

ORIGINAL RESEARCH ARTICLE

Internalised abortion stigma among women obtaining legal abortion in Türkiye

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Abstract

The purpose of this study was to examine the degree of internalized abortion stigma among women receiving legal abortion services and to evaluate whether these stigma levels vary based on sociodemographic factors. This cross-sectional study included a population of women who had received an abortion within the six hours following the procedure at the obstetrics and gynecology clinic of a public hospital. The researchers gathered data using a Personal Information Form and an Individual Level Abortion Stigma Scale (ILASS). The participants had a mean age of 30.84 ± 6.14 years, with 55% having completed only primary school and 62% having had an abortion for reasons related to women's health. The study findings indicated no significant differences between individual perceived internalized abortion stigma scores and demographic factors such as educational level, husband's educational level, employment status, income level, number of living children, method of conception, number of abortions, and time since the last abortion. However, a weak negative correlation was observed between age and "concern about judgment." The study indicates that women's perceived and internalized abortion stigma is largely independent of their demographic characteristics, with participants expressing the highest level of concern regarding social judgment. (*Afr J Reprod Health* 2026; 30 [19]: 81-91).

Keywords: Abortion; experience; sociodemographic; stigma

Résumé

L'objectif de cette étude était d'examiner le degré de stigmatisation internalisée liée à l'avortement chez les femmes bénéficiant de services d'avortement légal et d'évaluer si ces niveaux de stigmatisation varient en fonction de facteurs sociodémographiques. Cette étude transversale a inclus des femmes ayant subi un avortement au cours des six heures suivant la procédure dans la clinique d'obstétrique et de gynécologie d'un hôpital public. Les données ont été recueillies à l'aide d'un formulaire d'informations personnelles et de l'échelle d'évaluation de la stigmatisation liée à l'avortement au niveau individuel (ILASS). L'âge moyen des participantes était de $30,84 \pm 6,14$ ans, 55 % n'ayant terminé que l'école primaire et 62 % ayant avorté pour des raisons de santé maternelle. Les résultats n'ont montré aucune différence significative entre les scores de stigmatisation et les facteurs démographiques tels que le niveau d'instruction, le statut d'emploi, le revenu, le nombre d'enfants vivants, la méthode de conception, le nombre d'avortements et le délai depuis le dernier avortement. Cependant, une faible corrélation négative a été observée entre l'âge et la « peur du jugement ». L'étude indique que la stigmatisation internalisée chez les femmes est largement indépendante de leurs caractéristiques démographiques, la condamnation communautaire suscitant le plus haut niveau d'inquiétude. (*Afr J Reprod Health* 2026; 30 [19]: 81-91).

Mots-clés Avortement; expérience; facteurs sociodémographiques; stigmatisation.

Introduction

Abortion access is acknowledged as a basic human right.¹ Although abortion is a straightforward and common medical treatment, it is safe as long as it is carried out by a qualified healthcare provider and according to the gestational age.² According to the World Health Organization, six out of 10

unintended pregnancies end in induced abortion, highlighting abortion as a common health intervention. When performed using a WHO-recommended method appropriate for the gestational age and by a qualified individual, abortion is a safe medical procedure. However, approximately 45% of all abortions worldwide remain unsafe.^{2,3} According to a Turkish study, the

rate of induced abortions was 12.2% and the rate of unwanted pregnancies was 15%.⁴ In order to reduce unwanted pregnancies and the associated risks of induced or unsafe abortions, access to effective family planning methods must be improved. According to recent global data from the World Health Organization, an estimated 164 million women of reproductive age experience an unmet need for family planning services despite the overall demand among 1.1 billion women.⁵ According to data from the Turkish Demographic and Health Survey (TDHS), the percentage of unmet family planning needs in Türkiye increased from 10% in 2003 to 16% in 2018.⁶

Only 35 out of 1,000 women between the ages of 15 and 44 worldwide are known to have access to abortion services annually.⁷ Reasons for unsafe abortions often stem from a lack of trained healthcare personnel, self-induced abortion attempts, or non-compliance with legal and medical guidelines.⁶ Unsafe abortions result in maternal death, severe medical complications, and increased healthcare costs required to treat these life-threatening complications. Despite this, approximately half of all global abortions still occur in unsafe settings.⁷ Low socioeconomic status and education, unmarried pregnancy, religious beliefs and social viewpoints, and not using a medical facility because of a lack of knowledge about abortion are some of the factors that lead to unsafe abortions.^{8,9}

