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Barriers to Abortion Access in Croatia

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Abstract

Background: Since 1978, Croatia has had a tolerant legal framework for abortion access. While tolerant frameworks deter a proportion of unsafe abortions, they do not guarantee access in practice. Barriers such as excessive cost or non-referrals to willing providers can render abortions practically inaccessible and increase the unsafe abortion rate. Minimal research has explored barriers to abortion access in developed countries, especially those in Europe.

Objective: To explore barriers and facilitators influencing women's abortion access in Croatia.

Methods: This research was an exploratory qualitative study utilizing semi-structured interviews. Topic lists were constructed based on research concerning worldwide barriers to abortion access. Two experts, six obstetrician-gynecologists (OBGYNs) and eleven abortion receivers were recruited. These 19 interviews (20-40 minutes) were conducted in person, skype or via phone. Data was validated through member checks and analyzed by thematic analysis.

Results: Following analysis, barriers and facilitators in Croatia emerged: 1. Nearly every interviewee shared that abortion is stigmatized. OBGYNs and women mostly discussed external manifestations of stigma such as prayer protests; 2. Several women spoke about difficulty finding reliable information regarding abortion services. They detailed that forums or their support networks helped them find information; 3. Most women said their greatest barrier was negative health professional's attitudes as demonstrated by non-referral, verbal dissuasion or using ultrasounds to change their mind to abort. Conversely, women found positive health professional's attitudes greatly facilitated their access and subjective experiences; 4. Most OBGYNs stated that conscientious objection remains insufficiently monitored and regulated. Several considered that conscientious objectors do not refer women to willing providers; 5. OBGYNs noted medical abortion have limited availability. They held relatively positive views of wider distribution. Women also noted limited methodology choice; 6. Most OBGYNs and women perceived the cost of abortions to be high, especially for lower-income women. However, there was disagreement as to the affordability for women making an average salary.

Conclusion: Croatian women appear to encounter various barriers when accessing abortions. This research concluded that abortion services in Croatia are not synchronized to World Health Organization guidelines. While barriers such as non-referral may be surmountable for women with more resources and time; this could render the procedure inaccessible for more vulnerable populations of women and contribute to unsafe abortions.

Keywords: 'conscientious objection', 'abortion access', 'qualitative research', 'barriers to access'

Introduction

From the 1950s, beginning in Central and Eastern Europe, a trend towards legal liberalization and decriminalization of abortions emerged to combat unsafe abortions worldwide. [1] Tolerant legal frameworks are one tool used to alleviate the unsafe abortion rate. [2,3] Unsafe abortions have high complication rates which can leave women burdened by enduring financial, psychological or health consequences. These complications are principally preventable yet persist as major contributors to maternal morbidity and mortality globally. [2] Despite this trend towards liberalization, the World Health Organization (WHO) recognizes abortion remains a highly stigmatized procedure [4] and legal restrictions are not the only way to prevent or deter women from accessing abortions. [1,4]

While tolerant legal frameworks diminish the unsafe abortion rate, they do not inherently ensure abortions are accessible in practice. [3,5] Regions with liberal abortion laws, including Central and Eastern Europe, have moved towards access restriction through implementation of barriers such as waiting periods or pre-abortion counseling requirements. [1] Further examples of barriers limiting access include: cost, conscientious objection, inadequately trained professionals, reduced rural access and negative health professionals attitudes etc. [3] Irrespective of such barriers and restrictions, women will still seek to terminate their unwanted pregnancies, even if this means resorting to abortions under unsafe conditions. [4] Evidence supports that barriers increase the rates of unsafe, illegal and self-induced abortions. [3,6]

Doran and Nancarrow's recent systematic review delineated and identified barriers that women from developed countries experience when accessing first trimester abortion services including: negative health professional attitude, cost, limited medical abortion availability, stigma, gestational limits, conscientious objection, inadequate training and moral qualms to abortion provision. [7] They concluded that despite less legal restrictions to abortion access in developed countries, ease of access continues to be problematic. Furthermore, they concluded that even in developed countries, service provision is not yet synchronized to WHO recommendations. The authors noted inadequate research addresses barriers impact on women's abortion access in developed countries. Of the existing research they reviewed, the majority are from United States and Canada. Very few papers originate from Europe and none were available to review from Eastern Europe. [7]

Doran and Nancarrow also indicated minimal research evaluates conscientious objection's impact on abortion access. Conscientious objection is whereby health professionals abstain from aspects of abortion provision based on their moral, religious or ethical convictions. [7] Establishment of conscientious objection as a right has been seen in countries seeking reversal of abortion

liberalization. Conscientious objection has been implicated as an indicator that abortion services will become limited. [1] Conscientious objection is increasingly tolerated in Europe and is highly prevalent in Austria, Italy, and Portugal. In Austria, for example, it became so pervasive that regions were left without a willing abortion provider. [5] The aforementioned countries share similarities including tolerant legal frameworks establishing first trimester abortions on demand. [8] The Catholic Church acts as a socially and politically influential interest group in shaping reproductive health policies. [9,10] These countries alter reproductive health policies to attempt to stimulate fertility levels. [11] These countries also have limited monitoring and regulation of conscientious objection. [12] Croatia also shares these similarities and could develop accessibility issues.

Croatia's legal framework codifies that elective abortions may be provided solely on a woman's volition until ten weeks of conception. [13] However, the tolerance of this framework remains contentious with various forces seeking to restrict abortion access. [9,14] In 2003, conscientious objection as a right was established in Croatia. [15] Since then, there has been a decrease in the number of abortions. The Croatian Institute of Public Health documented 5,923 elective abortions in 2003 dropping to 3,002 in 2016. [16] Considering Croatia's presumably low contraceptive uptake, negative population growth and exceptionally low abortion rate, a paradoxical view emerges suggesting barriers to abortion service access may have arisen over time. [15]

This view is supported by the UN's special rapporteur who asserted, "retrogressive measures preventing access to safe abortion" are taking place in Croatia. [17] Correspondingly, the regional director for Europe from the Center for Reproductive rights stated, "Croatian women […] face […] a range of obstacles" in relation to abortion access. [18] Furthermore, a Croatian non-governmental organization's (NGO) self-published stakeholder analysis revealed identified a myriad of barriers limiting access including: conscientious objection, stigma, cost, misinformation, no access to medical abortions and service availability issues. [15] Beyond the analysis of Bijelic and Hodzic, no further studies evaluate or address abortion accessibility in Croatia.

If access is hindered, this could have consequential implications for the health system. Diminished access pushes women towards less safe abortion methods which could result in more women seeking treatment for complications. Complications from unsafe abortions are more costly to treat than the cost of administering safe abortions. [19] Complications requiring hospitalization result in substantial direct costs to the health system due to medications, health personnel time, supplies etc. [2] There has been minimal exploration into Croatia obstetrician-gynecologists (OBGYNs) and abortion receiver's perspectives regarding abortion access. Previous research has not included Croatian women who have accessed abortions in unlicensed private practices. Therefore, the barriers and facilitators Croatian women experience through the process of accessing abortions are not entirely

clear. Accordingly, the main aim of this research is, "to explore barriers and facilitators influencing women's abortion access in Croatia."

Methods

Study Design

This research was a qualitative exploratory study utilizing semi-structured interviews. To explore Croatian women's barriers to accessibility, a variety of perspectives were included with abortion receivers, OBGYNs, and experts participating. OBGYNs and experts were consulted for their insights into the contextual background, policies, health system information and experience related to abortion access or provision. Women have different considerations, compared to health professionals, concerning which abortion access issues are most crucial to them. Beyond sharing their experiences, women also contributed by elaborating on cultural perceptions and the political environment related to abortion in Croatia.

