

**COVERT ABORTION NETWORKS: HOW CIVIL SOCIETY SUBVERTS THE
STATE AND PROVIDES ABORTION, NO MATTER WHAT**

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ABSTRACT

This dissertation investigates the ability of Covert Abortion Networks (CANs) to provide abortion access in the face of legal threats and the erosion of the access environment. CANs operate across a variety of legal and practical contexts to help people access abortions, no matter what. A common refrain in the pro-choice community is that abortion restrictions do not work; this project investigates why they do not work. I argue that abortion restrictions fail to have a lasting effect on the birth rate because of civil society's organizing to provide abortions in the face of legal threats and erosion of the access environment. These networks establish both informal and formal linkages, ties, and organizations to facilitate access despite legal constraints. The level of institutionalization of civil society determines the shape of these CANs.

Using a comparative case analysis of communist-era Romania, Turkey, and Appalachia, this study illustrates how three distinct levels of institutionalization of civil society shape CANs. This study employs a mixed-methods approach to address these questions. A statistical analysis of birth rate data and abortion laws from 1960 to 2019 shows that abortion restrictions do not have a lasting effect on the birth rate. Then, through case analyses incorporating historical analysis, interviews with CANs, and organizational mapping, I demonstrate how CANs are formed and function in various civil society settings. Ultimately, this project shows that no, abortion restrictions do not work well. And they do not work well because of the will of civil society to supplement abortion access no matter what, through the creation and organizing of CANs. Abortion restrictions and erosion of the access environment are heavily undermined by civil society actors who mobilize covertly to maintain access under hostile conditions.

To my parents, whose support means the world to me.

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CHAPTER 1

THE STATE OF REPRODUCTION: THE POLITICS OF BIRTH CONTROL

Introduction

On June 24, 2022, the U.S. Supreme Court overturned the *Roe v. Wade* and *Doe v. Bolton*, decisions that protected abortion access at the federal level for nearly fifty years. States have been limiting abortion access increasingly over the past twenty years, with 108 abortion restrictions enacted in 19 states in 2021 alone, making up about 10% of all abortion restrictions passed since 1973 (Nash, 2021). Many engaged within the abortion community (non-profits, clinics, mutual aid funds, etc.) have been preparing for the overturning of *Roe* for years, especially as legal threats have increased over the past decade. The legal atmosphere is currently uncertain in many states as trigger laws and pre-*Roe* laws are being interpreted, and state courts begin making decisions. 12 states have banned abortion, as of June 2025, and six have gestational limits until 12 weeks, all in the South and Midwest (KFF, 2025). There is also increased misinformation around whether abortion is legal or not because of the state and federal divisions in the U.S. However, there is no uncertainty from those seeking out abortions; those who have unwanted pregnancies will continue to seek out abortion no matter the legal climate. What abortion restrictions do is make abortion illegal and, therefore, unregulated; but, they do not stop abortion, although they try. People will continue to seek out abortions despite the legal context in their state or country, and others will help them obtain abortions, acting to subvert the state to provide a service to those who need it.

The U.S. is but one country currently experiencing changes to its abortion laws. Globally, there is a wave of legalization in countries that have been historically restrictive

around abortion, such as Ireland, Chile, and Argentina. Countries that either face growing restrictions around abortion or have had a restrictive legal setting have seen changes in technology impact the provision of abortion in their clandestine settings. The rise of medication abortion- a pharmaceutical regimen of mifepristone and misoprostol has expanded abortion access around the world, inside and outside of the legal borders. With the combination of abortion pills and the internet, groups have been appearing over the past twenty years to help people access abortions online. Organizations such as Women on Web, Plan C, and Aid Access all have developed models to help people access the abortion pill online, despite the legal context of the recipient.

The World Health Organization (WHO) estimates that around 73 million induced abortions take place every year, with about 6 in 10 unintended pregnancies ending in abortion and 3 in 10 of all pregnancies ending in abortion (Abortion, 2021). Nearly 33 million abortions that happen every year are unsafe and occur in a clandestine setting where legal restrictions make abortions difficult to access. The abortion rate has increased in areas where abortion is legally restricted over the past 30 years, now meaning that 1 in 2 unintended pregnancies ends in abortion in countries where abortion is restricted (Bearak et al., 2020).¹ Banning abortion has never eradicated the practice of abortion; instead, it has removed abortion from the public sphere forcing the practice into the private (Kligman, 1998).

Abortion restrictions do not work. They make it harder to obtain an abortion, they make it illegal, and they make it less safe, but restrictions rarely work the way they are meant to, to stop abortion altogether. I accept that laws are intended to bring about some

¹ In this project abortion being restricted refers to any laws that prohibit abortion altogether, are permitted to save a woman's life, or are permitted to preserve health.

change, therefore if abortion is restricted, it should work by restricting abortion. Abortion will become inaccessible to many who will be forced to bear an unwanted pregnancy, but many will be able to access abortions despite the legal atmosphere. If they do not work, then how and why do abortion restrictions fail to achieve their desired effect of eliminating abortion? I argue that abortion restrictions do not work well because of Covert Abortion Networks (CANs) that organize in the wake of legal threats to abortion or when the access environment becomes endangered. Abortion restrictions come in many different forms. In the U.S., specifically, there are dozens of types of abortion restrictions that seek to erode access without making it outright illegal. These types of laws, such as Targeted Regulations of Abortion Providers (TRAP), restrict the clinical settings in which abortions may take place, require abortion providers to have hospital affiliations, require dimensions of hallways and rooms that abortions can take place in, require reading material to the patient that has been medically disproven (such as telling patients having an abortion raises their risk of breast cancer and suicide or that the abortion can be “reversed”). These types of laws create nebulous legal environments where abortion is “legal” but impossible to access in certain areas, making it effectively illegal. Other places have total abortion bans or abortion bans with minimal exceptions (typically rape, incest, or if the life of the mother is in danger). In all of these types of legal environments, I argue that civil society supplements the need for abortion by creating CANs that help people access abortion in a variety of legal contexts.

I argue that the presence of CANs (which operate even in legal abortion environments) creates an infrastructure where abortions can be accessed despite the legal environment. It has been well-documented that when abortion access becomes difficult,

people will turn to self-induced abortions or abortions outside of typical medical settings. In 2011, with the passage of House Bill 2 in Texas, the number of abortion clinics went from 40 to 19 in 3 years, with most remaining clinics being in major cities in North and East Texas (Ura et al., 2016). From 2011 to 2015, Google searches around self-induced abortion rose by 488% (Jerman et al., 2018) , and a New York Times analysis found that searches related to self-induced abortion, DIY abortion, abortion pills, and coat-hanger abortions were higher in states with abortion restrictions (Stephens-Davidowitz, 2016). Pre-*Roe*, the Jane Collective, and many other groups organized people within their local communities to help them access abortion despite abortion being widely illegal throughout the U.S (Kaplan, 1997). The Irish Abortion Journey saw 190,375 women from the Republic of Ireland and 65,495 women from Northern Ireland travel across the Irish Sea to the U.K. to obtain abortions from 1970-2021 (Abortion Statistics for England and Wales: 2021, 2022). These are more formal and well-documented networks that enabled people to obtain abortions, not to mention the less formal or notable networks that were more local, communal, or secretive. These journeys and networks in a pre-legalization environment are typically secretive and act in the law's shadow.

Today, we have many organizations that work more publicly to provide abortions in a variety of legal settings, either by providing medication abortion pills through the mail, and abortion funds that help pay for people to travel across state lines. In the U.S. there is a proliferation of abortion funds that are formal non-profits that help people travel out of state for abortion by organizing logistics and helping pay for the procedure, travel, and lodging. Although we are aware of some CANs, we lack a comprehensive understanding of the political nature of these groups and their relationship to the state, as

well as insight into how they operate. There is also a lack of understanding of how these networks are formed, maintained, and compare to each other. Is there a similar structure or formula for how these organizations are shaped and work? Is their relationship with the state and legal apparatus similar across time and space? What impact do CANs have on the ability of people to access abortion, and does this impact differ depending on contextual factors?

I answer these questions by utilizing a comparative case study of Turkey, Appalachia, and communist-era Romania. These cases are selected based on the varying levels of institutionalization of their civil societies. I argue that the arrangement of civil society prior to the CAN determines the type of CANs that will arise, how quickly they can form and grow, their reach, and whether they engage with politics. Appalachia, in the U.S., has a high level of civil society institutionalization, where organizations can be created both formally and informally without much fear of government interference, regardless of the topic. In Turkey, organizations can be created, but there is some level of fear from those organizing that they cannot act in certain ways or organize around certain topics. In communist Romania, there was no substantial civil society due to the state's structure until the early 1990s. This project accepts that CANs are going to exist despite the legal abortion landscape, so looking at the variation in the civil society environment will help us to understand how these organizations come about, how they operate, and ultimately how they achieve their goals of providing abortions when the state is limiting or eliminating access.

The State and Society

The rest of this project will address these questions; however, before we proceed, we need to understand two of the leading players: the state and society. To answer my primary research question, why don't abortion restrictions work as well as they are intended, we need to know why they are enacted in the first place. To understand why they do not work well, we need to understand what is pushing back against them. The relationship between the state and society is key to understanding the entirety of the project. This push-pull between state and society is one of the key relationships in all of political science and comparative politics. I argue that, although the topic of this paper may seem narrow, it addresses how people resist the state to preserve their autonomy in the face of state overreach. It is both about reproduction, abortion, and the body, while also being about social resistance to the state. This project explores key theoretical questions about state overreach and societal resistance to the state.

The State

To understand the state in this argument, I make an essential distinction. What the state is and what the state wants. What the state is, or the definition of the state that I am using, is my approach to studying the state. It is how the state functions and operates, as well as how to analyze it. What this definition lacks, which I find imperative, is that it does not encompass the motivation of the state and why it does what it does. This distinction is important because the state's motivation paints a more unilateral and cohesive image of the state than what exists in reality or in practice.

The state is a field of power marked by the use and threat of violence and shaped

by 1) the image of a coherent, controlling organization in a territory, which is a representation of the people bounded by that territory, and 2) the actual practices of multiple parts” (Migdal, 2001)

Migdal’s definition of the state is vital to understanding the reality of the state versus the more unilateral and cohesive images of the state that exist in other statist literature. By conceptualizing the state as a series of images and practices, one can understand the symbolic nature of the state and how the state is perceived versus what the state does.

Migdal’s conceptualization of the state tells us how the state can be conceived, understood, and studied. It counters other conceptualizations of the state, including the Weberian understanding of the state as unilateral and even anthropomorphic. I still acknowledge the importance of the threat of violence over a population in a territory that is key to almost all definitions of the state; this relationship is central to my argument. As I develop the conceptualization of birth and control throughout this chapter, it will become apparent that the control of the reproductive apparatus of a population is a form of violence. Migdal’s definition provides us with the how of the state, explaining how the state controls the population within a given territory, how the coherent image of the state developed, how the state acts, and how we study the state. What Migdal does not provide for us is the why. Why does the state function the way it does?

Many of the authors that Migdal is writing against focus on the why of the state. However, the state-in-society approach that Migdal championed is key to understanding the how; the why is just as important. The vacancy of the motivation of the state from Migdal’s definition left me thinking about how I can marry what I believe are the motivations with the state and a definition that was created as a reaction to the overemphasis on state motivations. As a student of political science, I’ve always been a

believer in the Hobbesian conceptualization of the state, even when I didn't find myself agreeing with the ontological approaches and arguments associated with it. I've always seen the state as predatory, the state of nature as undesirable, and the state as the lesser of all evils. But the story is never so simple, and this theoretical conceptualization, as Migdal and others argue, places too much emphasis on the state as a coherent and unilateral actor, even going so far as to make the state into an anthropomorphic character. I do not argue that the state acts in this unilateral way, but I still assert that there are motivations behind state actions that can be understood, while also emphasizing the complexity of the state's practices. When understanding the relationship between reproduction and the state, there is a need for the state to preserve and increase its power over time, meaning that it requires a population to do so (Kligman, 1998; MacKinnon, 1989). There is a direct need for the state to have control of the reproductive apparatus of the state, whether that be in controlling abortion laws, contraception, child-limit policies, etc. Although these state desires may seem unilateral in practice, they are shaped by politics, policies, debate, and changes.

With all those caveats regarding the motivation of the state not being the definition or function of the state, we should move on to what that motivation is. The state is predatory; it seeks to dominate and control a territory and a population (Hobbes, 1651; Levi, 1981, 1989; Olson, 1993; Petchesky, 1990). The state acts on its desires by using violence to maintain and gain control of the population. The state is rational not only in its actions but also in its existence; it makes sense how we wound up with the state as an alternative to the state of nature or roving bandits that exist in the lore of state creation. The exchange between society and the state exists; society forfeits some rights,

and the state provides amenities, goods, security, etc. The state also desires to make itself more powerful, and it can do so in various ways, materially, whether economically or militarily. What the state needs to operate in both these fields is people. The most powerful tool the state can control is the population within its territory. Nothing can make the state more powerful than controlling the reproductive apparatus of the population to work for the needs of the state.

However, that domination that is desired does not simply manifest itself; the state takes complicated processes to enact domination, some of which are at odds with itself (Migdal, 2001). The state may have its motivations, but the complexity of the state, including its branches of government, institutions, leaders, officials, and military branches, does not always act in accordance with itself, often resulting in conflict. This cannot be stressed enough: the state cannot will results and action, but rather, the will of the state influences the practices and policies put forth. Levi looks at this relationship: if the state is predatory, then why is there such variation in state policy (Levi, 1989)? Migdal's conceptualization of state practices is also used to explain how the state often is contradictory with itself and lacks coherence (Migdal, 2001). And what Migdal's definition of the state gives us most is the framework to understand the relationship between state and society. Other statist literature addresses the ability of society to push back against the state, but Migdal provides a way of studying how the state is closely ingrained with society; the image of the state comes from the imagination of society, and it is a push-and-pull. To conceptualize the state without space for the role of society is moot, as everyone reading this exists in a society where we understand the push and pull of politics in everyday life, the agreement and disagreements that take place around the

dinner table, people working on good provision outside of the government, people protesting against policies and actions. However, there is a significant lack of understanding and credibility in society when discussing the state, which is why any sound theory of the state must leave room for society.

Society

It is impossible to study society without understanding the state, just as it is impossible to truly understand the state without understanding society. The two are inextricably linked, as evident in our everyday lives. The state touches us constantly: the roads we drive on, the schools we attend, the birth control available, the foods on the market, and so on. However, we also constantly interact with the state; we staff its apparatus, we vote for governments, and we fight in wars. Discussions around the monopoly of violence, or the use of violence in a field of power, as the state's tool to wield to make a society subservient, are present in essentially every definition of the state, including my own. But conceptually, we think of this in terms of military might and police forces— the state can punish and enact justice against its citizens because it holds some level of legitimacy. I want to assert another aspect of violence that the state controls, and that is reproductive violence, including forced birth, sterilization, and abortion. I will elaborate on this point in detail later, but it is essential to establish it upfront so that the relationship between the state and society is clear. Describing the relationship between society and the state must emphasize the threat of violence that the state wields over its population, whether that be in our most brutal imaginings of state violence in totalitarian societies, in judicial punishments, or the everyday presence of

police patrols in neighborhoods. This threat looms over all societies, as it is inherent in the nature of the state. This threat, therefore, defines the relationship between the state and society, as all interactions will be viewed through the lens of punishment.

And with all that said, people resist the state every day. Resistance, as Scott tells us, takes many forms (Scott, 1985, 2009). What we remember are the rebellions, revolutions, protests, and so on. Still, the motivation behind many forms of resistance is often to avoid detection by the state, whether due to a desire to avoid a symbolic confrontation with the state or because their resistance is providing a good that the state does not permit (Scott, 1985). Society is most concerned with de facto changes that directly affect their lives; the practicality and accessibility of these changes are more important to people than de jure changes, which solidify their desires in law. This leads society to resist and implement de facto changes when the state refuses de jure changes. This project focuses on the de facto access to abortion that society pursues despite the legal climate; the legal environment provides a hindrance to access, but it does not completely prohibit it. I argue that society undermines the state when a good or service deemed necessary by society is restricted. This is apparent not only in this broader argument about abortion access but also when looking at illegal drugs (whether that be recreational or the distribution of pharmaceuticals), housing, etc.

The role of society in the story with the state is that the state cannot be extracted from society; the state exists within the context of society (Migdal, 2001). In many stories of state formation and development, there is a narrative about society pushing back on the state when the state overreaches (Hobbes, 1651; Levi, 1989, 1997; Scott, 1985). When state overreach happens, society pushes back either through protest,

violence, or everyday actions (Scott, 1985). This push-and-pull relationship is what gives boundaries, laws, and enforcement, and changes society's relationship with the state. When laws change in a way that is perceived negatively by society, it will push back. The pushback may take different forms, but depending on what is done, the urgency may be to supplement what has been taken – those de facto changes.

In my story, what is taken is legal abortions, although controversial within society, many deem it necessary to have and provide them and will do so despite the legal context. This project will demonstrate how society works to undermine the state when legal changes are enacted. We will see how three different societies work to provide abortion when the state makes it illegal. Examining the Appalachian region of the U.S., Turkey, and communist-era Romania reveals a rich variation in not only the political backgrounds of these states but also in their respective societies. These three cases illustrate how very different societies respond to provide a good they deem necessary in a variety of contexts and how, initially, the focus is on access, de facto changes. The de jure changes come later, if at all, because what is most important to people is that they have what they deem necessary, whether or not the state wants them to have it or not.

Civil Society

Civil society, which I am remarking as both a sub-division of society and an essential and distinct entity from society. Civil society exists within society but operates to pursue goals either through the state or in parallel to it. Civil society is a network of associations outside the state where individuals can come together for a common purpose (Putnam et al., 1994; Tocqueville et al., 2002). This definition I propose, addressing

Putnam and de Tocqueville's, is intentionally loose. An overemphasis on the goals of civil society or the imposition of structure can detract from the process of collectivization. Civil society can be anything from Putnam's bowling leagues to ubiquitous and powerful non-governmental organizations. For this study, the scope can range from the informal phone chains of the Jane Collective's beginnings to Planned Parenthood.

Civil society, as a concept, is also historically connected to the private sphere and the women's sphere. There are areas of life with boundaries that are implicitly taboo or unspoken. This connection is essential because the private collectives of women specifically are historic and ancient. Women have always been a part of women's business; the management of women's health from puberty until death was done in private and handled outside of the state. An understanding of civil society also needs to be understood within this framework because the phenomenon of people aiding each other in obtaining abortions is not a new phenomenon; it is historic. What is new are the more formal groupings and institutionalization of civil society that have led to things such as non-profits, mutual aid funds, and abortion funds, which have corresponded with the medicalization of abortion and the removal of women's health from the home and into medical facilities.

With that in mind, a looser definition of civil society is necessary to capture the needs and settings to evolve. By defining civil society as a network of associations outside the state apparatus, it encompasses all forms of organizing that people undertake with specific goals in mind. Book clubs, intramural sports, local political chapters, the NAACP, and beyond are all captured in this definition. At some point, each civil society

network begins as a conversation among friends with a purpose. The purpose does not have to be political and often is not, but the network created can be used to organize politically if it wants. In *The Story of Jane*, Kaplan recounts how the Jane Collective was founded in 1960s Illinois. It started with a friend calling another friend to ask how to get an abortion and for help, and then, as more people needed the procedure and heard from others who to call, suddenly a friend asking for advice turned into an extensive network of doctors, organizers, and abortion seekers (Kaplan, 1997). It did not start as a political organization and never fully developed into one; however, the people involved were political. The Jane Collective captures the meager beginnings of civil society and the growth and change that can happen. However, it also demonstrates how civil society can operate outside the state to subvert it and serve as an instrument of societal will.

Civil society does not exist exclusively within state borders; social movements happen globally and domestically. Transnational advocacy networks comprise “those relevant actors working internationally on an issue” who communicate and support one another (Keck & Sikkink, 1998). In the scope of my dissertation, we will primarily look at domestic networks and how civil society is working in an area to provide abortion access to the people in that area. But as I argue, this is also a global pattern to a domestic problem. There are international networks that work to guide and inform local entities by providing advice, setting goals, and even offering material aid, such as organizations that provide medication abortion pills via mail, with an international focus. This definition of civil society is loose, and I’ve argued that it is on purpose. Change is necessary to capture, and the ability and reality to change are essential to understanding this project; therefore, a definition that allows for it must be created and accepted.

Abortion and Birth

To understand the relationship between the state and society within this theoretical debate, this project will apply it to the context of abortion. There is a common understanding about abortion that all people in the abortion access community know to be true: making abortion illegal does not stop abortion. There are social media campaigns by non-profits and politicians, as well as signs at protests, that all convey this message, but there has yet to be research on this topic that looks beyond whether this happens and instead asks why and how. This project asks those questions: do abortion restrictions work, and why don't they work as well as they are meant to? How do people access abortion in a restrictive setting?

The data existing out there today have shown that there is not a strong causal relationship between abortion restrictions and the birth or fertility rate. Theoretically, if abortion restrictions work, there should be an increase in the birth rate because pregnancies are being carried to term rather than being terminated. After all, ideally, laws are effective, so abortions would no longer happen if they were illegal. Abortion laws do not have a significant or lasting effect on the birth rate (Fernández & Juif, 2023). Instead, what is being observed is that other variables (such as GDP per capita, education levels, women in the workforce, etc.) associated with development are driving changes in the birth rate rather than policies around abortion. The birth rate must act as my proxy for the abortion rate because so few countries collect abortion rate data, and even if they did, they could not estimate clandestine abortions even within a legal abortion environment (Popinchalk et al., 2022).

Abortion Networks

This sets up a theoretical puzzle about why these laws don't work as intended. I argue that these laws are ineffective due to the influence of civil society. Civil society sees abortion as a right and a need and, therefore, seeks to supply abortions through the creation of a network, an organization of like-minded individuals seeking to preserve access. This mirrors the discussion of the state-society relationship; the state has a desire to control, maintain, and promote power, while society has a desire to limit state overreach, which is evident here through the control of bodies. Individuals who seek to preserve access to this resource set up structures to maintain it by creating clandestine networks that the state is unable to control or limit. These structures form networks that enable communication and access throughout civil society. The networks are made up of those who perform abortions (abortion providers, who can be medical doctors, nurses, doulas, or midwives), those who maintain communication structures, and those seeking abortions. These networks have a primary focus on de facto abortion access, actually providing people with an immediate service. However, some networks can expand their efforts into de jure aspirations, whether that involves formal lobbying, hosting protests and campaigns, or organizing social media campaigns, among other activities. I call these Covert Abortion Networks (CANs) because their work is meant to be subversive, and in some cases, their actions are clandestine. There is an explicit intent to obscure and hide certain aspects of the work, even if it is a non-profit organization doing so. This is rooted in concerns around safety, protecting those abortion seekers, and in other cases, the providers and those who maintain the structure. It is also important to note that these

groups cannot completely supplement the need for abortion, as these clandestine abortions are conducted in a type of free market environment that has inherent risks to those involved, as well as those seeking the service. Those seeking a clandestine abortion must weigh options about high prices surrounding the procedure (set by providers who control the market and want to be compensated for the risk they are taking), risk, and need for an abortion over carrying a pregnancy to term. This may explain why CANs help to supplement people's need for abortion, but why these abortion levels are not at pre-restriction levels.

Institutionalization of Civil Society

I argue that CANs impact abortion provision. But the way CANs are shaped is through the institutionalization of civil society, which serves as my independent variable. This can be understood as the form that civil society assumes in relation to the state. High levels of institutionalization of civil society would mean that civil society can organize openly and form groups without fear, even with state support. State support can take various forms, including grant funding, tax exemptions, and nonprofit designation status. Low levels of institutionalization of civil society occur when civil society is not only unable to organize formally but may also be discouraged from doing so, fearing retribution from the state. Mid-levels fall somewhere in the middle, either by design or as part of a transitional process. An example of this is post-Soviet states that had transitioned from low to no institutionalization of civil society and were undergoing a

democratic transition, allowing for the opening up of organizations and groups, both foreign and domestic.

The institutionalization of civil society is distinct from the type of regime. Although there are assumptions that democracies would have high levels and authoritarian governments would have low levels, that is not necessarily true. Civil society is not causally linked to regime type (DeLue & Dale, 2016; Grahn & Lührmann, 2021). Civil society can help foster democratic ideas and promote democracy, but being a democracy does not necessarily mean you have a robust institutionalization of civil society (Bernhard, 2020). Similarly, being an authoritarian government does not necessarily mean you lack any civil society. It is crucial to this project to understand the institutionalization of civil society as a distinct variable from regime type. Creating this separation allows for an understanding of civil society as separate from the state and government, instead as a product of the state.

However, the strength of civil society is related to regime type endogenously. Democracies provide an environment that allows civil society to flourish, whether that be by making non-profit status accessible, a lack of fear of retribution, and encouraging collaboration. Civil society does not arise solely because of democracy, but democracy can indeed strengthen it. Whereas in an authoritarian context, civil society may still exist but is clandestine or covert because of the regime. There are fewer resources for civil society in this environment and a fear of backlash that limits how civil society can act, especially if they are acting to oppose or contradict the state. Therefore, civil society institutionalization, or the shape of civil society, is formed by the regime's attitude and allowance for civil society. The existence of civil society doesn't depend on regime type;

it exists because society wills it to. The institutionalization of civil society exists because of the space the state allows. Civil society will always exist to some extent, but its robustness is determined by the space the state allows for civil society to form.

Typology of Covert Abortion Networks

Not every restriction setting allows for the same types of networks to form and develop. I believe that the openness of civil society and allowance for its institutionalization before the adoption of abortion restrictions determine many of the characteristics of the CANs in the years to follow. At the core, each of these CANs requires key factors that define them as CANs, but I believe that the variation within these groups is directly linked to the type of relationship the state has with civil society generally. I argue that the fundamental requirement of CANs is that they have a network of people who facilitate abortions that are not strictly allowed legally. These networks may be loose, such as word-of-mouth chains, or formal, with bureaucratic functions such as registered non-profits. These networks will consist of health professionals who provide abortions or are associated with pre/post-abortion care (doctors, nurses, midwives, doulas, etc.) and organizers and network members who help to facilitate abortions by protecting and connecting health professionals with those seeking abortions. These network members have a vested interest in the preservation of abortion provision, but are not actively seeking abortions for themselves. Instead, they act to preserve the system over time. These network members do not have a specific characteristic or profession; instead, they are motivated by the preservation of the CANs, and their actions help to sustain the networks and connect abortion seekers to abortion providers. Finally,

the last component is the abortion seekers who will exist so long as there is no barrier to accessing abortions and there are unwanted pregnancies. These three pillars are what form all CANs and are necessary for the existence of the networks. What varies is how these networks look, how they are created, how far they reach, how fast they grow, what is their relationship to the state, and what are their political and legal motivations.

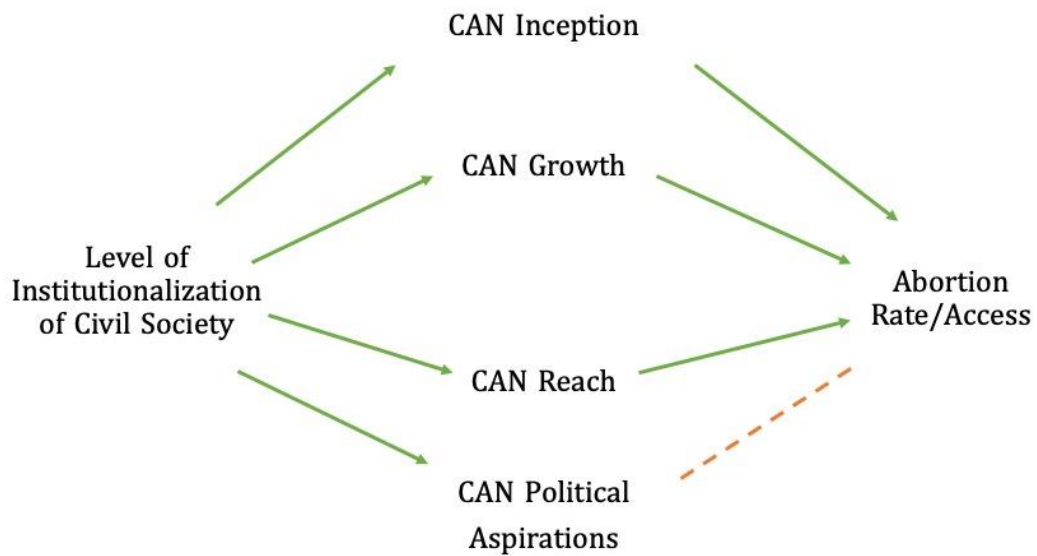


Figure 1: How Civil Society Institutionalization Affects Abortion Provision

Figure 1 refers to how the level of institutionalization of civil society will impact specific components of CANs, which in turn will affect the abortion rate. For example, suppose there is a high level of institutionalization of civil society. In that case, we will expect to see a quick inception of CAN after an abortion restriction is enacted or the access environment is threatened. This will then lead to rapid CAN growth, and the CAN will have a far-reaching impact, potentially expanding to a regional or provincial level. Not all CANs will have political aspirations to change the legal situation. Still, those that exist in high levels of institutionalization of their civil society will have state or federal

political aspirations. These CANs are created and grow so rapidly because this level of institutionalization of civil society already allows people to organize and participate in groups that are related to abortion. There may be feminist groups, women's health groups, reproductive health groups, politically minded women's groups, etc., and any of these could easily pivot to abortion provision and have an existing chain of individuals who are interested, passionate, and engaged with these issues already. It also means that there may be less associated fear with engaging in covert activities since there may be historically no fear of organizing around similar issues, allowing these groups to expand and engage more politically. This may be seen in groups like the Jane Collective in the U.S. pre-*Roe*, who were originally part of political and feminist groups who then turned to abortion provisions and had a political branch of the organization that advocated for changes in abortion laws (Kaplan, 1997).

In the wake of the *Dobbs* decision, what is beginning to emerge in the U.S. are non-profits and organizations that are helping to provide abortion to those in states with heavy restrictions. This can either happen through the provision of the abortion pill through the mail or by organizing travel and financial accommodations for people to travel out-of-state to obtain an abortion. Abortion funds in the U.S. existed pre-*Dobbs* as a way to supplement the needs of abortion seekers. Still, after *Dobbs*, it has become an integral part of the abortion landscape in the U.S., as many states have made abortion illegal outright, and travel to other states is now necessary for those seeking abortions. These are still considered CANs because the covert nature implies some type of subversion without it being outright clandestine. These legitimate non-profits are also more transparent with their work and what they are doing as a form of a legal and

political statement, explicitly saying that “if you live in X state, you can travel to Y state for an abortion” and that they can help provide resources to make that happen. This is a pattern emerging in the U.S. post-*Dobbs*, particularly in the South, where many states now have total bans in place.

Places with mid-levels of institutionalization of their civil society are where groups and organizations are allowed to form but perhaps may face restrictions around content or may face pushback from the government to form certain types of groups. For these mid-levels of institutionalization of civil society, we will expect to see slower inception of CANs because there may not be pre-existing groups that are organized around feminist causes, reproductive rights, abortion, etc. However, there may still be related groups such as women’s health clinics, pregnancy organizations, or broad women's political groups. This slower inception of CANs will then lead to slower growth because there may be some level of fear of engaging with abortion as a clandestine activity, so growing the network will be more delicate than in a more open civil society. Furthermore, we expect the CANs to be more centrally located for these reasons, either focusing on cities, counties, or larger rural areas. Due to this, the CANs may not have large political aspirations, such as national-level changes, but rather regional or provincial-level changes to abortion or contraceptive laws. There may be some interest in the de jure changes, but not a concerted effort to organize along these lines.

Locations with low levels of civil society institutionalization face greater challenges in creating these types of CANs. Thinking of totalitarian or authoritarian contexts where the only sphere is the public one and where civil society is highly restricted or completely absent, these groups will take a much longer time to organize. I

argue that they will exist because there is a need for the women of society to have access to abortion, so they will act, no matter the consequences, to have that provision. The inception and growth of these organizations will be much significantly more challenging than in other civil society contexts because there are no preexisting structures or organizations on which to build. Instead, the growth of these organizations will likely come from relationships, from providers who can perform abortions and those who know them and wish to help a network get started. This means the CANs in these contexts will be extremely limited; they will exist in neighborhoods, boroughs, towns, and small locations that are centered around the provider. Due to the repressive nature of a state that either eliminates civil society or greatly limits it, these groups won't have political aspirations of any type, as it is more costly for them to exist, perhaps than the other types of networks. The priority of these networks is on the provision, not on changing the legal or political environment; therefore, there will be a focus on expanding services before any consideration of politics. What all three levels have in common is that despite the levels of variation in civil society institutionalization, they will all produce CANs that act to provide abortions in a clandestine or limited legal scenario.

Part of my argument is that these CANs are subverting the state through their action. However, each organization will have a different relationship with the state and its political and legal tactics when facing off with the state. The state may seek to control and halt the actions of these CANs, so these networks must consider how they wish to be perceived and how far they are willing to go against the state. Applying these types to my cases, I argue that this depends on the level at which the network is working. If the country has high levels of civil society institutions (such as the U.S.), the networks (or

their legal branches) may have a public-facing arm of the group. This arm will engage with protests and legal tactics; Planned Parenthood has a clinical and a political branch, which have different priorities and organizational goals. In the context of the CANs, they are inherently engaging in illegal or subversive activity; therefore, many active members may not be outwardly vocal, but they may still receive public support. The Jane Collective, a CAN that operated in the pre-*Roe* U.S., had its operations anonymous (except by the founder), but the community was politically supportive and had a branch that engaged with politics. This allowed the actual abortion provision to be secure and anonymous, but to engage with politics through protest, advocacy, and by uniting with other social movements. I also argue that these groups in high levels of institutionalization may be more politically minded towards the national arena and want to change national laws, not just local or state laws. More modern examples of this have cropped up with legitimate non-profits providing and marketing that they will fund abortions in certain states by helping people in restricted states travel. Before *Roe*, this practice was conducted entirely clandestinely and blindly, with people relying on word of mouth rather than websites and social media to guide their decisions. Now, some organizations publicize that they help women in states where abortion is illegal to access abortion in legal states by providing funding for travel, the procedure, and other related expenses. I believe that this is due to the tolerance of civil society broadly within this type of state; this tolerance leads to an increasing boldness by groups to advocate for themselves and their causes with decreasing fear of harm.

States with mid-levels of civil society institutions, such as Turkey, where civil society may have a variety of institutions but government control and repression are a

possibility, have differing operations and considerations. CANs operating in these areas will have some form of political or public affiliation. Still, due to the network's reach and growth, they will be more city- or state/provincial-based than CANs operating in larger areas. They may also be tied to other organizations that are more public or politically active. However, due to the possibility of civil society restrictions and lack of reach, they have less political clout than more far-reaching networks. Finally, states with low levels of institutional development, such as communist Romania, where civil society is practically absent, have no political aspirations or legal tactics. This is due to the fear of repression and possibly violence from the state that seeks to eliminate the activity. The existence of CANs in this type of society is to provide a service and, less so, to engage with the state politically. They seek utmost secrecy and discretion to ensure the preservation of the group.

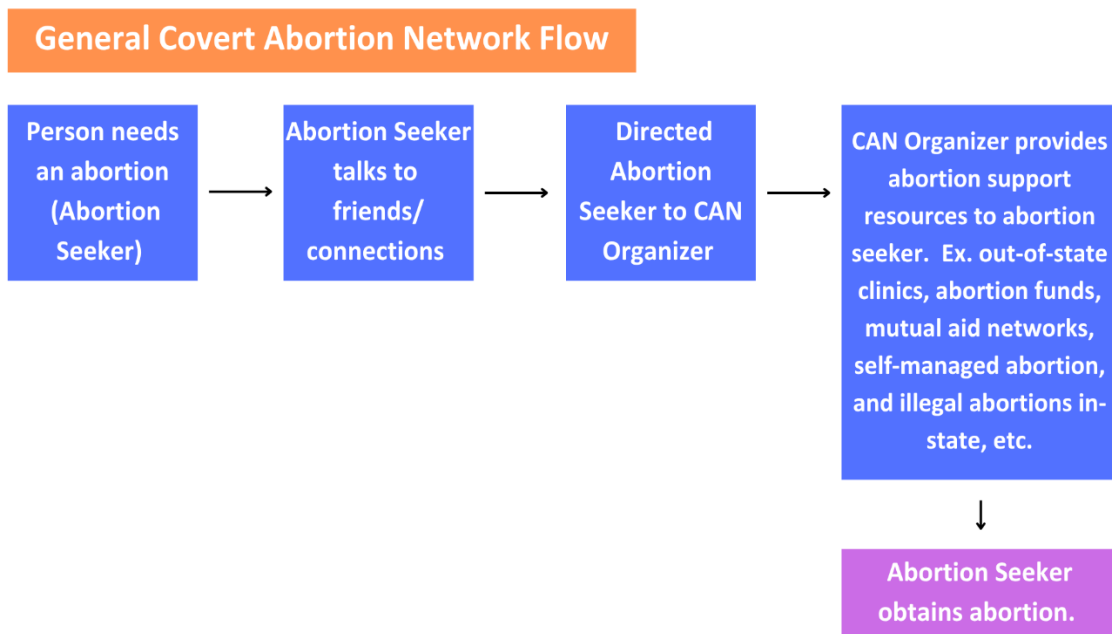


Figure 2: General CAN Flow

Despite the various levels of institutionalization of civil society, I argue that CANs are going to arise. Whenever abortion access is threatened, people will find a way to subvert the state and provide abortions. Figure 2 represents a general flow that abortion seekers will take as they access abortion through a CAN. This fits within an informal or formal CAN (those word-of-mouth networks or a non-profit). Once someone decides they need an abortion they will seek out information and comfort, this may be reaching out to a friend or loved one, or someone they know may be sympathetic. Then this person will help the abortion seeker find resources, who do they know that connect them, and what have they heard. And finally, the abortion seeker will be connected with someone that can help them access an abortion either legal or illegal. This general flow may have changed over time and it may be altered depending where you are, but the steps are typically the same when you are accessing an abortion in a clandestine, illegal, or restricted area. In a low-institutionalized civil society, all that may be available are informal CANs that operate only on word-of-mouth. This process may lead you through a few more hoops as you find the right people to talk to, find the right person to provide your abortion, and do so in a way that feels secure. In a mid-level institutionalized civil society, you may have some starting point, organizations that focus on women's issues that you can use as a starting point or you can possibly use the internet to order medication abortion online. In a highly institutionalized civil society, you can use social media, Google, and reach out to groups that focus on issues that may be more specific, like women's rights groups or reproductive health.

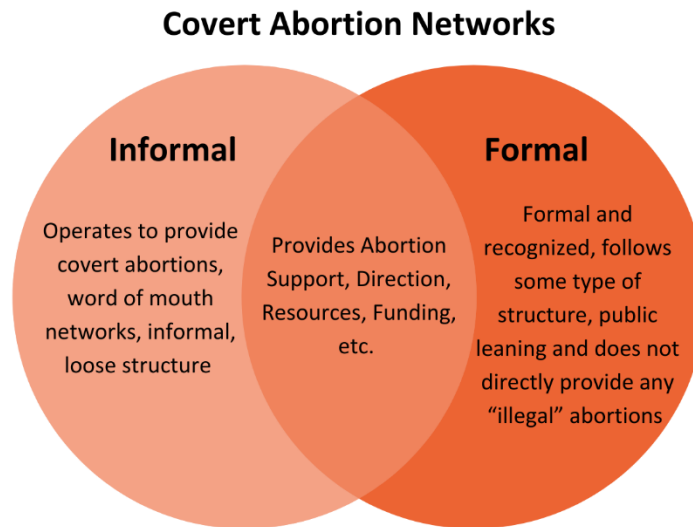


Figure 3: Venn Diagram Informal v. Formal CANs

Figure 3 depicts two major categories of CANs. CAN is an umbrella term that I use to capture all types of civil society networks operating to provide clandestine, restrictive, or difficult-to-access abortions. Depending on the level of institutionalization of civil society, these CANs may fall into one of these categories. An informal CAN is word-of-mouth based, has a casual or loose structure, and typically exists where the institutionalization of civil society is low to mid, particularly when there is a real threat to people organizing around this cause. A formal CAN is registered, such as a non-profit organization. It has a definite structure, and although it may be a volunteer network, the people involved have job descriptions and roles. Importantly, it is public-facing. This could be something that does explicit abortion access work, like an abortion fund or a large pro-choice organization. Or, it could be an organization that focuses on a broader issue but still deals with abortion seekers, like domestic violence shelters. In a low level

of institutionalization where civil society is negligible or banned, there may be no formal CANs. In mid- and high-level, however, there may be a mixture of formal and informal CANs.

Generally, someone needing an abortion when they are in a restrictive environment follows the same flow. It is a scary time for someone to find out they are pregnant and do not want to be; abortion is not easy, legal, or affordable to access, and they do not know where to start. In an interview I conducted with a CAN in Turkey, they remarked that even if someone knows they could get an abortion somewhere, they will often reach out to a friend or someone they trust to give them a referral because they need the comfort of the known and an okay from someone they trust, rather than going into an already scary situation blind. These connections are the foundation of word-of-mouth networks, but it is an essential part of accessing abortion even where it is legal or the information is easy to get. What happens after that differs depending on the shape and organization of the CAN; it may be a formalized process, such as through an abortion fund, or it may be directed to more people who direct you to someone else. But the universal is reaching out to someone and asking for help, and that there will always be someone there to help you find an abortion if you need it.

Hypotheses

To understand my central question, why don't abortion restrictions work as well as they are meant to? There needs to be an understanding of the CANs and their role in supplementing abortion extralegally. Throughout my project, I will be testing multiple

hypotheses through a combination of case studies and large-N analysis of abortion laws and birth rate data.

H₁: Abortion restrictions do not have a lasting effect on the birth rate.

It is important to note that most states have no record of an abortion rate, and if it does, it is an underestimation because it would only capture above-board legal abortions obtained in the country. People travel out of the country for abortions rather commonly, and it is unknown to the government or their healthcare providers (Zoro et al., 2023).

This hypothesis is set up to answer the question: Do abortion restrictions work well directly? If abortion restrictions worked well, they would eliminate abortion, and therefore, those pregnancies would be carried to term, and the birth rate would increase. Estimates vary based on location, but it is commonly believed that 1 in 4 to 1 in 3 women will have an abortion in their lifetime in the United States. It is also estimated that 3 in 10 pregnancies end in abortion globally (Abortion, 2021). If 30% of pregnancies end in abortion, we would see up to a 30% increase in the birth rate in the year after the restriction goes into effect. However, that is not observed. When we look at the large-N analysis of birth rate data and abortion laws, we will see that only one country has ever experienced that pattern: Romania. However, rather than countering my argument, Romania serves as an example of why my argument holds. A key element of this hypothesis and my argument, generally, is the word “lasting”. In Romania, we will see that the birth rate doubled the year following the introduction of the abortion ban. However, that rate then began to decrease after the third year and stabilized to near pre-ban levels. This case is set up to investigate why, which brings us to H₂.

H₂: Abortion restrictions do not work well because of Covert Abortion Networks.

The core of my argument is that the reason why abortion restrictions do not have a lasting effect on the birth rate is because of the existence of these CANs to provide abortions clandestinely. As I elaborated on in the typology of the CANs, not all CANs are created equal; they are a product of the civil society in which they arise, and that determines their efficacy and reach. However, there will always be CANs when abortion is not free, legal, and accessible, and, therefore, must be understood as a driving factor for understanding why a law may not be effective. As stated earlier, to know why abortion restrictions do not work well, we need to have an understanding of this as a state and society issue. Society deems abortion and birth control necessary, and therefore, whatever the state's actions around it, society will act to provide it, no matter what. That provision from society manifests itself as CANs. They will crop up anywhere where abortion is restricted because there will always be unintended and unwanted pregnancies, and for each of those, there is a person who does not wish to carry the pregnancy to term.

H3: Covert Abortion Networks work through an organization of people who create various levels of institutional links to provide abortion services in clandestine or restrictive contexts.

H4: Covert Abortion Networks work because of the determination of society to provide abortion services despite the legal context that they find themselves in.

In the case chapters, I will demonstrate how CANs are created and shaped by society to provide a service that is deemed necessary by society. By examining three distinct legal contexts in the cases (Appalachia, Turkey, and Communist Romania), a common thread will emerge that illustrates how CANs function and why they are effective. I argue that CANs will emerge regardless, and these three cases demonstrate how different levels of institutionalization within civil society influence the creation,

growth, reach, and political aspirations of CANs. However, despite their shape, CANs will provide abortion seekers with abortions.

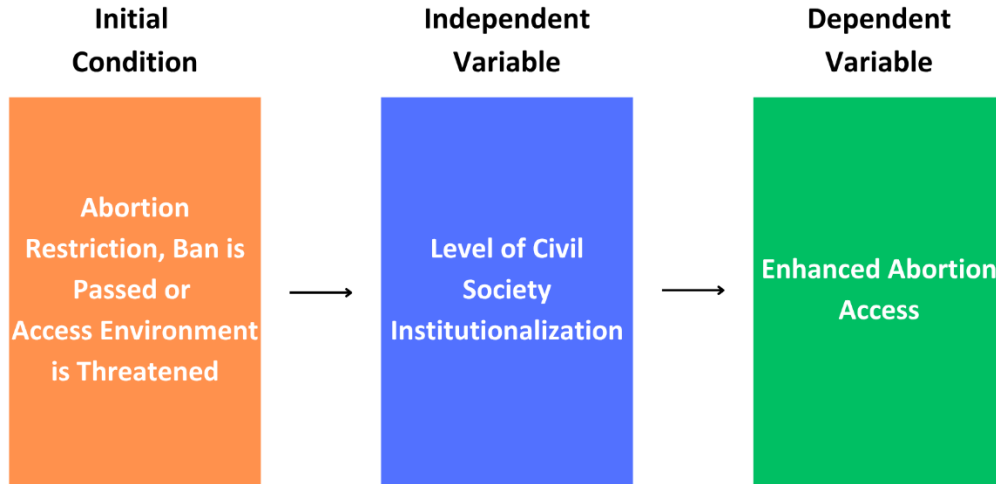


Figure 4: Variable Flow Chart

I argue that CANs are going to crop up in any condition to provide abortion access when the access environment or legal threats are enacted. The initial condition for CANs to activate is that there will be an abortion restriction or ban enacted legally, or the access environment becomes threatened through de facto erosion. When this condition is established, civil society then activates to provide covert and clandestine abortions to those that need them. I argue that no matter the setting, CANs will form in some way to provide abortion access when needed. The CANs are shaped by the level of institutionalization of civil society. The level of institutionalization of civil society determines what shape the CANs will take which affects how fast they are established, the rate of growth, their reach, as well as whether or not they may have political aspirations. The shape of the CANs then determines how effectively they are in helping people access abortions.

Case Selection

Table 1
Case Comparison

Case	Level of Civil Society Institutionalization	Abortion Legality	Access Environment	Religion	Polity Score ¹	Regime Type ²
Appalachia (U.S.)	High	Varied by State. Ranging from total ban to legal until 20 weeks.	Varied by state. Ranging from difficult to inconvenient	Protestant	8	Democracy
Turkey	Mid	Legal until 10 weeks.	Hard, legal but difficult to access especially in rural areas.	Islam	0	Closed Anocracy
Romania	Low	Illegal after 1968.	Very difficult.	Orthodox, state promotion of atheism.	-8 ³	Autocracy

Note: ¹ Marshall, M. G. (2020). *Polity5 Annual Time-Series, 1946-2018* [Dataset].

² Regime type determined by Polity Score guidelines.

³ Polity score taken from 1977, last updated score was from 1944 and was updated from this score in 1989.

To understand the relationship between these CANs and the state, I employ a comparative case study of communist Romania, Turkey, and the Appalachian region of the United States. This comparative case study will look at how differences in the legal environment and control of civil society shape what types of covert abortion networks arise. Each case represents the variation in the level of civil society institutionalization. Because I argue that the level of institutionalization is what shapes how civil society responds to abortion access threats, it is essential that each case varies on this independent variable. Therefore, we can examine how the institutionalization of civil society influences organizational responses. The legality of abortion in each case is

different, but they are all under either a threatened or illegal environment. In Romania and many of the states in the Appalachia case, abortion is illegal outright with few to no exceptions. In some of the other states in the Appalachia chapter and Turkey, abortion is legal with gestational restrictions, provision restrictions, and others. For those who live in any of these cases, abortion is not free, legal, or easily accessible. The abortion access environments differ, but each person seeking an abortion in these areas will face varying obstacles. I also do not believe that religion matters in this argument, either as a reason for why these restrictions are implemented or for who seeks out abortion and who provides it. I include the religion variable here to demonstrate that religion also varies in the cases.

Finally, I include polity scores and their corresponding regime-type designations as a means to understand the political environment in each state. Although polity scores do not capture everything, they do show that each of these cases comes from a varied regime background. I would like to note that these scores are based on Polity5, published in 2020 (M. G. Marshall, 2020). Romania's categorization is based on the most relevant score available from that era, 1977. However, the U.S. and Turkey's polity scores have changed over time, reflecting the response to political changes in each country. Turkey, most notably, has seen periods of military coups throughout the 20th century and an increasingly authoritarian government under the AKP and Erdoğan in the 21st century. These are substantial regime changes over time, going from open democracies to autocratic rule. I do not believe that regime type is a key variable at play, but I do recognize that it is related to the institutionalization of civil society. Theoretically, more

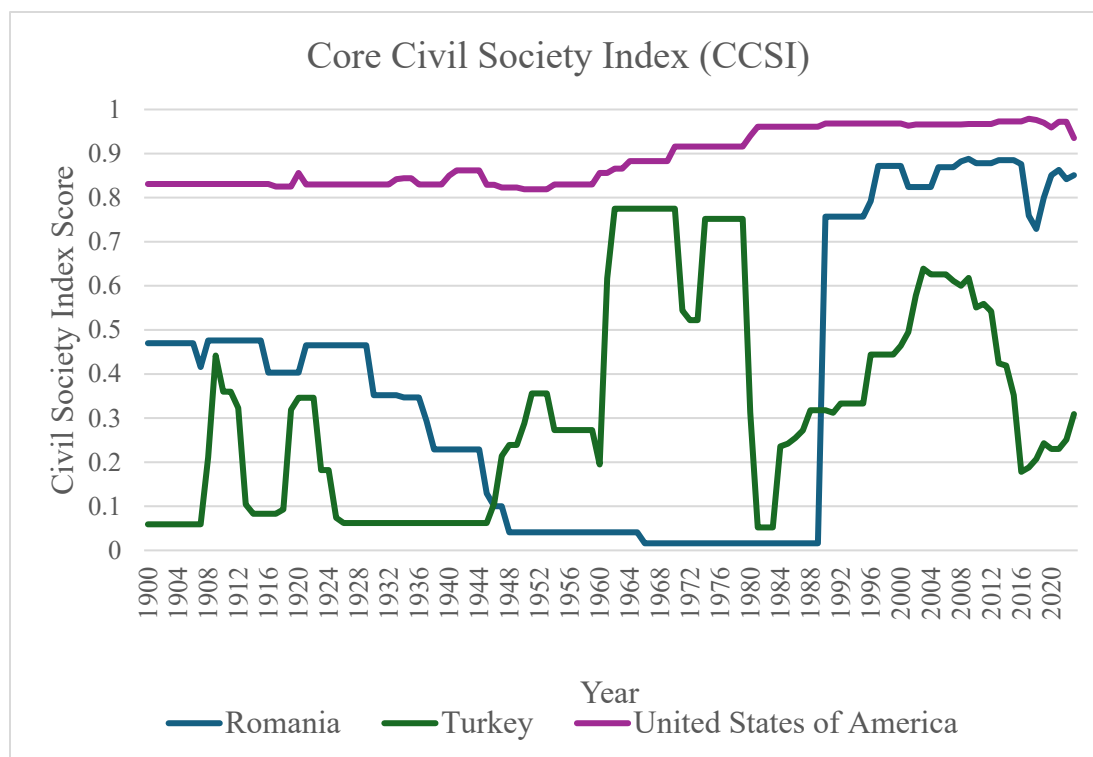


Figure 5: Core Civil Society Index (CCSI) by country (1900-2020)

open and free societies associated with democracies are more welcoming to civil society organizations. In contrast, our concept of authoritarianism is also related to restrictive attitudes toward civil society. That is true to an extent, but it is not always accurate, which is why we examine the institutionalization of civil society rather than the regime as our independent variable. Classifying the level of institutionalization separately from regime type allows for the nuance of cases to arise where civil society may be robust despite an authoritarian government. Countries such as Vietnam and Morocco have low polity scores and are not democracies; however, they do have present and influential civil societies that I would label as mid-level. Civil society and democracy may be correlated but I do not think that the link is causal in this regard when it comes to organizations related to abortion, reproductive health/rights, women’s issues, etc. What I argue is a

causal relationship is the level of civil society institutionalization and the provision of abortion through networks and organizations.

