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## Individual-Level Abortion Stigma and Affecting Factors in Women with Abortion Experience

Kürtaj Deneyimi Olan Kadınlarda Bireysel Düzeyde Kürtaj Damgalanması ve Etkileyen Faktörler

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### ABSTRACT

**Introduction:** Women may decide to have an abortion for various reasons such as not wanting a child, maternal/fetal health problems, age, financial difficulties, family or partner pressure and lack of social support. Therefore, many women face psychological problems as a result of the individual-level abortion stigma they experience for sociodemographic and cultural reasons. Measuring individual-level abortion stigma is important in terms of preventing individual stigma and the health problems it may cause.

**Objective:** This study aims to determine the individual-level abortion stigma and the factors affecting this situation in women with abortion experience.

**Method:** The population of this cross-sectional study consisted of women who applied to the gynaecology and obstetrics outpatient clinic of a hospital. The sample consisted of 127 participants who met the inclusion criteria and agreed to participate in the study. Data were collected using Personal Information Form and Individual Level Abortion Stigma Scale.

**Results:** In the study, 77.2% of the participants were between the ages of 18-35, 89.0% had at least one living child, and 92.9% had 3 or less abortions. Among women, 95.3% of abortions were for medical reasons and 89.3% of these were due to fetal indication. The mean score of the Individual Level Stigma in Abortion Scale was  $1.61 \pm 0.57$ . There was no significant relationship between socio-demographic and obstetric characteristics and scale score ( $p > 0.05$ ).

**Conclusion:** The individual-level abortion stigma was found to be at a moderate level in women with abortion experience. Individual-level abortion stigma was found to be independent of individual and environmental factors.

**Keywords:** Abortion, Abortion Stigma, Individual Stigma.

### ÖZET

**Giriş:** Kadınlar çocuk istememe, anne/fetüs sağlığı sorunları, yaş, maddi zorluklar, aile veya eş baskısı ve sosyal destek eksikliği gibi çeşitli nedenlerle kürtaj yaptırmaya karar verebilmektedir. Dolayısıyla birçok kadın sosyodemografik ve kültürel nedenlerle yaşadıkları bireysel düzeydeki kürtaj damgalanması sonucunda psikolojik sorunlarla karşılaşmaktadır. Bireysel düzeydeki kürtaj damgalanmasının ölçülmesi, bireysel damgalanmanın ve yol açabileceği sağlık sorunlarının önlenmesi açısından önemlidir.

**Amaç:** Bu çalışma, kürtaj deneyimi olan kadınlarda bireysel düzeyde kürtaj damgalanmasını ve bu durumu etkileyen faktörleri belirlemeyi amaçlamaktadır.

**Yöntem:** Bu kesitsel çalışmanın evrenini bir hastanenin kadın hastalıkları ve doğum polikliniğine başvuran kadınlar oluşturmuştur. Örneklem, dahil edilme kriterlerini karşılayan ve çalışmaya katılmayı kabul eden 127 katılımcıdan oluşmuştur. Veriler Kişisel Bilgi Formu ve Bireysel Düzeyde Kürtaj Damgalanma Ölçeği kullanılarak toplanmıştır.

**Bulgular:** Çalışmada katılımcıların %77,2'si 18-35 yaş aralığında, %89,0'ı yaşayan en az bir çocuğa sahip ve %92,9'u 3 veya daha az kürtaj yaptırmış. Kadınların %95,3'ü tıbbi nedenlerle kürtaj yaptırmış ve bunların %89,3'ü fetal endikasyon nedeniyle gerçekleşmiştir. Kürtajda Bireysel Düzeyde Damgalanma Ölçeği puan ortalaması  $1,61 \pm 0,57$ 'dir. Sosyo-demografik ve obstetrik özellikler ile ölçek puanı arasında anlamlı bir ilişki bulunmamıştır ( $p > 0,05$ ).

**Sonuç:** Kürtaj deneyimi olan kadınlarda bireysel düzeydeki kürtaj damgalanmasının orta düzeyde olduğu bulunmuştur. Bireysel düzeydeki kürtaj damgalanmasının bireysel ve çevresel faktörlerden bağımsız olduğu bulunmuştur.