Population and Procedure

OBGYNs, abortion receivers, and experts were recruited in parallel. This research aimed to include a diverse and representative sample of experienced public sector OBGYNs from different health system levels and regions of Croatia. OBGYNs were invited to participate by email or phone. Seven OBGYNs refused to participate. One refusal was from an OBGYN from Croatia proper who no longer worked in the public sector and had no interest to participate. A primary care gynecologist from Zadar stated they are pro-life and would not participate. A Croatian patient's rights NGO gave the researcher three OBGYN's contacts who presumably perform abortions, two from Split and one from Šibenik . However, upon contacting these OBGYNs they all stated they did not perform abortions and had no interest to participate. Upon calling a hospital in Split, which is the second largest city in Croatia, two separate gynecologists were invited to participate. On the first occasion, the OBGYN stated they do not perform abortions. On the second occasion, the OBGYN stated all doctors at this hospital have conscientious objection.

Beyond refusals to participate, three OBGYNs from Croatia proper did not respond to the email invitation. Two OBGYNs from Croatia proper were willing to be interviewed, but only via email and were not included in the research. Finally, an OBGYN from Čakovec agreed to participate, but their

email was sent to spam and was not seen until data analysis was completed. Of the nineteen OBGYNs that were initially approached, six ultimately participated and were from the regions of Istria or Croatia proper. Four heads of gynecology departments were included in the sample. Three of which are employed in university hospitals and one in a general hospital. One specialist from a university hospital participated and one primary care gynecologist.

The research sought to include two experts to elucidate abortion accessibility in Croatia. Initially, the Croatian Ministry of Health was contacted. Upon contacting through email, no answer was received. Afterwards, an in-person visit to inquire about the possibility of an interview was conducted. The researcher was told it would most likely not be possible to find someone to discuss this topic. Two experts were subsequently identified through Croatian parliament documents concerning abortion provision and agreed to participate. One was from the Office of the Ombudsperson for Gender Equality. The second expert is involved in seeking conscientious objection regulation. For the sake of clarity and privacy, OBGYNs and experts will not be differentiated between in the report and will be referred to as OBGYNs.

This research sought to include a diverse sample of Croatian women who underwent an abortion within the last seven years, with any termination method, age, educational background and religious ideology. Seven years was chosen as it was a recent enough time period that women could still recollect their experiences in greater detail. Additionally, conscientious objection became more prevalent within this time period and therefore could therefore be examined as a barrier to access. Initially, abortion receiver recruitment was attempted through the Dutch abortion rights organization Women on Waves. Recruitment was to include Croatian women who wrote this organization seeking abortifacients due to difficulty accessing abortions in Croatia. Forty women were invited via email, but none responded. Subsequently, a further forty women were contacted about their interest to participate. Of these, eleven women ultimately agreed and these women's characteristics can be seen in Table 1. Women were uninterested to participate primarily due to anonymity and privacy concerns.

Data Collection

Utilizing PubMed and Google Scholar, literature was collected to aid in familiarization of barriers women could encounter throughout the abortion process. This consulted literature is available in Appendix 1. Based on the literature, the constructed topic list included: health provider attitudes, conscientious objection, stigma, cost, procedural and legal restrictions. Separate topics lists were composed for women and OBGYNs respectively.

Table 1: Characteristics of Participating Abortion Receivers

Participant (N):	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11*
Abortion at Age:	18	20	22	23	23	24	25	26	28	37	38
Abortion Received (N) Years Ago:	6	6	3	7	3	7	7	1	1	1,5	2
Abortion at (N) Weeks Gestation:	8th	12th	9th	6th	6th	$8,5^{th}$	5th	8th	6th	4th	9th
Locality Where Abortion Took Place:	Split	Zagreb	Zagreb	Rijeka	Zagreb	Zagreb	Slavonski Brod	Zagreb	Krk	Rijeka	Rijeka
Method of Abortion:	Surgical	Surgical	Surgical	Surgical	Surgical	Surgical	Surgical	Surgical	Medical	Medical	Medical
Anesthesia:	Local	General	Local	Local	Local	Local	Local	General	-	-	-
Private or Public Practice:	Unlicensed Private	Public	Unlicensed Private	Public	Unlicensed Private	Public	Public	Licensed Private	At Home	Public	Public
Cost (KN):	2000	2000	2000	2300	2500	2500	2500	4000	Given Pill By Friend	900	900 + 300 RH Shot
Education Level:	University	University	University	High School	University	University	University	University	University	High School	University
Church Affiliation:	No	No	No	No	No	No	No	No	No	No	Yes

The women's topic list is available in Appendix 2 and OBGYNs in Appendix 3. Although the overarching topics of both list were similar, facets of each topic were oriented towards women or OBGYNs respectively. Appendices 2 and 3 also include examples of questions used to explore barriers.

Interviews with abortion providers and experts began with broad questioning related to their perspectives on abortion access in Croatia. Subsequently, more specific barriers to access were explored in further detail. Women interviewees were asked to detail their abortion experience from the start of seeking an abortion to completion. They were given space to recount their experience at their own pace and progression with limited interruption or probing. Upon listening to participants, barriers on the topic list naturally emerged. Topics which did not emerge were followed-up and discussed.

Interviewees had the option to be interviewed in Croatian or English as the researcher speaks Croatian. Only one gynecologist opted to be interviewed in Croatian. When participants wanted to express themselves in Croatian they were free to do so. Participants were interviewed in person, Skype or phone according to their preference or logistics. All six OBGYNs and two experts were interviewed in person. Seven of the women opted for in person interviews and three over Skype. One woman opted to be interviewed over the phone due to anonymity concerns.

All interviews were audio recorded unless participants opted out. This right to opt out was detailed in the informed consent form and reiterated verbally prior to the interview. One woman and OBGYN opted out. During these two interviews, short notes in relation to barriers which emerged were written. Directly after the interviews with participants who did not want to be audio recorded, the researcher audio recorded audio-memos summarizing the contents of the interview. These nineteen semi-structured interviews were conducted in the period of March 15-31st and April 25-June 19th of 2017 and had a median duration of 35 minutes (range: 20 to 40 minutes).

All audio recorded interviews were transcribed verbatim. After transcription, each transcription was written in summary form. The unrecorded interviews were also written as summaries. Summaries were tentatively by barriers or themes which later influenced the coding process. Eighteen participants were sent back the summaries as a member-check in order to validate the summary's accuracy and to receive feedback. However, the woman interviewed by phone requested their summary confirmed orally at the end of the conversation. Of the remaining eighteen participants, sixteen confirmed the accuracy of the interview content. Two OBGYNs did not respond to the member check email. Sending back summaries to participants was also used as an opportunity to ask for further clarification.

Data Analysis

Thematic analysis was used to interpret the data. Transcripts, audio recordings and summaries were thoroughly familiarized. [20] Data was continuously reviewed and analyzed through the research process to facilitate familiarization and inform subsequent interviews. Responses and clarification points from member checks were also integrated during familiarization. OBGYN's and women's transcripts were open-coded. Transcripts were then axially coded. During the axial coding process, analytic memos were used to aid in making connections between the codes, concepts and themes which emerged. Separate mindmaps for women and OBGYNs were also constructed during axial coding on the program Xmind8 (https://www.xmind.net/xmind8/). This was used to gain greater oversight of connections between barriers and direct focus to participant's main concerns. Once patterns, similarities, and deviant cases between all transcripts and summaries had been identified and taken into consideration, the transcripts were selectively coded by final themes and sub-themes such as stigma and conscientious objection. Additionally, quotations representing each theme or sub-theme were categorized in Microsoft Excel to aid in assessing the relevance of each barrier or facilitator. The results of the analysis were also discussed and refined in coordination with another researcher MW, who had familiarized themselves with the transcripts.

Ethical Considerations

This type of research did not require approval from the Dutch Medical Ethics Committee. There is no central Croatian ethics committee. Therefore, approval is done on an institutional basis. As women were recruited through social media and not hospitals, approval was not necessitated. Given the sensitive and stigmatized nature of this topic, special attention was devoted to keeping participants unidentifiable. The health system level and city in which OBGYNs practiced were not referenced together in this paper to avoid identifiability.

Separate informed consent forms were oriented towards OBGYNs or women respectively. Informed consent forms were written to emphasis the right to remove oneself from the study at any time. In person interviews began with a review of the informed consent forms. For interviews taking place over the phone or over Skype an informed consent form was sent in advance, then discussed at the beginning of the interview. Participants had time to voice concerns or ask questions about this research and the researcher. The informed consent form also detailed that the researcher MW would also have access to the transcripts.