Using the Varieties of Democracy (V-Dem) data project, Figure 5 shows changes in civil society over time in Romania, the U.S., and Turkey. V-Dem says the core civil society index (CCSI) “is designed to provide a measure of a robust civil society, understood as one that enjoys autonomy from the state and in which citizens freely and actively pursue their political and civic goals, however conceived” (Coppedge, 2024). The CCSI is a strong indicator for understanding the institutionalization of civil society, especially as a comprehensive and extensive indicator. Figure 5 displays the changes in Turkey, Romania, and the U.S. over time relating to the CCSI.

Romania

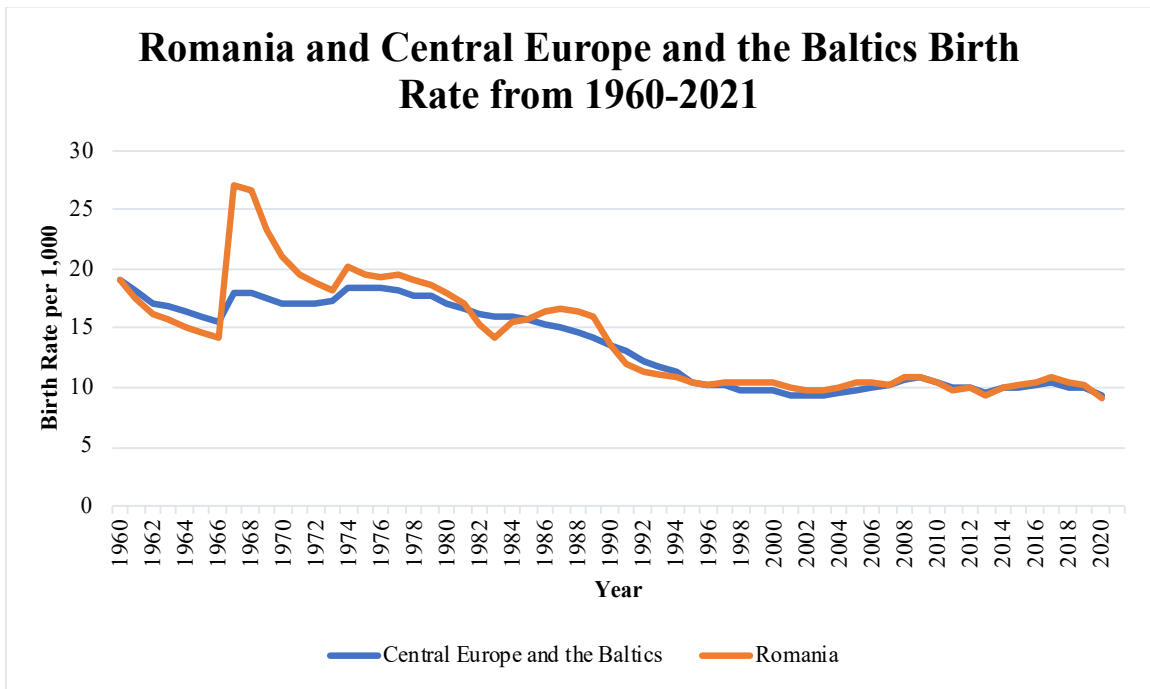


Figure 6: Crude Birth Rate per 1,000 people line graph for Romania and Central Europe and the Baltics

In the large-N analysis of birth rate data and abortion restrictions, Romania is one of the only outliers in my data. Where I predict that changes in the abortion law should not affect the birth rate, Romania shows the exact opposite. When Romania restricted abortion in 1966, the birth rate doubled, meaning that before 1966, an estimated 1 in 2 pregnancies in Romania ended in abortion. At first glance, this is a case that subverts my argument, but when investigating why Romania's birth rate doubled that year, it acts as perhaps the strongest example of my argument. Again, I argue that changes in abortion laws have little effect on the birth rate because of the existence of CANs that subvert the state by supplementing abortion services outside of a legal context. In Romania pre-1966, the communist regime, like many communist regimes at that time, abortion was not only free, accessible, and legal, but it was also the only available form of birth control in the country (Kligman, 1998). Meaning that if you had an unintended pregnancy and wished to have an abortion, you could easily access the service for no cost throughout the country. There was no need for CANs in a country where abortion was not only legal but also accessible; there were virtually no barriers to access for anyone. Further, in a communist society, there is no allowance for civil society to operate outside the state, let alone form organizations that would be contrary to state motivations, so when the abortion law went from this free and legal environment to completely illegal, with no alternative form of birth control, all of those pregnancies that year had to be carried to term. There was no infrastructure to obtain an abortion illegally, although there were trained professionals able to do them, resulting in that spike in the birth rate. Over time, the birth rate in Romania decreased, although abortion remained illegal, and there were no other forms of contraception.

According to Figure 6, in 1973, the birth rate reached levels comparable to those in the region. I argue that this decrease was the result of civil society organizing to subvert the state and create CANs in Romania. The drastic legal change in Romania creates a fascinating landscape where civil society had no previous need to organize against the state around abortion, suddenly needing to do so urgently. This is not the case everywhere, where abortion access is often eroded over time and through legal and medical contexts. This also fits in with my hypothesized typology of CANs. In places where civil society has low levels of institutionalization, the inception and growth of networks will be slow, which can be understood by the birth rate approaching pre-restriction levels. Further, these organizations will be more community and locally based with little political aspirations.

Turkey

Turkey, however, has a very different background with abortion. During the early Republic and Ottoman periods, there were pro-natalist policies in place to boost the population of the Ottoman Empire and the early Turkish Republic (Telli et al., 2019). However, after 1965, the state became worried about overpopulation and ended certain pro-natalist policies, including legalizing abortion in 1983 (Telli et al., 2019). Although abortion services remain legal in Turkey, since 2012, abortion has become harder to access, even in metropolitan areas, as the Erdoğan administration has started pushing pro-natalist rhetoric and called for abortion to be made illegal (Telli et al., 2019; Unal & Cindoglu, 2013). Studies have shown that there have been increasing levels of difficulty in accessing abortion in Turkey and that there has been misreporting of induced

abortions, probably stemming from stigma, which has only increased since the AKP made this statement (Mihciokur et al., 2014; Saraç & Koç, 2020). Although abortion is restricted in Turkey after 10 weeks, it remains legal before 10 weeks. The barrier in Turkey is not only legal, it is also in terms of access, as doctors and hospitals may deny abortion services despite there not being specific conscientious objection laws in effect, but there are de facto conscientious object practices (O'Neil et al., 2020).

I categorize Turkey as having a medium level of institutionalization, as the state does seek to control civil society, especially regarding certain politically motivated groups, but still allows freedom to organize. Due to the slow nature of erosion of the access environment in Turkey, as well as the constraints of civil society, CANs experience slower network growth and a smaller reach. I predict that I will find that CANs in Turkey will be more provincially focused due to the restrictions on civil society by the state. I also expect to see that many of the CANs are tied to other organizations such as feminist, women's issues, or reproductive health groups. They will utilize pre-existing organizations as a catalyst to establish networks of like-minded individuals who already share similar values and goals. The reach and scope of these pre-existing groups may work to limit the CANs to remain relatively close to home.

Appalachia

In my last case, I plan to examine the active development of CANs in the United States in the wake of the overturning of *Roe v. Wade*. I chose Appalachia rather than broadly the South because it is a historically underserved area with its own unique features within the South. This sub-national case is salient because it deals with issues

the other cases do not directly capture, such as rural healthcare access, ability to travel to surrounding states, and a robust history of community organizing. I focus on the mid-Appalachian region of the U.S. (including western North Carolina, western Virginia, eastern Kentucky, West Virginia, and eastern Tennessee). Appalachia is a unique region of the U.S. where it is both politically conservative and known for its grassroots organizations in the face of government failure in the area. The healthcare infrastructure in the region is sparse, with hospitals and healthcare centers concentrated in a few cities throughout the region. As a result, many areas lack adequate access to basic healthcare, let alone reproductive healthcare.

Furthermore, although this area may be relatively small, its geography makes travel difficult, especially during the winter months, hindering access. Due to this region being in multiple states other than West Virginia, no state capitals are in the region it provides a look into how various state governments affect a relatively small area of land and the access environment. This case, in terms of geography and timing, will provide an opportunity to examine how these organizations form, organize, and attempt to grow in a changing legal environment. Although my other cases are looking at federal and national laws and how they impact abortion provision, having a sub-national case will allow for an understanding of how state or provincial laws around abortion impact communities. The Appalachian case, as a whole, in terms of space, geography, and context, is intended to serve as a magnifying lens. My other cases look at how the abortion restrictions affect a country over time, but this Appalachian case will show us how these CANs form in the wake of a change to the abortion laws, how communities organize against it, and how sub-national areas react to federal-level changes. These states have had many state-level

abortion restrictions that they have been grappling with for decades. West Virginia and Kentucky have only had one abortion clinic per state for the past several years, as well as a shortage in Western North Carolina and Western Virginia. I anticipate that much of my information about Turkey and Romania will be tied to major cities, so the Appalachian case allows for an understanding of rural organization, which may help us understand the other instances in turn.

A comparison of these three cases will allow for an understanding of the efficacy of abortion restrictions and the creation and evolution of CANs. All three contain my dependent variable, the provision of abortion. Still, the circumstances in which they get to abortion provision are dependent on the civil society circumstances in which they exist. Romania is an extreme example of where civil society did not need clandestine abortions because abortion was free, legal, and accessible. Turkey, however, represents a gradual change in not only the legal abortion atmosphere but also a change in the medical and technological environment in which these CANs exist. The Appalachian case provides a real-time view of network inception and growth. These different legal and temporal environments enable me to investigate how CANs emerge, how they develop over time and in relation to various legal and access environments, and how the availability of medical and internet technologies has altered the landscape for these networks to operate.

Methodology

The following chapters lay out a story. Now that we have addressed the theoretical questions guiding this project, we need to gain a better understanding of the layout and puzzle globally. Chapter 2 is a statistical analysis of a large-N dataset of

abortion laws and birth rate data. I seek to answer H₁: abortion restrictions do not have a lasting effect on the birth rate. As I have hinted above, Romania's abortion ban was extraordinarily effective, but the birth rate quickly stabilized and even returned to pre-ban levels. Through a compilation of pre-existing datasets on abortion laws around the world from 1960 to 2019 I have created a robust timeline of 189 countries and changes to their abortion laws, as well as birth rate data, and a variety of other variables related to development and changes in birth rates.

Once the puzzle is established, we have our three qualitative cases that help to better understand how CANs in these three areas are shaped by the civil society in which they are founded. In Romania, our first case, data is limited in terms of civil society and any CANs that existed during that time. This is a historic case study that uses secondary sources to create a picture of what abortion access was like in Ceaușescu's Romania. There is data around the number of abortions provided during this time, birth rate data, and ample research into the policies and enforcement practices of the regime to control illegal abortions. Through a collection of this data, we can glean an image of how a Romanian woman would seek to obtain an illegal abortion during this time.

In Turkey and Appalachia, I conducted fieldwork where I reached out to CANs in the region. I spent two months at each location over the summers of 2023 and 2024. In Appalachia, I found that much of the CAN work was being done by abortion funds in the region. This led me to pivot my research design in Appalachia to primarily focus on gathering data on these abortion funds and other formal CANs operating in the area that were helping people access legal abortions, even if their state had bans or restrictions, by traveling out of state. I then compiled all the CANs in that region and gathered

information about them using annual reports, websites, social media, and interviews.

These were public-facing organizations that, for the most part, are registered non-profits, so data was readily available. Data on the number of abortion seekers aided and the amount of funding distributed to abortion seekers was also available and is used in the case.

Turkey had a mixture of formal and informal CANs that operated. During my fieldwork, I snowball sampled interview participants through a few leads of academics and listservs. Through these connections, I was able to talk with many people involved with abortion access in Turkey. CANs in Turkey are a mixture of formal and informal. There are large formal CANs that work on broader issues, such as gender equality and domestic violence, that deal with abortion seekers. Then, there are informal community-based CANs that aid people in accessing abortion by providing referrals or experiences that they've had. It is important to note that abortion is legal in Turkey up to 10 weeks, but what is lacking there is reliable information, and the access environment is threatened by a decline in public hospitals that provide abortions, not due to legal restrictions.

In each case, I take a different methodological approach out of necessity. The data available is directly tied to history, the openness of civil society, and ultimately the type of CANs working in the region. Appalachia was easy for me to find data on CANs because they are, for the most part, public-facing, producing information such as annual reports and being registered as non-profits. I pivoted from an interview-based approach because the data I was primarily interested in was already available, and also because I had a difficult time arranging interviews due to the high level of busyness in CANs' daily operations. In Turkey, this was the most difficult because I was snowball sampling and

did not speak Turkish, and was there for a limited time, which limited my ability to find more informal CANs. However, I did speak with the most prominent organizations working on abortion in Turkey. I was able to glean much about the access environment there and their efforts in aiding abortion seekers.

To test H2, H3, and H4, I tackle each case separately. To understand that abortion restrictions do not work well because of CANs, I need to establish that abortions are happening because of CANs. I do this by investigating birth rate data, abortion rate data, where available, and by looking at CANs. In Romania, there are records of abortions happening during the ban that were provided in hospitals, and doctors had said they had misdiagnosed women or changed medical records so they could perform abortions in hospitals. In Turkey, abortion is legal, but access to abortion is limited. CANs here help people navigate the access environment by debunking misinformation and connecting them through referrals. In Appalachia, there is a varied legal environment, with some states having total bans and others where abortion is legal. Here, CANs are visible and public, and they record how many abortion seekers they aid by helping them obtain legal abortions in states where it is legal. I investigate how CANs work through interviews, as well as by examining CAN websites and reporting on their findings where available, to understand how they operate and respond to changes in the access and legal environment. Each case brings a different context in terms of regime, culture, and history related to abortion, but what unites them is that there is a need by people in society to access abortions when it is threatened. This is the common thread that runs through each case I investigate.

Conclusion

This project aims to understand what happens when the state overreaches into the daily lives of society to control reproduction and population. The state has a motivation to control reproduction, both as a biological reproduction and also as social reproduction, that upholds the image and legitimacy of the state through the creation and sustenance of the nation (Kligman, 1998). I believe that civil society organizes to protect the resources of abortion and subvert the state in its attempts to control the reproductive apparatus of the population. By studying these CANs, I also aim to understand how time impacts these groups, examining the urgent need for civil society to organize against the state versus a gradual change in access. This project will have implications not only for knowledge around abortion in political science but also to further our understanding of how civil society pushes back against the state and acts to subvert the state when society deems the state has gone too far. This project is generalizable; it can be extended not only beyond the cases that I have chosen, but also to other areas where good provision is restricted. For example, this framework could be used to understand illicit goods and services provisions such as drugs, medications, education, or even cultural artefacts in restrictive settings. This is ultimately a story about how people fight for something they believe should be theirs. This project highlights those who are doing that work across the world, throughout time. The *Dobbs* decision has turned the spotlight to clandestine abortions and the future of abortion access in the U.S. Still, by including global cases in my work, I believe that there is much to learn about how society pushes back against the state and organizes across borders and time. At its heart, this is a story about the relationship between state and society, where the state overreaches and society pushes

back against it. Beyond furthering our understanding of abortion, birth, and the body, this research will fundamentally show how the relationship between the state and society is carried throughout time and borders.

CHAPTER 2

DO ABORTION RESTRICTIONS HAVE A LASTING EFFECT ON THE BIRTH RATE?

Introduction

When a law is passed, it is expected to work. But, of course, that is not what always happens. Various issues may arise to prevent a law from being effective, including a lack of enforcement, inability to monitor, political interference, or public resistance. In the case of abortion restrictions, oftentimes they do not work, and that may be due to a lack of enforcement, forbearance, and, as I argue, because of the role of civil society. The primary purpose of this chapter is to understand the proliferation of abortion restrictions globally, look at birth rate data over time, and examine the relationship between abortion restrictions and the birth rate. Birth rate data is used as a proxy for the abortion rate; abortion data is not recorded reliably, and even if it were, it would not accurately show any clandestine abortions.

In the previous chapter, I first asked, Why don't abortion restrictions work? What I mean by this is, why does a change in the abortion law not affect the birth rate significantly over time? Irrespective of abortion laws, it is estimated that 25-30% of all pregnancies result in abortion (Bearak et al., 2020). Theoretically, if an abortion ban goes into effect, we should see a significant increase in the birth rate the following year. However, that is very rarely observed (Bearak et al., 2020). Based on this finding, one would expect a significant relationship between abortion restrictions going into effect and an increase in births the following year. However, based on my research, I expect this to be a minimal change when compared to the number of abortions happening annually. I

hypothesize that H₁: Abortion restrictions do not affect the birth rate. Why? Because of the role of CANs in supplementing legal abortion through clandestine and covert means (illegal abortion, medication abortions, abortion tourism, etc.). However, there is also a global trend of birth rate decline; most countries are experiencing declines in their birth rates, with a variety of abortion laws. Birth rate decline may be tied to variables associated with development, such as gross domestic product (GDP) per capita, literacy rates, provision of contraceptives, and percentage of women in the workforce.

This chapter will investigate the relationship between the Crude Birth Rate per 1,000 people (CBR) and a variety of abortion laws. Through a series of regression analyses, I aim to investigate whether or not abortion restrictions affect the birth rate over time. If an abortion restriction worked well, it would lead to an increase in the birth rate, and that increase would be sustained over time. I do not expect that to happen. I expect that in the first one to three years of an abortion restriction going into effect, it will cause a slight increase in the CBR that will be significant, but over time, the effect and significance will decrease. I believe this is directly related to the creation and operation of CANs in supplementing the abortion rate. The level of institutionalization of civil society will determine how quickly CANs can be created, grow, and reach people who need help accessing abortion. In the short term, this could take time; people will likely be forced to bear unwanted pregnancies, especially in places where it is difficult to organize. However, in the long term, we will see people find ways around these rules, create sustainable structures for working together, and successfully subvert the state by providing access to abortions. Special attention is given to abortion upon request (also referred to as abortion on demand), which makes abortion widely legal. When discussing

whether abortion is legal or not, this is the law one refers to because it makes abortion legal to anyone for any reason. There may still be restrictions in place (gestational limits, waiting times, etc.), but it does not restrict the reason someone is obtaining an abortion. My analysis will also include a multivariate regression model to examine how other variables may influence changes in the birth rate. These variables interact and may drive birth rate change, alongside and without abortion laws. I anticipate that most of the change in the birth rate data will be explained by other variables.

Throughout this project, I will refer back to the relationship between the state, civil society, abortion policy, and the birth rate. This chapter pays special attention to the birth rate, and specifically its relationship to abortion laws as well as other country-specific variables related to demographic, political, and economic outcomes. Much of the literature on demographic change and declining birth rates focuses on issues related to development. The level of education of women, whether people can vote in their country at any level, infant mortality rates, GDP per capita, and other factors all play a significant role in determining whether people have children. High-income countries, which have significantly lower birth rates than lower-income countries, are now concerned about the low levels of their birth rates and how to increase them to above-replacement levels. This project is of notable political relevance, as we are seeing countries like the U.S., China, and South Korea, which have concerns over their birth rate levels, changing their rhetoric about birth, motherhood, and abortion.

There is no doubt that some states implement abortion laws because of a desire to manipulate the birth rate. This project will focus particular attention on Romania and the issuance of Decree 770 in 1966, which made abortion go from the only form of birth

control in the country to effectively illegal in every case. This led to the most drastic and marked change in the birth rate of any country, doubling the birth rate in one year. Decree 770 was explicitly enacted to boost the birth rate and encourage economic growth in Romania. Other countries, such as China and India, legalized abortion in the 20th century to control rapid population growth, which was seen as hindering their economies. Recently, there has been an increase in birth rates in U.S. states where abortion is banned. In states that banned abortion, where the distance to travel increased to 300 miles from 50 miles, there was an observed 2.8 percent increase in the birth rate, relative to what would be observed pre-ban (C. C. Miller & Sanger-Katz, 2025). These increases observed in the United States are significant to those who are on the end of wanting an abortion and unable to access it. The birth rate increases are markedly higher with Hispanic women, those with no college degree, and unmarried women (C. C. Miller & Sanger-Katz, 2025). However, the rates could be much worse, and a modest increase suggests that other factors are contributing to the low birth rates.

Figure 7 depicts five countries that have or had near-total abortion bans from 1960 to 2019. El Salvador has one of the strictest abortion bans in the world. Currently, it is a total ban with no exceptions. Before 1998 abortion was allowed only to save the life of the mother, fetal abnormality, or in cases of rape (Guttmacher Institute, 2022a). Similarly, Ireland had the most stringent abortion bans in Europe until 2018. Their abortion ban implemented an exception for saving the life of the mother in 1992, before the ban was lifted in 2018 (Irish Family Planning Association, n.d.). Pakistan continues to have an exception to save the life of the mother (Guttmacher Institute, 2022b). The Philippines has a total ban; abortion is not legal under any circumstances (Guttmacher

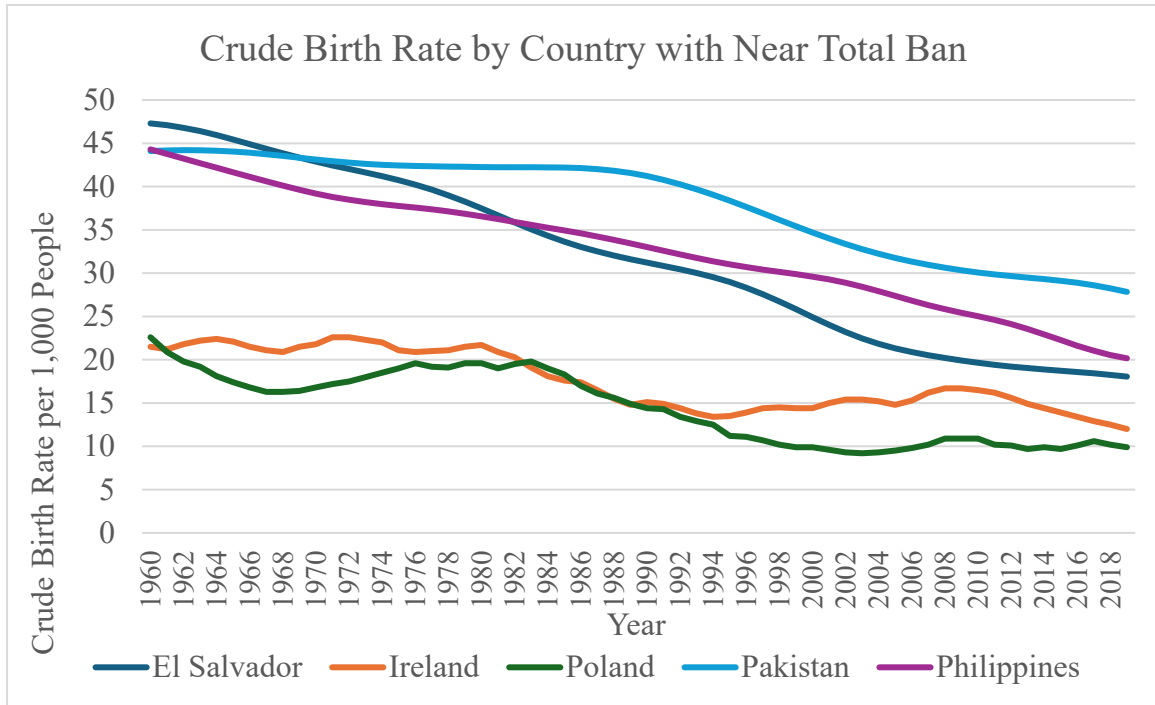


Figure 7: Crude Birth Rate per 1,000 by Country with Near Total Abortion Ban (1960-2019)

Institute, 2022c). Abortion on demand was legal in Poland until 1989 and in 1993 a harsh abortion restriction was imposed only in cases to save the life of the mother, fetal abnormality, or rape and incest (Guttmacher Institute, 2022d). Figure 7 depicts the birth rate over the past 60 years for these five countries that have some of the strictest abortion laws in the world. Moreover, by and large, we can see that birth rates are declining, even when abortion is not legally accessible. It must be said that El Salvador has a reputation for strictness around enforcement, which has falsely imprisoned many women suspected of abortion when they had suffered miscarriages, leading to the creation of the first ever abortion refugee who fled to Sweden after being detained for a miscarriage (Moloney, 2017). Even in areas with high enforcement, the birth rate continues to decline. I argue that access to abortion does not drive down birth rates, but other factors associated with development, such as access to education, do.

In this project, through three case studies, I look at the role that civil society has in supplementing the state in providing covert and clandestine abortions. First, I examine whether abortion restrictions work in driving up the birth rate over time. Logically, abortion restrictions should increase the birth rate, but I argue that this will not occur. This examination is necessary to understand how abortion restriction do, or do not, work. Through a robust quantitative analysis of abortion laws in 192 countries from 1960 to 2019, coupled with demographic data such as birth rate, fertility rates, and various developmental markers, I seek to investigate whether abortion laws lead to changes in the birth rate.

Theories of Population Rate Changes

Changes in the birth and fertility rates are of relevant concern for many around the world. The total fertility rate (TFR) for South Korea in 2022 was the world's lowest of just .8 (World Bank, 2025). TFR is defined as the number of children a woman will give birth to in her lifetime, if experiencing the current specific fertility rate. Concerns in East Asia over the fertility rate have become significant as the population ages, and many people do not have children to replace the population loss. Similarly, China has experienced a population decline for the third consecutive year, with declines in marriages (Reuters, 2025). This marked a change for China, which implemented its One-Child policy in 1979 to quell the booming population (Wang, 2012). This policy ended in 2015 and marked the beginning of the Two-Child policy, which was recently replaced by the Three-Child policy in 2023, and other measures that encourage family growth (Reuters, 2025).

Countries implement various policies to control the reproduction of their population. Sometimes states wish to limit population growth due to concerns about overpopulation, including resource scarcity, employment issues, overcrowding, and the strain on public services. Others may want to boost their population over concerns around labor shortages, aging populations, and housing declines, which lead to political weakness. Globally, the TFR has dropped from a high of 5.3 in 1963 to a low of 2.3 in 2022, with a replacement level of 2.1 needed to maintain a stable global population (World Bank, 2025). TFR and CBR vary by country and particularly by region and developmental markers. “Western and Central Africa” has the highest TFRs in the world, at 4.9, while the “Euro Area” (countries where the Euro is the form of currency) has the lowest at 1.45 in 2022 (World Bank, 2025). The CBR and TFR are often used interchangeably. However, I prefer examining the birth rate data because it is a simpler measure.

So, why has the CBR declined globally since 1960? There are many reasons, most of which are out of this project's scope, but one of the prevailing theories is that the fertility rate declines as countries develop (Bloom et al., 2009; Notestein, 1953; Thompson, 1929). The theory is that as countries develop economically, women work more and become more educated, resulting in a reduced need for, as well as a desire for, more children. The mid-20th century was also significant because of the development of birth control methods, such as the condom and the pill, which became more prevalent. Studies such as Fernández and Juif have found that fertility rate decline is not associated with abortion policies but rather is symptomatic of developmental variables. From a demographic perspective, the decline in the fertility rate is a matter of significant concern

for countries worldwide. However, it may not be of personal concern for many people who do not wish to have children or have as many as their families have had in the past. Abortion bans and restrictions may aim to force one's hand and give birth, but I argue that if the individual does not desire that, then they will find a way around the state.

Figure 8 illustrates a global trend of declining birth rates. Even in regions

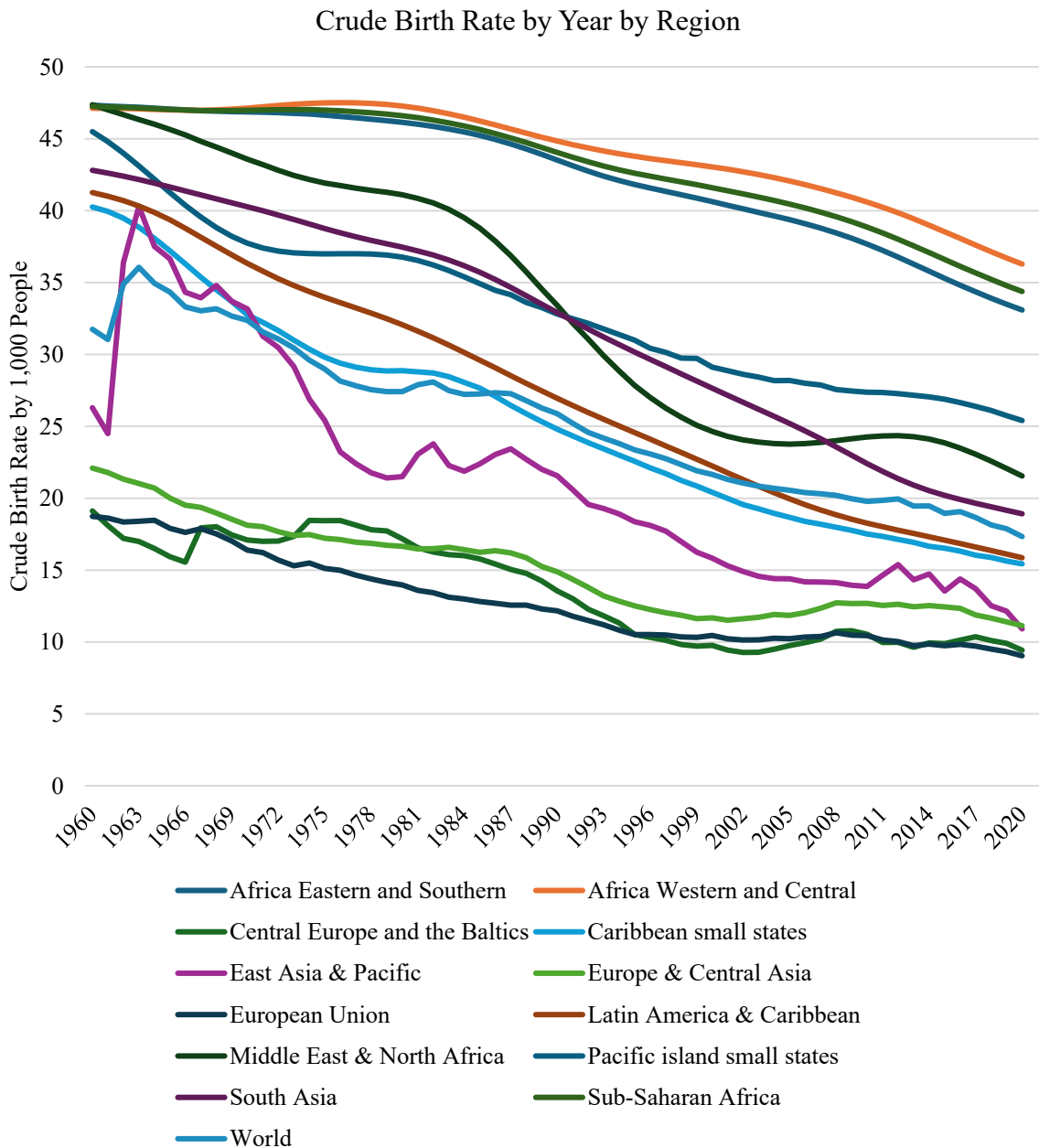


Figure 8: Crude Birth Rate per 1,000 people by Region by Year (1960-2019)

associated with a high birth rate, the trend is still decreasing. This is a substantive and robust global pattern. This pattern persists regardless of their abortion policies and is evident in geographical regions and economic-level designations, such as the Gross National Income (GNI), as shown in Table 2. The decline in birth rate is of grave concern to many governments because it has massive economic implications for national economies. South Korea's birth rate had been in decline for nine years, with the lowest observed fertility rate of 0.72 in 2023, rising to 0.75 in 2024 (Lee & Young Yi, 2025). In 2021, South Korea decriminalized abortion for the first time, happening 12 years into the fertility crisis. However, through robust social programs, including a government plan costing \$13.76 billion, South Korea plans to encourage births by making parenthood easier and more affordable for its citizens (Lee & Young Yi, 2025).

Table 2
Crude Birth Rate per 1,000 people by Gross National Income (GNI) by Decade

GNI Level	1960	1970	1980	1990	2000	2010	2019
High Income	21.55	18.53	15.60	14.22	12.31	11.58	10.07
Upper Middle Income	26.82	32.26	22.06	22.62	16.08	14.23	12.60
Middle Income	34.42	35.93	29.55	27.45	22.07	19.74	17.63
Lower Middle Income	42.94	39.94	37.33	32.62	27.36	24.19	21.45
Low Income	47.67	47.65	46.27	44.95	42.55	38.44	34.47

The Data

This study covers the abortion laws of 193 countries over a 60-year period from 1960 to 2019. The dataset used in this chapter was created by combining two extensive datasets on abortion policy worldwide. The Finlay et al (2012) dataset was the original dataset that covered abortion laws from 1960 to 2012. Their data categorizes whether there is an abortion law on six grounds that are most typical of abortion laws:

intervention to save the life of the woman, preservation of the physical health of the woman, termination of pregnancy resulting from rape or incest, suspicion of fetal impairment, termination of pregnancy for economic or social reasons, and availability on request (Finlay et al., 2012). To save the life of the mother is the most common abortion restriction, even in countries with the harshest abortion laws, which allow for an abortion to save the life of the mother. This typically is associated with a medical emergency, and up to the discretion of the doctors, in Ireland, before their abortion ban was lifted, they redefined the life of the mother to include if the mother was suicidal due to the pregnancy (Irish Family Planning Association, n.d.). The preservation of a woman's health is similar; it is just less acute or less urgent. Where the mother's health is in jeopardy due to

Table 3
Count of Legal Provisions on Abortion by Category and by Decade

Year	Save the Life of the Mother	Save the Health of the Mother	Rape or Incest	Fetal Abnormalities	Economic Reasons	Abortion Upon Request
1960	143	62	38	34	31	25
1970	132	78	46	42	42	26
1980	145	99	63	62	53	35
1990	155	115	75	75	59	44
2000	156	117	80	78	62	48
2010	169	127	96	94	67	54
2019	163	124	102	96	62	54

Note: There are 193 countries in the dataset, but many of which did not exist in the early years of the data (1960s). Soviet states were coded pre-independence as having the same abortion law as the USSR, but may lack other variables not collected until independence. A single country may be counted multiple times per decade based on their laws.

pregnancy. Abortion in cases of rape or incest is also common, but complicated because it requires legal proof that the pregnancy was caused under these conditions, and therefore, a criminal case must accompany the unusual pregnancy. Economic reasons are vague; essentially, the reasoning is that if the family cannot afford a child, they can legally obtain an abortion. It is seen as a broad and nebulous category. Abortion upon request means that abortion is legal for any reason and is not restricted by reason, but may be restricted by gestational age or provider restrictions. The variable, abortion index, is the sum of these laws up to 6, so if a country has abortion in the case of rape or incest, threat of the life of the mother and no others their abortion index would be 2. These dichotomous variables are coded in binary terms: zero indicates illegal, and one indicates legal. Any missing values are left blank. This is additive, so a country may have any value from 0-6 with any combination of these laws. However, if abortion upon request is legal that means that all other forms are legal as well, meaning that 6 not only represents legality of all 6 but that abortion upon demand is also legal.

I added an inverse variable of this, the abortion restriction index, which reverses the coding to measure a one-unit change as the implementation of an abortion restriction. Each abortion law is then coded in the inverse separately, 0 being legal and 1 being illegal, with the sum abortion restriction index being 6 if there is a total ban. This panel data is robust and provides a look specifically at a time in the 1960s and 1970s when many countries liberalized their abortion laws. However, I wanted to expand the dataset to be as modern as possible, so I used the Fernandez and Juif dataset to provide data from 2013 to 2019. The Fernandez and Juif dataset builds upon the Finlay et al. dataset as its starting point. However, they look at a 50-year period, from 1970 to 2019. The data they

Table 4*Count of Countries by Number of Abortion Provisions Enacted by Decade*

Year	0- Total Abortion Ban	1- Abortion Provisio n	2- Abortion Provisio n	3- Abortion Provisio n	4- Abortion Provisio n	5- Abortion Provisio n	6- Abortion Legal in All Cases
1960	38	78	28	5	1	6	25
1970	48	52	33	5	3	13	26
1980	35	43	34	8	13	12	35
1990	27	38	36	9	18	10	44
2000	28	37	34	8	21	8	48
2010	19	34	36	12	24	9	54
2019	15	28	33	15	27	6	54

had in common, from 1970 to 2012, was the same regarding abortion laws, so no changes were necessary during that period.

Table 4 shows the number of countries with abortion provisions in place by the decade from 1960 to 2019. A country that has an abortion index of 0 has a total abortion ban, which has notably decreased each decade. A country with an abortion index of 6 has abortion legal in all cases, including abortion upon demand, which has increased each decade since 1960. Countries with 0 have a total abortion ban, and there are 23 fewer countries with total abortion bans in 2019 than there were in 1960. The Philippines has had a total abortion ban in place since 1970; abortion is not permitted under any circumstances. Malta and El Salvador also currently have scores of 0. Ireland had previously been scored a zero, but in 2018 that number increased to six as abortion upon demand became legal (Irish Family Planning Association, n.d.). A score of three means that they have three abortion laws in place, but not abortion upon demand (which would, by nature, legalize all other types). Countries with a score of three include Argentina, beginning in 2012; El Salvador, before their total ban was implemented in 1998; Turkey,

before 1983; and Kuwait. As seen in Table 3, the most common abortion laws that could be included in these three are in cases to save the mother's life, to save the life of the mother, or in cases of rape or incest. As of 2019, 54 countries within the dataset have abortion legal in all cases, including abortion upon demand. These include many former Soviet states that have not changed their abortion laws, including Estonia and Azerbaijan, China, which has had strict abortion control policies throughout the 20th century, the United States since 1973, and many European countries like Norway. Abortion upon demand is primarily legal in European countries, North America, and Central Asia. Africa, Latin America, and the Middle East have more restrictive abortion laws, with very few countries in each of these regions having abortion upon demand legal.

I argue that abortion laws have little effect on the birth rate because of the role of civil society in providing clandestine abortions through CANs. However, a global pattern of decline in birth and fertility rates is evident in many countries. Birth rates may decline for various reasons, including economic growth, increased education, and the growing number of women in the workforce. I include variables in the dataset that examine these relationships, such as GDP per capita, life expectancy at birth, government expenditure on education (%), percentage of the labor force that are women, literacy rate, etc. The other variables used in this dataset consist of demographic information from the World Bank, political and social measures from the V-Dem dataset, as well as other variables collected by Fernandez and Juif.

Having a dataset spanning from 1960 to 2019 means that there will be many missing data points. Between 1960 and 1990, there is a significant amount of missing data because many countries in the dataset did not exist yet, particularly those that were

formerly part of the USSR. Former Soviet states have been coded to include USSR abortion laws from 1960 to 1990. Many of these countries are missing demographic data pieces from the World Bank because they were part of the USSR and therefore did not have a separate count. Some variables, such as the percentage of women in the workforce, were only collected starting from 1990. There are also various missing data pieces when countries did not report their rates of certain variables. Further, Australia, Mexico, and Nigeria all changed sub-national regulations of abortion during this period, meaning that there is sub-national variation in legality and accessibility (Fernández & Juif, 2023). For example, Mexico City legalized abortion in 2007 before it became federally legal in 2023.

The dataset is meant to capture the most significant piece of time available in abortion law data, with birth and fertility rate data. Other variables associated with driving changes in fertility are also included to control for other variables at play. If abortion laws are meant to work, then when enacted, they should drive down the birth rate theoretically. However, variables associated with development may be the more significant driving forces of the birth rate (Bloom et al., 2009; Notestein, 1953; Thompson, 1929). These variables are included in the dataset as well as the multivariate analysis to capture what is actually driving changes in the birth rate and how much explanatory power do abortion law changes hold over other developmental variables. I anticipate finding that variables associated with development and contraception are driving changes in the birth rate, and abortion restrictions going into effect will have minimal effect on the birth rate and minimal explanatory power in the models. I argue that abortion restrictions do not have a lasting effect on the birth rate. I anticipate seeing

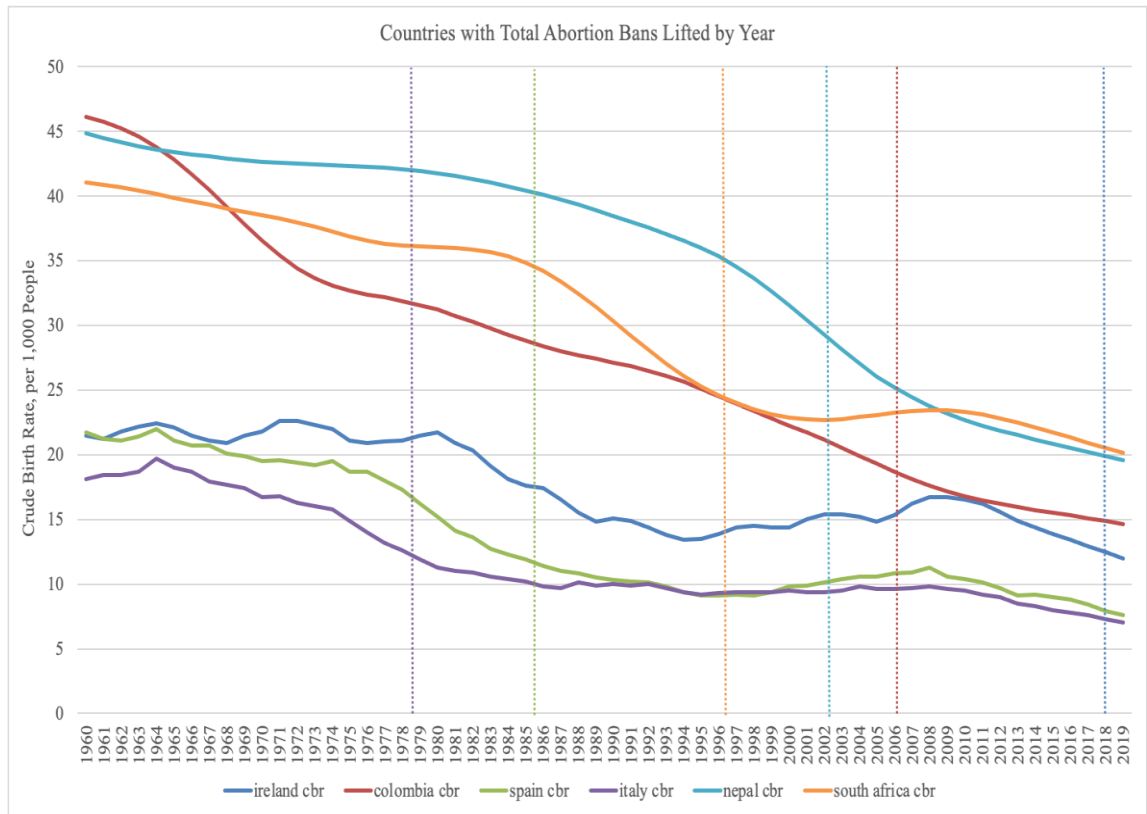


Figure 9: Countries with Abortion Bans Lifted by Year

some level of efficacy in the short-term, but believe that it will become less effective over time.

Results

If an abortion ban goes into effect, we anticipate seeing an increase in the birth rate. If the law worked perfectly, this increase could be an increase of 20-30% based on global abortion rates ranging from 17 to 44 abortions per 1,000 women by region and a global abortion rate of 39 abortions per 1,000 women (Bearak et al., 2020). Inversely, if an abortion ban is lifted, we would anticipate seeing a decrease in the birth rate due to people being able to access abortion legally. Figure 9 shows the birth rates of six countries from 1960 to 2019. These six countries (Ireland, Colombia, Spain, Italy, Nepal, and South Africa) all had total abortion bans and lifted their restrictions in the year

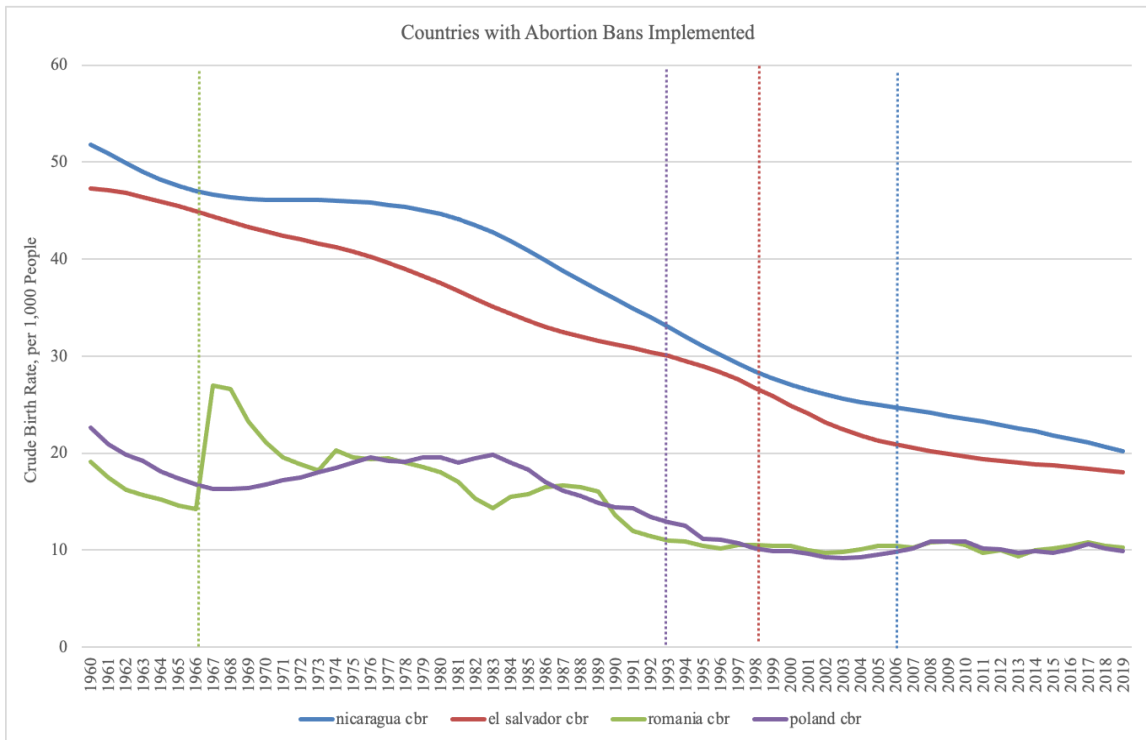


Figure 10: Crude Birth Rate per 1,000 by Year with Countries with Abortion Bans Implemented marked indicated by the vertically marked line. Each of the countries was experiencing a decrease in their CBR already when the abortion bans were lifted, and continued to have decreases in their CBR. Although easy access to abortion certainly would affect decreasing the birth rate, liberalization of abortion laws may be a final step on a general liberalization of society that may include gender equity measures, access to contraception, and income increases that are also associated with decreasing birth rates.

Conversely, Figure 10 shows countries that had abortion bans implemented when they had previously been legal in some way. There are few cases with this pattern because the story of the twentieth century in terms of abortion is one of legalization. Four instances during this period, from 1960 to 2019, followed this pattern: Nicaragua, El Salvador, Poland, and Romania. Before the total abortion bans took effect in Nicaragua and El Salvador, abortion had been widely illegal, and was illegal upon request. There were exceptions for therapeutic abortions (when the life or health of the mother is at risk)

and El Salvador additionally allowed abortion in cases of rape and incest which typically require a criminal charge against the perpetrator. So, these total abortion bans just made a restrictive environment worse. In Poland and Romania, however, abortion had been legal and accessible upon request under their communist regimes. When Poland transitioned to democracy in the early 1990s the influence of the Catholic church grew and resulted in an abortion ban being implemented that allowed for therapeutic abortions, rape or incest, or fetal abnormalities. An even stricter abortion ban was enacted in 2020 that removed abortions in the case of fetal abnormalities, no matter how severe. Romania is my outlier and one of my qualitative case studies due to this. It appears in this graph to counter my argument. I argue that abortion restrictions do not work well, but as shown this abortion ban worked exceptionally well, doubling the birth rate in the first year after adoption. I argue that the civil society landscape in Romania prevented CANs from supplementing

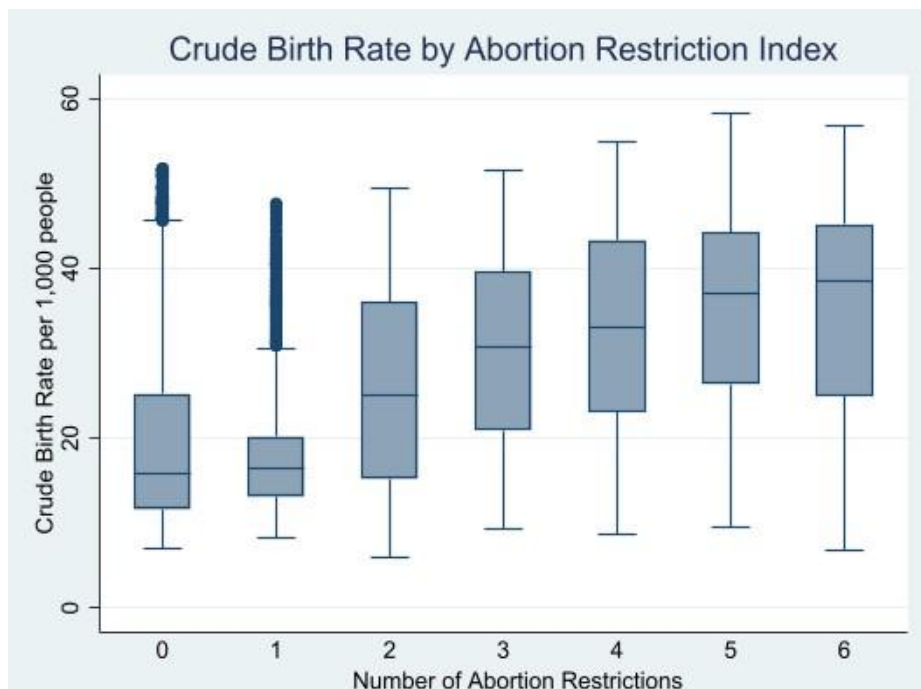


Figure 11: Box Plot, Crude Birth Rate per 1,000 people grouped by Number of Abortion Restrictions (0-6)

abortion in those initial years, but worked later to provide abortions even in an authoritarian regime.

$$\text{CrudeBirthRate}_{it} = \beta_0 + \beta_1 \text{AbortionLaw}_{it} + \beta_2 \text{it} + \mu_i + \lambda_t + \epsilon_{it}$$

To investigate whether abortion restrictions work after they are implemented, I conducted a fixed effects regression analysis of the abortion restriction index variable and CBR. A fixed effects regression model controls for any shocks that may occur over time (e.g., pandemics, conflict, crises) within countries and focus on how changes within each country over time affect the outcome variable. The Hausman test, in Appendix C, revealed a statistically significant difference between a fixed-effects and random-effects model, indicating that the fixed-effects model was preferred for this type of data. I also cluster standard errors because observations within countries are likely correlated with each other, which can sway significance levels and underestimate the standard errors. Clustering the standard error does not necessarily affect the regression coefficient, but it does adjust the standard errors and significance levels within the models. Clustering the standard errors and using the fixed effects model creates an unbiased and statistically valid model by accounting for these potential effects.

Table 5 looks at the effect of restrictions on abortion upon request to the CBR over time. Abortion upon request is a dichotomous variable measuring if abortion is legal broadly, if someone can get an abortion for any reason. Lagging the abortion law variables is necessary by at least one year because of the gestational period of a pregnancy, and because this law could have a change over time in its efficacy. I then created five lagged variables, from one to five years. I grouped the lagged variables into short-term (1-3 years) and long-term (4-5 years) to measure changes over time. When we

Table 5

Fixed Effect Model of Abortion Upon Request Restriction (Dichotomous) in Short-Term and Long-Term on the Crude Birth Rate per 1,000 people

Effect	Estimate	SE	t	p	95% CI	
					Lower	Upper
Short-term Abortion Restrictions	5.54***	1.15	4.83	< .001	3.27	7.80
Long-term Abortion Restrictions	1.91	1.02	1.88	0.062	-0.10	3.91
Constant	22.48***	0.86	26.19	< .001	20.79	24.17

R² (Within) = .054

N = 9,698; Standard Error Cluster Groups by Country = 189

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

Note: Short-Term Abortion Restrictions are lagged 1-3 years, Long-Term Abortion Restrictions are lagged 4-5 years.

discuss an abortion ban, we think of when abortion upon request becomes illegal because what is left is extraordinary circumstances such as cases of mother's life is at risk, fetal abnormalities, rape and incest. Abortion upon request means that abortion is legal broadly, so that someone may obtain an abortion because they want one. There still may be abortion restrictions in place, such as wait periods, gestational age limits, etc. However, this is a significant variable because other types of abortions (to save the life of the mother, rape or incest, etc.) are difficult to access because they require an emergency or extenuating circumstance, so the incidence of those abortions is not very high. Table 5 shows that abortion restrictions weaken over time. I hypothesize that over time, birth rates stabilize from a sudden change in the abortion laws due to the role of civil society acting to get around the restrictions. If abortion restrictions do make a significant impact on the birth rate, it will most likely be in the first two to three years. The first year after the restriction will see the pregnancies during that initial year brought to term, and the

second and third years will still be a learning curve for people and CANs in organizing. Those restrictions within the first through third year have a significant positive relationship with the birth rate, meaning that when an abortion restriction is enacted, it does drive up the CBR in the short term. However, in the long term (4-5 years), this effect is no longer significant and has a smaller effect, with greater uncertainty illustrated in the confidence interval. Furthermore, this model explains only a small portion of the variance in the CBR, accounting for 5.4% of the 9,698 observations in the data. What this tells us is that abortion restrictions may work, at first, but their effect decreases over time. I argue this is because of the role of civil society in helping to supplement abortion access. This regression analysis depicts that abortion restrictions are less effective over time.

