CHARLES UNIVERSITY
FACULTY OF HUMANITIES
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Women's Experiences with Gynaecological Examinations and Debates about Virginity in Ankara, Turkey

Diploma Thesis

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Thesis Supervisor: Dr. Ivy Helman

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I declare that I wrote the thesis independently using the sources dutifully cited and listed in the bibliography. The thesis was not used to obtain a different or the same title.

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Sebiha Gungor

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ABSTRACT

Key words: Gynaecological experiences, virginity, premarital sexuality, women's health, gynaecological health, Turkey.

This study explores the relationship of ideas about virginity and gynaecological health experiences of women in Ankara, Turkey. I conducted in depth semi-structured interviews with ten heterosexual, 23-30 years old, college-graduate Turkish women. Using intersectionality as a methodological lens, I seek to understand how gender, age, class and religion play a role in the correlation of virginity and gynaecology experiences. Five main themes illuminated the participant women's experiences: (1) feeling of inclusion, (2) the effect of religion, (3) class difference, (4) selection of doctors (5) access to information on gynaecological health. Findings revealed that participants define virginity as a taboo and a barrier during gynaecological healthcare experiences. In accordance with the previous researches, I have found that dominant virginity discourse limit women's access to knowledge on their gynaecological health. This study also dwelled on the differences in the experiences of women according to participant women's age, religion, class and social status. In addition to previous research, this study revealed that judgemental comments of the doctors and high fees of private clinics make participant women anxious about gynaecological examinations. Women in this study highlighted the need of structural formal education about gynaecological health.

CHAPTER 1

INTRODUCTION

“Gynaecologist (G): Have you lost your virginity before tonight?

Patient (P): Yes

G: Okay, It will stay between us…

P: [Sighs] I slept with everybody in the world.

G: Are you sure that you slept with everybody in the world?

P: [Sighs] At least I slept with someone…

G: But your hymen is still here. Sometimes it happens. Right now, I see it [hymen] very well. It cannot stand everyone in the world. Why do you say things like that?

P: I do not know… I am so tired. When I say I am a virgin, they do not believe me anyway. Leave me alone now.” (*Mustang* 48:23-50:16)

This dialogue is from Turkish director Deniz Gamze Erguven's movie *Mustang*, which was nominated as an Oscar candidate from France in 2015. The dialogue is between a gynaecologist and a woman brought for examination because she did not bleed on the first night of her marriage, after first sexual intercourse. The movie deals with the expectation of female sexuality based on virginity and an intact hymen within the patriarchal structure in Turkey. In fact, it pictures the everyday lives of women in a small town in Turkey. When I watched this scene in 2019, I was impressed by the character telling the doctor desperately that she has a sexual life. Especially, it was dramatic that she told him “I slept with everybody in the world” despite having had no sexual intercourse. The power and position portrayed by the doctor's statement that "it will remain between us" made me think of the vital importance of a report given by the doctor about the examination, to the whole family waiting for this examination’s result.

Interestingly enough, this scene paved the way for me to examine the relationship between gynaecological examinations and beliefs about virginity. I started to form my questions, both as a person who was inspired by the movie mentioned above, and a Turkish woman who had challenging gynaecological health experiences. As discussed later in the positionality section, based on my own experiences, I was interested in Ankara, the capital

city of Turkey. After watching how virginity and premarital sexuality ideas interact with a gynaecological examination in a small town, I wanted to look at the experiences of women in the capital city. Focusing on Ankara, I wanted to investigate what women experience in a larger metropolitan city where I assume that there is more training on gynaecological health, hence, access to knowledge. Therefore, I started with the idea to examine the story of women in Ankara to see how they perceive virginity, what factors affect their perception, what visible or invisible effects are present during healthcare practices, and how they learn about their gynaecological health.

The scene from *Mustang*, which inspired the subject of my research, is from a relatively recent date. However, its theme, social expectation, and control over women's sexuality is a longstanding problem in Turkey. Control over women's sexuality has been critically analyzed for a long time in feminist scholarship. The literature dwelling on the virginity discourse primarily addressed that the sexuality of women is not a person but rather a social issue, which argues women's sexuality is controlled by society in Turkey. Muftuler-Bac (1999), for example, highlights that virginity is the most visible form of control over women's bodies (310). Karacan & Bektas (2016) argues that the virginity of women is understood as having a social value that belongs to the entire family (89). Another author, Parla (2001) argues that to create a so-called stable and national family, a patriarchal society act as a controlling mechanism that wants women to accept the boundaries of sexual freedom determined by society (66, 84).

Studies of these authors in literature critically analyze patriarchal ideologies which support that women's sexuality is a threat to social order. Since women's sexuality is restricted, very important concepts around this subject of gynaecological health such as sexual health education and reproduction rights are also controlled and restricted. Although many studies are analyzing the virginity discourse and its perpetuating oppression on women in Turkey, few studies are covering how women deal with this oppression. Rather than historical analysis, there is a need to understand the coping mechanisms of women in an environment where women are surrounded by oppressive ideas about virginity.

Other than virginity and its controlling power on women, studies are covering conservative thought as a factor shaping the perception of virginity which affect the gynaecological examination process (Yasan et al.178, Sevil & Dasikan 77) or studies pointing to the anxiety of women during gynaecological examinations (Demir & Oskay

74). The work of Coskun et al. addresses the importance of regular gynaecological examinations for women's health (6390).

A gynaecological examination is the only way to diagnose the factors that threaten women's health (Aksakal 62). In Turkey, gynaecological examinations are conducted primarily during prenatal screening and diagnosis, treatment of sexually transmitted diseases, genital cancers, and other gynaecological diseases (Gunes and Karacam, 2016). Although the importance of regular health checks was highlighted, the social barriers while reaching the gynaecological healthcare and knowledge has not been widely discussed by feminist scholars. I would like to extend the previous research by identifying how the virginity concept creates barriers for women while reaching the knowledge on gynaecological health and sexuality. To understand barriers, I examine participant women's ideas on virginity and their resources of gynaecological knowledge. The details of my objectives will be discussed in the next section.

Objective of the Thesis

The aim of my study is to understand how society's expectations of women's sexuality and virginity affect women's lived experiences and knowledge of gynaecological healthcare. Applying intersectionality as a methodology to my study, I aim to analyze how the categories of gender, age, class and religion play a role in women's gynaecological health experiences. I would like to generate new evidence and insights on women's access to knowledge and education about gynaecological and sexual health. With these questions in mind, I mainly question the correlation between beliefs about virginity and women's gynaecological healthcare experiences in Turkey. To illuminate participant women's experiences on these topics by their own voice, I chose the interview method in my research project.

Structure

In this study, to trace how virginity discourse and gynaecological examinations of heterosexual women are intertwined in Turkey, I use participant interviews as primary sources and current studies in literature as secondary sources of information. I begin with my positionality as a researcher, which has shaped my perspective and my research questions. In chapter 2, I introduce the demographic characteristics of my research participants with a discussion of why the specific sample is chosen for my research. I also present the data collection period, methods used and faced limitations during the Covid19 pandemic.

In chapter 3, the relevant existing literature will be discussed. I provide background information on my topic by introducing the virginity concept and discourses, current studies on women's sexuality and its history, religion as a factor shaping the concept of virginity, and an overview of gynaecological healthcare in Turkey.

Chapter 4 deals with the in-depth overview of participant narratives from semi-structured interviews. In addition to the demographic characteristics of the research participants, I provide a summary of the introduction for each participant to get to know their stories in relation to the research topic before analyzing their original transcripts.

In the final chapter, I provide my research findings and discuss if my findings are in line with the studies in the literature. Then I discuss how the intertwining of virginity discourse with gynaecological examinations affects women's access to knowledge about their bodies, sexuality, and healthcare. Finally, I provide recommendations for possible further research.

Positionality

As a Turkish female researcher studying gynaecological practice experiences in Turkey, my background has influenced how I approach the topic itself in several ways. Firstly, my background has a direct effect on the choice of the research topic of gynaecological health. I realized that some of my questions had shaped during my teenage years, even earlier. I was struggling to build my knowledge about my body and health. Since it was a time without easily accessed Internet, I was trying to find something in the health books available at home. One day, one of our neighbors working in an education

association gave me a book prepared for children. This book, which I still remember the pages of, was the first book I read about the female and male body, the reproductive system, and the bodily changes. It was the first time I was able to read about the unspoken topics.

I was a child of a family where my parents treated me and my brother equally. My parents were communicating frequently to show care on many topics such as school, successes, or general health topics. On the other hand, in our family speaking about reproduction, sexual organs, sexuality, and gynaecological health was taboo. It was not appropriate to talk about those secret topics that were to postponed to later stages of life such as “after the start of sexual life with marriage”. The irony is that everybody requires knowledge on these “taboo” topics. When my puberty set in, I was vulnerable due to a lack of knowledge about my body. I faced the first changes in my body such as menstruation, body, and hormonal changes without enough knowledge instead of acknowledging them.

Growing up, the word gynaecology was only in the sentences of "married mothers" around me. My mother had fibroid surgery, and while talking to her gynaecologist, she whispered about her complaints so that no one could hear. While my mom and other female relatives would talk about some women's health problems such as hormonal topics or irregular menstruation, they told me "these problems may disappear when people get married". I did not know that they were talking about “sexual intercourse” which is assumed only in marriage. There was not a single discussion on contraception, the need for regular tests, or potential diseases. I only learned later on, outside of family discussions. They were taboo topics until marriage.

I was born and raised in the capital city of Turkey, Ankara, which is the focus city in this study. My gynaecological healthcare experiences in this city, which I will explain below, have given me a position that influences the questions I asked during the research process. For one, I know there are different clinics for women's health, so I was able to create some questions to ask for participant’s preferences of clinics. My prior healthcare experiences also affected approaching the health issue concerning concepts of virginity and chastity. In my family and close friend environment, the common question was “why would a single and virgin girl go to the gynaecologist?” The discussion on these issues was creating a weird tension because of the correlation with the virginity taboo in their mind. Even when the topic was about health, the tone of voice would be a whisper immediately. Having this questioning in my mind led me to start health checks late and to hide that I am going to the gynaecologist. Since I did not want my family and friends to judge me, this

turned to the fear of sharing it with them. Moreover, during my first gynaecological examination, I was feeling totally insecure. I was not aware of the possible health risks and topics that I should discuss with the doctor. When the doctor asked some questions about my body, I could not tell the doctor that it was my first examination because I did not know that regular checks are important. I had neither gone to a gynaecological health check nor thought about it until I became conscious by reading more about the women's health topics. As I see how all this ignorance has made me vulnerable, I approach my topic with the question of how the virginity concept is interrelated with the women's gynaecological health experiences. I would like to understand how access to information affects women's gynaecological health experiences.

In terms of my positionality to my research participants, our common backgrounds helped me during the interviews and analysis of participants' narratives. My socioeconomic background was similar to many of the research participants. For instance, when they mention that paying for a private gynaecology clinic is hard, it was easy for me to understand what they mean by "hard". Moreover, being able to speak our native language facilitated communication during our face-to-face conversations. However, my position as a researcher gave me a certain power by being the one asking the questions.

My prior knowledge of the health care system in Turkey had also affected my ability to search the different sources. I was able to find the local policies or any historical information quickly. On the other hand, I know that my position supported by my local knowledge could make me biased while criticizing health policies. The shared socio-cultural background with participants could have created assumptions about their experiences in advance. However, I have paid careful attention to the participants' statements during interviews to reflect their different experiences in this study.

CHAPTER 2

METHODOLOGY

To examine the relationship between women's healthcare experiences, gynaecological access to information, and the effect of perceptions of virginity, I conducted semi-structured in-depth interviews with ten Turkish women between the ages of 23-30. All were university graduates who work in professional positions. All respondents had gynaecological examination history in Ankara, the capital city of Turkey. Eight participants were unmarried, whereas two participants were married. All interviews were held between January and March 2021 via online video calls.

To recruit participants, I used snowball sampling which is a common method in qualitative research that yields samples through referrals (Biernacki & Waldorf, 1981. p.141). Since talking about topics of gynaecology, chastity and sexuality are perceived as private and possibly concerning, the referral system helped me to find participants who were informed about my research by their own trusted network.

To ensure a more diverse sample I started multiple snowballs. First, I started identifying initial respondents through my social circle and then relied on referrals for other participants. Secondly, I posted a short description of my study to a Facebook group called "ODTÜ Kadın Dayanışması" (METU Women's Solidarity) which was created by female students and graduates of Middle East Technical University (METU) in Ankara. Members of this group page use a closed network with 1.5K members to get advice from each other, mostly on gynaecological health issues such as birth control, menstruation, gynaecologist, and hospital advice. Although I did not actively use this page before the study, as I am also a METU graduate, my closeness to the university's culture and way of speaking among group members made it easier for me to be accepted to find people willing to join as participants.

Before personally interviewing each woman, I have contacted participants via email to set the time of the interview and to inform them about the details of the study. I have prepared a consent form informing participants about the aim of the study, the structure of the interviews, the confidentiality of the meetings, and the non-disclosure of participants' real names. All participants declared their written confirmation to take part in the study and confirmed having a recorded online meeting.

The interview method was compatible with my feminist research concerns because it allowed me to ask further questions to clarify the meanings of responses. As Reinharz (1992) states in the work "Feminist Interview Research", interviews gave me access to respondents' thoughts and memories in their own words rather than my pre-set words in a survey as a researcher (19). Since I aimed to bring women's voices to the stage, I preferred interviewing women rather than creating a survey template that they need to choose from limited and possibly not enough options. The interview process was rewarding because it encouraged me to think in different ways and to engage in political aspects of experiences such as women's right to access information on their healthcare.

Participants' great effort and willingness to share details of their experiences proved that the qualitative interview method was appropriate for my research topic because it created knowledge by giving voice to personal aspects of the experience. The qualitative interview method also allowed me to find a common ground with the research participants as a women researcher. During our conversations, I reflected on my own experiences and motivations to conduct this research on the relationship between virginity and women's health practices coming from my own experience in the past. However, although I assumed that there was possible common ground with participants before interviews, I needed to manage it carefully in order not to have an unconscious bias about my study results. For example, I had a taken-for-granted assumption that the choice of male or female gynaecologist depended on the patients' perception of chastity. Instead of statements that showed this assumption, I asked them to share their own experiences in order not to influence them.

2.1. Participants

In this section, I will present demographic information about participant women (see Table 1). I provide a summary table indicating their age, marital status, and health insurance information. These are the significant points to identify participants in my topic of gynaecological health experiences.

Since participants shared very personal experiences to contribute to this study, I use pseudonyms for each of them for the confidentiality of their personal information. All the women who participated in this study joined because they knew that their real names will not be used but a randomly assigned pseudonym will be used in the study.