Results

Context:

During interviews, contextual information about how abortion services are organized became apparent. This section will outline this context information prior to presenting the barriers and facilitators. The Croatian Health Insurance fund or ''HZZO'' does not cover reproductive health services including contraceptives and abortion services, unless there is a medical indication. There is no price-lowering or reimbursement for women of lower socioeconomic status or adolescents receiving abortions. All Croatian public hospitals with OBGYN wards are legally obligated to provide elective abortions until the 10th week of conception. Only public hospitals can provide the procedure with the exception of private hospitals which have been specifically licensed by the Ministry of Health. The only private institution currently licensed is Podobnik. Otherwise, private gynecological practices cannot be licensed.

OBGYNs and other health professionals can conscientiously object to aspects of abortion provision. Public sector OBGYNs exclusively are allowed to perform abortions. In interviews, OBGYNs indicated abortions are mostly conducted through dilation and curettage with local cervical anesthesia. A smaller proportion are completed via vacuum aspiration. Of the 31 wards where medical terminations could be implemented, only Rijeka, Pula and Osijek have. Terminations are completed with the abortifacient misoprostol. While misoprostol is registered, mifepristone, also known as RU-486 is not. In the following results section, barriers and facilitators to access are organized by the following themes: stigma, information, health professionals attitudes, conscientious objection, surgical versus medical, public versus private and cost.

Stigma:

Nearly all participating OBGYNs and women indicated that abortion is negatively perceived in Croatia. One OBGYN reported receiving written threats for organizing the hospital's abortions services. This OBGYN shared that anti-abortion information is continuously disseminated but the public health sector has insufficiently responded or addressed this. OBGYNs and women cited this negative perception is in part driven influenced by the Catholic church:

> *Quote 1, ''We have some places where people are not doing abortions because of conscientious objection. Several years ago, all the doctors were performing abortions. I think when the church started to interfere with politics this changed. The church is of course against it and the politicians have a big support in the church. Then the church started to interfere in all segments where they could, especially in those which are sensitive.'' OBGYN #4*

Quote 2, ''Croatia is a very strange situation. According to our constitution, we are secular country. However, in the field it's not like that because the Catholic church is mixing in everything. They are mixing in public hospitals and it's not allowed if you are a secular country.'' OBGYN #2

Several participants considered this negative perception had increased due to the growing prominence of the conservative party in Croatia:

''In the last couple of years with this wave of conservative backlash, if you did an abortion, you're a horrible person or someone who should be ''forgiven'' because you're ''broken''. It's incomprehensible in this general narrative that you can go on with life and you have a lot of other things which make you the person you are. This is just a smaller part of you.'' Woman #7

OBGYNs and women spoke about manifestations of this public disapproval coming in the forms of prayer protesters congregating outside publicly-funded hospitals and pro-life ''walks for life'':

''Unfortunately, the fact remains that in our society there exists some ''extra-institutional pressures,'' such as the church, that would prefer abortions not to be done. This is manifested in various ways. When you came into the hospital you saw at the entrance that prayer protesters are standing. So that in recent times has been more frequent.'' OBGYN #5

Four women referenced the presence of prayer protesters as inappropriate and two women expressed relief that protesters were not present at the time of their abortions:

Quote 1, ''They weren't there at the time of my abortion. Thank goodness, but I've been seeing them there for six months to a year. Half the time I go out, I see them there. They're even there at night. The hospital even granted them passage so they can go on the hospital grounds and protest there. That's probably the most painful part, that the hospital doesn't do anything to remove them from there. That's just insane.'' Woman #3

Quote 2, ''Interviewer: We were just talking a bit about the protesters outside and you were saying, ''if I had to go now…..''
Interviewee: Oh my, I think it would be very difficult. I don't know if I'd have the courage to go. If I put myself in that situation right now I think I'm a lot stronger but at that point when I was around 24, I would have been really freaked out to go.'' Woman #6

The majority of participating women shared that they were not open about their procedure beyond a few select contacts:

''I knew I couldn't tell my friends because they were like the other people in Croatia and their state of mind is hardcore Catholic. You get judged. It was social suicide to be open about it, even to my closest friends.'' Woman #1

One woman said she told her gynecologist in Split about her abortion and was told to be careful sharing this type of information:

''No, no, no, don't tell that to anybody. I'm good with it and thank you for telling me, but don't tell any doctors because they are not so open-minded.'' Woman #2

One woman said she got received an abortifacient from a friend who bought it online. Upon speaking about her motivations to self-induce, she said:

''Privacy, privacy, privacy was the first consideration because society here is very judgmental. That was the main issue. Now when I'm looking it, it was just important that nobody knows.'' Woman #9

Information:

All the women said they knew they could get abortions at public hospitals. Two discussed that they did not know at the time that private practices cannot provide abortions. Women who independently searched for abortion services went online. The first website they found was ''Klinika za pobačaje/Clinic for abortions'' which poses as a legitimate information source for abortion complications and where women can access abortions. This website claims abortions have greatly elevated risk for reproductive tract cancers, suicidal tendencies, post-traumatic stress disorder and sexual dysfunction. Although women did not consider this website their personal barrier, they considered its existence as disconcerting and deceptive:

''When we started researching, before we decided on a private clinic, we went online (…) That was maybe something I remember the most. It's this site called ''klinika za pobačaja.'' (…) There are pictures of dead babies or something. (…) I started crying because I thought I have so much support in this and some women are in some village, not educated and they have no support. They go online and they find out about this and it's just horrible. I felt so angry and frustrated.'' Woman #8

Women did not report information access as problematic if they had support networks, such as parents or contacts in the health system who informed them where and with whom to abort. Three women who aborted in Zagreb expressed that reliable information was not easily accessible online or otherwise. Women searched first online using forums and found this to be a negative experience:

Quote 1, '' I was trying to research it online, which is like a terrible, terrible, terrible thing to do, because you go on forums. It's just awful. You cannot find support there, any kind.'' Woman #6

Quote 2, ''It is quite hard. You literally can't Google it. There is no way to Google it. So I think that there is no information. People don't know what is available. People don't know who to ask.'' Woman #8

Comparatively, women from Rijeka did not think information access was difficult. They said it is ''common knowledge'' that Rijeka's hospital abortion services are easily accessible. A woman who aborted in private practice did not consider information access to be difficult as she phoned health professionals directly:

> *''Interviewer: How did you find the private gynecologist?*
> *Interviewee: They are everywhere. You just need to write private gynecologist into Google and go ask them. Nearly every one of them is doing this.'' Woman #5*

Health Professionals Attitudes:

Women reported experiencing health professionals interfering with their decision to terminate their pregnancies. According to women, this constituted the most distressing and access limiting barrier in their respective experiences. Women said health professionals imposed their own viewpoints in respect to the procedure. Six of the eleven women reported encountering verbally encouragement to forego an abortion:

> *''I needed this referral slip so I can go to the hospital (…) The doctor who was on that day (…) told me, ''why are you doing this to me? Why are you doing this? I cannot do that.'' He told me, how old are you? You are just a child.'' (…) He was like no he absolutely cannot, why are we asking this horrible thing from him. We are putting this huge burden on his shoulders.'' Woman #7*

One of these women said they were verbally discouraged but did not perceive it as their primary barrier. However, they expressed frustration about health professionals attitudes towards women accessing this service:

> *''It's important to note that they have attitudes that you don't want in this period of your life, you know, someone judging and looking at you. You need someone who is very serious and you believe he will mind his business.'' Woman #5*

Some women encountered health professionals using unrequested ultrasounds to dissuade women from aborting:

> *''He had an ultrasound done and everything. He was telling me the whole time how my baby was healthy and I was going to be a great mother. (….) I was just telling him, ''ok, but I want an abortion. Where can I get it? (…) He told me, ''no, don't talk about nonsense, you can't do that. You're his mother now . Then he turned around the monitor and showed me, ''look! This is his heart beating.'' That was the moment that I broke apart because that was the moment I realized this is murder. I mean he told me it was murder. '' Woman #3*

