring to reproduction capability of the woman. Therefore, we can argue that Selda is using the risks of medical complications as an excuse for her ethical preference regarding abortion. When I asked her about women's motivations behind abortion, instead of explaining the circumstances and women's preferences, she uses the word "selfish" and provides her own judgement as a reason.

Similar accounts were given by some other midwives as well. Ceylan is a delivery midwife who is working during the nightshift. At the time of my fieldwork in the clinic, I coincided with her shift change which allowed me to see Ceylan regularly in the dayshift. She is younger than many other delivery midwives and has been working in the clinic for over a year. After we had several informal interview sessions in the waiting room, I realized that Ceylan was the most knowledgeable midwife about women's stories of abortion in the delivery room. Because she knows more insights about women's personal stories, I expect her approach to be different than Selda. However, Ceylan has similar opinion with Selda, evaluating abortion as a murder. I ask her opinion about what she thinks about abortion:

> "I cannot understand why women do not use protection. If she doesn't want a baby, she should take precautions. There are lots of birth control methods. Here, doctors keep committing murder every day because of 5-minutes-of-pleasure" [8]

In addition to this account, there is also a delivery midwife who offered an extreme criticism over women's sexual behaviour with regard the topic of abortion. Midwife Mehtap - grumpy and cold – is the oldest delivery midwife in the clinic. The first time I explained my

project to her, I realized that she is the most intolerant worker with regard to topic of abortion. In the waiting room, I ask her what kind of women visit this clinic for abortion. She replies:

> "The kind of girls that have no honour *(namus)* at all. Once they started to spread their legs, they never close them. They know nothing about our morals. They keep getting pregnant and come here to abort the child" [9]

Regardless of the circumstances that compel women to get abortion, Mehtap is criticizing women's sexual behaviour; accusing women for violating the moral rules. Similar to her account, all of the other interviews show midwives' prejudices towards abortion. Doctors perform both abortions regularly, yet still, midwives are very critical of this practice; accusing women for being selfish and having unprotected intercourse.

The words "murder" and "killing" that midwives used in expressing their opinions, were previously used by President Erdoğan and other JDP politicians to condemn the abortion. This shows how pronatalist discourses promoted by the government officials are taken up by medical professionals as well.

Alongside the prejudice towards women and the abortion, none of the midwives mention men as women's partner or husband and their responsibilities over this process. In other words, whenever midwives talk about the abortion, women are the only ones that they blame for not using any contraceptives. This perspective can be associated with the societal control over women's sexual behaviour; and her mothering role in the society.

In her discussion of birth control, Lowe (2005) argues that women are judged not only by their ability of mothering, but also complying with the medical surveillance of contraception. Regardless of its biological consequences on women, the purpose of contraceptive is to discipline women's body and to prevent any threat to social order (Lowe 2005, 363). Moreover, a study carried out by Hawkes (1995) in a family planning unit, indicates that for many health care providers, women's sexual behaviour is associated with the notion of

responsibility. In this regard, women with multiple partners are evaluated as irresponsible by medical personnel and their sexual behaviour creates anxiety about traditional motherhood. (Hawkes 1995, 272)

According to midwives' accounts, getting abortion is a symbol of woman's giving up on her motherhood which is a violation of tradition role of Turkish woman. Similar to what Hawkes' study pointed, midwives I have talked to have anxiety about women's reproductive capacity after the abortion. They talk about women who undergoes voluntary abortion as selfish, immoral, and irresponsible individuals. From this point of view, delivery midwives evaluate women as the individuals who does not comply with the medical surveillance with regard to reproductivity-related activities.

Thus far, I have showed delivery midwives' personal opinions on voluntary abortion to provide insights about medical professionals' attitude on this matter. In the next section, based on midwives' narratives and the participant observation in the clinic, I will discuss doctors' arbitrary initiatives in performing abortion.

### 3.4. Discretionary attitudes of the obstetricians

In the hospital, there are two doctors in the gynaecological unit. Doctors' offices are located two floors up from the delivery room and they come downstairs approximately three or four times in a day. The interviews that I conducted with the delivery midwives shows that there are different types of discriminations among patients. These discriminations are either based on the abortion type – spontaneous or elective – that women demand, or the marital status of women, single vs. married.

As previous studies in Turkish hospitals demonstrate medical professionals approach two types of abortions in different ways. When they use the term abortion *(kürtaj)* they usually mean voluntary abortion. The spontaneous abortion is usually described as miscarriage *(düşük)*.

In my research, I observed different attitudes of medical professionals depending on abortion type. For instance, although spontaneous and voluntary abortions are medically identical operations, they were subjected to different pricing.

Selda, the most experienced delivery midwife in the clinic, whom I was directed by Dr Zeynep, gave me some insight about the pricing procedure of the clinic. In her account, the prices paid for abortion differ from patient to patient. About a halfway through my first interview with her, I asked her about the economic profile of the patients, whether low-income women prefer this clinic for abortion. She replies:

> **Selda:** "Yes, they (low-income group) come here for abortion. Though, pricing differs depending on the circumstances. For instance, if the woman is married, the price is lower. But if single, it is higher. Sometimes there are exceptional cases as well. If the woman explains her situation to doctor, there might be a discount. For instance, there was a woman who exposed to violence by her husband and got pregnant by force… She talked to the doctor and price was reduced for her." [10]

Here, midwife Selda's articulation highlights that the price paid for the voluntary abortion differs depending on women's marital status. If the price of abortion can be lowered only for married woman, it is more difficult to get abortion for a single woman. Additionally, the example of a woman who was exposed to violence shows that doctors can practice positive discrimination towards their patients when they find it necessary. However, throughout the rest of the interview, there is no indication that single women receive any positive discrimination as married ones.

Selda's account shows that doctors may take initiatives for some exceptional cases to provide convenience by lowering the abortion price. The initiatives that doctors take do not follow any administrational rule, rather, they are dependent on doctors' personal judgement over the patients. Although doctors were performing voluntary abortion regularly, they were differentiating single pregnant women from married pregnant ones by charging single women

with more fee. This was the most salient portion of my interview with Selda, which later formulated the significant contribution to my research. Because I want to make sure doctors' discriminative attitude based on the marital status of women, I decided to ask other midwives separately.

Midwife Emel, who worked at three private hospitals before coming here, has completed her second month in this clinic and has witnessed many different abortion operations. One morning I wento to the delivery room, I came across with the ongoing abortion which is operated during midwife Emel's shift. In the afternoon, I ask Emel whether there is any difference between single and married women for the abortion:

> **Emel:** "Yes, of course there is. For instance, remember the single woman you saw here this morning? That woman paid 1850 TL for her intervention *(müdahale)*. But if the woman is married, or the [baby's] heartbeat stops and must be evacuated, it costs around 800-900 TL." [11]

Emel's account highlights another significant aspect of this operation in the clinic. According to her, the price differs not only depending on the marital status, but also on the abortion type. I carry on asking whether there is any medical difference in performing two abortion types.

> **Emel:** "No, they are identical as medical operation".
> **Q:** Yet, their prices are different?
> **E:** "Well, if it is a normal miscarriage, Social Security Institution (SSI) covers the expenses. But the other one is completely luxury. At least hospital and SSI consider it as luxury. Because, think about it; she can continue the pregnancy. It is a discretionary decision either way." [12]

Emel indicates the price difference between two abortion types stems from SSI coverage for the spontaneous abortion. Articles which discuss state's financial support on abortion cost can be found in newspapers (Öngel 2014; Süzer 2014). According to these articles, with the declaration of Official Journal on 18 March 2014, SSI extends the scope of its coverage; now it covers not only the spontaneous abortion, but also voluntary abortion (Tezel 2014). In other words, state's financial support for the spontaneous abortion can be

applied to voluntary abortion as well. For instance, when a woman requests voluntary abortion, state hospitals must do the operation for free. If the surgery happens in a private clinic, SSI will pay between 191 to 382 TL to the patient for the operation[11].