In addition to this summary, I will provide a short description of each participant in the analysis section of this study to provide a glimpse into the participants' lives.

Table 1. Description of participants

Participants by pseudonym	Age	Marital Status	Private Health insurance**
Ada	29	Married	yes
Cemre	23	Unmarried	no*
Deniz	25	Unmarried	yes
Esra	27	Married	yes
Leyla	27	Unmarried	no*
Nilay	25	Unmarried	yes
Oya	26	Unmarried	yes
Selin	29	Unmarried	yes
Yasemin	26	Unmarried	no
Zeynep	27	Unmarried	yes

* not insurance holder but self-payer who prefers private clinics

**Private insurance is an alternative & additive to public insurance. All participants are entitled to public health insurance which allows them to use public health services

During our conversations, participants expressed their willingness to contribute to a study about gynecological health, which has an important place in their lives. The participants stated that it was important for them to contribute to this topic because they suffered from the ideas around virginity in gynaecological examination processes and it was challenging to obtain information on this subject for them. All of the interviewees stated that they were happy to encounter a study on this subject, and even the content of our meeting was instructive for them. Participants stated that they want to read the final version of the study to get information about the results. This feedback also helped me too with recruiting because after our meeting most of the participants said they wanted to inform other people who might be interested in taking part. They stated their willingness to give detailed answers to convey their experiences in full since there were not many

channels they talk to outside of their close friend groups. However, the positive feedback of participants did not eliminate the limitations I faced totally, especially on finding more participants. These limitations will be discussed in detail in the next section.

2.2. Limitations

Since the current Coronavirus (COVID19) pandemic which was caused by the spread of the infectious disease has forced social-distancing rules all over the world (World Health Organization, 2020), I was not able to travel to Turkey to organize face-to-face interviews and to find more participants. This situation also limited my sample size because due to COVID19 restrictions and lockdowns people faced a lack of privacy needed to talk about their ideas on chastity and gynaecological experiences in their houses. For instance, two of the participants preferred to be in their office during the interview instead of at the home that they share with their families or partners. I anticipated approximately fifteen participants for this study, but the final number was ten. Although I regret it is a small size sample, my study will be a more specific and detailed analysis of the experiences of respondents. Therefore, my aim as a researcher is to demonstrate a deeper understanding rather than to generalize to a larger population.

To replicate the face-to-face interviews virtually, I organized online meetings via the Zoom video-calling application. Although I was able to use the cost-effective online tools for these remote interviews, conducting my research during a global pandemic produced three main challenges. The first challenge was having a limited benefit of powerful human interaction that supports the effective production of knowledge. As DeVault and Gross (2012) indicated in their work “Feminist Research: Experience, Talk and Knowledge”, human speech is complex because there are nuances in speech, gestures, facial expressions, and the use of silence which help to uncover subtle meanings of speech (206). Even in a video call setting which is the most like in-person interviews because one can see and hear the participants at the same time, there was still limited body language and eye contact. The missing human contact urged me as a researcher to promote a natural and relaxed conversation by asking ice-breaker questions at the beginning of each interview. Moreover, since participants may have a live image of themselves on the screen during the video call, this can encourage them to talk directly to themselves or can be distracting to see their own facial expressions.

Secondly, I was not fully aware of the distractions participants faced such as not having a separate room to express their ideas about virginity and experiences that they do not want to share with family members. Due to the coronavirus outbreak and pandemic situation, mandatory quarantines declared by governments force all family members to be in the same place. For instance, some participants changed their location at home during the interview to have a more private space in their lockdown situation.

The third limitation of remote interviews due to Covid19 restrictions was more an ethical consideration because I presented different time suggestions for the interviews and reported that timing is always open to change because I gave priority to the well-being and health of the participants. Sometimes the interviewers wanted to postpone the meeting because they had Covid19 case in their family or they did not feel well enough to contribute to a study. While the current coronavirus crisis added some new limitations to the qualitative research interview process, online communication tools helped me to schedule calls easily with different timing options, to send automatic reminders to participants for our meeting set, and to record interviews securely.

2.3 Research Question Formulation and Theoretical Framework

To formulate my research questions and to determine which questions merit investigation, I draw from the discussions of intersectionality concept to understand which overlapping systems were present in women's health experiences in Turkey. Although it is a commonly used contemporary concept today, the intersectionality concept was named by Kimberlee Crenshaw in 1989 to illustrate Black women's experiences and roots of political movement in Black feminist history (Carastathis 306). In Crenshaw's widely recognized work "Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color", she describes intersectionality as a "provisional concept" mapping the intersections of gender and race to disrupt the tendency to see them separable (1244, n9). Crenshaw argues that looking at race and gender dimensions separately is not enough because women are differently situated in the economic, social, and political world and have overlapping disadvantages (1244, 1250).

Patricia Collins in her book *Black Feminist Thought* published in 2000 summarizes Black feminist history's selected core themes including intersectionality. Collins describes intersectionality as conceptualizing particular forms of intersecting oppressions that play a role in injustice which cannot be reduced to one type or category (18). Collins exemplifies

that women's sexualities uphold multiple layers where systems of oppression converged such as heterosexism, class, race, nation, and gender (128).

As an additive model to the intersection of differences, Ingunn Moser (2006) focuses on the conceptualization of interactions between these differences in her article "Sociotechnical practices and difference: On the interferences between disability, gender, and class" (537). She argues that intersectionality is a common paradigm and metaphor in feminist-gender studies to examine gender, sexuality, class, race as connected systems rather than separate systems (540). However, not to have limitations such as adding or ranking the oppressions, she dwells on how these systems and differences interact with each other in everyday life (541). Moser argues on the concepts of interference and enactment of differences by stating that we explore differences that may support, reinforce, or unmake each other therefore operate in complex ways (543). In other words, she examines the differences such as gender, sexuality, disability, and class to show how they can be interfering with each other because they may "clash, challenge even undo each other" (541). She also adds, "throwing the metaphor of interference into debates on relations and interactions between differences is, also an instance of interference, an attempt to contribute to moving our efforts at conceptualizing and dealing with the difference in new directions." (543).

In line with Crenshaw, Collins, and Moser's discussions on intersectionality, Ramazanoglu and Holland (2002) state in their book *Feminist Methodology*, targeting only "the gender can have the effect of excluding significant divisions between women" (147). Not to privilege gender over other differences such as class, I integrated questions regarding the socioeconomic situation and aimed at a target group of female participants of different ages from different marital statuses. Stanley & Wise (1990) argued in "Method, Methodology, and Epistemology in Feminist Research Processes" that "the social contexts within which different kinds of women live, work, struggle and make sense of their lives differ widely between different groupings of women" (21). To illustrate, if I ask the same questions to women from different age groups or another city we may expect different experiences. Hence, not all women are subjugated for the same reasons in gynaecological healthcare in Turkey.

At this point, the intersectionality concept that emerged from Black women's dual oppression experiences due to their race will provide a lens to understand layers of experience differences of Turkish women. By looking through an intersectional lens, I aim

to analyze how gender, age, religion, and class categories affect the virginity and gynaecological examinations correlation and Turkish women's access to gynaecological health knowledge. To illustrate, in black feminist thought, ethnicity was a difference that was suggested to be addressed by Crenshaw. Differences in Turkish women's gynaecological healthcare practices include class differences because women have different financial abilities for healthcare services. The healthcare experience may vary for unmarried women at younger ages and married women. Moreover, as the relationship of virginity and gynaecological health is my question, there can be different factors in different levels such as religion shaping the virginity concept of participant women. Having the question of difference builds the relationship between Black women's dual oppression experiences due to their race and Turkish women's gynaecological experiences.

Drawing from both these arguments on intersectionality and interactions of differences, as well as my researcher positionality, I formulated my main research question and sub-questions below.

Main research question:

What is the relationship between beliefs about virginity and women's gynaecological healthcare experiences in Turkey?

Sub questions:

1- To what extent do women think the virginity concept and society's expectations of women's sexual experience have an impact on their gynaecological examination experience?
2- In what ways do demographic situations and religion play a role during these healthcare experiences?
3- What criteria are considered when choosing a gynaecological clinic?
4- How do ideas about virginity affect Turkish women while researching the information about their gynaecological health? What are their main sources of information?
5- What is the effect of the doctor's approach during gynaecological examination process? What are the women's expectations from the physician?

CHAPTER 3

LITERATURE REVIEW

In this chapter, I will provide relevant studies from literature corresponding to the order of my research questions. Firstly, the following two sub-sections present the literature discussing expectations of women's sexual experience and traditions in Turkish culture as a reflection of these expectations. Secondly, I will analyze religion, as an element affecting virginity concepts and gynaecology processes. Lastly, there will be a closer look into processes of gynaecological health, education, and medicalization processes in Turkey.

3.1. Women's image and virginity in Turkey

To understand the beliefs on female sexuality, it is helpful to give an overview of virginity and women's image in Turkey. As I aim to understand the impact of society's expectations on the sexuality of Turkish women during the gynaecological examination experience, in this section I will present discussions around an image of women and virginity. In the article "The Female Body in Patriarchal Capitalist Society", published in 2012, Melda Yaman Ozturk dwells on the male domination of controlling the female body by arguing that patriarchal norms and state institutions had dominated women's bodies by controlling their activities of sexuality and fertility (276-280). She explains that in the patriarchal capitalist society the body of women is constrained by two functions: first, playing a role in the reproduction of society; and secondly, creating value and workforce for capital by being responsible for family care (275- 276). In her, work Ozturk supposes that women's sexuality has been dominated by patriarchal societies for thousands of years by redefining womanhood with chastity and honor categories and by glorifying motherhood (277). Based on this argument, she criticizes that the norm for female sexuality is straight, married, and monogamous women (Ozturk 277).

Another author Gul Ozyegin, in her article "Virginal Facades: Sexual Freedom and Guilt Among Young Turkish Women" from 2009, draws upon meanings and

contradictions associated with virginity and the relationship of these meanings to sexual identity among young college students in Turkey (103-119). Similar to Ozturk, Ozyegin argues that being a virgin (having unbroken hymen) before marriage is the normative and dominant expectation for women (103). Additionally, Ozyegin examines the strategic responses of young women when their quest for sexual freedom contradicts the expectation of society about virginity (105). She uses the term "virginal facades" to describe the identities created by women concerning women's state of virginhood (113). Virginal facades are purposefully constructed identities by young women who both engage in the emerging premarital sex culture and also tend to meet and negotiate conflicting expectations and judgments of others - such as family and peers (113). Ozyegin claims these facades are created purposefully ambiguous by women to navigate the expectations by hiding sexual activity from parents but accepting not being a virgin, especially if they have a sexual experience in a romantic relationship (113 - 119). Ozyegin finds these identities problematic because they create the "false sense of self" and "guilt" among young women (116-117).

Importantly, Ozyegin relates the adaptation of these identities to societal classification because she claims there is no space for unmarried non-virgin women as the name women itself comes from one's virginity status (104). She points out how in the Turkish language "two dividing social statuses" (110) of women; "kadın" (woman) is for addressing married women, while the word "kız" (girl) is used for addressing unmarried women because being technically not a virgin is only acceptable after marriage (104). Furthermore, she enriches the discussion by arguing that this usage of language for categorizing women ignores the existence of unmarried but sexually active females (104).

Another approach to this language categorization based on one's virginity status is from the author Robin Turner, in the article "How Do You Know She's a Woman?" (2006), where he investigates the categorization of the Turkish words "kadın" (woman) and "kız" (girl) to show the relationship between culture and language. Turner indicates that having different words to call females is common in other languages and cultures as well. Yet, in the Turkish language, the significant factor to distinguish between those words is not adulthood but "being a virgin or not" (220). Simply, "all things being equal, a kız is a virgin and a kadın is not" (220).

This can lead to what Turner labels "category stress," leading to cognitive dissonance and the search for alternative words (221). Moreover, he states that the speaker's state of mind and intention are determining factors for the categorization (222). Importantly, he is concerned that the categorization of kadın/women and kız /girl words is difficult and stressful due to its psychological impact because miscategorization causes cultural consequences (229). Simply, if one calls an unmarried person a 'kadın' (woman) it can trigger the moral question "How we know she is a woman" because being a woman means one is not a virgin, and not being a virgin is unacceptable for an unmarried woman (232). Turner seems to be quite successful to indicate that giving such significance to virginity causes stress while categorizing. He argues that virginity is both linguistically and socially significant (232).

3.2 **Virginity and Chastity concepts and traditions**

Having women's image and virginity discussions gives an overview of beliefs about female sexuality in Turkey. Additionally, this section presents the concepts around virginity and the reflection of these concepts in Turkish traditions. Meltem Muftuler-Bac, a Turkish author who writes about virginity and chastity shows the link between chastity and purity; meaning not conducting any premarital or extramarital sex in her article "Turkish Women's Predicament" in 1999 (309). Muftuler-Bac states that the chastity of women is used as a controlling mechanism over female sexuality and freedom in Turkey (308). She proposes that the social class also determines the description of the concept because in different social classes chastity ("namus" in Turkish) is jeopardized by different behaviors (309). For instance, for the middle class, sexual activities are strictly forbidden and a determinant of chastity, while for the lower classes even going shopping alone as a woman is not tolerated (309). She points out that since women are reproductive, their sexuality is seen as a way of transmission of values and traditions (310). Therefore, it is seen as essential to control women's sexuality for the survival of norms (310). While norms and customs measure and control female sexuality, Muftuler-Bac also proposes that sexual purity is the criteria to determine a woman's value in Turkish society (311).

Similar to Muftuler- Bac's approach of threats to chastity, Arin (2001) in the article entitled "Femicide in the Name of Honor in Turkey", argues that the expected purity of

women can be destroyed even by the slightest of acts (823). For instance, flirting, listening to a love song on the radio, not adopting a conservative style of dress, or strolling in the town alone can be examples of these slightest acts of women (823). Arin states that especially in the conservative areas of Turkey women are seen as representatives of honor and chastity by being accepted as property of the family. The standing of the family is diminished if women are disobedient to social norms around sexual activity before marriage (823). Even further, to show the importance of controlling women's sexuality, she highlights that women are expected to be virgin and "clean" when they are married, otherwise the cost of freedom is "honor killings" which are the worst result of not being chaste and virgin (822).

In the article "Health Science Students Attitudes About Women's Gender-Based Honor And Sexuality" by Gursoy et al. (2019) it is emphasized that women are expected to keep their virginity, control their behaviors by adopting conservative behavior, and pay attention to their way of living (4863). Similar to Arin's point, the authors indicate the honor culture in Turkey does not permit any sexual activity for women before marriage. Moreover, Gursoy et al. (2019) state that the description of chastity concept differs for men and women because while chastity is a condition of honor for women, for men honor means dignity and being honest (4863). Most importantly, this study shows that even health science students who take courses on gender equality and the health of women, consider that chastity of women is damaged by being a not virgin before marriage whereas they think a premarital sexual activity is "trivial for men" (4866).