**Anahtar Kelimeler:** Kürtaj, Kürtaj Damgalanması, Bireysel Damgalanma.

### INTRODUCTION

Abortion is defined as the process of termination of pregnancy due to the woman's own will or a maternal/fetal medical necessity (1). According to World Health Organisation data, approximately 73 million elective abortions occur worldwide every year. 61% of unwanted pregnancies and 29% of all pregnancies result in elective abortion (2). According to Turkey Demographic and Health Survey 2018

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data, the level of abortion on demand in Turkey is 5.6% (3). Women are more likely to have abortions for individual and socio-cultural reasons such as not wanting children, financial difficulties (4), age (very young or advanced age), family or partner pressure, lack of social support, lack of readiness to become a mother (5), medical reasons related to fetal (6, 7), and maternal (5, 8, 9) health problems. Many women experience various types and levels of stigmatisation as a result of these decisions (10).

The term 'abortion stigma' is used to describe the negative attitudes and beliefs held by some people towards women who have undergone or are considering an abortion. These attitudes are often expressed in ways that mark women as inferior to the ideals of femininity (1). Women who have abortions are exposed to abortion stigma by their husbands/partners or family and social circles with different expressions such as irresponsible/careless (11). This type of stigmatisation, which also negatively affects social life, may cause women who have voluntary abortion to experience negative emotions such as loss of social status (12), being judged by family members or loved ones (13), guilt and shame (11, 14, 15). In addition, (1) women who associate the abortion experience with the rejection of the maternal role may define themselves as immoral (11) or consider themselves as sinful or evil due to their religious beliefs or cultural norms (16). All these negativities cause women who have abortion to experience individual abortion stigma (11-14, 16).

Individual abortion stigma is defined as the internalisation of perceived or experienced social stigma related to abortion, feelings of guilt or shame, or a response to other negative feelings about oneself (11, 16). Women's experience of individual stigma related to abortion varies depending on many factors such as age, education, religion/religiosity, race/ethnicity, social support resources or the time since the abortion (6, 10, 13, 14, 17, 18). Problems such as depression, post-traumatic stress disorder (6) and anxiety (19) can be seen in women who experience individual abortion stigma.

In the prevention of individual-level abortion stigma and the health problems it may cause, it is very important to measure the individual-level abortion stigma and to create social awareness by determining the factors affecting it. For this reason, the aim of this study was to determine the individual-level abortion and the factors affecting it in women with abortion experience in Şanlıurfa.

## **METHOD**

### **Type of Research**

The research is cross-sectional type.

### **Population and Sample of the Study**

The study population comprised women who had applied to the the gynaecology and obstetrics outpatient clinic of a training and research hospital. In order to calculate the sample size, a pilot study was conducted with 30 women who applied to the hospital. The standard deviation of the individual level abortion stigma scale score obtained from the pilot study was 0.63, the margin of error was 0.11, and the required number of people was calculated as 127 with a 95% confidence level. The study was conducted between September 2023 and April 2024.

*Criteria for inclusion in the sample;*

- $\geq 18$  years of age,
- Experienced an abortion within the last year and at least two weeks have passed since the abortion procedure,
- To know Turkish, and to have no communication problems related to language.

*Exclusion criteria;*

- Presence of a diagnosed psychiatric illness.

## Ethics Committee Approval

The necessary permissions were obtained from the authors of the scale, the hospital where the study was conducted, the ethics committee of the Harran University Clinical Research Ethics Committee (dated 21.08.2023 and numbered HRU/23.15.19) and the provincial health directorate. The study was conducted in accordance with the principles set forth in the Declaration of Helsinki, and informed consent was obtained from all women who participated in the study.

## Data Collection Tools

Data of the study were collected through the Personal Information Form, which was created by the researchers and included questions about the socio-demographic and obstetric characteristics of the participants, and the Individual Level Abortion Stigma Scale, using the face-to-face interview technique. The data collection forms were filled in by the literate participants themselves and by the researchers for the illiterate participants. Each interview lasted approximately 10-15 minutes.