While this declaration remarks that there is no differentiation between both abortions on paper, delivery midwives indicate that doctors' attitudes differ. In practice, rather than focusing on the medical aspect of the operations, doctors consider the motivation behind the operation; whether the abortion is elective, or it occurs out of medical necessity. For instance, regardless of SSI coverage, doctors might charge elective abortion with higher fee, considering it as luxury. Therefore, we could argue that there is a discretionary attitude of doctors towards the patients who requests abortion.

In considering the discursive division of abortion as spontaneous and voluntary, Erviti et al. (2004, 1062) claims that this distinction is mainly produced by medical staff and is associated with their moral judgement of "first being guilt free, second deserving of blame". In a similar vein, the price difference between two abortion types might stem from doctors' moral judgement over the patients; the elective abortion that deserves punishment with higher fee and the other one which is more innocent. The discursive discrimination that Erviti et al. (2004) discuss, can manifest itself through price difference in practice.

After I listened to Selda and Emel, I want to gain more insight about doctors' power which enables them to take arbitrary decisions in the clinic. Delivery midwife Ceylan, is the second experienced worker after midwife Selda in the delivery room. In our previous interview, she showed her stance against voluntary abortion, evaluating it as a murder. In the breaktime, I come across to Ceylan in the waiting room, the place where midwives gather around to spend

[11] "Yasal sınırlardaki kürtaj ücretini SGK ödeyecek" (SSI covers abortion cost). *NTV*. 20 March 2014. Retrieved from https://www.ntv.com.tr/saglik/yasal-sinirlardaki-kurtaj-ucretini-sgk-odeyecek,D3XpWMEpmkKBf10ez89uHQ?_ref=infinite.
See also "SSK Kürtajı Karşılıyormu" (Does SSI cover abortion?). Retrieved from https://www.sgk.gen.tr/sgk-haber/ssk-kurtaji-karsiliyormu.html

their free time by talking and drinking coffee. This time I was mainly interested in doctors' authority in the clinic, whether there is some rule to limit their decisions, or someone whom doctors assure that they are following the rules. I ask Ceylan about the price differences, she replies:

> **Ceylan:** "As far as I know, the institutional price for the voluntary intervention *(isteğe bağlı müdahale)* is fixed and it is 1000 TL (US$ 163). But if baby dies, it is different. I guess around 600 - 700 TL. It happens by doctors' own initiatives. If there is no heartbeat and the bleeding does not stop, that means there are particles left in the uterus. That has to be cleared out. So, doctors make it easier for the patient". [13]
> **Q:** No discount for single women?
> **C:** "I don't think so. If the woman is married, have several kids already and cannot afford another one, doctor can make discount. But if she is single, and seems like she is able to pay, doctor says higher price, I think around 1800 TL." [14]

Here, Ceylan's account highlights another exceptional case in which doctors lower the price of abortion. If the woman is already a mother and financially incapable of looking after another child, doctors are moderate, in fact, they can make the process easier for the women. However, this treatment is not valid for the single women.

Although midwives kept pointing out the different pays between single and married women, none of them were providing a concrete reason for this difference. Ayse is the youngest a delivery midwife in the clinic. She is 24 years old and has been working in this clinic for over two months. Before she starts working here, she completed her internship in a state hospital of Diyarbakır, one of the largest cities in south-eastern Turkey, where she had witnessed lots of deliveries and miscarriages. Because we were at the same age and we got along so well, I was more comfortable expressing my ideas to her and asking about the doctors, and abortion practices. After I explained her my confusion about the financial discrimination between single vs. married women, and voluntary vs. spontaneous abortion, she responds:

> **Ayse:** You know why there are different? s/he [doctor] thinks that if she is single and having sex without protection, she must take the responsibility for it. She must deal with the situation on her own.

[Pause]
Actually, this [attitude] should be the same for married ones as well because they might also have sex without protection but… this is how they[doctors] think and do.

### 3.5. Discussion

Terzioğlu (2018, 232) points out that the privatization of health service in Turkey brought new meanings to health by making it a personal responsibility of the individual. According to Balta (2012) the establishment of private hospitals in Turkey was the primary step for transformation of health into a commodity that could be obtained by money. As a result of the privatization of health services, economic inequalities became more visible and this exacerbated unequal accession to health right (Balta 2012, 162).

In a similar vein, this research demonstrates that because abortion care is available only through private hospitals, it can only be provided to those who can afford it. Ultimately, this situation reinforces the inequality in the health sector. Moreover, inequality in health services is not only based on the economic disparity, it is also related to the context of the health service. For instance, doctors in the clinic perform abortion regularly, however, women are still subjected to a discrimination based on the moral judgements over the medical operation, in this case, abortion care.

Ellison (2003) who examined women's perceptions about the social stigma and structural violence on single mothers, indicates that while single fathers and male fertility have never been subjected to moral or political debates, single women's bodies have always been sites of biopolitical controversies. Furthermore, the cultural censorship about abortion perpetuates the social burden and structural violence on single women's sexuality, fertility. (Ellison 2003, 338). Considering doctors' arbitrary initiatives, when the pregnancy is unwanted within the legal relationship, or when the woman already has several children and cannot afford to raise another child, the termination of pregnancy becomes socially acceptable.

In their discussion of health disparities in clinical care, Bourgois, et al. (2017) assert that clinical professionals should assess "structurally vulnerable patients" – those who have been exposed to poverty or social discrimination based on their race, gender or legal status – and consider their background in order to allocate health resources equally. Similar to this discussion, just because single woman's pregnancy is culturally unacceptable in Turkey, pregnant single woman can be evaluated as structurally vulnerable. Because of their vulnerable position in the society, Turkish health carers should practice positive discrimination in providing health service towards single pregnant women. Nevertheless, they make the cost of abortion higher for a them.

In doctors' view, if a single woman wants to terminate her pregnancy, they should pay the price for taking risk of unprotected intercourse. In this regard, doctors reinforce the social burden of the single women, and compel them to comply with medical surveillance on their body. As a result of this, in performing abortion, doctors' discriminative attitude towards single women exacerbates women's structural vulnerability, and reproduce local hierarchy based on their marital status.

Thus far, I have discussed how abortion practices is evaluated in the political realm and provided insight about medical professionals' viewpoint on abortion. In the next chapter, I will focus on women's vantage point of pregnancy loss. In doing so, I will present women's narratives of spontaneous abortion after a miscarriage *(düşük)*.

# CHAPTER IV :

# BLAMING ONESELF, BLAMING THE HEALTH SYSTEM: WOMEN'S NARRATIVES OF PREGNANCY LOSS

In this chapter, based on my semi-structured interviews with eight women who experienced pregnancy losses in various ways, I discuss how women feel about their miscarriages and abortions; how the process of pregnancy loss informs women's relations to their body, and their perspective on reproduction. While previous chapters focused on the political agenda and the medical professionals' attitude towards abortion, this chapter underscores how pregnancy loss is experienced and narrated by women.

Attitudes towards abortion are a two-way street: how abortion is perceived by medical professionals influences the attitudes of those who experience this event. By analysing pregnancy loss process through the women's eyes, we could see that how medical professionals' approach inform women's experiences. In chapter three, I discussed differences between spontaneous abortion and voluntary abortions, here focusing on women's accounts of abortion, I situate doctors' varying attitudes towards these types of operation from the perspective of women. Previous chapters focus mainly on the abortion practices in one private clinic of Istanbul. However, because the women I interviewed, had seen different clinics beforehand, they could compare obstetricians, midwives and nurses across clinics. This perspective will expand our knowledge on how women's experiences differ from each other, depending on the hospital, and the medical staff.

After spending two months in the delivery room, the delivery midwives were fully aware that I was studying women who undergo abortion and they offered some assistance for my research. In one of my regular visits, the delivery midwife Selda suggested that I talk to the pregnant women who visits the delivery room regularly, that they might have experienced pregnancy loss before. This is how I decided to interview with pregnant women about their previous pregnancy loss experiences, if they had any.