Social standards also stigmatize women, which makes it difficult for them to obtain safe abortion services.¹⁰ Stigmatization is defined as the denigration or humiliation of an individual based on specific values is known as stigmatization. Individual traits like economic standing, religious beliefs, and cultural values influence stigmatization.⁹ Numerous factors contribute to the stigmatization of abortion, including the state's perspective on the procedure, the sacredness attached to motherhood, and social norms and views on women's roles.^{7,11} Access to safe abortion services is hampered by the stigmatization of abortion, discrediting, anger, regret, grief, and guilt.^{7,12} According to a qualitative study of women who had abortions outside of a medical facility, cultural obstacles, humiliation, and fear of the medical staff's attitude caused the women to have

unsafe abortions.¹³ In a different qualitative study on the emotions and experiences of women who had abortions, the women stated that they were influenced by societal opinions, that abortion was not acceptable because of their religious convictions, and that family and social support systems were inadequate during the procedure. Women's physical, emotional, social, and financial circumstances are negatively impacted by the stigmatization of abortion. Remorse, anger, despair, and psychological stress might result from the stigmatization of abortion.¹⁰ In a study involving 4,000 women, an estimated 58% of those who underwent an abortion required emotional care following the procedure.¹⁴

Legalization of abortion is crucial for lowering the stigma associated with the procedure as well as the mortality and morbidity rates associated with it.¹⁵ In South Africa, for instance, the number of maternal deaths attributable to abortion fell by 91% between 1996 and 2000 after the procedure was legalized in 1996.¹⁶ The Population Planning Law of 1983 made induced abortions lawful in Türkiye. This law permits any woman who required one to have a voluntary abortion within the first 10 weeks of pregnancy. Data from the 2013 Turkish Demographic and Health Survey (TDHS-2013) demonstrated a significant decline in the proportion of pregnancies ending in induced abortion, falling from 18% in 1993 to 5% in 2013.¹⁷ Furthermore, this survey reported that 62% of these procedures were performed in private clinics or hospitals.¹⁷ In terms of individual prevalence, the subsequent 2018 survey (TDHS-2018) revealed that approximately 15% of married women reported having had at least one elective abortion in their lifetime.⁶

Determining the stigmatization status of women who have had abortions is crucial in order to create interventions that will lessen the stigma associated with abortion. Although abortion is legally permitted in Türkiye under the 1983 Population Planning Law, societal norms, cultural expectations, and religious beliefs continue to fuel abortion-related stigma.¹⁸ However, limited empirical literature exists in Türkiye specifically addressing the individual and sociodemographic factors influencing abortion stigma among women.¹⁷ Therefore, the purpose of this study was

to evaluate the levels of perceived and internalized abortion stigma among Turkish women receiving legal abortion services, and to examine whether these stigma scores significantly differ based on their descriptive and reproductive characteristics. Research questions

1. What is the level of perceived internalized abortion stigma among women following a legal abortion?

2. Are there significant differences in the level of perceived internalized abortion stigma based on women's sociodemographic characteristics?

Method

The research is cross-sectional and descriptive. The study population comprised all women who underwent an abortion at the obstetrics and gynecology clinic of Health Sciences University Istanbul Training and Research Hospital in Istanbul, Türkiye, between January 1, 2022, and December 31, 2022. Turkish-speaking, mentally healthy women aged 18–45 who consented to participate and underwent either an elective or a medically indicated abortion at the hospital on the specified dates were included in the study. A total of 187 women presented for abortion services between the designated dates. The study eliminated seventy women who did not fit the inclusion criteria and seventeen women who declined to participate. One hundred women who volunteered to participate in the study and fit the inclusion criteria were included in the study. The women who had signed up for an abortion at the clinic were informed about the study's objectives and content. The women gave their informed consent. Within the first six hours following the procedure, the researchers at the clinic gathered the study data. Privacy was protected while the data was being collected. Each participant took about fifteen minutes on average. Based on self-reporting, the participants under observation filled out the data collection forms.