The anthropological fieldwork study of Patricia Scalco, exploring the reproductive rights and politics of chastity among young, unmarried, and sexually active women in Istanbul, suggests that notions of chastity locate sexual activity within marriage for the purpose of reproduction (324). In her study "The politics of chastity: marriageability and reproductive rights in Turkey", Scalco points out virginity is accepted as the presence of unbroken hymen, due to no sexual conduct. This unbroken hymen is the key element of notions of chastity attached to purity and virtue (324). In other words, she seems to describe virginity (unbroken hymen) as a prior condition and element of chastity (purity). Moreover, Scalco claims that chastity notions reinforce virgin-centric marriage which asks for evidence of an unbroken hymen, like after the first night of marriage as a bloodstain on a bedsheet (324- 325). In this article, she introduces two concepts of social space: home and away from home and states unmarried women engage in sexual activity when they are

away from home and they tend to hide any evidence of their sexual activity to retain marriageability (325- 328). Scalco enriches the discussion around the categorization of women according to their chastity and virginity and states that reproductive rights are seen as exclusive rights of married women (325). Additionally, since sexually active, young, unmarried women have limited access to reliable contraceptive methods, Scalco categorizes them as " women without a place" (333-336). She defines young and sexually active women in her study in that way because of the lack of recognition of sexuality of unmarried women (336).

Similar to Scalco's significance of protecting virginity for marriageability discussion, Kalav also points to marriageability by illustrating its historical root causes in her study Namus (honor) and Gender in 2012. Kalav exemplifies the private property and family theories of Engels and the study of Tillion's in Mediterranean societies, arguing that honor arises from the relationship between property and kinship (155). Kalav discusses that the transition to monogamy from polygamy bans plural marriage. While men have private property rights, women lost their say in the house and became nurturer slaves who give birth to the children of men (156). Importantly, this transition forced women to convince that the children were from their husbands because men wanted to make sure that with whom they left their legacy were their own children. This in turn supported the perception that "protecting the honor of women is also the duty of men" (156-157). If women have a sexual experience before marriage, this was seen as the family's lack of control over women and a property crime against the daughter's father (Blank 2008, as cited in Kaval 2012, 156). This can be seen as a creation of anxiety over women's sexuality.

Karacan and Bektas in their article "The Social Control of Sexuality: An Examination of Gender and Regional Effects on Turkish Young Adults" (2016) posits that gender is an important factor controlling young Turkish adults' sexual activities because this control is supported primarily for women (103-104). They argue that the virginity of women is not a personal but rather a social issue that is controlled by society and seen as belonging to the family in Turkey (89). In addition to discussions of other mentioned authors around virginity and premarital sexuality of women, Karacan and Bektas's study confirms that both in the traditional and metropolitan areas of Turkey, the virginity of the unmarried women is expected by society while the non-marital sexuality of men is permitted (89, 103).

Ilkkaracan and Seral in their work “Sexual Pleasure as Woman’s Right”(2004) approaches the control by marriage discussion with the perspective of space: women’s position determined by patriarchal order in public and private realm (188-190). Authors claim that the while in private sphere rules governing women's sexuality was used as a tool to keep women under the control of their fathers and husbands, by attributing roles such as marriage and childbearing to women which are, the sexual codes of conduct restricts the mobility of women in the public sphere (189).

Returning to the concept of virginity, Ayuandini in the article “Demedicalization of the Broken Hymen” posits that hymen, a membrane in the vaginal canal, is believed to be a hallmark of the virgin (89). In the article Ayuandini investigates the medical practitioners' approach to hymenoplasty, which is a medical surgery to alter the shape of the membrane to make women bleed on their wedding night as proof of virginity: being sexually untouched (88-90). Ayuandini indicates that broken hymen is a misconception because having intact hymen is not an indicator of the absence of sexual intercourse (90). She states that the need to fix the membrane is a result of cultural beliefs, such as wedding rituals. For her, there is no place in medical understanding (90-92). Ayuandini also indicates that medical practitioners explain to women while consulting for a hymenoplasty that the hymen can be in different shapes and none of these shapes proves the absence of sexual penile penetration (92).

Similar to Ayuandini’s study, the work of Robatjazi et al. “Virginity Testing Beyond a Medical Examination” (2015) investigates the perceptions of 16 medical practitioners about virginity tests. The study argues that there is no causal relationship between the shape of the hymen and virginity, and, therefore, a diagnosis cannot be certain (152). The authors state that the hymen cannot be a suitable sign of virginity because it is an elastic mucous; partially enclosing the vaginal orifice which can be ruptured or not during penile penetration (153). Moreover, even in a ruptured hymen case, sexual penetration is not the only way to because it can happen: by tampon usage or physical exercise (Hegazi & Rukban as cited in Robatjazi, 2015). Despite the ambiguity of the result of this virginity testing, these tests are performed for social reasons (162). The results include informal reasons for the test such as an individual’s fear of a broken hymen; beliefs and social reasons for testing, such as the need for proof before wedding night (156-159).

These arguments of different researchers reveal that family expectation from women was being able to marry, which means being heterosexual, a virgin, and having

unbroken hymen. On the other hand, it is a gendered discourse because while men's sexuality is more than welcomed, women's premarital sexuality is seen as dishonor. For example, there is a term in Turkish "Milli olmak" which celebrates men's first sexual intercourse regardless of marriage. This defines men's sexuality as a victory but women's premarital sexuality as a threat to family dignity.

Traditions

Given the utmost importance of having an unbroken hymen for marriageability is reflected in different traditions and cultural figments in Turkey. Society appeals to various methods to check whether a woman has a heterosexual relationship. Although they are more common in rural areas, these traditions are still maintained.

As exemplified in Turkey's Ministry of Culture and Tourism website explaining wedding traditions, the maidenhood (chastity) belt is used as a wedding day tradition, especially in rural areas of Turkey where virginity is extremely important for family and relatives. In the article "The Ageless Tradition in Turks and Russian: Wedding" where Demir and Topbasoglu (2014) evaluates the traditions peculiar to Turkish and Russian culture. The authors state that in the Turkish tradition, a red ribbon, the maidenhood belt, is tied around the bride's waist by her father or brother on the wedding day during a ceremony called "gelin alma" -fetching the bride (13). This red ribbon is a symbol implying that the bride is chaste and a virgin: so never had sexual intercourse. This also shows how the female body and sexuality are being turned into a commodity during the marriage process because the bride is pictured as an item bought in the form of a gift pack wrapped in red ribbon, and this is maintained as a tradition.

Another example of displaying the sexual purity of women is one tradition of seeking virginity in blood-stained sheets on the day of marriage. As Kalav (2012) examined in "Namus and Gender" article, in the morning of the day after marriage, the bride hands over a bedsheet stained with the blood of virginity to the groom's family, as a sign that she has maintained her so-called sexual purity until the day she got married (160).

3.2 Historical information on women image and control over women's sexuality

In this section, I will present historical events of the foundation of the Turkish Republic to demonstrate how women's experiences in reproductive health are a topic that is discussed only in the private realm, instead of the public realm. Turkey is a place where women gained political and public visibility eventually along with the Republican reforms in the early 1900s. Therefore, it is important to look at historical milestones to see how and to what extent the woman's body and image were shaped historically.

Yesim Arat in her article "Women's Rights and Islam in Turkish Politics: The Civil Code Amendment" published in 2010, examines the Turkish modernization process through secularism and how women's rights were instrumental in this process by discussing the significance of the 1926 civil code and amendment of the code in 2001 (236 -241). Art argues that the Swiss Civil Code, which replaced the Islamic rule (Sharia) after the foundation of the Turkish Republic in 1923, was adopted and expanded women's custody over children, provided equal rights on marriage, and outlawed unilateral divorce (237). Art discusses that to build a nation-state and become a part of the Western world, this new revolutionary code was introduced and especially urban and more educated women of the Republic celebrated the new secular rules without questioning them effectively for many years (237-238). Art argues that after the 1980s feminists in Turkey found the first adopted civil code problematic because it was putting women as symbolic actors by positioning men as head of the family and supporting a paternalistic, patriarchal order where women were positioned as helpers (239). The defined role for women was helping their husbands through unremunerated labor at home, the private sphere (239).

Importantly, Arat discusses the amendment of the code which came with Turkey's efforts to be part of the European Union. This process had helped feminists and feminist organizations in 2000-2001 because the negotiations depended on the criteria of "cultivating a liberal democracy where human rights, including those of women and minorities, were respected" (242). Art often points out the "catching the West" ideology and its effects on defining women's position in society.

Similar to Arat's analysis, Parmaksiz in the article "Paternalism, Modernization, and the Gender Regime in Turkey" published in 2016, argues that during the process of creating a nation-state after the republic's foundation, while women were enabled to become modern, the shape and limits of modernity were described by the rule of the state

in Turkey (41). Parmaksiz uses the concept of paternalism which she defines as treating others as a child while acting as a father, to describe the modernization of women and gender regime in Turkey (43-44). Parmaksiz stresses that the notion of women's emancipation was used as an underlying tenet of nationalist modernization which leads to a gender regime, especially in the familial realm (44).

To illustrate, Parmaksiz exemplifies fathers who were epitomized as agents of modernization because they let their daughters receive an education and participate in the public sphere, but, in return, these girls were expected to minimize their contact with other men and suppress their sexuality until marriage (49). Since as long as women's participation in public life was defended if it does not challenge the men of the family (father or brother), Parmaksiz claims that "women had to be modern yet modest" (50). In sum, maintaining a balance between the modernity of the western world and the traditional culture was expected from women and thus emancipatory reforms were combined with domestic expectations for women (45, 50).

Another author, Ferhunde Ozbay, covers the modernization and women topic in her gendered space analysis work "Gendered Space: A New Look at Turkish Modernisation" (1999). Ozbay argues that women's movements for emancipation were part of the rising nationalist modernization movements, focusing primarily on the public-private space division and the place of the family (556-557). While public life was the place for reflection on equal legal, social, and political rights; the private experiences of women in households, such as childbirth and reproduction find their place under medical history without being the focus of gender studies of modernity (556). Ozbay posits that in the name of modernization, "the double standard of modern society" expected women to be the lady outside the home but act as a servant for the household, which, in turn, did not help women develop their identities (566).

One of the most critical sociologists Kandiyoti (1991) in her work "End of Empire: Islam Nationalism and Women in Turkey" correlates the creation of new modern women's image with the concept of "paternalistic benevolence." She argues the period of the foundation of the Turkish Republic was an authoritarian era reproducing a uniform citizenry that hindered the autonomous and political women's movements by not explicitly addressing them (41-43). To illustrate this point, she emphasizes the refusal of the Women's People Party which was founded in 1923 because of it being divisive and untimely (41). In addition, Kandiyoti argues that the 'new modern woman" image was

promoted, from ballroom dancing to official ceremonies by women public figures for broader endorsements (41). This demonstrates the paternalistic approach of the state which position again where women positioned as helpers to the new Republic by their appearance and new image.

Similarly, Patrick Rear (2014) in "Atatürk's Balancing Act: The Role of Secularism in Turkey" discusses this demonstration of modernity approach as "state feminism" which puts women as the guardians of the reforms and progress in society while mandating Western norms of dress and outlook to limit religious expression (5). In other words, this state-sanctioned feminism was more an appearance to outsiders, but not feminist in terms of women's rights. Importantly, Rear classifies the feminist movement after the foundation of the new Turkish Republic as "republican feminists" (state feminist) and "liberal feminists" (6). While in republican feminism there was the reliance of women to the state as a guarantor of rights, in the 1980s Turkey's liberal feminism arose in opposition to state policies to discuss issues like domestic violence, divorce, and abortion (6-7). Rear seems to clarify that state feminists were not able to touch on such topics that directly influence women's experience and rights till the 1980s.

Similarly, Fatmagul Berktay in her work "The Position of Women in Turkey and the European Union: Achievements, Problems, Prospects" published in 2014, dwells on the feminist challenges of the 1980s. Berktay states that the movement was challenging the traditional gender roles in the family and patriarchal attitudes toward women have remained unchanged despite the reforms of the republican regime (25). During this period, the first consciousness-raising groups, publications of women groups, campaigns against discrimination in a private realm such as domestic violence, reflections in the academic world as the foundation of women research centers came to the stage (26-27).

Parla's article "The Honor of the State: Virginity Examinations in Turkey" published in 2001 argues that the feminist liberation movement of the 1980s contributed to cultivating discussions around sexuality and virginity tests (65-66). According to Parla, persistent activities had pressured the state and this led to the amendment in 1999 requiring women's consent for virginity examination (66). She states that before 1999, if women suspected of illegal prostitution, or charged with immodest acts while staying in dormitories or orphanages, a state-appointed doctor carried out the virginity tests with the initiative of police or school counselors (65). Parla argues that these tests were unacceptable forms of violence towards women's bodies and played a powerful role

illustrating just how routine the state's intrusion into women's bodies without consent was (66, 82-83).

In addition, Parla addresses ruptures that challenge the expectation of being chaste and modest by exemplifying several feminist activist campaigns such as the women march in 1987 with slogans “Enough it is our turn to speak”; the foundation of “Temporary Women Museum” including items related to sexual rights such as ICUs - intrauterine contraception, and the “Purple Needle” campaign organized by feminists from Ankara and Istanbul against sexual harassment with slogans “Our bodies belongs to us” (76). The works of Parla Berktay and Rear show that the movements after the 80s encouraged women to raise their voices on individual issues to find solutions to their actual needs rather than class or family-related positions (Ilkkaracan and Berktay, 2002).

3.3 Religion as a factor shaping the control over female sexuality

Karacan and Bektas in their work “The Social Control of Sexuality: An Examination of Gender and Regional Effects on Turkish Young Adults” published in 2016 discuss that religion is a major social controlling institution that governs especially female sexual activity because of its traditional rules that are used to control women’s bodies (90). Karacan and Bektas remark that in traditional Islamic societies, women’s sexuality is considered a threat to the social order, supported by the belief that women are not able to control themselves (103). In line with this belief, their research describes how parents monitor daughter’s activities more than son’s because there is a “double standard” supported by religion (103). This supports the authors’ claim that social control is a mechanism regulating relationships in social life to maintain the patriarchal order in many societies (104). Importantly, findings of this research with young adults from different regions of the country include two points: first, they emphasize that religious orientation affects sexual behavior more in rural areas rather than urban areas; and second, religiosity is a predictor of sexual behavior but there can be the mutual existence of liberal and Islamic gender ideologies in Turkey (104). Karacan and Bektas's study demonstrates that this is not only faith in religion shaping the sexual behavior of young adults in Turkey. More liberal behavior on sexuality, which is not affected by religious thought is also present, especially in urban areas.