Two women expressed frustration that OBGYNs did not consult or inform them during aspects of their abortion care:

> *Quote 1, ''I really didn't like the way we were treated there (…) Once I got in the room you get the cocktail of drugs to calm you down. I asked them what they were giving me. They wouldn't actually tell me (…) Once the doctor got in, he started the examination and 2 or 3 students came in. The doctor said, ''so look through this. There's her uterus. It's apple sized now.'' So you have people examining you and you didn't give consent for them to examine you.'' Woman #6*

> *Quote 2, ''When my mother paid, he said, ''you need to come for a little check up tomorrow.'' (…) The next day I go to the appointment (…) and he's like ''Let's just put you on the table for a bit more, we had a problem with the pump yesterday.'' It hurt way worse because it was still sore from yesterday. It was the worst horror. You think it's finally over, but then he doesn't even tell you you're going to have to go through it again tomorrow (…) I started screaming because it was awful. The nurse held me. She felt horrible for me, but she was like ''shhhhhh'' so that other women in the waiting room wouldn't hear me scream.'' Woman #1*

Three women reported their connections facilitated their access to an abortion. For example, a connection could be a family member who practiced medicine at the hospital where they received the abortion. Women considered the connection resulted in their preferential treatment and care:

> *''Once I had this connection, they were really nice to me because he is the head of the department. The process was really easy with this connection, but before when I was going on a checkup it was hard. (…)The nurses were like, ''you can't do an abortion because this is a new life in you.'' So it's really difficult. I think it's really difficult for women who want to do that because of those reasons. In hospitals they are really tough about it. They can do it, but if they can, they will try to talk you out of it.'' Woman #2*

Another woman was subjected to a four week waiting period by an unlicensed private gynecologist. Upon returning, the gynecologist said they were only willing to perform the procedure as the mother had been a long term patient. She attributed this health professional connection as facilitating her access:

> *''My mom came in with me to the room. (The gynecologist) had this really weird expression on his face when I said I still wanted to get an abortion. He asked her, ''so you're her mother?'' (…) He said, ''I'm going to do it because we care about our long time patients (…) so I'm going to do it, but actually I was going to say no.'' So he was going to leave me hanging after eight weeks and if that wasn't my mother, I would have just been hanging and have had so little time to find someone else to do it.'' Woman #1*

Two women with no connections encountered difficulty both in access and health provider attitude. These women were denied referrals while seeking abortion services:

> *''I went to Sestre Milosrdnice. That was a bad experience. Once I got there, I had to talk to a nurse to get an appointment. At that point, I was actually 8 weeks pregnant (…) and had*

only a week and a half to get an abortion. She went through the little notebooks which was empty and said, ''we don't have any available for the next month.''(…) She made me really upset and I started crying there in the middle of the waiting room with pregnant women all around me.'' Woman #6

Women who were denied referrals found this profoundly stressful and had negative views concerning abortion accessibility:

''It has an almost illegal, finding a new dealer and meeting him in the dark alley feel to it.'' Woman #3

Conscientious Objection:

OBGYNs differed in opinion as to the extent conscientious objection hinders access. However, the majority recognized it as the most concerning unchecked barrier to women's access. While conscientiously objecting OBGYNs are legally obligated to refer abortion seekers to willing providers, certain participants were skeptical whether this is enforceable or occurs in practice:

''So if you cannot choose a doctor in a public hospital, how do you come across a doctor who performs abortions? When you read the law, if one doctor cannot or does not perform something, then this doctor should refer or resolve this problem for this patient. In practice in Croatia the doctor says, ''I do not perform this'' and does not refer, this is hugely stressful for the patient.'' OBGYN #6

OBGYNs emphasized that conscientious objection remains unregulated and unmonitored. Two specifically cited lack of regulation is a concern for continued access because no barriers deter OBGYNs from abstaining:

''It must be regulated because now it exists as purely regulation, because you can say one day, I will not do this procedure tomorrow and sign a piece of paper and that's it (…) There's no commission to say, ''yes it's ok you have a reason to have conscientious objection.'' It's nothing like that today in Croatia. You can just say, ''I'm not working that job tomorrow.'' OBGYN #2

An expert indicated objection extends without legal restriction to all health professionals. In particular, they raised concern that residents specializing as OBGYNs object:

''Conscientious objection is also a problem for those doing their residencies in gynecology. They have to learn how to do curettage and residents object. Those who are objection will not know how to perform this procedure once a woman's life is in danger. I think it's very important that all residents try to learn this and this is not regulated.'' OBGYN #7

Several OBGYNs noted this ease of abstention is coupled with inadequate monitoring by the Ministry of Health. For instance, hospital administrations alone collect conscientious objection forms. As such,

no central registry or external oversight mechanisms monitor and ensure adequate provider number per hospital. In the quotes below, OBGYNs posited minimal monitoring derives from inadequate willpower to address a politically unpopular procedure's accessibility:

> *Quote 1, ''Interviewer: I read that the Ministry of Health was seeking to produce a register? Respondent: Yes, but this is just talking. They talked about that for a couple of years. About a registry, nothing is done. Maybe it's because everything in Croatia is politics. We had a left party in control until a year ago and now it is the right party. They do not have any interest in that. They support that pro-life initiative.'' OBGYN #2*
>
> *Quote 2, ''I don't know how conscientious objection is managed in other countries. In Croatia, in general, there is much hypocrisy in society. This is in different aspects of life including democracy, human rights and gay rights. The right of women to abortions is one of these hypocritical themes where the government doesn't have efficacious control or there is an absence of willingness to control these problems.'' OBGYN #3*

Some OBGYNs implied hospital left to self-monitor for adequate provider number resulted in cases of ''institutional conscientious objection,'' whereby all gynecologists within a hospital objected. This occurred despite state-run hospital's legal obligation to ensure abortion services. Subsequently, the Ministry of Health mandated that hospitals with this situation must employ an externally contracted gynecologist to provide abortions. OBGYNs were generally satisfied by this solution, but the following OBGYN was doubtful to the extent this solution is employed in practice:

> *''Some hospitals such as Sveti Duh in Zagreb stopped performing abortions. Under these circumstances, the MOH would have to bring an externally contracted gynecologist from outside the hospital. Unfortunately, that is not the situation and that is not the only institution in which this happens. This happens in some other county hospitals.'' OBGYN #5*

One woman explicitly mentioned conscientious objection as a barrier. She reported avoiding a hospital with high conscientious objection rates:

> *''Because of conscientious objection, I knew it was going to be hard. That's why I went online (…) I did not know where to look.* It *was hard to find somebody. It was hard to decide where to go. It was hard to know whether they would actually take you or not. (…) I knew immediately that Petrova was a no. A huge no, because as much as I gather, everyone had conscientious objection. I was like, no way am I going there.'' Woman #6*

Surgical versus Medical:

Several OBGYNs stated women travel from different regions to hospitals offering medical terminations. Another OBGYN posited that women go to private practice for medical terminations as well. Generally, OBGYNs had favorable views of medical abortions increased distribution:

Quote 1, ''That's the practice I'm hoping will be better in Croatia considering that only from recent times from 2015 Rijeka started with that practice. I'm hoping that more hospitals start with that practice. They should start with that practice.'' OBGYN #8

Quote 2, Respondent: ''So we are waiting for legalization and women are asking me about it, but I can't give it to them legally. (…) I just advise them if they have some relatives in Austria or a nearby country to go there a few days.
Interviewer: would it be helpful if medical abortion was more available?
Respondent: Yes, of course because it's less invasive.'' OBGYN #4

An OBGYN in Zagreb had a positive view of further implementation, but stated Zagreb has a complicating factor preventing this. Of Zagreb's five public hospitals, Sveti Duh and Petrova do not consistently provide elective abortions. Therefore, this gynecologist raised concern that if only one hospital introduces medical abortions, an excess of women will be diverted from other Zagreb hospitals which have not introduced medical abortions. This in turn would disrupt the hospital's ability to handle other necessary gynecological services and impact resource availability. They also expressed more women would travel from other cities to obtain medical abortions as they intimated is the case with Rijeka.