**Personal Information Form:** It consists of a total of 11 questions, including 7 questions about the socio-demographic characteristics of the participants (age, educational status, marital status, language spoken, employment status, economic status, family type) and 4 questions about obstetric characteristics (number of living children, number of abortions/reason/time since last abortion).

**Individual Level Abortion Stigma Scale (ILASS):** It was developed by Cockrill et al to assess the individual internalised stigma perception of women with abortion experience (10). Turkish validity and reliability was performed by Çetinkaya et al (13). The Likert-type scale consists of 4 subscales and 20 items. The 8th, 9th and 10th items in the 'Isolation' subscale of the scale have a Likert-type evaluation between 0-3, and all other scale items have a Likert-type evaluation between 0-4. Scoring of the scale differs according to the subscales. The lowest-highest item score ranges that can be obtained from the total scale and its subscales are 0-3 for the 'Worries about Judgement' subscale, 0-3.5 for the 'Isolation' subscale and the 'Total Scale', and 0-4 for the 'Self-Judgement' and 'Community Condemnation' subscales. Item scores are summed and divided by the number of items, thus total scale and subscale scores are obtained. High scores obtained from the scale and subscales are evaluated as women perceiving themselves as highly stigmatised. The scoring of seven items of the scale (items 8, 9, 10, 11, 12, 13 and 15) are reversed. The Cronbach's alpha values of the scale were reported to be between 0.80-0.90 and the total scale Cronbach's alpha value was 0.88. There are no clear thresholds or cut-off points related to stigmatisation between the scale and subscales (10, 13). In this study, the Cronbach's alpha value of the scale was calculated to be 0.73.

## Statistical Analysis

The data obtained from the participants were evaluated with the statistical package programme (SPSS 24.0). The dependent variable of the study is the total score of the participants from ILASS. The independent variables of the study are socio-demographic and obstetric characteristics of the participants.

In the analysis of the data, descriptive statistics, including percentage, mean, and standard deviation were used. The Mann Whitney U (MWU) test was used for univariate analyses in the comparison of two groups (age, educational level, marital status, employment status, family type, number of abortions, reason for abortion, and reason for fetal or maternal indications). The Kruskal-Wallis One-Way ANOVA test was used in the comparison of three or more groups that do not fit a normal distribution (most spoken language at home, income level). Spearman's correlation analysis was performed for ordinal data (age, number of living children, number of abortions, and time since last abortion) in groups that did not fit the normal distribution in the relationships between dependent and independent variables. The findings were interpreted at 95% confidence interval and  $p < 0.05$  significance level.

## RESULTS

77.2% of the participants were between the ages of 18-35. 98.4% of the participants were married, 70.9% lived in a nuclear family, and 94.5% were not employed. 92.1% of the participants have completed primary education and below. 70.1% of the participants their income level as 'medium', and 78.7%

speak a language other than Turkish at home (63% Arabic, 15.7% Kurdish). The number of abortions of 92.9% of the participants was between 1-3, 95.3% of the abortions were for medical reasons, and 89.3% of these were due to fetal indications. In 70.1% of the participants, the time since the last abortion was 9-12 months (Table 1).