There are other studies examining the relationship between the level of faith in religion and premarital sexuality in Islamic culture. Yasan et al. conducted a “Premarital

Sexual Attitudes and Experiences in University Students" study in 2009 with female and male participants. In this study, Yasan et al. assess the level of religious faith and break practitioners into three groups: conservative religious who perform daily worship of Islam; liberal religious who perform some of the worship but have faith in Islam: and lastly unreligious who do not perform any worship but have religious faith (176). Yasan et al. argue that according to their study the rates of premarital sexual activities among these Turkish students were higher than the rates of traditional Islamic countries but lower than rates in Western countries (178). They argue that although conservative levels of religiosity bring less sexual activity, they observed respectively liberal religious behavior that does not limit sexuality as well (178). However, the authors seem to underline the gender-based double standard for male and female sexuality due to the traditional Islamic view which limits women's sexuality (180). Moreover, Yasan et al. highlight women's experiences of "feeling guilty" after sexual relationships within Islamic culture that prohibit premarital sexuality (179-180).

As Muftuler-Bac (1999) stated, within monogamous religions like Islam, the father image of God is preserved in the patriarchal order. This father image legitimizes male dominance in a patriarchal society and controls female sexuality. Moreover, the main motivation for controlling women's sexuality is men's desire to have legitimate birth and secure fatherhood (309). Muftuler-Bac links this securing of fatherhood with women's value determined through being reproductive agents in traditional Islamic societies (309). This claim can support that in Islamic culture married women's sexual activity is allowed if procreation is the aim of sexual activity.

In the article "Psychosocial Factors Restraining Gynecological Examinations" (2017) authors Sevil and Dasikan examines psychosocial factors that hinders gynaecological examinations and states that upbringing with strict religious and moral beliefs creates the traditional female sexual role perception and this is a psychosocial factor that affecting gynaecological health (77, 82). Sevil and Dasikan argue that religious conditioning is observed in some women with sexual problems because the families of these women expect them to obey religious rules strictly from childhood (77). The authors underline that the sexual responsibility of women is not allowed to develop and that female sexuality is a source of anxiety in such houses (77). In addition, Dasikan and Sevil state that the conservative structure, the importance given to the hymen, beliefs that prevent recognition of the woman's own body are effective in the incidence of vaginismus, which

is female psychosexual problems that disable sexual intercourse (77-78). In other words, they explain how repressive sexuality can manifest itself as a disease.

Similar to the "feeling guilty" concept of Yasan et al. (2009), Dasikan and Sevil also argue that strict religious and moral values cause guilt and shame in the evaluation of the sexual organs (77). In addition, Dasikan and Sevil state that women who grow up in conservative family environments with negative attitudes towards their sexuality and bodies may avoid questioning their reproductive and sexual health, causing them to avoid health checks to not to show their intimate sexual organs to a stranger, even due to illness (77- 78, 82). Similarly, another study, called "Evaluation of Women Having Pap Smear Test by Health Belief Model Scale" conducted by Meltem Demirgoz Bal in 2014, discusses how conservative religious belief and cultural values in Muslim societies could prevent women from gynaecological examinations (136). Bal also claims that some women do not feel comfortable showing intimate organs (breast / genital organs), especially to a male doctor (137).

Concerning the selection of female and male doctors based on religious faith, one example in the literature is Uskul and Ahmad's study "Physician-Patient Interaction: A Gynaecology Clinic in Turkey" published in 2003. It examines gender differences in physicians' communication (205-214). Uskul and Ahmad report that since religion limits women's sexuality, the effects are also visible in the gynaecological setting, which includes issues related to sexuality and requires the interaction of women with unknown male or female physicians (206). Uskul and Ahmad argue that in Turkey women's communication with men outside the family is lower in conservative settings, especially about the taboo topics related to sexuality and gynaecological health which can cause less disclosure by women to male doctors (213). Uskul and Ahmad point out that the women from different religious backgrounds see having the option to be examined by a woman gynaecologist as vital (214).

On the contrary, another study with more participants directly focusing on the gender of the doctor published in 2014 by Bal et al., entitled "Muslim Women Choice for Gender of Obstetricians and Gynaecologist in Turkey". The authors argue that socio-cultural reasons, rather than religious ones affect the selection of female gynaecologists (64, 70). Importantly, Bal et al. state that Islamic theologians suggest the Muslim women take medical services from female physicians unless compulsory (65,67). Bal et al., state that although Turkey is mostly Muslim-populated, religion is not a major factor affecting

the preference for female practitioners due to the secular pattern of Turkey (65). However, Bal et al., also discuss in other Islamic countries such as the United Arab Emirates, female patients prefer female gynaecologists for primarily religious reasons (65).

Pinar Ilkkaracan, in the preface of her work Women and Sexuality in Muslim Societies published in 2004, argues that in order to protect the male-dominated system, the body of women is suppressed and sexuality and fertility are controlled by various manipulations (14). She continues that religion is abused as a powerful tool of manipulation to "justify" women's rights violations, and the female body is turned into a sphere of political conflict (14). In other words, Ilkkaracan focuses on the danger that in some Muslim countries authorities deceive society by saying their malpractices are requirements of Islam (14-15). To illustrate, she gives examples as the law of proving rape of women in Pakistan and Malaysia; and in Africa, the practice of cutting the female genitalia to prevent pleasure (15-16). Another important argument of Ilkkaracan is that Islam views men and women as opposed to sexual pleasure: it defines men as rational while seeing women as emotional and to be controlled (17). Ilkkaracan argues that this idea was created based on interpretations of religion aiming at controlling female sexuality in order to preserve the social masculine order in the name of Islam (18). Ilkkaracan points out that the control of the female body ranges from denial of women's freedom of movement to virginity tests and murders in the name of honor (19). For this reason, Ilkkaracan states that religion is used as a tool of fear in Muslim societies which make women afraid to raise their voices, and this creates the "resistance to entering those areas considered culturally taboo" (19-20).

3.4 Women & Gynaecology in Turkey

"Psychosocial- Medical Aspects of Gynecological Examinations" article published in 2001 by Orhan Aksakal is an elaborate analysis that sheds light on the importance of gynaecological examinations for women's health and of ways to increase the frequency of these checks by analyzing the perception of women in different studies (61-67). Aksakal indicates that gynaecological examination is the only way to diagnose the factors that threaten women's health (63). However, there are few patients who only applied for routine control without any complaints in Turkey (63). He argues that gynaecological or pelvic examinations are seen as different than the other medical checks because they may cause 'negative cognitive and behavioral states' (63). To illustrate the reasons for the 'negative state', Aksakal states that women have concerns about the doctor's attitude, of being naked, of risk of a significant illness, or damage to the genital area due to the examination or the

fear that the doctor will find out something about their sexual experience (64-65). Through a critical review of studies on doctor's attitudes, he highlights that doctors should give more information about examination methods, take a full gynaecological and medical history, and embrace the different experiences of patients (65- 66).

In their study "Knowledge about Cervical Cancer Risk Factors and Pap Smear Testing Behavior among Female Primary Health Care Workers" published in 2013 Coskun et al. examine the knowledge level of gynaecology practitioners on the importance of routine controls for early diagnosis of cancers risking women health (6389). Coskun et al. argue that primary healthcare workers are driving the healthcare programs for women therefore their knowledge level should be at an adequate level (6389). While questioning the attitudes of healthcare practitioners in this particular area, researchers position healthcare professionals as role models for women. (6391). They discuss that practitioners are not conducting required tests such as pap smear tests for early diagnosis because of the following reasons: finding it unnecessary, seeing tests as lack of time, and neglecting the timing of test (6391). Coskun et al. argue that there is ignorance because of a declining age for first sexual intercourse and an increasing need for regular check-ups to ensure the health of the young in Turkey (6390). This study is important because it shows that although pap smear tests are important for women's gynaecological health, and knowledge about these tests plays an essential role in protection, even doctors may neglect this importance due to lack of knowledge (6391). They point out the need for in-service training for doctors to emphasize the importance of diagnostic tests (6391).

Kivrak and Ulker's study, "The Effect of Information About Gynecological Examination on the Anxiety Level of Women Applying to Gynaecology Clinics" published in 2016, examines the effect of providing women with information at the pre-examination stage of examinations in order to lower the anxiety experienced by women during these healthcare services in Turkey (2). Although Kivrak and Ulker seem to be primarily concerned with decreasing stress levels before the examination rather than the sources of stress. However, they argue that women's unfamiliarity with the hospital environment, crowded waiting rooms, lack of information about their bodies and examination methods, fear of pain, traditional thoughts on women's sexual role in society are the root causes of this anxiety experienced by women (1, 2). Kivrak and Ulker indicate that although it is needed to lower the anxiety level of women for routine gynaecological controls that prevent serious diseases and infections, the timing of information is important because providing

information just before the anticipated examination (i.e. in waiting room) is not sufficient (6). Decreasing the anxiety level of women during gynaecological examinations should start with more targeted and strategic education rather than brief information (7).

Another study conducted by Tugut and Golbasi in 2014, “Aspects of Emotional and Physical Discomfort in Gynaecologic Examination: A study of Turkish women” pays attention to the discomfort associated with gynaecological examinations by addressing why women avoid these exams: limited information on medical procedures, loss of control over their body and embarrassment about being undressed (1777). Another reason for discomfort that is discussed is the concern that gynaecological practitioners can deduce something about the patient’s sexual activities or any illness (1777). Similar to Kivrak and Ulker’s arguments on knowledge about lowering anxiety, Tugut, and Golbasi state that providing information about the details of the examination and the equipment used can help to turn the examination process into a positive one (1778). The results of the study are important because of their stress on emotional discomfort.

Tugut and Golbasi argue that since in Turkey sexual organs have special significance and are seen as private parts of women's bodies that need to be protected, women can see the gynaecological examination process as a loss of privacy (1777 and 1782). They state that being exposed to messages systematically from childhood that the sexual organ is something "to cover " may create concerns and embarrassment for women during examinations (1778). Related to this embarrassment and these feelings about privacy, the authors also dwell on the preference of women on the gender of the practitioners and indicate that women tend to prefer female physicians (1782).

In “Women’s Experiences of Gynecological Examinations and Their Expectations from Healthcare Professionals”, Demir and Oskay (2014) compared the choice between the gender of the physician and female patients’ educational status and found that as the education level of women increased, the rate of female doctor preference decreased in their study conducted in Turkey with 350 women aged between 20-49 (73). It was similar to other studies mentioned above, however, Demir and Oskay found that women experience stress due to reasons such as not paying enough attention to privacy, not providing a special area to prepare, not being respected by the healthcare professional, and not being allowed to share their fears and concerns before the examination (74). On top of these reasons, Demir and Oskay indicate that the majority of participants in their study (69.7% of participants) declared they prefer to have present a relative or friend who can support them

during the examination (74). Apart from female doctor preference of patients, Demir and Oskay state that the doctors who are knowledgeable, not judgmental, and take time to answer questions play an important role for a positive examination experience (75). Accordingly, the positive gynaecological examination experience plays a major role in the continuation of the women to the next examinations (76).

Demirel et al. suggest "age of the woman affects the level of vulnerability regarding the first gynecological examination" in their recent study "Anxiety Levels and Methods of Coping with Stress of Adolescents Undergoing their first Gynecological Examination" published in 2019 (134). According to their research results, Demirel et al. argue that among 223 women participants aged between 15- 23, the majority of them (67.7%) stated that they had no information about gynaecological examinations (132-133).

The mechanisms to cope with stress due to the first gynaecological examination are ineffective if women have low levels of education and do not have spousal and social support for the examination (134-135). Demirel et al. argue that since women with low levels of education have insufficient access to information, their coping methods surrounding stress are also ineffective (134).

Ilkkaracan and Seral dwell on the topic of access of women to proper sexual and reproductive healthcare information, in the article "Sexual Pleasure as a Woman's Human Right: Experiences from a Grassroots Training Program in Turkey" (2000). The authors argue that education on women's health is very restricted as sexuality or any related topic was not covered in the formal education system or family (187). Ilkkaracan and Seral state that women and sexuality include issues from reproductive health and sexual rights to violence against women as well as sexual expression and fulfillment (190). The authors explain their experiences from the training of the Women for Women's Human Rights (WWHR) association, for building an affirmative approach towards sexuality and bodily integrity (190). They state that they needed to cover sexuality modules as an integrated part of human rights training because they believed covering sexuality as a self-standing module would be impossible because of the internalization of messages that had been given for years to women about suppressing their sexuality (190-191).

In "The Importance of Sexual Health Education" published in 2011, Gursoy and Gencalp argue that there is no sexual health education in Turkey due to the belief that talking about sexuality may lead the younger generations to have earlier sexual experiences

(29). Gursoy and Gencalp discuss that sexual health education should be reachable in formal education but in Turkey, it remains limited with the temporary training programs of some national and international organizations (30-31). Gursoy and Gencalp argue for the need for systematic education starting from early ages because, on average, one out of every three young people in Turkish country have sexual experience, but generally they are not protected and there is a lack of knowledge about sexuality (32). Gursoy and Gencalp emphasize that sexual education should be given in schools and should be supported by teachers, family members, health professionals, religious officers, and counselors specialized in this field, especially in societies as Turkey where any sexual matters are taboo (34).

CHAPTER 4

Analysis

To examine the respondents' narratives and viewpoints, I transcribed the interviews to generate themes that I will describe individually in this chapter. I identified recurring patterns while transcribing and translating the interviews. In the narrative of the participant women, there emerged four themes responding to my main research question and sub-questions.

Themes:

1- Expressions of participants perceptions related to virginity
- Where do I belong?: Perceptions on participants' feelings of inclusion
- I am not religious, but....: The effect of religion

2- Can I afford the service? : Class differences and the freedom to choose health care
3- I wish I knew: Access to information on gynaecological health
4- Where is the doctor that I can trust?: The selection of a healthcare provider

While the first theme reflects the thoughts of the participants on the virginity concept, other themes were determined to elaborate the different areas within gynaecological healthcare processes related to concepts of virginity. In this chapter, I will be exploring each of the themes separately by including participant's own sentences and narratives.

Getting to know the stories: A brief description of participants

It is helpful to provide a short description of the participants to demonstrate their backgrounds and socioeconomic positions at the time of data collection. These short introductions can be helpful to clarify to whom my study findings apply. It can also shed light on possible limitations.

Ada, a twenty-nine-year-old, married woman has a job in the private sector. She gives extra importance to her gynaecological examination process and visits plenty of doctors since she had a special gynaecological health problem. She shared her

disappointment because there is no treatment method in public hospitals for her illness. She needed to go to private clinics instead of public hospitals. Since the psychological dimension of the gynaecological treatment affects her very much, she also pays extra attention to the choice of the doctor.