Table 6
Fixed Effect Model of Abortion Restriction Index in Short-Term and Long-Term on the Crude Birth Rate per 1,000 people

Effect	Estimate	SE	t	p	95% CI	
					Lower	Upper
Short-term Abortion Restrictions	1.11***	0.23	4.91	< .001	0.66	1.55
Long-term Abortion Restrictions	0.70***	0.18	3.79	< .001	0.34	1.06
Constant	22.77***	0.76	29.98	< .001	21.27	24.27

R² (Within) = .108

N = 10,139; Standard Error Cluster Groups by Country = 189

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

Note: Short-Term Abortion Restrictions are lagged 1-3 years, Long-Term Abortion Restrictions are lagged 4-5 years.

The abortion restriction index (a sum of abortion restrictions on a scale of 0-6, where 6 is completely illegal and 0 is legal in all cases) is lagged from 1 to 5 years to show how effective abortion bans are over time. The abortion restriction index variable discussed earlier considers six grounds for restricting abortion, including abortion upon request. Table 5 considers only the dichotomous variable of abortion upon request being legal/illegal, whereas Table 6 is the index variable. Similar to Table 5, I categorize the lagged variables into short-term and long-term groups to examine their effects. Table 6 shows the relationship between an increase in the abortion restriction index and the CBR. As a country adopts an abortion restriction, its birth rate increases by 1.11 births per 1,000 people in a statistically significant way. Like Table 5, the short-term effects of abortion restrictions are statistically significant, but the effect size is smaller. This model includes abortion upon request but also includes abortion restrictions that have less abortions associated with them (to save the life of the mother, rape or incest, etc.). Using this index variable with the within-country model enhances the model's explanatory power beyond that of the binary variable in Table 4. Unlike Table 5, the long-term restrictions are also statistically significant, although the effect is much smaller at 0.7 births per 1,000 people. The long-term variable may remain significant because it captures a broader range of circumstances and cumulative pressures surrounding abortion. It takes into consideration how cumulative abortion restrictions create a more difficult access environment for people to navigate. This can also be understood by the increase in R^2 from Table 5 to Table 6, which almost doubles the variation it explains over time.

Both models are significant in terms of their explanatory power, both statistically and in our discussion. I tend to prefer Table 5 over Table 6, not for any statistical reason but because abortion upon request is the most essential abortion restriction theoretically. When we discuss whether abortion is legal, we discuss whether it is legal upon request, and therefore, it means it is widely accessible. Thus, Table 5 shows the impact of whether abortion is legal or illegal, rather than the index, which shows if it has been chipped away. Table 6 is also significant theoretically because many times countries erode abortion access over time, so abortion restrictions may slowly increase rather than go from 0 to 6 at once. Alternatively, they may have many abortion restrictions in place with 1 or 2 exceptions, which makes abortion perhaps effectively illegal if only a minimal number of people can access it. For a descriptive look at the distribution of birth rates per the number of abortion restrictions, we can refer back to Table 3, Table 4, and Figure 10.

Much of the literature on birth rate changes suggests that contraceptive access and developmental changes are the most significant drivers of changes to the birth rate. Table 7 examines six regression models with various independent variables to explain the variation in the CBR. Model 1 exclusively looks at the relationship between abortion restrictions in the six categories and the CBR. These abortion restriction variables are all lagged by 1 year, since we would not know the CBR until the year after it goes into effect. All abortion restrictions have a significant effect on the birth rate except to save the life of the mother. Theoretically, an abortion restriction should have a positive effect on the birth rate. However, a restriction on abortions for economic reasons has a significant adverse effect. Model 1 only explains 17.9% of the variation in the CBR. Model 2 looks at the impact that contraceptive policies have on the CBR and uses the

Table 7
Fixed Effects (Within) Regression Results Predicting Crude Birth Rate per 1,000 people (CBR)

Effect	Model 1 CBR	Model 2 CBR	Model 3 CBR	Model 4 CBR	Model 5 CBR	Model 6 CBR
Abortion Restriction Life ⁺	-0.063 (-0.05)					
Abortion Restriction Health ⁺	5.238*** (4.10)					
Abortion Restriction Rape ⁺	3.632* (2.10)					
Abortion Restriction Fetal ⁺	2.240 (1.18)					
Abortion Restriction Econ ⁺	-1.786 (-1.06)					
Abortion Restriction Request ⁺	3.357* (2.46)		-1.239* (-2.14)	-0.468 (-0.91)		-0.442 (-0.80)
Contraceptive Prevalence		-0.383*** (-19.70)	-0.166*** (-4.08)	-0.115** (-3.04)	-0.114** (-2.99)	-0.115** (-3.16)
Pill Purpose		-1.797 (-1.88)	-0.338 (-0.52)	-0.330 (-0.54)	-0.333 (-0.56)	-0.270 (-0.46)
Pill Sale		2.400 (1.32)				0.817 (0.52)
Pill Prescription		-1.143 (-0.97)				-0.684 (-0.70)
IUD		-1.914 (-1.36)				-1.920 (-1.89)
IUD Doctor Insertion		0.597 (0.67)				0.928 (1.28)
Sterilization		0.248 (0.84)				0.0418 (0.13)
GDP per Capita (logged)			1.394** (2.83)	1.135* (2.35)	1.160* (2.43)	1.208* (2.51)
Government Expenditure In Education			0.170 (1.26)	0.153 (1.40)	0.146 (1.34)	0.182 (1.60)

Table 7
(continued)

Effect	Model 1 CBR	Model 2 CBR	Model 3 CBR	Model 4 CBR	Model 5 CBR	Model 6 CBR
Average Year of Women's Education			-2.965*** (-7.75)	-1.906*** (-4.77)	-1.874*** (-4.71)	-1.968*** (-4.80)
Women Civil Liberties			-1.801 (-1.33)	-0.591 (-0.36)	-0.526 (-0.33)	-0.321 (-0.20)
Suffrage			-4.338*** (-3.80)	-4.002*** (-3.38)	-4.932*** (-3.53)	
Civil Society Participation			0.0625 (0.04)	0.0921 (0.06)	0.119 (0.08)	
Infant Mortality Rate			0.0667*** (5.62)	0.0678*** (5.71)	0.0647*** (5.51)	
Urban Population			-0.123** (-3.09)	-0.126** (-3.14)	-0.128** (-3.22)	
Constant	21.790*** (24.87)	51.00*** (11.81)	45.79*** (10.57)	44.88*** (10.29)	43.87*** (10.70)	45.33*** (11.12)
R ²	0.179	.706	.774	.806	.806	.811
N	10,450	4,856	2,211	2,185	2,202	2,155
F	26.31	67.65	53.45	71.07	73.45	53.95

p<.05, **p*<.01, ***p*<.001. *t* statistics in parentheses. + Variable lagged by 1 year.
Standard Error Cluster Groups by Country = 189

Abortion Upon Request Restriction as a control. Model 2 shows that all contraceptive variables are statistically significant with most driving down the birth rate, especially prevalence of contraceptives, birth control pill availability, and IUDs. Model 3 builds upon Models 1 and 2, incorporating the most salient variables and key development indicators associated with reducing birth rates, including GDP, expenditure on education, average years of women's education, and a women's civil liberties score. In addition, it takes into consideration abortion upon request restrictions.

When we think of an abortion ban, we think of abortion upon request being made illegal, which is why this is the variable I use in comparisons in this regression analysis.

In this model, the abortion restriction is less significant, but it is also negative. In Model 1, there are no controls, and it is a simple model that lacks much explanatory power. Furthermore, it may be an issue of correlation rather than causation, as other controls are not included in this model, which may be biasing the results positively. In Model 3, there are important control variables, and the explanatory power has increased significantly, allowing the model to account for what is truly driving changes in the CBR while also isolating the impact of abortion upon request within the model. However, all other variables, except for women's civil liberties, are significant at $p < .001$. It also has a high R^2 score, accounting for 78.8% of the changes in the crude birth rate in this model. Model 4 includes abortion on request, contraceptive variables, and key development indicators, including urban population and infant mortality, as well as key political indicators, including suffrage and liberal democracy. Abortion upon request restrictions are not statistically significant in this model. Model 5 is identical to Model 4, except that it does not include the option for abortion on request. All variables remain significant with an R^2 of 81%, meaning that the abortion upon request did not provide any additional explanatory power in that model. Model 6 includes the abortion on request variable as well as all other control variables. When controlling for all other demographic, political, social, and economic indicators, the legality of abortion on request does not have a significant negative impact on the birth rate. This model shows that when abortion is legal and changes in the birth rate are observed, it is likely a reflection of other factors rather than abortion provision.

The findings in Table 7 are compelling evidence that abortion restrictions have a minimal effect on the CBR. What drives changes in the CBR are things such as

contraceptive access, the average years of women's education, suffrage, and infant mortality rates. The results show the complexity of the issues, but also demonstrate that the legality of abortion is not a driver of the CBR in a significant way. Tables 5 and 6 also underpin that notion, that any effect felt in the short term lessens in the long term when it comes to restricting abortions. If abortion restrictions are meant to drive up birth rates, why do they lose their efficacy over time? In part, the regression indicates that they do indeed lose their effectiveness over time. But, they also do not explain much of the changes in the CBR. Table 5 does demonstrate how other variables drive birth rate changes, specifically around gender equality, such as access to education, who has the right to vote, and whether they have access to contraception.

Discussion

The above analysis seeks to establish that abortion restrictions do not work as they are intended to. If an abortion restriction worked well, it would completely restrict abortion and lead to a significant increase in birth rates that would be sustained over time (Bearak et al., 2020). That is not observed. What is observed is that when an abortion restriction is put into effect, it has a minimal increase in the birth rate in the short term. That effect decreases and is no longer statistically significant in the long term. I can then reject the null hypothesis and accept H_1 , abortion restrictions do not have a lasting effect on the birth rate. People are going to access abortions whether or not they are legal. What is happening between the short term and long term? I argue it is the proliferation and development of CANs that act to supplement abortions for people who need them.

The story of the twenty-first century is one of birth rate decline and the

legalization of abortion. Mexico, Ireland, South Korea, and Argentina have all lifted abortion bans in the past 10 years, and others have liberalized their abortion laws. Abortion upon request is legal today in about 75 countries; many others have various levels of restrictions, but only a few have seen a national-level restriction go into place since 1994 (Center for Reproductive Rights, n.d.). As the world continues to develop, birth rates are likely to continue declining. Birth rate decline is often associated with developmental factors such as access to contraception, increases in GDP, literacy, and labor rates for women, suffrage, etc. This is a growing concern for political leaders, who are increasingly worried about shrinking and aging populations and what that may mean economically, politically, and socially for their countries. In the U.S., political leaders have used these concerns about population growth as a way to rationalize abortion restrictions and bans in states. This pattern could increase as more countries become concerned about the demographic makeup and future of their country.

What needs to be answered moving forward is why abortion restrictions do not work well. From Tables 5 and 6, we can see that the effect of abortion laws is negligible on the CBR. However, that effect not only becomes less statistically significant over time, but it also has minimal explanatory power over the variance in the CBR. Only 5 to 10% of the CBR data is understood by changes in the abortion laws. I argue that this happens because of the role that civil society plays in providing abortion access in a variety of legal contexts. These CANs act to provide abortions because there will always be a demand for abortion services. Abortion laws have less efficacy when there is an operator in society working directly against the law to provide abortions despite the legal context. The creation, growth, and outreach that CANs do in the first few years of an abortion

restriction or ban have a long-term effect on the birth rate. It may take CANs a few years to organize themselves operationally, but once those avenues are established, they remain open, which is why, in the long term, we see a decline in the birth rate. To understand what is happening in the short term and its long-term implications, we can examine case studies and gain a deeper qualitative understanding of CANs and the relationship between the legal environment, civil society, and the birth rate.

What the qualitative case studies of Romania, Turkey, and Appalachia will show is that when there are nebulous, tenuous, and restrictive legal environments around abortion, civil society will act to facilitate abortion. The structure and services offered differ among these CANs from formal non-profits to word-of-mouth networks in communities, but they all act to subvert state restrictions by providing access to abortion. In my data, shown in Figure 10, Romania is my outlier. It is a visible case of when an abortion ban was implemented, the birth rate spiked, doubling what it had been the year prior. Seemingly, it is the exact counter to my argument; this is an abortion ban that worked exceptionally well. However, Romania was in a totalitarian communist regime during that time; there was no civil society, and it was extremely restrictive of how people organized and had a strong arm on enforcement early on. Contraception was illegal, the only form of birth control was abortion, leading up to Decree 770, and abortion was easy to access and affordable. So, when the ban went into effect, there was no civil society infrastructure to provide clandestine abortions or to help navigate changes in the laws until several years later, when the birth rate started to decline to pre-ban levels. Each case throughout this dissertation will look at a unique instance of when an abortion restriction or ban is implemented, how civil society organizes in the wake of

that, and ultimately, how people can access abortion despite the legal obstacles in place.

Chapter 3 will investigate these patterns presented in this chapter through a detailed qualitative case study of Romania in the Ceaușescu era.

CHAPTER 3

ROMANIA: ABORTION IN THE TIME OF CEAUȘESCU

Introduction

Romania is one of the most prominent cases of abortion, population, and demographic control. In 1966, Decree 770 was enacted, which heavily restricted abortion in Romania. The year after the abortion ban went into effect in Romania, the birth rate doubled. Approximately 80% of pregnancies ended in abortion in 1965 (Ross & Mauldin, 1988). 1.1 million abortions were documented in 1965, the last full year abortion was legal in Romania, and in 1967, only 205,000 abortions were reported, a decrease of 81.5% (Kligman, 1998). However, I still contend that no, abortion restrictions do not work well. They do not work because of the role of civil society in facilitating clandestine abortions. In communist Romania under Ceaușescu, there was no real civil society, and especially no civil society organizations focused on gender issues, women's reproductive rights, or health care access. There were no civil society organizations (CSOs) in Romania, and all social groups were under state control. But groups organized around reproductive health, or rights, weren't needed before this law; before the abortion ban, abortions had been free, legal, and accessible for the 10 years prior. This chapter focuses on why this abortion ban worked so well and what eventually led to the decline in the birth rate in Romania during Ceaușescu's rule. Why, out of every country in the world, did Romania in 1967 have a birth rate double? And, what led to its decline?

I argue that civil society is going to organize to provide clandestine or covert abortions no matter what. So, what happens when there is virtually no civil society? If CANs are going to form no matter what context they lie in, what if the independent

variable, the institutionalization of civil society, is set to zero, or near zero? Romania explores this theoretically because civil society was minimal, if not absent entirely. However, abortions were still provided in these circumstances. The CANs that did form in Romania were extremely limited, informal, and hyper-local. The limitations and restrictions around civil society under Ceaușescu's regime would have made larger associations, networks, and groups a target (Kligman, 1998). But people in Romania continued to get abortions after the ban was introduced. There was documentation of doctors who would provide illegal abortions, or would falsify medical records to provide abortions legally, and there were those who used herbs and other traditional methods (Kligman, 1998). Survey data from the 1990s is available about how many Romanian women were able to access abortion legally and illegally under Decree 770 (Johnson et al, 1994). However, there are limitations to the data available for this case. Given the historical context of this case, which occurred in an authoritarian regime, the available data is limited. There were no formal CANs operating, and the informal CANs that were in operation did not have substantial documentation surrounding their existence, beyond the fact that they existed. This creates a problematic area in which to operate; we can infer their existence due to patterns of abortion provision, maternal mortality rates, survey data done in the early 1990s, and birth rate data. Romania serves as an important theoretical puzzle, and one that sets the stage for us to understand better and explore the relationship between civil society and abortion provision.

Beyond an abortion ban, birth control was also limited in Romania. Birth control pills, condoms, and any implants, such as IUDs, were all banned. The only forms of contraception widely available were natural methods such as the rhythm method (only

having sex during certain times in your cycle) and withdrawal, both of which are unreliable, with failure rates of 13.4 to 13.9% (Cleland & Ali, 2004) . Following the steep increase in the birth rate in 1967, the birth rate began declining in 1969 until 1989, when the communist regime fell, and abortion was legalized in Romania. How did the birth rate decline when there were no contraceptive or legal abortion options? Illegal abortion became prevalent in Romania following Decree 770. This chapter will lay out the motivations of the communist state to control the reproductive apparatus of the population, highlight the plight of Romanians under Ceaușescu around reproduction and daily life, and then detail how Romanians were able to subvert a totalitarian state to provide themselves with abortion services.

Background and Context

History of Abortion in Romania

In 1936, abortion remained illegal and formalized in the criminal code, 11 years before Romania became a communist state. In the 1930s, Romania had the highest birth, death, and infant mortality rates in Europe (Baban, 1999). It also had a strong rural peasant class, where around 80% of Romanians worked in the agricultural sector (David & Baban, 1996). The communist project in Romania would significantly impact all aspects of society, including class, the rural-urban divide, religion, and moral arrangements. Like many abortion bans, abortion was not totally banned under the 1936 criminal code; it allowed for abortion in cases to save the life of the mother or in cases of severe genetic disorder. Abortion remained illegal in the early parts of the Socialist Republic of Romania, which began in 1947.

Socialist, or command, economies relied on the availability of labor. It was therefore necessary for socialist governments to control the population, including its reproduction. Romania's national interest was to ensure the availability of labor in the long term. The State Commission for Planning was established in 1948 to create a plan to nationalize the economy (Kligman, 1998). The plan included general development plans centered on education, resulting in mass urbanization, an influx of skilled workers, and housing shortages in urban areas. From 1948 to 1957, abortion was illegal in Romania, except in a few circumstances, but was not heavily monitored. It was only classed as a misdemeanor, and legal abortions were done at the discretion of doctors rather than being observed by the state (Kligman, 1998). At this early period of the building of the socialist state, the connection between control of the reproductive apparatus and the state's interest was not yet drawn.

In 1957, abortion on demand became legal and then became the only legal form of contraceptive available to Romanians. Two years earlier, the USSR had legalized abortion on demand, and it was seen as part of gender and social development projects. Contraception remained unavailable in Romania, as there was a restriction on importing foreign goods, including all family planning methods (Baban, 1999). Abortion was the only form of family planning, and access to other contraceptives was difficult and expensive to procure on the black market. Meaning that from 1957 to 1966, the only form of family planning was abortion. The number of abortions in the early 1960s was high, with Filantropia hospital in Bucharest reporting that there were 14 abortions for every live birth in the hospital during the first six months of 1962 (Johnson et al., 1996). In 1965, there were 1.1 million abortions reported in a country whose population was 19

million people. It was not uncommon for a woman to terminate twenty-plus pregnancies throughout her life in Romania (Johnson et al., 1996; Pop-Eleches, 2006). During the 1950s and 1960s, significant demographic changes occurred throughout Romania. No longer was 80% of the population engaged in agriculture and living in rural areas as in the 1930s; people were moving to urban areas, becoming educated, and were guaranteed minimum wages and a general standard of living (Pop, 2020). The urban population grew by 15%, and the workers' state guaranteed minimum living standards and wages (Kligman, 1998). As shown in the previous chapter, rising development indicators are associated with declining birth rates. By the mid-1960s, Romania and Hungary had the lowest fertility rates in the world, at 1.9 children per woman, and their annual population growth rate was less than 1%, the lowest in Europe . Although the population was growing, it was at a much slower pace than what was needed to sustain a command economy over time.

When Ceaușescu took office in 1965, concerns over the population became his primary concern. The Ceaușescu regime aimed to increase the population by 30 million, representing a 156% increase in the population. In 1966, Romania's population was 19.2 million. By 1989, it had risen to 23.1 million. What is striking about the discussion around abortion in Romania under Ceaușescu is that it was a blatantly pro-natalist policy. The images that the state projected were those of productive members of society, not only in terms of labor but of reproduction.

Decree 770. The low birth rate prompted the new General Secretary of the Romanian Communist Party, Nicolae Ceaușescu, to undertake a massive demographic rebuilding project. Sworn in in 1965, it took him only one year to introduce one of the

most influential decrees of his time in office. Ceaușescu was inspired by Stalin's 1936 law to restrict abortion due to concerns of population growth. In October 1966, Decree 770 was issued, banning abortion in most cases. Decree 770 states that interruption of pregnancy is prohibited with limited exceptions for: life of the mother is in danger, one of the parents suffers from a serious hereditary illness, pregnant woman has severe physical, mental, or sensory disabilities, the woman is over the age of 45, the woman has given birth to four children, the pregnancy is the result of rape or incest (Consiliul de Stat al Republicii Socialiste România, 1966). Other provisions of Decree 770 include that the exceptions must be done in the first month unless to save the life of the mother, obstetrician-gynecologists must perform the abortions, authorization must be granted by a district or city medical commission, if the abortion must be done immediately the doctor must notify a prosecutor within 24 hours, and that if any of these are disobeyed then it is punishable by the criminal code.

Decree 770 has a reputation as one of the severest abortion restrictions in history. The content of the law is not what makes this decree unique; it is the level of enforcement of the law over a society that cannot organize itself. One week after Decree 770 was enacted, Decree 779 came into effect, which amended the Romanian Family Code. These amendments created obstacles for couples seeking divorce, including court interventions that required reconciliation and increased bureaucratic processes. Pressure was put on judges to deny divorces and to preserve marriage, especially for couples with no children or young couples who could still have children. Although birth control was already unavailable in Romania, it was also made illegal in 1966 (Pop-Eleches, 2009). This meant that only in very extreme circumstances could a woman legally obtain an

abortion, and that with no access to any contraceptive methods, women had a high probability of getting pregnant. Further, the level of enforcement, especially in the first few years, ensured that doctors obeyed the law in hospitals.

When Decree 770 was enacted in 1966, Ceaușescu established a direct connection between reproductive policies and the social reproduction of the socialist state (Kligman, 1998), allowing for the population to be both boosted and limited at will. Kligman, in her seminal work on abortion in Romania from 1998, states that by “legislating reproductive behavior, the state intruded into the most intimate realm of social relations” (p. 22). The socialist machine worked to implement the plan of the planned economy, which directly required the physical control of workers’ bodies to execute the plan. It was each citizen’s responsibility to ensure the building of socialism. Decree 770 affected every person in Romania. All couples of child-bearing age now had to worry about family planning without access to abortion or contraceptives, all single young people faced fines and taxes for being childless, couples could not divorce easily, and children then may have faced worsening conditions in changing family environments.

Restricting abortion would not have worked as well as it did in Romania without the level of enforcement Ceaușescu used. The Department of State Security (Departamentul Securității Statului), or Securitate, was established in 1949. The Securitate was tasked with patrolling acts considered dangerous to society but not necessarily crimes (Pop, 2020). The Securitate then became enforcers of the abortion ban in Romania in 1967; they were present in hospitals to ensure that no illegal abortions were being performed. Their presence waned after a couple of years in hospitals, and with their absence, legal abortion numbers increased, as well as the number of

spontaneous abortions (miscarriages). The use of the Securitate was essential to the early success of Decree 770; it put the Socialist state in the hospital room with the doctor and patient. The state directly monitored any abortions conducted and, therefore, could be questioned and punished. The Securitate is an essential fixture of communist Romania, especially under Ceaușescu. It enforced the socialist plan in all facets of life, even to the extent that economic crimes committed against the state could be punished by death (Pop, 2020). This level of enforcement is rare; to deploy a policing body to hospitals to monitor the enforcement of an abortion law is unheard of and is directly responsible for the drop in the number of abortions and the increase in the birth rate in Romania during 1967.

The success of Decree 770 in the first year was astronomical. The birth rate increased from 14.2 in 1966 to 27 in 1967, nearly double. The recorded number of abortions went from 973,447 in 1966 to 205,783 in 1967. The abortion rate went from 50.7% in 1966 to 10.5% in 1967. By all statistical measures, this was a huge success. However, the initial success of Decree 770 began to wane after the second year. By 1974, the birth rate had returned to its levels in the early 1960s when abortion on demand was available. This led to the Ceaușescu government issuing a strategy that included easing the burden of parenting, such as revising the labor code to allow for lighter workloads for pregnant women and nursing mothers (Hord et al., 1991). The 1974 reform also reduced the age limit to access abortion to 40. However, these reforms did not work, and the number of legal abortions kept increasing, while the birth rate decreased. By 1985, the birth rate in Romania was the same as in 1963.

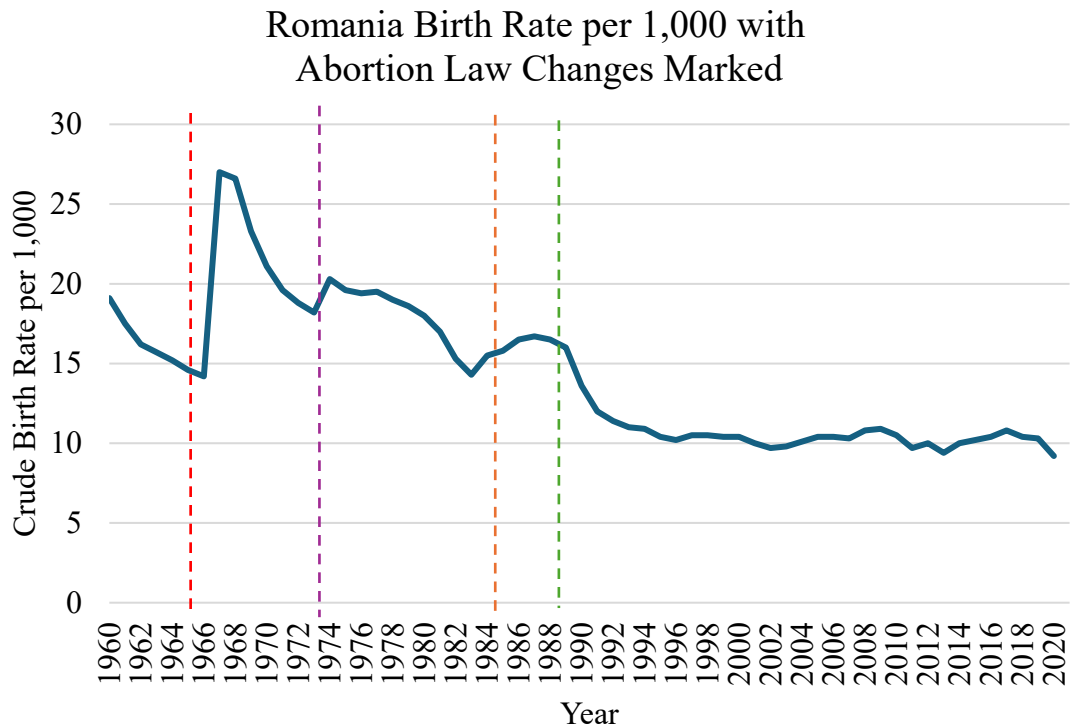


Figure 12: Crude Birth Rate per 1,000 people with abortion laws marked

1985 marked a turning point for the abortion policy in Romania. It was clear at this point that, other than the initial success in 1967 and 1968, the number of abortions was increasing each year, the abortion rate was high, and the birth rate kept declining. As a last-ditch effort to drive up the birth rate, wide-ranging changes were made not only to Decree 770 but also to various family laws in 1985. The marriage age was lowered to 15, “demographic command units” were implemented to give women gynecological exams at work, a party executive had to be present to approve any abortions in hospital, the minimum number of children needed to qualify to have an abortion increased to 5, and the age limit was increased to 45 (Kligman, 1998). In the next section, I will discuss the demographic command units at length, but these were party observers who monitored the health and fertility of Romanian women and couples. The Romanian government

also made various expenditures to increase the birth rate, including offering bonuses for the birth of children, imposing taxes on those over 25 who were childless of both sexes, and providing childcare and maternal care (Kligman, 1998). Despite the amount of effort that the Romanian government put into controlling the reproductive apparatus of its population in the two decades since 1967, the birth rate had only increased by 1.8 births per 1,000 women and the population only increased by 3.6 million people, a far cry from Ceaușescu’s desired increase of 30 million people.

Table 8
Romanian Abortion Law Details

Year	Abortion on Demand	Exceptions				
		Life of the Mother	Genetic Abnormalities	Rape or Incest	Age of Mother	Number of Children
1936	No	Yes	Yes	No		
1957	Yes					
1966	No	Yes	Yes	Yes	45	4
1974	No	Yes	Yes	Yes	40	4
1985	No	Yes	Yes	Yes	45	5
1989	Yes					

With the enforcement of Decree 770 also came a propaganda campaign by Ceaușescu to promote the new social ideals of the state. In 1986, for International Women’s Day, Ceaușescu stated, “the fetus is the socialist property of the whole society. Giving birth is a patriotic duty. Those who refuse to have children are deserters, escaping the law of natural continuity” (Ceaușescu, 1986, p. 217). The images of Ceaușescu were those of a father guiding his children, and of “father knows best” (Popescu, 1993, p. 237). Communist education taught women that sexuality was meant for procreation, and sex without the intent to reproduce was immoral and could lead to insanity (David & Baban,

1996). The image that the Ceaușescu regime promoted was that of a woman on the frontlines of socialism; she was a heroine in her motherhood, a devoted wife, who took care of the home and children, worked to promote the socialist cause, and was an integral part of her socialist community (David & Baban, 1996). Women were therefore not only meant to reproduce, but through their reproduction, they were producing socialism (Kligman, 1998).

The highest patriotic citizens' duty for each family is to have and raise children. It is inconceivable to imagine a family without children... There cannot be anything more precious for a woman than to be a mother... to procreate, to ensure the continuous development of the people, of our nation. (Nicolae Ceaușescu , 1988)

During the 23 years Romania was under the restrictive Decree 770, the messaging and propaganda campaign created a direct tie to reproduction and the success of the socialist state. The pronatalist tie in Romania was undeniable and unescapable.

The pronatalist policies affected every facet of couples' lives. There became increased anxiety over having sex because there was no reliable way to avoid pregnancy except for abstinence. Women said the only benefit of this era was that they were less worried about their husbands having affairs (Johnson et al., 1996). Demographic policy was crucial to building socialism in command economies (Kligman, 1998). Kligman argues that demographic policy was connected to state sovereignty, autonomy, and self-determination. Moreover, through this demographic policy, it legitimized state intervention into the private lives of citizens through their reproduction, birth, education, labor, and even death. Decree 770 was not the only measure in Romania to control the population; other measures during this time made divorces extremely difficult. In 1966, approximately 26,000 divorces were recorded in Romania; in 1967, there were 28 (Hord

et al., 1991). The idea was to, at all costs, retain the family, especially that of young married couples, so they could fulfill their duty to the state and start a family. Furthermore, taxes and fines were levied on childless citizens over 25, including both men and women, regardless of whether they were single or married. These taxes could be 10-20% of their annual income each year, and the rate rose in 1983, which preceded the doubling down on Decree 770 in 1985 (Pop, 2020). The regime also increased family allowances, cut taxes for families with three or more children, and offered mothers who were seen to embody the “superwoman” ideal that Ceaușescu promoted (Anton, 2018; Kligman, 1998; Soare, 2013). The promotion and production of the family and the population were the primary focus of the Ceaușescu regime.

Abortion seekers were not the primary targets of the regime’s enforcement; the medical personnel were. Decree 335 was issued in 1983, which stipulated that all medical personnel were responsible for assisting the state in achieving its demographic objectives, including reducing infant mortality rates and increasing the birthrate. If a doctor failed to meet these criteria personally, they were fined 15% of their salary for each indicator they did not meet (Kligman, 1998). Doctors were asked to do gynecological exams on factory workers in 1985 regularly and to report any pregnancies. In interviews done with doctors, many report that the pronatalist state forced doctors to abandon their professional ethics or face retribution from the state, that they would check for pregnancy when it was not routine, or they would lie and falsify reports because the task was too large (Kligman, 1998). One doctor recounted that “a certain fear existed... as fear became endemic, we became accustomed to it” (p. 155). The state’s involvement of medical doctors in achieving ends was both an attempt at significant levels of

enforcement and an attempt at undermining their cause. Doctors were not loyal to the state and often found themselves at odds with the pronatalist policies of the day. Instead, they could act to counter pronatalism by subverting the state through their actions. These actions may have been falsifying findings of gynecological exams, misdiagnosing pregnant women purposefully, and falsifying records to help women obtain a safe and legal abortion on paper. However, when the state could no longer maintain the level of enforcement it had in 1967, birth rates decreased because, by then, people had learned how to operate in the shadow of the state. When the regime doubled down in 1985 and experimented with medical enforcement, the birth rates did not react as drastically as intended because of medical non-compliance as well as people's knowledge of how to obtain abortions through other means.

As the abortion laws in Romania grew stricter in the 1980s, the national attitude toward reproduction was grim. Kligman recounts multiple jokes that were told during this era. "Joke: Why does a Romanian hen sing every time she lays an egg? Because she is overjoyed that she is not pregnant!" (Kligman, 1998, p. 67).

A policeman caught a couple making love behind the bushes. After they were booked, they went on to court. During the trial, the girl was congratulated for her patriotism; the boy for his initiative; the policeman was arrested for the illegal interruption of a pregnancy. (Kligman, 1998 p. 69).

The national attitude towards the regime's reproductive policies was so bleak that they had to be laughed at. The situation in Romania was dire, and the levels to which the regime tried to convince citizens to cooperate were unheard of. The regime used a variety of tactics to encourage women to give birth, including tax breaks, increased services, and even early retirement (Kligman, 1998). Women could retire early,

depending on how many children they had raised, with a minimum retirement age of 50 and a standard retirement age of 55. Starting in 1951, the state would award women based on the number of children they bore, in the order of the “Heroine Mother” (Kligman, 1998; Oprea, 2016). A woman who delivered and reared ten children was awarded the title of Heroine Mother, seven to nine children the Order of Maternal Glory, and five to six children the Maternity Medal (Kligman, 1998). These awards were seen as a massive movement to indoctrinate women into the pronatalist and communist narrative. That they were heroes because they were not only able to bear and raise five to ten children, but they were also working and reproducing future communist workers.

Romanian Civil Society

To understand civil society in communist Romania, it is imperative to understand the state's power. My argument in this project is about the level of institutionalization of civil society, rather than the type of regime. Romania was undoubtedly authoritarian during communist rule, but it was arguably totalitarian under Ceaușescu. Totalitarian and authoritarian regimes exist with various ideological rules. Lefort tells us that perhaps the left was initially resistant to totalitarianism because the right had created it (Lefort & Thompson, 1986). However, Lefort categorizes totalitarianism as distinct from plain authoritarianism because it erases the separation between state and society. What we have discussed of the Ceaușescu regime thus far has shown its efforts to close society off, destroy autonomy, private lives, and merge them with the state. Decree 770 merged a person’s body with the property of the state. There are no personal decisions, private life, or sex life in Romania without the state’s presence.

The execution of Ceaușescu and his wife on Christmas Day in 1989 was seen as a toppling of not only an indomitable figure in Romania but of an obstacle to progress. However, introducing a new political system into Romania was not as easy as it seemed, and the assumption that civil society would take root easily proved incorrect (Haddock & Caraiani, 1999). Civil society did not naturally crop up in Romania because the regime had so badly eradicated it for the past 50 years. During the communist period, civil society had been eradicated, either through the absorption of some civil society activities or through bans, threats, and surveillance (Burlacu, 2014). Civil society, or any social space exceptional to the state, had been eliminated by the authoritarian government. The state absorbed what civil society had been in the 1940s by either taking on the groups themselves or completing their missions around redistribution. The state then created community groups, youth groups, and other organizations aligned with the party, which were no longer independent (Hopkins, 2012). This acted as a mirage of civil society that was, in reality, another arm of the Communist Party in Romania. And with the presence and threat of the Securitate, there was reinforcement that any seemingly non-state or social area of life was not real. Kligman characterizes public life under Ceaușescu as an “invention of the regime and was highly ritualized” (1990, p. 398). No social activities were tolerated; they were seen as threatening and as opposition to the regime, and could result in imprisonment for 5 to 10 years (Todor Arpad, 2008). There was an atmosphere of fear because of the punishment that the Securitate would dish out for clandestine social activities. Under Ceaușescu, minorities were not allowed to converse in their languages, people could not freely associate with whomever they pleased, foreigners were marked, and the Securitate patrolled the city streets (Kligman, 1990).

In 1971, Ceaușescu delivered a speech now known as the July Theses, marking the beginning of a cultural revolution in Romania. The July Theses were introduced to the Executive Committee of the Communist Party on July 6, 1971, and were followed by a document outlining the new agenda of the Communist Party (Rus, 2024). The 17 points included expanding political propaganda, controlling cultural media, including radio, performances, and TV, and ensuring ideological oneness in academia (“The Theses of July,” 2014). These points created a new focus for the regime, which nationalized the industries and observed the industrialization and urbanization of its population. To sustain communism in Romania, it became apparent that control over the population's culture was necessary. The July Theses followed state visits by Ceaușescu to North Korea, North Vietnam, and China, which had inspired him to create a communist narrative in the lives of the population (Rus, 2024). Between Decree 770 in 1966 and the regime's reprioritization of cultural control, the public and private lives of Romanians were firmly in the hands of Ceaușescu.

Informal networks existed in Romania during the Ceaușescu era. But these networks existed in only the most basic forms. Various authors note the Group for Social Dialogue (Grupul pentru Dialog Social or GDS) as the most organized and influential network because it was comprised of the country's intelligentsia, including academics. They played a crucial role in the post-communist political landscape by promoting democratic ideals. Kligman argues that civil society cannot exist without a public sphere, and Romania after the fall did not have either. There were no institutionalized structures to foster social relations or informal associations, unlike elsewhere in Eastern Europe, where large anti-regime movements emerged (Kligman, 1990). What existed for

Romanians outside of regime control was the black market, primarily found in urban areas. Contraceptives were only available through the black market in the 1960s and 1970s, but by the 1980s, they were no longer available there, nor were affordable food supplies available during shortages (Kligman, 1998). The black market in Romania was perhaps one of the only networks that existed outside of state control. It was expensive, and most may not have used it, but it did exist as a collection of people providing services (Hopkins, 2012; Kligman, 1998).

In 1989, the number of civil society organizations in Romania was minimal, but had grown to around one thousand by 1994 (Grunberg, 2000). By 1994, around four million people were reported to be active in a non-governmental organization (NGO). Grunberg's research into NGOs in Romania during the early post-communist period in the 1990s illustrates how Romania's civil society was decimated under Ceaușescu. The growth of Romania's civil society after the fall of communism was markedly slower than that of other former communist or Soviet states, emphasizing the level of control of the totalitarian regime (Burlacu, 2014; Grunberg, 2000). In other states, informal networks and underground societies would typically be the first to form as NGOs or CSOs after the opening up of society; however, this was not the case in Romania. Very few organizations surfaced in 1989; it took time for them to form in the early stages of the new government. An exception was the GDS, which formally formed in 1990 but had been an underground network of intellectuals in Romania against the Ceaușescu regime.

Romanian Civil Society and Abortion. The totalizing character of the Ceaușescu regime over every aspect of life, especially the body, meant that there was an exceptional risk to moving against the state. The regime desired total control over the

reproductive apparatus of the state because it was a reproduction of the socialist character. As argued earlier, there was no private and public divide in Romania, not even in the bedroom. In 1967, after Decree 770 had gone into effect, the Securitate was stationed in hospitals monitoring abortions to ensure that only legal abortions were happening (Pop, 2020). This level of enforcement is exceedingly rare; deploying the secret police to monitor doctors and patients to ensure that the law is being followed is not a common occurrence. It was also a significant strain on the Securitate and state resources, and this level of enforcement waned after the first year or two (Pop, 2020). What is also observed during this time was that in the first two years of Decree 770 being in effect, the number of abortions had dropped significantly from their pre-restriction levels. However, after the first year, the number of legal abortions began to increase. The pattern of legal abortions happening in hospitals directly coincides with the absence of Securitate enforcement in the hospitals.

Civil society in Ceaușescu's Romania was virtually non-existent. This meant that people seeking abortions, outside of the legal parameters, had to find out how to get abortions for themselves: no organizations or even formal networks to help women navigate this significant problem. However, there were still CANs; they were just informal, hyperlocal, and based on word of mouth. Women who wanted an abortion would typically have to rely on doctors in hospitals to falsify their medical records to provide them with an abortion, even if technically outside of the legal qualifications. Doctors would diagnose women with diabetes or another disease or condition that meant they were eligible for an abortion (Pop, 2020). They would even prescribe them medication that had contraindications around pregnancy, such as chemotherapy (Pop,

2020). However, to identify which doctors were willing and able to do this, some type of linkage would be necessary. These informal CANs would resemble friends of friends, people you know and trust, asking someone they know and trust; that is how word spreads. What Romania under Ceaușescu had that many other countries with restrictive abortions do not have was a large number of doctors trained and experienced with abortion provision. Abortion education is not typical for every medical doctor, not even for obstetricians or gynecologists (OB-GYNs). So, Romania was in a unique situation where abortion was illegal, but there were trained professionals around the country who could provide abortions if they wanted to.

As with most cases of abortion restrictions, abortions are always available to those who can afford them. Doctors faced significant risks from the Ceaușescu regime for providing illegal abortions, even if they covered their tracks by falsifying medical records. Punishments for illegal abortions applied to the abortion provider, the person seeking the abortion, and any accomplices who connected the two (Kligman, 1998). Women were expected to pay doctors for their services, even if they were provided in a state hospital, due to the risks to the provider. When women could not bribe their doctor, they would turn to an “abortionist”, characterized as a non-medical professional who provided back-alley abortions, or they would self-induce through old remedies such as herbs or even turn to self-harm (Kligman, 1998). Romania saw the highest ever recorded maternal mortality rate in Europe during the Ceaușescu period, including increases in infant mortality (Horga et al., 2013; Johnson et al., 1996, 2004; Kligman, 1998). Illegal abortion was the primary method of birth control in Romania during the Ceaușescu era (Kligman, 1998). The Ministry of Health indicated that around 60% of emergencies

related to pregnancies between 1966 and 1989 were due to incomplete abortions that women or non-medical professionals attempted (Kligman, 1998).

In the mid-1980s, the Ceaușescu regime attempted to drive up birth rates again by revising Decree 770 in 1985 through Decree 441. This attempt coincided with an extensive propaganda campaign, increases in surveillance not seen in hospitals since the late 1960s, and the breaking up of abortion networks (Kligman, 1998). In 1985, demographic command units were established to examine women in their workplaces gynecologically (Kligman, 1998; Pop, 2020). The units were tasked with monitoring women to discover at the soonest possible moment when a woman was pregnant and would then monitor her pregnancy through frequent meetings. The units would also question childless women and couples about their sex lives and provide advice and treatment for infertility. Reports would be provided to the Communist Party about the discovery and potential elimination of any illegal abortion networks (Kligman, 1998). These efforts were effective for a short time, much like in 1967, but the impact was less drastic. What was observed was not the drop of some 700,000 abortions in one year, a 40% drop in the abortion rate, but a decrease of around 100,000 abortions, or a 5.5% decrease in the abortion rate from the previous year. However, the birth rate in those years increased minimally, from 15.8 to 16.7, between 1985 and 1987. The regime was enforcing the abortion law heavily as it did in 1967, but we do not observe that drastic increase in the birth rate that we did in 1967. Why? Because at that point, Romania had 20 years of experience in subverting the state to provide clandestine abortions. Civil society had been eliminated, but there was an underground network of people who may

be acting in the most local and personal networks, to provide abortions for those who want them.

Theoretical Framework

Romania plays an important role in this project. This is our first qualitative case, as it will serve as a foundation for building on the ideas of civil society and CANs. Romania under Ceaușescu is the case where there is little to no civil society, and therefore, there is no existing institutionalization or structure, nothing to build on. Civil society was extremely restricted under Ceaușescu, making it complex to form networks, let alone organizations or groups. But people resisted, no matter how difficult, to create these covert networks and find clandestine abortions. This is part of the hidden transcript of life for those under the Ceaușescu regime; they played the part of the dutiful Romanian citizen, but their practices were acts of subversion against the state (Scott, 1990). Scott's hidden transcripts tell us that "the more menacing the power, the thicker the mask" (Scott, 1990, p. 3). And Ceaușescu's power was menacing, the Securitate was a powerful force in the lives of the Romanian people, and especially around abortion and birth, the Securitate's power was felt in the early days of Decree 770. Romanians were then expected to behave as loyal citizens, even if their practices and actions did not align.

To subvert the state, the Romanian people had to become unseen and unknown to avoid interference. Their networks had to be informal and rely on word of mouth, as any more structured approach could not remain hidden. Returning to the typology of CANs put forth in Chapter 1, with low or no institutionalization of civil society, we will see only informal CANs. CANs are going to appear no matter what when abortion is restricted,

banned, or the access environment becomes threatened. The institutionalization of civil society determines the shape that CANs take. In Romania, with no civil society and persistent threats to those who are defiant, CANs had to remain hidden, informal, and loose. This sets our independent variable at zero, allowing us to examine the relationship between our independent and dependent variables without considering the role of institutionalized civil society. Through the other cases, we will see how differing civil societies alter the shape of the CANs; however, in many ways, Romania is the most basic. Romania is what happens when one of our variables is set to zero. How are CANs shaped in the absence of civil society?

I argue that when an abortion restriction is passed or if the access environment is threatened, CANs will be created to provide abortions no matter what. What shapes the CANs is the level of institutionalization of civil society. The setting where the CANs are constrained limits their capabilities by restricting the types of associations they can form, the methods of communication, and the size they can be, among other factors. In Romania, I have demonstrated that under Ceaușescu, society was heavily threatened and monitored by the state, and there was virtually no civil society; everything public was the property of and closely associated with the state. So, the only shape that CANs could take in Romania was in underground networks, spread by word of mouth, in casual links or whisper networks. Abortions were still provided in Romania despite all these obstacles. However, the state documented the number of abortions performed at hospitals these are only part of the abortions provided in Romania during this time, it does not consider the number of people who self-managed abortions through traditional methods or who procured an illegal abortion outside of a hospital.

The level of civil society institutionalization also hinders the formation of CANs. Decree 770 happened suddenly; there was no warning or degradation of access. In a day, abortion went from legal and accessible to illegal. There was no need for CANs leading up to Decree 770, and there were no CSOs around similar issues, and therefore no infrastructure for providing clandestine abortions or pre-determined connections. So, when CANs did form, it took longer because these connections needed to be made between organizers, providers, and seekers. There were hundreds, if not thousands, of doctors who were trained abortion providers who suddenly were told to halt their practices. Many of which provided clandestine or illegal abortions, but organizers needed to be connected to who was willing to do it, and for how much. Organizers needed to be activated to make connections between seekers and providers. And seekers needed to find organizers. This takes time, especially when there is a significant risk that each person involved is taking. That is why the development of CANs is slower in this type of civil society setting, and why it would take longer for the birth rate to be lowered, as abortions would take time to be provided. We can therefore anticipate a spike in the short term, but that may be lowered over a few years and continue to decline.

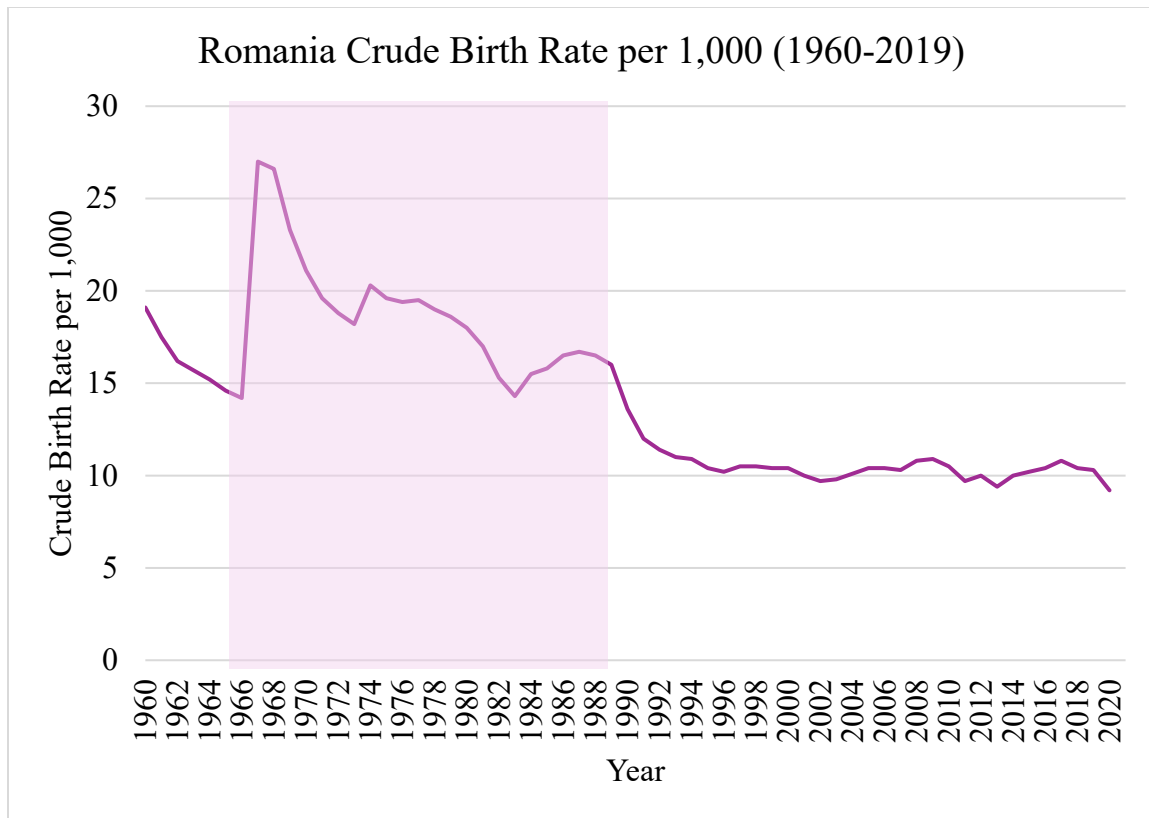


Figure 13: Romania Crude Birth Rate per 1,000 people with Abortion Ban Years Highlighted

Research Questions

I ask, do abortion restrictions work? And, why do they not work as well as they are intended? In Romania, Decree 770 worked well, at least for the first few years. This chapter aims to explain why this policy had such a drastic impact on the birth rate in those first two years, and why the birth rate eventually declined and returned to its pre-ban rates. This is the only birth rate graph in the world that looks like this, and I argue that this law was so effective in those first years because of how slowly it took for CANs to form. The eventual lowering of the birth rate and then stability throughout the 70s and 80s I believe is due to CANs working to provide abortions during this time period.

Figure 13 shows the CBR in Romania with the years of the Decree 770 highlighted from 1966-1989. This graph provides the basis of many of the questions that drive this case study. Why did the birth rate spike in 1967? Why did it begin to decrease in 1969? How can it get to pre-ban levels again in 1983? H₁ of my project, abortion restrictions do not have a lasting effect on the birth rate, can be visually represented in this birth rate chart. We can see that yes, Decree 770 had an impact on the birth rate, but it eventually declined and returned to pre-restriction levels. I argue that abortion restrictions do not work well over time because of CANs, which work to create levels of institutional links to provide abortion services in clandestine contexts. It is the determination of society to provide abortion services despite the legal context. What we see in Figure 13 is that CANs took time to form, but when they began to form and help people access clandestine abortions, the birth rate started to decrease as more and more abortion seekers were able to access abortion services. We can also see that, unlike the spike in 1966, there was no significant decline in the birth rate in 1990. This insinuates that people were able to access abortions before it became legal in 1990, but they were not accessing them in 1967. In 1989, the CANs were already well-established and had 23 years of experience in subversion.