**Table 1.** Sociodemographic and Obstetric Characteristics and ILASS Scores of the Participant

Characterics	N	%	ILASS Score		
			Median (Min-Max)	MWU*	p
<b>Age (Years)</b>					
Between 18-35	98	77.2	1.57 (0.40 - 3.30)	1362.000	0.735
Between 36-44	29	22.8	1.45 (0.60 - 3.15)		
<b>Education level</b>					
Primary school and ↓	117	92.1	1.55 (0-3)	1362.000	0.735
Secondary education and ↑	10	7.9	1.58 (1-2)		
<b>Marital Status</b>					
Married	125	98.4	1.55 (0.40 - 3.30)	32.000	0.072
Single	2	1.6	2.47 (2.05 - 2.90)		
<b>Employment Status</b>					
Yes	7	5.5	1.60 (1.20-2.60)	351.500	0.469
No	120	94.5	1.55 (0.40 - 3.30)		
<b>Family Type</b>					
Nuclear family	90	70.9	1.55 (0.40 - 3.30)	1651.500	0.943
Extended family	37	29.1	1.55 (0.85 - 2.90)		
<b>Number of Abortions</b>					
1- 3	118	92.9	1.52 (0.40 - 3.30)	518.000	0.903
4 and ↑	9	7.1	1.60 (0.60 - 3.15)		
<b>Reason for Abortion</b>					
Induced abortion	6	4.7	2.10 (1.20 - 2.60)	195.000	0.056
Fetal or maternal indications	121	95.3	1.50 (0.40 - 3.30)		
<b>Reason for fetal or maternal indications (N=121)</b>					
Maternal	13	10.7	1.55 (0.55 - 2.90)	708.500	1.000
Fetal	108	89.3	1.47 (0.4 - 3.30)		
<b>Characterics</b>	<b>N</b>	<b>%</b>	<b>Mean Rank</b>	<b>X<sup>2**</sup></b>	<b>p</b>
<b>Most Spoken Language at Home</b>					
Turkish	27	21.3	75.78	3.656	0.161
Kurdish	20	15.7	58.08		
Arabic	80	63.0	61.51		
<b>Income Level</b>					
High	11	8.7	63.09	1.244	0.537
Medium	89	70.1	61.99		
Low	27	21.3	70.98		
<b>The Time Since the Last Abortion</b>					
1-4 months	18	14.2	68.56	0.701	0.704
5-8 months	20	15.7	67.83		

\*Mann Whitney U test, \*\*Kruskal-Wallis test.

Age (MWU= 1362.000, p= 0.735), educational levels (MWU= 1362.000, p= 0.735), marital status (MWU= 32.000, p= 0.072), employment status (MWU= 351.500, p= 0.469), family type (MWU= 1651.500, p= 0.943), number of abortions (MWU= 518.000, p= 0.903) and reason for abortion (MWU= 195.000, p= 0.056), there was no significant difference between the mean ILASS scores (p>0.05). It was determined that there was no significant difference between the mean ILASS scores of the participants in terms of the most spoken language at home (X<sup>2</sup>= 3.656, p= 0.161), income level (X<sup>2</sup>= 1.244, p= 0.537) and time since the last abortion (X<sup>2</sup>= 0.701, p= 0.704) (p>0.05) (Table 1).

The mean ILASS score of the participants was 1.61±0.57. The mean scores of the subscales of the scale are 'Worries about Judgement' 0.82±0.79, 'Isolation' 2.28±0.94, 'Self-Judgement' 1.75±1.12 and 'Community Condemnation' 1.99±1.40, respectively (Table 2).

There was no significant difference (p>0.05) between the participants' age, number of living children, number of abortions and the time since the last abortion and ILASS score (Table 3).

**Table 2.** Women's ILASS Scores

Subscales	ILASS Score	
	Mean±SD	Range
Worries about Judgment Subscale	0.82±0.79	0-3
Isolation Subscale	2.28±0.94	0-3.5
Self-judgment Subscale	1.75±1.12	0-4
Community Condemnation Subscale	1.99±1.40	0-4
<b>Scale Total Score</b>	1.61±0.57	0-3.5

**Table 3.** Correlation of Some Participants' Characteristics and ILASS Scores (N=127)

Characterics	ILASS Score		
	n	rho	p
Age (Years)	127	-.132	0.139
Number of Living Children	127	-.062	0.490
Number of Abortions	127	.045	0.616
Time since Last Abortion (Months)	127	-.059	0.510