Cemre, a twenty-three-year-old, unmarried woman who has experience in women studies in her professional life. She shared that her perception of virginity was shaped by university socialization. Also, her gynaecological examination process started at this time. Although she has experiences both in public and private clinics, she shared her preference for private ones as a self-payer without private health insurance.

Deniz is a twenty-nine-year-old, unmarried participant from the education sector. She started gynaecological examinations early with her mother because of her vaginal cyst problem. She considers herself advantaged because holding private health insurance enabling her to get rid of long queues in public hospitals. Deniz was not satisfied with her few gynaecological experiences in public hospitals because of the nurse or doctor comments that limit her ability to explain her health problems or to ask questions. She criticizes the constantly changing policies of the government regarding women's health.

Esra, a married twenty-seven-year-old consultant in the private sector, is the only participant who identifies herself as religious. Although she grew up well informed about women's health issues thanks to her mother, gynaecological examination was still a difficult experience for her especially before she got married. Being married had changed her gynaecological experience in a good way because she had options available and had space to discuss more with doctors. There was no lack of resources that she can reach the information, at least from Esra’s point of view. Moreover, she was the only participant who definitely prefers a female doctor due to her embarrassment caused by being underdressed during the examination.

Leyla, a twenty-seven years old, unmarried, financially independent woman working in the private sector. Leyla has no private health insurance that can grant her to go to private gynaecology clinics without high fees. Therefore, she defines her struggle to go to the gynaecologist as double pain. She particularly stated that she could not speak comfortably about gynaecological health with her family. For this reason, she went to the gynaecology clinic in order to be examined without even being recorded in the hospital records when she was not economically independent.

Nilay, a twenty-five-year-old woman who identified herself as not religious. She prefers private clinics because she had economic independence and private health insurance. Since her childhood years, she hesitates to talk about gynaecological issues with her family and close environment. She said she could not talk about her vaginal cyst problem with her friends and that it was because she was afraid of stigmatization of "sexually active unmarried girl". She takes medication regularly because of her chronic gynaecological health problem. She regrets not going for check-ups before her disease because of not having access to information at an early age.

Oya is a twenty-six-year-old working professional in the private sector. Having economic independence enables her to go to private clinics. This is a must for her. She stated that she was lucky to have the chance to choose a doctor, but she feels discomfort during the gynsecological examination most of the time. Her gynaecological disease, which had been going on for years, was not taken as a serious one by doctors. She thinks that the concept of virginity creates a hierarchy for the approach of doctors to the diseases. She stated that because she could not get information from the doctors and her environment, she developed a reaction to the treatment and her trust in healthcare professionals decreased.

Selin is a twenty-nine-year-old participant working in the healthcare industry. She feels lucky to have private health insurance. She defines going to the public hospital as Russian roulette because of not being able to select the doctor and timing. She prefers a private clinic there because she is afraid of doctors who might blame her for having a sexual experience. She said that going to the gynecologist during her adolescent years caused stress and fear because she was not informed well about her body and the healthcare process.

Yasemin is a twenty-six-year-old unmarried participant working in the private sector. She stated that she felt the social pressure shaped by the virginity beliefs in gynaecological examinations, also in the form of doctor pressure. For instance, she hesitated to ask about contraception methods because of doctor's judgemental comments. She identifies herself as lucky to have access to early books on the female body and reproduction thanks to the biology teacher in her family. She frequently stated that she did not experience fear in her first examinations, but she was uncomfortable with the comments about virginity. She cannot go to the private clinics because she does not have private health insurance covering expensive tests.

Zeynep, a twenty-six-year-old unmarried participant shared her definition of chastity had changed eventually from a conservative view to modern one after socialization in university. During puberty period, Zeynep was confused about her own body and sexual health, while her brother could speak more about his sexual experiences within family members, which she defined as a double standard. As she had hesitation for sharing her gynaecological problems with her family, she was telling her mother that she went to ultrasound screening instead of a gynaecological examination. At the time of our meeting, she was working in the private sector providing her with private health insurance. She prefers private clinics rather than public ones to not to face discrimination over the perception of virginity.

4.1 Expressions of participants' perceptions related to chastity and virginity

When I asked for their definition of virginity, all the participants connected their definition with words such as taboo, barrier, and control over women's sexuality. Their definitions of the concepts were not significantly different from each other, but on the other hand, they emphasized different issues as reasons for seeing virginity as problematic concepts for women. Associating virginity with loss, seeing hymen as the evidence of virginity, determining chastity and virginity concept in different ways for men and women were recurrent and emerging reasons in their narratives.

Firstly, they have started discussing the definition of virginity concept by saying "unfortunately". The quote below from Leyla's interview is a good representation of participants' common feeling of being under pressure:

> Unfortunately. I associate the concept of virginity with pressure. It is a barrier placed by society in front of a healthy sexual life. There are not such great meanings, but I am aware of the taboo created by society. It [virginity] exists in society as a taboo and a ban until marriage (Leyla)

Apart from seeing virginity as a barrier for unmarried women, participants were not comfortable with associating having a sexual relationship with "loss" of virginity and girlhood. They were against the idea of problematizing being not a virgin by pitting

"losing" something against "protecting" purity. Selin and Nilay stated that sexuality is not a deterioration of women's purity, but is a right that every woman should have if they are willing to do so.

> I am uncomfortable that virginity is being associated with losing something. I do not think it is [first sexual relationship] such a big milestone. Sexuality is a right. Every woman should have it with their consent. (Selin)

> They [the society, others] think that you [women] will lose your respectability when you are sexually active without getting married. I do not like it. Rarely, I did also encounter women who were mocked for being virgins. This is also wrong, and both put pressure on women. (Nilay)

Deniz, a 25-years-old participant, also complained about women's chastity and respectability deriving from sexual experience:

> Virginity is thought to be something to protect. There is a perception that the more you protect it [virginity], the more honorable you will be. Although I do not define it that way, I am subject to such definitions. (Deniz)

These participants' ideas above are in line with the discussions around virginity and purity connection in literature. As stated in studies of Meltem Muftuler-Bac (1999), sexual purity is seen as a criterion to determine a woman's value in Turkish society (311). She also claimed that women's purity, which means not conducting any premarital or extramarital sexual activity is a condition for women for being chaste (309). Another issue that participants were uncomfortable with about the concept of virginity was that seeing something as "provable". Three women stated they found it ridiculous that the status of hymen offers proof of virginity. Oya, Yasemin, and Deniz were speaking confidently while denying the hymen as virginity proof. They declared that they do not believe in the existence of any physical proof of virginity.

> There is no such thing as virginity. In the medical sense, it does not give any data to doctors. Unfortunately, this is purely a social taboo created as the moral code of society. (Oya)

> I have friends who warn doctors not to break the hymen while being examined. But for me it's the opposite, there is no such thing [hymen and virginity connection] (Yasemin)

> They [society] try to understand something about virginity from a membrane called hymen by checking a woman's body. They think membrane is supposed to be present on the body of women until the first sexual intercourse. There is no evidence of active sexuality. This [hymen] is just a body structure, but it is equated with honor. Like our nail, everyone has it, but we cut the nail when it grows. We do not attribute any meaning to it. However, the hymen is seen as protection or proof. (Deniz)

The ideas of participants on proof of virginity reflect the Ayundani and Robatjazi's works in the literature that reject the hymen as virginity proof. While Ayuandini claims that, due to its different shapes, the hymen cannot be an indicator of the absence of sexual intercourse in medical understanding (90-92), Robatjazi (2015) states a diagnosis cannot be certain due to the elastic structure of hymen (153). Robatjazi also covers the women's fear of broken hymen (156) which my research participant Yasemin mentioned as a source of fear as well. I find important participant Deniz's comparison of different parts of the body to exemplify the given importance to the hymen. She questioned why people put too much emphasis on a membrane in the vagina even it is just as much a part of the body as nails that people do not care about at all.

Participants also emphasized that the virginity expectation of society is rooted in gender inequality because the expectation is not the same for women and men. Leyla and Zeynep named this situation as a double standard:

> Virginity is a double standard because it is different for men and women. Pre-marital sex is not taboo for men but associated with morality for women (Leyla)

> My brother (not married) could speak more clearly about his sexual experience, and that was never a problem. This seems to me to be a double standard. (Zeynep)

Their responses reflect the ideology that is covered in literature: women are expected to be virgins whereas men are free from this control. For instance, amplifying different norms for female and male sexuality is present in Karacan and Bektas's study from 2016 that reveals non-marital sexuality of men is permitted (89, 103). Similarly, the experiences of Leyla and Zeynep shared above reveals that they faced the same inequality that shaming and stigmatizing women engage in sexual activity while normalizing the men's sexuality. Cemre was also questioning the so-called proof mechanisms of female and male virginity. Cemre not only rejects the hymen as virginity evidence for women, and also challenges the normative idea of society on male sexuality perpetuating gender inequalities.

> Sexual activity is not only penetration. For society, sexuality is considered as penetration. A relationship between women and men. So, how will they measure virginity for men? It's not fair. (Cemre, 23)

At different points of our conversations, all participants repeated that the concept of virginity is used, even created, by society as a boundary of sexual freedom. They see society's expectation as a mechanism that forces women to be chaste by avoiding any sexual acts and protecting "their virgin status". All of the participants shared their disappointment with this expectation of society on female sexuality because their understanding does not align with society's views. The narratives revealed a struggle for participant women to find their place in society because of their opposite views on sexuality. In the next section, I will analyze narratives showing how they feel during gynaecological examinations while trying to adjust to this perceived struggle.

4.2 Where do I belong ?: Participants' feelings of inclusion

Following the ideas of participants and society's expectations on virginity, I have asked whether they observe any effect of these ideas during gynaecological examinations. Views on premarital sexuality curtail participants' healthcare experiences in several ways but the most significant point I would like to share in this section is that participants lack the feeling of inclusion. Due to the ambivalent positioning of "unmarried but sexually active women", these women need to clarify their social and marital status to find an acceptable place in the realm of healthcare. All of them shared that they need to answer one question at the very beginning of the gynaecological examination: "Are you married?". This question is asked by doctors or nurses to understand the way of the examination. Ultrasound examination can be performed from the abdomen or vagina but is performed only from the abdominal region for virgin female patients. This is the reason for the thought that there will be damage to the hymen if the doctor inserts any tools in the vagina during the gynaecological examination. Basically, sex is seen as only legitimate for married heterosexual women who have already so-called 'broken' their hymens. Therefore, having married patients seems to give the doctor the "power to decide" the examination style. Moreover, they become judgemental if the female patient is unmarried.

Although married participants, Ada and Esra, told that they do not need to explain themselves anymore after marriage, both married and unmarried participants experience the fear of being judged by a gynaecologist at some stages of their life. Unmarried participants informed me that they constantly correct the question as "I am not married but sexually active". However, it does not increase their feeling of inclusion because they think this marital status categorization is shrouded in stigma. The example extract from Nilay reveals the participants' emerging concerns:

> "Are you married?" I'm tired of correcting this question. When I say that I am sexually active, it feels like I am talking to the doctor in a straightforward manner. I think the nurse next to the gynaecologist is very important. Once the nurse said to me, "You take care of yourself, you're just too young." [too young for sexual acitivities]. I am always very nervous in the room where I prepare for the examination. When it happens, I question myself. I'm only here for my health. Why this tension?

> Who am I? Why am I explaining? What do they think about me? I ask myself where do I belong in their eyes? (Nilay)

Selin, the twenty-nine-year-old participant, explicitly communicates her antipathy towards the marriage question after her long years of gynaecological examination experiences:

> The question of whether you are married or single… They ask to understand whether you have an active sexual life or not. Some doctors judge us [unmarried women]. They [doctors] don't know their limits. (Selin)

Zeynep, a participant who is even feeling ashamed of seeking gynaecological health because of her family's possible judgemental comments, explained her first gynaecology experience as traumatic due to lack of inclusion in the clinic. When she encountered gynaecologist's humiliating question at the first visit, she was also trying to find out how her active sexual life will affect her social situation in her personal life.

> I went to the gynaecologist for the first time with the fear of judgment. When the doctor was just at the door (waiting patients could hear us) he shouted: if you were single or married. Then he yelled: are you a virgin? Since I went for the first time, I said I was a virgin because I was afraid of the people there. It was cyst treatment, actually vaginal examination would be helpful, but he examined with ultrasound because I said I am a virgin. I felt I could never explain myself to the doctor when under pressure. I felt excluded. (Zeynep)

Zeynep's narrative also reveals another layer in the inclusion discussion that not all the methods of examination are open to unmarried patients. Although she wanted to have a better understanding of her health problem via vaginal examination, she had an ultrasound option because of feeling stress to declare that she is sexually active. This limits women's right to choose the examination method by stigmatizing or creating marriage as a prerequisite step. Cemre's example also demonstrates this similar tension over premarital sexuality and way of examination:

> In a public hospital, they [doctors] asked me to fill in a consent form stating that I am aware of the vaginal examination while having a pap

> smear test. If you are registered as ‘not married’ in the system, they automatically think you are a virgin. The doctor wanted a consent form to avoid me claiming "my virginity was broken during the doctor's test". (Cemre)

Cemre’s narrative shows an interesting point that for the medical professionals, there is a lack of clue about hymen and virginity connection. Doctor asks the patient’s confirmation that the examination itself did not rupture the hymen and hymen was broken before the examination. As it is not possible to understand virginity due to the shape of hymen, the doctor wants a patient to declare it. This is actually in line with the Ayundani’s study in the literature indicating that hymen can be in different shapes and none of these shapes proves the absence of sexual penile penetration (92). Due to the tension over virginity, medical professional asks for the consent and confirmation.

Narratives of participant women demonstrate that the conservative thinking about premarital sexuality of women creates the source of stigma and ambivalent self-positioning. It is important to recognize that while participants feel that stigmatization in different public and private spaces, they also try to find ways to have their own space for living as they like. To illustrate, eight of participants explicitly asserted that even premarital sexuality is taboo; they do not let that taboo regulate sexual behaviour. In other words, they have active sexual lives but they bear the possible consequences such as stigmatization and exclusion. Moreover, within their family, they also do not explicitly speak topics related to their premarital sexuality or gynaecological experiences. Nilay, Cemre, Leyla and Zeynep mentioned in their college years they even hide that they had gynaecological examination.