OBGYNs pointed to several reasons why medical abortions should be promoted. For instance, one indicated it is preferable for use in nulliparous women due to less risk of cervix damage. Several OBGYNs said women pay for this service and therefore should have methodology choice. Also, medical terminations are less expensive and increase access. Women also indicated they consider methodology choice important. Finally, another OBGYN considered medical abortions make doctors feel less complicit in having performed the abortion, thereby minimizing negative health provider feelings toward the procedure:

''The person who gives the tablets or puts the tablets in the vagina, it is not the same feeling as when you grasp the tissue (…) It's the feeling of the person, and the person feels that he does not perform an abortion (with tablets). When you grasp the tissue and pull out something, the feeling of the operator is not good, it is very bad. So in this way, we resolve the feeling of the operator.'' OBGYN #6

One women said they would feel less culpability undergoing surgical termination because they would not have to view the products of the conceptus. Another woman who self-induced with mifepristone had a similar opinion as the OBGYN above about complicity:

''I know a couple of girls who have done it done surgically and it's more trauma. I think it's more trauma when you do it that way. (…) It's much more easy (with the medication), you don't have that knowledge that something has been done to your body.'' Woman #9

Public versus Private Practice:

Mostly, OBGYNs had favorable views of allowing private practices to be licensed to perform abortions. However, one OBGYN argued that they should not be licensed as the procedure should be free in the public sector with adequate accessibility and quality of care. Despite its illegality, OBGYNs speculated that women opt for private practice and supported this by indicating statistical discrepancies:

> *''So Split is the second largest city in Croatia and the number of births is nearly about that number in Zagreb (…) I think it was the 2009/2010 official statistics said that Split had 9 pregnancy terminations. Sisak has 120/130 per year and 900 births, so strange numbers. After that, I didn't read anything that the government, ministry of health, or insurance company said a question mark to that number. (…) Are there gynecologists that perform pregnancy terminations in their private practice? I don't know, but I think that's the answer'' OBGYN #3*

OBGYNs had different opinions on why women seek out private practice. One gynecologist said women go to private practice because vacuum aspiration are available. Another posited that they offer medical terminations. They considered women are primarily motivated however by privacy concerns:

> *Quote 1, ''They go privately here because private practice uses vacuum aspiration (…) that is one reason and the other reason is discretion. You know hospitals aren't big and there is always someone who can see you there and that somebody knows somebody that knows your parents or friends.'' OBGYN #4*
>
> *Quote 2, ''So the system in Croatia is an open system, everything is public (…) because when you enter in the hospital then your name and everything which we do is present on the list. There is no special private list and it is open to many persons. So this is the reason, not only in Croatia, but also in Europe that many women try to resolve this in closed, small ambulatory clinics or small private hospitals, where the name is kept private.'' OBGYN #6*

An OBGYN from a general hospital considered privacy is especially concerning for religious women:

> *''Many religious women get abortions performed. They are often nervous and get them in a different city so nobody will see they've been here on the computer. I've known patients who came with complications and asked them, ''where did you abort?'' For example, they've aborted in Zagreb or Koprivnica and so on and some women come here from other parts of Croatia so nobody would know they had aborted. From smaller localities like ours, this can pose a problem for women.'' OBGYN #5*

Three participating women had abortions at unlicensed private practices. Two women did not even consider public practice and opted initially for private practice due to their perception of better privacy and quality of care. These women specifically mentioned their abortions were recorded as

''miscarriages.'' In contrast, the third woman initially went to public practice but was directed to their colleague's private practice. A woman stated her motivations for choosing private practice:

Interviewee: ''It was easier. It was easier (…). It's anonymous and no one is going to ask you anything. You just go there, you pay and you're done. It's less fuss about it.
Interviewer: Was privacy a concern for you?
Interviewee: Of course, I don't want my neighbors to know what went on in my private life it's none of their business. It's not for everyone that's for sure (…)
Interviewer: When you went privately, did you think the quality would be different from a public hospital?
Interviewee: Yeah, I thought the quality would be better. It was better.'' Woman #5

Two women who terminated medically in Rijeka considered the quality of care at the public hospital as high. Comparatively, the majority of remaining women shared markedly negative perceptions of public practice in terms of accessibility, health professionals attitudes, quality of care and privacy. The following woman unsuccessfully sought out private practice with help from her primary practice gynecologist reflected on her public practice experience:

''I think I would feel secure, a bit more secure, in private practice because they want to protect their reputation. I think I might have been treated better than in a public hospital (…) I feel like private practice would have been a better choice.'' Woman # 6

In another example, a woman sharing her experience stated she wished she had opted for private practice to avoid health professionals intrusive opinions and attitudes:

''The only reason I would have gone then to private practice is more comfort. The experiences I read all said they treat you more nicely, normally, like you're a human being and you have more privacy.'' Woman #7

Cost:

Participating women did not personally consider cost as their primary obstacle because they were financially supported. Most women received support from close family members, partners and one used scholarship money. With the exception of two women from Rijeka, all the women had financial support. Most women considered the cost should be covered by the National Health Insurance. Nearly all the women perceived the cost in private and public sectors as high for Croatian standards:

''So 2000 kunas is like half of the average salary in Croatia. So it's a big amount, a significant amount. So it should be cheaper definitely. It should be free if we're speaking in this way. The partner I was with would have helped me with that, so that wasn't the main thing, but that was a big concern.'' Woman #9

Most OBGYNs did not consider cost as the predominant barrier to access. However, the majority indicated the procedure should be covered by the National Health Insurance. Opinions were divided as to the affordability for women making average salaries. For example, one OBGYN said women aborting tend to be older and financially established. Therefore, they did not consider affordability as the most pressing issue. However, another considered the cost as disproportional to women making average incomes. Another OBGYN was concerned that unlicensed private practices could take advantage of women and charge exorbitant prices. OBGYNs generally agreed that cost predominantly effects accessibility for low income women, college students and teenagers:

> *''I have one woman now who is in a very difficult situation with two children. She had two children at 18 and one child is has a (congenital birth defect). She is pregnant and she wanted to abort, but doesn't have the money (…). So the problem of cost is sometimes with teenagers, but mainly those people with lower socioeconomic status. So really, the cost of an abortion is a problem for them. It is.'' OBGYN #4*

Discussion

This research identified several barriers and facilitators influencing Croatian women's abortion accessibility. In Croatia, abortion appears to be stigmatized and external demonstrations of this including prayer protests and negative health professionals attitudes aim to deter abortions seekers. Women did not have reliable sources of information online or from health professionals detailing: where to get abortion services, with whom, price and methodology availability. Conversely, internet forums and women's support networks i.e friends and family, aided women in attaining this information. Women's greatest barrier and facilitator to access was health professionals negative or positive attitudes towards them. Health provider attitude and willingness to perform abortions seemed modulated by women's health system connections.

Conscientious objection was problematic mostly from OBGYN's perspectives, yet they disagreed as to the extent it limits access. OBGYNs noted several systemic issues regarding conscientious objection including: hospitals self-monitoring for adequate providers, minimal regulation, no central monitoring and ease of abstention. For abortion methodology in Croatia, women focused on lack of choice while OBGYNs noted lack of medical abortion availability. Women shared somewhat negative views of public practice in terms of quality of care and privacy and these appeared to be influential factors in opting for private practices. Cost appeared to be consequential primarily for Croatian women in vulnerable financial positions including adolescents, students and low-income women. These results support barriers identified by Doran and Nancarrow's systematic review for first trimester abortion barriers in developed countries [7] and reflect those identified by Bijelic and Hodzic's stakeholder analysis of Croatian women's abortion accessibility. [15]

The woman who self-induced at home was concerned her family members and community would find out. Although she knew Rijeka offers abortion services, she was concerned someone would recognize her at the public hospital. Culwell and Hurwitz found stigmatization does not seem to decrease the amount of abortions. Instead, it increases women's likelihood of terminating under unsafe conditions. [20] In a systematic review from Hanschmidt et al. about abortion stigma found when women perceived abortions to be stigmatized, this was linked to their desire to terminate in privacy. They also found non-religious women were less likely to perceive abortion-related stigma than Christian women. [21] The majority of Croatian women identify as Catholic and could conceivably be quite concerned about their privacy due to stigmatization. This could divert women towards private practices, travelling for abortions or self-inducing.