The research was designed as a cross-sectional and descriptive study. The study population comprised women who presented for abortion services at the obstetrics and gynecology clinic of a public hospital in Istanbul, Türkiye, between January 1, 2022, and December 31, 2022. During this period, a total of 187 women applied to

the clinic for an abortion procedure. The inclusion criteria for the study were: being aged between 18 and 45 years, having undergone an induced abortion (either elective or medically indicated) within the study timeframe, being literate and fluent in Turkish, having no diagnosed psychiatric illness or cognitive impairment that would impede informed consent or survey completion (verified via hospital electronic medical records and clinical assessment), and voluntarily consenting to participate. Of the 187 women evaluated, 70 did not meet the inclusion criteria and 17 declined to participate. Consequently, the final study sample consisted of 100 women who met all inclusion criteria and voluntarily agreed to participate. Prior to data collection, women were informed about the study's purpose, procedures, and voluntary nature, and written informed consent was obtained. Data were collected by the researchers within the first six hours following the procedure in a private interview room at the gynecology clinic to ensure participant privacy and confidentiality. The self-report data collection forms were completed by the participants and took approximately 15 minutes to finish.

Data collection forms

Personal information form

There are 17 questions on the form that the researchers made based on the literature. Identifying details including age, family type, education level, income level, and employment position are requested in the form's introduction. The data collection form also included questions regarding gestational age at the time of the abortion and the reasons for requesting the procedure.^{7,8,11}

Individual level abortion stigma scale (ILASS)

Cockrill et al. (2013) created the scale to measure each woman's internalized stigma perception after having an abortion.¹⁹ The scale's initial Likert-rated version, known as the "Individual Level Abortion Stigma Scale (ILASS)," had 20 items and four sub-dimensions. All other scale items have a Likert-scale score between 0 and 4, while the eighth, ninth, and tenth items in the sub-dimension of being left alone have a value between 0 and 3. The sub-

dimensions determine how the scale is scored. The sub-dimensions "Self-judgment" and "Community Condemnation" have score ranges of 0–4, the sub-dimensions "Isolation" and "Overall scale" have score ranges of 0–3.5, and the sub-dimension "Worries about judgment" has a score range of 0–3. The sum of the item values and their division by the total number of items yields the scale's and the subscales' total values. High scores on the scale and in the sub-dimensions indicate that the women believe they are heavily stigmatized. Seven items on the scale—items 8, 9, 10, 11, 12, 13, and 15—are reverse-scored. The scale's Cronbach's alpha values fall between 0.80 to 0.90, while the scale's overall Cronbach's alpha value is 0.88. Between the scale and the sub-dimensions, there are no distinct cut-off values or thresholds for stigmatization. When feasible, it has been proposed to use the scales as continuous variables.¹⁹ Çetinkaya et al. (2019) carried out the scale's validity and reliability assessment in Turkish. The scale's Cronbach's alpha values ranged from 0.83 to 0.94, and the scale's overall Cronbach's alpha value was recorded as 0.85.⁴

Ethics approval

The study was approved by the Health Sciences University Istanbul Training and Research Hospital's Clinical Ethics Committee (Date: 10/14/2022, Number: 310) and the Istanbul Provincial Health Directorate granted authorization to work there. The subjects' voluntary involvement in the study was guaranteed, and their informed consent was acquired. The Declaration of Helsinki's guiding principles were followed throughout the entire investigation.

Study variables

The dependent variable of the study was the women's score on the ILASS and its sub-dimensions (Self-judgment, Community Condemnation, Isolation, and Worries about Judgment). The independent variables included socio-demographic characteristics (age, educational level, employment status, income perception) and reproductive history characteristics (gestational age, number of living children, history

of prior abortions, and reason for abortion).

Statistical analysis

IBM SPSS Statistics for Windows, Version 22.0 (SPSS INC., Chicago, IL, USA) was used to analyze the study's data. The descriptive characteristics of the participants were summarized using frequencies and percentages, while scale scores were presented using means and standard deviations. To ascertain if the research variables were normally distributed, kurtosis and skewness values were examined (Table 2). Kurtosis and skewness values of the variables between +1.5 and -1.5 (19) and +2.0 and -2.0 (20) are recognized as normal distributions in the pertinent literature. It was discovered that the variables had a normal distribution. The data were analyzed using parametric techniques.^{20,21} The differences in scale scores across women's descriptive characteristics were evaluated using independent samples t-tests and one-way analysis of variance (ANOVA). Post hoc tests (such as Tukey) were not performed, as no statistically significant differences were detected among group means ($p > 0.05$).