Methodology

There are limitations to the Romanian case. Given its historical context and authoritarian nature, there is a lack of data surrounding CANs. The existing data is retrospective, relying on secondary sources and using proxies such as maternal mortality rates. However, this case is theoretically valuable, providing data and insights that other

Table 9
Romanian Birth and Abortion Statistics from 1960-1989

Year	Crude Birth Rate per 1,000 ¹	CBR Change from Previous Year	Population ¹	Women of Reproductive Age (15-49)	Number of Abortions ²	Abortion Rate per 1,000 women
1960	19.1		18,406,905	4,020,988		
1961	17.5	-1.6	18,555,250	4,053,394		
1962	16.2	-1.3	18,676,550	4,079,892		
1963	15.7	-0.5	18,797,850	4,106,390		
1964	15.2	-0.5	18,919,126	4,132,883		
1965	14.6	-0.6	19,031,576	4,149,359	1,112,704	268.2
1966	14.2	-0.4	19,215,450	4,189,448	973,447	232.4
1967	27	12.8	19,534,242	4,258,953	205,783	48.3
1968	26.6	-0.4	19,799,831	4,316,858	220,193	51.0
1969	23.3	-3.3	20,009,141	4,362,493	257,496	59.0
1970	21.1	-2.2	20,250,398	4,423,699	292,410	66.1
1971	19.6	-1.5	20,461,567	4,469,829	341,740	76.5
1972	18.8	-0.8	20,657,957	4,512,731	380,625	84.3
1973	18.2	-0.6	20,835,681	4,560,410	375,752	82.4
1974	20.3	2.1	21,029,429	4,602,816	334,621	72.7
1975	19.6	-0.7	21,293,583	4,669,683	359,417	77.0
1976	19.4	-0.2	21,551,634	4,726,273	383,220	81.1
1977	19.5	0.1	21,756,096	4,771,112	378,990	79.4
1978	19	-0.5	21,951,464	4,813,956	394,636	82.0
1979	18.6	-0.4	22,090,488	4,835,056	403,776	83.5
1980	18	-0.6	22,207,282	4,860,619	413,093	85.0
1981	17	-1	22,353,070	4,892,528	427,081	87.3
1982	15.3	-1.7	22,475,741	4,919,378	468,041	95.1
1983	14.3	-1	22,560,478	4,937,925	421,386	85.3
1984	15.5	1.2	22,640,547	4,955,450	303,123	61.2
1985	15.8	0.3	22,732,999	4,975,685	302,838	60.9
1986	16.5	0.7	22,836,841	4,998,414	183,959	36.8
1987	16.7	0.2	22,949,430	5,023,056	182,442	36.3
1988	16.5	-0.2	23,057,662	5,046,746	185,416	36.7
1989	16	-0.5	23,161,458	5,069,464	193,084	38.1
1990	13.6	-2.4	23,201,835	5,078,302	992,265	195.4
1991	12	-1.6	23,001,155	5,034,378	866,834	172.2

Note: Crude Birth Rate (CBR) and population data are used to calculate the CBR Change and Abortion Rate. The Abortion Rate per 1,000 women is calculated as (Number of Abortions/Number of Women of Reproductive Age (15-49)) *1,000

¹(World Bank, 2025)

² (Kligman, 1998)

cases do not. Romania logged the number of legal abortions that occurred in hospitals during the communist era. As discussed earlier, these were abortions performed in hospitals and may be legally nebulous due to doctors falsifying medical records. There is also robust birth rate data during that time that can be used to show the intended effect of the abortion restriction, a boost in the birth rate.

Table 9 shows the birth rate, number of abortions, abortion rate, and the changes in these rates from the previous year. Here we can look at the general pattern of data from before and after Decree 770 went into effect in late 1966, as well as the effect that legalization in 1989 had on the birth and abortion rate. In 1966, Romania saw the lowest birth rate in Europe, 14.2 births per 1,000 people. The birth rate had also been decreasing each year since 1960. In 1965, abortion had been legal on demand in Romania for eight years, and by that time, 1.1 million abortions were performed annually. It is estimated that the number of women of reproductive age (15-49) in Eastern European countries was between 40% and 45% of the female population. To calculate the abortion rate per 1,000 women, I assume the number of women of reproductive age was 42.5%, meaning I calculate the abortion rate as $(\text{Number of Abortions} / \text{Number of Women of Reproductive age (15-49)}) * 1,000$. The abortion rate is always underestimated due to illegal abortions; this only captures recorded abortions by the Romanian government, it does not include successful illegal abortions performed outside of state hospitals. However, what we can glean from this data is that the abortion rate in Romania was high before and after the Ceaușescu regime was in power. That essentially 1:4 women of reproductive age received an abortion annually before 1967. For reference, it is estimated that 1:4 women will have an abortion in her lifetime in the United States (Jones, 2024).

Women were still receiving abortions after Decree 770, but the rate at which they were receiving them was significantly lower than it had been before 1967. This increased the birth rate from 1966 to 1967 to nearly double from 14.2 to 27 births per 1,000 people, an increase of 12.8. However, the birth rate decreased yearly, except for 1974 and 1984-1987. This ambition to increase Romania's population by 30 million people fell flat. Ceaușescu, in his 29-year rule, only achieved an increase of 4.1 million people. Going back, Figure 11 shows the relationship between the birth rate and various legal changes to the abortion laws from 1960 to 2019. There was a change in the birth rate in 1967 and 1989, resulting from the most drastic changes in the abortion laws during that period. It is also important to note that the legalization of abortion in 1989 only led to 2.4 births per 1,000 decreases in the birth rate in 1990. The birth rate doubled in 1967 because abortion had been the only form of family planning available to Romanian women prior to that, and because of the level of enforcement in hospitals by the Ceaușescu regime in the first two years. In 1989, we did not see a significant decrease in the birth rate as abortion on demand became legal, even though contraceptives were still not readily available. This is because of the level of illegal or clandestine abortions in Romania before legalization.

Abortion Survey Reporting and Maternal Mortality

The levels to which Romanian women were able to obtain illegal abortions are not known; instead, they are implied. In 1996, Johnson et al. published the results of interviews conducted in 1991 and 1992, asking Romanian women about their experiences with abortion. They found that 24.2% of their respondents had had a previous illegal abortion, and 44.8% had had a previous legal abortion. This could mean that 44.8% of

respondents had had an abortion that was classified as legal, even if there may have been some level of deceit by them or the doctors to obtain it. When asked, “If abortion on request were again banned and you had an unwanted pregnancy, would you keep the pregnancy or seek an illegal abortion?” responses were divided into five regions and cities in Romania (Johnson et al., 1996). Answers ranged from 67.5% saying they would obtain an illegal abortion to 14%. When asked, “Which would you prefer, to have an abortion or prevent the unwanted pregnancy?”, women responded prevention with a minimum of 93% saying yes. When asked “When would you like to have your next pregnancy?” answers ranged from 58% saying never to 77% responding never. This study was significant for various reasons, but primarily because it revealed the extent to which women went to prevent pregnancies in Romania during the Ceaușescu period and how they sought some semblance of control over their fertility.

One of the primary concerns of Romanian women around pregnancy was the level of maternal mortality they faced. The women that Johnson et al. interviewed in the early 1990s resoundingly expressed their concerns around returns to abortion restriction. They say, “I would do anything to get rid of a pregnancy; I’ve had enough problems with the previous four children, and I don’t want another one.” Another stated, “The consequences [of a clandestine abortion] would not interest me. I wouldn’t keep a child; I don’t want more children.” A third, “I would find someone to perform an abortion on me. There are a lot of experienced women” (Johnson et al., 1994, p. 526). However, what most of the women who were interviewed expressed was their belief that any new abortion restrictions would increase illegal abortion and, therefore, an increase in maternal mortality (Johnson et al., 1996). In 1989, there were 170 maternal deaths per

Table 10
Romanian Maternal Mortality (1960-1991)¹

Year	Maternal Mortality per 1,000 live births	Deaths from Post-Abortion Complications per 1,000 live births	Number of Maternal Deaths	Number of Deaths from Post Abortion Complications	Percent Change from Year Previous, Maternal Deaths
1965	0.85	0.17	237	47	
1966	0.86	0.23	235	64	-0.9
1967	0.91	0.27	481	143	51.1
1968	0.96	0.36	506	192	4.9
1969	1.05	0.55	491	258	-3.1
1970	1.16	0.73	497	314	1.2
1971	1.31	0.91	522	363	4.8
1972	1.3	0.95	506	370	-3.2
1973	1.35	0.96	512	364	1.2
1974	1.21	0.89	517	381	1.0
1975	1.23	0.91	516	385	-0.2
1976	1.3	1.04	542	432	4.8
1977	1.45	1.11	614	469	11.7
1978	1.29	1.07	536	447	-14.6
1979	1.25	1.03	514	422	-4.3
1980	1.32	1.11	527	441	2.5
1981	1.4	1.2	533	456	1.1
1982	1.71	1.48	589	511	9.5
1983	1.71	1.47	547	471	-7.7
1984	1.49	1.28	522	449	-4.8
1985	1.37	1.18	493	425	-5.9
1986	1.51	1.29	571	488	13.7
1987	1.5	1.28	575	491	0.7
1988	1.56	1.38	591	524	2.7
1989	1.71	1.49	627	545	5.7
1990			263	181	-138.4
1991			183	114	-43.7

¹(Kligman, 1991)

100,000 births, the highest level since 1970 (Johnson et al., 2004). That same year, 148 were abortion related deaths per 100,000 live births. However, what is most amazing is that when abortion upon demand became legal, the maternal mortality rates dropped

drastically, primarily due to the decrease in abortion related deaths. By 2002, there were 22 maternal deaths per 100,000 live births, and 9 out of those were abortion related deaths per 100,000 live births (Johnson et al., 2004). The abortion upon request rate in 1990 was 160 requests per 1,000 women, which has since dropped to less than 20 since 2005 (Horga et al., 2013).

Maternal mortality rates are considered one of the most valuable indicators collected. They measure the number of maternal deaths per 1,000 live births, but have other uses. High maternal mortality rates are associated with gender inequality, poor healthcare, general health disparities, income inequality, and abortion restriction (Vilda et al., 2021). As Decree 770 went into effect in 1967, the maternal mortality rate increased by 51.1%. When Decree 770 was lifted and abortion upon demand was legalized, the maternal mortality rate decreased by 138.4%. Table 10 and Figure 14 also notably show that the majority of maternal deaths from 1967 to 1989 were from abortion complications. It must be said explicitly that the legality of abortion is tied to lower maternal mortality rates and that abortion is an incredibly safe procedure. Further, even the use of Dilation and Curettage (D&C) abortions, which safer methods of providing abortions have replaced, was still safer than any clandestine methods women may have been driven to otherwise (Cates Jr. et al., 2003). The number of abortion related maternal deaths and maternal deaths generally were low before and after Decree 770 because women were not forced to seek out illegal and often unsafe alternatives.

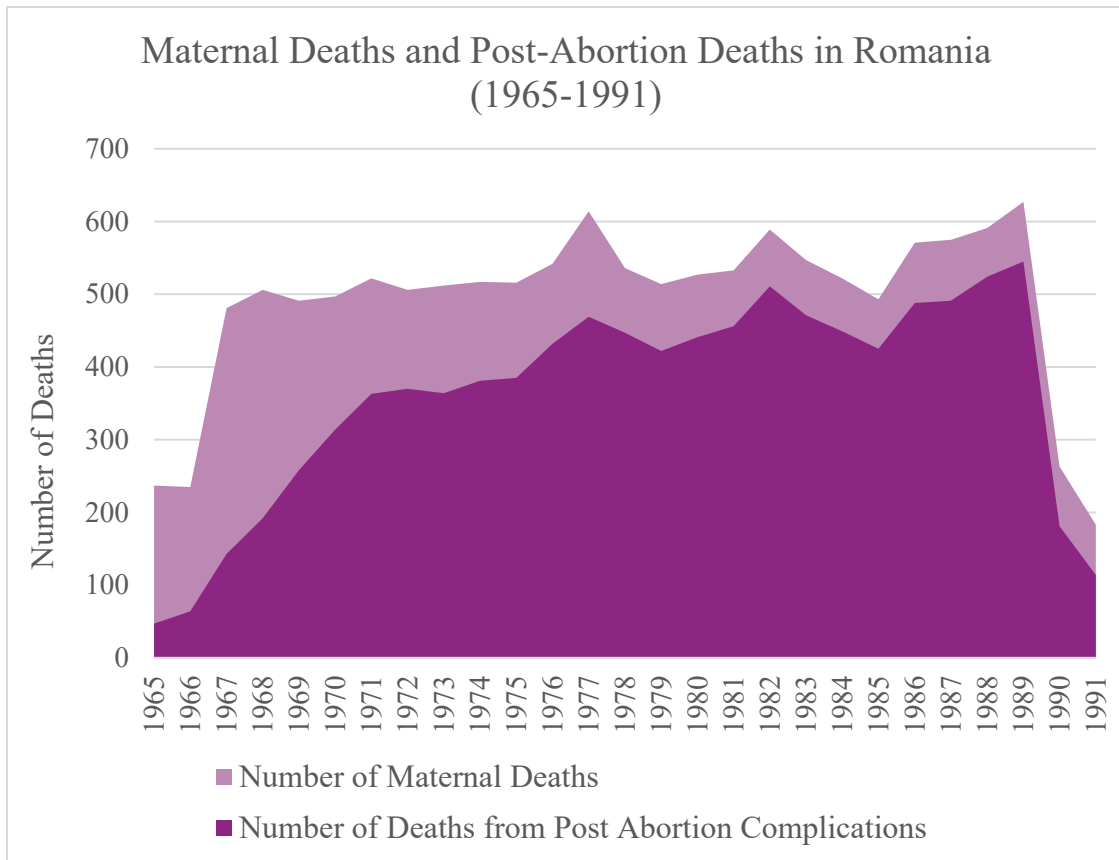


Figure 14: Maternal Deaths Total Compared to Post-Abortion Complication Related Deaths

Findings

The data in Romania during the 23 years following the issuance of Decree 770 paints a startling picture. In this dissertation, I argue that no, abortion restrictions do not work, at least not as well as they are meant to. Theoretically, if abortion is made illegal, then nearly every pregnancy should be held to term, driving up the birth rate. That is not observed, except in 1967 in Romania. In Romania, we can see in the data that at least 1 in 2 pregnancies had ended in abortion previously, because the birth rate doubled that year. We also know that in Romania, abortion was the primary form of birth control before 1966, and there were no other alternatives for contraception. What makes Romania unique in this case was the vacancy of civil society. There were no community

groups, health collectives, mutual aid organizations, non-profits, or anything else we have in other societies to help supplement people's needs. When Romanian women got pregnant, there was nowhere to turn for help, at least at first.

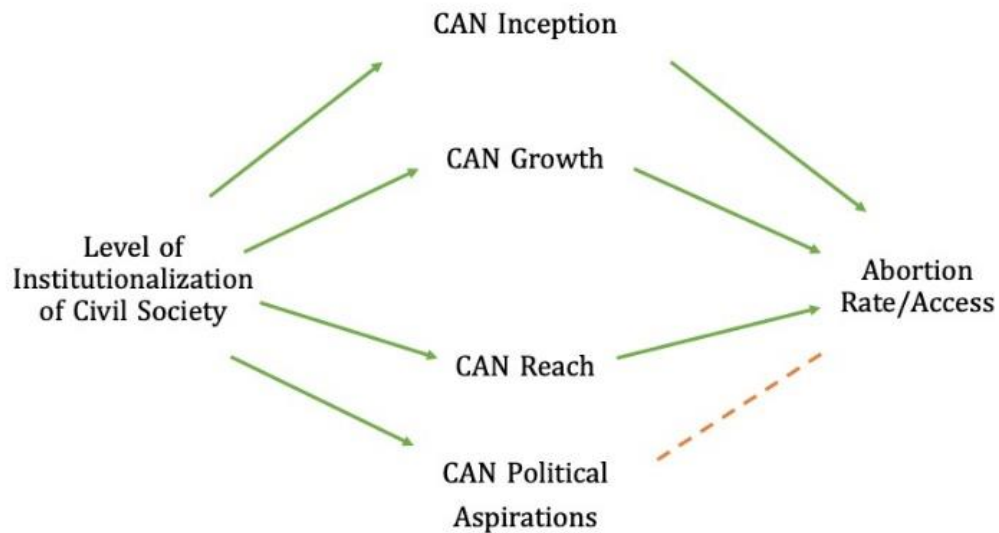


Figure 15: General CAN Chart

I argue that the level of institutionalization of a country's civil society directly ties into how CANs operate. When CANs operate well, the abortion rate and access to abortion will increase. In Romania, I argue that there was no civil society, and when it did exist, it was minimal due to the Securitate under Ceaușescu and tangible threats of imprisonment. When there is no/low civil society, I argue that formal CANs cannot form, let alone grow and expand. Informal CANs do form, but they are small word-of-mouth networks and hyperlocal. The level of civil society institutionalization dictates the shape that CANs will take by constraining their ability to operate. Returning to the theoretical argument laid out in Figure 15 we can visualize that once abortion is restricted, CANs will form. The level of civil society institutionalization intervenes in this process to

shape and constrain the CANs to form to whatever best suits that context. In a low-to-no level of institutionalization of civil society, there are serious repercussions for civil society groups that act to subvert the state, so their constraints force them to operate in small, clandestine, and shadowy networks. Based on the available data in Romania, we can draw the following conclusions.

If someone does not want to be pregnant, and they have no options, they will find a way to end their pregnancy. This may result in a safe abortion, done by a doctor who is bribed, it may be done by a back-alley abortionist, “old remedies”, or through attempts at self-harm in the hopes of ending the pregnancy. What the CANs in Romania were able to do was to work in personal networks to help abortion seekers find resources, including doctors willing to do these, or provide traditional knowledge on pregnancy termination through herbs, or provide illegal abortions provided outside of a hospital setting. The CANs still existed. However, they looked different from what we will see in Turkey and Appalachia. The context in which Romania CANs had to form and grow meant that they were virtually untraceable. Still, we can glean their existence through the data that is available such as increases in the number of abortions, increases in the maternal mortality rates, and the Johnson, et al. 1996 surveys conducted from 1990-1991.

No other explanation other than that there was some level of organization to clandestine abortions happening in Romania could explain the patterns in the data. Without contraception available in the country, the only way women could have controlled their births to that level would have been through mass abstinence. But if abstinence were practiced to that degree, we would not have seen the increases in the maternal mortality rates that are evident, the recorded legal abortions, nor evidence from

doctors as well as patients claiming they obtained or provided clandestine abortions during those years. The data speaks to the fact that covert abortions were happening to a level that insinuates a level of organization we can categorize as CANs. These CANs were small-scale whisper networks, but they helped, and there was an unknowable number of them helping facilitate illegal and clandestine abortions in Romania under Ceaușescu.

CAN Inception

In Romania, with no to low civil society institutionalization, forming CANs was incredibly difficult. There were no formal CANs ever documented in Romania, ones that were large enough to have a name and people operating in some organizational capacity. I argue that this is because there were no civil society organizations in Romania under Ceaușescu that were outside of state control. Social activities were seen as opposition to the regime, and people could not congregate in large groups without fear of retaliation (Burlacu, 2014). Romania had absorbed all former civil society organizations, groups, and operations into the state apparatus in the 1940s and 50s (Grunberg, 2000; Hopkins, 2012). The media was censored, there was mass repression, imported goods were illegal, and there was no distinction between private and public (Burlacu, 2014; Gal & Kligman, 2000; Grunberg, 2000; Kligman, 1990; Legge, 1985; Soare, 2013). There was no public life in Romania after 1989, let alone civil society (Kligman, 1990). Under Ceaușescu, Western ideas of a private life, a life where the state did not touch, were utterly irrelevant. The state touches every aspect of people's lives, from their conception to their death.

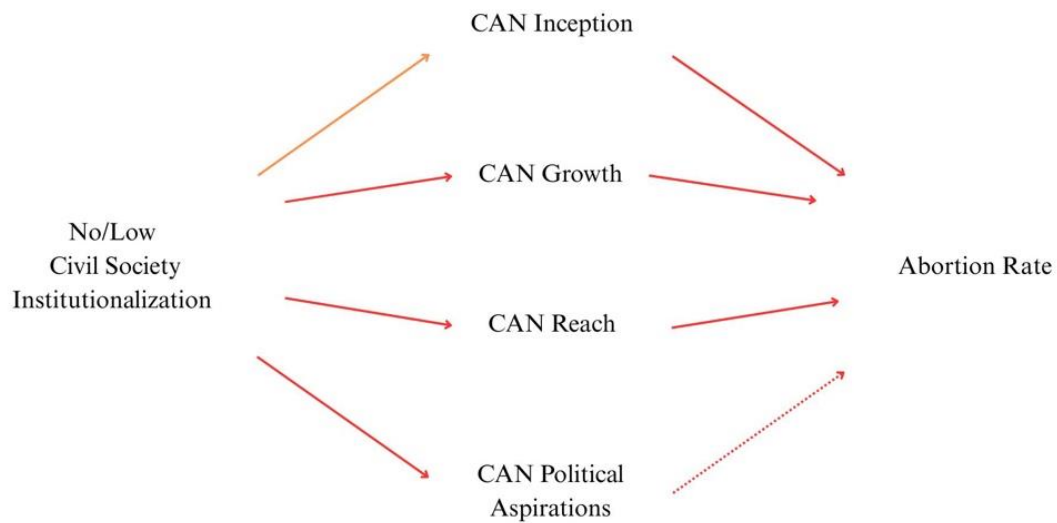


Figure 16: Romania CAN Chart

The forms of civil society that did exist during that period were the black market and personal relationships. With a ban on imported goods, the black market in Romania sold things from food to condoms. However, the black markets were unreliable at providing goods. However, these black markets were also seen as one of the primary areas of civil society under Ceaușescu. What else existed were informal CANs comprised of informal word-of-mouth networks. These can be best understood as more social connections, such as knowing a friend of a friend who can help. When abortion became illegal in Romania and as the totalizing power of the state grew, there was fear surrounding someone who needed to evade or deceive the state. How would you know where to get an abortion in 1970 if you needed one? You would ask your friend.

Informal networks and word of mouth were the primary ways that people accessed abortion in the Ceaușescu era. There were no formal CANs that operated and managed people to help direct them to sympathetic doctors or other alternative methods

of accessing abortion. There was also no abortion tourism in Romania because it was difficult to cross the border. In the U.S., there is the famous Jane Network, which facilitated illegal abortions in the 1960s and 1970s before *Roe* made abortion legal (Kaplan, 1997). In Ireland, there was the Irish abortion journey, which was a well-known path women took to the U.K. to access abortion legally (Earner-Byrne & Urquhart, 2019). In Romania, some women opposed Decree 770 and resisted in silence, either finding illegal abortions or self-inducing unsafe abortions (Anton, 2022; Popa, 2016). Doctors estimated that only 50% of illegal abortions performed outside of a hospital were successful, which meant that no harm came to the women; the other 50% were hospitalized or died (Kligman, 1998). This can be further understood from Figure 14, which depicts the share of post-abortion complication maternal deaths in Romania. If that many women were dying of post-abortion related deaths under Decree 770, then from what the doctors theorized we can assume double that number at least were obtaining illegal abortions outside of a hospital setting. Kligman remarks that in the 1980s, illegal abortion networks were broken up as the final push to drive up birth rates. The Securitate would intimidate, blackmail, and use fear tactics to get people to reveal the names of those who were related to abortions (Kligman, 1998). There is not much information on these illegal abortion networks. But they did exist. These informal CANs likely had loose associations; they were linkages of people who could help guide abortion seekers to abortion providers by providing names, how to make appointments, or where to meet. These CANs existed as a threat and an acknowledgement that there had to be some level of organization happening to supplement abortion services and keep the birth rates so far down.

The most common way that people were able to obtain an abortion in Romania was by bribing doctors. Doctors would perform illegal abortions in the hospital and then classify the abortion as legal under a parameter, such as diagnosing the patient with a disease or providing them medicine that contraindicated pregnancy. However, doctors who provided abortions were watched closely. In the early days of Decree 770, the Securitate was stationed in hospitals and would investigate any abortions being conducted. Later, the Department of Health was obligated to report any doctors or health officials who had any suspicious activity around abortion (Kligman, 1998). The state would also monitor doctors' records to look for any patterns around the number of abortions provided or the reasoning for the abortion. Dr. B.M., interviewed by Kligman, said that most of those who were arrested for illegal abortions were not medical doctors; of the 1,700 or 1,800 cases in 1987 or 1988, only a dozen or two were medical doctors (Kligman, 1991, pp. 157-158). These interviews with doctors show that many women went to extreme means to abort, either by seeking out an illegal abortionist, self-harming, attempting to self-manage their abortion, or to deceive doctors by beginning to self-manage in an attempt to look like they were miscarrying so the doctor could legally perform an abortion. Further, many doctors performed clandestine abortions for financial reasons. It was an incredibly lucrative business for doctors who had once earned substantial incomes before the communist regime. These accounts are more well-known than those who provided abortions in unsafe conditions, those who did not have a medical degree, or those who helped women procure herbs or other remedies. People learned how to end their pregnancy from others, establishing these informal CANs characterized by these word-of-mouth networks. It was women asking their friends and

families for help, and chains of association of someone who had heard of someone who could help. Sometimes these chains ended in a doctor in a hospital directly, other times it ended in an unsafe abortion, other times it ended in tragedy, as we can see from the number of maternal deaths due to abortions from 1967 to 1989.

CAN Growth, Reach, and Political Aspirations

What we know about the CANs in Romania during that time is sparse. There is only the vaguest detail about networks in the most detailed work about abortion provision in Romania in the Ceaușescu era. What can be derived from this is that, substantively, CANs were hyperlocal, personal, and informal. The networks that existed were also understood as word-of-mouth networks. Someone reaching out to a friend and asking for help, and that friend knowing of someone who maybe could, and perhaps that person knew a doctor to bribe, a back-alley abortionist, or where to get herbs to self-induce. As we will see in Turkey and Appalachia, CANs can be powerful and organized forces; that is not what happened in Romania. What we saw happening in Romania was people helping those they knew, because those are the only people they could trust. In a totalitarian regime like Romania under Ceaușescu, people feared retaliation. Some people were imprisoned for providing and assisting in abortion provision, the childless were taxed, and the Securitate was present everywhere. There was no safe space for people to communicate freely and openly, discouraging CANs from forming and operating. So, when we discuss anything beyond CAN formation, including growth, reach, and political aspirations, we are not discussing much. Formal CANs could not form in Romania, let alone grow their numbers through outreach, extend beyond

neighborhoods and small enclaves, or have any political aspirations in a regime where any dissidents were imprisoned.

Conclusion

The policies and actions of the Ceaușescu regime were extraordinary. That cannot be overstated. Nowhere else can we observe a birth rate chart like that in Romania. It is not the law that is extraordinary; many countries change their abortion laws, and some have even harsher restrictions than Romania. However, what makes Romania unique is not the law, but rather the level of enforcement, coupled with the absence of a strong civil society in Romania. When an abortion restriction goes into place somewhere where there is a robust civil society, and people have an infrastructure to organize, the restriction does not drive up the birth rate the way we observe in Romania. Texas, which has a near-total abortion ban, only with an exception to save the life of the mother, had a birth rate increase of 2.8% when women have to drive over 300 miles to obtain an abortion (Myers et al., 2025). This statistic is significant for those in Texas who want an abortion and cannot get one or have huge barriers to access. However, the difference is startling when comparing the data to that of Romania in 1967. Why was an abortion ban more effective in Romania than in Texas? Because civil society in Texas and surrounding states was able to organize to help people access abortion despite the laws. There are mutual aid funds, huge national abortion organizations, community-based networks, and abortion funds that work to help people in the U.S. navigate abortion bans and ease logistical and financial barriers to access. In Romania, women were left to deal with this burden on their own when the ban took effect. They did not have community groups, churches, or even

doctors they could trust to help them. It was a lonely, threatening, and terrifying position to be in.

It cannot be said enough that Romania under Ceaușescu was one of the most brutal periods for women in modern history. During this period, Romania was the primary inspiration for Margaret Atwood's novel *The Handmaid's Tale*. This case plays a crucial role in this dissertation, as it serves both as an outlier in my data and as an illustration the extraordinary lengths civil society will go to to supplement abortion access. Through variations of this project, I explored different cases, except for Romania, which I knew would always be my first case chapter. For those who study abortion, family planning, and demography, Romania stands out as the most potent example of what a state can do to its population. With a desire to completely revolutionize the country's population and build a robust command economy, Ceaușescu created the strictest and effective abortion ban ever. For the first few years, he did as he wanted; he achieved the high birth rates that he desired in 1967 and 1968, but after the peak, they decreased significantly. Why? Because the law could no longer be enforced the way it had been previously, and because when someone does not want to be pregnant, they will go to extraordinary circumstances to end that pregnancy. Ultimately, Decree 770 failed in its mission. Ceaușescu aimed to increase the population by 30 million, over double the 1966 figure, but by 1989, it had only grown by 3.6 million. In 1983, the birth rate had returned to pre-ban levels, marking the lowest recorded fertility rate in Europe. People were having abortions. In one study conducted from 1991 to 1992, 44.8% of respondents said they had at least one legal abortion in their lives, and 24.2% said they had had at least one illegal abortion (Johnson et al., 1996). 13.6% reported having more than one

illegal abortion in their life, some with as many as 30 illegal abortions; 18.6% responded having more than one legal abortion in their life, again with as many as 30 reported (Johnson et al., 1996). What this data suggests is that abortion was prevalent in Romania, despite how hard the regime tried in the first two years of Decree 770 going into effect, and then in their efforts to double down in 1985. People were able to get abortions, despite the legal circumstances.

Through this analysis of Romania under Ceaușescu, we can draw several conclusions from the available data. First of all, I must restate, that there is no other viable explanation to explain the birth rate data in Romania other than to say that abortion was prevalent. Without any form of contraception available to Romanians and the unlikelihood of mass abstinence, we must conclude that abortions were happening in Romania. This, coupled with the accounts of doctors and abortion seekers stating that abortion was prevalent, we can also account that informal CANs were helping people access abortions by providing them with connections to illegal abortions or to doctors willing to falsify documents and provide them with an abortion in a hospital. In Romania, we can accept the hypothesis that abortion restrictions do not have a lasting effect on the birth rate. And further accept that this abortion restriction did not work well because of the CANs. The Appalachia and Turkey cases will elaborate on how CANs work internally, but Romania establishes that when there is no civil society, CANs will still emerge and are capable of having a significant effect on the birth rate.

This chapter is a warning in many ways, but can also be hopeful. By and large, the pattern globally of abortion is not what happened in 1966 in Romania; it is what happened in 1989. Countries are liberalizing their abortion laws, not restricting them.

But I am writing this in the U.S., where abortion is banned in many states, and millions of people live and get pregnant under these bans. In Romania and the U.S., the majority of people seeking an abortion are already mothers who know the burden of having a child. Being pregnant is dangerous; maternal mortality rates in states with abortion bans and Romania were high, and those rates only increase as you age. As many as 12 states in the U.S. currently have abortion laws stricter than Romania's Decree 770, with about 75 million people living under these laws (Center for Reproductive Rights, 2024). In 2022, Gail Kligman wrote an Op-Ed for The Washington Post warning Americans about what could happen in a post-*Dobbs* world. She wrote about the lives of the Romanian women she had been interviewing and working with since the 1980s, she wrote about the ban and the level of enforcement of the Ceaușescu regime used to monitor Romanian women, but what she left with was the real threat American women face because of the ability returned to our government to surveil us. They do not need to deploy doctors to perform gynecological checks on us at work; we use menstruation tracking apps. We Google family planning, birth control, where to obtain an abortion, what to do when you get pregnant, and they can see our digital footprint (I probably have one of the most incriminating in the country). Moreover, lastly, she warns that as laws are introduced that encourage people to act as informants around abortion (like in Texas), not to give in, by creating a culture of fear in society, it strengthens the ability of the state to control more and more (Kligman, 2022).

The impacts of the abortion ban in Romania are still felt. The children born in the late 1960s were called *decreței*, which comes from the word for decree, because they were born as a direct consequence of the 770 decree. It has been estimated that upwards

of half a million children under Ceaușescu were raised in orphanages, and it has been perhaps the longest felt legacy of the communist era (Pop-Eleches, 2006). As a child, I remember seeing infomercials raising money for Romanian orphans who were seen not as the direct consequence of this policy, but as victims of communism. Those children born after the decree had worse educational and labor market outcomes than those born before (Pop-Eleches, 2006). The totalizing power of the Romanian state during the Ceaușescu era decimated society. There was no civil society, people distrusted their coworkers and neighbors, and community was absent. This absence, not the law itself, is why the abortion ban in Romania was so effective. Civil society can act as a counterbalance to the state, helping people access and freely share resources and ideas with one another. Without that, the state can impose and have totalizing power over society, leading to drastic and significant policy consequences. So, did abortion restrictions work in Romania? Yes, incredibly well at first, then not so much. Why? Because civil society had been eliminated, there were no networks and organizations of people able to help each other to supplement the need for abortion. However, people still found a way, which was more dangerous and had severe consequences, but they still found a way, as they always will.

CHAPTER 4

TURKEY: EROSION OF THE ACCESS ENVIRONMENT

Introduction

Abortion in Turkey is a case where it is technically legal but practically inaccessible. The barriers to abortion in Turkey are different from those they were under Ceaușescu in Romania and in Appalachia. In Turkey, abortion is legal up to 10 weeks. It is available on request, meaning that anyone can get an abortion if they want it. However, there are limits to this, both legally and in terms of access. Legally, an OBGYN needs to perform the surgery; only surgical abortion is legal. Medication abortion is banned, parental consent is necessary for those who are under a certain age, and if the woman is married, then spousal consent is required. These legal barriers create a significant burden, especially for vulnerable women who are in domestic violence situations. Further, the number of hospitals providing abortions in Turkey is declining rapidly despite there not being any legal changes to the abortion law (O'Neil, 2017; O'Neil et al., 2020; O'Neil & Komut, 2019).

These barriers to access are steep considering that abortion is technically legal in the entire country. As in every case, there are rural-urban divides in access, as well as class divides. Misinformation around abortion is also a substantial barrier, with hospitals even telling patients that abortion is illegal (O'Neil et al., 2020). Despite the many barriers to accessing abortion, I argue that civil society, through CANs, supplements abortion access where it is limited, despite the challenging environment. In Turkey, this means helping people access legal abortions by guiding them through the barriers to find a legal and safe abortion. However, as I found in my fieldwork, women in Turkey often

turn to clandestine or illegal abortions despite abortion being legal. Frequently, this is due to not being able to afford abortions in private hospitals, being able to travel to a hospital that provides abortions, or preferring a medication abortion, which is banned.

This chapter provides a detailed look at the history of abortion in Turkey and its current status, as well as an overview of civil society in Turkey. I employed snowball sampling to conduct formal interviews and informal discussions with CANs in Turkey over a two-month period in 2024. Through discussions with a variety of civil society members, I found that abortion is not a key focus of many CSOs, which focus on more general issues such as gender, migration, or human rights. Instead, many organizations have organically adopted abortion into their practices because abortion is a less salient issue than others, but people still need help navigating the legal barriers. CANs provide referrals for doctors and hospitals where abortion is still being practiced, and frequently work directly with abortion seekers. Setting out into the field, I anticipated finding many smaller or localized CANs that were formally registered. Instead, what I found was that many prominent, national NGOs that are not abortion specific but still work with abortion seekers and informal word-of-mouth networks. However disparate these are in organization, size, and operations, I categorize them both as CANs due to their connection with abortion seekers and abortions.

Background and Context

The Republic of Turkey

The modern history of Turkey is a fascinating one. It has been portrayed in an Orientalist light as a country that straddles East and West, serving as the bridge from

Europe to Asia— from modernity to the ancient. I did not pick this case for any of these reasons. The Republic of Turkey’s history is only 100 years old, even though the cities within it are some of the oldest in the world. Turkey’s modern political history is why I chose this case, because although many things make this country unique, it is not an uncommon story. Many countries in the 20th century declared independence and embarked on creating a modern Republican democracy, which required an overhaul of their political and social systems. Many countries experienced military coups during the 20th century as well. This case embodies transitional democracies and economically-developing countries typical of the third wave.

In October 1923, the Republic of Turkey was formally declared. This followed the loss of the Ottoman Empire in World War I, when occupying forces divided up Anatolia. From that occupation, the Turkish War of Independence was fought from 1919 to 1923. The Turkish National Movement fought to separate from the Ottoman Empire and end the occupation established in Anatolia and Thrace under the Sykes-Picot Agreement to create a Turkish Republic. Led by Mustafa Kemal Atatürk, the Turkish National Movement did eventually win. This led to a renegotiation of land with the Allied forces under the Treaty of Lausanne, which established the modern borders of Turkey and recognized the Republic of Turkey and its government formally as the victors of the war. From this war, the Ottoman Empire, which had ruled since 1299, was defeated and replaced by a Republican government.

One of the hallmarks of the Early Republican period in Turkey is the vast national building projects undertaken by the government. The Kemalist government aimed to modernize and westernize Turkey through a series of social, cultural, and political

reforms. Atatürk ruled from 1923 to 1938, and although not elected, he saw the purpose of his rule as establishing a democracy that would remain when he left office. Major reforms in this era included adopting a Latin alphabet for the Turkish language and abandoning the Arabic script, banning the fez, adopting a new criminal and civil code, the inclusion of secularism in the Constitution, the Surname law to establish consistent family names, full political rights to women, and a vast literacy project throughout the country. Specific reforms were more controversial and did not last, such as mandating the call to prayer be done in Turkish instead of Arabic. However, no matter the normative value of these reforms, they were sweeping and drastically altered the country's landscape and its citizens. Daniel Lerner's *The Passing of Traditional Society* begins with an anecdote about the changes in the Turkish village of Balgat. A famous chapter, it describes modernization over time in the mid-20th century through the eyes of a traditional figure, the Chief, and the modern figure, the Grocer (Lerner, 1958). The imagery of Balgat changing rapidly in the decade Lerner spent visiting it is at the heart of what we think of as modernization in the Middle East. Although this parable contemporaneously does not hold the weight it once did, it does show how people perceived the changes in the Turkish countryside, from rural villages to suburbs. It was due to the state's tremendous and swift changes that fundamentally altered the country.

The Turkish state-building effort profoundly altered the lives of every person and impacted nearly every aspect of the country. Compared to the other Axis powers after World War I, Turkey emerged relatively well. The Ottoman Empire was already in decline and facing serious political threats when the war began. Although the empire lost many of its traditional landholdings, the Turkish War of Independence was able to regain

lost territory and form what we now know as Turkey. However, since the founding of the Republic, it has not consistently or smoothly functioned as a democracy. One-party rule lasted for 7 years after Atatürk's death, under İnönü, spanning World War II, until the first elections were held in 1946. İnönü lost the election in 1950 with a peaceful transition of power. However, in 1960, the first of four military coups d'états occurred. In the iterations of the Turkish Constitution, the military has the primary goal of protecting the Turkish Republic from internal threats as well as external. These coups have typically been conducted when there is some threat to the Kemalist founding principles, including secularism.

Between 1960 and the late 1990s, there was a military coup approximately every twenty years. During some of these periods of coups, political parties, political activities, and civil society groups were banned if they were perceived as having a political nature. Since 1984, there have been military altercations between Kurdish groups and the Turkish government both inside and outside of the country. In the 1980s, the Kurdish Workers' Party (PKK) and the Turkish government were in open conflict in the southeast Kurdish portions of the country. The conflict is still ongoing, although much of it has now taken place inside Syria and Iraq since the 2010s. Furthermore, the Justice and Development Party (AKP) has been in power since 2002, with Erdoğan serving as both Prime Minister and President. This period has raised concerns about growing authoritarianism in the country, and the country also experienced a failed coup attempt in 2016. After the failed coup, there were substantial purges in the government, military, academia, and the media. To reiterate, Turkey has not historically been a stable political or social entity since its founding. There have been substantial and real concerns among

citizens over time and today about organizing and addressing issues that are not in alignment with the Turkish constitution.

Mid-Level of Civil Society Institutionalization

Concerns about organizing around political, social, or economic issues that may be contrary to the interests of the Turkish state are of genuine concern. Turkey represents the mid-level of civil society institutionalization in this project. It is mid-level because there is a robust civil society. There are various groups, including religious, community, and political organizations, that can meet. However, there have been periods of Turkish history where civil society has been formally limited, disbanded, and pressured not to organize. There is a fear of government interference, surveillance, and intervention by groups working on projects that may be contrary to the state's interests.² So, although there are many CSOs in Turkey that operate in a variety of areas, there is also a looming threat from the government. The state has established that it can and will intervene when a perceived line is crossed, whether that involves cracking down on groups, leaders, or civil society as a whole. After the attempted coup in 2016, 1,519 CSOs have shut down in Turkey, as well as 150 media outlets (The Center for American Progress et al., 2017).

The threat to civil society is real in Turkey, and there is an awareness of that in CSOs. However, despite the threats, Turkey has a relatively robust civil society. Currently, over 100,000 registered associations operate in Turkey, in addition to an unknown number of informal networks and groups (Türkiye, 2024). Turkish youth have expressed a preference for expressing their political concerns through involvement in

² These concerns are validated through interviews of Turkish CANs.

CSOs and informal groups rather than through the formal political process (The Center for American Progress et al., 2017). From 1983 to 2004, the number of CSOs in Turkey tripled, with a surge happening especially in the 90s (Şimşek, 2004). Although there was a surge in the creation of CSOs during this time, which is also a global pattern, the type of CSOs in Turkey was not necessarily politically oriented, unlike many in the West (Şimşek, 2004). Many of the types of CSOs that were created were founded to address social and community-based issues, which may have political undertones but are not outwardly political. Of course, this is also tied to the political environment in which they were created, spanning the 1980 Turkish coup and leading up to the 1997 memorandum coup. Civil society faced a crackdown by the Turkish government, so groups that were being created had an incentive not to be outwardly political.

This pattern continues today, where participants in civil society are aware of the threat of crackdowns but still choose to engage in groups. These are all connected to this mid-level of institutionalization of civil society. The mid-level in this project insinuates that civil society can organize and collect, but the freedom with which they may do so is limited. In the case of Turkey, CSOs are plentiful, but the groups' goals implement self-imposed limits on their purpose, fear government intervention, or obscure and unregister themselves. Groups with controversial or contrary viewpoints to the state, such as Kurdish groups or LGBTQ+ groups are not as prevalent as they may be if the government did not have such a strong position against them. One way to avoid government interference is to unregister or refrain from formally registering your group as a CSO. This limitation is not only detrimental to organizational goals but also hinders productivity and reach. However, if doing something contrary to state goals, it may be

necessary for a group to be undetected and ensure survival. The presence of institutionalized CSOs is well known, but numerous informal networks and groups also exist in Turkey (The Center for American Progress et al., 2017). This mix of the formal and informal, fear and freedom, are all elements of the mid-level institutionalization of civil society.

History of Abortion in Turkey: The Natalist Narrative

In the modern era, the abortion conversation was not salient to feminist groups in Turkey until Erdoğan adopted anti-choice rhetoric that “abortion is murder” (“Erdoğan: Sezaryene Karsıyım, Kürtaj Cinayettir,” n.d.). Much of the West made abortion legal in the 1970s due to rising maternal mortality rates related to illegal abortions. In 1983, 10 years after *Roe* in the U.S., Turkey made abortion legal with few exceptions, up to 10 weeks for the same reasons. Facing high levels of maternal and infant mortality rates, Turkey legalized abortion on demand, with exceptions being for minors who required a parental signature and married women who required permission from their husbands. In 2012, when Erdoğan threatened to make abortion illegal and took a moral stance on abortion, it galvanized civil society in Turkey to make abortion a more central issue in their feminist causes. But Turkey, in the late Ottoman era, has a history of changing abortion laws based on population trends and the needs of the state.

The Ottoman and Early-Republic Era. Much of Turkey’s and the Ottomans’ relationship with abortion is typically framed in terms of the natalist needs of the empire and the state. I contend that this is not only the correct framing to understand abortion in Turkey based on rhetorical needs, but understanding abortion policy in terms of natalism

is also helpful for understanding abortion policy broadly. In the late Ottoman era, abortion was permissible up until 120 days when ensoulment happened, which is typically also called the quickening, or when the fetus moves for the first time in utero (O'Neil & Komut, 2019). It is unclear how common abortion was in the Ottoman era, but it was theoretically allowed until 17 weeks, 4 months of pregnancy.

In the late 18th and early 19th century, the Ottoman Empire began restricting abortion access through several means. In 1838, the Firman was enacted, which gave the Ottoman government control of abortion (Demirci & Somel, 2008). It was the summation of orders that restricted pharmacists from selling abortifacients, prohibited midwives from aiding in abortion and distributing herbal remedies, and prohibited non-Muslim communities from abortion provisions. This follows a pattern that occurred in much of Europe and the U.S. at this time, where women's health shifted from the private sphere of the home, where it was managed by other women, to the public sphere, where the state and medical apparatus exerted more control over the body. Before formal medical institutions were established, much of women's health was done at home, with midwives and female family members managing each other's health, whether that be birth, abortion, or other needs. The formalization of medicine and the establishment of hospitals, medical schools, and other institutions led to a decline in private home treatment, resulting in more close monitoring of women's health by the government.

At this time in the early 19th century, the Ottoman Empire was experiencing a decline from its height, losing territory and experiencing military losses. The 1838 decree coincided with a period when the Ottomans were attempting to enhance their strength both economically and militarily, which led to the belief that the population needed to

increase to achieve this goal. With the 1838 decree, they restricted abortion so heavily that it would lead to increased births and boost the population and, therefore, the empire. This also meant that the framing of those women who would obtain abortions was now that they were enacting a crime not only against their bodies but also against the empire. It made motherhood “identical to citizenship” and women’s role in the empire as directly tied to their sexual and reproductive abilities rather than any social or political value (R. A. Miller, 2007). This echoes the sentiments of Ceaușescu’s Romania and globally, as reducing women’s role in the state to their ability to reproduce and produce citizens for the state. The edict of 1838 was subsequently incorporated into the Ottoman criminal code in various iterations until the empire's collapse following World War I. An interesting note about the criminal code is that it did not punish those who obtained an abortion but rather the abortion provider, which is a common tactic of many modern governments seeking to limit abortion without making it illegal outright.

With the establishment of the Turkish Republic in 1923 came an ambitious nation-building project throughout Anatolia aimed at creating a secular, modern state. Due to World War I and the subsequent War of Turkish Independence, there was a major decline in population at the beginning of the Republic’s history. While Turkey embarked on their massive nation-building project, which included changing the alphabet, mass literacy projects, and changing the call to prayer to Turkish, it also included continuing to restrict abortion to rebuild the population. In 1938, abortion was put into the Republic’s criminal code in a section called “Crimes Against the Health and Integrity of the Race” (O’Neil & Komut, 2019). This section categorized abortion as a crime against society and the state, and that women’s reproductive ability and production were the property of

society and not of individual women. It did not frame abortion as a moral issue of life and death or religion; it framed it as a crime against the state to limit the production of citizens, which in turn would produce for the state in the military, economically, or with their bodies.

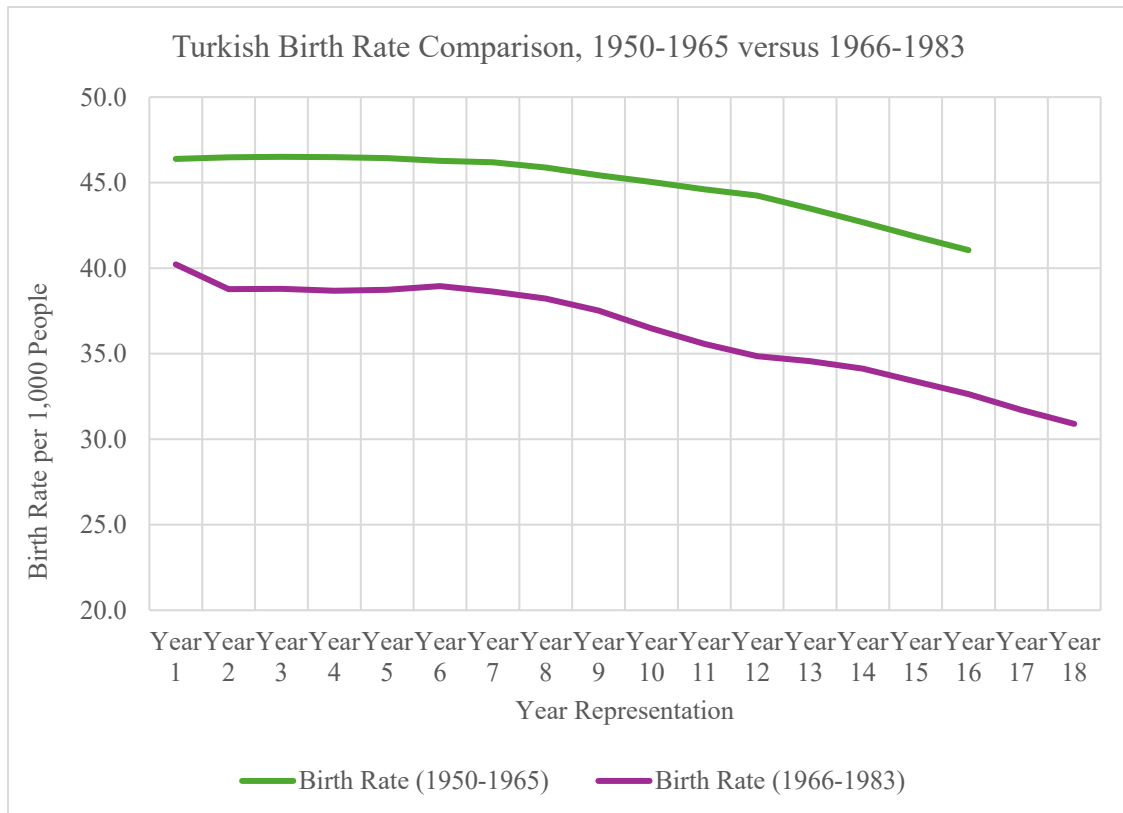


Figure 17: Crude Birth Rate per 1,000 people Comparison 1950-1965 v. 1966-1983

In 1955, Turkey’s birthrate reached its highest point, with nearly 50 births per 1,000 women annually, as shown in Figure 17. The fertility rate in 1960 was 6.4 live births per woman in her lifetime. By 1960, the population had doubled, sparking discussions about the relationship between overpopulation and underdevelopment in Turkey. In 1965, Turkey enacted the Population Planning Law, which allowed for the establishment of family planning clinics throughout the country, coinciding with a shift in

government rhetoric. Previously, the government emphasized that it was a family's responsibility to have as many children as possible, but with growing concerns about overpopulation, the rhetoric shifted to focus on maintaining a quality of life that was not necessarily tied to having a large family. These family planning clinics did not make abortion legal, but they did make knowledge of contraception and contraceptive devices legal. Pre-1965, there was virtually no knowledge of birth control, and even condoms were illegal, meaning the only form of contraception available to people was the rhythm method, where women monitored their fertility monthly, and the pull-out method, both of which were unreliable. There was also growing concern at this time, as there was globally, about concerns of illegal abortion. There are estimates as high as 400,000 illicit abortions that happen annually in Turkey, leading to some 10,000 deaths (Aydin, 2000). Interviews conducted about illegal abortions in Turkey cite the hoops women had to jump through to obtain an abortion before it was made legal. Women report having to ask their families to take out loans to pay for their abortions, and others report that they obtained abortions in unsafe and unhygienic clinics by non-licensed practitioners (Gürsoy, 1996). However, it took nearly 20 more years for Turkey to legalize abortion after the introduction of these family planning clinics.

Table 11
Turkey, Change in Birth and Fertility Rates

Year Range	Raw Change in Birth Rate	Raw Change in Fertility Rate	Percent Change in Birth Rate	Percent Change in Fertility Rate
1950-1965	-5.3	-0.44	-12.9%	-6.8%
1966-1983	-9.3	-1.91	-23.13%	-32.21%

From 1966-1983, Turkey saw a dramatic decline in both the fertility rate and birth rate. The fertility rate, measured as the number of births per woman, declined from 5.93 births to 4.02 births. A decrease of 1.91 children per family in an 18-year time frame. The World Bank began collecting fertility and birth rate data in 1950, so the 18-year mark before 1965 is unknown, but we can measure a 16-year difference. Between 1950 and 1965, the fertility rate decreased by 0.44 births per 1,000 people. The birth rate, measured as births per 1,000 people per year, declined from 46.4 to 41.1 from 1950 to 1965. A decline of 5.3 births in 16 years. Compared to 1966-1983, where a decline of 9.3 births per 1,000 people was observed.