Several women had difficulty finding credible information about abortion services. When women searched online, they first come into contact with the misinformation site ''klinika za pobačaja'' or ''clinic for abortions'' which deters women from accessing abortion services. The WHO considers ''access to relevant health information'' as a right and recognizes information access can help deter unsafe abortions. [4] Rowlands et al. and Bijelic and Hodzic suggest including termination information on hospital websites. [15,19] This ''clinic for abortions'' website could be problematic for less educated or health literate women and contribute to delays in abortion access.

Participating women voiced that health professionals interfered with their decisions to abort or experienced non-referrals. One woman in this research experienced two non-referrals as well as negative health professional attitudes. This delayed her access to abortion services from her 6th week of pregnancy until the 9th. Caroline Moreau et al. found a weak correlation between complexity of abortion access and time delay. They found that issues with access to care led to women more negatively perceiving care quality. [22] However, Caroline et al. did not interview women did not ultimately manage to attain an abortion, which may have led to an underestimate of the correlation. Negative health professional attitude could contribute to delays for women putting them over the gestational limit. As second trimester abortions are not electively available in Croatia, some women may seek to self-induce.

Although Croatian regulations require conscientious objectors to refer abortion seekers, participating OBGYNs were concerned this may not occur in practice. This research found two cases where women in Zagreb were denied referrals close to their gestational limits. A third woman was denied referral by a primary care gynecologist in Slavonski Brod, until her family member who is a doctor intervened. This non-referral concern is supported by a vignette survey of 1154 U.S. OBGYNs from Rasinski et al. Their vignette scenario outlined an elective abortion seeker who is not referred by a conscientiously

objecting doctor to a willing provider. 12% percent of OBGYNs considered the lack of referral acceptable. [23] Curlin et al. found similar results in a confidential survey among 1144 U.S. based physicians, only 71% of respondents felt ethically obliged to refer patients to a willing provider. [24] Curlin et al. and Rasinski et al. studies found doctors with religious convictions have a higher tendency to consider non-referral. [23,24] Rowlands et al. suggested that accessibility could be improved by central booking through hospital's websites. [19] Ostensibly, Croatian physicians conscientiously object due to religious convictions. As religiously affiliated physicians are less likely to refer, this could limit Croatian women's access. This non-referral issue could be circumvented by Rowland's central booking suggestion and minimize delays in access.

OBYGYNs also raised concerns about inadequate regulation and monitoring surrounding conscientious objection. One woman reported altering her behavior when choosing a hospital due to her perception that Petrova hospital had a high prevalence of conscientious objection. Rowlands and López-Arregui recognize that minimal regulation and monitoring of conscientious objection leads to its unrequested prevalence. [19] According to Minerva, no empirical evidence has substantiated a level which does not limit access. She suggested Italy's level of 70% has created undue difficulties for women. [25] Bo et al. corroborated this theory and found this level creates delays in abortion administration by increasing non-objector workload. [26] If other women change their abortion access pattern based on their perception that an institution has a high prevalence of conscientious objection, they may avoid these institutions, opt for private practice or travel to other regions or hospitals where abortions are less negatively viewed.

OBGYNs noted that medical abortions are not widely available in Croatia. They had relatively positive views about its wider implementation. Doran and Nancarrow recognize limited distribution of medical abortions as a barrier to abortion access. [7] Lie et al. in their qualitative synthesis found medical abortions may be beneficial in reducing both health professionals and women's culpability in the procedure, thereby diminishing guilt in having undergone or performed the procedure. [27] Given the stigmatization surrounding abortions in Croatia, diminishing culpability of those undergoing and providing the procedure could be a useful tool in increasing both accessibility and acceptability.

Most women indicated they wanted a choice in abortion methodology. An OBGYN indicated more than 85% of patients opt for medical terminations in Rijeka and travel there specifically for them. Doran and Nancarrow outlined that medical terminations are well-established in England, France, Scotland and Sweden with more than half of women choosing this method. They indicated women travel for their preferred methodology choice. [7] Ruggeri et al. cited cost as a factor stimulating medical travel. [28] Plausibly then, if Croatian women prefer medical abortions and the cost is lower,

women may travel to Rijeka, Pula and Osijek to access them. This could have implications for these OBGYN departments resources being used primarily for terminations.

OBGYNs had generally positive perceptions of allowing licensing of private practices so they can be monitored and price regulated for women. Three women in this research underwent abortions in unlicensed private facilities. Not all of them knew private practices cannot legally perform abortions. With the exception of two women from Rijeka, participating women shared negative perceptions of public practice in terms of quality of care, waiting times, privacy and health professional's attitude. Lie et al. in their qualitative synthesis found British women opted for abortions in private practice due to expectations of ''better personal treatment'' and ''confidentiality'' in comparison to public practice. Furthermore, women are driven to terminate in private practice due to privacy concerns when abortions are stigmatized. [27] Culwell and Hurwitz also found that women who negatively perceive public practice, in terms of privacy and confidentiality, are motivated to seek out private practice. [20] This research result could lend some credibility to claims that Croatian women terminate in private practice. Conceivably, inadequate monitoring of the private sector could leave women open to maltreatment, unsafe abortions and unfair pricing.

Cost was not perceived as the primary barrier for access by OBGYNs or this sample of women. However, eight women had financial support from family members, partners, scholarships etc. in order to pay for the procedure. The majority of women were university students when they became unintentionally pregnant. They indicated that without financial support, paying would have been exceedingly difficult. Rowlands et al. considered that cost as a barrier can increase the number of women turning to self-induction or unsafe providers which results in greater costs to the health system due to the high cost of treating complications. To prevent unsafe abortions Rowlands et al., suggest price should correlate to women's ability to pay and that exemptions or subsidies should be considered. [19] Doran and Nancarrow noted low-income women experienced greater delays accessing abortions due to cost. [7] This issue of mismatched pricing compared to the average Croatian salary could be particularly consequential for lower-income women and adolescents.

Strengths and Limitations

A strength of the research was that participating OBGYNs had substantial years of practice and experience. They specialized prior to the establishment of conscientious objection and could thereby impart in-depth insights into how abortion access may have changed due to this. Additionally, they could share how cultural perceptions or political acceptability of the procedure have changed. A further strength was the varied perspectives OBGYNs contributed. While they all considered abortion

services need to be easily available and accessible, not all OBGYNs were still currently providing abortions and had conflicting feelings regarding their roles in administration. They also had disparate views as to the acceptability of conscientious objection, so a less one-sided view of strongly pro-choice participants was avoided and allowed for a more nuanced view. Also there were a couple of factor encouraging participant truthfulness as there was no monetary compensation for participation and the researcher was a doctor with Croatian background, which may have helped women and OBGYNs speak more candidly. A further strength among participating women was the variety in termination methodologies and different pathways taken to access abortion services. Additionally, the majority of women were well educated or had interest in sexual and reproductive health rights and could therefore speak more authoritatively on their experience and the milieu surrounding abortion services in Croatia.

For limitations, only women who had ultimately managed to get an abortion were interviewed. Those women who unsuccessfully accessed abortion services are missing from this sample and could have encountered other barriers. Another limitation was that no OBGYNs from southern Croatia were recruited and only one woman who aborted in southern Croatia. By interviewing OBGYNs and women from primarily northern Croatia, the extent to which accessibility is diminished in Croatia may be obscured when taking into consideration participants opinions regarding abortions being more negatively perceived in Southern Croatia. Additionally, the sample of women was not representative of the Croatian population at large or the typical abortion receiver. The majority of women in the research were university educated. However, only 16% of Croatian women are university educated. [29] The majority of women were young compared to the average Croatian abortion receiver who receives their abortion from the ages of 30 to 39. [16] Additionally, participating women were not religiously affiliated, while 86% of Croatians identify as Catholic. [30] However, religious women are also accessing this procedure and could have other barriers compared to non-religious women.