The associations between the scale sub-dimension scores and continuous variables were analyzed using Pearson correlation analysis.

Results

Table 1 displays the findings for the women's descriptive characteristics. A primary school level of education was the most common educational attainment among women (55%), as well as among their spouses. All participants (100%) reported an urban area as their longest place of residence. Ninety-three percent of women lived in nuclear families, and eighty-four percent were employed. In terms of finances, 64% of women said their income was at least as much as their expenses.

Forty-five percent of them had two or more children. Regarding reproductive characteristics, 56% of the women had a history of two abortions, and 89% had a spontaneous pregnancy. The condom is the most often used family planning method (80%). Abortion was most frequently performed for the mother's health (62%). The husbands' average age was 33.45 (min: 20, max:

Table 1: Descriptive characteristics of the women

Descriptive Characteristics	N	%
Educational status		
Primary school	55	55.0
Secondary school	29	29.0
University and above	16	16.0
Spouse's educational status		
Primary school	45	45.0
Secondary school	43	43.0
University and above	12	12.0
Longest place of residence		
Rural	0	0
Urban	100	100
Working status		
Employed	84	84.0
Unemployed	16	16.0
Family type		
Nuclear family	93	93.0
Extended family	7	7.0
Family income		
Income < Expense	36	36.0
Income = Expense or Income > Expense	64	64.0
Number of living children		
0	39	39.0
1	16	16.0
2 and above	45	45.0
Conception status		
Spontaneous pregnancy	89	89.0
Infertility treatment	11	11.0
Total lifetime abortions		
1	20	20.0
2	56	56.0
3 and more	24	24.0
Family planning method		
Condom	80	80.0
Intrauterine device	17	17.0
Oral contraceptive	1	1.0
Hormonal Contraception	2	2.0
Time from last abortion		
Less than one year	47	47.0
1-3 years	25	25.0
4 years and more	28	28.0
Reason for Abortion		
Spontaneous abortion	8	8.0
Not wanting children	24	24.0
Fetal health problems	6	6.0
Maternal health problems	62	62.0
	Mean	SD
Age	30.840	6.144
Age of spouse	33.450	6.847
Gestational age at current abortion (weeks)	8.460	1.872

50), the women's average age was 30.84 (range 19,-42). The mean gestational age of the women at the time of the current abortion procedure was 8.46 weeks (range: 4–12).

Women's internalized stigma around abortion as a whole has a mean score of 0.845. Overall, women exhibited a low level of internalized abortion stigma, with a mean score of 0.845, which falls well below the theoretical midpoint of the scale (score range: 0–3.5). The sub-dimension "Worries about judgment" has a mean of 0.326, indicating a lesser level of stigmatization, whereas the sub-dimension "Isolation" has a mean of 1.157, indicating a higher level of stigmatization. The sub-dimension "Community condemnation" has the highest level of stigmatization, with a mean value of 1.550, whereas the sub-dimension "Self-judgment" has a mean value of 0.914. Overall, women scored lowest in the 'Worries about judgment' sub-dimension and highest in the 'Community condemnation' sub-dimension (Table 2).

Table 3 displays the findings of the research done to examine how individual internalized stigma in abortion scores differed by descriptive variables.

No significant difference was found between factors like educational status, husband's educational status, employment status, income status, number of living children, mode of conception, number of abortions, and time since last abortion when analyzing women's individual internalized stigma scores on abortion by demographic characteristics ($p > 0.05$). This demonstrates that the level of abortion-related stigma showed no statistically significant difference according to sociodemographic characteristics.

Age and worry about judgment were shown to have a weak negative connection ($r = -0.202$, $p = 0.044$), indicating that worry about judgment somewhat declines with age. However, no statistically significant correlations were found for gestational age or spouse's age across any of the stigma sub-dimensions ($p > 0.05$). Post hoc tests were not performed because none of the one-way ANOVA analyses showed a statistically significant overall difference among the group means (all $p > 0.05$).