Pregnant women were visiting the delivery room to have regular non-stress test (NST)[12]. Therefore, I conducted the interviews mainly in the NST rooms of the clinic. NST sessions last approximately twenty minutes. In order to have this test, a woman must be at least in her third trimester. Most of the pregnant women I talked to in the NST room experienced one or two miscarriages, and in some cases, they experienced spontaneous abortion as well. Whenever I encountered with a pregnant woman entering the delivery room for NST, I would introduce myself to her and then show her the room. After the midwife help her to lay down on the bed and tie her belly to the NST machine, I ask her whether she experienced any miscarriage or abortion before. Depending on their answer, I explain the purpose of my research and ask her if she would be interested in speaking to me more extensively about her pregnancy loss story.

In order to have longer interview sessions, I offered all of my interlocutors to have the interviews outside of the clinic. However, only three of them accepted to have the interview outside of the clinic, while remaining five preferred to get it done during the NST session. The three interviews I conducted outside of the clinic were recorded on the tape. Women who preferred having their interviews conducted in the NST room were not comfortable being recorded on tape. However, they permitted me to take notes during their interviews, which I did. I also assured all of my interlocutors about anonymity and confidentiality of the research. Hence, I do not use the real names or any identifying information of the participants in this thesis.

NST sessions last approximately twenty minutes, and so did most of my interviews. Other three interviews which I conducted in the cafeteria next to the clinic, lasted about forty-five minutes. I was mainly interested in how women experience miscarriage in an environment where their reproductive identity is frequently politicized in public debates. How do the women

[12] NST is a common prenatal test to measure the heartbeat and the regular movement of the baby.

feel/think when they realize they're having miscarriage first time? How do the hospitals and medical milieu react when a woman enters the clinic while having a pregnancy loss? How does miscarriage inform the notion of motherhood and women's relations to themselves? Through the analysis of women's narratives of spontaneous abortion and miscarriage, I will discuss whether pronatalist politics and attitudes inform women's subjective experiences.

### 4.1. Distrust and denial: "Don't believe I've miscarried"

Miscarriage is a type of pregnancy loss that is widely encountered during the first trimester of the pregnancy.[13] While miscarriage occurs in various ways, spontaneous abortion is the operation that is undertaken immediately after the foetal or embryonic death, to clear out the particles left inside of the uterus. To decide whether or not to perform spontaneous abortion after a miscarriage, doctors consider specific conditions, such as the size of the foetus, the intensity of haemorrhage or, women's preference for having abortion. In some cases, doctors prefer not to make any intervention to the process and wait until miscarriage is over by haemorrhaging. Therefore, it is important to emphasize that not every woman whom I interviewed experienced the spontaneous abortion.

However, I frequently came across with women who experienced both spontaneous abortion and miscarriage. Although women's stories are subjective as they get, there are some common themes of the interviews with regard to the feelings they had. My first interview was with Handan who is a close friend of midwife Selda in the delivery room. One day when I was at the clinic, she came to the delivery room to visit her friend. She and midwife Selda spent some time together in the waiting room. When Handan was just about to leave the clinic, Selda

[13] For instance, the probability of having a miscarriage for a twenty-five-year-old woman during her first pregnancy is 29 percent. For a comprehensive review, please see: Miscarriage Probability Chart https://datayze.com/miscarriage-chart.php

introduced me to her and told me about Handan's miscarriage experience. After Handan agreed to participate in my research, we left the delivery room and went to the café, nearby the clinic.

Handan works at a Family Health Centre as a cleaning lady. She is 38 years old and is married for five years. She and her husband spent their last three years trying to have their first baby. So far, she had three pregnancies, but all of them were lost by miscarriages. One of her pregnancies was an ectopic pregnancy[14]. In addition to the miscarriages, she underwent three spontaneous abortions. The most significant experience was her last pregnancy which she had the highest hope to become a mother. I asked her how the experience was like and how she felt throughout the pregnancy and miscarriage. She responded:

> "Pregnancy was a beautiful experience. At the end of the first trimester, baby's heart stopped. I saw a little bleeding first. I went to the doctor and he said, "there is no heartbeat". I didn't believe it. I went to another hospital. There too, doctor said there was no heartbeat. I didn't believe him either and went to another hospital. They said the same. There, I spent the whole day struggling with this situation and visiting one hospital to another until the midnight. The next day, I went to my own doctor, the one who took care of my pregnancy since the beginning. She told me that "My dear, there is nothing we can do. Its heart has stopped. When the bleeding starts, come to me and I'll take the baby out." It was too difficult. I had been through too difficult situations during pregnancy. You get your hopes up, believe that you will become a mother. You become attached to the child. It was hard. But of course, my age is my obstacle" [16]

Handan was telling her story in a grieved manner. Nevertheless, she was not hopeless for being a mother. At the time of our interview, she and her husband were trying to have a baby. Perhaps, her faith in having a child manifests itself in her story, through her disbelief to doctors' diagnosis. In her last miscarriage, she doesn't believe what doctors say and keeps visiting different hospitals to make sure what was going on with her body and pregnancy. After visiting her own doctor whom she trusts the most, she finally believes that her baby was not alive. Until

[14] Ectopic pregnancy is a type of complication where the fertilized egg settles outside of the uterus. It eventually has to be evacuated, usually by abortion.

that point, Handan doesn't trust to doctors who are stranger to her body, who had not ever examined her body, or follow her previous pregnancies before.

Considering Handan's enthusiasm towards being a mother, one may not find surprising that Handan could hardly believe her pregnancy was miscarried for the third time. However, as I continue my interviews with other interlocutors, I realized that the distrust to doctors' diagnosis regarding miscarriage was not specific to Handan. Some other women reported similar accounts.

While I was taking notes in another day in the delivery room, a young pregnant woman named Elif, visits the clinic for NST. After the midwife lets her in, I escort her to the NST room introducing myself and explaining my research. She agrees to tell her story during the session. After the midwife ties her belly to the machine, she leaves me alone with Elif.

Elif is a small, twenty-four-year-old woman. She is thirty-two-week-pregnant with her first child and had one miscarriage before. She is one of Dr Zeynep's patients in this clinic. Throughout her miscarriage, she visited four different public hospitals. After witnessing attitudes of medical staff in state hospitals, she preferred coming to a private clinic for her current pregnancy. Because this clinic is quite affordable and closer to her house, she comes here regularly. During her first pregnancy, she was working as a sales assistant at an optician store. However, because her job created difficulties during the miscarriage and pregnancy process, she chose not to work until she gives birth. Below, I quoted a small portion of my interview with her. I asked how the miscarriage had been for her and how she felt throughout the process:

> **Elif:** "It was a disappointment, of course. First, I could not believe that I was having a miscarriage. I started to bleed, and I went to the state hospital. The only thing they told me there was "The miscarriage has begun". I did not believe them, and I went to another hospital. There, they did not examine me at all. They just told me "Come back one week later, when the miscarriage is completed". I left there and went to another

state hospital. First, they made a pregnancy test to make sure that I was pregnant, though I told them I was pregnant already! But we had to wait for the result. Later, they performed a blood test and we had to wait for another two hours. [17]
**Question:** Meanwhile you were still bleeding?
**E:** Yes, yes. I kept bleeding the whole time. I left that hospital. Finally, I went to another doctor through a connection of a close friend. Only that doctor explained it with numbers "Look, your pregnancy level was at 1500 before, but now it is 800… It is slowly going down." After he explained it in detail, I finally believed that I was having a miscarriage. Then, he examined me, and they gave me antibiotics. So, it [miscarriage] is completed by itself." [18]
**Q: So, you didn't get the [spontaneous] abortion right after?**
**E:** "No, I did not. Doctor asked me actually. He said, "I can either clean out the area, or prescribe a medicine to let it abort by itself". I preferred the medication. After all I had been through in state hospitals, with that suspicion in my head, I wouldn't have had the surgery there. I thought to myself, "If this baby is truly aborting right now, it should happen by itself. I will not intervene it". [19]

Elif was describing her experience in a confused manner, surprised by the attitudes of the medical professionals in state hospitals. Throughout the interview, she kept highlighting the difficulties she encountered. When the haemorrhaging begins, although she worries about her pregnancy, what she encounters is the reckless attitude of medical personnel who doesn't examine or provide any treatment. In another state hospital, even though she tells health professionals that she was pregnant for sure, they waste their time on pregnancy tests. Because she doesn't receive any detailed explanation or medical attention from the doctors, she does not believe that she is having a miscarriage. The distrust she builds towards state hospitals during the whole process leads her to refuse any intervention to her body, even after a doctor finally, explains the situation.