Conclusion

Croatian abortion services are not synchronized to WHO safe abortion technical guidelines. Although Croatian women have a legal right to abortion on paper, in practice, their ease of access is limited by various barriers. While the barriers identified such as non-referral may be surmountable for women with more resources and time; this could render the procedure inaccessible for more vulnerable populations of women and contribute to unsafe abortions.

References:

1. Finer L, Fine JB. Abortion law around the world: progress and pushback. American journal of public health. 2013 Apr;103(4):585-9.

2. Grimes DA, Benson J, Singh S, Romero M, Ganatra B, Okonofua FE, Shah IH. Unsafe abortion: the preventable pandemic. The Lancet. 2006 Dec 1;368(9550):1908-19.

3. Åhman E, Shah I. Unsafe abortion Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008 [Internet]. 2011 . Available from: http://whqlibdoc.who.int/publications/2011/9789241501118_eng.pdf

4. Safe Abortion: Technical and Policy Guidance for Health Systems [Internet]. 2012. Available from: http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf

5. Heino A, Gissler M, Apter D, Fiala C. Conscientious objection and induced abortion in Europe. The European Journal of Contraception & Reproductive Health Care. 2013 Aug 1;18(4):231-3.

6. Sedgh G, Singh S, Henshaw SK, Bankole A. Legal abortion worldwide in 2008: levels and recent trends. Perspectives on sexual and reproductive health. 2011 Sep 1;43(3):188-98.

7. Doran F, Nancarrow S. Barriers and facilitators of access to first-trimester abortion services for women in the developed world: a systematic review. J Fam Plann Reprod Health Care. 2015 Jul 1;41(3):170-80.

8. Abortion Policies: A Global Review [Internet]. un.org. [cited 8 August 2017]. Available from: http://www.un.org/esa/population/publications/abortion/profiles.htm

9. Shiffman J, Skrabalo M, Subotic J. Reproductive rights and the state in Serbia and Croatia. Social Science & Medicine. 2002 Feb 28;54(4):625-42.

10. Van der Wal F, Verloo M. Religion, church, intimate citizenship and gender equality: an analysis of differences in gender equality policies in European Catholic countries. Series of QUING, Why Papers Vienna, Austria: IWM. 2009.

11. Abortion policies and reproductive health around the world [Internet]. United Nations Library. 2014 [cited 9 August 2017]. Available from: http://www.un-ilibrary.org/population-and-demography/abortion-policies-and-reproductive-health-around-the-world_3fc03b26-en

12. Zampas C, Andión-Ibañez X. Conscientious objection to sexual and reproductive health services: international human rights standards and European law and practice. European Journal of Health Law. 2012 Jan 1;19(3):231-56.

13. Croatia's Abortion Provisions [Internet]. Center for Reproductive Rights. [cited 15 January 2017]. Available from: https://www.reproductiverights.org/world-abortion-laws/croatias-abortion-provisions

14. Dedic J. Issue Histories Croatia: Series of Timelines of Policy Debates. QUING Project, Vienna: Institute for Human Sciences (IWM). 2007.

15. Bijelic N, Hodzic A. ''Grey Area'': Abortion Issue in Croatia. Zagreb: CESI; 2014 p. 2-14.

16. Abortions in Healthcare Institutions in Croatia 2015 [Internet]. Zagreb: Croatian Institute of Public Health; 2016 p. 7,9. Available from: https://www.hzjz.hr/wp-content/uploads/2016/10/Pobacaji_2015.pdf

17. “There’s no sliding back” UN right to health expert urges Croatia to seize the opportunity [Internet]. United Nations Human Rights Office of the High Commissioner. 2016 [cited 18 January 2017]. Available from: http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=20988&LangID=E

18. U.N. Committee Calls on Croatia to Expand Reproductive Health Services and End Discrimination Against Women [Internet]. 2015. Available from: https://www.reproductiverights.org/press-room/un-committee-calls-on-croatia-to-expand-reproductive-health-services-and-end-discrimination-against-women

19. Rowlands S, López-Arregui E, Expert Group on Abortion, European Society of Contraception and Reproductive Health. How health services can improve access to abortion.

20. Culwell K, Hurwitz M. Addressing barriers to safe abortion. International Journal of Gynecology & Obstetrics. 2013;121:S16-S19.

21. Hanschmidt F, Linde K, Hilbert A, Riedel- Heller S, Kersting A. Abortion Stigma: A Systematic Review. Perspectives on Sexual and Reproductive Health. 2016;48(4):169-177.

22. Moreau C. Access to health care for induced abortions: Analysis by means of a French national survey. 2017.

23. Rasinski KA, Yoon JD, Kalad YG, Curlin FA. Obstetrician-gynaecologists opinions about conscientious refusal of a request for abortion: results from a national vignette experiment. Journal of medical ethics. 2011 Dec 1;37(12):711-4.

24. Curlin FA, Lawrence RE, Chin MH, Lantos JD. Religion, conscience, and controversial clinical practices. New England Journal of Medicine. 2007 Feb 8;356(6):593-600.

25. Minerva F. Conscientious objection in Italy. Journal of medical ethics. 2014 May 24:medethics-2013.

26. Bo M, Zotti CM, Charrier L. Conscientious objection and waiting time for voluntary abortion in Italy. The European Journal of Contraception & Reproductive Health Care. 2015 Jul 4;20(4):272-82.

27. Lie ML, Robson SC, May CR. Experiences of abortion: a narrative review of qualitative studies. BMC Health Services Research. 2008 Jul 17;8(1):150.

28. Ruggeri K, Záliš L, Meurice CR, Hilton I, Ly TL, Zupan Z, Hinrichs S. Evidence on global medical travel. Bulletin of the World Health Organization. 2015 Nov;93(11):785-9.

29. Population Aged 15 and Over by Education Attainment and Sex, 1961-2011 Censuses [Internet]. Dzs.hr. 2011 [cited 28 September 2017]. Available from: https://www.dzs.hr/Eng/censuses/census2011/results/htm/usp_10_EN.htm

30. Population by Ethnicity and Religion 2011, census [Internet]. Drzavni Zavod Za Statistike. 2011 [cited 28 September 2017]. Available from: https://www.dzs.hr/Eng/censuses/census2011/results/htm/E01_01_12/E01_01_12.html

Appendix 1: References Used to Construct Barriers to Abortion Topic List

1. Baum S, DePiñeres T, Grossman D. Delays and barriers to care in Colombia among women obtaining legal first-and second-trimester abortion. International Journal of Gynecology & Obstetrics. 2015 Dec 1;131(3):285-8.

2. Bijelic N, Hodzic A. ''Grey Area'': Abortion Issue in Croatia. Zagreb: CESI; 2014 p. 2-14.

3. Cano JK, Foster AM. “They made me go through like weeks of appointments and everything”: Documenting women's experiences seeking abortion care in Yukon territory, Canada. Contraception. 2016 Nov 30;94(5):489-95.

4. CARE BT. Barriers to Abortion Care in California.

5. Chavkin W, Leitman L, Polin K. Conscientious objection and refusal to provide reproductive healthcare: A White Paper examining prevalence, health consequences, and policy responses. International Journal of Gynecology & Obstetrics. 2013 Dec 1;123(S3).

6. Culwell K, Hurwitz M. Addressing barriers to safe abortion. International Journal of Gynecology & Obstetrics. 2013;121:S16-S19.

7. Doran F, Hornibrook J. Rural New South Wales women's access to abortion services: Highlights from an exploratory qualitative study. Australian Journal of Rural Health. 2014;22(3):121-126.

8. Finer L, Fine JB. Abortion law around the world: progress and pushback. American journal of public health. 2013 April;103 (4):585-9.

9. Fried MG. Abortion in the United States: barriers to access. Health and Human Rights. 2000 Jan 1:174-94.

10. Hajri S, Raifman S, Gerdts C, Baum S, Foster DG. ‘This Is Real Misery’: Experiences of women denied legal abortion in Tunisia. PloS one. 2015 Dec 18;10(12):e0145338.