Table 2: Mean scores on the individual level abortion stigma scale (N=100)

	Mean	SD	Min	Max	Min-Max	Kurtosis	Skewness	Alpha
Total score	0.845	0.499	0.100	2.050	0-3.5	0.006	0.919	0.875
Worries about judgment	0.326	0.476	0.000	1.710	0-3	1.444	1.578	0.856
Isolation	1.157	0.911	0.000	3.170	0-3.5	-0.882	0.489	0.843
Self-judgment	0.914	0.917	0.000	3.200	0-4	0.546	1.126	0.839
Community condemnation	1.550	1.347	0.000	4.000	0-4	-1.218	0.227	0.842

Table 3: Distribution of individual level abortion stigma scale scores in abortion according to descriptive characteristics

Demographic Characteristics	n	Total score Mean±SD	Worries about judgment Mean±SD	Isolation Mean±SD	Self-judgment Mean±SD	Community Condemnation Mean±SD
Educational status						
Primary school	55	0.862±0.514	0.343±0.461	1.170±0.940	0.949±0.955	1.536±1.228
Secondary school	29	0.740±0.374	0.217±0.426	1.006±0.742	0.848±0.833	1.500±1.458
University and above	16	0.975±0.624	0.464±0.589	1.385±1.080	0.913±0.982	1.688±1.601
F=		1.227	1.487	0.906	0.113	0.104
p=		0.298	0.231	0.407	0.894	0.901
Spouse's educational status						
Primary school	45	0.864±0.398	0.298±0.490	1.230±0.935	1.000±0.899	1.411±1.193
Secondary school	43	0.821±0.564	0.349±0.484	1.062±0.897	0.870±0.960	1.628±1.444
University and above	12	0.854±0.622	0.345±0.424	1.222±0.917	0.750±0.866	1.792±1.588
F=		0.085	0.132	0.403	0.435	0.499
p=		0.919	0.876	0.670	0.649	0.609
Working status						
Employed	84	0.856±0.511	0.345±0.497	1.191±0.911	0.891±0.902	1.554±1.320
Unemployed	16	0.784±0.440	0.223±0.342	0.979±0.921	1.038±1.015	1.531±1.533
t=		0.524	0.939	0.849	-0.586	0.060
p=		0.601	0.350	0.398	0.559	0.952
Family income						
Income < Expense	36	0.817±0.460	0.258±0.415	1.125±0.835	1.017±1.079	1.347±1.319
Income = Expense or Income > Expense	64	0.860±0.522	0.364±0.506	1.175±0.957	0.856±0.816	1.664±1.360

t=		-0.417	-1.068	-0.259	0.838	-1.130
p=		0.678	0.288	0.796	0.404	0.261
Number of living children						
0	39	0.778±0.521	0.289±0.458	1.030±0.848	0.882±0.947	1.474±1.487
1	16	0.831±0.492	0.268±0.349	1.042±0.924	1.063±1.016	1.594±1.158
2 and more	45	0.907±0.485	0.378±0.531	1.307±0.955	0.889±0.870	1.600±1.308
F=		0.695	0.495	1.124	0.246	0.099
p=		0.501	0.611	0.329	0.782	0.906
Conception status						
Spontaneous pregnancy	89	0.853±0.505	0.339±0.489	1.161±0.927	0.928±0.909	1.539±1.353
Infertility treatment	11	0.777±0.462	0.221±0.352	1.121±0.810	0.800±1.024	1.636±1.362
t=		0.472	0.773	0.136	0.435	-0.224
p=		0.638	0.441	0.892	0.664	0.823
Number of abortions						
1	20	0.970±0.571	0.364±0.487	1.433±1.028	1.010±1.023	1.600±1.334
2	56	0.796±0.446	0.281±0.438	1.083±0.880	0.900±0.912	1.482±1.304
3 and more	24	0.852±0.555	0.399±0.556	1.097±0.874	0.867±0.870	1.667±1.501
F=		0.894	0.595	1.159	0.145	0.172
p=		0.412	0.554	0.318	0.865	0.842
Time from last abortion						
Less than one year	47	0.821±0.527	0.222±0.404	1.078±1.021	0.949±1.052	1.830±1.408
1-3 years	25	0.922±0.528	0.451±0.580	1.313±0.853	0.880±0.827	1.500±1.299
4 years and more	28	0.814±0.427	0.388±0.466	1.149±0.766	0.886±0.767	1.125±1.207
F=		0.399	2.283	0.541	0.063	2.496
p=		0.672	0.107	0.584	0.939	0.088
		r/p	r/p	r/p	r/p	r/p
Age	r	-0.130	-0.202*	-0.015	-0.072	-0.076
	p	0.199	0.044	0.882	0.474	0.449
Gestational week at last abortion	r	-0.079	-0.189	0.016	-0.011	-0.073
Age	p	0.433	0.059	0.876	0.915	0.470
Age of spouse	r	0.143	0.180	0.082	0.044	0.067
	p	0.155	0.073	0.419	0.661	0.509