Elif's story resembles Handan's experience in terms of the feelings she built throughout the process. While both Elif and Handan don't believe the diagnosis of doctors who were stranger to their body and deny that they were having miscarriage, Elif's story is significant in terms of showing the careless attitude of clinical professionals towards miscarriage and spontaneous abortion in state hospitals.

Another example would be Aslı who is also one of Dr Zeynep's patients. Aslı is pregnant with her first child, and had experienced a miscarriage with spontaneous abortion beforehand. During her first pregnancy, she went to another private clinic. Because of the good references she heard about Dr Zeynep, she prefers this clinic for her current pregnancy. She agreed to talk about her story during the NST session:

> "It was my first pregnancy. I went to my doctor for a routine control, from the ultrasound. There was no heartbeat. I could not believe it. The doctor examined me from below as well. She told me to go to another hospital to check it. You know, to eliminate the suspicion in my mind. Because I did not want to believe that it was a miscarriage. You know, it was my first pregnancy and it is difficult to figure it out. I went to another hospital and they told me the same. So, I had an abortion. Doctor gave me antibiotics in case there is an infection" [20]

Aslı has no haemorrhage and her doctor diagnoses with the ultrasound. However, before performing the spontaneous abortion, the doctor advises her to consult other hospitals so that she has no doubt that her pregnancy is lost due to the embryonic death. Here doctor encourages her to eliminate any suspicion she might have towards doctor's diagnosis of miscarriage.

The interviews I conducted led me to believe that many women feel the necessity of collecting views from different doctors in order to believe that they are miscarrying. According to their narratives, women's first reaction to miscarriage is disbelief and denial. For that matter, they don't believe that they might have lost their chance of becoming a mother. Moreover, women's disbelief in losing their pregnancy is exacerbated by the careless attitude of the medical personnel who do not provide reasonable explanation for their miscarriage. Therefore, unless they hear detailed explanation from different doctors, they chose to deny.

This section discussed women's attitudes towards pregnancy loss by showing their primary reactions to the miscarriage. In the next section, I present women's subjective reasonings for the miscarriage, which would be the second step to analyse women's relationship with the pregnancy loss.

### 4.2. Subjective causes of the losses: "My fault was..."

One of the key themes that emerged from the interviews was that women frequently blamed themselves for miscarriage for one way or the other. The women I interviewed narrated, some of their "faulty action" that might have triggered miscarriage. Beste's story is an example of this.

Beste, twenty-eight-year-old woman, is a thirty-six weeks pregnant with her first child. She is one of Dr Erdem's – the other obstetrician in the clinic – patients. She prefers this clinic because of its accessible location. Earlier, she experienced a chemical pregnancy, which is a term to describe very early miscarriage. She agreed to participate in my research and offered me to interview her where she worked, which is the bookstore nearby the hospital.

Because Beste and her husband were so enthusiastic about having a child, she was regularly having manual pregnancy tests at her home. Therefore, she was able to find about her first pregnancy in the beginning of the fourth week, whereas other women typically find out at around the sixth week. Two weeks after she found out however, she starts having haemorrhage and goes to the hospital. After she learns about her miscarriage, doctor gives her detail explanation on how and why it was miscarried. I asked her how chemical pregnancy is different from other pregnancies, and how her experience had been for her:

> **Beste:** "Let me show you like this; [illustrating with a fork and knife on the table] consider my two punches as my ovary; and fork and knife would be road to my uterus. In chemical pregnancy, fertilized egg reaches out the uterus; but because embryo is not healthy, the uterus doesn't keep it. Without needing an abortion, uterus throws it out by haemorrhage. That is how doctor explained me." [21]
> **Q**: So, when your haemorrhage started, you figured that it was miscarriage?
> **B**: "Well, yes. It was my period day actually. But because I discovered my pregnancy before, I knew there was something wrong with that bleeding. I mean, my fault was going to a doctor's consulting room instead of going to the hospital. There was a doctor who I found knowledgeable. But of course, it was not a hospital, so they did not make any intervention. If maybe, they have given me a progesterone injection, it might have been different. We lost a lot of time actually. I mean, first the bleeding starts, then we go to the hospital, they check my pregnancy level etc. It took around three hours. By that time, the miscarriage was already completed." [22]

The fork-knife illustration is important here. It implies how the image of miscarriage appears for Beste. By describing her miscarriage with materials, she resembles her pregnancy loss to something that is external to her body and independent from her own actions. However, interestingly, even though she acknowledges that her body acted autonomously during the miscarriage, she thinks that there was a way to change the result by the immediate intervention at the hospital. Beste implies that progesterone injection might have prevented the miscarriage. If she had gone to the hospital and had received the right medicine and interventions, the result might have been different. Therefore, Beste believes that she had a role in this process and takes a partial responsibility for her miscarriage.

This perspective was also highlighted by some other interlocutors as well. My first interviewee, Handan, who is working as a cleaning lady at an FHC and who had three miscarriages, reported stress as the potential cause of her miscarriage:

> "It happened because of stress. It has huge impact on pregnant woman. My dear, take my word for it; if you ever want to have a child someday, don't think about any negativity. Don't think about any conflict that you have with your husband or anyone else. Just go and grab tea or coffee or take a walk and relax yourself. Because in the end, it's the woman who handles everything. The surgery, the narcosis, all happens to your body. Nothing happens to the man. He just waits beside you. Everything is on your body." [23]

Handan was reporting a subjective cause of miscarriage, which is related to her body and dependent on her actions. To her, stress is something that pregnant women should control. For that matter, she even recommends me to do whatever was necessary to avoid negative thoughts and stress during pregnancy. Therefore, Handan believes that miscarriage is something that can be prevented, as long as the woman does everything in her power not to get stressed.

Dilara is another woman who is sharing the similar experience with regard to the attitudes of medical professionals. Dilara is 31 years old and pregnant with her first child. She had one

miscarriage which had to be terminated by spontaneous abortion. Her story was different from those of other women, because she had late miscarriage which is also called as mid-trimester pregnancy loss. On the fifteenth week of her pregnancy, she wakes up with heavy cramps which makes her feel like "something was bursting inside" as she describes. She goes to the state hospital where medics give her induced labour drug, without any explanation. She describes those moments as followed:

> **Dilara:** "After inducing my labor, I felt like rushing to the toilet. But it was not just that, it was the baby. It fell into my hand. I could not even figure out what was going, they started to vacuum the baby and only said they had to evacuate with abortion in case there is any particles left. They never told me anything. No medicine, no test, no pathological analysis, no information about what was going on." [24]
> **Q:** They didn't tell you why it happened either?
> **D:** "No, there was no reason, but the thing is I had this thyroid disease. When I got pregnant my thyroid went up and they [medics] tried to reduce it. And, to reduce it, they gave me medication. Plus, I had a huge abscess appeared in my ear. For that I had to use antibiotics. I think all together made it [miscarriage]". [25]

Dilara is talking about medical professionals as strangers, keep addressing them as "they" instead of pointing out who the doctor was, or nurses or midwives were. Apparently, she didn't know who they were. Dilara wasn't told anything about what was going on about her body neither during the process nor after the abortion. Therefore, Dilara's story is similar to Elif's[15] story, which highlighted the reckless attitude of the state hospital personnel who didn't provide careful examination or any explanation about her miscarriage.

Moreover, even though Dilara didn't receive any medical analysis or reasonable explanation from the doctor, she believes that the combination of antibiotics and medication triggered her miscarriage. Similar to what I observed in other women's narratives, Dilara

[15] The woman who I presented in the previous section, who didn't receive any healthcare or examination and had to through unnecessary medical tests during her miscarriage.

believes that the cause of miscarriage is external, partially dependent on her actions, and something that can be controlled.