11. Hanschmidt F, Linde K, Hilbert A, Riedel- Heller S, Kersting A. Abortion Stigma: A Systematic Review. Perspectives on Sexual and Reproductive Health. 2016;48(4):169-177.

12. Harries J, Cooper D, Strebel A, Colvin CJ. Conscientious objection and its impact on abortion service provision in South Africa: a qualitative study. Reproductive health. 2014 Feb 26;11(1):16.

13. Harris LF, Halpern J, Prata N, Chavkin W, Gerdts C. Conscientious objection to abortion provision: Why context matters. Global public health. 2016 Sep 13:1-1.

14. Heino A, Gissler M, Apter D, Fiala C. Conscientious objection and induced abortion in Europe. The European Journal of Contraception & Reproductive Health Care. 2013 Aug 1;18(4):231-3.

15. Henshaw SK. Factors hindering access to abortion services. Family planning perspectives. 1995 Mar 1:54-87.

16. Improving Access to Safe Abortion Care and Related Reproductive Health Services in the European Region [Internet]. Riga: World Health Organization and International Planned Parenthood Federation; 2012 p. 14-18. Available from: http://www.euro.who.int/__data/assets/pdf_file/0020/174260/e96675.pdf

17. Izvješće o radu za 2014, Report on Activities for 2014 [Internet]. Pravobraniteljica za ravnopravnost spolova, Ombudsperson for Gender Equality. 2015. Available from: http://www.prs.hr/index.php/izvjesca/2014

18. Johnson BR, Kismödi E, Dragoman MV, Temmerman M. Conscientious objection to provision of legal abortion care. International Journal of Gynecology & Obstetrics. 2013 Dec 1;123(S3).

19. Low WY, Tong WT, Wong YL, Jegasothy R, Choong SP. Access to Safe Legal Abortion in Malaysia: Women’s Insights and Health Sector Response. Asia Pacific Journal of Public Health. 2015 Jan;27(1):33-7.

20. Minerva F. Conscientious objection in Italy. Journal of Medical Ethics. 2015;41(2):170-173.

21. Moel-Mandel C, Shelley JM. The legal and non-legal barriers to abortion access in Australia: a review of the evidence. The European Journal of Contraception & Reproductive Health Care. 2017 Mar 4;22(2):114-22

22. Norris A, Bessett D, Steinberg JR, Kavanaugh ML, De Zordo S, Becker D. Abortion stigma: a reconceptualization of constituents, causes, and consequences. Women's health issues. 2011 Jun 30;21(3):S49-54.

23. Rao KA, Faundes A. Access to safe abortion within the limits of the law. Best Practice & Research Clinical Obstetrics & Gynaecology. 2006 Jun 30;20(3):421-32.

24. Safe Abortion: Technical and Policy Guidance for Health Systems [Internet]. 2012. Available from: http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf

25. Schwandt HM, Creanga AA, Adanu RM, Danso KA, Agbenyega T, Hindin MJ. Pathways to unsafe abortion in Ghana: the role of male partners, women and health care providers. Contraception. 2013 Oct 31;88(4):509-17.

26. Seid A, Yeneneh H, Sende B, Belete S, Eshete H, Fantahun M, Gizaw A, Yimer B. Barriers to access safe abortion services in East Shoa and Arsi Zones of Oromia Regional State, Ethiopia. The Ethiopian Journal of Health Development (EJHD). 2016 Feb 2;29(1).

27. Smith SS. The challenges procuring of safe abortion care in Botswana. African journal of reproductive health. 2013 Jan 1;17(4):43-55.

28. Warriner IK, Shah IH. Preventing unsafe abortion and its consequences: Priorities for research and action. Guttmacher Institute; 2006.

Appendix 2: Final Topic List for Women's Barriers to Abortion Access

Form of Interview

Women were asked to describe their abortion experiences from the beginning of their pregnancy. As such, this included the process of accessing and receiving abortion services. Furthermore, the post-abortion care period was discussed. The topic list shows examples of how these facets were assessed. Forms of these questions were utilized during the data collection process or inductively evaluated in the data analysis process.

Autonomy

Were there barriers preventing women from freely exercising their right to an abortion on demand? Were they able to choose the type of procedure, be it D & C, vacuum aspiration or medical abortion? Did women have a choice in receiving either general or local anesthesia? Were health professionals influencing their decision to get an abortion?

Barriers specific to those under 18

Cost

What were women's perceptions of the cost? Did the cost hinder their accessibility? Did they have financial support in order to receive the procedure?

Legal

Were women aware of their right to abortion services? Were women aware of gestational limits? Were women concerned about gestational limits? Were doctors following legal protocols in regards to their legal obligation to refer patients if they conscientiously object?

Logistics and Accessibility

Were there delays which diminished accessibility? Did women need to travel for a provider? Were they aware where they could get an abortion? How was their ease of access in finding a provider? Which factors facilitated or hindered their abortion experiences?

Misinformation/Information

How did women find information about where to get abortion services? If they found information on the internet was it from credible sources, such as a hospital website? Were there websites that hindered accessibility through spreading misinformation regarding abortion services?

Procedural

Were they subjected to procedural obstacles? Were they given waiting periods to think about their abortion?

Private and Public Practice

Why did women pick a private practice instead of public and vice versa? What are women's perceptions of public and private practice? Were women concerned about privacy in public practice? What were women's perceptions of quality of care?

Stigma, Attitudes and Society

1. internal attitudes and stigma

What are their opinions towards abortion? Did they feel it was difficult to access the service due to their own negative attitudes towards the procedure? Did they feel shame for accessing the procedure?

2. external attitudes and stigma

How did health professionals interact with women receiving abortions? Were women concerned about judgment from health professionals while accessing or receiving abortion services? Did women hide their abortions from family members or friends due to fear of judgment?

3. Society

How are women who received abortions seen by society? What is the narrative surrounding abortion in Croatia? Is there regional variability in perception of abortion services?

Appendix 3: Final Topic List for Doctors and Experts

The topic list below includes examples of the types of questions utilized during the data collection process. Interviews started more broadly with questions as to their perceptions regarding accessibility and availability in Croatia. This then this led to topics that were participant driven with respect to their perceptions concerning most relevant barriers.

Stigma and Society

How are doctors who are abortion providers treated? Are doctors concerned about performing abortions due to, for example, protesters or the influence of the church? What are participants perceptions of doctors internal attitudes towards performing abortions? How are abortions perceived by Croatian society? Do doctors consider women's internal stigma towards the procedure a barrier in accessing care?

Legal Barriers

What are doctors perceptions of the current legal framework for abortion access? Are there any areas of concern such as a restricted gestational limit or limiting access in private practice? What are their perceptions of conscientious objections legal framework?

Procedure and Procedural barriers

What are the procedural steps of women getting abortion and do they consider these reasonable? Is there a standardized protocol for surgical/medical procedures and are these applied uniformly?

Logistical issues and Availability

How well are abortion services distributed through the country? Do women tend to travel to different parts of Croatia due to accessibility issues? Are women able to access primary care gynecologists in a timely manner to get their abortion referral slips? Are women able to access appointments in the public hospital in a timely manner? How well is access to medical abortions distributed through Croatia? How is the distribution of willing providers in Croatia?

Ministry of Health

Is the Ministry of health ensuring abortion providers are at every hospital? Is there a willingness of policy makers and health professionals to implement abortion services? Does the Ministry of Health have regulatory mechanisms to help check whether abortion is available? Does the Ministry of health verify that externally contracted gynecologists are employed in cases where there is institutional conscientious objection?

Conscientious objection

What is their perception on conscientious objection and its influence no accessibility? Are women being referred to willing providers? What regulatory mechanisms are missing in monitoring conscientious objection? Is conscientious objection a concern for the quantity of professionals trained to perform abortions?

Cost of abortion services

Is the cost affordable for women? Should the procedure be covered by the national insurance policy? Have they had women who have struggled with the cost of the procedure? Is there cost variability according to hospital?

Barriers to women under 18

Access to post-abortion care