Table 11 shows that during these two time periods, a decline was experienced in both, but the rate of decline accelerated with the opening of family planning clinics

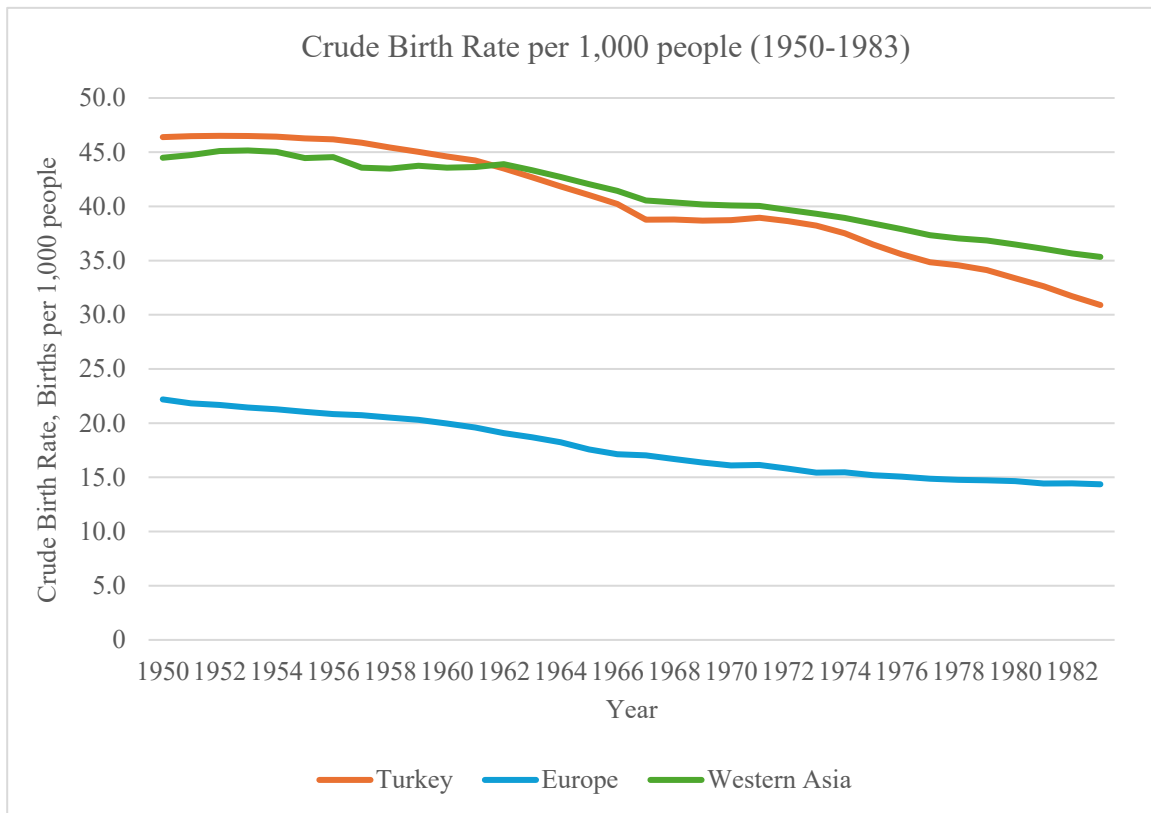


Figure 18: Crude Birth Rate per 1,000 people 1950-1983

nationwide, the legalization of contraception, and the dissemination of information on family planning. Further, this is also tied to the political language being used by the state about reproduction, switching from a focus on having large families to prioritizing quality of life. Although there was already a pattern of decline from 1950 to 1965, the rate of decline increased when the Population Planning Law was introduced. By the time abortion was made legal in Turkey in 1983, the birth rate had been experiencing a steady decline.

Figure 18 represents the crude birth rate, measured as births per 1,000 people each year, for Turkey, Europe, and Western Asia. Turkey is counted in the Western Asia region's average using this United Nations Population Division data. The European data measurement is also included due to geography and Turkey's interest in the 1990s and 2000s in European Union (EU) membership. Once the Population Planning Law in Turkey took effect in 1965, the Turkish birth rate dropped below Western Asia's average, a trend that has continued since. Table 12 presents the CBR from each decade marker in Turkey since 1950, illustrating the percentage change from one decade to the next. Although population growth has continued, the birth rate has declined steadily. Important markers are between 1960 and 1970, when the Population Planning Law went into effect; during this time, the birth rate declined by 13.2%, and when the Family Planning went into effect from 1980 to 1990, the birth rate declined by 22.5%, which was the steepest level of decline measured. As will be discussed at length in the analysis of birth rate data globally, many variables explain the birth rate decline related to economic and social development. Although these variables are surely at play in Turkey over time as the country and people become more educated, wealthy, and more women work, it must also

Table 12
Crude Birth Rate per 1,000 Percent Change from 10 Year Previous

Year	Crude Birth Rate per 1,000	% change from 10 year previous
1950	46.4	
1960	44.6	-3.8%
1970	38.7	-13.2%
1980	33.4	-13.8%
1990	25.9	-22.5%
2000	21.4	-17.2%
2010	17.7	-17.2%
2020	15.0	-15.3%

Note: (World Bank, 2025)

be considered related to variables around family planning. We observe the most drastic declines in the birth rate from 1960 to 1970, where a 9.4 percentage point decrease occurred, and from 1980 to 1990, where an 8.7 percentage point decrease occurred, which correlates with changes in family planning laws in Turkey. Although I am not arguing that policy is the driver of declines in birth rate data, the ease of access to family planning services certainly allows for more choice around pregnancy, which was not the case previously.

Modern History of Abortion in Turkey. In 1983, the Population Planning Law was passed in Turkey, which legalized abortion. Like many other countries that legalized abortion during the 1970s and 1980s. This legislation was related to growing concerns around illegal abortion, leading to increased rates of maternal and infant mortality. Additionally, in Turkey, the rhetoric remained tied to nativism and concerns about overpopulation. The law defines population planning as “the freedom of individuals to decide on the number and timing of their children. The State shall take the necessary measures for the provision of education on and services for population planning” (The Population Planning Law, 1983). The Population Planning Law also legalized the

sterilization of both men and women for the first time. The Population Planning Law legalized abortion up to 10 weeks with no restrictions, also called at-will or upon request, except for minors and married women, and emphasizes that terminations “shall be performed under State supervision and control.” Minors need the permission of one parent or guardian, and married women need the consent of their husbands to obtain an abortion.

The restriction of abortion around marriage has been one of the biggest rallying points in pro-abortion rhetoric, especially related to women who are in abusive relationships. Abortion is allowed after 10 weeks only when the woman’s life is in danger, or there is a significant fetal defect, which requires an OBGYN and another “specialist in a related field” to confirm in writing this finding. It also allows for emergency calls to be made if the mother's life is in danger, but a written report must be submitted to relevant government facilities within 24 hours. An important part of the Population Planning Law, which is often overlooked, is that it stipulates that only OBGYNs may perform abortions legally in Turkey. In other countries, general practitioners, general surgeons, nurses, and others may legally perform surgical abortions. The law also allows physicians, nurses, and midwives to administer contraceptives. The stipulation of OBGYNs is significant because of the lack of specialists in rural areas, which makes accessing abortion even more difficult. It is also important to note that not only can many different medical doctors perform surgical abortions easily (family, OBGYNs, general surgeons, internal medicine, etc.), but many different medical professionals can as well, such as nurses and physicians assistants. This is not to mention those who could prescribe medication abortions within Turkey’s medical system (which

are not available in Turkey and were not widely available until the 2000s), which include doctors, nurses, physicians' assistants, and pharmacists.

When the Population Planning Law went into effect in 1983, a survey showed that 36% of women had reported having had an abortion in their lifetime (Hacettepe University Institute of Population Studies, 1989). This is on par with the estimations that there had been as many as “400,000 illegal abortions a year and 10,000 women having lost their lives from complications of illegal abortions” (Aydin, 2000). Hacettepe, in conjunction with the Turkish government, conducts a survey regularly of married women and their abortion history. In 1988, 5 years after abortion had been made legal in Turkey, 42% of women surveyed said they had had an abortion (Hacettepe University Institute of Population Studies, 1989). These rates have significantly decreased in the 37 years since. In 1993, 28% of ever-married women had an abortion in their lifetime. This decreased to 23.9% in 2003, 13.5% in 2013, and 15% in 2018 (Hacettepe University Institute of Population Studies, 2004, 2014, 2019; Ministry of Health [Turkey] et al., 1994). This also translates to the rate of induced abortion for ever-married women in Turkey per 100 pregnancies being 18 in 1993, 14.5 in 1998, 11.3 in 2003, 10 in 2008, 4.7 in 2013, and 5.9 in 2018. The reported abortion rate has decreased significantly in the past 30 years. The report does not offer theories as to what is driving down the abortion rate. Still, it must be a combination of many factors, including the prevalence of contraceptive access as well as development factors. Only surveying ever-married women is also problematic because there could be underreporting, especially of young women, of unmarried women who have had abortions. Further, in the 2018 report, 64% of respondents were not using

any form of contraception leading up to their abortion; additionally, 60% of respondents were still not using contraception after their abortions.

Theoretical Framework

Turkey provides a very compelling case of where abortion is legal, with restrictions, and civil society is present, with threats. This case then allows us to understand how abortion is provided when access is limited, and there are legitimate threats to civil society. Additionally, it highlights that the legal environment is not the driving force, but rather the restrictions in the access environment. My argument is that civil society helps people access abortions despite the legal landscape. In Turkey, this was compelling because abortion is legal but is often difficult to access, as the research on public hospital provision details and the ban on medication abortion pills. Further, there are legitimate threats to civil society that are both documented and perceived. Where this real threat to civil society exists, I still anticipate observing organizations around abortion provisions due to changes in the abortion environment. The abortion literature in Turkey is robust, especially from a public health perspective. What is lacking is a political study of abortion and looking at the relationship between abortion and civil society in Turkey, which I argue are essential and related.

Abortion Access in Turkey

After reviewing the Population Planning Law and understanding the generally broad legal grounds of abortion in Turkey, it is then essential to say how limited abortion access is in Turkey. Looking at other abortion laws around Europe and the Middle East,

we see that Turkey has a relatively liberal abortion law. The Center for Reproductive Rights has it listed as “Abortion on Request,” where gestational limits vary; it is 1 of 66 countries listed under this category. Turkey, the U.S., and Kosovo have the most amendments in this categorization. The U.S. states that “legalization explicitly permits abortion only to protect the physical health of the mother,” and parental authorization/notification, and that the federal government allows states to determine the legality of abortion (Center for Reproductive Rights, n.d.). Kosovo has a gestational limit of 10 weeks, parental authorization, and sex-selective abortion is prohibited. Turkey has a gestational limit of 10 weeks, parental authorization, and it is the only country out of these 66 that requires spousal approval for abortion. It is also estimated that Turkey has one of the highest abortion rates in the world, with a MENA estimate of 53%, and middle-income countries have the highest levels of abortion (Bearak et al., 2020). It is crucial, generally but also within the context of this project, to constantly contextualize abortion laws, especially as we get into details around abortion provision, the access environment, and the salience of abortion as a political issue.

During my fieldwork, I often heard from people that abortion was not a salient feminist issue in Turkey until 2012. The legality of abortion, as well as the comparative perspective when compared to other countries in the region, it was seen that abortion was not a pressing issue, the way others, such as domestic violence, are. Turkey and Tunisia are the only countries in the MENA region that are categorized by the Center for Reproductive Rights (CRR) as Category I.: Abortion on Request. Although the abortion laws have not changed in Turkey since 1983, the abortion environment in Turkey has

changed, and many point to the change in rhetoric by the AKP and Erdoğan, specifically when the change took place.

In 2012, Erdoğan declared that “abortion is murder” and that the abortion law would need to be changed in Turkey. This was not only a significant moment because of the threat to the abortion law but also because it was the first time that Turkey had moralized abortion and adopted the language used by many anti-abortion political figures. As shown, the Ottoman Empire, as well as the Turkish Republic, had only engaged with abortion in natalistic terms related to the strength of the state/empire, population growth, overpopulation, etc. Although this promise to make abortion in Turkey illegal on these moralistic grounds has not come to fruition, the government has manipulated the system to make abortion more difficult to access without changing any laws. The interviews conducted, as well as existing research, highlight this claim by showing that public hospitals have been showing declining rates of abortion provision, often refusing to perform the service broadly (O’Neil, 2017).

As we can see through the discussion of abortion legislation in the U.S. and changes to the access environment, it is typical that changes correlate with laws. Abortion restrictions take many forms around the world: limiting abortion pill provision, wait times, gestational limits, TRAP laws, etc. These types of laws are meant to erode abortion access by either limiting the type of abortion a patient can get or limiting the clinic or provider in some way. But what has been observed in Turkey since 2012 is not a change in the abortion laws, but rather the shift in rhetoric by the AKP has led public hospitals and government services to either stop providing abortion, downplay their

services, or be intentionally vague with patients. This means that there is a de facto abortion restriction in Turkey without an actual ban.

The nebulous nature of abortion access in Turkey comes from a combination of barriers that are not necessarily enshrined by law but rather are de facto practices that have changed the abortion environment without changing the law. One of the significant barriers to access is the lack of public hospital abortion provision in Turkey. In 2016 and 2020, there was a substantial study of public hospitals and abortion provision in Turkey conducted by Dr. O’Neil to find out the number of state hospitals that provide abortions. In 2016, 7.8% of 431 state hospitals with gynecology departments said they offer abortion services, 78% of hospitals said they provide if it is a medical necessity (which is not defined), and 11.8% of hospitals refused to provide abortion care under any circumstance (O’Neil, 2017). There are also 10 provinces without public hospitals that provide abortion services. Of the 431 public hospitals surveyed, only 34 were “performing abortions without restrictions as to reason” (O’Neil, 2017). The emphasis on public hospitals is important because Turkey has universal health care, so accessing health services at the public hospital is free to citizens; private hospitals are plentiful but expensive. O’Neil also reports that there was misinformation on the part of the hospitals when the survey was being conducted, including hospitals claiming that abortion was illegal, refusing to provide information, and claiming doctors did not want to perform the procedure.

The 2020 report done by O’Neil and Kadir Has University shows that overall, in Turkey and specifically in certain regions, access to abortion in public hospitals has only gotten worse. They contacted 518 public hospitals, all of which have gynecology

departments, which is required to provide abortion. Only 295 hospitals responded to the mystery patient telephone survey, which was also used in 2016. 54% of hospitals reported that they provide abortions with restrictions, 14% if medically necessary, 5% with conditions, and only 3% of public hospitals surveyed provided abortion without restrictions as to reason (O’Neil et al., 2020). Only 10 public hospitals out of 295 in Turkey provided abortion without restrictions in 2020, even though abortion is legal without restriction before 10 weeks. In 2017 and 2020, the highest responses were abortions provided when it was a medical necessity or with restrictions. Both of these answers are nebulous, but also at the discretion of the doctor and hospital. Legally, this is typically understood as a conscientious objection; however, conscientious objection is not recognized as a legal option in Turkey. Nevertheless, there appears to be an informal de facto practice of these laws being observed.

Conscientious objection is when a healthcare worker (provider or administrator) objects to administering information or a service based on conscience or religious belief. Regarding abortion, this would result in a doctor, nurse, or other medical professional refusing to perform or aid in an abortion service or a hospital worker refusing to provide information based on conscience or religion. Some countries that allow conscientious objections have safeguards so that it does not impede a patient’s access to a specific service. Practices like the law do not extend to patients whose lives are at risk if care is denied; they are offered referrals that will be expedited, or institutions do not have the right to object conscientiously. Where conscientious objection laws are legal and not mediated, they pose a tremendous obstacle to abortion and family planning services. In Italy, 70% of gynecologists refuse to provide abortions, which led to International

Planned Parenthood Federation (IPPF) – European Network to take Italy to the European Court of Human Rights, citing the high rate of objections impeded women’s ability to access legal abortions in Italy (*International Planned Parenthood Federation – European Network (IPPF-EN) v. Italy*, 2012). The court found that women had to travel out of region and country to access abortion in some cases, that objections placed too high a cost on women, and that there was a rise in clandestine abortions observed in Italy despite abortion being legal (Law and Policy Guide: Conscientious Objection, n.d.). Even though conscientious objection is not legal in Turkey, it is practiced, as evidenced by the lack of abortion care in public hospitals. If there is a gynecology department at a public hospital, then abortion should be available on demand under the Population Planning Law. Instead, what has been observed is that there is not only a lack of availability, but in many provinces, there are no public hospitals where abortion is accessible. As in Italy, the lack of abortion providers is a result of a lack of government intervention to ensure that abortion is available under the legal parameters.

A further limitation of abortion services occurs with medication abortion. Medication abortion was introduced in 1988 in France and China and since then has been approved in 96 countries (Sedgh & Taqi, 2023). Medication abortion, where available, is the desired form of abortion before 10 weeks. Medication abortion is typically a pharmaceutical regimen of misoprostol and mifepristone. Mifepristone ends the pregnancy, and misoprostol expels the pregnancy. Misoprostol is commonly prescribed during spontaneous abortions (miscarriages) as well as for ulcers and can be used by itself to terminate a pregnancy if mifepristone is not available. In 2012, Turkey banned medication abortion. Before 2012, misoprostol was available at pharmacies without a

prescription, meaning that women could self-manage their abortions. In much of Latin America, where abortion is restricted or not legal, misoprostol is available over the counter, leading to high rates of safe but illegal abortions. In 2012, with the changing language around abortion politically and the elimination of misoprostol available over the counter, the abortion landscape in Turkey began to change, even if the laws did not. However, a study conducted in 2012 found that 60% of OBGYNs had conducted a medication abortion using misoprostol alone (Akin et al., 2012). In 2016, Turkey banned the most prominent mail-order medication abortion organization globally, Women on Web. Advocates for medication abortion emphasize that its provision is vital to the de-medicalization of abortion. Abortion used to be done in private non-medical spaces, such as the home, and with this technology, it does not require interventions by medical professionals or the state. By regulating medication abortion and encouraging medical interventions, such as administering pills at doctor's offices, it allows more space for surveillance and interference into the body.

Civil Society in Turkey

Turkish civil society was booming in the 1990s and 2000s. After martial law was fully lifted in 1987, after a military coup in the 1980s, civil society was allowed to reform. The 1990s were a time of significant growth for civil society internationally, marked by increased globalization and the collapse of the USSR, as well as democratization in post-Soviet spaces. Turkey was also applying for EU membership in the 1990s and early 2000s, which fostered their inclusion and promotion of civil society to boost their chances of approval. From 1983 to 2004, the number of CSOs in Turkey

tripled, and many groups focusing specifically on human rights were formed (The Center for American Progress et al., 2017). In 2001, the 1983 Associations Law, was liberalized and it opened up civil society even more allowing for more CSOs to be formed.

However, under the AKP and especially after the attempted coup on July 15, 2016, Turkey experienced a crackdown on civil society. A two-year state of emergency was declared, and during that time, 35,000 people were convicted of links to the Gulen movement, which was accused of orchestrating the coup, 125,000 public sector jobs were eliminated, and 24,000 people were expelled from the military (Ibrahim, 2022). Further, after the coup attempt the government held a referendum in 2017 to vote to change the political system from a parliamentary system to a presidential one, which succeeded.

The 2016 attempted coup is a pivotal moment in modern Turkish history, particularly in understanding the role of civil society. After the coup attempt, some 1,519 CSOs were forced to close (Karataş et al., 2023). It has also been said that the government used the coup attempt to close down and crack down on opposition to the AKP (Ibrahim, 2022). Additionally, civil society in Turkey has not rebounded, and CSOs have experienced increasing restrictions and difficulties in forming and functioning. A case against the civil society activist managers of Rosa's Women's Association for allegedly being members of a terrorist organization. Rosa's Women's Association was founded in December 2018 in Diyarbakir, which is the largest Kurdish majority city in the Turkey, as a gender equality and violence against women foundation ("Rosa's Women's Association," 2024). Starting in 2020, their leadership has been experiencing arrests and court proceedings. This is but one example of how the coup escalated tensions with civil society in Turkey. In 2013, widespread protests, known as

the Gezi Park protests, took place around the country involving over two million people (The Center for American Progress et al., 2017). This was seen as a significant turning point in the relationship between the AKP government and Turkish society, which was only widened and increased after 2016.

Women's involvement in civil society and CSOs has been a challenge in Turkey. Women are underrepresented by CSOs, and their participation is negligible. In a survey done of CSOs in Turkey, women make up 20% of those association members (Karataş et al., 2023). Furthermore, only 8.7% of CSOs operating in Turkey have a target audience of women, whereas children and young people account for 61.7% of the audience of CSOs. Of the over 101,000 CSOs represented in this study, there are about 1,529 organizations focused on rights and advocacy, about 1.5% of all CSOs in Turkey. One in five CSOs reported difficulties during the start-up phase and increasing physical and verbal assaults on the bases of gender and sexual identity. They also report increases in auditing by the government and general interference with operations. The "We Will Stop Femicide" platform was closed with the case citing that they were acting outside of their mission and would be disbanded.

The civil society environment in Turkey is robust. However, when it is related to issues such as gender and women's rights it is sparse, and it is increasingly dangerous to form associations around LGBTQ+ or Kurdish identities. Groups that focus on LGBTQ+ identities are .3% of all CSOs in Turkey, and those that focus on ethnic and cultural groups are 3.8% (Karataş et al., 2023). Civil society has not experienced a crackdown as a whole, but rather specific groups or topics have led to increased monitoring, auditing, cases brought forth, or closures. This contributes to our understanding of a mid-level of

institutionalization of civil society. There are many regulations stipulating what can and cannot be done; however, for the most part, the present civil society operates in various parts and sectors of society, addressing a range of issues. Restrictions and government interference are present when it is an issue that may be seen as in opposition to the state or have political associations with groups the government classifies as dangerous.

Research Questions

There are no CSOs in Turkey that center around abortion. The formal CANs that do exist in Turkey that work around abortion are more broadly working on gender and violence against women. However, informal CANs do work on abortion through word-of-mouth and whisper networks (Esengen, 2024). Informal civil society groups are not subject to government regulations and are plentiful, often existing as community-based or casual groups (The Center for American Progress et al., 2017). In Turkey, because abortion is legal until 10 weeks, legal abortion remains available. However, the declining accessibility of abortions in public hospitals, as well as the scarcity in some regions of the country, has created an access crisis. The misinformation that is present in Turkey around abortion further confuses people seeking abortions, as they do not know if it is legal or where they can obtain it, especially as hospitals misrepresent the laws when asked.

I argue that CANs help people navigate the access environment in Turkey to find both legal and illegal abortions. Both formal and informal CANs work in Turkey to help people obtain the correct information around abortion as well as find a hospital, doctor, or provider. The distinction between the formal and informal CANs in Turkey is

pronounced, as both are prominent. Formal CANs are composed of CSOs, and informal CANs are hyperlocal and community-based chains of linkages of organizers aiding abortion seekers. I argue that CANs work through these organizations of people who create various levels of institutional links to provide abortion services in clandestine or difficult-to-access contexts. Their work is because of a determination of society to provide abortions despite the legal context that they find themselves in. In Turkey, these CANs work to help people navigate a confusing and difficult access environment that has been consistently eroding for ten years. This project seeks to understand what types of CANs are operating in Turkey, how they help abortion seekers access abortions, and generally how civil society relates to and affects them.

Accessing Abortion. To better understand how a woman would access abortion in Turkey, I want to employ a theoretical that an average woman in Turkey seeking an abortion would go through. For example, a 22-year-old named Ayla who lives in Izmir finds out that she is pregnant, and she does not want to be. She decides that she wants to have an abortion. Ayla calls the public hospital closest to her to ask for an appointment for a pregnancy termination, but she is told over the phone that abortion is illegal and not offered at the hospital (O’Neil et al., 2020). Ayla is confused because she thought that abortion was legal in Turkey, and she is only seven weeks pregnant. Ayla googles how to get an abortion in Turkey but cannot find any reliable information about where she can get one. Ayla knows some people in her school who are involved in a feminist organization advocating for women’s rights, so she decides to ask them for help. Ayla reaches out to this group of people and says that she thought abortion was legal in Turkey, but the hospital told her it was illegal. Did they know what to do? At this point,

a week has passed, and Ayla is now eight weeks pregnant. The women in the group tell her that abortion is legal in Turkey. Still, many of the public hospitals will not perform them anymore, and none in Izmir or the Aegean area, so she will have to travel to Tekirdag or Ankara to get an abortion at a public hospital (O'Neil et al., 2020). But Ayla cannot take the time to travel to another province, and she does not want to be alone to travel and get her abortion. She asks the women if there are any other choices. The women tell her that she can get an abortion at a private hospital easily, but it will cost her more money, approximately \$196 (7,684 TRY), and the price increases for every additional week, and she is near the term limit (Villalon, 2022). Ayla says she does not know what to do; she cannot afford that much and cannot ask her parents to help because she does not want them to find out she's pregnant. The women then offer to help her, but they will need to be repaid when she can. They give Ayla the name of a private hospital in Izmir and the name of a doctor they know will perform the abortion because they have helped other women go there. Ayla is able to call and make an appointment for the next week, and one of the women accompanies her to provide comfort. Ayla is then able to obtain her abortion legally.

In this example, Ayla is an abortion seeker who is within her legal right to obtain an abortion in Turkey. She is within the term limits and does what she is supposed to do, and calls to make an appointment. What she runs into is misinformation as well as a blockage from a hospital, not only telling her no, but also providing her with misinformation that abortion is illegal. This is a common occurrence; research has shown that more and more public hospitals in Turkey not only refuse to perform the procedure but will lie to the abortion seeker about the legality of the procedure (O'Neil, 2017;

O'Neil et al., 2020). When Ayla does not know what to do next, she turns to people she thinks will be sympathetic to her cause. The women she turns to are not part of a group about abortion or reproductive rights, but Ayla guesses they would be empathetic because they are involved in a feminist group. This feminist group is not a CAN. However, the women who are helping Ayla and have helped other people in the past access abortion are part of an informal CAN. They are individuals in the community who signal their sympathies, attracting people who come to them asking for help, which they are then able to provide. They help Ayla by providing her with the correct information, as well as her options of travelling to another province for an abortion or going to a private hospital in Izmir. Further, they can help her afford the abortion, but they ask to be repaid because they cannot afford to keep doing this if they are paying for people's procedures. Ayla is then able to obtain a legal abortion within the term limits.

I employ this use of a hypothetical to highlight that although abortion is legal in Turkey, there are significant barriers to access that must be addressed. Turkey, on paper, has a liberal abortion law, especially for its region. But in practice, abortion is increasingly difficult for people to access, and that is all that matters in the end. Although the right to abortion may be in place legally, there are several obstacles that an abortion seeker must navigate to get to the abortion procedure. This hypothetical highlights those most common barriers. The lack of public hospitals providing abortion services, the misinformation around the legality of abortion, an inability to look up what hospitals near her provide abortion, the barrier to travel out of her province or seek an expensive abortion in a private hospital, and the unknown of doing it alone. These are a significant burden on the abortion seeker and difficult, if not impossible, to navigate

without someone helping you. Ayla does not know any of the women in the group personally, but instead knows of them. She can guess their sympathies based on their other social indicators and believes they can help her. These women have helped others navigate these decisions as well and are prepared to help Ayla, both in finding an abortion and in helping her pay for it, as well as attending her appointment with them. The service of an informal CAN like this one is not only to help someone get the abortion, but to guide them gently during this time and provide comfort. As we proceed with the paper's findings, this hypothetical will be further enlightened from the CAN's point of view through the interviews. But this hypothetical serves as an aid in understanding the journey an abortion seeker goes on in Turkey, and how the legal environment does not accurately reflect the reality of access.

Methodology

Due to the robust availability of research on abortion in Turkey, my focus for research was to understand the role that civil society plays in abortion access. In the U.S. specifically, civil society and abortion are closely related, especially as threats to abortion rights have increased. However, abortion was not a salient feminist issue in Turkey until 2012; many feminist groups did not take abortion seriously because of the more pressing issue of other issues, such as domestic violence and LGBTQ rights. When abortion rights became threatened, feminist groups started integrating abortion rights and family planning issues into their organizations more. In this context, CANs are understood more as organizations, networks, NGOs, and groups that help guide people to abortions in Turkey. Often, these organizations guide people to legal abortions in Turkey, but these

legal abortions are often hidden and obstructed by the government. For example, an organization may help refer patients to abortion services by having a private list of providers who they know are willing to provide abortions, even if they are not widely known. A common occurrence during my fieldwork in conversations is that many people believed that abortion was not legal in Turkey. People would go to these CANs asking for help, unaware that they were legally entitled to access this service.

I began my fieldwork by creating a list of organizations that work on gender issues in Turkey and started outreach, including posting on listservs for abortion advocates globally. Snowball sampling was not only necessary because of the nature of this topic in Turkey, but also helpful because the community of people working on abortion in Turkey is relatively tight-knit. I recognized that I had reached everyone possible using this type of sampling once my referrals from organizations became cyclical, and I had already reached all the people I was being referred to. I was based in Istanbul for 7 weeks, from June to August 2024, and interviews took place at that time. It is important to clarify that I was interviewing CANs and not individuals; those interviewed answered on behalf of their organization, whether that be a formal NGO or a network.

Recruitment focused on CANs that had some relationship with abortion, whether that be providing abortion referrals or their mission/goals were aligned with reproductive rights/health or abortion. I held an initial meeting with most organizations determine if their organization qualified for an interview and to establish a relationship of trust. I met with ten organizations during my fieldwork, which resulted in four formal interviews. With abortion-related topics, especially in an area where civil society does have explicit

threats, it is essential to establish trust and ensure that the research being done is in good faith. These initial meetings focused on whether their organization helped people access abortion, referred people to abortion services, or worked with people who provided these services. Whether or not these organizations had done any of the above, they were all asked if they knew of any other people or organizations that might be helpful for me to reach out to next. If the organizations had done any of the listed activities, I invited them to participate in an interview.

Of the ten organizations from preliminary meetings, I invited six to participate in more formal interviews. Four of those six agreed and moved on to the formal interview. Some organizations I met with had concerns that their organization did not focus enough on abortion, even if I had expressed that they met the criteria. From the meetings I had as well as the interviews, there was a clear pattern that abortion was not a salient issue for many organizations, and that there was no organization that focused solely on abortion in the entire country. I acknowledge that the limited number of interviews creates a imperfect view of CANs in Turkey. Still, it is also a natural consequence since so few organizations are focusing on this work. For future research, I foresee an ethnographic approach as being appropriate, along with less stringent rules flexible recruitment criteria. The interviews were held either over Zoom or in person in Istanbul. All interviews were recorded using a voice recorder and then transcribed loosely. Since I was interviewing organizations and not individuals, I chose not to transcribe verbatim at many points, as the representatives might have shared personal details or made grammatical errors. At points, I did pull exact quotes from my interviews, but many responses were taken in note form rather than a direct transcription of their transcribed.

Findings

These interviews showed not only how CANs operate, their goals, and functions, but also provided a robust look at the relationship between the state, civil society, and abortion provision. Three of the four interviews given are from established and well-known organizations in Turkey, Mor Çatı, Women for Women's Human Rights (WWHR), and Women on Web (WoW). WoW is an international non-profit that works to provide medication abortion through the mail. Mor Çatı and WWHR are both based in Istanbul and focus primarily on Turkish women for a variety of issues, including domestic violence, gender-based violence, sexual and reproductive health, etc. It is also important to note that Mor Çatı, WWHR, and WoW have worked together to launch a new initiative called Kürtaj Hakkım (My Right to Abortion) which is a platform to help women who need to access abortion in Turkey by providing them with relevant resources. They developed this with a grant from Safe Abortion Action Fund (SAAF), which is a global fund dedicated to providing safe abortions around the world. I did not interview Kürtaj Hakkım as a separate organization, but the organizations did discuss this initiative in their interviews separately. The fourth interview was with an anonymous CAN representative, who helped form several word-of-mouth networks in Ankara. These four interviews, as well as informal conversations I had during fieldwork, created a picture of how Turkish women access abortion and the increasingly limited options they face despite no changes to the law.

The interviews focused on questions around their organization's inception, growth, reach, future goals, and perceptions of civil society and abortion in Turkey. The interviews contained the same or similar questions but allowed for a free-flowing

conversation when the respondent desired. The first set of questions was focused on background information on the organization. Some questions asked were: “Where is your organization based,” “How did your organization begin, was there an impetus for its creation,” “What were the original organizational goals/mission,”. Then these questions pivoted to growth and change over time, “Have your goals/mission changed in recent years, why,” “How does your organization respond to changes in abortion rhetoric in Turkey,” “Have there been organizational structural changes as a result of the political climate (new positions, changes in job descriptions, etc.)” “Can you explain your organizations pattern of growth in Turkey,” “Does your organization have goals for growth (expansion, following, partnerships, etc.)?”. These questions were aimed to get as much background as possible and to understand change over time and how the political climate interacted with how the organization responded. Then I asked about organizations reach: “How large is your organization’s reach,” “What is the reach in Turkey,” “Do you have goals around reach, general or specific,” “How many abortions do you think your organization aids in annually.” Then I asked questions about political advocacy: “Does your organization participate in political advocacy, ex. lobbying, supporting parties/candidates/issues, working with political figures, etc.” “What are your organization’s goals around your advocacy work?”

Finally, I ended the interviews with a discussion of civil society generally, “What does your organization believe Turkey’s attitudes are toward civil society are? On a scale of extremely restrictive to not restrictive at all,” “Do you believe Turkey’s attitudes towards civil society affect organizational freedom,” “Does this change your organizational goals? How?” “Does Turkey’s attitudes towards civil society play a role in

abortion access?”. Finally, I end on a set of general questions to get a feel for the climate on abortion: “Does your organization believe that there are clandestine or illegal abortions happening in Turkey?” “Why do people access clandestine abortions?” “How do people access them?”. These questions were developed to fit into the theoretical model to understand how CANs affect abortion access, but also how the level of institutionalization of civil society affects CANs. Through these interviews as well as other conversations I had with civil society members and my research into abortion in CSOs in Turkey, I found that the way that civil society is shaped does play a significant role in people’s ability to access abortion.

CAN Inception and Growth

Of the three formal organizations interviewed, two are based in Turkey, and the other is an international organization. Mor Çatı and WWHR are both based in Istanbul, Turkey, and Mor Çatı was founded in 1990, and WWHR was founded in 1993. The 1990s was a significant time of civil society growth in Turkey, it was coming out of a military coup that had eliminated all civil society and disbanded political parties in the 1980s. The 1990s were also seen internationally as a significant time for civil society development globally, with many significant conferences held by international organizations to support the proliferation of civil society organizations on national and subnational grounds. Mor Çatı and WWHR were both founded by feminists in the early 1990s and became two of the first and most prominent NGOs in Turkey, especially those focused on gender issues. Mor Çatı is a grassroots feminist organization that emerged from a campaign to address gender violence and subsequently formalized its

establishment as the first feminist organization in Turkey. WWHR has focused on civil society development around gender, with three programmatic pillars: human rights education programs, advocacy, and “feminist knowledge production and dissemination” (Women for Women’s Human Rights, personal communication, July 2024). They also have trainers around the countries who helped organizations in local communities get started and train them within their model, which then leads to them being affiliated with WWHR.

WoW, however, is formally registered in Canada but operates around the world with members in many countries. It is the sister organization Women on Waves which is a famous abortion non-profit that provides abortions via a mobile clinic on water travelling offshore of countries with harsh abortion restrictions. WoW was born out of the realization that they cannot go to all countries, so they would establish a telemedicine abortion service to help people access abortion at a distance. Established in 2002, it came at a time when abortion technology was developing quickly, as medication abortion was approved in multiple countries in the 1990s and 2000s. WoW also highlighted that abortion is so often gatekept by medical professionals, and countries (like Turkey) usually have laws that limit who can provide abortions from only doctors to only doctors in certain specialties. It creates an unnecessary barrier for those seeking abortion because anyone with prescribing power could administer a medication abortion, and as WoW has shown, people can safely self-manage their own abortions.

These CANs have not experienced massive changes to their original missions or goals. WoW focused on a harm reduction strategy, to say that they knew people were accessing abortions in unsafe and illegal conditions anyway. So, offering medication

abortion services via the mail would help people access abortion safely when they would potentially access it unsafely if not for them. Their mission has changed recently as telemedicine and self-managed abortions have become safer and more desirable to people; they are also focused on the human rights of abortion care, not just harm reduction. They care about patient-centered care and providing quality abortion access, especially if medication abortion or telemedicine is not an option, even if surgical abortion is legal.

Mor Çatı's organization focuses on gender violence and building solidarity between women against violence. As a grassroots organization, they have not altered their mission or strategy, but rather remain responsive to the needs of the people they assist. WWHR's focuses have also remained the same, focusing on those three original pillars. In the interview, WWHR acknowledges the significant changes in civil society in Turkey from the 1990s to the 2020s, largely attributed to the current government. They remark that the 1990s had a sense of vibrancy and optimism, and now they are in an era where these hard-won rights are being taken away and threatened. In the 1990s, they were focused on political reforms and pushing through new ideas and advancements. In the 2020s, they are focused on preserving and fighting to save those same rights. WWHR even remarked, "we are not proactive anymore, we are reactive now," and that there is a shrinking space in the civil society sphere in Turkey (Women for Women's Human Rights, personal communication, July 2024). Further, they remarked that hate and backlash have been organized, evil is being globalized, and it is difficult to progress.

These organizations deal with a variety of focuses, but each works to support abortion seekers. WoW is the only organization directly dedicated to providing abortion

services, Mor Çatı and WWHR have more general focuses on gender issues, including gender violence. Mor Çatı has women across the country reach out with issues related to domestic violence and they provide support and resources for them. Many of these women also include those who are pregnant, and do not wish to be. A common thread between all the interviews is the level of misinformation around abortion in Turkey. It is not just political rhetoric of threatening abortion access. Still, when women call hospitals, they are told that abortion is not legal, that it is not performed at hospitals, etc. Mor Çatı remarked that sometimes women reach out when they have been denied care and the organization will help them find providers and hospitals in their area that they know will provide an abortion, even if the public hospital has denied services (Mor Çatı, personal communication, July 2024). They also say that it is challenging for women in rural areas or in Anatolia, who have fewer hospitals they can access and may not have the money to go to a private hospital. A significant barrier when someone is denied an abortion in Turkey is the 10-week gestational limit; many women do not know they are pregnant until the 6th week or later, so they have to act quickly to obtain an abortion. Similarly, WWHR will have women reach out with concerns and confusion about accessing abortion, and they will also refer them out. WWHR, WoW, and Mor Çatı have developed a website, Kürtaj Hakkım, that has information about the right to abortion in Turkey, how to access it, and what to do if you have been violated or denied. This is the only website in Turkish that provides this information and centers around abortion access and information. Its goal is to help break those misinformation barriers and help people to realize and access their rights.

As the only international organization that I interviewed, WoW had a unique experience in its expansion into Turkey. As a telemedicine abortion service, WoW relies on people reaching out, where they then consult abortion seekers and aid them in accessing abortion through medication abortion pills. In 2012, WoW began a project to expand into Turkey, including making a Turkish language website. The political climate spurred this on at the time in Turkey because it is when Erdoğan first expressed restricting abortion in Turkey. In 2012, misoprostol was withdrawn from pharmacies in Turkey, which is one of the two pills used in a medication abortion. Misoprostol can also be used alone, but it is typically not done unless there is a limitation of mifepristone. In 2016, WoW's website was banned by the Turkish government (which I experienced when doing my fieldwork), so they created various proxy websites to circumvent censorship. WoW then created a safe abortion app, which has also been restricted in Turkey. Their main obstacle in operating in Turkey is censorship. They remarked that they did media to spread the news about their services and medical abortion because, at the time, it was relatively unknown. They released a podcast episode in Turkish in their media campaign, and that episode was subsequently banned in Turkey.

Before 2016, when their website was banned, they had additional team members working on the expansion into Turkey. The government's censorship meant that they received very few requests and interactions from Turkish women, compared to the regular number they had received before. When asked about the pattern of growth in Turkey, WoW said that they had an increase in abortion seekers from 2013 to 2016 when their website was live and operational (Women on Web, personal communication, June 2024). However, after 2016, there were few consultations or emails because they didn't

know about the resource or could not access it because of the censorship. In 2020, WoW decided to take the issue of censorship to court, but their case was denied, and the ban was ruled allowable. They also stated that they will continue to pursue their legal case until they reach the European Court of Human Rights. In this part of the interview, WoW took the time to rearticulate that at that time, from 2013-2016, they were the only organization in Turkey that was discussing medication abortions. Although they might not have had the lasting impact on abortion seekers in Turkey they did bring the conversation about medication abortion to the country. Now it is a clear feminist demand in the country.

I will refer to the anonymous word-of-mouth network as CAN X in the discussion of the interview, and they will be cited as CAN X Turkey. CAN X was started by a member who had built informal networks in multiple places during the COVID-19 pandemic. These typically started by being approached by abortion seekers and acting as a way of connecting seekers to abortions. CAN X started through friendships as well as being involved with thematically related organizations, such as ones around feminism and human rights. These organizations themselves did not focus on sexual and reproductive health and rights (SRHR). CAN X's purpose was to help people find abortions. CAN X was approached by people seeking an abortion because the abortion seeker knew that CAN X would help them. What CAN X emphasized throughout the interview was that abortion seekers do not want to be judged for their decision and seek out people who can help guide them through the experience in a gentle way.

CAN Reach

Filling the need for abortion access is a crisis in Turkey. As shown earlier, fewer and fewer hospitals are providing abortions (or saying they do) in every province, including in urban centers like Istanbul (O’Neil et al., 2020). WoW highlighted that they were serving people in Turkey, but now receive few emails directly from abortion seekers. Globally, WoW aids around 12,000 women in accessing abortion each year, in countries where abortion access is restricted. Now, their work in Turkey is in partnership with organizations such as WWHR and Mor Çatı. Mor Çatı aids 1,200 women annually, but not all are abortion seekers. They do not seek to expand their services, but see it as their duty to serve women and to keep that steady from year to year. They serve women around the country, but also will intervene if the violence happens in Turkey to foreign nationals, or if the perpetrator of violence is Turkish. People find them in a variety of ways because they are one of the most prominent organizations in Turkey. Further, they are even referred by public institutions when they do not want to deal with a particularly difficult case; the public institution will pass them off to Mor Çatı, knowing that they will accept it. Both Mor Çatı and WWHR say that most people who find their organizations do so through social media or Google.

One of WWHR’s major programs is human rights education program that aims to enhance local grassroots organizing. Through this, they have 100 local organizations in 61 provinces, which either have a local trainer or have been trained through the program. In the interview, WWHR emphasized the importance of the local level multiple times and stated that it had become a primary focus of their organization over time. Discussing this with WWHR was insightful because they have numerous affiliated organizations engaged

in grassroots work. None of the organizations interviewed had concrete numerical goals as an ambition for year-to-year growth. Mor Çatı limits its numbers on purpose to provide the best services, and WWHR focuses on thematic goals, including making progress at the local and grassroots levels through their training programs. In the earlier parts of these conversations, it was noted how vibrant civil society was in Turkey in the past, and now it is a much more challenging environment. However, in my discussion with WWHR, their refocus to the local and grassroots levels has, in ways, created a new proliferation of organizing around human rights, gender, and sexual and reproductive health, where it had not necessarily been happening before, especially in non-urban areas.

The reach was not large for CAN X, it was limited to a network of acquaintances, and there was no desire to expand. They explained that multiple networks exist in different places, and are created through word-of-mouth or friends. People with common interests and shared areas connect to form the CANs. This means that they remain small and limited, but are also too numerous and informal to be quantified. When asked how many abortion seekers they had connected with, it was unknown, but they guessed that maybe 25 have been linked directly. CAN X also added that if you are in an urban area seeking out an abortion, finding it is not necessarily difficult so the need for large CANs is unnecessary because you can find someone to help easily. They also remarked that finding an abortion was not necessarily difficult in Turkey, because accessing a private abortion is easy. What is difficult is the stigma and fear around bias from your doctors. They emphasize that people feel safer when they have been referred to a service, because it eliminates the unknown. CAN X dealt with people in Ankara, who largely knew that abortion was legal, but they were afraid of going to a hospital without knowing what

would happen, how the doctor would treat them, or how the medical staff would treat them. They add that trust is essential for people accessing abortion, because there is so much mistrust in the medical system in Turkey.

CAN Political Aspirations

Political advocacy is a significant concern for each of the CANs interviewed. They are all inherently political organizations due to the issues they focus on and their increasingly contrasting views with the current government. WWHR and Mor Çatı do not directly support parties or candidates; instead, they focus on issues directly related to their work. WWHR goes further with working directly with opposition parties on multiple levels to collaborate. WoW works directly with party members, but they do not support specific candidates. For example, they will do abortion reform campaigns and work with multiple parties in a coalition. However, in Turkey, they find that they lack an “organic link” with any parties due to the country's censorship (Women on Web, personal communication, June 2024). But they would look forward to working with parties in Turkey in the future and working collaboratively on projects, especially about medication abortion.

WWHR is the most politically engaged of the organizations that I interviewed. One of their three pillars is advocacy. They also engage with numerous organizations across the country, which has deepened their advocacy. The current government has completely shut off communication with them, and they have since tried working with mainstream opposition parties around issues such as gender equality, abortion issues, and whatever else is at the table that is relevant. Where they have focused much of their

efforts is on the local level and working in municipalities. This was a common theme of the interview. Through the evolution of civil society in Turkey and the threats at the national level, particularly in terms of rhetoric and power within the AKP, they have found themselves unable to engage with national politics as they once did. Instead, they have moved to working at provincial and municipal levels, where opposition parties are often in power and competitive in elections. They often work with the Cumhuriyet Halk Partisi (Republican People's Party or CHP) and the Halkların Eşitlik ve Demokrasi Partisi (Peoples' Equality and Democracy Party or DEM), which are opposition parties to the AKP. They also emphasized how they were fighting to preserve rights in this current climate, rather than advancing issues that had been the focus in the 1990s. Because of this, they must collaborate with broad political coalitions to work on preservation, as the AKP holds a majority in government. Many local governments have the CHP in power and WWHR remarks that it is easier to enact policies, open up shelters, provide childcare, and women's empowerment at the local level rather than trying to fight at the national level.

Perceptions

I ended each interview by asking how they saw civil society in Turkey. The aim of this was to gain a deeper understanding of how they perceived themselves and their work within the context of Turkish civil society. WWHR and Mor Çatı noted that they are both established and well-known organizations in Turkey, which affords them a level of protection from increased public scrutiny. It was also expressed in the interviews as well as outside conversations that many do not engage in this work on a more minor scale

publicly, out of fear, subversion, and that covert actions are normal. I'd also re-emphasize here that neither of these two organizations is solely focused on abortion; it is an accessory to their other work. There is no formal "abortion" CSO in Turkey. As we can see from this sample, organizations are working on gender broadly, and abortion is a facet of their work, but not the focus. This was a major hindrance to my fieldwork in Turkey and recruitment, because many organizations did not see their work as relevant enough to warrant research, even if I had categorized them and invited them to participate.

Another hindrance to research was how participants colored civil society in Turkey. In my categorization in this project, Turkey is at the mid-level of civil society institutionalization. Especially in a comparative work like this, when compared to Romania, it is much freer, and there is an ability to organize that was not available in Romania or in times of martial law in Turkey, such as in the 1980s, when civil society was disbanded. Unanimously, when asked on a scale from extremely restrictive to not restrictive at all, how does your organization categorize civil society in Turkey, each respondent said that civil society in Turkey was extremely restrictive. This was a consistent and evident finding I had in each interview, but also in my conversations with other people. WWHR remarked that civil society in Turkey was extremely restrictive but added, "We are not Egypt yet, but they want to bring us there" (Women for Women's Human Rights, personal communication, July 2024).

Each organization has faced its own obstacles with the current government and fears of retaliation or surveillance. WoW noted that their website had been banned in Turkey for 8 years at the time of the interview, which they considered a massive violation

of freedom of expression. They also remark that there are other organizations allowed to operate, but WoW is a prominent abortion organization globally that has been banned. They had to adapt to the censorship, so everything changed in their goals and operations. WoW also had concerns that if they did anything in Turkey substantially, they would be leaving people in the country in danger from association because they have been a target of the regime through censorship. Further, they had members who lived in Turkey who avoided associating themselves with WoW professionally, such as censoring their LinkedIn profiles. They are used to taking precautions and Turkey is not unique, as they are a global non-profit that focuses on providing in areas where abortion is illegal or difficult to access. Although WoW is banned in Turkey, they have partnered with WWHR and Mor Çatı on their new abortion project Kürtaj Hakkım, which aims to help Turkish women access abortion resources in Turkey, which are legal. At the time of the interview, the platform was in its early stages and was still being developed, although it was still publicly available online.

When asked how the restrictiveness of civil society affects their organizational goals and functions, Mor Çatı and WWHR had disparate answers. Mor Çatı emphasized the need for caution. On principle, they do not shy away from what needs to be said, and they will remain outspoken. But, they experience the pressures from the bureaucratic nature of being a registered foundation. As any organization, they are subjected to audits. What they find is that they must be diligent and more careful than another organization because if any “human mistake” is made it would be an excuse for being shut down or penalized in some way (Mor Çatı, personal communication, July 2024). They do not stray from being political because of their core values as an organization, so they are in

the spotlight, for better or for worse. In the interview, Mor Çatı emphasized that they have to remind themselves in restrictive times to hold firm or when there is more pressure. Adding that, “if something is going to happen, it is happening because of what we have to say” (Mor Çatı, personal communication, July 2024). Many other organizations, they note, are unable to do this and shut down, so they remain one of the rare ones that who continue to criticize what is happening when others may stop. WWHR remarked that they do not let the restrictions change or alter their own operations.

I then asked if Turkey’s attitudes towards civil society play a role in abortion access. The answers on this question varied drastically because of how respondents perceived civil society and the role of organizations in access. For WoW, which is a CSO that directly provides abortion access, their answer was a clear yes. They noted that there is fear and stigma around abortion, and no groups were working on abortion in Turkey until recently. They also noted that things are happening constantly in Turkey; there is always a new issue to be raised and an event to be concerned about, so it draws attention in many different directions. Mor Çatı, which deals with many women who seek abortions after facing violence, also remarked that yes, the state does limit civil society’s role in helping people access abortion. However, WWHR said no, that civil society in Turkey does not play a direct role but that messaging is important and helping people gain information on their rights and facts around abortion with so much misinformation.

Finally, I asked my participants about clandestine and illegal abortions in Turkey. It is common practice, in any civil society context, that if abortion is difficult to access,

people will find alternative ways to access abortions. With the de facto restrictions in Turkey and the number of public hospitals refusing to perform abortions increasing, and the expense of travelling or going to a private hospital, it is assumed that some will attempt to obtain an illegal abortion. In many of these cases, normally, WoW would be a place where women would reach out. However, as they are censored and receive very few requests from Turkey since 2016, they are no longer a popular option as a way to receive a safe clandestine abortion. When asked, WoW said that there were definitely illegal and clandestine abortions in Turkey. Access is so restricted, and they know that the number of miscarriages is increasing, which is most likely due to misreporting of abortions, they speculate. As abortion is provided less and less in the public sector, people will look elsewhere for affordable options. Even if you can access a legal abortion either by living near a hospital that does provide it or by being able to afford an abortion at a private hospital, if you are married and your spouse refuses to sign off on your abortion, you may resort to a clandestine abortion. Further, they remark that many people prefer medication abortions and they will look for the pill in the underground or black markets. They also note that there are illegal places where people can access abortion, especially in and around large cities. WoW explained that they did not want to say illegal clinic, because there are likely no doctors working there, and a clinic would legitimize their practice, especially considering the abortions performed are likely unsafe. Further, people may go back to more traditional ways, especially in rural areas, by trying to ingest herbs that are meant to “bring menstruation”. These are often dangerous and unstable and may not result in an abortion, but could do other harm. WoW ended the

interview by saying that “people do dangerous things to themselves to end their pregnancies” (Women on Web, personal communication, June 2024).

WWHR ended their interview by discussing the changing access environment. They emphasized that abortion is legal for 10 weeks, but the issue is that it is difficult to access. Hospitals say they do not provide it, that abortion is illegal, which is false. They say that there is conscientious objection in the law, which is false. And these lies and the erosion of abortion access are most felt in rural areas and for women who cannot afford to travel or pay for a private hospital. It restricts who can get an abortion and where they can get it. So, it drives many women to the black market to either get an often unsafe, surgical abortion or to get medication abortion pills that may be offered locally compared to a legal abortion in a hospital.

My interview with CAN X offered a competing view of politics, civil society, and abortion access in Turkey compared to the more formal CANs. CAN X, having started in 2020, did not have the same experiences as the other CANs regarding the change in political rhetoric or civil society due to their limited institutional knowledge. When asked how Turkey views civil society in general, it is noted that the state's treatment of civil society depends on the topic of the organization, specifically in the context of formal organizations. CAN X remarked that they think Turkey is extremely restrictive only if the CSO is about Kurdish rights or LGBTQ+ rights. And that for gender, it is not very restrictive, and it is encouraging of NGOs for migration issues. They remark that they do not know of any organizations in Turkey that focus on abortion. However, they are aware of some organizations that focus on gender issues, but do not explicitly have SRHR as a primary focus.

When asked about how they perceive Turkey's attitudes toward civil society play a role in abortion access, they say yes, but it is worse elsewhere. They emphasize that it is difficult to find a public hospital that will perform an abortion, but private hospitals will do it, which makes it easier to find. They also say that for many people the abortion at a private hospital is not too expensive; if you cannot afford it, you can ask a friend to borrow. CAN X also emphasizes that they would never refer or recommend that someone go to an NGO that needed an abortion. They acknowledge that maybe the NGO can help, but a significant reason why people seek out informal CANs is because they want someone who they can trust to help guide them through the process, and that it may make them feel less safe to speak to a stranger at an NGO and then go to an unknown hospital and doctor.