> If possible, my family should not know. Cause I do not want to have tension with them over it [virginity]. I do not need to break the perception [premarital sexuality as a taboo] that they have. (Nilay)

> There was no exchange of conversation about health, relationships, or sexuality. When there is something [relationships] associated with morality, it is not easy to say it. (Leyla)

> These issues were treated as if they did not exist in my family. I have not talked to anyone, I cannot talk. (Cemre)

These participants mentioned they behave as if they comply with the virginity norms created by society and their close family. Since society accepts sexual activity only within marriage, participants see themselves as outliers of the virginity norm. This negotiation of participants is similar to Ozyegin's terminology in literature: "Virginal Facades", constructed identities by young women who both engage in sexual activities before marriage and tend to negotiate the conflicting expectations of others (113). Ozyegin describes this purposefully created identity as the result of contrasts between young women's values concerning virginity, and their parents' generation (109). As Ozyegin's study supported that in-between situation of participant women leads them to feel excluded and invalidated.

4.3 I am not very religious, but…: The effect of religion

In order to understand religion as a factor influencing the approaches of participants regarding sexuality and virginity, I asked participants questions on how religion affected their virginity concept and its possible effects on their gynaecological health processes. According to the literature, religion can play a fundamental role in controlling women's bodies due to its traditional rules (Karacan & Bektas 90). As mentioned in the literature review, Sevil and Dasikan also argue that strict religious practices create the traditional female sexual role and virginity perception which become a psychosocial factor affecting the gynaecological health practices of women (77, 82).

Interestingly, nine out of the ten participants do not see religion as a basis for shaping their concepts of virginity. These participants, except for Esra, see the effect of religion in the gynaecological examination experiences due to the virginity taboo in the society, but not due to their faith and religiosity. After starting the sentence with "I am not religious" they added: it is inevitable to feel the influence of religion, as it is a huge factor that shapes society's concept of virginity.

The narratives of Cemre and Selin exemplify this as follows:

> For me, religion does not affect my definition of virginity. But religion has a lot of influence on the culture. In Turkey, it is hard to separate them [religion and culture]. Although I am not very religious, there is a controlling effect of religion in the health process due to the influence of religion on culture. (Cemre)

> If a woman puts religion in an important place in her life, it also affects her thoughts about virginity. I do not have such a situation. In Islam, there is a marriage concept and women's premarital sexuality is forbidden. I think the problems during gynaecological treatment are due to social pressure. The influence of religion is on such social pressure, but not in my definitions. My view is not shaped just because religion dictates. (Selin)

In the literature, religion is discussed as a factor that prohibits the premarital sexuality of women and can lead to "feeling guilty" after sexual relationships (Yasan et al. 179-180). Yasemin's narrative is in contrast with that feeling of guilt:

> I am not a believer. I even had a reaction to religion because people put women under pressure by using religion as the source. I think this is not only in Islam. They want feelings of guilt. The thought that the woman should protect herself… If there is religion, virginity is taboo in this phenomenon. But it is not what I personally feel. (Yasemin)

When it comes to the effect of religion on the virginity concept and the gynaecological health processes, the participants started to point the malpractices in the name of Islam. Similar to Yasemin's approach above, Deniz's argument below was in line with the Pinar Ilkkaracan's study in the literature suggesting that there are malpractises on women's sexuality bring in oppression in the name of Islam (Ilkkaracan 14). She argues religion as a tool of fear, whichaims at controlling female sexuality (18, 19).

> In the gynecological health process, I hesitate to be involved in the state policies fed by religion: "What if I am pregnant? How can I get out of this system as a single woman?" Now the regulations on the female body in our country are also associated with religion. They [the government] are discussing abortion… If it is a right or not… Since I live in a country ruled in this way, I cannot deny the effect of the moral rules of religion on gynaecological processes. (Deniz)

In this extract, Deniz's hesitation is coming from the policies that govern the abortion rights for unmarried women. Although she does not identify herself as religious, being part of a system does affect her experience. She is not specifically afraid of religious rules itself, but feeling restricted by the abuse of these rules is a source of fear for her. Another participant Ada alludes the putting religion as a source of moral code to create fear as follows:

> You are being judged in every way. You are strange for wearing a short skirt, you are judged with your heels. They [the society] gets involved in your life by using religious excuses (Ada)

Other than religion as a source of fear, in the literature, Uskul and Ahmad argue that the gender of the gynaecologist is also important for women in Islamic religion (Uskul & Ahmad 214). In line with that, Esra does prefer female doctors. She explains herself as follow:

> It's an individual decision. Surely affected by my religiosity. I open my hair to the dermatologist, but the genital area is not the same for me. It feels like it's not fitting my religion. I see it [vagina] as a very private area. (Esra)

In the extract, Esra links the reason for female doctor preference with her sense of shame. She describes the vagina as "a very private area". This was reflected in the literature by Meltem Demirgoz Bal in her study in 2014. While discussing the effect of religious values during gynaecological examinations, Bal argues " women do not feel comfortable showing intimate organs" (Bal 137). On the contrary, in this study the rest of the participants declared they do not pay attention to the gender of the doctor. They declared that religion does not have a direct effect on the selection of a specific doctor and their feeling of intimacy.

In this section, I discuss Esra's experience separately because she describes herself as religious and this affects her gynaecological experience when it comes to the gender of the doctor. However, in her narrative, religion is a factor affecting her "own preferences"

during the gynaecological examination. Nevertheless, her narrative below shows that she is aware of the pressure on the woman's body based on the malpractices of religion.

> While there are studies in different countries to break the perceptions about the vagina, in our country, virginity is the discussion… We have to skip them and start talking about health. These are individual preferences. Religion is also individual. (Esra)

The narratives composing this theme were the critique of using religious rules as a tool to control female sexuality. Esra's narrative on the gender of the doctor, has shown once again how analyzing the narratives with the intersectionality lens is useful. There are no unified gynaecological experiences for Turkish women. As mentioned in the literature, in her study "Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color", Crenshaw argues that awareness of intersectionality makes us know and ground differences among us (1299). In line with that, the gender of the gynaecologist was important for the participant who identifies herself as religious but it was not a selection criterion for patients who see themselves as "not very religious". If we look from an intersectionality lens, this enables us to understand how religion and gender converge during gynaecological experiences. Intersectionality provides the means for recognizing the multiple dimensions in gynaecological experiences.

4.4 Can I afford the clinic fee? : Freedom to choose the health care service and class difference

According to the Turkey Health System Review (2011) report of the World Health Organization, in Turkey, The Ministry of Health is the governor and dominant provider in the healthcare system (15). While there are both private and public healthcare service facilities, universities can also own their health care facilities operating in the public sphere (15). In public healthcare centers and hospitals, a social security scheme finances the health services that are governed by the Ministry of Health (16). The Ministry of Health also provides maternal and family cares services through family health and population health centers (22). Private hospitals provide contractual base services for social security benefits directly to patients with private health insurance (15).

During our conversations, when participants talk about their preferences for gynaecological clinics, they often mentioned that they prefer private clinics rather than public hospitals. This requires private health insurance or the financial ability to pay the high fees of the private gynaecological clinics. The main reasons for choosing the private clinics are first, having more frequent appointment options; second, a high chance of finding an available doctor who is not tired by so many patients, and, third, having expert doctors who answer questions in longer sessions. Moreover, participants stated that if they do not want their families to know about their gynaecological examinations, they go to a private hospital without any official registry in the system. Nilay, Cemre, and Leyla stated they needed to go to private clinics to hide that they go to gynaecologists especially when they were students and financially dependent on their families. Cemre feels privileged due to having private health insurance or being able to afford the high fees.

> I go to the private hospital because I have a chance to choose. I do not want to wait in long queues in a public hospital. I don't want to deal with the late test results there. I have an advantaged situation because I can pay the fee of a private clinic (Cemre).

Another participant Leyla declared her ability to afford private clinics gives her also a social advantage because she feels independent from her family. In addition, if a service is not available in a public hospital, she has the power to go to another hospital due to her socioeconomic class.

> Most people cannot access private healthcare. I can go to a private clinic because I have the financial freedom that complements my social independence. I am only responsible for myself and my freedom does not depend on my family's income. During the Covid restrictions, I needed to go to the nearest health facility, the Family Health Center in our neighborhood, but they were only supporting pregnant women at that time. I went to a private institution to get alternative views. I would not be able to do this without my financial advantage (Leyla)

When talking about private gynaecology clinics, Nilay positioned those services as the option available to not to be judged by their family. She repeatedly stated in the public healthcare system, their family could see a registry in a gynaecology clinic. This could be a sign of having problems intrinsic to sexually active women. As being sexually active

would also be a problem for their families, they use the private clinic option as a strategy for taking care of their healthcare issues on their own.

> Definitely private hospital because I can choose my doctor and go the next day. I am not worried that my mother and father may see my gynaecology patient registry from the electronic system of the state. Also, I can easily reach people in the private clinic who will give detailed information when I have any problems. (Nilay)

Participants also emphasized the changing policies of the government on the registration system of public hospitals. Deniz mentioned that she would feel insecure in a public hospital but there are other women facing difficulties because of not being able to go to a private hospital.

> If an unmarried woman has no money to go to a private hospital for an abortion, the scenario she will live in is very different and difficult. I do not know what will happen to me in a public hospital. There are constantly changing policies. I heard hospital officers could send a message to the family about your treatment details. This system is not the one I would like to participate in (Deniz)

The comments of the participants on being able to afford the private clinics resonate with Moser's concept of interference. In the article "Sociotechnical Practices and Difference: On the Interferences Between Disability, Gender, and Class", Moser (2006) argues this concept of interference and enactment of differences by stating that we explore differences that may support, reinforce, or unmake each other therefore operate in complex ways (p.543). She examines the differences such as disability, gender, and class to show how they can be interfering with each other. She also adds, "throwing the metaphor of interference into debates on relations and interactions between differences is, then, also an instance of interference, an attempt to contribute to moving our efforts at conceptualizing and dealing with the difference in new directions." (543). While participants think their gender and marital status difference gives them an inferior position in a health examination,

class difference unmakes this position by ameliorating the inferior position. They feel relatively privileged because of the financial “ability” - being able to afford a private clinic.

The different gynaecological experiences due to different insurance types of participant women show the intersectionality of experiences as illustrated by Crenshaw in literature. Crenshaw draws a correlation between differences among women and the way of subordination by showing intersections of race and gender. In Turkish women’s gynaecological health experience, being able to afford private insurance changes their experiences which shows the intersection of class and gender.

Nilay and Ada argued that being able to go to a private clinic cannot be a complete advantage. Those participants declared that although they try to escape from monitored female sexuality or less quality service in public hospitals, they have concerns about private clinics as well. They are uncomfortable with the price of the tests and the financial barrier to receive proper gynaecological health care. They think this is not an advantage, but an injustice because every test adds more financial stress on them.

> A private clinic is better because I can get detailed information. However, I am wondering if the private hospital has commercial concerns. What if doctors in private hospitals do unnecessary tests just to earn extra money? While I being examined, I sometimes think "Please do not ask for an extra test" (Nilay)

Ada told that a private gynecological clinic is not a choice but a requirement in some cases.

> I do not feel advantageous in Turkey even with private health insurance. There is no treatment method for my gynecological problem in public hospitals. State insurance does not cover my treatment. Why do I need to go private clinic? This is not an advantage. (Ada)

4.5. Where is the doctor that I can trust? : Selection of healthcare provider

Another theme underlying the stories of participant women relates to trusted relationships with gynaecological healthcare providers. In the narratives of the women I interviewed, it was evident that all of them were seeking gynaecologists who can guide them as trusted mentors. Although the information needed by women varies, the repetitive theme was that patients want gynaecologists to understand their problems with empathy

and to provide all related details. For instance, while a married participant needs detailed information on reasons of her pain during sex with her husband, another participant's desire was learning the different contraception methods for her health. Regardless of the topic, from the very beginning of examination to the end, participants would like to see doctors or nurses explain every step in detail. Extracts from Ada's and Deniz's interviews highlight the points that are repetitive for other participants:

> When I go to the gynaecologist, I get nervous because they usually overlook my problems. I expect them to understand and inform me. But I'm trying so hard to get information by asking questions. I am making notes before examination to explain my problem and to learn more. (Ada)

> The doctor should explain the examination to me better. It would be better to have someone there to help me. Someone kindly telling me "you do this, you will put your leg in this way" etc. They assume we know everything by default. Once, I couldn't tell the doctor that I took the day after pills, unconsciously. I was afraid of being judged because of this not informing but judging behavior. (Deniz)

> If the doctor acts recklessly, I'm scared. If the doctor does not explain the examination steps in detail, it is not good. I want him to inform me as a patient. Maybe doctors do not have time in public hospitals, they help 50 patients in a day but people go there without knowing. Their [doctors'] approach is very important. (Yasemin)

As visible from Deniz's and Yasemin's experiences above, despite the fact that these women expect gynaecologists as mentors to explain every issue in detail, they experienced the other way around most of the time, especially during their first visits at younger ages. However, it is not only marital status or virginity playing an active role in this patient-doctor relationship but also, age and class. Leyla's extract below shows how being unmarried but sexually active shapes the doctor's approach. Nilay's narrative

demonstrates why being in a different class may alter the way of communication with the chance of choosing the clinic:

> I feel like I am not receiving the answers I expected. [when she says she is sexually active and unmarried] I am feeling uncomfortable and getting angry. I'm not ashamed of being sexually active. There should not be personal judgments in the medical profession. If I feel that they are looking completely objectively, if I have detailed information and a warm approach, I can relax. (Leyla)

> Once, I had to go to the public hospital due to a very emergency situation, I did not have time/ money to go to a private hospital. It [the public hospital] was filled with urgent patients. And the doctors pushed me to tell my problem in front of all patients. I needed to tell that there was a condom left in my vagina, in front of everyone…Doctor replied sarcastically: "Ok ok, you are the second one today..." It was very traumatic for me. I cried in front of the hospital for 3 hours after I got out of there. Actually, I just had to worry about my health and receive doctor's help. (Nilay)

Another important point that these examples demonstrate is the paternal relationship with the authoritative gynaecologists. In other words, women are expected to act as children seeking the advice of the healthcare provider who is in the role of father. Hierarchical relationships with female or male gynaecologist was evident in participant narratives. Moreover, participant women shared that they felt their voices ignored by the voice of medical authority. Another extract from Nilay's interview shows her negative interaction with the doctor because of "advising her":

> I don't want doctors approaching me by giving me advice on my personal choices. Or I fear that they might criticize and manipulate me about my decisions such as not to have children. Because of the first gynaecologist, I have a lack of confidence. She acted as "decision maker" for me. I heard the disturbing questions related to premarital sex at very early age from her. (Nilay)

Experience with judgemental or ignorant doctors lead women to continually research to find the “best clinic” . Both unmarried and married women rely on their social networks such as friends from school, websites or forums for doctor ratings and recommendations to find the best possible option. Zeynep shared her way to find a more responsive doctor as an ongoing process for her because she constantly search for better options:

> I get the doctor's advice from my social circle. Especially, if someone talks about a gynaecologist examination I write the clinic name aside (as reflex), because I know I will definitely need it. (Zeynep)

Yasemin’s narrative below demonstrates the disappointment during the selection process. She mentioned it is very hard to find an appointment from a trusted doctor due to the electronic appointment system for public hospitals. Even she search the doctor beforehand, there is limited doctor capacity.