In her discussion on cultural perceptions of miscarriage, Kilshaw (2017) argues that the main difference between women's reactions to pregnancy loss stems from women's willingness to have agency and control over their lives and pregnancy. The women whose interviews I analysed in this section showed how women claimed that they have a role in this process highlighting subjective causes for their miscarriage. Moreover, these causes seem to be controlled by simple behaviours such as avoiding stress or taking or avoiding certain medications. In this way, similar to what Kilshaw pointed out, women reduce the unpredictability for their future pregnancy and find comfort by giving themselves agency and control. In the next section, I will discuss how fertility medications can be powerful in women's consideration of preventing the miscarriage.

### 4.3. Magic Pill: The unquestionable power of the fertility medications

While analysing the women's narratives of pregnancy loss, I realized that "hope in medicine" emerges as another common theme in these narratives. Medicine is seen as an effective way of increasing the chances of having a child. Some of the interviews I conducted led me to think that women who experience more than one miscarriage, commonly feel anxious about their reproductive capability. Furthermore, women who gave birth to one or two children and who also experienced two miscarriages before giving birth, believe that it was the fertility medications that made possible for them to have a child.

Melike's story exemplifies the above analysis. I met her in the waiting room, when she visited the clinic for appointment with Dr Erdem, the obstetrician. After her NST was over, I learned that she had experienced miscarriages before, and asked her if we could arrange an

interview outside of the clinic. Luckily, she needed to wait for her husband to pick her up from the hospital. Meanwhile, she agreed to tell me her story at the cafeteria which is one floor above the delivery room.

Melike is a twenty-seven-year old, young-looking woman. She has been married for three years, has a two-year-old son and was thirty-six weeks pregnant with a baby girl during the interview. Because she has never been occupied with any profession, the main source of the household income is her husband's employment. Before she gave birth to her son, she had experienced two miscarriages, in which one of them resulted in spontaneous abortion.

Her first pregnancy was a normal pregnancy and lost by haemorrhage. Because she wasn't aware of her first pregnancy until the haemorrhage starts, she thought that it was menstruation bleeding. Soon after she goes to the hospital, and finds out that she was pregnant, and that she was having a miscarriage. Because her first miscarriage is completed without a medical intervention, she considers it as the smooth, and easy one: "I didn't have any trouble during the first miscarriage, it went by itself. I went to the doctor when I started to bleed. Doctor said it had gone by the menstruation blood. It was too small anyway; I didn't feel it".

However, her second pregnancy was ectopic, and it was terminated by abortion. In the beginning, I asked her about both her miscarriages, what she had been through, and how she felt afterwards. Throughout the interview, she mainly focused on telling her ectopic pregnancy and the difficulties she encountered in the hospital during the miscarriage. Because Melike's story was quite comprehensive and had many similarities with women's experiences that I discussed in the previous sections, I want to share her story in detail. Below, I quoted at length a portion of my interview with her:

> **Melike:** "I had an ectopic pregnancy. I started bleeding and went to a small private clinic. They didn't examine me. I left there and went to a state hospital, but I was not hospitalized there because of the over-crowdedness. Then, I went to another state hospital where they treated me like I am a cadaver *(kadavra).* I mean, I am lying on

the bed in the middle. Everyone comes and goes, and they do nothing basically. They just look and go. No [medical] intervention, no attendings [physician], they only have juniors [doctor]. I got angry and told them to let me go. Finally, we went to the oldest gynaecological hospital of Istanbul. There, I had an [spontaneous] abortion. You know, it is a very frustrating process." [26]
**Q:** And, you got pregnant to your son after these?
**M:** "No. Actually, my pregnancy level didn't go down for a while. Even though I had the abortion. Very interesting. So, I kept having blood tests every day until my pregnancy level goes down to zero. Lastly, I gave blood to check my genetics. I mean, after having two miscarriages, I wanted to know whether there is something wrong with my genetics… And one of my levels [blood] was disordered *(bozuk)*, which was commonly encountered in many women; a blood clot which results from low B12 level. Apparently, I have it [low B12] in my genetics." [27]
**Q:** The tests were applied to see if you have a specific problem?
**M:** "Yes, exactly. If you have blood clot for instance, the baby cannot reach to the uterus, then you have a miscarriage. Before I took the results of the test, I found that I was pregnant to my son. So, doctors told me to use Clexane 4000, the blood thinner injection, throughout my pregnancy. Additionally, I used Coraspin 100, another blood thinner medication. But, in the first trimester of my son, I had another haemorrhage in the placenta. Later I found out that using two medications causes bleeding and is unnecessary." [28]

Similar to other women in the previous sections, Melike is frustrated by the hospital personnel who don't pay the necessary medical attention to her pregnancy. She visits several hospitals until she receives reasonable explanation regarding her pregnancy and the medical care. Moreover, having two miscarriages in a row leads Melike to question her genetics and to have blood test that would check her genetics. As a result of the test, doctors tell her that because her B12 level is "incompetent", her body creates a blood clot which prevents her from carrying the pregnancy to term. Although Melike learns that her situation can widely be seen in many other pregnant women, she considers her genetics as "disordered", after having diagnosed by the doctors. Such a description attributes blame to Melike's body, which makes her believe that her body is at fault and needed to be regulated by medications. With this anxiety in her mind, upon doctors' prescription, she uses two medications at once, which causes overmedication in her body.

Another part that surprised me in Melike's story was the way that she believes how medication can be powerful in treating her reproduction capability. After she told me the

medications she used for her pregnancy, I became more interested in how medicines informed her mindset about her pregnancy. I asked her opinion about why doctors prescribed that much medication, she responded:

> **Melike:** I guess, to guarantee that baby wouldn't be lost again. Later, doctors who works at another hospital told me to use Folic acid only for nine months and to quit the injections. So, I quitted taking injections, used Folic acid for the rest of my pregnancy, and gave birth to my son. Right now, I continue using folic acid for my daughter. Soon I will have her with the God willing *(inşallah).* [29]
> **Q:** Do you think that your pregnancies are succeeded because of these medications?
> **M:** Well, I don't know that. I do not think about it that much. I am not a pro-medication *(ilaç taraftarı)* person. Still, after having these difficult experiences, and the miscarriages, you start thinking like 'I have to use it, what if something happens to my baby again?" [30]

Considering the frustrating process that Melike faced during her miscarriages, one can conclude that she didn't want to risk her pregnancies. Therefore, she took medications without questioning what their effects really were on her body. Although she isn't really sure if it was for the injections that carried her pregnancy to term, and she doesn't enjoy using drugs, she uses them for her second pregnancy as well.

In another day in the delivery room, I had a similar interview Nevra. I first met with her in the NST room. Nevra, thirty-year-old woman who is a mother of one daughter, thirty-six weeks pregnant with a baby girl and had two miscarriages before having the first child. In the first trimester of her first pregnancy, Nevra learns about her pregnancy loss during the ultrasound examination, and the doctor tells her that the heartbeat stopped. Nevra was telling about her miscarriage experience and expressed her annoyance at how she was treated by the doctor:

> **Nevra:** "The doctor at the private clinic did not give me any convincing information, the only thing she said was that "your baby is gone". I just could not figure out what was going on. Nobody told me anything about the abortion. I left that hospital and went to another place and had my abortion there. Later, during my second miscarriage, they [medical staff] told me that it was too small, and to wait until it is completed by itself. And it did. But, after the second miscarriage, I had my blood levels checked. But the private clinic asked for 1500 TL to test my and my husband's blood levels. At that time, I learned that state hospitals can also proceed with this blood test after the second miscarriage for free." [31]

**Q:** State hospitals can test you after the miscarriage?
**N:** "Yes. I mean, if you experienced miscarriages two times in a row, state hospitals can do a research. They check your blood levels. So, I had my test results there, turns out that I have blood clot. At the same time, I found out that I was pregnant. They told me that I must start using blood injection immediately, that the first trimester was crucial. Because, I mean, if the heartbeat stops, it could happen in the first trimester. So, I started using Clexane 4000 immediately. I used it for over six months. Thank God *(çok şükür)* my daughter was born in perfect health. For this one [showing her belly], the doctor told me that I have blood clot around the sac [gestational]. So, I am still using the injection right now." [32]
**Q:** Do you think that your pregnancies are succeeded thanks to the injection?
**N:** "Yes, I think so. That's why I'm using it right now. And if I ever get pregnant again, I will be using it again. Because I have this problem [blood clot] genetically. Doctor confirmed it as well". [33]

Similar to the previous account, having two miscarriages leads Nevra to have her body checked, and to see whether she has a specific problem which would prevent her from becoming a mother. With this concern, she has her blood levels examined in the state hospital. As a result of these, Nevra set her hopes on fertility medication, and she states that, unquestionably, she would always use medications if she ever gets pregnant.