During the part of the interview about clandestine and illegal abortions, CAN X described a story I had not yet heard during my fieldwork that is essential to the understanding of younger women's attitudes towards abortion. CAN X was shocked I had not yet heard of the story of a young girl's father receiving an automated text from a hospital saying, "Congratulations, your daughter is pregnant!". I will discuss this story in more detail in the discussion, but in the interview, CAN X remarked that this was a pivotal moment that happened in the 2010s that made young women terrified of going to state hospitals, especially for their reproductive health. It created a deep sense of mistrust in young people because their medical records were being misused. CAN X remarks that the system has changed and is still more secure now, but theoretically, the government has your records at a state hospital and could see if you were pregnant, had an abortion, etc. This then led women to give fake names when obtaining a legal abortion, so it was

not attached to their medical records. They acknowledge that illegal and clandestine abortions happen in Turkey, but even with legal abortions, there is a level of subversion happening there too.

Discussion

During my time in Turkey and through numerous discussions with members of civil society, I found a surprisingly young civil society. The political history of Turkey is turbulent; the country has experienced numerous military coups, periods of martial law, and a gradual transition to democracy in the early 20th century. But civil society did not develop until the 1990s. Internationally, the 1990s were also seen as a period of significant global civil society development, which was further emphasized by the collapse of the USSR and the democratization of many countries in Eastern Europe and the Caucasus, both of which border Turkey. This means that much of civil society in Turkey is as young as that in post-Soviet states emerging from countries that had disbanded civil society entirely and were reforming new political parties as well. Particularly for WWHR and Mor Çatı, they have remained steadfast in the feminist values on which they were founded in the early 1990s.

Many of the organizations I talked to did not deal with abortion directly. This was a common theme, as there is no formal CSO in Turkey dedicated to abortion. For some organizations, such as WWHR and Mor Çatı, abortion was not a salient political issue when they were founded. They do deal with abortion seekers and with abortion, but it is not the purpose of their organization. Others had downplayed their association with abortion or had changed their mission statements to focus on migration rather than

abortion, even if they still dealt with abortion among migrants. I found this interesting because abortion has become a more salient political topic in Turkey, especially after 2012. However, I did not speak with any CSOs that were founded after that time. What this tells me, and also what Mor Çatı remarked in their interview, is that more prominent organizations have a level of protection because they are so well known. It is more difficult for a new organization to emerge because it faces scrutiny or may have a more challenging time in arranging its foundational and organizational elements.

Although abortion has become a more salient political issue for feminists in Turkey, there is a lot of other work. WoW said in their interview that there are so many different things for people to focus on that it is difficult to focus on one issue. Other organizations emphasized this point, saying that they have transitioned in the past 10 years to concentrate on migration issues because of the refugee crisis from Syria. It was a more acute crisis than abortion, especially considering that abortion is legal and was more available 10 years ago than it is today. In January 2024, the Constitutional Court in Turkey issued a ruling that allowed married women to retain their own surnames for the first time. WoW used this as an example of all these small fights for rights that people are engaging in, which draws a lot of attention; there must be a difficult fight for a small win. This is to say that abortion is legal; there is no right to fight for, it is already in place. The level of access erosion, as well as the amount of misinformation, has not yet been viewed as an acute crisis.

My interview with CAN X was very different from the other interviews and conversations I had with other groups. This was because they were an informal CAN, but also because they were relatively young. The informal nature meant that they did not

have an institutional history to draw on like the other CANs interviewed; they also did not experience a shift in the abortion rhetoric in 2012 because they had not been around until 2020. They also had a perspective of working with young women in Ankara that people could find an abortion if they tried, but what abortion seekers wanted most was comfort and peace of mind. Ankara is one of two provinces in Turkey with two public hospitals that said they provide abortions (O’Neil et al., 2020). The abortion seekers they worked with reached out to them so they knew what to expect and that the doctor and hospital could be trusted. During the interview, the CAN shared a story from the news about an app run by the Ministry of Health that sent a father a message stating his daughter was pregnant in 2012. The daughter had gone to the doctor and had blood work done, and her guardian was informed of the results directly on his phone (“Congratulations, Your Daughter Is Pregnant,” 2012). CAN X remarked that this was a massive scandal at the time, and that it stuck in the minds of young women that if they went to the public hospital and were pregnant, it could be leaked to their parents. It was also reported that one of the major concerns was that the results of the pregnancy test were related not only to the family but to the state. Privacy, comfort, and anxiety were common themes in the interview with CAN X, and that is understood better knowing that many Turkish women grew up with a story like this in the news.

Before embarking on my fieldwork in Turkey, I had identified potential organizations to contact, but I also anticipated encountering smaller organizations. As part of my research plan, I aimed to utilize these large CSOs to identify smaller, regional formal CANs. Instead, what I uncovered in Turkey was a dearth of smaller formal organizations operating in the country around abortion access. What I’ve presented is

that there are larger, established organizations working on issues related to gender, and informal CANs operating at a hyper-local level. The shape of civil society related to abortion in Turkey took a different form than I expected. I anticipated finding a mixture of CANs, based on my high-level institutionalization case and low-level institutionalization case, with an organizational structure in the middle that was smaller-scale, operating at the local or provincial level instead of the national level. Instead, what I found was a different type of mix; it contained both national, formal, and older organizations that existed in the high-institutional cases, as well as informal, word-of-mouth networks that were prevalent in places with low levels of civil society institutionalization.

This finding was one I did not expect, but it is compelling and makes theoretical sense within my framework. There are two types of organizational shapes in Turkey: the larger national formal organizations, which are slightly insulated from the state, and smaller CANs that operate almost invisibly, thereby remaining an unknown quantity and posing a lesser threat. Through the interviews and discussions with CANs, I found that there is increasing anxiety under the AKP, and many lived through the martial law in the 1980s, as well as retaliation after the coup attempt in 2016. Further, as one of my interviews pointed out, there is an awareness of what is happening elsewhere in the Middle East, that civil society is something that can easily be threatened and taken away. It would be difficult, if not impossible, for a smaller-level organization to crop up and focus on abortion. It may not withstand the pressures of the political climate, but as argued elsewhere, it is not seen as pressing as something such as gender violence.

This attitude and reality of CSOs in Turkey have led to a proliferation of informal CANs. These types of CANs are too informal, too small, and too covert to draw attention and, therefore, are somewhat insulated from political attacks. The structures are informal and loose because they may also not persist over time. Another study interviewed urban-educated women on how they used their social networks to access abortion care (Esengen, 2024). The study found that women use their social networks to access abortion providers and then build solidarity networks to help others in the future. Of their interviews, 13 respondents had had an abortion, and 12 were part of a social solidarity network. It found that networks helped abortion seekers find an abortion, but also provided comfort and helped seekers deal with stigma. This study corroborates that informal CANs not only exist in Turkey but are also hyperlocal and covert. My interview with an informal CAN was insightful into the way they operate and their motivations. Further, it also sheds light on the fact that there is an unknowable quantity of these operating because they are so informal. It is friend to friend, acquaintance to acquaintance, helping others in need access abortion. But with the level of misinformation about abortion in Turkey and the lack of access at public hospitals, these CANs aid people in finding real information rather than being deterred by hospitals that say abortion is illegal. They may also connect people with accessing medication abortion pills via the black market and potentially refer them to illegal surgical abortions. I do not believe that these CANs have just cropped up since 2012; I believe they have always been a part of abortion access in Turkey since pre-legalization and have evolved and persisted, especially in areas where access has always been difficult.

What these CANs have revealed is that abortion is still being accessed in Turkey, although the access environment is increasingly limited. Through their advocacy efforts, referrals, and engagement with abortion seekers, CANs are helping people access safe abortion in Turkey. By maintaining lists of hospitals and doctors who they know will provide the procedure, they can refer abortion seekers to reliable practitioners rather than leave them to access them alone. Further, the creation of Kürtaj Hakkım is a valuable resource to Turkish women regarding their rights and resources in accessing abortion services. Informal CANs that operate on personal networks are also providing valuable work in helping people navigate the access environment by helping relay what others have done, what has worked, and what has not. The abortion law may be the same as it was in 1983, but the way in which Turkish women talk about abortion and can access it has changed. Those who work at hospitals that answer inquiries have been documented as lying and misleading patients in their pursuit of a legal abortion (O'Neil, 2017; O'Neil et al., 2020). The political threats in place, as well as widespread misinformation, have put the onus on civil society to help educate women about their rights.

Although abortion has become more of a salient issue in feminist circles since 2012, it has taken a backseat to other issues. Because of this, the level of organizing for abortion has not been at the level of other issues that are pressing for women in Turkey today. At least 403 women were murdered in Turkey in 2023 (Wieting & Fraser, 2024). Femicide is a major issue that has received a ton of media attention, as well as protests and organizing across the country. In comparison, abortion rights are recognized in Turkey. The gestational limit is low, but there is no level of urgency around abortion as there is gender violence. As WWHR stated in the interview, in recent years, there has

been a shift from fighting for rights to a focus on preserving them. Although the right to abortion is being eroded through access, the right still stands even if the access is gone. There is also a lack of awareness of how fast the access environment has changed, as O’Neil et al. have shown in their reports of the availability of abortion in state hospitals in Turkey (O’Neil, 2017; O’Neil et al., 2020).

Conclusion

Abortion in Turkey highlights many of the important dynamics in this project. The legal environment has historically evolved and even employed explicit natalist language to explain policy changes. But as abortion has been legal in Turkey for the past 42 years, it has experienced changes in the access environment rather than in the law. Erosion of abortion rights in Turkey has taken a different shape than they have in, for example, the United States. In the U.S., abortion rights pre-*Dobbs* were eroded through smaller laws that tried to make accessing abortion more difficult, since it could not make it illegal outright. TRAP laws such as House Bill 2 (HB2) in Texas did not aim to make abortion illegal in the state. Still, they did mandate that abortion clinics meet physical specifications such as dimensions for hallways and room sizes, and if the clinic failed to meet those guidelines, they had to close. When HB2 was passed, 42 abortion clinics were operating in Texas, and once HB2 took effect, 19 were left open (Ura et al., 2016). Although HB2 was struck down by the Supreme Court in 2016, the number of abortion clinics never recovered in Texas, leaving much of West and North Texas unserved, until Texas passed an abortion ban in 2022. These laws erode access through the law. What

we see in Turkey is a de facto restriction taking place as there has been no legal mandate to limit abortion.

The de facto restriction and banning of abortion in Turkey is cause for alarm. The number of state hospitals in Turkey that provide abortions has been decreasing over time. In 2016, 34 state hospitals performed abortions without restriction (N=431), and 336 (78%) performed abortion services if there was a medical necessity (O'Neil, 2017). These numbers decreased in 2020, of the 295 public hospitals contacted, ten of those hospitals provided abortion services to the full extent of the law, 185 did not, and only 14% performed them when medically necessary (O'Neil et al., 2020). The sample size decreased in 2020, with one of the primary limitations being the COVID-19 pandemic, during which many hospitals reportedly did not answer their phones despite repeated attempts. What is curious is that the number of hospitals in 2016 that reportedly would perform an abortion, if they deemed it medically necessary, decreased by 62 percentage points four years later. These studies demonstrate how rapidly the access environment is evolving in Turkey, despite no formal changes. The cause of these changes is unknown, but they are creating tangible consequences for those affected by these limitations.

Turkey has experienced a gradual decline in its birth rate since 1950. There was no shock in the abortion rate in 1983, even though reports of women accessing abortion legally were recorded. Insinuating that women were accessing abortion already in Turkey illegally, pre-1983, which the surveys conducted by Hacettepe corroborate (Hacettepe University Institute of Population Studies, 1989). Further, the birth rate has not experienced any significant changes in Turkey since 2012, when the AKP and Erdoğan rhetorically threatened abortion. Since 2016, as we have seen, there has been a

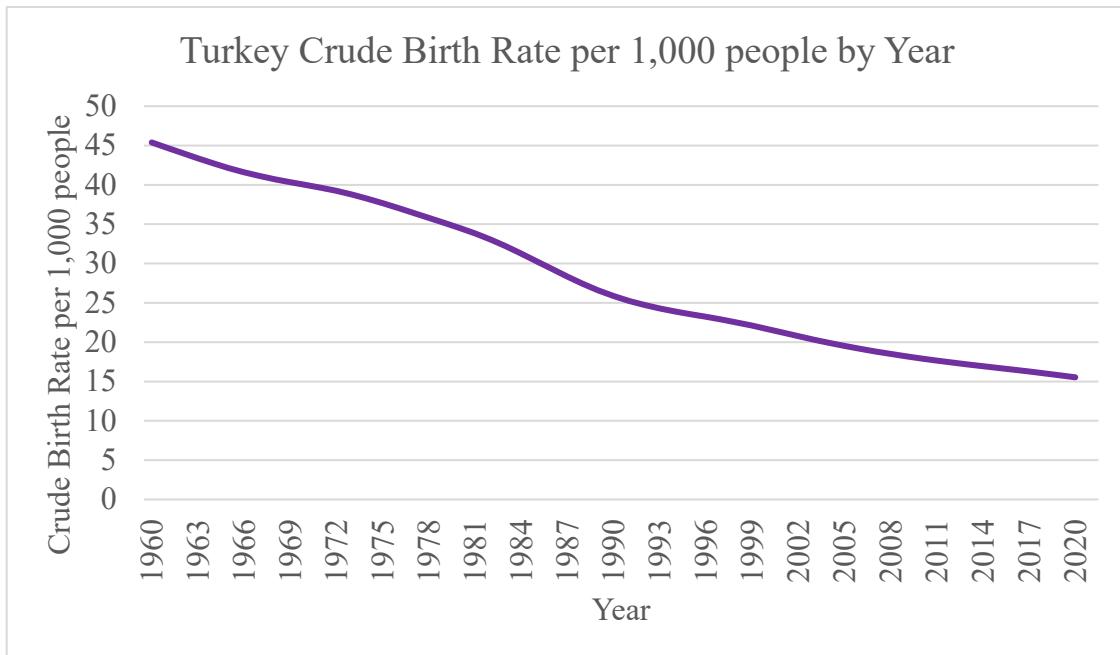


Figure 19: Turkey Crude Birth Rate per 1,000 people (1960-2019)

drastic decline in abortion provision at state hospitals in Turkey, and there have also been no changes in the birth rate, which has continued to decline. I argue this is because people are still having abortions, although the access environment has become exceedingly difficult over the past decade. This may be accessing abortion in private hospitals, obtaining medication abortion pills clandestinely on the black market, or through illegal surgical abortions. CANs, as I've shown in this chapter, have been connecting abortion seekers with abortion providers despite the medical establishment and regime's attempts to block access. There are people who work to help provide safe abortions to those who need them, and work to help people access them even with increased barriers. People are always going to get abortions if they need them. What CANs do is to expedite the process and make meaningful and helpful connections with people in a stressful time of their lives.

From the data that is available around abortion in Turkey, including the number of public hospitals that will perform abortions, birth rate data, and abortion data, we can make inferences about abortion access in Turkey. I have established that although the abortion laws have not changed since 1983, the access environment has been experiencing rapid changes since 2012. Through interviews with CANs, these barriers to access have been corroborated by their statements regarding the amount of misinformation, the lack of provision at public hospitals, and confusion about their rights and what to do next. However, women are still navigating this challenging access environment, but they often need help to do so. I can accept that CANs can do their work through an organization of people who are creating institutional links to provide abortion services in clandestine or nebulous settings. Further, I can accept that CANs work because of the determination of society to provide abortion services despite the legal or access context they find themselves in. The case of Turkey has demonstrated that CANs are still forming in a mid-level civil society institutionalization setting, and that the civil society in their country significantly shapes them.

This case shows how a country where abortion is legal and has not had a change in the law for the past 42 years can experience access crises. The erosion of the access environment in Turkey provides insight into how people navigate in this atmosphere, both in terms of abortion access, political, and social. Although there is a robust civil society, it operates with a distinct wariness toward the possibilities of changes in its ability to exist and operate. There is less freedom in civil society in Turkey than in the U.S., and there is significantly more freedom in civil society than existed in Romania. This mid-level has shown how the institutionalization of civil society shapes CANs in

Turkey, by protecting large organizations, ignoring informal ones, and limiting smaller organizations that may focus explicitly on abortion, or any subject that may be seen as controversial. I argue that people will be able to access abortion no matter what. But how they access their abortion and the network of people connecting them to that abortion changes in shape and power based on the institutionalization of civil society.

CHAPTER 5

APPALACHIA: A SUBNATIONAL ANALYSIS OF A RAPIDLY CHANGING ABORTION ENVIRONMENT

Introduction

Appalachia officially encompasses 423 counties in 13 states, spanning from southern New York to northern Mississippi (“About the Appalachian Region,” n.d.). It is a vast region of the country that is often overlooked or reduced to stereotypes perpetuated during the War on Poverty in the second half of the 20th century. What is important to note is that not only does Appalachia stand out for its geography, but it also has a unique character within American history. There is a distinct culture in the region that goes beyond “Southern”, “Rust Belt”, or “Northern” which are found in other areas of the states encompassing Appalachia.

For this project, I am examining the central Appalachian region, as defined by a combination of the Appalachian Regional Commission (ARC) and commonly accepted definitions. Figure 20 depicts the states which host the central Appalachian region. Figure

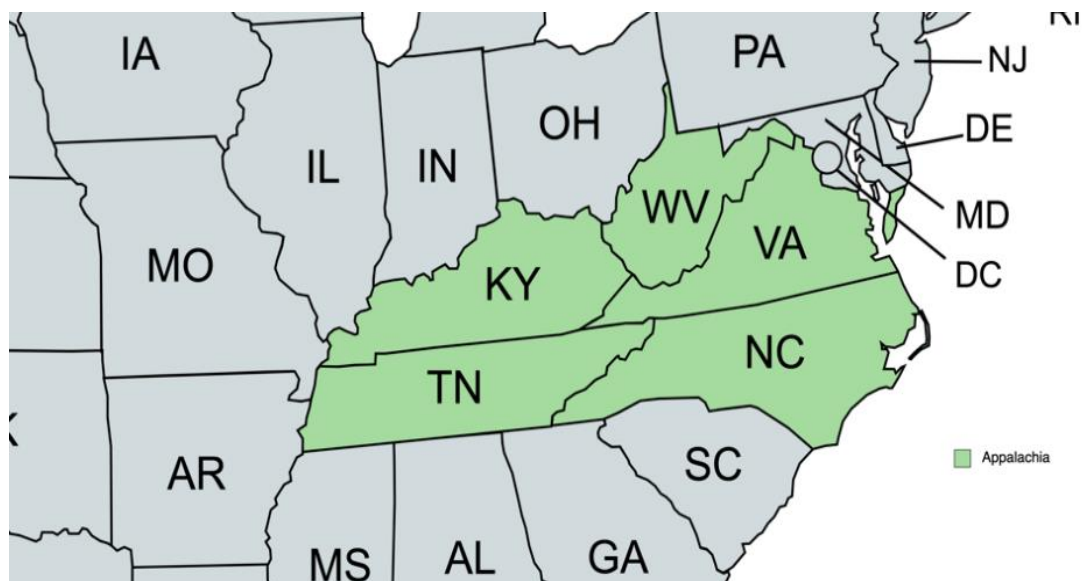


Figure 20: States containing “Appalachia”, for the purpose of this project.

21 defines the central Appalachian region by county within the states: West Virginia, Virginia, Kentucky, Tennessee, and North Carolina. These are not all the “Appalachian” states, nor all the counties, but they do make up the area most commonly and culturally associated with “Appalachia”. These specific geographic boundaries are significant for this project due to the history and stigma associated with this area within the American imagination. When people think of Appalachia they think of Deliverance, hillbillies, Hatfield and McCoys, endemic poverty, lack of education, coal mining, etc. What is not understood in the imagination is the sense of community, pride, communal living, and distinction that makes this area of the country unique in so many ways. Johnson’s “War on Poverty”, in the 1960s, did not have the consequences that were initially intended. What it did instead was to create images in Americans’ minds about the type of poverty that existed in this area, rural white poverty. But so many of the programs that target issues like poverty, poor healthcare access, and lack of education that operate in the area

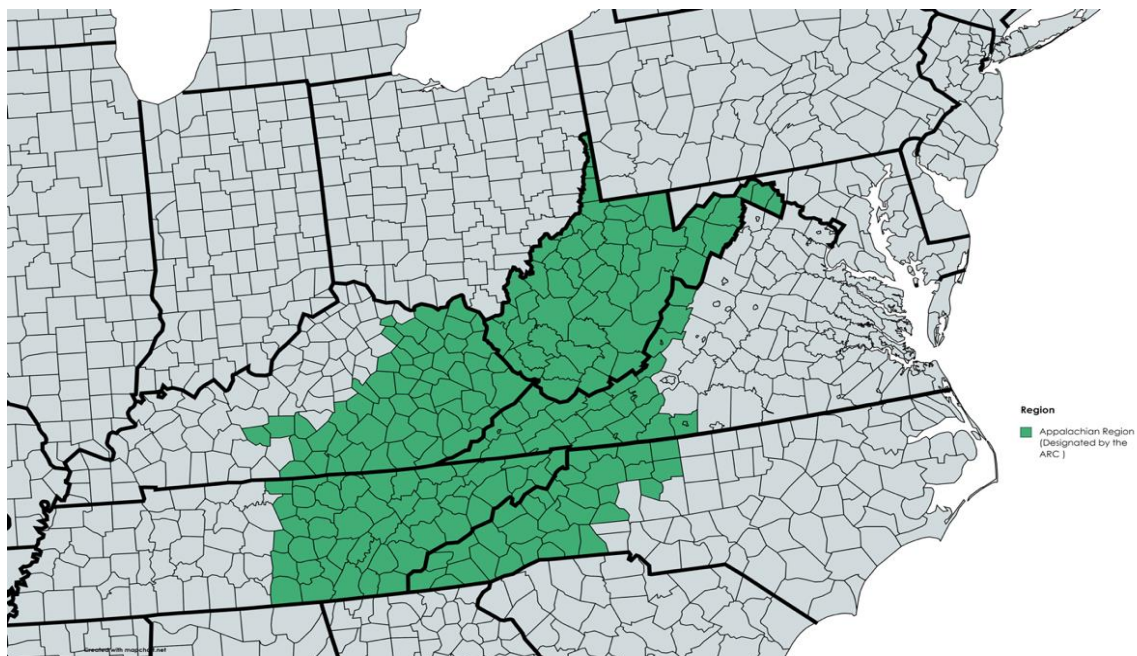


Figure 21: Appalachian Counties, as designated by the Appalachian Regional Commission (ARC) within states studied for the purpose of this project.

have not been able to remedy the situations in these areas. Stigma plays a significant role, both in the stigma surrounding Appalachia from the outside and in the internal stigma among Appalachians. Those who claim to want to help and remedy, but instead create and perpetuate these images in the media.

Why have I started my case study like this? Because it is essential to understand where Appalachians are coming from and where outsiders are coming at Appalachia from. There is a profound cultural stigma around this region of the country that has created significant barriers to entry and access. This area is proud; it has a distinctive cultural existence, unique musical and food histories come out of this region, it has a history of progressive labor movement, and it has a history of exploitation of not only the land but the people. This has created a sense of distrust in the region toward the state, as people must travel long distances over rough terrain to access their local schools, often requiring hours to reach the closest hospital or a doctor's appointment. Hurricane Helene has only highlighted access and provision issues in the region since it made landfall in late September 2024. It was a once in a millennia rainfall event in the region, that destroyed entire towns and made the water in the area's largest city, Asheville, unpotable for two months (Hackett & BPR News, 2024; Thiem & Lindsey, 2024). Why would the people of this area trust the state that has denied them essential services and made a mockery of them?

Background and Context

High Institutionalization of Civil Society

Despite all these feelings and histories, this region remains within the U.S. The level of oppression is present, especially in Appalachia, but people are free to organize, to say what they want, pro or anti-state. There is no substantial fear of organizing under a cause, no substantial fear to speak in one way or another, and knowledge that this is possible. According to V-DEM, the civil society participation index is .98, one of the highest rates of participation in the world. The U.S. has approximately 1.5 million registered non-profits (Bureau of Democracy, Human Rights, and Labor, 2021). This does not count the unknown number of community groups, informal networks, and unregistered organizations operating within the U.S. Despite the massive number of non-profits in the U.S., there is also a growing pattern of surveillance and threats to those civil society groups (Brechenmacher, 2024). Threats that have been occurring for some civil society members include doxing, surveillance, threats, etc. These are known threats for those doing abortion work, with providers being followed home by protestors, their addresses doxed, and in extreme cases, assassinations. The U.S. has one of the most robust civil societies in the world, and it is relatively free from state oppression. Still, there are growing threats, especially regarding abortion, that threaten that freedom. In Tennessee, a possible surveillance system to be used by police has been facing pushback from multiple civil society groups because of speculation it would increase monitoring of those seeking abortion care, contraception, and migrants, which is illegal (Elliot & Hale, 2024). Although the U.S. has a free and open civil society, there are growing threats to that freedom, which CSOs are aware of and take measures against. It is not just threats

from the state that threaten CSOs, but also citizens who may engage in violence against people doing work. However, typically in the U.S. there is not much backlash with CSOs or community group memberships. And Appalachia is one of the regions in the country with a large and thriving civil society.

There is a strong sense of regional pride and distinctness that is important to Appalachia. People in this region are united in a sense and distinct from those that occupy areas outside of it (which is why the county map in Figure 20 is essential compared to the state map of Figure 1). Due to the many hardships faced in this region, numerous local and regional organizations operate to provide community services, including those related to healthcare, financial support, substance abuse, job training, education, and agriculture. In Boone, NC, the heart of the High Country in North Carolina, there is a restaurant on the main downtown strip, F.A.R.M. Café, which provides meals to people regardless of their financial means. It is a pay-what-you-can establishment created to feed the insecure. Other organizations, such as Appalachian Voices and the Southern Appalachian Highlands Conservancy, among many others, aim to promote sustainable development and natural conservation efforts in the area. There is a prosperous civil society in the region which may be a mixture of the terrain and ruralness of the region, but also a consequence of the difficulty of accessing the area. The aftermath of Hurricane Helene has also highlighted the crucial role that civil society plays in rebuilding communities through mass fundraising efforts throughout the region. West Virginia is the only “Appalachian” state where the entirety of the state, and most importantly, the state capital, is located in the area. Frankfort, Nashville, Raleigh, and Richmond are all outside the Appalachian region, and much of the area of the states, let alone population are not

located in Appalachia. This has led to an isolation in the region that promotes regional unity and connectivity, people in western North Carolina may find a stronger sense of oneness with someone from eastern Tennessee than they do with someone from Durham. Not only connected by geography but also through culture and community that exist in these areas that aim to serve the region rather than the state.

For all the reasons I've listed so far, Appalachia has a very robust civil society, one that is explicitly aimed at supplementing healthcare access that may not be as readily available in other areas of the states in which they are located. Table 13 shows the number of primary care physicians (PCP) per 100,000 located in Appalachia from 2013 (J. L. Marshall et al., 2017). Appalachia, using the ARC definition, has a varied number of PCPs with certain regions reaching above the national average and others below, and economically distressed counties have 28 fewer PCPs per 100,000 people (J. L. Marshall et al., 2017). The United States, on average, has 201 PCPs per 100,000, and Appalachia has 131 (J. L. Marshall et al., 2017). Within the states I'm researching, the "Appalachian" parts of the states, which have 186 in Kentucky, 242 in North Carolina, 133 in Tennessee, 80 in Virginia, and 110 in West Virginia (J. L. Marshall et al., 2017). Only North Carolina exceeds the national average with 242 PCPs per 100,000; the next closest state is Kentucky, with an average of 186 PCPs per 100,000 in Appalachian counties. Distressed counties in Appalachia have, on average, 28 specialty physicians per 100,000 people, whereas non-distressed counties contain 115 specialty physicians per 100,000 people. The healthcare disparities are important to highlight in Appalachia because they demonstrate that outside of the reproductive health and abortion realm Appalachians already suffer healthcare disparities.

Table 13*Primary Care Physicians per 100,000 People by Geography and Economic Status, 2013¹*

Region and Economic Status	Number of Counties	Population in 2013	Primary Care Physicians per 100,000 Population
United States	3,113	314107084	75.56445294
Non-Appalachian U.S.	420	25367886	66.83967219
Appalachian Region Total	2,693	288739198	76.33098982
Northern Appalachia	86	8354698	69.97293513
North Central Appalachia	63	2426928	72.71420156
Central Appalachia	82	1909019	50.92550836
South Central Appalachia	85	4759012	76.89651687
Southern Appalachia	104	7918229	59.5255709
Economic Status			
Distressed	84	1691115	40.89403503
Non-Distressed	336	23676771	68.69284111

¹ (Marshall et al. 2017)***Abortion in the United States***

Abortion has been practiced in the United States far longer than we imagine it to have. In the 19th century, abortion was common but unregulated, as it was typically performed by midwives in women's homes. Before the medical establishment was

formalized in the U.S., women's health was usually treated in the private sphere, meaning in their homes, and midwives and healers would attend to them. In the mid-19th century, the American Medical Association (AMA) was established and advocated for the formalization of medicine in the United States, including the opposition to midwives ("Abortion in the Nineteenth Century Through the Lens of Ann Lohman," 2025). This shift in the mid-19th century moved healthcare from the home to the hospital, including all women's health. This is also significant because at this time, all doctors were men; they did not know women's practices around birth and abortion as women did. Further, during this time, the AMA also campaigned to have abortion made illegal and criminalized throughout the country as a way to establish a medical morality.

Those laws around abortion persisted in most states until 1973, when *Roe v. Wade* was decided. In the mid-20th century, abortions became endemic; illegal underground abortions were common throughout the country, as well as the world. Back-alley abortions, as they were known, created a significant public health crisis, as many women were dying from unsafe abortions. In the 1960s, abortion became a more central focus of feminist advocacy. The Jane Network, which is a famous CAN that operated in the 1960s and 70s, connected abortion seekers anonymously to doctors who they knew could provide safe abortions. The beginnings of the Jane Network were friends of friends helping each other, then it became a massive CAN, but also a political movement advocating for the legalization of abortion (Kaplan, 1997). With this maternal mortality crisis, many states legalized abortion before *Roe* was decided, including New York, Washington, Hawaii, and Alaska (Historical Abortion Law Timeline: 1850 to Today, n.d.).

Roe v. Wade and *Doe v. Bolton* were decided alongside each other in 1973 and were the legal basis on which abortion was legal in the U.S. until 2022. The decision made abortion legal nationwide and provided abortions on the basis of the 14th Amendment and the right to privacy. The stipulations of the decisions remarked that in the first trimester, there was no state interference with abortion, in the second trimester, regulation was allowed to protect maternal health, and in the third trimester, states could restrict or ban abortion except to save the life or health of the mother. Nearly immediately, abortion became highly politicized at the state and national levels and became a focus of the moral majority of the 1970s and 1980s. The Helms Amendment restricted the use of foreign aid to fund abortion services. The Hyde Amendment was introduced in 1976, which restricted federal funds for abortion, primarily Medicaid, but also funding of organizations such as Planned Parenthood. In 1984, the global gag rule was put in place, which prevents foreign organizations from receiving U.S. aid if they advocate, refer to, or provide abortion. This rule has been instated by every Republican president since Reagan and rescinded by every Democrat, typically on their first day in office.

Starting in the 2000s, there was a concerted effort at the state level to erode abortion access by attacking it legally. In 1992, *Planned Parenthood v. Casey* replaced the trimester system with undue burden. This allows for restrictions as long as it does not create an undue burden on the person seeking an abortion. This opened up the avenue for abortion restrictions to be put in place on the state level. In the 2000s, there was a rise in TRAP laws, which were aimed at abortion providers, their clinics, and staff, and created medically unnecessary standards. From 2001 to 2011, 189 abortion restrictions were

enacted in the U.S; from 2011 to 2013, 205 were enacted (Boonstra & Nash, 2014). More abortion restrictions were enacted in those three years than in the previous decade (Boonstra & Nash, 2014). TRAP laws, such as HB2 in Texas, were aimed at shutting down abortion clinics. Multiple states had only one abortion clinic before *Dobbs* was decided, including Rhode Island, Missouri, North Dakota, South Dakota, Mississippi, and West Virginia (Jones et al., 2022). One month after *Dobbs* overturned *Roe*, 11 states had banned abortion completely, all in the Midwest and South, or had banned abortion starting at six weeks (Kirstein et al., 2022). The new climate of abortion in the U.S. is a tenuous and changing one. This project began years before the *Dobbs* decision; however, the majority of the research for this chapter was conducted after the *Dobbs* decision. The legal environment in the U.S has faced increasing numbers of restrictions and attacks since 2010, particularly. But without *Roe*, states have an easier time restricting and banning abortion than ever, especially in the South and Midwest.

Abortion in Appalachia

As of June 2025, there are only three Appalachian counties with abortion clinics in them. Two are in North Carolina, in Buncombe and Forsyth counties, in Asheville and Winston-Salem. The other is in Bristol, Virginia, on the border with Tennessee. Since *Dobbs v. Jackson* overturned *Roe v. Wade*, many states have severely limited abortion rights in their states, including making it outright illegal, including Tennessee, Kentucky, and West Virginia. Abortion rights are not guaranteed in North Carolina or Virginia, but for many in Appalachia and the South, those two states are the nearest abortion clinics to them.

Table 14
Appalachian States, Abortion Occurrence and Policy

Appalachian States	2024 Total Abortion Ban	2024 Gestational Limit Ban, Including total Ban ¹²	Total Abortions by State, 2023 ³	Total Women 15-44 ⁴	Maternal Mortality Rate (2018-2022) ^{5 6}	Estimated Abortion Rate ⁷
Kentucky	1.00	1.00	0.00	858,924	35	0.00
North Carolina	0.00	1.00	47,850.00	2,144,190	27	22.32
Tennessee	1.00	1.00	0.00	1,409,993	41	0.00
Virginia	0.00	0.00	33,110.00	1,732,796	33	19.11
West Virginia	1.00	1.00	0.00	311,556	24	0.00
Total	3.00	4.00	80,960.00	6,457,459		
Average					23	8.28

¹ Does not include gestational bans categorized as “Near Viability” by KFF’s categorization.

² (Abortion Policy: Gestational Limits and Exceptions, 2024)

³ (#WeCount Report April 2022 through June 2024, 2024)

⁴ (U.S. Census Bureau, 2024)

⁵ (Hoyert, 2024)

⁶ Maternal Mortality Rate is calculated by number of maternal deaths per 100,000, data is collected by the CDC.

⁷ Abortion Rate calculated using (“Total Abortions by State”/Total Women 15-44)*1000

Currently, only two states in the central Appalachian region can legally provide abortions: Virginia and North Carolina. North Carolina does have a gestational limit to its abortion law, only providing abortions until the twelve-week mark, which took effect in July 2023 (Center for Reproductive Rights, 2024). This leaves 2,580,473 women in Kentucky, Tennessee, and West Virginia ages 15-44 without access to abortion services in their state. As I have argued, that does not mean that 2.5 million women in these three states are unable to access abortion, but they do face a harder time accessing abortion than the women in North Carolina or Virginia. People in Kentucky, Tennessee, and West Virginia have options to access legal abortion care, but they must drive to a state where it

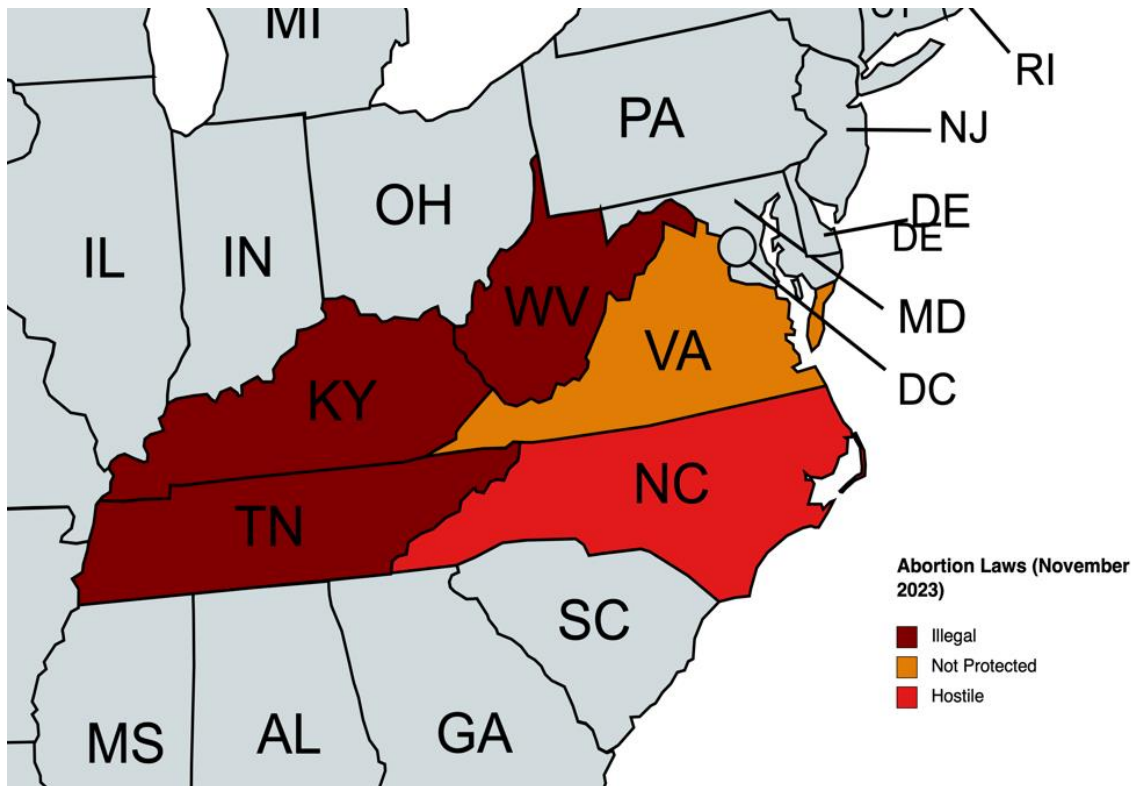


Figure 22: Appalachian States by Abortion Law

is legal. For many, this may be driving to North Carolina or Virginia, but for others it may require going to other bordering states.

In West Virginia, abortion is completely banned except in the case of a “nonmedically viable fetus”, ectopic pregnancy, or a medical emergency (Center for Reproductive Rights, 2024). Abortion is allowed in cases of rape or incest up to 8 weeks, and only if there has been a police report filed against those who perpetrated the crime (Center for Reproductive Rights, 2024). The total abortion ban in West Virginia went into effect on September 13, 2022. Before this date, only one abortion clinic existed in the state. The state still has pre-ban restrictions in place, meaning that if abortion is legalized, it would still be heavily restricted, including a 24-hour waiting period, blocked Medicaid coverage, and a ban on telemedicine provision (Center for Reproductive Rights, 2024). West Virginia has 311,000 women 15-44 who are directly affected by

these laws. From 2018 to 2022, West Virginia has also had a slightly higher than average maternal mortality rate, 24 deaths per 100,000.

Virginia, out of all of the states of interest, has the most liberal abortion laws; however, abortion rights are still categorized by the Center for Reproductive Rights as “Not Protected”. In 2020, Virginia repealed many of its restrictions around abortion and has been one of the few Southern states not to introduce hostile legislation after *Dobbs* in 2022. In Virginia, abortion is illegal after viability (generally 23 weeks) unless in the case of a threat to the mother’s life or would impair their mental or physical health (Center for Reproductive Rights, 2024). In 1975, Virginia repealed their pre-*Roe* abortion ban, but there is no legislation protecting abortion rights in the state that has been passed after.

In North Carolina, abortion is legal up to 12 weeks, which took effect on July 1, 2023, fourteen months after the *Dobbs* decision. On top of the gestational ban, North Carolina also requires mandated counselling, a 72-hour waiting period between counselling and the procedure, and TRAP laws targeted at the abortion providers and the facilities where abortions can be performed, and that a medical doctor must perform abortion care (Center for Reproductive Rights, 2024). The North Carolina governor signed an executive order 5 days after the gestational restriction went into effect, saying that North Carolina would not provide “assistance or cooperation with out-of-state investigations and legal actions (including extradition) that arise from the provision of reproductive health care that is legal in North Carolina” (Center for Reproductive Rights, 2024). This is significant because North Carolina is one of the most southern states where abortion is legal beyond six weeks, so those seeking an abortion from Florida,

Georgia, or South Carolina would need to travel to North Carolina to obtain an abortion from 6-12 weeks and to Virginia if needing one after 12 weeks.

Tennessee had a trigger ban in place, which went into effect when *Roe* was repealed in 2022. This trigger ban prohibits abortion except in cases when it is deemed medically necessary. They did not repeal their other abortion laws, so if abortion is legalized, there will still be restrictions in place, like in West Virginia. Tennessee has always been one of the most hostile states to abortion. In 2020, during the COVID-19 pandemic, an executive order was issued with an attempt to ban all “elective and non-urgent” procedures, including abortion care, but the Supreme Court rejected this (Center for Reproductive Rights, 2024).

Kentucky also had a trigger ban, which is now in place. But in November 2022, Kentucky voters voted on Amendment 2, which would have amended the Kentucky state constitution to explicitly say that it does not protect abortion rights (Schreiner & Campbell, 2022). Kentucky voters rejected this, so although it did not change the state constitution or the abortion laws in the state, it also did not further restrict abortion in Kentucky. It is important to note that each of these states (Kentucky, Tennessee, North Carolina, Virginia, and West Virginia) abortion providers are subject to criminal and civil charges if they violate state laws. Each of these states also restricts abortion provision to only licensed physicians, and if they are found to have violated the abortion laws in the state, they may be charged with a crime. There is fear from abortion providers that if they do perform an abortion when medically necessary, it may lead to criminal punishment if the state does not agree with their decision. The vagueness of the laws

medically creates uncertainty for abortion providers who are either avoiding providing or leaving their states (Selena Simmons-Duffin, 2022).

All of this is to say and emphasize the landscape of abortion access in Appalachia. Like so much of the United States right now, the legality of abortion is in limbo, and states are introducing a variety of bills and laws that create complicated legal limits to what can and cannot be done. However, many in the country have been fighting these complications for an extended period, with so many states eroding *Roe* before *Dobbs* was even introduced. Before *Roe* was overturned, Appalachia was not an abortion haven;

Table 15
States Bordering Appalachia, Abortion Laws and Incidence

States Bordering Appalachian States	2024 Total Abortion Ban	2024 Gestational Limit Ban, Including total Ban ¹	Total Abortions by State, 2023 ²	Total Women 15-44 ³	Estimated Abortion Rate
Alabama	1	1	0	1,001,029	0.00
Arkansas	1	1	0	599,670	0.00
District of Columbia	0	0	10,510	183,515	57.27
Georgia	0	1	29,580	2,280,916	12.97
Illinois	0	0	94,130	2,475,698	38.02
Indiana	1	1	4,690	1,344,723	3.49
Maryland	0	0	41,940	1,215,054	34.52
Mississippi	1	1	0	584,158	0.00
Missouri	1	1	10	1,202,857	0.01
Ohio	0	1	22,680	2,243,557	10.11
Pennsylvania	0	0	38,480	2,448,056	15.72
South Carolina	0	1	8,240	1,038,252	7.94
Total	5	8	250,260	16,617,485	
Average			20,855	1,384,790	15.00
National Average			19,856		15.34

¹ (Abortion Policy: Gestational Limits and Exceptions, 2024)

² (#WeCount Report April 2022 through June 2024, 2024)

³ (U.S. Census Bureau, 2024)

there were few abortion clinics in the area. Previously, Kentucky had two abortion clinics, one having just opened in 2020; Tennessee had seven clinics, none of which are offering abortion care currently, two closed entirely, and five remain open for other services; West Virginia's only clinic had to stop offering abortion services as of 2022 (Willingham, 2022). Three states in my case have no abortion services being legally provided to the 13.2 million people in Kentucky, Tennessee, and West Virginia. North Carolina and Virginia are the only two states in the region with abortions currently being provided, although North Carolina has introduced a 12-week limit and threatened to restrict it further. Rural residents, both within and outside Appalachia, face additional barriers due to wait limits and must travel long distances multiple times a week.

Table 15 and Figure 23 draw on data from the Society of Family Planning's #WeCount effort. Their abortion incidence data includes all clinician-provided abortions and does not include any self-managed abortions or ones provided or obtained outside of the healthcare system (#WeCount Report April 2022 through June 2024, 2024). Looking at Table 15, of the 12 states that border the Appalachian states of interest in this study, five of them have total abortion bans while eight have either a total ban or a gestational limit ban. Tennessee, Kentucky, and West Virginia have total abortion bans, meaning that abortion seekers must go out of state to obtain legal abortions. Tennessee has eight states bordering it, only three of which have legal abortions available, and two of those states, Georgia and North Carolina, have gestational bans of six and 12 weeks. Virginia has legal abortion and a clinic in Bristol, which lies at the Tennessee border, which is also in close proximity to the North Carolina, West Virginia, and Kentucky borders. Kentucky borders seven states, three of which have legal abortion (Illinois, Ohio, and Virginia). West

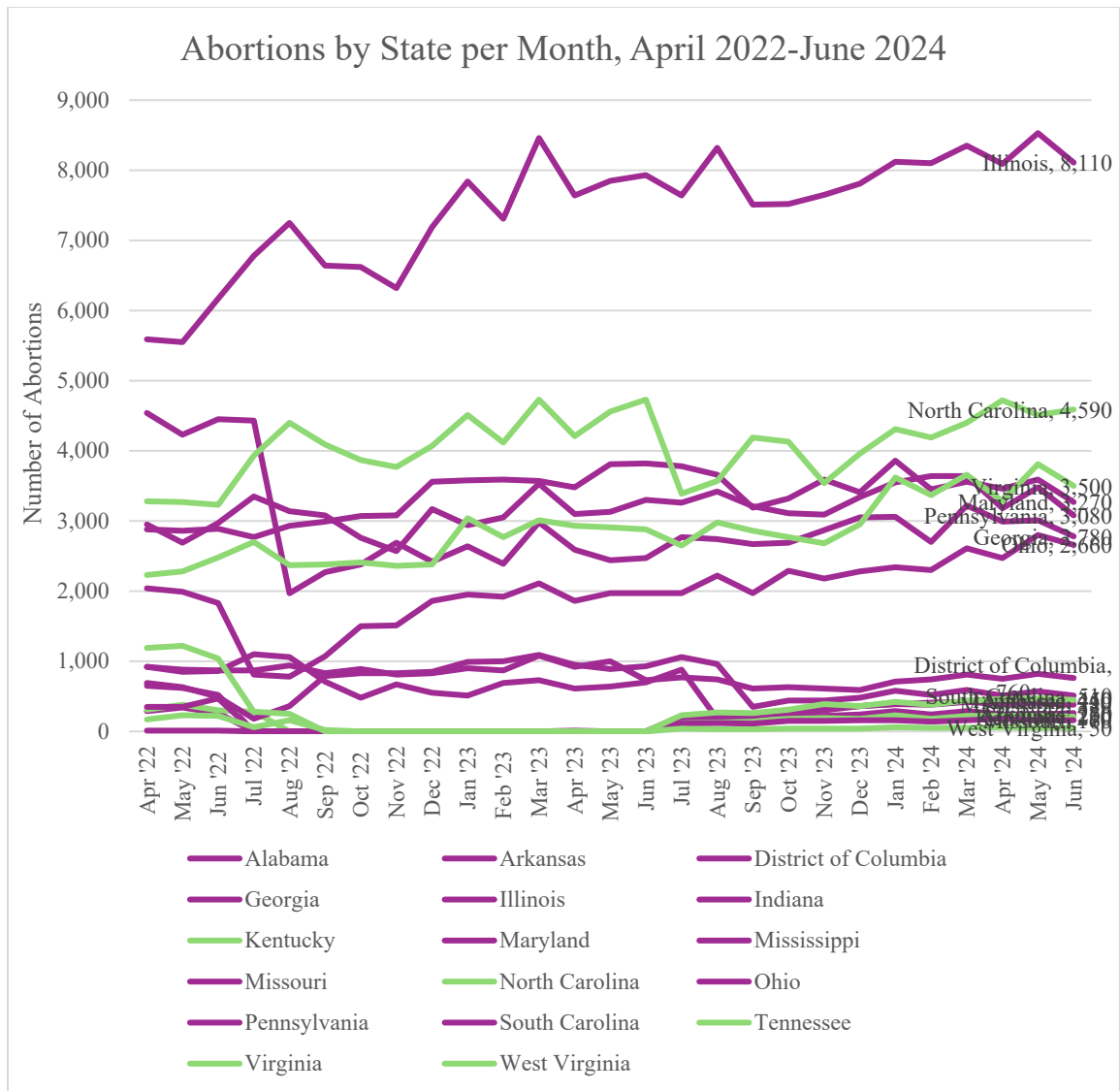


Figure 23: Abortions by State by Month (April 2022 to June 2024), #WeCount June 2024 Report, 2024.

Virginia borders five states, four of which have legal abortions available (Ohio, Pennsylvania, Maryland, and Virginia).

Figure 23 shows the recorded number of abortions per state per month from April 2022, three months prior to the *Dobbs* decision, to June 2024. The states reported here are the Appalachian states of this study, marked in green, and the states that border them, marked in purple. Many of the states with total abortion bans saw zero abortions from

the period of August 2022 to June 2023. From June 2023 to June 2024 there are a low number of abortions reported in states with total abortion bans, primarily due to exemptions for cases of rape, incest, or if the mother's life is in danger. A flaw of this abortion data is that it does not provide an accurate look over time, pre-*Dobbs*, to understand trends better. Many of the states with total abortion bans post-*Dobbs* already had many obstacles to accessing abortion, regardless of whether or not it was legal. For example, Kentucky had two abortion clinics in the state with a population of 4.5 million, and approximately 900,000 women 18-45 years old. The EMW Women's Surgical Center and Planned Parenthood, both in Louisville, were the only abortion clinics in the state. However, Planned Parenthood in Louisville had just begun abortion services in 2020, and the EMW Women's Surgical Center had been Kentucky's only abortion clinic for years before. This meant that many people in Kentucky were already living in a post-*Roe* reality long before the Supreme Court's decision. Louisville is located in the northern part of Kentucky, situated on the Ohio River, which marks the border between Indiana and Kentucky. EMW was one mile from Indiana, but about 200 miles from the southeastern corner of the state, in the heart of Appalachia. Residents in that area before *Dobbs* would have been better off traveling out of state to Virginia or North Carolina.

It is important to remember this when looking at data and expecting to see dramatic plunges or rises, people in states that were hostile to abortion before the ban already were travelling out of state to get abortions, they already knew it was difficult and that their states would make it as challenging as possible to get it. It is states where it is legal and more protected that see the higher reported abortion rates because of people traveling out of state to obtain them. In North Carolina, from 2020 to 2023, there were

13,890 more abortions, a 44% increase, even with the 12-week abortion ban in place and one fewer clinic (Jones et al., 2024). The states bordering those with total abortion bans, nationally, not just in Appalachia, take in abortion seekers from those places with bans. But again, this has been happening for years leading up to the *Dobbs* decision. Why this is important to consider in this context is that although the *Dobbs* decision triggered abortion bans in 13 states to go into effect immediately, and more states followed, it was not perceived as sudden in the abortion-provision community. Laws have been introduced at an increasingly rapid rate since the early 2000s, to erode access without the legal overturning of *Roe*. Indeed, it came as a shock to most people when *Roe* was overturned in June 2022. But, for millions of people across the U.S., they were already living in hostile abortion landscapes where they may have needed to travel out of state for an abortion. The patterns of the abortion incidence or abortion rates may not seem drastic because there were no drastic changes. In Kentucky and West Virginia, the closing of their one abortion clinic was devastating to the community. Still, plenty of people were already travelling out of state or circumventing the abortion clinics in one way or another. Civil society didn't spring into action when the *Dobbs* decision was made; civil society has been actively working on abortion since the 1960s, politically and beyond measure in practice. CANs were able to provide travel funds, counselling, logistical help, and other means of support for abortion patients for decades with the knowledge that their rights could be taken away at any time but the need would not change.

Theoretical Framework

Accessing Abortion in Appalachia

To best understand how abortion access works in Appalachia, let us employ in a hypothetical. For example, there is an 18-year-old person in West Virginia named Tina who is 6 weeks pregnant and needs an abortion. They know they are pregnant and that they want to terminate the pregnancy. There are no abortion clinics in West Virginia, and abortion is illegal in the state. Tina has a friend who had an abortion last year, so Tina asks her for help. Tina's friend tells them that she reached out to someone who helped her find an abortion out of state and money to fund her travel and abortion. Tina reaches out to this person, who works with a group of volunteers who provide their support. Tina is then able to schedule an abortion in Bristol, Virginia, for two weeks later, 4 hours from her town, and the abortion fund pays for her procedure as well as travel money.