> Even if I search for doctor names on the internet, in public hospitals, it is not very useful. It is necessary to book the doctor's time like a ticket. There is not enough capacity. I hear that the doctor is good, but they give an appointment for 15 days later. (Yasemin)

4.6. I wish I knew: Access to information on gynaecological health

In this section, I will analyze the participant women’s main sources of information on gynaecological health. The difference of this “access to information” theme from other themes is the coexistence of participants’ frustration due to lack of education and their ways to solve this problem. In other words, while sharing how the stigmatization of sexuality created an extensive ignorance of gynaecological health for them, participants also dwell on how reaching information to become conscious was a struggle for them.

Participants expressed concern about feeling inadequate in terms of gynaecological and sexual health knowledge. While repeating the phrase "I wish I knew", they saw this as both a reproach to the past and a way against the patriarchal order that impeded their way. As mentioned in the literature review, Kivrak and Ulker (2016) also discuss the unfamiliarity with the gynaecological health topics and women’s lack of information on

their own body create obstacles for them to have more pleasant gynaecological healthcare experiences (1, 2). This is also in line with Demirel's study discussed in the literature review on anxiety levels of women during gynaecological examinations. Demirel argues low levels of education and insufficient access to information leads stress during gynaecological examination (132,134). As the extract from Deniz's interview demonstrates, since gynaecological health is associated with the taboos of virginity and this issue is muted, it is not easy for women to understand that they need an education on this subject at first place:

> First of all, it was a matter of realizing that I needed information about my body. I realized late at first that I needed to understand my own body and to have knowledge about gynaecology. I wish there was a mechanism for me other than learning misleading information on sexuality from a friend or searching on the internet. (Deniz)

Other than pointing out the needed awareness on female body and health, Deniz's statement also reveals the lack of structured and correct information. This experience is not unique to Deniz, because eight of the participants declared they did not have a specific education on gynaecological and sexual health other than their self-efforts such as internet search or conversations in their social network at later ages. However, one exception to this is the menstruation training by a private sanitary company that is seen as problematic in many aspects by participants. This training will be discussed later in this section.

On the gynaecological health education, Yasemin and Esra, other than the rest of the participants, mentioned that having mothers as biology teachers and healthcare professionals helped them for learning the basic information on genital organs, at least. However, they also agreed that there was no possibility to learn about gynaecology and sexual health at school. Oya and Leyla expressed their concerns about this matter by highlighting the vulnerability caused by lack of information and inability to speak comfortably:

> I wish my parents had told me about it [sexual and gynaecological health] and I would have seen it at school. If everything about my sexual health for me had been an informed choice, I wouldn't have reaction fear of gynaecological treatments. I always progressed by searching myself. I wish I knew it could happen to anyone. (Oya)

> I wish there was a process that started at an early age in primary school. I could talk more comfortably about these issues [women's health, sexuality, gynaecology]. Children and adolescents should be able to talk more comfortably on this topic. It's always like a sealed box because society link them to sexuality taboo (Leyla)

Having no space to speak openly the gynaecological and sexual health was not the only problem these women encountered. Participants also see the information on other sources such as internet and social network as not enough, misleading or comprehensive. Esra highlights this misleading information and possible fear of young women:

> There is a learning process with inaccurate information among the young female groups. If you are lucky, you will hear something true on possible diseases or sexuality and will not fear after all the rumors among teenage groups. (Esra)

Following the experience of Nilay demonstrates the struggle with complicated and insufficient information that frustrates her.

> I tried to read myself a lot. I tried to read something on the Internet, but I had difficulty, I did not understand. I did not even fully understand the ovarian structure. (Nilay)

Deniz highlighted that she was also not happy about the hierarchy in the information system. For example, she mentioned having many resources on reproduction, motherhood, and pregnancy on hospital websites. On the other hand, she mentioned that the resources related to female sexual health are limited:

> There is a lot of information on pregnancy. Women's health is not just about fertility. I wish I could read that the body of a woman is actually a structure that can also have pleasure or important diseases when I was young. (Deniz)

I find the information hierarchy mentioned in Deniz's experience important as this is actually the result of the mentality that disgraces sexual activity outside of marriage and without the aim of reproduction. The mentality that opposes female premarital sexuality emerges as restricting resources on the female body and sexuality. On top of the vulnerability of women due to insufficient information about their own body, learning sexuality after their first relationship with their male partner creates equally devastating effect. Later in her narrative Deniz shared her frustration on this as below:

> I wish I knew more. Our learning of sexuality always comes from friends or partners. I wish my fate was not left to the conscience of my first partner. (Deniz)

Similar to Deniz's concerns on vulnerability caused by learning sexual health from partner, Cemre also shared her insecurity due to lack of information on her body:

> I wish I knew better what "consent" means, what is women's health, why sexual health is important, and the ways of protection. I wish I was trained. (Cemre)

Narratives of Deniz, Cemre Nilay and Esra reveals that age is another factor making the gynaecological experience of the participant women intersectional. Crenshaw's analysis in "Demarginalizing the Intersection of Race and Sex" argues that failure to consider intersectionality misses the experiences of the Black women because race and gender are mutually grounded in their experiences (139,140). Similar to Crenshaw's multidimensional analysis of the Black women experience, disadvantages on the gynaecological health of Turkish women are not unified but multi-layered. Interaction

of age and gender reflects once more the intersectional experience of women in this study. To illustrate, participants point out that because of the virginity taboo, they were more vulnerable at younger ages due to a lack of knowledge on possible diseases or misleading information among young teenage groups. Thus, narratives are quite revealing that the gynaecological experience of a young woman is more different and discriminatory than other women. As the young women encounter this combined subordination due to age, my analysis tatakesntersectionality into account not to frame the experience as only "women's", but to dwell on the distinct issues women confronting during gynaecological experiences.

Another inference that could be drawn from Oya and Zeynep's statement is that the lack of information about women's health is also an issue of class difference:

> I have always reached information [on gynaecological health] by searching myself, because I had to. Regarding my gynaecological disorder, I wanted to get training from a specialist in women's health in Ankara when I was a student. But it was expensive, I could not afford the workshop. (Oya)

> If you search today, even in social media account, there is always the same content. This content targets the upper-middle class. I do not think the content can be reached by people who are economically disadvantaged and have a low education level. (Zeynep)

Extracts from Oya and Zeynep's interviews reveal not only the lack of structured knowledge but also the question of who access the existing information. This illustrates that having financial power facilitates access to the existing informal information. First, Zeynep mentions that the information on the Internet has a language that people with upper-middle level education can understand creates another inequality. Understanding the language and content used in the resources is not easy for everyone. Finding a level of basic information that can appeal to everyone presents a different challenge to women. Secondly, Oya and Zeynep shared that even they want a comprehensive education on gynaecology, having limited financial power makes them remain out of the learning cycle, as the online workshops are expensive. Importantly, Oya and Zeynep's comments shed light on class as

a difference which shows the need for intersectional analysis rather than “single-axis analysis distorting the experiences” (Crenshaw 139).

After analyzing participant women’s struggles on the ways of learning about their health and body, it is also helpful to elaborate on the one common training that they all participated in. As mentioned at the beginning of this section, this training organized by a corporate company producing sanitary pads is on menstruation health. Although this training was not in the curriculum of their schools, in primary school, all participants attended the training that they found problematic in many aspects. For example, Cemre, Leyla, and Zeynep stated that they find the menstruation training ridiculous because trainers forced male students to leave classroom during the workshop. Leyla's following narrative shows that giving this training only to the girls created a stigma that categorize menstruating women as deviant.

> In only one secondary school, a company provided training on menstruation and sanitary pad usage. While girls were kept in class, boys were removed. Actually, I could not get any information. We were hiding the sanitary pads that company gave us as promotion. Why were they separating male and female students? Why they gather us in this “secret meeting?”(Leyla)

This, in fact, reveals an approach to the gynaecological health of women. This separation practise creates the taboo that gynaecological health is a secret discussed only among women.

Similarly, another participant, Zeynep, said:

> I learned in that training environment that I should hide my sanitary pad from men. It was not good training. It made menstruation seem like something to fear or something to hide. (Zeynep)

However, Nilay was happy that despite the wrong method applied, this training had the potential to introduce the menstruation topic to female students.

> There was training on menstruation for girls. It was a nightmare day. It was a very wrong method, they gathered us all together as if they were going to give a secret. But...was it useful? Some girls saw a pad for the first time in their life. at least it was helpful to talk about this topic. (Nilay)

CHAPTER 5

Discussion and Conclusion

In this study, I aimed at investigating the influence of virginity beliefs on Turkish women's experiences and knowledge on gynaecological healthcare. To explore the answers to my research questions, I conducted in-depth reviews with ten heterosexual women between the ages of 23-30 from Ankara, Turkey. My thesis sought to provide a glimpse into the gynaecological experiences of participant women by examining the intersection of different factors surrounding their experiences such as age, class, gender, and religion. As Carasthasis (2014) argues, to reveal the construction of simultaneous oppression and to unveil the structural, hegemonic, and interpersonal dimensions of power (307), I applied intersectionality as a methodology to shape my research questions and to analyze the narratives of respondents.

In a quest to answer my main and sub-questions, understanding the perception of participants on virginity was crucial. My study revealed that the women I interviewed see virginity as a barrier created by society's controlling mechanism on their sexuality. Associating sexual relationship with "loss" of virginity and respectability are problematic for participant women. This was evident in the relevant literature as well that the sexuality of women seen often linked to purity and the value in Turkish society (Muftuler-Bac 309; Ilkkaracan & Seral 188-190; Ozturk 276-280; Karacan & Bektas 89). These women do not accept the negotiation that if they engage in sexual activity they will lose their respectability. Studies denying the link of hymen with virginity (Ayuandini 90; Robatjazi 152) were evident in testimonials of three of the participants who reject the existence of any physical proof of virginity such as intact hymen. However, during the gynaecological examination, they encounter doctors who operate as if hymen exists as proof of virginity.

When it comes to the impact of society's expectations on women's sexual experience in gynaecology, especially eight unmarried participants shared their stress associated with fitting in some category as "unmarried but sexually active" women during gynaecological examinations. They need to answer the "Are you married?" question as a way of telling if they are sexually active or not. In a gynaecology clinic, this question serves as a determining way of examination because some methods such as vaginal examination are seen as appropriate only for women who have sexual penile penetration. The question is asked to understand if the hymen is intact or not. Medical professionals ask marriage

questions as if hymen does show whether or not one is a virgin. Moreover, this limits women's right to reach certain examination methods by stigmatizing or creating marriage as a prerequisite step.

This locating sexual activity only within marriage for reproduction and excluding unmarried women was also evident in literature as referring them "women without space" (Scalco 333-336; Ozyegin 109). In Scalco's study, while reproductive rights are seen as exclusive rights of married women (325); young, unmarried women have limited access to reliable contraceptive methods, are categorized as " women without a place" (333). As the sexuality of unmarried, young women is not recognized, participants in this study have ambivalent self-positioning as well. This also corresponds to McGann's (2011) study called "Medical-therapeutic Regulation of Sexuality" where she discusses how medical-therapeutic approaches such as medicine, psychiatry, psychology may help to enforce society's sexual hierarchy and norms to decrease sexual deviance (365-366). Mcgann argues medical response to "violations of sexual norms is a form of sexual social control" (365). The narratives presented in this study also reveal that gynaecological examinations play a role in the medical-therapeutic approach which perpetuates the control over participant women's sexuality.

In the narratives of my research participants, this social control in the form of medical control was observable in different ways. First, narratives show that the norm of sexual activity is being married. Participants need to declare marital status as a sign of sexual activity to find an acceptable place in the realm of healthcare. The question of "are you married" in the medical realm shows how "culturally-defined sexual ideals regarding valid forms of sexual activity and institutionally supported" (McGann 375). Secondly, three women ignored the physical proof of virginity in this study but they encounter gynaecologists who ask the marriage question first to understand their hymen's status. Seeking the physical proof of virginity through the shape of the hymen is a form of medicalization. Doctor's advice and report on hymen are also forms of "legitimizing the criminalization of non-standard sexual practices" (McGann 366-67).

Another sub-question of this study was in what ways the differences in demographic situations and religion play a role during gynaecological examinations. In terms of demographic situations, the effect of the class difference was significant as a source of anxiety in this study. Although the literature on anxiety and gynaecological health in

Turkey is focusing on fear of pain, unfamiliarity with the hospital environment (Kivrak and Ulker 2) or being naked, risk of illness (Aksakal 64-65) in terms of stress points for women, how women from different socioeconomic situations encounter different levels of stress was not widely covered. In addition to studies in literature, narratives of women showed the healthcare system in Turkey adds another layer to their stress by offering two different health insurance: private (paid) and public health insurance (government coverage). Having private health insurance enables women to choose the doctor, clinic, and timing of appointment and to have high-quality health service. Also, these private hospitals offer gynaecological healthcare services on some special diseases such as vaginismus that are not included in public hospitals.

Most importantly, participants like to use private hospitals to escape from the government monitoring their gynaecological examination history. In Turkey, in public hospitals, people need to be registered to the system by their name, treatment method, clinic, and prescription for their disease if applicable. Nine women in this study were afraid of this personal information record because they do not trust public hospitals for keeping this data private. They think the conservative thinking of policymakers in Turkey may use unmarried but sexually active women's information against them as a controlling mechanism.

The uncertainty and lack of trust about the security of information can be expected because of the discussions that gained wide coverage in the media. To illustrate, in 2012, many portals in social media and mass media brought up a message sent to the father of a woman who had a positive pregnancy: "Congratulations, the pregnancy test was positive, go to the family doctor as soon as possible" ("Tebrikler Kızınız Hamile"). It was discussed that the doctor's notification to the father about his single daughter's pregnancy is against both personal safety and human rights ("Tebrikler Kızınız Hamile"). In the news, it was stated that the Ministry of Health sent letters to all laboratories that performed pregnancy tests and requested the list of those who tested positive and their contact information, including mobile phones. Family physicians were asked to contact the family of the woman who was tested positive. In the same period, a social media campaign has started with women posting photos of their bodies written "My body, My decision" as a reaction to the controlling mechanisms of the state while the restrictions on abortion were being discussed (Gharip 2012). It seems that the effect of these discussions still manifests itself as insecurity and distress on women during the gynaecological healthcare process. Unmarried women

in this study do not want their family to learn the historical information on their gynaecological health, they go to private hospitals they trust or even try not to register at all. However, in this case, participants need to pay high fees for these private services or they should have an employer who covers the private insurance for them.