F: Anova Test; t: Independent Groups T-Test; r: Pearson Correlation Analysis

Discussion

This study examined the degree of internalized stigma that women experience when having an abortion and whether it varies based on various demographic factors. According to the study's findings, individual internalized abortion stigma scores did not differ significantly by demographic factors such as educational status, spouse's educational status, employment status, income status, number of living children, mode of conception, number of abortions, and time since last abortion. However, there was a slight inverse relationship between "judgement concerns" and age.

The study's individual women's abortion stigma score was 0.845 ± 0.499 . The ILASS scores in two further Turkish studies were 1.61 ± 0.57 and 1.46 ± 0.56 .^{4,22} Li et al. reported a score of 1.49 ± 0.60 in women who had an abortion owing to fetal indication in China, whereas the mean score in the study by Belfrage et al. in Mexico was 1.59 ± 0.60 .²³ The ILASS score was found to be lower than the others in this study. This discrepancy is thought to be related to the timing and clinical context of data collection. In contrast to earlier research, which collected data at least two weeks following the procedure, our data were obtained within the acute post-abortion period (first six hours) while participants were still in the hospital. At this immediate stage, women are primarily focused on their physical recovery and the immediate relief of a completed procedure within a supportive healthcare setting, which may temporarily diminish their active focus on internalized social stigma compared to measurements taken weeks later in non-clinical settings.

Individual scores for internalized stigma did not significantly differ based on educational status in this study ($p > 0.05$). This finding demonstrates that the stigma attached to abortion is unaffected by educational attainment. Additionally, Özgen et al. discovered that educational status had no bearing on women's ILASS scores.²² In a similar vein, Li et al. found no correlation between education level and stigma among women who had abortions.²⁴ Higher educated women experienced greater stigma than others, according to a study by

Rasoulyan et al..²⁵ Similarly, higher-educated women were reported to score significantly higher on the ILASS and exhibit greater internalized abortion stigma compared to those with primary education or less.²⁶ On the other hand, Turan et al. (2023) observed that stigmatization was greater among women with lower educational attainment.⁹ In our study, the lack of significant variation across education levels suggests that abortion stigma is deeply rooted in pervasive societal and cultural norms that transcend educational boundaries. These contrasting findings across literature further indicate that educational attainment may interact with stigma differently depending on regional socio-cultural contexts, health literacy, and women's willingness to disclose internalized feelings on self-reported scales.

The degree of stigmatization and work status did not significantly differ in this investigation. According to Li et al., stigmatization of abortion is linked to unemployment.²³ On the other hand, research done in Türkiye found no connection between the stigmatization of abortion and occupational position.^{9,22} Similarly, there was no discernible relationship between an individual's internalized stigma and income position. Contrary to what we found, Grinberg (2021) found that stigmatization from abortion was more common among those with higher income levels.²⁷ According to Mosley et al., there is a negative correlation between abortion stigma and economic level.¹² According to Rasoulyan et al., people with higher incomes had higher internalized stigma ratings.²⁵ While some research indicates that individual stigma in abortion is correlated with work status and income level, other research indicates that individual stigma in abortion is unrelated to these factors. This discrepancy across studies is likely driven by variations in regional cultural norms, gender roles, and socio-economic expectations surrounding abortion, which shape how income and employment influence perceived stigma in different societies.^{26,27} The number of live children did not significantly affect the level of stigmatization, according to the study. The number of children and abortion stigma did not significantly correlate, according to Li et al.²⁴ In contrast, Rasoulyan et al. found that as the number of

children grew, the stigma associated with abortion declined in Iran.²⁵ In the United States, Shellenberg et al. discovered a negative correlation between stigmatization and the number of children.¹⁴ Turan et al. discovered a positive correlation between the stigmatization of abortion and the number of children in a Turkish study.⁹ These discrepancies could result from a person's religious beliefs, the legal status of abortion in culture, or social norms and expectations surrounding the number and composition of families.