In this example, Tina is living where abortion is illegal. The abortion in Bristol is entirely legal, but how Tina must navigate the system through a word-of-mouth network, contact an abortion fund, and travel across state borders is what makes abortion covert within this context. This is the case for many accessing abortions across the United States currently, there is demand for crossing state borders (and in the southwest crossing into Mexico) to access a surgical abortion. But accessing abortion doesn't always mean accessing surgical abortions; it also means accessing abortion pills, which are easier and more desirable in many instances. As *Roe* was threatened and eventually overturned, there has been a proliferation of organizations that exist to provide medication abortion through the mail. Many of these only send the pills with no instructions or details on how

to use them. Still, many organizations offer counseling and guidance on the regimen, timing, side effects, and pain management.

As in my earlier example, Tina uses a word-of-mouth network to find information about an abortion fund that could help make arrangements at an abortion clinic in a bordering state. These word-of-mouth networks, like in the example of Tina, may just be a friend who knows someone. The person in question is part of an informal CAN. They are either directly affiliated with a group (formal or informal) that can supply guidance. I categorize members of a CAN in three non-mutually exclusive roles: provider, organizer, and user. A provider is a person who provides the actual abortion; this may be a doctor, midwife, nurse, etc. Providers do not necessarily need to be present in a CAN, especially if the CAN directs to legitimate abortion funds or clinics. However, providers are an essential element of a CAN and historically have been targeted as “back-alley” abortionists. Second, and most commonly, there are the organizers, like Tina’s example, who direct and help people access abortions. Third, there are the users Tina in this example, who is a member of a CAN by accessing an abortion through the network, but also users can become organizers or providers in this instance. This typology is helpful to understanding who operates the networks, but also that these are networks, they may encompass organizations, but they also encompass people who act individually and collectively to provide a service to people who need it.

Civil Society in Appalachia

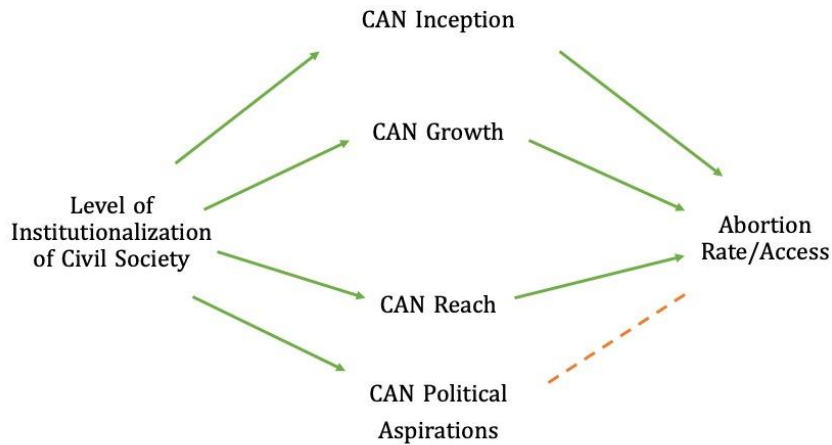


Figure 24: How Civil Society Institutionalization Affects Abortion Provision

This is all to say that the United States has a high level of institutionalization of civil society. There are an estimated 1.8 million non-profits in the United States, according to the National Center for Charitable Statistics. Communities are full of organizations that supplement a need, whether that be child poverty, women in politics, animal welfare, or reproductive health. It is normal for people in the United States to interact frequently with formal non-profits but also informal groups as well. Typically, these organizations are also need-based, they fill a hole that exists within a community or society at large. This is no different than abortion and pro-choice organizations that crop up when abortion rights or reproductive rights are threatened, they exist to fight and supplement a need within society. I argue this point further, that networks also crop up that aim to protect abortion access by providing it directly or directing people to how to get one. I call these organizations Covert Abortion Networks (CANs). Covert in this case means that there is an element of secrecy or deception due to any number of elements, including stigma, legality of the procedure, obtaining an abortion illegally, etc.

Covert Abortion Networks

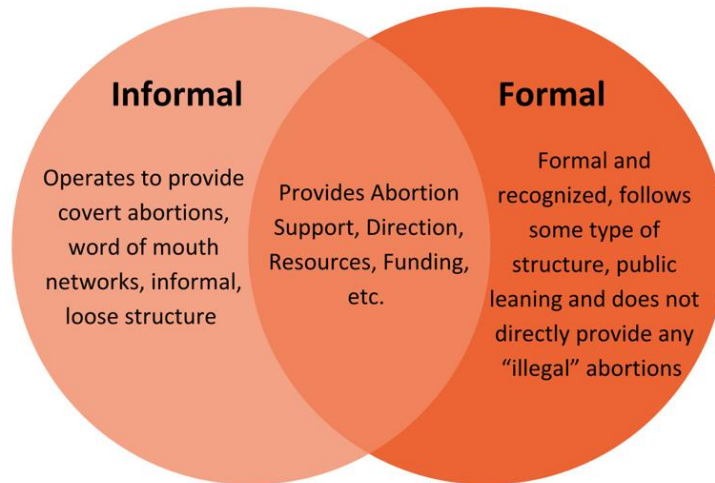


Figure 25: Covert Abortion Network (CAN) Informal and Formal

The formulation of CANs in this chapter is more developed than in the Romania or Turkey cases. This is because the shape of the CANs is dependent on the level of institutionalization of civil society. In a high-institutionalization case, we see CANs that are created in an environment where civil society is robust, organized, and relatively free to operate without fear of repression. This leads to an ease in creation, growth, reach, and even an ability to pursue political aspirations. Contrarily to this is the case of Romania and Turkey, which we have already explored. No or low levels of institutionalization lead to informal networks and difficulty in organizing, mid-level leads to a mixture of these large organizations and informal networks, and high levels lead to robust CANs that operate at a national, regional, state, and local levels. There are large organizations that operate in the U.S., such as Plan C or the National Network of Abortion Funds (NNAF), that help people access abortions, as well as Planned Parenthood, Reproductive Freedom for All, among others.

There are also smaller, more regional, state, and sub-regional organizations that specifically focus on funding and providing logistical support for abortion seekers. Abortion funds are a unique facet of the U.S. abortion landscape. This is due to abortions being expensive in the U.S., primarily offered in clinics, and a lack of insurance coverage for abortion services (Attia, 2025; Interactive: How State Policies Shape Access to Abortion Coverage, 2025). Abortion funds work by abortion seekers seeking out their organization, and the abortion fund helps them find an abortion provider, schedule the service, and help them get there, all while helping the seeker pay for the procedure, travel, and other expenses. These abortion funds fall under the formal CAN categorization because they are registered non-profits, typically 501(c)(3)s. My research is mainly comprised of abortion funds that serve Appalachia, as well as doula collectives, and an informal CAN. Informal CAN here refers to those working outside of the formal CANs who connect abortion seekers with abortion services. These may be people involved with community activism, women's health, or, as one interviewee put it, someone who is on social media talking about these issues (CAN X Appalachia, personal communication, July 2023). The informal networks in Appalachia, and in the U.S. broadly, are there to help people obtain an abortion outside of the medical-industrial complex (CAN X Appalachia, personal communication, July 2023; KHJN, 2024). Both formal and informal comprise my typology of CANs in a highly institutionalized civil society, as well as in the U.S. and Appalachia.

Table 16
Organizations by State

States	Appalachian Regional Organizations per State	Regional Orgs, non-Appalachian per State	State-wide Orgs	Total Orgs Operating in State
Kentucky	0	0	2	2
North Carolina	2	0	1	3
Tennessee	2	0	3	5
Virginia	2	2	1	5
West Virginia ³	2	0	2	2

³ West Virginia counts Appalachian and state-wide the same, as West Virginia is entirely in Appalachia. There is one organization in West Virginia that is represented in the map in Figure 27 but not Table 16. Western Pennsylvania Fund for Choice, which is located in Pittsburgh but reaches out specifically to people in West Virginia.
N=17

The organizations represented in Table 16 do not represent all CANs in this area. Rather, these are legitimate organizations (non-profits, mutual aid funds, and doula collectives) that do CAN work but are attached to a CSO. In other words, these are formal CANs in the region. Furthermore, I only count formal CANs operating in Appalachia directly or in the states of interest; I do not count national organizations that may also be operating. This is not unique to Appalachia or even the United States; I argue that any country with a high level of institutionalization of civil society will experience this. They will have these recognized and public organizations doing this type of work, which in other governments may seem to be illegal or clandestine at the very least. Why does this happen? Specifically, in the United States, there is a convergence of factors that influence these networks and organizations. Abortion rights have been rescinded in the United States, where for 50 years previously they had been upheld and legally, politically,

and culturally accepted to an extent. Abortion was always controversial, but it was still legal and accessible in every state.

In 2022, that changed drastically; it went from a legal and semi-accessible abortion landscape to one where whole regions of the country have outlawed or severely restricted abortion. But the U.S. also protects civil society to an extent. Some may criticize this point, but within a global context, the U.S. is a relatively free country with protections for its citizens, civil society, and the right to gather, organize, and engage in free speech. The combination of these two things has led to a vocal majority of people who support abortion rights in the United States. 85% of Americans think abortion should be legal in some or any circumstances (Where Do Americans Stand On Abortion?, 2023). And after *Roe* was overturned, there were mass protests around the country, and many women's rights and other organizations voiced their discontent over the overturning and dissolving of abortion protections in the United States. Many organizations vocally proclaimed that they would continue to operate until the government shut them down, and many clinics would be working in precarious grey areas when laws were passed and court appeals were introduced, causing a stop-and-start to care (Willingham, 2022). Due to the openness of society in the United States, as well as with many highly industrialized democracies, there is not a direct threat of punishment by the government. However, there is some level of enforcement of these laws. From 2000 to 2020, 61 people were criminally investigated for self-managing their abortions or aiding someone in getting an abortion (Huss et al., 2023). Since 2022, there have been various arrests of providers and patients who have either violated state provision laws or have induced abortions illegally (Abortion in the United States After Dobbs, 2023), he concerns that those involved with

helping abortion seekers subvert abortion access, which is growing as these threats persist.

Research Questions

This brings us back to the research questions driving this project. Why don't abortion restrictions work as well as they are meant to? As I've established previously, abortion restrictions are meant to work (like any law); they are meant to restrict or eliminate all abortions severely. In West Virginia, Tennessee, and Kentucky, there should be no abortions because it is illegal in all cases. In Figure 23, we saw that the recorded number of abortions in these states was little to none, but these are legal abortions performed in the state. Those in West Virginia, Tennessee, and Kentucky are not forgoing having abortions; they are obtaining them outside of the state, either legally or illegally. What we are seeing instead is people obtaining medication abortions via the mail, people traveling out of state, and perhaps people getting illegal abortions in-state. To answer the question, I argue that CANs drive the abortion rate by providing abortions despite the legal environment in which it is found. In the United States, because abortion laws are determined at the state level, people can travel within the country easily and freely to a state that has an entirely different set of laws around abortion. For someone in east Tennessee, where abortion is completely illegal, they can travel over the border to North Carolina and go to a clinic in Asheville without having any travel documents, flights, overnight stays, etc. This is an undue burden on the patient, but it is more accessible than many people globally find abortion to be, and that is an important aspect to keep in mind when reading this chapter.

If CANs can supplement, or at least nearly supplement, abortion access despite the laws found at the state level. This leads us to a series of questions about CANs, including variations, how they work, and why they work. I argue that the level of institutionalization of civil society in a state influences the strength of the CANs that will be found. The stronger the institutionalization of civil society, the stronger the CAN and the stronger the ability of the CAN to supplement abortions will be. Appalachia represents the high level of institutionalization of civil society in this project. As described earlier, Appalachia has many different issues with access, not only in terms of reproductive health but in healthcare in general, food deserts, poverty, etc. There is a strong presence of civil society in the region that aims to supplement the lagging economic opportunities, the lack of healthcare facilities and doctors, and ecological and environmental needs, among others. It is no different for those who live in this region, which is also encapsulated in the South politically, that there is a need for organizations that supplement abortion access.

At the time of this writing, it is too soon to say if these CANs affect the birth rate, as the laws have only been in place for a couple of years and are subject to frequent change. However, what we can study is how these networks emerged in the past year, whether they existed before *Roe* was overturned, what their goals are, how they are organized, what their focuses are, etc. That is what I aim to do in this chapter: create an idea of the organizational spread and structure of the CANs operating in this area. There are many formal CANs that operate in this region that are available to study, and there are still informal CANs at play too. I focus primarily on understanding the formal CANs in this region because of their substantial role in abortion access. Although Turkey had

formal CANs too, they were not nearly as focused on abortion access and advocacy as they are here. This is due to the political context in which we find them, as well as their ability to speak more freely against the state. In the future, I anticipate more longitudinal research on the birth rate and the impact of formal CANs in the region, which have helped people to access abortion. For now, we cannot get that zoomed out look, but we can look at how the early days of the *Dobbs* decision have impacted these CANs' inception, growth, reach, as well as their political aspirations.

Methodology

My goal with this chapter is to understand how CANs work at the moment to supplement abortion access in a region that is experiencing rapid changes to the legal landscape. This required creating a dataset of pro-choice and abortion organizations that do abortion support work. This dataset is of legitimate organizations and groups; it is composed of 501(c)(3) non-profits that are composed of abortion funds, abortion doula collectives, and abortion support groups that provide guidance, by combing through resources such as the National Network for Abortion Funds, pro-choice groups, social media, etc. I was able to compile a list of organizations in the region that provide some form of abortion support, with 17 directly represented. Each group was categorized based on whether it served a region or an entire state, its location, the type of services it provided, and its overall reach. I did not count national organizations, such as Plan C or Planned Parenthood, because their work is focused on the national rather than state or regional levels. This dataset contains information on the establishment dates of organizations, the services they provide, and their scope of operation. I analyzed annual

reports from organizations with available data, as well as mission statements and other key focuses from their websites.

The high level of institutionalization of U.S. civil society has led to the formalization of networks into CANs as I define them. It is a mixture of non-profits, community groups, and informal networks. In the dataset, I collected data on formal groups, which are registered non-profits, have websites or social media, and annual report data. As stated earlier, the *Dobbs* decision was not seen as sudden, and many of these states had seen consistent erosion of their abortion rights. There were already many groups doing similar work, if not the same work, before the overturning of *Roe*. However, many people in informal networks continue to work on organizing and directing individuals to these more legitimate organizations. Therefore, these organizations comprise much of the research, including organizational spread and understanding timelines. I may specifically call out organization vs. CAN because I am describing those organizations that are public and recognized. I may say CAN generally refers to those working independently, but also perhaps affiliated with an organization. Organizations are formal and recognized, have a rigid structure of employment or volunteers, and do not provide “illegal” abortions. Informal CANs are those that are word of mouth networks, as found in Romania and Turkey as well, that may help people access illegal abortions as well as direct abortion seekers to formal CANs who can provide additional aid. Where they overlap is that they provide abortion support, direction, resources, and funding for abortion seekers.

I also met with and interviewed a few members of CANs in the region. One was with a formal non-profit, Kentucky Health Justice Network (KHJN), and the other was

with a member of an informal network. Initially, this research structure was going to rely more heavily on interview data. The interview with the informal CAN, cited as CAN X Appalachia, was conducted under an IRB protocol that was later abandoned. I changed my research focus due to the limited responses from informal CANs and a desire for a more organized understanding of CANs in this region. The interviews conducted helped to provide a sense of organizational attitudes towards civil society and the state.

In H4, I argue that CANs work because of the determination of society to provide abortion services despite the legal context that they find themselves in. Through social media statements, blog posts, mission statements, interviews, and various other sources, I have compiled information from CANs operating in Appalachia that highlights how they operate, the services they provide, and their impact on the broader political landscape. Through a compilation of all these elements, I can create a robust look at how CANs operate in Appalachia and overcome abortion access barriers to help provide abortion seekers with abortion services despite the legal climate they operate.

Findings

CAN Inception and Growth

For those in the pro-choice and abortion rights arenas, the change in abortion law wasn't surprising; it has been a long-awaited possibility. Many states have faced constant legal challenges to *Roe* for 20 years, with various laws seeking to erode abortion access if not eliminate it outright. During those 20 years, there have also been medical developments around abortion. Long gone are the days of the curettage abortion with the stigma around the sensation and the large vacuum attachment. Now surgical abortions are

completed with a manual vacuum aspirator (MVA), which is lightweight, small, plastic, and reusable. But even more revolutionary is the introduction of the abortion pill, a pharmaceutical combination of mifepristone and misoprostol. It is extremely safe to use, as are surgical abortions, but something surgical abortions do not have is the ability to be sent via the mail.

The boundaries and borders of abortion access have been pushed constantly throughout history, but especially in the past two decades. In 1999, Dr. Rebecca Gumperts provided abortions at sea on Greenpeace's vessel the Rainbow Warrior II. Off the coast of South America, in international waters, Dr. Gumperts provided abortion for women who had been raped, had no way to access abortion otherwise, or did not have the means to access an abortion. Since this voyage, the organization Women on Waves has not only been providing abortions at sea but also sending drones and robots carrying abortion medications across borders. Offshoots of Women on Waves, such as Women Help Women and Women on Web, have surfaced whose mission is to send abortion pills in the mail across the world. In the U.S., Plan C is a non-profit that offers abortion care support and provides user guides on how to access abortion pills either legally via in-person or online clinics, or directs users to websites that sell abortion pills illegally. Plan C regularly tests the efficacy of third-party pills to ensure that they are safe and real, even outside of FDA guidance. The proliferation of these types of organizations is a result and reaction to the introduction of abortion restrictions and continued barriers to access that people face. Plan C estimates that they have served 400,000 people since the fall of *Roe* and an estimated 15-20,000 people per month through "a few dozen providers in six states to serve the entire U.S." (Plan C Annual Report 2024, 2024). Plan C lists online

abortion pill suppliers that provide medication abortions for as low as \$25. They routinely lab test these medications for themselves to ensure quality. These third-party sites do not offer support, but Plan C does (Plan C Annual Report 2024, 2024).

The data collection of CANs operating in Appalachia consisted of creating a dataset of the formal CANs operating. The dataset includes examining when these organizations were founded to establish when growth in this area of civil society occurred, and to provide historical context for their existence. Of the 24 organizations that operate in or around Appalachia, the majority were founded after 2010. The first was the Women's Health Center of West Virginia, which was founded in 1976. Initially an abortion and reproductive health clinic, post-*Dobbs*, it has remained as a reproductive health clinic but has also become an abortion fund serving West Virginia.

Figure 26 depicts an interesting pattern is that there is an uptick in the early 1990s, where in 1990 there were two organizations working in the region, and by 1998 there were eight. This finding is also congruent with Turkey which marks the 1990s as when their civil society blossomed and grew drastically. This may be tied with the International Conference on Population and Development (ICPD) in Egypt in 1994, which was run by the UN and established a global definition of reproductive health and rights (*Programme of Action*, 1995). At the ICPD, there was an emphasis on the role of non-governmental organizations and the role of civil society in reaching population and development goals. They state in the report, “non-governmental organizations are important voices of the people, and their associations and networks provide an effective and efficient means of” reaching population and development goals (*Programme of Action*, 1995). The report furthers this statement saying that non-governmental

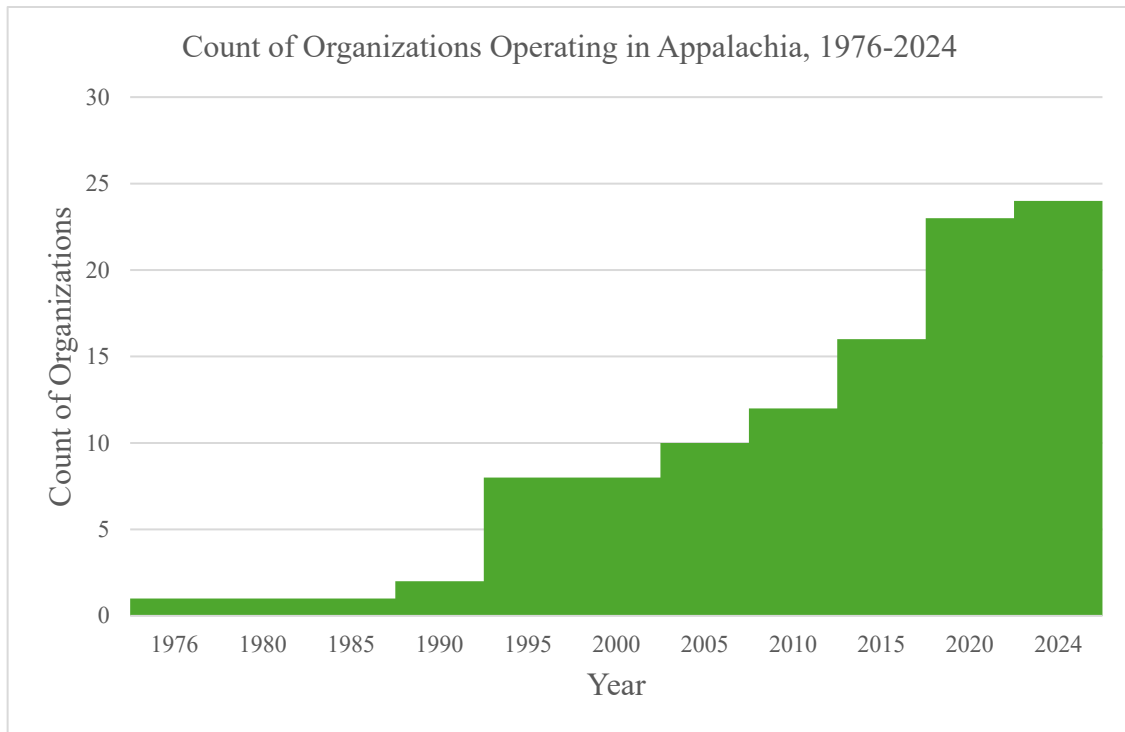


Figure 26: Appalachian Organizations by Year Founded

organizations related to women’s health, reproductive rights, and family planning should be seen by their government as essential partners in cooperation. After the ICPD in 1994 there is a fundamental change in the language used around reproductive rights, and the introduction of the term reproductive justice, as well as the number of non-governmental organizations dealing with reproduction. It is seen as a turning point to more formally establish organizations working on abortion, family planning, etc. and working to provide access. Immediately before the ICPD, a group of black American women coined the term “Reproductive Justice”. The women who originated this term then formed SisterSong, a reproductive justice collective based out of Atlanta. Reproductive justice goes beyond rights, it is the belief that it is a human right to “maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities” (SisterSong, n.d.).

A pattern among many of the formal CANs in the region was that they were initially started as more informal networks. In an interview, KHJN said that they were originally started to help drive people to and from the clinic, focus on the lack of reliable transportation in Kentucky (Kentucky Health Justice Network, personal communication, October 2024). That original mission grew as they developed their abortion fund and now help people from Kentucky, where abortion is banned, get legal abortions. The Blue Ridge Abortion Fund (BRAAF) was founded in 1989 when members of Charlottesville NOW put a pickle jar to help collect money for someone's abortion (*Blue Ridge Abortion Fund*, n.d.). The request came through a "whisper network", a community gathering money to help a person in need that then turned into a major abortion fund in Virginia. The Mountain Area Abortion Doula Collective (MAADCo) "was formed in response to the lack of gender-inclusive practical support" for people needing an abortion in or around Asheville (*Mountain Area Abortion Doula Collective*, n.d.).

Many of these CANs that do exist in Appalachia are, by and large, not new. They are relatively new, but not created by the *Dobbs* decision. Instead, they have existed as abortion rights have been eroded nationally and in the region for the past 20 years and barriers to abortion access have cropped up. There is more urgency, visibility, and demand for these CANs now, but they were not created as a result of a federal change in the law. I argue that CANs will appear wherever and whenever they are needed, regardless of the legal context in which they operate. If there is a demand for abortion support, then CANs will appear, whether or not abortion is legal. Legality is not as important to someone seeking an abortion as access. In many places, abortion is legal broadly, but difficult to access. Before *Dobbs*, abortion was legal in the United States;

every state had at least one abortion clinic. But for someone in the middle of the country, that made access incredibly difficult, even though it may have been legal.

Mission Statements and Values. Nearly all of the CANs in this project have websites and social media with histories about their organization. KHJN states that they “advocate, educate, and provide direct services to ensure all Kentucky communities and individuals have power, access, and resources to be healthy and have agency over our lives” (Kentucky Health Justice Network, n.d.). A Fund, which is the oldest abortion fund in Kentucky, aims to provide financial assistance for those seeking abortion, “raise public awareness of the psychological effects of unwanted pregnancies on men and women”, work with national and local organizations, and raise donations (A Fund, n.d.). Both of these Kentucky abortion networks focus on providing those direct services. A Fund also has on their home page the quote, “Abortions will continue to be needed and their cost will increase—a cost that falls most heavily on the most vulnerable.”

Tennessee and West Virginia’s abortion networks also have similar themes running through their mission statements and values as another state with an abortion ban. Abortion Care Tennessee (ACT) says that they fund procedural costs for Tennesseans travelling to access abortion. Holler Health Justice (HHJ) “was founded by a group of young reproductive health, rights, and justice activists looking to meet the substantial need of funding and practical support for West Virginians seeking abortion care” (*Who We Are & What We Do*, n.d.). And the Women’s Health Center (WHC) of West Virginia Choice Fund is an abortion fund set up through a former abortion clinic in West Virginia. Although they cannot provide abortion care anymore, they do “ensure that no West Virginian is denied an abortion because they cannot afford it” (Women’s Health

Center of West Virginia, n.d.). Before *Dobbs*, WHC was the only abortion clinic in the state of West Virginia, located in Charleston. In 2021, they provided abortion care for 1,300 patients, and 25% of those patients needed help paying for the cost of the procedure (Women’s Health Center of West Virginia, n.d.). In 2022, the Choice Fund paid for nearly 200 patients’ abortion care. They also remark on a common sentiment, that “the number of patients seeking abortion care will not decrease because of the new ban in West Virginia. But the need for abortion funds will surely continue to increase”. The missions, focuses and values of states with total bans is on directly serving their populations and helping them travel out of state. They have established relationships with clinics in other states, some of those being in Virginia and North Carolina, and others being in Illinois, Maryland, Ohio, and Pennsylvania.

For the CANs that exist in North Carolina and Virginia, where abortion is legal, they aim to serve people in their states but also to do more direct work. BRAF was founded in 1989, which is old compared to the other CANs, and has been working to provide financial support, transportation, and lodging assistance. But they also focus on doing “education and community outreach to reduce stigma and increase awareness” (*Blue Ridge Abortion Fund*, n.d.). Virginia has the most liberal abortion laws in this region, and in the entire South, and there is an abortion clinic located in Charlottesville, where BRAF is located, although not technically in Appalachia according to ARC. New River Abortion Access Fund (NRAAF) is located in southwest Virginia and has an explicit focus on those in that area and in Appalachian Virginia. Carolina Abortion Fund (CAF) states that abortion is a social good, and that they treat abortion seekers with “compassion, dignity, and respect” (Carolina Abortion Fund, n.d.). MAADCo, also based

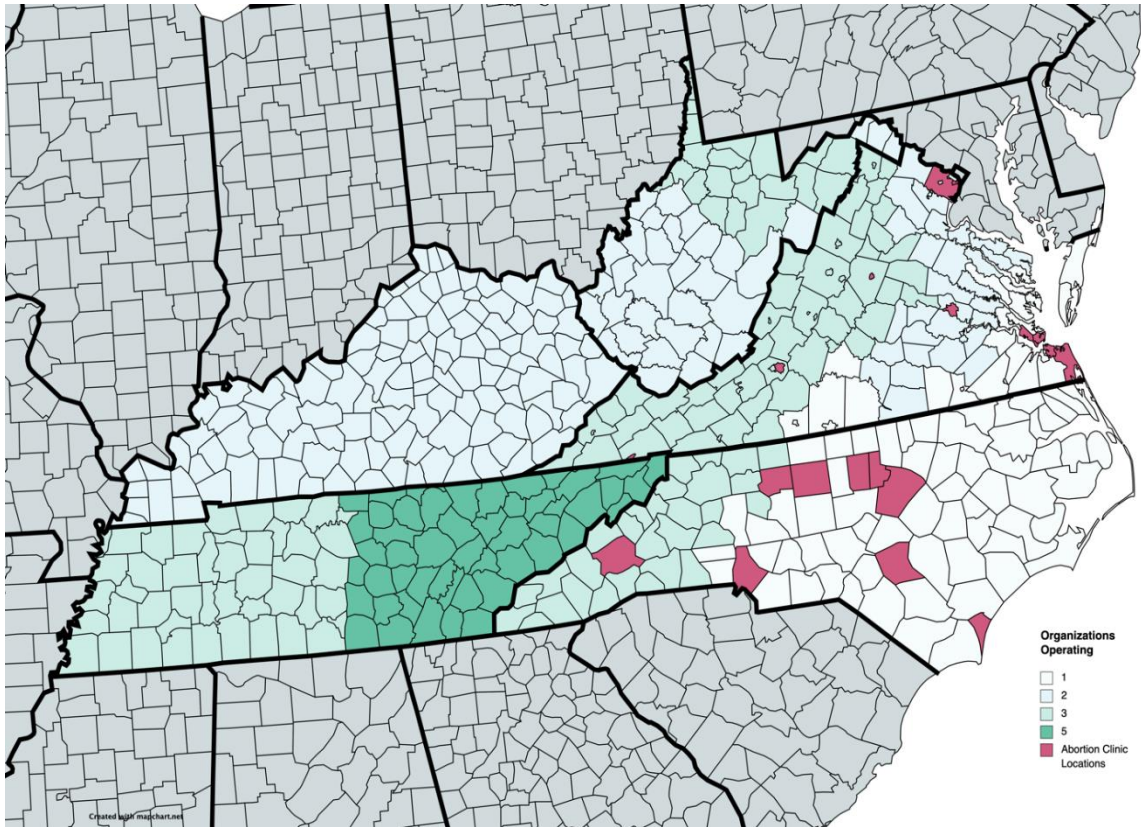


Figure 27: Appalachia Organizational Spread Map

in North Carolina, was founded in Asheville to help people in the region access abortion (*Mountain Area Abortion Doula Collective, n.d.*).

CAN Reach

Six organizations work on abortion access specifically in Appalachia. These organizations are centered in North Carolina, Tennessee, West Virginia, and Virginia. However, some of these organizations, such as Mountain Access Brigade (MAB), are included in the organizational spread count found in Table 16. This was done for two reasons: first, these are the centers where the CANs send patients rather than conducting outreach themselves; second, they are legally and operationally compliant with state

guidelines and must adhere to these standards to remain open. These organizations, from doula collectives to abortion funds, counsel, fund, guide, and transport people to these locations for surgical abortions; they are the endpoint for many people's abortion journey, whereas this study is interested in the beginning and middle.

In the United States, where there is a high level of institutionalization of civil society, we find that CANs are both informal and formal. They either have ties to nonprofits, mutual aid organizations, funds, collectives, or are part of these groups themselves. Both formal and informal CANs have a social media presence, advertising their services, providing educational support, or directing individuals to funding opportunities. What I have found in Appalachia, specifically, is that there are regional organizations typically based in a city within the region that then conduct outreach work to people in the surrounding areas. Meaning that if an organization is centered in Asheville, NC, they typically do work in western North Carolina in general, and reach out to eastern Tennessee, which can be a 2-3 hour perimeter (CAN X Appalachia, personal communication, July 2023; *Mountain Area Abortion Doula Collective*, n.d.). Figure 27 depicts a map of the organizational spread of organizations operating in the region. These are known organizations, including abortion funds, abortion clinics, doula collectives, etc. Many of these organizations are state-focused, such as ACT but others are regionally focused such as the MAB.

Many abortion funds, especially those in states where abortion is banned, typically focus on providing access to abortion seekers in their state. A FUND says on their website that "Though abortion currently is illegal in Kentucky, we continue to assist Kentucky and Metro-Louisville clients pay for abortions at clinics in other states and

support initiatives to make contraception more accessible” (A Fund, n.d.). In an interview with KHJN, also in Kentucky, they said that they focus on abortion seekers in the state, but they will have people reach out from surrounding states, which is complicated because they have seven neighbors. They have seven clinics that they work with daily to help organize funding and care, but they also will work with other clinics if the seeker wants to go somewhere else (Kentucky Health Justice Network, personal communication, October 2024). ACT specifically funds procedural costs for Tennesseans who need to travel out of state to fund an abortion through block grants to partner clinics, which then distribute funds to patients (*Abortion Care Tennessee*, n.d.). MAB is focused on East Tennessee and states that they know traveling out of state “disproportionally affects people with lower incomes,” so they seek to provide procedural support with confidentiality and no judgment (*About Us*, n.d.). These abortion funds centered out of states with bans are interesting because they have pivoted to helping abortion seekers travel out of state. KHJN remarked in our interview that they have a strong relationship with clinics, and that patients often find them through clinics when they need financial support.

The organizations represented in Figure 27 and Table 16 are not the only ones operating in these states or Appalachia. CANs can, and do, act independently of these organizations and direct patients to more legitimate sources. CAN X expressed that they were motivated by their own beliefs, felt compelled morally to help, and had a personal connection to clandestine abortion experiences (CAN X Appalachia, personal communication, July 2023). They also affirmed that they work with other groups that are supportive and do abortion access work, but mandates do not direct that work. They are

independent of that group but are connected through the group; the group does not assign or create expectations for those affiliated, and there is a high degree of freedom for people to work independently. The members of the CAN direct people to legitimate organizations (either abortion funds, doula collectives, or clinics themselves). The members may also be members of these other organizations or affiliated with them in some way, but they act first as a helping hand and then provide various resources, rather than acting with or for any legitimate organization. They also remark that Google is less helpful now, that when people search for abortions, they are often served websites of crisis pregnancy centers (CPCs) or misinformation because they cannot distinguish what is legitimate and what is not.

CAN X provided a detailed look at how someone needing an abortion in rural Appalachia might get one. They said that if someone in a rural community needed an abortion, the first thing they would do is to turn to someone they trust or someone in their orbit that they believe may be sympathetic. CAN X notes that people reach out to them because they see social media posts about issues that indicate their sympathy. Then, when they are in contact with someone involved in a CAN, what they then need to demonstrate is how far you need to travel, and how much money you need. Rural Appalachia is rugged terrain, so on a map, a clinic may appear closer than it actually is due to accessibility issues in the mountains, which have only worsened since Hurricane Helene. CAN X then remarked that they may refer them to an abortion fund, which can help them access money and schedule an appointment at a clinic. They may continue to provide additional support.

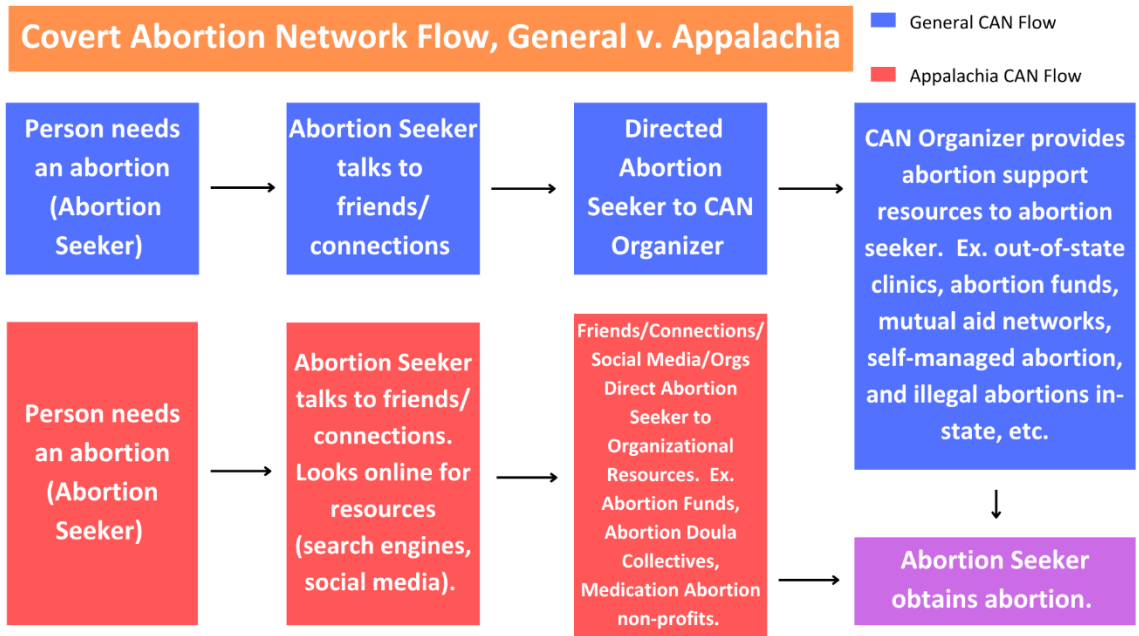


Figure 28: CAN General v. Appalachian Flow

Figure 28 depicts the similarities and differences in the CAN flow from Appalachia to a general typology. In Appalachia, with a highly institutionalized level of civil society, there are more resources legally available for abortion seekers. Someone needing an abortion in Appalachia will typically confide in friends but also Google what to do. When googling, they will discover organizations that provide some level of direction, helping them determine what to do, where to go, and who to contact, among other things. Examples may be the NNAF, which is a non-profit that manages a database of abortion funds around the U.S. and helps people seeking an abortion not only find one but figure out how to pay for it, how to plan it, etc. Whereas in other civil society contexts, an organization such as NNAF may not exist, or could not exist. Therefore, in a place where civil society is highly institutionalized, it is found that much of the work that CANs typically do is being replaced by these organizations. Many of these organizations,

such as Plan C, indirectly help abortion seekers obtain illegal, yet safe, self-managed abortions by assisting them to find sites that send medication abortion through the mail to any state. Because of this, I incorporate these organizations into part of the CAN flow. Although many of the same steps remain, in Appalachia and the U.S., there are legitimate organizations that assume a significant portion of the burden of organizing and funding. When someone, like Tina, needs an abortion, they would go through the same steps as any person would in any political context. They find out they are pregnant; they talk to friends they think are sympathetic, knowledgeable, or have been through a similar situation. And that person helps set them on their journey to obtaining an abortion. This may be to an organization such as the CAF or the MAB, or they may be sent to a CAN organizer who is working without being affiliated with any of these organizations but directs them to them.

Funding and Abortion Seekers. Drawing from websites and annual report data, we can see the financial and practical support impact these CANs have made in Appalachia. Table 17 shows the self-reported services that CANs provide. Almost all of these organizations offer abortion funding and practical support to abortion seekers. This looks like paying for their abortion at the clinic, funding travel and lodging, organizing childcare, and organizing travel, etc. An in-clinic surgical abortion in the first trimester can cost up to \$800, but typically is about \$600, while a second trimester abortion, on average, is \$715, but later in the second trimester can be upwards of \$2,000 (Attia, 2025). If an annual report is not available, these CANs often post the most recent data available on their website, typically including the number of calls they fielded and the dollar amount of support provided, among other details. Table 17 provides a look at the most

recent funding data available, as well as any information related to practical support, calls, etc. Many of these organizations do not have many annual reports available, or have not generated them in the past, so looking at the most recent data is the most robust comparatively.

Not every CAN in this dataset provides annual report data, and the data that is presented is not standardized in terms of what is reported. However, many of the CANs in the region, specifically abortion funds, provide detailed information in terms of calls they receive, donations, the number of abortion seekers supported, and the amount of practical support offered annually. Table 17 provides the most up-to-date information from the CANs in the region that are available online. The inconsistency in data reporting does not yield an accurate figure; however, Table 17 provides a glimpse into the impact that these CANs have on people in the region, as well as the number of people they assist annually and the associated financial cost.

Table 17 is arranged by state and only contains CANs that had available impact or annual report data or that reported these numbers on their website. I also included Access Reproductive Care (ARC)- Southeast in the data which is headquartered in Atlanta but directly services those in Tennessee. ARC has a particularly powerful impact, funding 3,360 people in 2024 and dispersing \$2.1 million in direct aid to them. The DC Abortion Fund is also included because it borders Virginia and is in close proximity to West Virginia and directly serves abortion seekers in those two states, as well as those in North Carolina. They reported that in February 2024, they saw a 450% increase in calls from people in North Carolina (DC Abortion Fund, 2024).

Table 17
Formal CAN Annual Report Summary

Organization Name	State	Most Recent Funding Year	Calls	Donations/ Fundraised	Practical Support #	Practical Support \$
Kentucky Health Justice Network ^a	KY	2024	980		980	200,842
A FUND ^b	KY	2024		380,170	3,434	139,121
Carolina Abortion Fund ^c	NC	2023	4,182	670,000		90,060
Abortion Care Tennessee ^d	TN	FY 23–24		182,723	616	157,700
Access Reproductive Care – Southeast ^e	TN, HQ in GA	2024			3,360	2,100,000
Mountain Access Brigade ^f	TN	2023		133,408	373	
Blue Ridge Abortion Fund ^g	VA	FY 23–24	2,490		1,583	961,564
New River Abortion Access Fund ^h	VA	FY 22–23	2,800	672,627	1,910	48,503
DC Abortion Fund ⁱ	VA	2024	7,060	1,555,440	2,939	2,080,000
Holler Health Justice ^j	WV	Since 2019			2,719	1,105,932
Women's Health Center of West Virginia Choice Fund ^k	WV	2022			200	

Note: a Data from Kentucky Health Justice Network (2024). <https://www.kentuckyhealthjusticenetwork.org/annual-report.html>
b Data from A FUND (2024). <https://www.kyafund.org/2022-report-to-donors>
c Data from Carolina Abortion Fund (2023). <https://www.carolinaabortionfund.org/statements/2023/12/20/2023-in-review-122023>
d Data from Abortion Care Tennessee (2023). <https://static1.squarespace.com/static/64a7276232ca5c4e5ba7dc61/t/66e356f60d26087cb6ceafd8/1726174970891/2023-2024+%281%29.pdf>
e Data from Access Reproductive Care – Southeast (2024). <https://arc-southeast.org/2025/01/14/2024-impact-report/>
f Data from Mountain Access Brigade (2023). <https://mountainaccessbrigade.org/>

Table 17
(continued)

Organization Name	State	Most Recent Funding Year	Calls	Donations/ Fundraised	Practical Support #	Practical Support \$
f						
Data from Mountain Access Brigade (2023). https://mountainaccessbrigade.org/						
g						
Data from Blue Ridge Abortion Fund (2023). https://blueridgeabortionfund.org/about-us/						
h						
Data from New River Abortion Access Fund (2023). https://www.newriverabortionfund.org/						
i						
Data from DC Abortion Fund (2024). https://dcabortionfund.org/2024-annual-report						
j						
Data from Holler Health Justice (2024). https://www.hollerhealthjustice.org/						
k						
Data from Women's Health Center of West Virginia Choice Fund (2022). https://www.womenshealthwv.org/choicefund						

The number of abortion seekers and the money that are being provided by these CANs in the region are hugely impactful. HHJ only has cumulative data available, but since 2019, it has supported 2,719 abortion seekers and distributed 1.1 million dollars in practical support to West Virginians. The BRAF and NRAF both support Appalachian Virginia and have together fielded 5,290 calls, provided valuable support to 3,493 people, and distributed almost \$1 million to abortion seekers. Both funds specifically focus on Western Virginia and giving support to those in rural areas of Appalachia. NRAF is located in southwestern Virginia. ACT is in the process of merging with MAB; together, their impact for their last reported years would be aiding 989 people in practical support, and ACT distributed \$157,700 to their portion of abortion seekers.

Through my interview with KHJN, I gained a better understanding of their annual numbers. KHJN in 2024 aided 980 people in obtaining an abortion and distributed \$200,842 to those people. In their annual report, they provide a more detailed breakdown of their total amount distributed, \$110,201 went to abortion appointment funding for Kentuckians, and \$20,085 went to non-Kentuckians (KHJN, 2024). In my interview with

KHJN, they elaborated that they very rarely help non-Kentucky residents, but they may if a clinic calls them with an urgent funding crisis (Kentucky Health Justice Network, personal communication, October 2024). They also reported a 45% increase in their transportation funds from 2023, which amounted to \$43,113. They also provided a total of \$17,042 for lodging and \$10,401 in other support, including childcare and meals for abortion seekers. KHJN provides the most detailed breakdown of how their practical support is spent of any CAN, and it gives a deep look into how abortion seekers spend their money. 65% of the funding provided goes directly to paying for the abortions, the remaining 35% is allotted to helping people get to their appointments and being able to take the time to get there.

In our interview, KHJN also added that before *Dobbs*, the most significant hurdle many faced was paying for the abortion procedure, and that if they had to drive, it was not as far as it is now. This is in line with our understanding of abortion in rural areas, but also in places where travel out of state is necessary. Most women who have abortions are already mothers, and in Kentucky, Tennessee, and West Virginia, they are forced to travel out of state, often requiring an overnight stay. The funding that these abortion funds provide not only pays for an abortion, but it also pays for the time and freedom to get it. They also added in our interview that they do not have quantifiable goals to achieve each year because they are driven by need. However, they want their practices to remain sustainable.

CAN Political Aspirations

Table 18 illustrates how the 16 organizations in the region and states structure the services they provide. These are categorized based on the “about us” or similar pages on their websites. All but one organization directly includes funding for abortion services,

Table 18
CAN Self Reported Services Provided

Services Provided	Count
Abortion Funding	15
Practical Support	10
Education	2
Advocacy	1
Care	3
	N = 16

mentioning financing for the procedure itself as well as travel. Practical support means that they have volunteers or staff members who can help abortion seekers arrange travel, find clinics, and provide logistical support to abortion seekers. Two organizations say that

they provide education services to help educate the public in their area about abortion access. Three provide, in addition to practical support, care. This is described in terms of not only helping to organize logistics but also providing emotional support to people during this time.

Only one organization explicitly states that they do advocacy work. Some of these groups participate in community outreach events (such as fundraisers and event sponsorships), but they do not explicitly state that they engage in advocacy work. Although they may not engage in direct advocacy work, such as having someone on staff or directly interacting with policies and politicians, the work is inherently political. It is also important to note that any 501(c)(3) organizations are not allowed, by their designation, to support specific candidates but may broadly support issues. However, each of these organizations is political just by their very purpose of providing abortion funding, support, care, etc. to people who are experiencing trouble accessing abortion

legally or safely due to laws. When new laws were implemented or during the *Dobbs* decision, these organizations were vocal about the political and legal landscape of abortion in the areas where they operate.

However, through social media and these CANs' online presence, a significant way that they engage with advocacy work is through "educational advocacy" (CAN X Appalachia, personal communication, July 2023). There is an increase in misinformation online around abortion, and one issue after *Dobbs* was confusion about whether abortion was legal or illegal. Contrary to belief, there was not a surge of people contacting abortion funds after *Dobbs*. Instead, there was a dip due to misinformation (Kentucky Health Justice Network, personal communication, October 2024). KHJN remarked in the interview that immediately after the *Dobbs* decision, they had fewer abortion seekers reaching out for support through their channels because abortion seekers did not realize they could travel out of state to have an abortion. The dip has rebounded, but messaging at the national and state levels was so confusing that abortion seekers did not know what their options were. But the role of many of the CANs in the area is through social media, partnering, and attending events to not only address stigma around abortion but to spread information about options. All the formal CANs have social media presences. Still, you'll also find smaller collectives that use social media too and will cross-post, especially educational information about contraception, abortion access, medication abortions, etc. (CAN X Appalachia, personal communication, July 2023).

Perceptions

In my interview with KHJN, we discussed the atmosphere towards civil society related to abortion. They expressed that we have only begun to see the tip of the iceberg in terms of attacks on abortion seekers in Kentucky (Kentucky Health Justice Network, personal communication, October 2024). Just before our interview, it was revealed that the former Attorney General of Kentucky, Daniel Cameron, had tried to charge abortion providers using clinic records to show a misuse of public funds (Acquisto, 2024). This was pursued after abortion was banned in Kentucky in 2022, for abortions provided legally before the *Dobbs* decision, and when the EMW clinic closed. This was brought up in our interview around worries that KHJN has about bad actors trying to access information on abortion seekers and concerns about state surveillance. They said they keep up robust digital security practices, but seeing this in the news is worrying (Kentucky Health Justice Network, personal communication, October 2024).

Both interviews I conducted also discussed the number of illegal and clandestine abortions that happen. KHJN helps people access legal abortions by helping abortion seekers in Kentucky travel outside of the state. However, they know that people access clandestine and illegal abortions in other ways. They noted that networks have existed longer than the medical-industrial complex has been around, and that they will continue to exist. They do believe that these types of abortions have probably increased since the *Dobbs* decision was made, as people's options became more limited.

Additionally, my interview with CAN X was more explicitly about clandestine and illegal abortions. CAN X also emphasized that COVID-19 had a large part in driving more community activities, especially around reproductive health care access in the

region, as healthcare access was already difficult before the pandemic and only worsened during it. There was also a general interest people had in working more with their communities, which they think was driven by a need to be around people after lockdown, and the *Dobbs* decision energized people to work on abortion and reproductive health work. During our discussion, CAN X stated that “networks are crucial to keeping people alive” and that they are essential for ensuring people have access to critical resources, such as supplies, information, community, and one another (CAN X Appalachia, personal communication, July 2023). Through these conversations, both on and off the record, I gathered that people are generally worried about the political climate and changes in the laws. However, there is also a sense of knowing that they are helping people bridge those gaps, and they will continue to do so.

Discussion

Through this analysis of CANs in Appalachia, we can see a picture of how abortion is provided in a rural region, which has differing laws around abortion, and requires abortion seekers in three out of five states to travel to another state. I argue that CANs crop up in the face of restrictions to abortion access. So it is no surprise that nearly all of these organizations existed before the *Dobbs* decision. Abortion was already difficult to access in these states, especially West Virginia and Kentucky, which only had one abortion clinic each. In our interview, KHJN said that Kentuckians were already living in a post-*Roe* landscape. People in these states were travelling long distances to access abortion before the decision, and that has only been amplified now. KHJN also pointed out that their funds are used primarily to fund the abortion procedures, but now

they provide travel and other practical support because that is also what people cannot afford.

Returning to Figure 23, it is important to understand the impact that CANs have on the abortion rate by understanding how they are created, their growth, reach, and political aspirations. Their creation, growth, and reach, I argue, have the most considerable impact on abortion access, but political aspirations can also affect access to abortion. Most of the CANs I have looked at in this study have directly provided support to abortion seekers by logistically helping them find clinics, making the appointments, helping them pay for the abortion, paying for travel and lodging, and even paying for food and childcare. These organizations are registered non-profits; they are formal and recognized by the federal government when they act subversively against state policies. This case falls under the high level of institutionalization of civil society due to the way civil society is structured in the U.S. There are non-profits, community groups, collectives, etc. at every level all over the country that can operate counter to the state but still be visible to the state. Although there are concerns about retaliation and surveillance, these organizations still operate under a formal structure established by the state and adhere to these codes (Kentucky Health Justice Network, personal communication, October 2024). The U.S. has a robust and thriving civil society that has allowed these types of organizations to emerge and formalize their processes over time.

Half of these CANs had been founded by 2010. 2010 is marked as one of the turning points in abortion legislative history, even being seen as the beginning of the downfall of *Roe v. Wade* (North, 2019). In 2010, 15 states enacted 39 laws related to abortion (Guttmacher Institute, 2011). This year marked Nebraska's ban on later-term

abortion, citing that a fetus feels pain after 20 weeks, which led to the adoption of this law by 38 states that year. Abortion access was already threatened across the U.S. in 2010, which I argue led to a need by society to make abortions more straightforward to access. These CANs began to fill those needs by popping up during this time; they provided financial, logistical, and often emotional support for abortion seekers who had difficulty navigating the restrictions put in place. It was accepted in pro-choice communities that *Roe* was not a promise; it was always seen as tenuous (*Blue Ridge Abortion Fund*, n.d.). Many people had prepared for the reality of a post-*Roe* world.

The CANs were almost entirely founded pre-*Dobbs*, but they saw a surge in growth and reach post-*Dobbs*. The NNAF, which serves as a database and platform for abortion funds across the U.S., and which most of these formal CANs are members of, released a report in 2024 stating that among its members, there was a 39% increase in requests for support to access abortions (*Critical Role of Abortion Funds Post-Roe*, 2024). Abortion funds supported a total of 102,855 abortion seekers in the year following the *Dobbs* decision. They disbursed a total of \$36,971,667 to those seeking abortions, which grew their funding budgets by 88%. Furthermore, they disbursed \$10,080,317 in practical support, including lodging and travel expenses, which represented an increase of 178% from the previous year. Abortion funds also reported a surge in donations post-*Dobbs*, which quickly fell off, but demand only increased. The amount of work these CANs can provide is significant, as it shows how many people are seeking abortions and need direct support for them. This does not capture those who can access abortion without needing help from a CAN, those who can afford to travel and pay for their appointments, or those who procure medication abortions clandestinely through Plan C or

other services, or those who access illegal abortions outside of the medical complex.

This is to say that CANs can have a profound impact on abortion provision and access in the U.S. because of the ability of civil society to organize itself and boost its messaging without acute fears of retaliation.