In her cultural analysis of reproduction, Martin (2001, 45) explains that the modern society has this fear of "lack of reproduction, disused factory, failed business". Therefore, medical textbooks use terms like "degenerate, weak" when they are depicting menstruation and menopause as a failure of reproduction. Similar to what Martin pointed out, both Melike and Nevra had the anxiety of lack reproduction, emphasizing their incompetent blood values.

In this chapter, I analysed women's narratives of pregnancy losses, and focus on their strategies to cope with this process, their feelings throughout the process, and their relations with their body during post-pregnancy loss period. Their narratives elicited women's perspectives on motherhood, reproduction; and how medical professionals act during this process. Most of the women are frustrated by insufficient medical attention and unconvincing explanation of the medical personnel. While some of the women manage this process by

reporting their faulty actions that triggered the miscarriage, others find comfort in using medicines which regulate the flaws in their bodies.

# CHAPTER V:
# CONCLUSION

My aim in this thesis has been to show the local story of pregnancy loss experience in Turkey, where the notions of family, motherhood, fertility, reproductivity is praised, whereas the induced pregnancy loss are frequently condemned by the political figures. In order to understand the factors that inform women's experiences, I analysed the social and political actors who contribute to this process.

After the introduction, in the second chapter I focused on the political aspect of reproduction in Turkey. In the first section of this chapter, by deploying from a Foucauldian framework, I discussed how pronatalist understanding in global scale gave rise to population control in Ottoman state, and how state actors began to get involved into reproductivity-related matters. Along with the dissemination of pronatalist understanding in global scale, the population became a salient instrument to gain power for the Ottoman state. Therefore, the state decided to manage population in two ways. First, they medicalized the reproduction via health and education institutions. Opening of The School of Medicine *(Mekteb-i Tıbbiye)* in 1839 was the initial step to monitor reproduction, specifically focusing on childbirth, pregnancy, induced-miscarriages. Through this system, reproductivity-related issues began to be run by the professional doctors. In this way, state was able to restrict the local health activities, such as the treatments of local healers, pharmacists or midwives.

Second state initiative was transferring reproductivity issues into the legal sphere. Prohibiting induced miscarriages by the legal edicts and exercising legal sanctions for those who gets abortion was another way of monitoring reproductivity-related activities. With the

help of Balsoy's analysis on Ottoman population policies, I showed how political actors began to be involved into reproduction activities in Turkish society.

During the Republican period, the politicians continued to evaluate large population as a power resource and encouraged people for multiple births. Through the secondary resources, I elaborated population policies and legal amendments regarding abortion and termination of pregnancy during the Republican era. Additionally, to show how pronatalism disseminated into the cultural and social realm, I presented some of the famous quotations by the intellectuals of that period. I also showed how population policymaking had changed towards the end of the Republican era, that how state retreated from pronatalism, and legalized abortion.

In the last section of the second chapter, to show how pronatalist political approach has revived in contemporary Turkey, I presented anti-abortion discourses of JDP politicians, which I collected from online newspaper channels. The pronatalist discourses started with Erdoğan's "at-least-three-children" statement and were followed by other JDP politicians. Through the analysis of pronatalist discourses from different media resources, I showed how the concepts of childbirth, motherhood, family, were promoted regularly, whereas the induced abortion was condemned frequently. As a result of these developments in the political realm, I argued that having a pregnancy loss is perceived as an irregular, extraordinary incident, which led women to refrain from talking this experience explicitly.

In the third chapter, I presented the data that I gathered through the fieldwork in a private clinic of Istanbul. Here, my main focus has been the approach of health professionals towards voluntary abortion in Turkey. The existing research on abortion showed that the abortion care is rarely provided in Turkish hospitals. Through an analysis of a local medical site, I showed how the attitudes of delivery midwives and obstetricians towards abortion were in the clinic, and how moral values of the obstetrician impact on abortion practices. Alongside the overall

scarcity of abortion care countrywide, the obstetricians in the delivery room where I conducted my research were regularly practicing abortion. However, both delivery midwives and obstetricians manifested their own prejudices towards voluntary abortion in different ways. The interviews I presented revealed that the delivery midwives who witness women's pregnancy loss experiences from the first-hand stand against voluntary abortion, regardless of why it is demanded. Delivery midwives kept disapproving for those who terminate their pregnancy voluntarily and held responsible only women for having unprotected intercourse. Additionally, even though obstetricians practice abortion in accordance with the law, they discriminated women, based on the abortion type that is requested, and women's marital or economic status. For instance, the price paid by the single women for voluntary abortion is higher than the price that married women pay. Moreover, although both abortions are medically identical, obstetricians request two times higher price for voluntary abortion than the spontaneous abortion. This showed that the obstetricians also consider the motivations behind abortion. Therefore, obstetricians discriminated women by showing more tolerant for those who are married with kids, compare to the single women with no children.

Following this, the fourth chapter focused on women's narratives. In this chapter, I presented the interviews that I had with eight women who experienced pregnancy losses in different ways. Throughout the chapter, I discussed three themes that emerged from the interviews. The first common theme was women's distrust to doctors' diagnosis and disbelieving that they were having a miscarriage. Most of the time, because women did not believe that they had miscarried in the first place, they visited several hospitals and felt the need of hearing same diagnosis from other doctors. Moreover, women frequently reported that they were annoyed by the negligent attitude of the health personnel in the hospitals during this process. In most cases, medical personnel didn't examine women who were having haemorrhage, or they didn't provide any medical treatment.

Second theme that emerged from the interviews was women's self-blame for having a pregnancy loss. Three women that I interviewed indicated that the miscarriages they had were triggered by external actions, rather than biologic causes. According to them, miscarriages were avoidable to a certain extent, which made women to feel partial responsibility for not preventing the miscarriage. Women kept statinf the faulty actions they made during the miscarriage process, and the ways of avoiding miscarriages. As a result of these discussions, borrowing Kilshaw's (2017) language, I argued that women's self-blame or bearing responsibility, stems from willingness to control over their body and reproduction capability. By proposing ways of avoiding miscarriage, women reduce the unexpected circumstances during their pregnancy, and make their future pregnancy more predictable.

The last section of the fourth chapter focused on two cases. Here, I underlined how Melike and Nevra, two women who experienced miscarriages in a row, unquestionably believed in power of medicines in treating their reproduction capability. In Melike's case, after doctors had diagnosed her, she felt incompetency in her body. This situation led her to overmedicate herself, in order to overcome the issue that prevents her becoming a mother. Similarly, Nevra believed that it was the medicines that enabled her to become a mother and stated that she would always use medicine for her future pregnancy. These cases showed how both women perceived the notions of motherhood and family, and how these concepts are meaningful in their lives.

This thesis provided analysis on voluntary and involuntary pregnancy loss in Turkey, the political and medical actors involved into the process, and how their involvement inform women's experiences. Even though pregnancy loss is a common incident, the fact that women avoid speaking about their pregnancy loss experiences led me to investigate the complexities behind this process. While I consider political figures as visible actors, obstetricians and delivery midwives appear as other powerful actors that implicitly informs the pregnancy loss

process. Indeed, both political and medical actors have impact on women's relations with this process and their bodies. Further research is necessary for making comprehensive analysis to unfold the complexity of the relations between the state, obstetricians, women and women's partners. Therefore, inclusion of other actors such as state hospital obstetricians, women who get voluntary abortion, and women's male partners is suggested for further research.