## DISCUSSION

In this study, which investigated the individual-level abortion stigma in women with abortion experience, it was determined that women's individual-level abortion stigma was at a moderate level (1.61±0.57). The mean ILASS score (1.46±0.56) obtained by Çetinkaya et al (13) in their study in Turkey and the mean score (1.59±0.60) obtained by Belfrage et al in their study in Mexico are compatible with our study (14). Li et al reported that the individual-level abortion stigma score in women who had abortion due to fetal indication in China was at a moderate level (1.49±0.60) (7). In Germany, Hanschmidt et al reported that women who thought that the chance of survival of the fetus was low experienced lower individual-level abortion stigma than those who did not (6). The results of our study are similar to the scores reported by women who had abortion for various reasons. In the literature, it has been stated that abortions performed for fetal or maternal indications are more acceptable than abortions performed for socioeconomic reasons (20, 21). In different studies conducted in Turkey, it is also stated that abortion is more acceptable in case of maternal or fetal health problems (13, 22, 23). In this study, 95.3% of the participants had an abortion reason for fetal or maternal indications, and 89.3% of these were due to fetal indications. The results of the studies show that individual-level abortion stigma is a universal experience for women despite the reason for abortion and cultural differences.

In many recent studies, demographic characteristics such as race/ethnicity, age, education and partner support have been reported to be effective on individual-level abortion stigma (6, 10, 13, 17, 18). While studies have found that women's ILASS scores increase with age (7, 24), there are studies showing that contrary to these results, it decreases with increasing age (10, 18). In the study of Oginni et al, it was found that those with higher education had higher ILASS scores than those with primary education and below (18). In the same study, it was stated that women with higher education were more likely to express individual-level abortion stigma than other women. Hanschmidt et al reported that women with high partner support had lower individual-level abortion stigma scores (6). Similarly, Li et al reported that women who received social support had significantly lower individual-level abortion stigma scores (7). In our study, it was found that ILASS scores of women were not affected by age, education and marital status. It is thought that almost all of the women may not have been able to express individual-level abortion stigma sufficiently because they had primary education and below. In addition, it is an expected result that women in traditional and conservative societies such as Şanlıurfa experience individual-level abortion stigma regardless of their marital status. In this study, the most spoken language at home was considered as an indicator of ethnicity and the individual-level abortion stigma among women from different ethnic backgrounds was evaluated. The difference between the most spoken language at home and ILASS scores was not significant. Although the women had different ethnic backgrounds, it is thought that their individual-level abortion stigma were similar because most of them had abortions for fetal indications. Furthermore, religion may be an important common denominator between different ethnic groups. Religious beliefs about abortion may be similar among these Muslim groups, which may lead to similar individual-level abortion stigma regardless of language.

In our study, it was found that the number of living children, the number of abortions and the time since the last abortion did not affect the ILASS score. Similarly, Makleff et al. reported that the number of living children did not affect the ILASS score (24). In the study of Li et al. and Cockrill et al. it was reported that having more than one abortion did not affect the ILASS score (7, 10). In the study of Hanschmidt et al completed with 130 participants, it was reported that the time since the last abortion did not affect individual-level abortion stigma (6). In contrast to; Biggs et al., in their study with 928 participants, stated that the individual-level abortion stigma perceived in the five-year evaluations following the abortion decreased significantly as the time since the abortion increased (17). This may be due to differences in the design and locations of the studies.

### **Limitation of Study**

In the region where the study was conducted, fertility is accepted as an indicator of femininity, while the number of children is seen as a symbol of status for women and power for men. Therefore, the data collection process took a long time in this region where abortion rates are quite low.

## **CONCLUSIONS AND RECOMMENDATIONS**

In this study, it was found that the individual-level abortion stigma of women with abortion experience in Şanlıurfa was at a moderate level. It was determined that the individual-level abortion stigma in women was independent of sociodemographic and obstetric characteristics.

In order to reduce abortion stigmatisation at the individual level, it is recommended to carry out educational activities to raise awareness of the society, especially women, and to provide psycho-social support services to women who have had or are considering having an abortion. In addition, to reveal the factors that cause individual-level abortion stigma, it is recommended that qualitative or mixed-method studies be conducted in different sample groups, especially through in-depth interviews with women who prefer abortion on demand without fetal or maternal indication.

## **DESCRIPTIONS**

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