Although many of the CANs looked at in this study do not have lofty political aspirations, that is not to say that none do. Many pro-choice organizations, such as Planned Parenthood, Reproductive Freedom for All (formerly NARAL), and SisterSong, do have explicitly activist, advocacy, and political goals and are focused at the national and state levels. I do not argue that these play a direct role in increasing abortion access. However, they could affect abortion access in a variety of ways. It could encourage lawmakers to secure abortion rights, pass pro-abortion legislation, and increase awareness of abortion laws, which would lead to increased donations and abortion seekers to CANs. Even if these CANs do not directly engage in political advocacy, they do engage with educational advocacy that increases their orbit's political awareness and educates them on the rights and resources available to them.

Conclusion

I chose Appalachia as my sub-national case because of the history of governmental neglect, rich civil society, and the range of abortion laws by state. Appalachia, in many ways, is a unique area of the U.S. Still, I do not believe that Appalachia is unique regarding civil society and abortion provision within the U.S. Rather, I think that this case has shown how robust civil society is in providing abortions despite all odds. CANs in other parts of the country may be denser, have more resources,

and serve a larger number of people in smaller areas. But Appalachia is rural, abortion is illegal or heavily restricted nearly everywhere, and CANs serve a large swath of land. If abortions are being provided here and are facilitated by such dedicated organizations, then it is likely happening everywhere.

The CANs of Appalachia highlight how civil society can organize in a high-level institutionalization of civil society setting that faces a rapidly changing legal and access environment. The *Dobbs* decision was too recent to look at birth rate patterns in these states, but it is an avenue for future research. But through the CANs operating in Appalachia, we can accept that these networks operate through an organization of people who create various institutional links to provide abortions. This happens at both a formal and informal network level, guiding abortion seekers to the services that they desire. Further, through mission statements, origin stories, and interviews, we can conclude that these CANs work due to the determination of society to provide abortion services despite the legal context that they find themselves in. Even in this high-level of civil society case, there are still concerns about backlash and retaliation. CAN organizers go to tremendous lengths to aid abortion seekers. The Appalachia chapter helps us to understand how CANs work as well as how and why they were formed.

There are nearly 100 abortion funds registered with the NNAF (National Network of Abortion Funds, n.d.). NNAF connects abortion seekers and donors to abortion funds around the U.S. Through them, abortion seekers can access abortion funds in their state, as well as neighboring states, to access abortion. This is a national database of CANs that connects abortion seekers to the appropriate CANs. In a study of abortion funds from 2010-2015, it was found that abortion seekers depend on abortion funds to be able to

afford their abortions, and this is increased among younger, single, and abortion seekers of color (Ely et al., 2017). Further, a study of abortion fund service recipients in Florida found that those needing abortion fund services were primarily people of color, single, and already parents (Ely et al., 2020). These studies of abortion fund recipients are significant because they highlight that those who are most vulnerable to increased restrictions and tightening of the access environment are those who have less access to resources broadly. In the U.S. specifically, whether abortion is legal or illegal, it is expensive and requires people to obtain a significant amount of money in a short period. Abortion funds exist to supplement these needs, and they are a unique and essential element of the U.S. abortion environment.

Through this research on CANs in Appalachia, you can get a better picture of how CANs work in the U.S., particularly in the South and rural areas. Appalachia is a unique region of the country that has faced its share of hardships, both historically and in recent times. What exists in Appalachia, however, is a vibrant community of people who have created strong community networks to support themselves and each other. This can be seen through this research, as well as in the aftermath of Hurricane Helene. This also speaks to the CANs in the South. Each of these states lies in the South, which has had abortion access decimated. Virginia is the only state in the South that has not added further restrictions since the *Dobbs* decision. North Carolina has a 12-week ban, and Georgia, South Carolina, and Florida have six-week bans; every other state in the South has banned abortion. Although I have focused on Appalachia and abortion provision in Appalachia, it is essential to note that these states also lie in the South, which is experiencing an acute abortion access crisis. Examining this sub-region, however, offers

hope and provides clarity. Suppose people are accessing abortion in rural Appalachia, which the Census designates as one of the areas of the country with persistent poverty (Benson et al., 2023). In that case, there is hope that people anywhere in the U.S. can access abortion with help from CANs.

CHAPTER 6

THE POWER TO PROVIDE

This project began before I had applied for a PhD program. In 2018, I was working for the pro-choice non-profit Medical Students for Choice (MSFC) and knew I would be pursuing my PhD in the future. During that time, I was surprised by the dearth of political science literature on the power of civil society related to abortion. Through my work, I was aware of dozens of non-profits worldwide that were actively working on this issue and had significant influence. I had been working with Irish medical students during the Repeal the 8th movement, where Europe's strictest abortion ban was lifted and abortion became legal in Ireland for the first time. I knew from these medical students that abortion was being provided in Ireland, either clandestinely or through the Irish abortion journey to the UK. I also learned that, as threats in the U.S. were growing, abortion providers and medical students were preparing for a post-*Roe* reality. Many of the medical students were already experiencing that reality pre-2022, especially those located in the deep South, where access to abortion education, let alone abortions themselves, was increasingly limited. During this work, I realized the power of civil society, and specifically the power of these networks of people working to provide abortions no matter what. That is where this project is rooted, in my personal experience of working and being a tiny part of these networks.

However, when I began to formalize this project, I still did not anticipate seeing the fall of *Roe* happen as suddenly as it did. It was something I knew the pro-choice community had been preparing for at least 20 years; *Roe* was always seen as tenuous, and the erosion of abortion laws was a more acute threat. My Appalachia case looked very

different in the early stages of my dissertation research; West Virginia, Tennessee, and Kentucky all had legal abortions at that point. But the access environment in these states had already been significantly eroded. West Virginia only had one abortion clinic, Kentucky had one for years, and a second was added only for *Roe* to fall shortly after, and Tennessee had been experiencing an onslaught of abortion restrictions. Even then, North Carolina and Virginia were seen as the only states in that region that were not experiencing that level of attacks on the access environment.

Writing this in 2025 is a bit more complicated. Not only have we been living in a post-*Roe* world for three years, but the way that our politicians discuss abortion and birth has changed drastically. In JD Vance's first public address after being sworn in as Vice President, he declared, "I want more babies in the United States of America" (Eaton, 2025). This comes after years of Vance promoting pro-natalism; it has been a standard line from him over the campaign. In April 2025, the Trump administration heard proposals on how to boost American birth rates. One proposal would provide a \$5,000 "baby bonus" to every mother after delivery, while another suggested creating a medal for mothers of six or more children (Kitchener, 2025). JD Vance has also indicated that those who are childless should pay more taxes (Gomez Licon, 2024). These may seem familiar, considering Ceaușescu implemented each of these same policies to encourage the birth rate to grow. They did not work then, and they will not work now.

I argue that when abortion is restricted, banned, or the access environment becomes threatened, CANs are going to form to help people access abortion. People will access abortions no matter what; if someone does not wish to be pregnant, they will find a way to end their pregnancy. CANs are created based on a societal will; there is a critical

service that needs to be provided, and if the government is not offering it, then people will act to fill that role. The level of institutionalization of civil society then shapes these CANs. The formation, operation, and organization of the CAN are determined by the broader functioning of civil society in a country. Where the level of civil society institutionalization is low or absent, CANs will still form, but they will be informal whisper networks and operate on a hyperlocal scale. There will be a need to not only be covert but also shadowy if civil society is so constrained that it does not exist meaningfully in a state. Where civil society institutionalization is at a mid-level, these informal CANs will still operate and may provide access options, but formal CANs will also begin to emerge. These formal CANs may resemble non-profits, women's shelters, community groups, and other similar organizations. They may, or will not be focused on abortion, but they may be able to aid abortion seekers nevertheless. And, finally, in a place with a high level of institutionalization of civil society, we will see more formal CANs that are arranged explicitly on an issue like abortion and reproductive rights rather than hiding within more general groups. These formal CANs may even be messaging that they are helping people subvert the state by accessing abortion. Although these CANs have a wide range, their function is the same: to help abortion seekers access abortion in a nebulous or restrictive legal atmosphere or where access has been eroded. These CANs perform an essential function and are a consequence of restricting abortion access.

Studying CANs and abortion access is more critical now than it has been. Although the global pattern of the past 70 years has been to liberalize and legalize abortion, the growing concerns over birth rates could lead to further restrictions. In the

U.S., we are seeing pronatalist language rise as our abortion rights are being eroded state by state. In much of the West, as well as in East Asia, birth rates are declining and have fallen below replacement levels. Concerns about the future of social networks, economies, and sustainability could lead to an increase in pronatalist language and policies. In Romania, we saw this play out in a totalitarian regime where civil society was highly restricted. Abortions still happened there. If the same patterns were to be extended elsewhere, say in countries with high or mid-levels of civil society institutionalization, abortion would still be accessible. Still, it would rely entirely on civil society to facilitate. This issue is of more urgent concern now than perhaps ever. We could see a complete change in abortion policies happen if leaders think the only way to have more babies is to force women to bear them, rather than making having children more desirable.

Key Findings

This project has had many moving parts, but the core argument remains steadfast. Through a multi-method approach, I have shown the relationship that abortion laws have with the birth rates over time and how abortions have been provided in various legal settings. Through the qualitative cases we have looked at how CANs networks are created, grow, and reach out to abortion seekers and help them access abortion when it is difficult. Below are the hypotheses put forth in the Theory chapter:

H₁: Abortion restrictions do not have a lasting effect on the birth rate.

H₂: Abortion restrictions do not work well because of Covert Abortion Networks.

H3: Covert Abortion Networks work through an organization of people who create various levels of institutional links to provide abortion services in clandestine contexts.

H4: Covert Abortion Networks work because of the determination of society to provide abortion services despite the legal context that they find themselves in.

Statistics

To understand why abortion restrictions don't work as well as they are intended, we first need to establish that they don't work. Through a large-N analysis of abortion law data from 1960 to 2019, I was able to show that changes in abortion laws did not have a lasting effect on the birth rate. In a fixed effects regression analysis, in the short term, an abortion law did have a significant positive effect on the birth rate; however, that had been diminished in the long term. I argue that this happens because of the time it takes CANs to form and organize to mediate the abortion rate. This chapter also explored why birth rates change over time, other than abortion laws. This showed that variables associated with development, such as the percentage of women in the workforce, literacy, and suffrage, were more highly associated with driving changes in the birth rate. In this multivariate regression, the explanatory power of the abortion laws on the birth rate is around 10%. In contrast, models that include other independent variables, including contraceptive access, explain 81% of the variance in the birth rate data.

The statistics chapter is there to set up this puzzle, that abortion restrictions do not have a meaningful and lasting impact on the birth rate. After establishing that abortion restrictions do not work well, we are left to answer why they do not work well. When a

law is enacted, it is intended to work. If a new crime law is implemented, we expect to see a change in the crime rate. When that does not happen, we are left thinking that this policy is ineffective or failing. Abortion laws should do the same thing theoretically. If abortion is banned, then we should see increases in the birth rate, because all those pregnancies would then be held to term. When that pattern is not observed, we need to categorize it as ineffective and understand why the policy is inadequate. The statistics chapter gives us this takeaway: abortion restrictions do not have the desired effect on the birth rate, or if it does, it does not last past the short term. The qualitative chapters are designed to understand why this does not happen. The existence of CANs directly subverts the abortion restrictions by providing abortions despite the legal atmosphere.

Romania

Our first qualitative case study examines the relationship between CAN formation and abortion rates most directly, with minimal influence from our independent variable, the institutionalization of civil society. In communist Romania, there was little to no civil society; it was strictly controlled and eliminated by the regime. Theoretically, this means that we are setting our independent variable to zero, allowing us to examine more directly what society is capable of without a pre-existing infrastructure. Further, Decree 770 happened suddenly and without warning. As we saw in Appalachia and Turkey, these changes are gradual and occur over a period of many years. In Romania, abortion became illegal overnight after being the only form of family planning available. In 1967, the birth rate doubled from what it had been in 1966. Without the civil society infrastructure in place, there was nowhere for women with unwanted pregnancies to turn;

they had to bear them. However, after the first two years, the birth rate started to decline. Although data is sparse, what we can compile and glean from what is available is that people were accessing abortions in Romania through bribing doctors to perform them in hospitals, paying for illegal abortions outside of a hospital setting, and pursuing traditional abortion methods such as herbal remedies. To facilitate so many abortions in such large numbers that it had a significant effect on the birth rate, it meant that CANs had to organize them.

The fact that we have limited data on CANs in Romania does not imply that they did not exist, but it does suggest that they were indeed covert, shadowy, and informal. There are mentions of the regime breaking up abortion networks in the 1980s, but beyond that, not much is said about them (Kligman, 1998). Through the pattern in the birth rate, we can visualize that something was happening to drive down the birth rate. Through the case, what was found through interviews with doctors during that period, survey data done in the 1990s, and post-abortion complication maternal deaths, we can see that there was considerable provision of abortion despite the laws. With no other contraceptive methods that were available or legal in Romania, we can infer from the data that the decreases in the birth rate in the 1970s and 1980s were due to the provision of clandestine abortions. Further, this case informs us that even in the most restrictive settings where there is no infrastructure for civil society, people will still gather to provide abortions no matter what. This is the most significant finding of Romania, because it tells us that society will always find a way. Appalachia and Turkey inform us how civil society acts to shape CANs, but when civil society is set at a near-zero level, abortion provision still

happens, and CANs still form. However, it may take longer to create, remain confined to informal personal networks, and retain a shadowy nature.

Turkey

Turkey and Appalachia offer a glimpse into what happens to CANs when an existing civil society is present. Turkey, in particular, examines what happens when there is a mid-level of civil society institutionalization. Romania has established that CANs will form, regardless, but the CANs in Romania are significantly different from those found in Turkey. Turkey's civil society had to be rebuilt in the 1990s after it was disbanded in the 1980s. During the 1990s, a flourishing of civil society emerged, accompanied by a significant effort to develop this area of life, which also coincided with hopes of joining the European Union at the time. Many nonprofits were founded during this time, including those centered around gender and feminist causes, which continue to exist today. Turkey also has numerous formal CSOs that are registered with the government and hold some level of status. However, in recent years, there have been more crackdowns on civil society, including on organizations that relate to Kurdish issues as well as LGBTQ+.

What I found in Turkey was that there were no formal organizations that worked solely on abortion access or rights. Instead, there are major organizations that incorporate those issues as part of a general gender issue. Further, Turkey had restricted a significant abortion NGO from operating or even advertising in the country, Women on Web. Through interviews with CANs operating in Turkey, as well as various conversations I had during the time, I found that there is misinformation around abortion in Turkey that

has become prevalent. Abortion is legal in Turkey, up to 10 weeks, but it is becoming increasingly difficult to access at public hospitals. Public hospitals will even tell patients that abortion is not legal when asked (O’Neil, 2017; O’Neil et al., 2020). Further, the language that the current government has used around abortion has made their intent to threaten the legality of abortion in the country. These threats have manifested themselves in the lack of access at public hospitals, but abortions are still offered at private hospitals, and they cost significantly more.

This access crisis and the tenuousness of the abortion laws in Turkey have led to civil society needing to organize to supplement and help guide people to abortions. When there is a level of misinformation about the legality and accessibility of abortion, it creates uncertainty and fear in people who need to access abortion but do not know what is legal and what is not. When people face uncertainty, they often turn to those they believe can assist. In many cases, this involves reaching out to a friend or acquaintance whom they think may have the answers. Other times, especially in a more acute crisis, you may reach out to a shelter that helps women experiencing violence. This is what I found during my field work in Turkey: there is a mixture of formal and informal CANs working to help facilitate legal abortions. In the informal CANs, people may know that abortion is legal, but need help going somewhere that can be trusted. My interview with an informal CAN in Turkey highlighted this point, that during this time of anxiety for an abortion seeker, they want some level of comfort, and that often comes in the form of a referral to a doctor that their friend says they can trust. Formal CANs in Turkey that I interviewed also mentioned that they would help refer abortion seekers to hospitals or doctors they know provide abortions. Three of the formal CANs I interviewed in Turkey

have also teamed up to create a website that helps Turkish women know their rights around abortion and to access abortion legally.

What can be understood in Turkey through this work is that the institutionalization of civil society did shape CANs. The CANs that existed in Romania persist in Turkey, particularly in areas where there is more stigma around abortion, such as more religious or rural areas. Informal CANs also exist to help provide comfort to abortion seekers and to help them find reliable and trustworthy medical care. Unlike Romania, there are formal CANs in Turkey that could not exist in Romania. These formal CANs do not solely work on abortion; they have much larger missions around gender, but they often find that they deal with people seeking abortion. Turkey is a curious case where abortion is legal, but increasingly challenging to access, coupled with rampant misinformation. The role of CANs in Turkey is to help people find legal abortion access and to navigate a changing and purposefully confusing abortion environment. The level of institutionalization of civil society in Turkey has shaped CANs to grow in response to an access crisis, and these organizations exhibit variations in reach, ranging from nationwide to hyperlocal, with growth occurring as the access environment becomes increasingly threatened. This case study provides an essential component to the dissertation. The mix of CANs in this mid-level case is not so much a blend of the high and low cases, but rather a mosaic. It preserves much of the informal CANs that were established in Romania out of necessity. Still, there is also an infrastructure in civil society to support these larger CSOs and formal CANs, which we also observe at high levels.

Appalachia

I chose Appalachia because I felt I had to select a U.S. case, especially after *Roe* fell, but I wanted to explore a sub-national region that was not strictly the South. Growing up in the South and having a strong connection to Appalachia, it was necessary to shine a light on the strength and power of the communities in that region, both in terms of fulfilling a goal within this project and as a personal duty. The U.S. provides a rich tapestry of understanding the effects of abortion laws on populations because each state is allowed to have so much control over its laws, which was only increased with the *Dobbs* decision. In these five states I chose to highlight, the disparities in abortion laws and access provide a unique climate for abortion provision. Furthermore, the U.S. has a highly institutionalized civil society. There are an estimated 1.8 million non-profits that operate in the U.S., and hundreds (if not thousands) of them focus on abortion, reproductive rights, and reproductive health. When *Dobbs* fell, or when states enacted restrictions, these organizations were prepared to handle the outcomes. This is because the civil society setting in the U.S. allowed for there to be an infrastructure around abortion provision, access, funding, education, etc., that is not found in the other cases.

The Appalachia case looks at a region of the country that is not only underserved in terms of abortion, but also in terms of health care in general. The area has significant variations in abortion laws, and clinics are available in only two of the five states of interest. Additionally, the proliferation of formal CANs in Appalachia enables a more in-depth examination of how they form and function, which the Romania and Turkey cases cannot provide. Through an analysis of the formal CANs in the region, we can see that all but one of them were founded before the *Dobbs* decision, when abortion was banned in

three of these states. The high level of institutionalization of civil society allowed for abortion specific formal CSOs to be formed when threats to access were occurring, and they then acted to supplement abortion access in the region through their operations. The formal CANs in Appalachia also provide another deviation from the low and mid-levels we've looked at, because it is not as covert or shrouded as those. These CANs proudly say that they help people access abortions in a clandestine setting by assisting people to afford to travel to obtain legal abortions in neighboring states. Further, there are also organizations such as Plan C that say they provide medication abortion via the mail, even if it is illegal. However, it must also be noted that these CANs are threatened by state and federal laws, which have put them under pressure and scrutiny for their work. However, they have also consistently and persistently stated that they will continue this work, regardless of the legal challenges they face or the pushback they receive.

Takeaways

What we can learn from this project is that abortions will be provided no matter what. That does not mean that some people will be unable to access it; they will, especially those groups that are most marginalized, primarily low-income individuals. But, there is a powerful force in society, in every society, that helps people to access abortions no matter what. Even in one of the most totalizing dictatorships in modern history, with a massive secret police force, in rural Appalachia, there will be seen and unseen forces that help people obtain abortions. The power of these networks lies in their ability to be visible or remain hidden, yet their work will persist, and those who need them can find them.

This is an ambitious project that puts together a novel case comparison on an uncommon topic in political science. When comparing these cases together, we can gain a clear understanding of how civil society influences the CANs that emerge from it. It constrains their growth and operations by revealing what can and cannot happen within the context. In each case, we saw informal CANs operate; this is the baseline of what happens when abortion is restricted or illegal. In Romania, this was the only type of CAN that could exist. In Turkey, this is perhaps the most prevalent, but there are other forces. And in Appalachia, informal CANs persist to provide abortions for those who do not wish to obtain a surgical abortion in a clinic, or to have their abortion within the medical-industrial complex. The informal CANs remain relatively unchanged; they are based on word-of-mouth and involve chains of acquaintances and communication linkages. The formal CANs are what change most in the cases. Romania has no formal CANs; they could not and did not exist because of the absence of civil society under Ceaușescu. In Turkey, they do exist, but they do not exist with abortion access as their sole purpose; they exist under umbrella organizations that do broader work around gender and feminist issues. In Appalachia, many formal CANs provide access to abortion at the regional and state levels, not to mention the many large national organizations that work in the region, too.

The institutionalization of civil society constrains and dictates what shape the formal CANs can or cannot take. What we can take away from this project is that abortion restrictions do not work as well as they are intended. This is common wisdom in the pro-choice community, which is substantiated. Further, this analysis of CANs that work to provide abortions in tenuous or clandestine settings establishes that the reason

the restrictions do not work is because of the will and organizing work that civil society does. The people working on abortion access around the world have a tangible and real effect, not only in the lives of the individuals they help, but in a significant and global pattern. Their work may seem localized and or insular, but they are part of a broader community of people working on this topic, and that is highly significant.

Contributions

This project significantly contributes to the literature on civil society, abortion, and our understanding of the relationship between civil society and good governance. This is a generalizable project, applicable not only to other cases but also to other topics. I believe this framework proposed could be used to understand any illicit good or service that society deems necessary, such as drugs, medications, education, or even cultural artefacts in highly restrictive contexts. This argument broadly discusses the power of civil society to provide services to a culture that demands them, as well as the restrictions that limit this ability. It is a far-reaching story about the power of people and how, at the smallest individual and local levels, people are working to change other people's lives. And there are so many people doing that around the world that it has significant patterns at the regional and country level analyses.

This also significantly contributes to the abortion literature and its importance in political science. So much of the discussion around abortion is specific to the U.S. or, in terms of political conversations, language, and morality. Rather, I treat abortion as an essential service; I do not wish to engage in discussions of morality or politics. Instead, here, abortion is inevitable. And treating it as such allows for an analysis and

understanding of policy efficacy that is not engaged with elsewhere. The comparative nature of this project enables us to zoom out and examine patterns among civil society related to abortion, understanding that the way civil society organizes to subvert the state in various contexts has solid through lines. Understanding how civil society relates to an issue like abortion when it is being restricted in some way by the state also has policy implications. CSOs and CANs that are already doing this work know that they are helping people and that there are many people in need. But this project allows them to point to something and say that there are small informal CANs around the world that, over time, have been doing the same work they've been doing. It provides power and knowledge that their work is connected to something much bigger, and that people around the world have them to thank for their work.

Limitations and Future Research

This project was ambitious, and at times too much so because I was not able to gather the amount of data that I wanted to, especially in Turkey. There are constraints when it comes to time in the field, language, working with a historical case, and certain data not existing due to authoritarian regimes, as well as the vast scale on which I was working. Although this project has limitations with the data, it provides avenues for future research, for myself and others. In Turkey, particularly, doing a more ethnographic approach to the research would have been more conducive to valuable and usable data, as well as spending a longer time in the field. Some issues were that I did not have access to the number of informal CANs I wanted because I was not sufficiently ingrained in the local community, but I had exhausted my formal CAN snowball sampling.

With the *Dobbs* decision being so recent, there will be an abundance of research on abortion provision in the U.S. From working papers and early reports, it appears that much of this is centered on public health rather than political science. I think using this framework that centers civil society concerning policies can further our understanding of how abortion access looks in the U.S. through abortion funds, mutual aid networks, advocacy organizations, etc. The amount of CSOs around abortion is unique to the U.S. because abortion access is so varied in the U.S., and the procedure is also expensive. Doing this type of analysis through the National Network of Abortion Funds (NNAF), coupled with interviews of abortion seekers, or even a longitudinal approach of checking in with abortion seekers who used abortion funds over time, would all produce rich research and data that could help people significantly in the future.

Final Reflection

Throughout this project, I have aimed to highlight the efforts of members of CANs within communities, as well as the universality of their work. These hyperlocal networks and associations of people working to help their community members exist around the world and over time, enabling individuals to make informed decisions about their bodies when the state restricts those choices. Their work is essential; it is vital to the health of communities and people's lives to be able to have autonomy, no matter how hard the government tries to strip it away from you. This project has demonstrated that individuals working in small communities are part of a larger-scale operation, whether they are aware of it or not. There is a network of people around the world who perform

this work in secret, and others who can do it openly, but they are all creating a durable association that provides an essential service to the public.

The CANs that we have explored in this project, as well as those that exist elsewhere, aim to impact people's daily lives positively. Their missions are not just to help people access abortions, but to provide quality care, to support people emotionally and financially during a trying time in their lives, and to validate their decisions. CANs not only provide logistical help, but also offer a sense of comfort that you are not alone and that other people have undergone this same journey and were okay. CANs act as a guide on a journey where you're not sure how to get there, but you know where you want to go; they help guide you over the rocky terrain and let you go when you've reached your destination. This is not to over sentimentalize this project, or the work that CANs do, but to stress the reality of people with an unwanted pregnancy face when they have no idea what to do next, and how essential it is that they have somewhere to turn.

We can learn a valuable lesson from CANs about the importance of community, connectivity, and trust. Both online and in-person communities are vital for sharing collective knowledge. Through our interactions with one another, we can build trust and instill a sense of belonging and importance, recognizing that we are important and valuable. CANs foster those sentiments through their work, that although the state has discounted, devalued, and dehumanized your decisions, the people surrounding you see your choices as valid and trust your decision-making. What we can gain from CANs is an acknowledgement of the force of the societal will, that as individuals we are collectively powerful if we come together. This work is essential, not only for CANs but also for researchers to continue collaborating with these groups to study and understand

the vast impacts they have on communities, as well as to help identify areas of need that civil society can address. As a researcher, I strive to conduct work that makes a meaningful difference in my community, and I aim to aid as many people as possible through my research. That is the power of good scholarship, that it extends beyond the ivory tower and makes a consequential change in the way that we live.

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APPENDIX A

ABORTION PANEL DATASET CODEBOOK

country: name of independent state

year: year of observation

Abortion Law Variables (Fernández & Juif, 2023; Finlay et al., 2012):

The following variables are taken from Fernández & Juif, 2023 and Finlay et al..
Finlay et al. is the original dataset with abortion laws from 1960-2012, Fernández
& Juif provide abortion law data coded in the same way from 2013-2019.

Binary: 0 Illegal, 1 Legal.

ablife: abortion to save the life of the mother

abhealth: abortion to preserve the physical health of the mother

abrape: abortion in the case of rape or incest

abfetal: fetal impariment

abecon: socioeconomic reasons

abrequest: available upon request

Sum of Laws:

abindex: sum of abortion laws (0-6)

Re-coding as Restrictions: Recoded the variables as restrictions (flipping the
binary) to show a movement to abortion becoming illegal.

Binary: 0 Legal, 1 Illegal

abrestlife: abortion to save the life of the mother

abresthealth: abortion to preserve the physical health of the mother

abrestrape: abortion in the case of rape or incest

abrestfetal: fetal impariment

abrestecon: socioeconomic reasons

abrestrequest: available upon request

Demographic Variables (World Bank, 2025).

All of the following variables were taken from the World Bank in 2025.

cbr: Crude Birth Rate (births per 1,000 people)

tfr: total fertility rate

indep: year of independence (Finlay)

gdp: GDP per Capita

lifeex: Life Expectancy at Birth

gni: Gross National Income per Capita

exed: Government Expenditure in Education, percentage of GDP

labwom: Percentage of Women Working

agland: Agricultural land (% of land area)

gdpgrow: GDP growth, annual %

goveff: Government Effectiveness Estimate

lirate: Liferacy rate, adult total (% of people ages 15 and above)

noed: Percentage of population with no Education

slum: Population living in slums (% of urban population)

pop: Population Total

urbpop: urban population (% of total population)

conprev: Contraception Prevalence

matmor: Maternal Mortality Ratio

infmor: Infant Mortality Ratio

Contraception (Finlay et al., 2012):

The following data is from Finlay et al. and range from 1960-2012. Unlike the abortion law data, Fernández & Juif did not elaborate in their dataset on these datasets which is why this data ends in 2012.

IUD: IUD legality

0: Illegal

1: legal

IUDdoc: IUD Doctor Install

0: Illegal

1: Doctor only inserts

2: Doctor or other inserts

ster: Sterilization

0: illegal

1: permitted for therapeutic purposes

2: legal status unclear

3: permitted for contraceptive purposes

pillpurp: pill sale pupose

0: Illegal

1: Non-contraceptive

2: contraceptive

pillsale: pill sale location

0: illegal

1: Pharmacy

2: Shop

pillpresc: pill prescription

0: illegal

1: Prescription Required

2: Prescription not required

Democracy and Civil Society Measures (Coppedge et al., 2025):

All of the democracy and civil society measures were drawn from the 2025 V-Dem dataset. Information on each variable is taken from the V-Dem codebook.

poly: v2x_polyarchy Electoral Democracy Index Ordinal:

“*Question*: To what extent is the ideal of electoral democracy in its fullest sense achieved?” (Coppedge et al., 2025).

libdem: v2x_libdem: Liberal Democracy Index

“*Question*: To what extent is the ideal of liberal democracy achieved?”

Clarification: The liberal principle of democracy emphasizes the importance of protecting individual and minority rights against the tyranny of the state and the tyranny of the majority. The liberal model takes a

"negative" view of political power insofar as it judges the quality of democracy by the limits placed on government. This is achieved by constitutionally protected civil liberties, strong rule of law, an independent judiciary, and effective checks and balances that, together, limit the exercise of executive power. To make this a measure of liberal democracy, the index also takes the level of electoral democracy into account.

Scale: Interval, from low to high (0-1)" (Coppedge et al., 2025).

freeex: v2x_freexp_altinf: Freedom of Expression and Alternative Sources of Information Index

Question: To what extent does government respect press and media freedom, the freedom of ordinary people to discuss political matters at home and in the public sphere, as well as the freedom of academic and cultural expression?

Clarification: This index includes all variables in the two indices v2x_freexp and v2xme_altinf.

Scale: Interval, from low to high (0-1)" (Coppedge et al., 2025).

suffr: v2x_suffr: Share of population with suffrage

Question: What share of adult citizens as defined by statute has the legal right to vote in national elections?

Clarification: This question does not take into consideration restrictions based on age, residence, having been convicted for crime, or being legally incompetent. It covers legal *de jure* restrictions, not restrictions that may be operative in practice *de facto*. The adult population as defined by

statute is defined by citizens in the case of independent countries or the people living in the territorial entity in the case of colonies. Universal suffrage is coded as 100%. Universal male suffrage only is coded as 50%. Years before electoral provisions are introduced are scored 0%. The scores do not reflect whether an electoral regime was interrupted or not. Only if new constitutions, electoral laws, or the like explicitly introduce new regulations of suffrage, the scores were adjusted accordingly if the changes suggested doing so. If qualifying criteria other than gender apply such as property, tax payments, income, literacy, region, race, ethnicity, religion, and/or 'economic independence', estimates have been calculated by combining information on the restrictions with different kinds of statistical information on population size, age distribution, wealth distribution, literacy rates, size of ethnic groups, etc., secondary country-specific sources, and — in the case of very poor information — the conditions in similar countries or colonies. The scores reflect *de jure* provisions of suffrage extension in percentage of the adult population. If the suffrage law is revised in a way that affects the extension, the scores reflect this change as of the calendar year the law was enacted.

Responses: Percent.

Scale: Interval, from low to high (0-1)" (Coppedge et al., 2025).

cspart: v2x_cspart: Civil Society Participation Index

Question: Are major CSOs routinely consulted by policymakers; how large is the involvement of people in CSOs; are women prevented from

participating; and is legislative candidate nomination within party organization highly decentralized or made through party primaries?

Clarification: The sphere of civil society lies in the public space between the private sphere and the state. Here, citizens organize in groups to pursue their collective interests and ideals. We call these groups civil society organizations CSOs. CSOs include, but are by no means limited to, interest groups, labor unions, spiritual organizations if they are engaged in civic or political activities, social movements, professional associations, charities, and other non-governmental organizations. The core civil society index CCSI is designed to provide a measure of a robust civil society, understood as one that enjoys autonomy from the state and in which citizens freely and actively pursue their political and civic goals, however conceived.

Scale: Interval, from low to high (0-1)” (Coppedge et al., 2025).

Additional Variables, (Fernández & Juif, 2023):

All of the following variables were taken from the Fernández & Juif 2023 dataset.

Additional sources where Fernández & Juif sourced data are cited beside each individual variable below.

medage: Median Age of Population

yrwomed: Average years of women’s education.

Average years of education of women 15+ (K.C. et al., 2024).

doccap: Physicians per capita.

Rate of physicians per 1,000 individuals. Data are from World Bank (2020) and Banks et al. (2020).

contprev: Contraceptive prevalence

Median estimate of the percentage of married women 15-49 that use modern contraceptive methods. We select the value of married women because it produces the smallest number of missing values. Data are from United Nations (2020).

womcivlib: Women's civil liberty

The index is formed by taking the point estimates from a Bayesian factor analysis model of the indicators for freedom of domestic movement for women (v2cldmovew), freedom from forced labor for women (v2clslavef), property rights for women (v2clprptyw), and access to justice for women (v2clacjstw) (Coppedge, 2021).

neighab: *Mean value in abortion policy index 2 in neighboring countries.*

“Average value in *abortion policy index*... in neighboring countries in that year.

Neighboring countries are defined as separated by land or river border or less than 400 miles of water. The contiguity dataset is from Stinnett et al. (2017).”

catholic: percentage of catholics. (Maoz & Henderson, 2013)

muslim: percentage of muslims. (Maoz & Henderson, 2013)

APPENDIX B

DO CODE FOR ABORTION PANEL DATA ANALYSIS

```
***Importing data and variable naming

rename CrudeBirthRatebirthsper10 cbr

rename totalfertilityrate tfr

rename GDPperCap gdp

rename LifeExatBirth lifeex

rename GNIPerCapita gni

label define gni 1 "Low" 2 "Lower Middle" 3 "Upper Middle" 4 "High"

label values gni1 gni

rename GovtExinEd exed

rename LaborWom labwom

rename Agriculturallandoflandare agland

rename GDPgrowthannual gdpgrow

rename GovernmentEffectivenessEstima goveff

rename Literacyrateadulttotalof litrate

rename PercentageofpopulationwithNo noed

rename Populationlivinginlumsof slum

rename Populationtotal pop

rename Urbanpopulationoftotalpop urbpop

rename ContraceptionPrevalence conprev

rename MaternalMortalityRatio matmor

rename InfantMortalityRatio infmor
```

```
rename PillSalePurpose pillpurp
rename PillSaleLocation pillsale
rename PillPrescription pillpresc
rename IUDlegal IUD
rename IUDInsertion IUDdoc
rename SterilizationLegal ster
rename v2x_polyarchy poly
rename v2x_libdem libdem
rename v2x_freexp_altinf freeex
rename v2x_suffr suffr
rename v2x_cspart cspart
rename medianage medage
rename avgyearofedwom yrwomed
rename physicianspercapita doccap
rename contraceptive contprev
rename womencivilliberty womcivlib
rename neighbor_aboindex2 neighab
label define legal 0 "illegal" 1 "legal"
label values ablife legal
label values abhealth legal
label values abrape abfetal abecon abrequest legal
describe pillpurp
list pillpurp
```

```

encode pillpurp, generate(pillpurp1)

label define pillpurp1 0 "Illegal" 1 "Non-Contraceptive" 2 "Contraceptive", replace

label define pillsale 0 "illegal" 1 "pharmacy" 2 "shop"

label values pillsale pillsale

label define pillpresc 0 "Illegal" 1 "Prescription Required" 2 "Prescription Not Required"

label values pillpresc pillpresc

label values IUD legal

label define IUDdoc 0 "Illegal" 1 "Doctor Inserts" 2 "Doctor or Other Inserts"

label values IUDdoc IUDdoc

label define ster 0 "Illegal" 1 "Permitted for Therapeutic Purposes" 2 "Legal Status
Unclear" 3 "Permitted for Contraceptive Purposes"

label values ster ster

****panel data

encode country gen(country1)

xtset country1 year

**lag abortion data 1 year

gen lagabindex1 = L.abindex

gen lagablif = L.ablife

gen lagabhealth = L.abhealth

gen lagabrape = L.abrape

gen lagabfetal = L.abfetal

```

```
gen lagabecon = L.abecon
```

```
gen lagabrequest = L.abrequest
```

```
**Summary Statistics
```

```
summarize country1 year ablife abhealth abrape abfetal abecon abrequest abindex tfr  
indep gdp lifeex gni gni1 exed labwom agland gdpgrow goveff litrate noed slum pop  
urbpop conprev matmor infmor pillpurp pillsale pillpresc IUD IUDdoc ster poly libdem  
freeex suffr cspart medage yrwomed doccap contprev womcivlib neighab catholic  
muslim
```

```
estpost summarize country1 year ablife abhealth abrape abfetal abecon abrequest  
abindex tfr indep gdp lifeex gni gni1 exed labwom agland gdpgrow goveff litrate noed  
slum pop urbpob conprev matmor infmor pillpurp pillsale pillpresc IUD IUDdoc ster  
poly libdem freeex suffr cspart medage yrwomed doccap contprev womcivlib neighab  
catholic muslim, detail
```

```
esttab using summary_stats1.rtf, cells("mean median sd min max count")
```

```
**hausman test
```

```
xtreg cbr lagabrequest pillpurp1 IUD contprev libdem suffr yrwomed gdp gdpgrow gni1  
poly freeex urbpob catholic muslim,fe
```

```
estimates store fe_model
```

```
xtreg cbr lagabrequest pillpurp1 IUD contprev libdem suffr yrwomed gdp gdpgrow gni1  
poly freeex urbpob catholic muslim, re
```

estimates store re_model

hausman fe_model re_model, sigmamore

****lagging abindex**

gen lagabindex1 = L.abindex

gen lagabindex2 = L2.abindex

gen lagabindex3 = L3.abindex

gen lagabindex4 = L4.abindex

gen lagabindex5 = L5.abindex

******ABORTION RESTRICTIONS**

*******lagging abrest variables**

gen lagabrestlife1 = L.abrestlife

gen lagabresthealth1 = L.abresthealth

gen lagabrestrape1 = L.abrestrape

gen lagabrestfetal1 = L.abrestfetal

gen lagabrestecon1 = L.abrestecon

gen lagabrestrequest1 = L.abrestrequest

gen lagabrestindex1 = L.abrestindex

gen lagabrestindex2 = L2.abrestindex

gen lagabrestindex3 = L3.abrestindex

gen lagabrestindex4 = L4.abrestindex

```
gen lagabrestindex5 = L5.abrestindex
```

```
gen lagabrestrequest2= L2.abrestrequest
```

```
gen lagabrestrequest3 = L3.abrestrequest
```

```
gen lagabrestrequest4 = L4.abrestrequest
```

```
gen lagabrestrequest5 = L5.abrestrequest
```

```
***Boxplot
```

```
graph box cbr, over(lagabrestrequest1) title("Crude Birth Rate by Abortion Upon Request  
Legal Status")
```

```
graph box cbr, over(lagabrestindex1) title("Crude Birth Rate by Abortion Restriction  
Index")
```

```
*** Create GDP log
```

```
gen gdplog = ln(gdp)
```

```
***CBR Graphs
```

```
xtline cbr if inlist(country, "Romania", "United States", "Turkey"), overlay
```

```
title("Crude Birth Rate: Romania, United States, and Turkey")
```

```
ylabel(, angle(horizontal)) legend(order(1 "Romania" 2 "United States" 3 "Turkey"))
```

```
**** to cluster a regression, rerun with fixed effects and cluster the standard error by  
country
```

```
,fe vce(cluster country)
```

```
**Create short term and log term lagged effects abrestrequest
```

```
gen short_term_abrest = (lagabrestrequest1 + lagabrestrequest2 + lagabrestrequest3)/3
```

```
gen long_term_abrest = (lagabrestrequest4 + lagabrestrequest5)/2
```

```
**regression with short and long term abrequest
```

```
xtreg cbr short_term_abrest long_term_abrest, fe vce(cluster country1)
```

```
***Create short term and long term lagged effects abrestindex
```

```
gen short_term_abrestindex = (lagabrestindex1 + lagabrestindex2 + lagabrestindex3)/3
```

```
gen long_term_abrestindex = (lagabrestindex4 + lagabrestindex5)/2
```

```
**regression with short and long term abrestindex
```

```
xtreg cbr short_term_abrestindex long_term_abrestindex, fe vce(cluster country1)
```

```
**Big Model with clustering standard error and fixed effects
```

```
xtreg cbr lagabrestlife1 lagabresthealth1 lagabrestrape1 lagabrestfetal1 lagabrestecon1
```

```
lagabrestrequest1 , fe vce(cluster country)
```

```
estimates store model1
```

```
xtreg cbr contprev pillpurp1 pillsale pillpresc IUD IUDdoc ster, fe vce(cluster country)
```

```
estimates store model2
```

```
xtreg cbr lagabrestrequest1 pillpurp1 contprev gdplog exed yrwomed womcivlib, fe  
vce(cluster country)
```

```
estimates store model3
```

```
xtreg cbr lagabrestrequest1 pillpurp1 contprev gdplog exed yrwomed womcivlib suffr  
cspart infmor urbpop , fe vce(cluster country)
```

```
estimates store model4
```

```
xtreg cbr pillpurp1 contprev gdplog exed yrwomed womcivlib suffr cspart infmor urbpop  
, fe vce(cluster country)
```

```
estimates store model5
```

```
xtreg cbr lagabrestrequest1 contprev pillpurp1 pillsale pillpresc IUD IUDDoc ster gdplog  
exed yrwomed womcivlib suffr cspart infmor urbpop, fe vce(cluster country)
```

```
estimates store model6
```

```
esttab model1 model2 model3 model4 model5 model6 using resultstable8.doc, stats(r2 N
```

```
F)
```

APPENDIX C

HAUSMAN TEST RESULTS

Table 1
Hausman Test Comparing Fixed and Random Effects Models

Predictor	Fixed Effects (b)	Random Effects (B)	Difference (b – B)	SE of Difference
Abortion Restriction	-1.864268	-2.367386	0.5031186	0.2934442
Request Lag1				
Pill Purpose	-0.8258035	-0.3531447	-0.4726588	0.2823563
IUD	1.415355	0.903324	0.5120257	0.5214847
Contraceptive Prevalence	-0.114465	-0.1435341	0.0290876	0.0170834
Liberal Democracy	-2.527738	-2.436049	-0.0916882	1.426314
Suffrage	-1.870509	-2.6937549	0.8232459	0.7020902
Average Years of Women's Education	-2.57344	-2.440588	-0.1328519	0.2527406
GDP	0.0000855	0.0000731	0.0000123	0.0000108
GDP Growth	0.0202931	0.0174975	0.0027956	0.0030104
GNI	0.237356	0.0494978	0.1878378	0.0997491
Polyarchy	2.028681	1.301332	0.727349	1.133139
Freedom of Expression	-0.3196174	-0.2097027	-0.1099147	0.3693188
Urban Population	-0.1746043	-0.1035949	-0.0710095	0.0360432
Catholic	4.007435	1.949313	2.058122	1.935339
Muslim	5.332524	0.2921218	5.040403	3.100036

Note. *b* = consistent under both null and alternative hypotheses; obtained from xtreg.
B = inconsistent under the alternative, efficient under the null; obtained from xtreg.
 Hausman test of systematic difference in coefficients:
 $\chi^2(14) = 42.75, p = .0001$

APPENDIX D

SUMMARY STATISTICS OF ABORTION PANEL VARIABLES

Table 2

Summary Statistics of Abortion Panel Variables

Variable	Mean	Standard Deviation	Minimum	Maximum	Count
country	95.5	54.84992	1	190	11400
year	1989.5	17.31886	1960	2019	11400
Ablife	.8459842	.3609805	0	1	10882
abhealth	.5714942	.4948849	0	1	10882
abrape	.3914722	.488102	0	1	10882
abfetal	.378515	.4850392	0	1	10882
abecon	.2956258	.4563445	0	1	10882
abrequest	.2213747	.4151913	0	1	10882
abindex	2.695796	2.189216	0	6	10917
tfr	4.055544	2.028851	.914	8.864	10983
indep	1946.024	48.21358	1776	2011	11201
gdp	7419.112	16078.27	11.80132	204263.8	9673
lifeex	63.46706	11.44458	11.995	84.35634	11046
gni1	2.396701	1.114392	1	4	6002
exed	4.354774	2.17915	0	66.90031	4448
labwom	40.3597	9.725696	7.685902	54.95178	5250
agland	38.59345	21.93768	.2628205	93.44075	10970
gdpgrow	3.810599	6.140128	-64.04711	149.973	8719
goveff	-.0677896	.9961166	-2.450314	2.426029	3846
litrte	80.0746	21.34699	5.40465	99.99995	910
noed	.1311786	.1895126	0	.7502332	151
slum	45.28803	25.27056	.001	98.9	606
pop	2.16e+07	7.43e+07	5321	1.37e+09	11337
urbpop	48.66423	24.76211	2.077	100	11340

Table 2
(continued)

Variable	Mean	Standard Deviation	Minimum	Maximum	Count
conprev	46.04457	22.85243	.8	87.7	1169
matmor	67.68238	168.9621	0	2241	2673
infmor	51.13533	45.48784	1.5	272	10342
pillpurp	0
pillsale	1.105937	.4248801	0	2	7344
pillpresc	1.23543	.5155806	0	2	7344
IUD	.7645867	.4242855	0	1	7404
IUDdoc	1.130917	.7647086	0	2	7394
ster	2.217723	.6863145	0	3	7730
poly	.4147924	.2862396	.007	.923	9428
libdem	.3234028	.2742762	.005	.897	9336
freeex	.5337129	.3338842	.01	.989	9452
suffr	.9318646	.2321527	0	1	9452
cspart	.5232101	.2985438	.013	.988	9452
medage	23.50214	7.994519	13.113	54.282	8158
yrwomed	6.81117	3.240024	.2	13.304	7484
doccap	119.5674	128.9272	.4	841.99	7803
contprev	33.45289	22.4719	0	79.3	7589
womcivlib	.6048	.2706669	0	.981	7481
neighab	3.350376	1.846827	0	7	5647
catholic	.3044931	.3443952	0	.9802	1408
muslim	.2495517	.364903	0	1	1408
<i>N</i>	11400				

APPENDIX E

INTERVIEW MATERIALS: TURKEY

Interview Questions, Turkey Organizations.

You are being interviewed to represent an organization. Any quotations and references to this interview will remark that “X organization said Y”, your name will not be attached to the interview. If for some reason you do not wish to give the name of your organization, you will be referred to as “CAN X”. You may refuse to answer questions and we can carry on or stop the interview at any time. You may also say that your answer to a certain question should remain anonymous, that answer will go under a separate interview and be referred to as “CAN X”.

What is the organization that you are representing in this interview?

Discuss your organization’s **inception**.

- Where is your organization based?
- How did your organization begin?
- Was there an impetus for its creation?
- What were the original organizational goals/mission?
 - Have they changed in recent years? If so, why?
- Does your organization deal directly with abortion seekers?
 - If so, how does that work? What are the steps they go through? What do you believe are the steps it takes for them to access your organization?

Non-Turkish Based:

- When did your organization introduce itself in Turkey? Why?

Discuss your organization's **growth**.

- How has your organization responded to changes in abortion laws and abortion rhetoric in Turkey?
- Have there been any organizational structural changes as a result? Examples, new positions, changes in job descriptions, additional hiring, focus on tactics/messaging, etc.
- Can you explain your organization's pattern of growth in Turkey?
 - Increased/decreased abortion seekers
 - Increased/decreased funding
 - Changes in government and political attitudes toward abortion and organizations
- Does your organization have goals around growth in Turkey? Ex. Creating an online presence, recruiting participants/funders, growing partnerships with other organizations, etc.
- Have you seen growth or decline regarding abortion seekers in Turkey?

Discuss your organizations **reach**.

- How large is your organization's reach? Participants, countries, etc.
- What is your organization's reach, in Turkey?
- What are the goals of your organization's reach? General and specific to Turkey.
- Using estimations, how many abortions do you think your organization aids in annually? Both general and specific to Turkey.

- Where do you believe most abortion seekers using your organization as a resource come from (in Turkey)?

- Ex. Organically found on the internet, referred from friends, etc.

Discuss your organization's **political aspirations**

- Does your organization participate in political advocacy? Ex. Lobbying governments, organizing for/against candidates/parties/issues.
- If so, what are your organization's goals?
- Does your organization have specific goals in Turkey?

Discuss your organization's perception of **civil society**.

- What does your organization believe Turkey's attitudes towards civil society are? On a scale of Extremely Restrictive to Extremely Liberal?
- Do you believe Turkey's attitudes towards civil society affect organizational freedom?
 - How does this change your organizational goals and actions?
 - Example: the ability for organizations to form and act on their mission statement without fear of repression?
- Does your organization believe that Turkey's attitudes towards civil society play a role in abortion access?
- Does your organization believe that there are clandestine or illegal abortions happening in Turkey?
 - If so, why do you think people access clandestine abortions?
 - How do you think people get them?
 - Are there any closing thoughts or statements you would like to share?

APPENDIX F

INTERVIEW MATERIALS: APPALACHIA

Organizational Questions

You are being interviewed to represent an organization. Any quotations and references to this interview will remark that “X organization said Y”, your name will not be attached to the interview. If for some reason you do not wish to give the name of your organization, you will be referred to as “Org X”. You may refuse to answer questions, and we can carry on or stop the interview at any time. You may also say that your answer to a certain question should remain anonymous, that answer will go under a separate interview and be referred to as “Org X”.

What is the organization that you are representing in this interview?

Discuss your organization’s **inception**.

- Where is your organization based?
- How did your organization begin?
- Was there an impetus for its creation?
- What were the original organizational goals/mission?
 - Have they changed in recent years? If so, why?
- Does your organization deal directly with abortion seekers?
 - If so, how does that work? What are the steps they go through? What do you believe are the steps it takes for them to access your organization?

Discuss your organization’s **growth**.

- How has your organization responded to changes in abortion laws and abortion rhetoric in the US and in your state?
- Have there been any organizational structural changes as a result? Examples, new positions, changes in job descriptions, additional hiring, focus on tactics/messaging, etc.
- Can you explain your organization's pattern of growth?
 - Increased/decreased abortion seekers
 - Increased/decreased funding
 - Changes in government and political attitudes toward abortion and organizations
- Does your organization have goals around growth?
- Have you seen growth or decline regarding abortion seekers?

Discuss your organizations **reach**.

- How large is your organization's reach? Participants, countries, etc.
- What is your organization's reach?
- What are the goals of your organization's reach?
- Using estimations, how many abortions do you think your organization aids in annually?
- Where do you believe most abortion seekers using your organization as a resource come from?
 - Ex. Organically found on the internet, referred from friends, etc.

Discuss your organization's **political aspirations**

- Does your organization participate in political advocacy? Ex. Lobbying governments, organizing for/against candidates/parties/issues.
- If so, what are your organization's goals?
- Does your organization have specific goals around political aspirations?

Discuss your organization's perception of **civil society**.

- What does your organization believe the U.S's/Appalachia attitudes towards civil society are? On a scale of Extremely Restrictive to Extremely Liberal?
- Do you believe U.S.'s attitudes towards civil society affect organizational freedom?
 - How does this change your organizational goals and actions?
 - Example: the ability for organizations to form and act on their mission statement without fear of repression?
- Does your organization believe that US's attitudes towards civil society play a role in abortion access?
- Does your organization believe that there are clandestine or illegal abortions happening in the U.S. and Appalachia specifically?
 - If so, why do you think people access clandestine abortions?
 - How do you think people get them?
- Are there any closing thoughts or statements you would like to share?

APPENDIX G

LIST OF COVERT ABORTION NETWORKS IN APPALACHIA

Table 3

List of Covert Abortion Networks (CANs) in Appalachia

Organization Name	State	Year Founded
Kentucky Health Justice Network	KY	2013
AFUND	KY	1993
Carolina Abortion Fund	NC	2011
Mountain Area Abortion Doula Collective	NC	2019
Abortion Care Tennessee	TN	2019
CHOICES Patient Assistance Fund	TN	2009
Access Reproductive Care- Southeast	TN	2015
Mountain Access Brigade	TN	2016
Richmond Reproductive Freedom Project	VA	2004
Stigma Relief Fund	VA	2008
Blue Ridge Abortion Fund	VA	1989
New River Abortion Access Fund	VA	2019
DC Abortion Fund	VA	1995
Holler Health Justice	WV	2018
Women's Health Center of West Virginia Choice Fund	WV	1976
Western Pennsylvania Fund for Choice	WV	1995

N=16