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## APPENDIX:
## ORIGINAL QUOTES

[1] Bize isteğe bağlı kürtaj olmaya gelenler geliyor. Bazen çok geliyorlar bazen hiç gelen olmuyor. Genelde kışın çok geliyorlar. Yazın hamile kalıp kışın aldırmaya çok gelenler oluyor. (...) Tabi bizim fiyatlar diğer yerlere göre uygun. O yüzden buraya çok geliyorlar.

[2] Devlet hastaneleri isteğe bağlı kürtajı hiç yapmıyorlar zaten. Zorunluyu da yapmak istemiyor çünkü anestezi çok zaman aluyor. Lokal anestezi isterseniz olur diyorlar ama o da ağrılı diye istemiyor kadınlar. Çekilemeyecek bir ağrı değil ama yine ağrılı.

[3] Kurum kararıyla yapmıyorlardı. Ahlaki bulmuyorlardı müdahaleyi. Müdahaleyi öyle her özel hastane de yapmıyor zaten. Ben daha önce üç hastanede çalıştım. Hepsi özeldi. Hiç biri yapmıyordu. Tabi hepsi İslamı kurumlardı.

[4] Hastayı devlete ya da müdahale yapan farklı bir kuruma yönlendiriyorduk.

[5] Bence zaten kürtajın vicdani yükü çok fazla, ben olsam ben de yapmam. Küçücük canlıyı öldürüyorsun, bunun vicdani yükünü üstlenemem mesela ben doktor olsam.

[6] İstemiyorsa korunsun. Kürtaj doğum kontrol yöntemi değil ki. Burada bile doktor çok tercih etmiyor yapmayı. E tabi, riskli bir şey çünkü. Yani bir sürü komplikasyonlara sebep olabilir. İleride çocuk sahibi olmayabilir.

[7] Bazen bencillikten istemiyorlar. Bizle çok konuşmaz hastalar, genelde doktora anlatırlar. Bazen çocuğu kadın istiyor, koca istemiyor. Bazen ameliyattan çıkınca pişman olduklarını söylüyorlar, narkozun etkisiyle heralde. Bazen hem kadın hem erkek istemiyor. Bazen de evli ama başkasından çocuğu olan kadınlar var diye duyuyoruz, ondan aldırıyorlar.

[8] Yani ben anlamıyorum kadınlar neden korunmuyor. Bebek istemiyorsa önlemini alsın. Bir sürü korunma yöntemi var. Burda doktorlar 5 dakikalık zevk için her gün cinayet işliyor içerde.

[9] Buraya gelen kızların tabi uçkur yerlerde. Açmış bacaklarını zamanında, bir daha kapanmıyor, namus filan da gitmiş tabi. Hiç ahlak filan kalmamış yapıyor çocuğu geliyor buraya aldırmaya.

[10] Kürtaja gelenler oluyor evet. Ücretlendirme burda daha farklı oluyor durumlarına göre. Mesela evliyse kürtajdan daha düşük ücret alınıyor. Bekarsa biraz daha yüksek. Bazı özel durumlar da oluyor tabi ki, doktora durumunu anlatınca ona göre indirim yapıyor doktor. Mesela bir kadın vardı, kocasından sürekli şiddet gören biri, dayak var ve kocasının zoruyla hamile kalmış. O durumda doktora durumunu anlattı, ondan farklı ücret alındı.

[11] Öyle tabi canım. Bak mesela bu sabah gördüğün bekar kadından 1850 TL aldı doktor. Ama öyle evliyse, kalbi durdu filan diye alıyorsa işte 800 - 900 civarı bir şey alıyor.

[12] Normal düşüğü SGK karşılıyor. Diğeri tamamen keyfi. Yani hastane ve SGK en azından bunu öyle kabul ediyor. Her türlü lüks. İsterse devam ettirir çünkü hamileliği. O yüzden diğerini karşılamıyor.

[13] Benim bildiğim isteğe bağlı'da 1000 TL kurumun belirlediği zaten. Ama bebek ölmüşse ücreti farklı. O zaman 600-800 civarı bir şey. Doktoun kendi insiyatifiyle olan bir şey bu. Yani mesela kalbi durmuşsa ama kanaması durmamışsa içeride parça kalmış demektir. O zaman o alınmalı. Doktor da kolaylık sağlamış oluyor.

[14] Yok, sanmıyorum bekarlar için. Yani mesela evli, 4-5 tane çocuğu var, bakacak gücüm yok diye anlatıyor doktora, o zaman indirim oluyor mesela. Ama bekarsa, bakıyor ödeyebilecek gibi, o zaman yüksek söylüyor.

[15] Niye ikisi farklı diye düşünüyor biliyor musun? Zaten bekarsa ve korunmadan seks yapmışsa sorumluluğunu alsın diye düşünüyor. Kendi başının çaresine baksın diyor yani. [...] Aslında aynı durum evli olsa da bu durum aynı. Onlar da korunmadan seks yapabilirler ama öyle düşünüyor işte doktorlar.

[16] Hamilelik güzeldi. Bebeğin üç ay sonra kalbi durdu. Önce minik bir kanamam oldu. Doktora gittim ve kalbi durmuş dedi. İnanmadım. Başka bir hastaneye gittim. Orda da aynı şeyi söylediler. Ben yine inanmadım ve başka bir hastaneye gittim orda da kalbi durmuş dediler. O gün, gece 12'ye kadar hastane hastane gezerek bununla uğraştım. Ertesi gün kendi doktoruma gittim. Bu, benim hamileliğim boyunca benimle ilgilenmiş, beni bilen doktora. Bana, "Handan'cığım yapacak bir şey yok, dedi. Kalbi durmuş, kanaman olunca gel alalım tamamen bebeği" dedi. Çok zor süreçlerden geçtim. Tabi insan çok bağlanıyor, ümitleniyor çocuğa. Ama tabi benim yaşım da var biraz. O durumu zorlaştırıyor.

[17] Yani tabi biraz hüsran oldu benim için. İlk ben inanamadım zaten düşük yaptığıma. Dört tane hastane gezdim. Devlet hastanesine gittim önce, düşük başlamış, dediler. Sonra başka bir devlet hastanesine gittim, ikinci gittiğim yer beni muayene bile etmedi. "Bir hafta sonra düşük kesinleşince gel" dediler. Sonra ordan da çıkıp başka yere geçtik. Orda benim kanamam varken önce hamilelik testi yaptılar hamilelikten emin olmak için. O sonucu bekledik, sonra kan testi yapıldı üstüne iki saat daha bekledik.

[18] Evet evet, bu süre boyunca hep kanıyorum ben yani. En sonunda başka bir devlet hastanesine tanıdık vasıtasıyla gidince doktor karşıma geçip bana rakamlarla durumu izah etti. Bana önce "Bak senin hamilelik seviyen 1500 müş, şimdi 800 e düşmüş" diyerek rakamlarla açıkladı düşük yaptığımı. O böyle açıklayınca ben inanabildim. Onun dışında hiç bir yer ilaç vermedi bana, ya da hiç bir açıklama yapmadı.

[19] Hayır olmadım. Doktor sordu bana, istersen ben bölgeyi temizleyebilirim ya da istersen ilaç verebilirim kendisi düşer, dedi. Ben ilacı tercih ettim. Yani açıkçası devlet hastanelerindeki o şüphe yüzünden ameliyat olamazdım. En sonunda "Eğer bu düşük şu anda gerçekten gerçekleşiyorsa ameliyatla müdahaleyle filan olmasın, kendi kendine olsun" dedim.

[20] Benim ilk gebeliğimdi. Ben doktora kontrole gitmiştim, ultrasona. Doktor orda baktı "Kalbi durmuş" dedi. Ben inanamadım. Doktor alttan da muayene etti, "Başka yerlere de sorun isterseniz" dedi, kafamda şüphe kalmasın diye. Ben çünkü inanmak istemedim en başta. Yani tabi bir de ilk hamilelik, insan tam bilemiyor. Sonra ben başka hastaneye gittim, orda da aynı şeyi söylediler. Sonra orda kürtaj oldum. Doktor antibiyotik verdi, enfeksiyon riskine karşı.