Parmaksiz (2016) in her article "Paternalism, Modernization, and the Gender Regime in Turkey" defines paternalism as "to act like a father or to treat another person as a child to hold power over others with the justification that one is acting for the good of others, even without their consent" (43). The risk of personal data availability shows the paternalistic approach of the Turkish government that has all the information and right to use it on behalf of female patients. Participants who do not trust the government's electronic healthcare system, feel insecure and try ways to afford the higher private clinic fees. Nevertheless, the financial barrier to receive proper gynaecological health care remains because women of low economic status cannot easily reach the clinics that they trust.

The role of religion as a factor affecting gynaecological examinations does not fully correspond to the studies in literature that argue the difficulty of showing intimate organs at the gynaecologists (Bal 137) and the importance of the gender of the doctor (Uskul & Ahmad 206). Nine participant women in this study declared they do not have a preference to go to female doctors because of their faith in Islam. They do not have any concerns about showing intimate areas to the male doctor because religion prohibited them, or they do not suffer from being naked during the gynaecological examination due to religious concerns. However, they criticize using religion-based policies and conservative thought as a tool to regulate their sexuality. Narratives of participants showed that they see the effect of religion in the gynaecological examination experiences due to the virginity taboo in the society, but not due to their religiosity. Consequently, it shows religion does not have a direct influence on their personal description of virginity. As discussed in Chapter 4, their narratives can be summarized in one theme "I am not religious, but I see the effect of it on the definitions of virginity"

In line with understanding the virginity and gynaecology relationship, I seek to understand participant women's expectations from gynaecologists, the criteria considered when choosing a gynaecological clinic, and the effect of the doctor's approach to the gynaecological examination process. Women in this study seem to expect doctors to explain every step of the examination in detail. It is evident that unmarried but sexually

active participants hesitate to encounter the judgmental comments of doctors or nurses about their sexual activity. It is a constant struggle for them to find a doctor who they can trust and they can ask any question they have about their gynaecological and sexual health. As discussed in the theme selection of healthcare providers in Chapter 4, I observed their trust and ignorance problem about doctor selection. Importantly, the hierarchy between themselves and doctors makes them nervous because they feel their voices are ignored by the voice of medical authority. Their hesitation and feeling insecure at gynaecologist corresponds with the studies of Tugut and Golbasi (2014) in literature discussing that providing information about the details of examination help women to have a positive experience by decreasing emotional discomfort (1778). This observation is in line with the medicalization of virginity and the paternalistic approach in gynaecological healthcare process.

On the doctor's approach during gynaecological experiences, it is important to point out that in my study, even doctors seem to have the bias against the premarital sexuality of these participant women. Doctor's behavior such as asking about the marital status, yelling at the patient, not explaining the details of the examination, ignoring their questions show the ignorance level and institutionalized support of virginity discourse. This seems like a reflection of paternalistic and patriarchal culture in society in the medical field.

Interestingly enough when researching gynaecological experiences in Turkey, I found a blog where women post their gynaecological violence stories in 2012 in Turkey (Jinekolojik Siddet 2012). Two academicians Burcu Ertuna and Ezgi Emre created this website where they encourage women to post their gynaecological experience stories whose personal stories are quite similar to my participants. Yet, the experiences were characterized as violent. Although the gynaecological violence stories of Turkish women on their website were posted nine years ago, it was interesting that these stories are very similar to the participant women's narratives in this thesis study conducted in 2021. Similar to my participant's experiences posts are pointing to the judgemental comments of doctors about premarital sexuality on that website. It shows a long-lasting need to combat the violence in gynaecological healthcare services.

In literature, Coskun et al. (2013) discuss a similar concern that gynaecologists need the increased in-service training to ensure better healthcare service for the young women in Turkey (6390). Similarly, in the study on health science student's attitude on gender-based sexuality, Gursoy (2019) points out that even health science students who take courses on gender equality consider that chastity of women is damaged by being a not

virgin before marriage whereas they think a premarital sexual activity is “trivial for men” (4866). More future feminist studies should address this “less visible violence” for the promotion of the humanistic approach in gynaecological healthcare. Most importantly, policy makers for healthcare practices should ensure the reporting mechanisms for the victims of gynaecological violence in Turkey.

The Parliamentary Assembly of the Council of Europe (PACE), which Turkey is a member state, by its Resolution 2306 (2019) report addresses the need of eliminating violence against women, including obstetrical and gynaecological violence for the authorities (Obstetrical and Gynaecological violence 1). In this report, PACE asks member states “to ensure treatments respectful to human rights, promote a caring approach in gynaecology, promote mechanism to examine patient complaints and ensure training for obstetricians and gynaecologist, and importantly ratify and implement the Istanbul Convention” that already assign clear responsibility to member states on the fight against all kind of violence (2). However, by adopting a deplorable attitude, Turkey announced the termination of being a party to the Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence (the “Istanbul Convention”) in March 2021, which is a “first withdrawal from a human rights treaty by the President” (UN Women 2021; Çali 2021). Although the defined problem and solution paths are addressed with the efforts of member countries, the solution for gynaecological violence seems unrealistic for Turkey in near future.

The last sub-questions of my research were how participant women reach information on their gynaecological health and what is the effect of beliefs on women’s sexuality on this access to information process. I analyzed their narratives on access to education under the theme of “I wish I knew” because it was evident that these women suffered from a lack of information on their bodies during gynaecological examinations. Firstly, women in this study have concerns due to lack of knowledge and feel inadequate in terms of gynaecological and sexual health knowledge. As gynaecological health is associated with the taboos of virginity there is no formal education in schools (Gursoy & Gencalp 29). Secondly, they gain primary knowledge via the internet, webpages of hospitals, and social networks that lead not enough and misleading and not inclusive information. To illustrate, as conservative thinking disgrace sexual activity outside of marriage and without the aim of reproduction, the content on hospital webpages about women's health includes more information on pregnancy or motherhood but not on sexual health. Importantly, two

participants declared lack of information made them vulnerable and insecure because of learning sexuality from their male partner after their first relationship.

The participant women's stories on their way of learning their own body and sexuality also illustrate the "sexual shame" concept discussed by Michael Warner in his work "Ethics of Sexual Shame". Warner (2000) argues:

> "Moralities that insist on the permanence of sexual norms have an especially stunting effect on people who lack resources of knowledge or experiment. The more people are isolated or privatized, the more vulnerable they are to the unequal effects of shame. Conditions that prevent variation, or prevent the knowledge of such possibilities from circulating, undermine sexual autonomy" (12).

In Turkish women's gynaecology experience, the sexual norm of moralists is heterosexual couple's sex only within marriage. Having no education on sexuality or gynaecological health at school or lack of inclusive information on the internet and social environment is kind of "preventing the knowledge of possibilities from circulation". The sexual shame imposed on women is demonstrated during their gynaecological examinations through judgmental comments. Moreover, this shame prevents women to learn more because alternative ways are restricted. Warner also argues that the hierarchy between sexual stigmas and distinctions between sex created by moralists such as accepting heterosexual, married, monogamous sex as normal/good; whereas seeing homosexual, unmarried, polygamous sex as abnormal/bad (25). He argues that stigmatization comes if people are on the "wrong" side of the hierarchy which is a belief that has no purpose other than preventing variance and knowledge (26). In Turkish women's knowledge of gynaecology experience, it is evident that the stigma of unmarried but sexually active women causes limited resources on the female body and sexuality.

In Turkey, examples of women's health programs carried out by the Ministry of Health are Projects Programs Pre-Marriage Health Counseling, Antenatal Care Services Program, Vitamin Support Program for Pregnant Women, Mother-Friendly Hospital Program, Birth-Cesarean Section Program, Maternal Mortality Monitoring Program (Simsek & Cakmak 48-49). Pre-Marriage Health Counseling Guide prepared by the Turkish Public Health Institution (Türkiye Halk Sağlığı Kurumu) in 2014 for consultancy before marriage targets women and men who are preparing for marriage as the target audience, and states that their purpose of work is to support a good family structure (1-3). These educational programs of the government focus on motherhood and family rather than the unmarried young female

population to inform about gynaecological health directly. In this study, participants had no special training on gynaecological health other than menstruation and the use of sanitary towel training by a private company. All participants' narratives mentioned this menstruation training as a way of increased the stigmatization of menstruation.

In Turkey, The Association of Women's Human Rights - New Solutions (Kadının İnsan Hakları – Yeni Çözümler in Turkish) works to spread the awareness of rights and also carries out projects for the advancement of sexual and physical rights in Muslim societies. Turkey Health and Family Planning Foundation's initiation "Sexual Health Programme" is another project to increase knowledge of the young population on sexual health initiated. They work with school counselors to organize seminars and provide information and consultancy services over the phone and on the internet (TAP Foundation, n.d.). The TAP Foundation also conducts a "Women's Health Training Programme" in collaboration with local municipalities carrying out women health workshops in different regions of Turkey since 2010. Y-Peer Turkey (Sağlıkta Genç Yaklaşımlar Derneği) is another non-governmental organization that empowers young people especially on sexual health, reproductive health and human rights and access to youth-friendly health services with the help of their project named "Reproductive Health Peer Education Project" with the partnership with United Nations Population Fund. They use a peer education model in which peers in 17-25 age groups are accepted as information providers for their peers. Their peer educators go to two-day thematic training and workshops on different areas of Turkey primarily about HIV and AIDS (Sağlıkta Genç Yaklaşımlar Derneği, n.d). None of the participants in this study has trained such as in the workshop of nongovernmental organizations or seminars on gynaecological or sexual health. Although there are several programs by NGOs in different regions including Ankara, it was interesting that not to hear any names from the participants. It seems outreach and funding of those programs should be increased to reach more women. More importantly, it seems women in this study encountered paid training rather than the free ones by NGOs or the government. In fact, it shows once again how inequalities related to class and gender are interrelated and why we should evaluate access to gynaecological health experience and education problems with the lens of intersectionality.

5.1 Future Research

As Mcgann argues, reserving sex only for married women supported by doctor's marital status question in my study sees vaginal penetration as necessary for "sex" (374-375). The stigma due to being sexually active generates an ambivalent self-positioning for women in this study. Creating examination categories over marital status and hymen status not only stigmatize unmarried women but also exclude divorced and LGBT+ people because sex is seen as reserved for married and heterosexual couples. Exploring the discrimination that sex being reserved for heterosexual married people comprehensively is beyond the scope of this study but this phallocentric concept of sexuality and virginity should be discussed in further research.

The gender of the gynaecologist, in other words choosing female doctors, was important only for the participant who identifies herself as religious. It is an important point where the intersectionality of the experiences is visible because the location and education of the participants seem to affect doctor selection as well. As this study focus on one of the biggest cities of Turkey, Ankara, women in this study had access to university education. Women who have received a university education in a big city may not be worried about going to a male gynaecologist. For this reason, the gynaecologist choice of women with lower education who live in a smaller city should be examined in further research. It should be studied that whether the women in small cities in Turkey have a "chance to choose the doctor" or what kind of problems they face in a more conservative environment. This shows a limit for the present study with participants who declared they are not religious and have relatively more access to university education. Therefore, the experience of religious women and women without university education in other areas of Turkey should be studied in detail in further research.

5.2 Concluding remarks

I started my research with the question of whether there is a correlation between gynaecology examinations and virginity discourse in Turkey. By looking through an intersectional lens with my sub-questions, I aimed to examine how the intersection of differences such as gender, age, religion, and class categories affect the experiences during gynaecological examinations. To understand the dynamics of the experiences from a feminist perspective, I choose the interview method to give voice to the participants in Ankara, Turkey. The in-depth interviews with ten heterosexual women showed that there is a correlation between virginity discussions and gynaecological health experiences of women in this study.

My findings showed that participants define virginity as a barrier because conservative thinking about the premarital sexuality of women creates the source of stigma and ambivalent self-positioning during gynaecological examinations. Due to dominant virginity discourse, women in this study are anxious about gynaecological examinations. It seems there is the effect of religion during the gynaecological experiences due to the virginity taboo in the society, but not due to their faith and religiosity of participants in this study.

It is important to point out that in my study, even doctors seem to have a bias against the premarital sexuality of these participant women. Stigmatization and lack of trust in doctors are part of their healthcare experiences, especially for unmarried women in this study. Due to the judgemental comments of doctors to sexually active and unmarried patients, participants pay more money to have a better experience in private clinics. They feel their voices ignored by the voice of medical authority.

Participants in this study highlight the need for more education on gynaecological and sexual health. They hide their health problems and feel insecure because of not having proper information on their body and health. They highlighted that healthcare providers and policymakers for public education should capitalize on this struggle for opening a space for gynaecological and sexual health education. There should be training in formal education in place to transform the lack of access to gynaecological health education. Further and larger studies are needed to support these findings and to depoliticize the issue because the findings of this study are supported by the literature it is not a private or unique experience of women in this study.

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APPENDIX I

Interview Questions

Introduction

Can you please briefly introduce yourself? Could you tell me your age, education, relationship status and occupation? What do you do in your daily life, both in and outside of your home?

Effect of chastity perceptions

- As my topic is related to women's gynecological experiences and chastity/ virgintiy concept, How do you define these concepts? Do you think society expectations align with your concept/ wishes?

- How do you experience the effects of these ideas in your gynecological examinations?

Demographic effects (advantage disadvantages)

- Do you think you can get the gyn healthcare you want? Do you feel advantaged/ disadvantaged? Why?
- Do you believe your financial situation/ health insurance has an impact on getting the gynaecological treatment you want? What would you like to change about this?

Effect of religion

- What impact does religion have on your life?
- Have you ever felt religion (of you or your family) determined certain things about your gynecological examination experiences ? How?

Selection process of women on health service & Access to information of gynecological health

- How is the preparation process for you for gyn examinations? Selection of the doctor or clinic, with whom to go with? What criteria do you look for?
- From what sources are you seeking recommendations? (e.g. To whom are you talking for selection?)

Doctor approach and its' effects on women's gynecological health care knowledge and access

- How is interaction with a practitioner? Do you feel any kind of challenge, anxiety,fear, shame about gynecologic examination? How?

-Extra questions

- *Family*:
    - Have you ever felt your gynecological healthcare process affected by your family? How? Whom are you talking about your gynecological health in your family?
    - How do you feel supported about your gynecological health issues? Have you ever experienced a difference with your brother (if there is one)? How?
- *Demographic effects:* How do you think your marital status affects the gyn treatment process?
- *Doctor approach:* How would you like your gynecologist to communicate with you, and how would this make you feel?