There was no discernible variation in the level of stigmatization based on the number of abortions in this study. In contrast to our findings, a nationwide study conducted in the United States by Shellenberg et al. found that higher numbers of abortions were associated with lower perceived stigma and an increased likelihood of concealing the procedure.¹⁴ This divergence may be explained by socio-cultural differences in abortion norms and concealment mechanisms across regions. In contexts where repeat abortions carry severe social disapproval, women in our study may continue to experience persistent internalized stigma regardless of their reproductive history. This implies that healthcare providers should provide non-judgmental, comprehensive care to all women undergoing abortion, irrespective of whether it is a first or repeat procedure. The degree of stigmatization and the amount of time since the last abortion did not significantly differ in this study. This demonstrates that the sense of stigmatization is not substantially altered by the amount of time that has passed since the abortion. The amount of time since the abortion and the level of stigmatization did not significantly differ in the Özgen et al. study.²² According to Rasoulyan et al. (2024), stigmatization declined as the amount of time following an abortion increased.²⁴ There are not many studies looking at how stigmatization is affected by the amount of time that passes following abortion. These disparities across studies may be attributed to differences in personal psychological coping and the persistence of social judgment. Over time, some women may process their emotional experience and internalize less stigma as time elapses after the procedure. However, in traditional socio-cultural environments where abortion carries severe social

taboos and moral judgment, internalized stigma may remain persistently high regardless of how much time has passed since the abortion.^{7,10,19}

Age and fear about judgment were found to have a weakly negative connection in this study. According to this research, women's worries about being judged for having an abortion seem to lessen as they get older. Contrary to this study, Rasoulyan et al. found that women were more stigmatized as they became older.²⁵ Our study postulates that this decline in judgmental concerns with age may be rooted in socio-cultural dynamics in traditional societies. As women age, gaining greater emotional maturity and autonomy within the family may enhance their coping capacity against social judgment. Conversely, younger women often face heightened vulnerability due to stricter cultural expectations surrounding sexual morality and limited social support. Contrary to the findings of some studies, which indicate that women's ILASS scores rise with age,²⁵ other studies indicate that they fall with age.²⁷ According to Yegon et al., young women are burdened with the stigma associated with abortion and do not have access to a supportive environment that can provide them with information on how to avoid an unintended pregnancy and where to seek assistance.²⁸ As women age, it is considered that they learn to cope with the shame associated with abortion.

Strengths and limitations

This study has several notable strengths. To our knowledge, it is one of the few empirical studies evaluating abortion stigma in Türkiye using a validated, multi-dimensional stigma scale (ILASS). Furthermore, collecting primary data directly from women with a history of abortion in a clinical setting provides valuable insight into internalized stigma in a socio-culturally sensitive environment. Nevertheless, there are various limitations to this study. First, every participant came from a single hospital in a single area. Therefore, more research is required to ascertain the degree to which women who have had abortions are stigmatized in various nations or areas. Second, all information was gathered through self-report, which could introduce bias, especially in the answers to the awareness questions. Third, the cross-sectional study

methodology restricts the comprehensive examination of the connection between stigma and associated variables in women who have undergone abortions.

Conclusion

This study demonstrates that demographic characteristics have limited bearing on women's levels of perceived internalized abortion stigma. The widespread presence of perceived internalized stigma among participants underscores the pervasive influence of prevailing social norms and the societal view of abortion. Educational initiatives and social awareness programs are essential for reducing abortion stigma. Furthermore, health policy interventions that reduce stigmatization in health services and support systems must be developed. Women's experiences of stigmatization may be lessened with professional assistance in addressing the emotional and psychological challenges they face during this process. Therefore, it is critical that medical professionals make post-abortion support services more accessible. It is advised that qualitative or mixed methods studies be carried out in various sample groups in order to identify the factors that contribute to the stigmatization of abortion at the individual level. In particular, in-depth interviews with women who choose to have an abortion on their own initiative without fetal or maternal indication are advised. Additional long-term research should be carried out in the future to verify the long-term consequences and cause of individual stigmatization of abortion.

Conflicts of interest

The authors declare no conflicts of interest.

Data availability statement

The data that support the findings of this study are available on request from the corresponding author.

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None

Authors' contributions

BE: Conceived and designed the study, coordinated data collection, performed statistical analysis, and drafted the manuscript. **GAC:** Participated in study design, collected data, and assisted in literature review and manuscript revision. **NS:** Supervised the project, provided critical guidance on methodology, and critically revised the manuscript for important intellectual content. All authors read and approved the final manuscript.

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