[21] Bak şöyle anlatayım (eline çatal ve bıçak alıyor ikisini birleştiriyor); şimdi bu şekli yumurtalık gibi düşün ellerim yumurtalar; çatal ve bıçak da yol olsun. Şimdi döllenmiş yumurta bu yoldan geçerek tam ortaya yani rahme ulaşması gerekiyor. Benim vakada döllenmiş yumurta rahme ulaşmış ama embriyo sağlıksız diye rahim onu tutmamış diye anlattı doktor. Kimyasal gebelik bu oluyor yani. Kimyasalda kürtaj olmuyorsun. Regl kanıyla birlikte atılıyor.

[22] Evet, yani o gün benim adet günümdü aslında. Ama ben daha önceden hamile olduğumu öğrenmiş olduğumdan o kanamadan şüphelenmiştim. Yani benim hatam, hastaneye gitmiyordum uzak diye. Bana yakın bir muayenehane vardı. Orda çok bilgili ve sevdiğim bir doktor vardı, ona gidiyordum. Orası hastane olmadığı için tabi müdahale yapamadılar. Progesteron iğnesi var belki onu yapsalardı olabilirdi. Çok vakit kaybettik tabi. Yani kanama başlasın, o haliyle hastaneye git, hamilelik değerine bakılsın, o sırada kanama devam etsin derken tabi artık düşük gerçekleşmişti yani.

[23] Benimkisi stresten oldu. Çok etkiliyor hamile kadını. Bak güzelim, benden sana abla tavsiyesi, sen de ilerde bir gün hamile kalırsan sakın hiçbir yerdeki olumsuzluğu dinleme. Duyma insanları. Eşinle yaşadığın tartışmayı filan boşver. Git bir yerde kahve iç, alışveriş yapmaya git. Durma o ortamda. Çünkü her şeyi kadın çekiyor. Narkozu o alıyor. Bedenine ameliyatı o oluyor. Kolay değil bunlar. Erkeğe bir şey olmuyor ki. O sadece bekliyor yanında. Olan senin bedenine oluyor.

[24] O suni sancıdan sonra ben hemen tuvalete koştum. Tuvalet sandım ilk. Ama değildi, bebekmiş. Elime düştü bebek. Ben daha ne olduğunu anlamadan vakum vermeye başladılar, içerde herhangi bir parça kalmışsa belki diye. Bana hiçbir şey anlatmadılar. Sonrasında da ne bir ilaç, ne bir test, ne patoloji raporu... hiçbir bilgi vermediler neler olduğuna dair.

[25] Yani bir sebebi yok, ama şöyle; ben tiroid hastasıydım. Hamile kaldığımda tiroidim birden çok arttı, onu düşürmek için ilaç verdiler bana. Sonra bir de kulağımda bir apse çıkmıştı, onun için de antibiyotik kullanmıştım. Sonra dedik heralde bütün ilaçlar bir araya gelince böyle bir şey oldu.

[26] Ben dış gebelik geçirdim. Kanamam başladı. Ben ilk öğrendiğimde özele gitmiştim. Orda "Buna müdahale etmiyoruz" dediler. Tıp merkeziydi orası. "Devlete git" dediler, gittik. Orası da çok yoğun olduğu için yatışım yapılamadı. Sonra başka bir devlet hastanesine gittik oradan çıkıp. Orda da bana kadavraymışım gibi davrandılar. Ben yatıyorum ortada, gelen bakıyor giden bakıyor. Müdahale yapmıyorlar, uzman doktor yok zaten. Asistan geliyor sürekli. Dayanamadım artık ve "Benim çıkışımı verin" dedim. Ordan çıktık ve en eski kadın-doğum hastanesine geçtik. Orda kürtaj oldum işte. Yani yıpratıcı bir süreçti gerçekten. Hem duygusal olarak yıpranıyosun hem de fiziksel olarak..

– Sonra oğluna mı hamile kaldın?

[27] Yok, işte bundan sonra benim hamilelik değerim düşmedi. Yani kürtaj olmama rağmen düşmemişti, çok ilginç. Ben de her gün kan vermeye gittim işte. Hamilelik değerim sıfırlanıncaya kadar kan verdim. En son genetik kanı verdim. Hani, genetiğimde problem mi var acaba iki düşükten sonra diye.. Bir değerim bozuk çıktı, o da her kadında rastlanabiliyormuş. B12 eksikliğinden kaynaklanan bir kan pıhtılaşması. Benim genetiğimde de varmış o.

– Bu testler "sende bir sorun var mı" düşüncesiyle yapılıyor değil mi?

[28] Evet aynen. Kan pıhtılaşmasından dolayı bebek bazen yerleşemiyomuş, düşük oluyomuş filan. Biz de bunu öğrenmek için yaptık. Öyle bi sıkıtımız olmadı, o kanı verdik, sonucu almaya yakınken de oğluma hamile kaldığımı öğrendim. İşte özel hastane oğluma hamileyken bu değerim bozuk diye bana Clexan 4000 verdi, kan sulandırıcı iğne. Bir de tabi ben Coraspin kullanıyordum. O ikisi bende üçüncü ayımda kanama yaptı plesentada. Benim o tedaviyi uygulamamam gerekiyormuş yani, iki ilaç birden fazlaydı yani.

[29] Yani, işlerini biraz garantiye almak için. Bebek düşmemesi için. Sonra başka hastanedeki doktor bana "Senin sadece Folikasit'i 9 ay boyunca kullanman gerekiyor. Seni bir değerin bozuk hepsi bozuk değil, bu yüzden Folikasit kullan sadece " dedi. Ben de zaten iğneyi hemen kestim oğlum için üç ay sonra. Coraspin'i de kestim. Folikasitle devam ettim. Oğlumun doğumu gerçekleşti işte. Bunda da yine kızımda da Folikasit kullanıyorum. İnşallah onun doğumu da gerçekleşecek yakında.

– Peki sence Folik asit kullandığın için mi gerçekleşiyor hamilelik?

[30] Bilmiyorum ya. Onu çok düşünmedim hakikaten. Çok düzenli ilaç kullanma taraftarı bir insan değilim. Ama yine de işte böyle kötü tecrübeler yaşadığım için beynen "kullanmam gerek", "bebeğe bir şey olursa" korkusu yaşıyosun düşüklerden sonra.

[31] Bana ikna edici bilgiler vermedi özel'deki doktor. Tek söylediği "bebek ölmüş" oldu. Hiç anlamadım neler olduğunu yani. Kimse bana kürtaj filan da demedi. Başka hastaneye geçtim, orda oldum kürtajı. İkincisinde de bana "çok küçük, kendi kendine düşmesini bekle" dedi. Düştü de. Ama ikinci düşükten sonra ben kan testi oldum. Özel benden 1500 TL istedi, ben ve kocam için ayrı ayrı. Sonra devlete gittim, orda da ikinci düşükten sonra yapılıyormuş bu test.

– Devlet'de ikinci düşükten sonra kan testi mi yapılıyor?

[32] Evet. Devlet araştırma yapıyor peşpeşe iki düşükten sonra. Kan değerlerine bakıyorlar. Ben de işte bu testi oldum. Sonuçlarda öğrendim ki bende kan pıhtısı varmış. Bir de tabi hamile

olduğumu öğrendim sonuçla birlikte. Bana “Hemen iğne kullanman lazım dediler”. İlk üç ay çok önemliydi. Çünkü yani eğer kalp durursa ilk üç ayda duruyor biliyosun. Clexane 4000 kullanmaya başladım hemen. Altı ay boyunca kullandım. Çok şükür kızım sağlıklı doğdu. Bunda [gebelik] da doktor, kesede kan pıhtısı var, dedi. Ben de hala kullanıyorum.

[33] Evet bence öyle. O yüzden şimdi de kullanıyorum. Yine hamile kalsam yine kullanırım. Bende genetik olarak varmış bu kan pıhtısı. Buradaki doktor da öyle söyledi zaten.