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Costa Rica's Therapeutic Abortion Law:

A Qualitative Study of Public Health Implications

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Costa Rica’s Therapeutic Abortion Law:

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An abstract of a thesis submitted to the Faculty of the Rollins School of Public Health

of Emory University in partial fulfillment of the requirements for the degree of

Master of Public Health in Global Health

2022

Abstract

Background: Since the 1970s, Costa Rica has permitted abortion in the case of imminent risk to women's life or health due to pregnancy. In 2019, the Costa Rican Ministry of Health released the Technical Norm for therapeutic abortion in an attempt to clarify the protocols for approving the procedure. However, there are minimal data about therapeutic abortion making it difficult to ascertain implications of the law on the realization of the human right to life, health, privacy, freedom from discrimination, and freedom from cruel, inhumane, and degrading treatment.

Objectives: This study aims to determine the human rights implications Article 121 of the Penal Code and the Technical Norm for therapeutic abortion by assessing the perceptions of abortion availability, accessibility, acceptability, and quality (AAAQ) among key stakeholders.

Methods: We conducted 22 in-depth interviews. Eight interviews were conducted with community stakeholders from a range of legislative, social activism, and research backgrounds. Thirteen interviews were completed with clinicians —10 experienced physicians and 3 medical residents.

Results: Across groups participants described barriers to therapeutic and illegal abortion care availability, accessibility, acceptability, and quality. Participants reported religious and cultural influences on the acceptability, availability, and quality of abortion care. Clinicians felt limitations in their training and subsequent abilities to administer abortion care due to the ambiguity of the Technical Norm and restrictions caused by criminalization of abortion. All participants addressed the ways abortion acceptability, availability, and quality intersect with the dimensions of care accessibility (financial, physical, and informational) for people seeking abortion services.

Conclusion: The current therapeutic abortion law and Technical Norm introduce and maintain barriers to therapeutic and illegal abortion care across the components of the AAAQ framework. The maintenance of the therapeutic abortion law through the Technical Norm has not improved clarity about or access to therapeutic abortion. In alignment with human rights based approaches, our findings suggest that decriminalization and legal allowances for rape, incest, and fetal anomly are necessary to mitigate the barriers to informational, financial, physical, and non-discriminatory accessibility to abortion care.

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A few days after I got into Emory in early 2020, as my Dad was reflecting on my accomplishments and academic pursuit he said “Some of it’s your mom, some of it’s me. A lot of it is you.”

To my parents: You are my foundation. My bedrock. My guiding lights. I believe I have the capacity to achieve many great things in life, and much of that comes from me. However, the will to achieve greatness comes from you. Thank you, and I love you.

I was, and continue to be, raised by a village. To all of my tribe who have guided and supported me through the years, thank you.

I would like to extend a heartfelt thank you to my advisors, both formal and informal, who guided me through this process: Dr. Dabney Evans, Dr. Anna Newton Levinson, Dr. Roger Rochat, and Dr. Joanne McGriff. You have all made my experience and education at Rollins truly transformative, and I am thrilled to continue in this field with your lessons as my foundation.

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Acronym List

AAAQ—Availability, Accessibility, Acceptability, and Quality

CCSS—Caja Costarricense de Seguro Social

CEDAW—Convention on the Elimination of All Forms of Discrimination Against Women

CESCR—International Covenant on Economic, Social, and Cultural Rights

CCPR—International Covenant on Civil and Political Rights

CAT—Convention Against Torture

CIDT—Cruel, Inhumane, and Degrading Treatment

HRBA—Human Rights Based Approaches

IACHR—Inter-American Commission on Human Rights

ICPD—International Conference on Population and Development

LAC—Latin America and the Caribbean

MCH—Maternal and Child Health

MDGs—Millennium Development Goals

MMR—Maternal mortality rate

OHCHR—Office of the United Nations High Commissioner for Human Rights

PAC—Post-abortion care

SDGs—Sustainable Development Goals

SRHR—Sexual and reproductive health and rights

SRH—Sexual and reproductive health

RR—Reproductive rights

RJ—Reproductive justice

Chapter 1: Introduction

Similar to its regional counterparts, Costa Rica's national policies restrict abortion abortion access (WHO, 2021). The current law only allows abortion in cases where the pregnancy poses a physical threat to the pregnant person's life. This form of abortion care, termed therapeutic abortion, does not make allowances for mental health concerns or fetal deformities and has been historically difficult to access. Aside from the few cases that have received regional attention from the Inter-American Commission on Human Rights (IACHR), there are minimal data about the ability to access therapeutic abortion services or the use of clandestine abortion methods/services (IACHR, 2020). Restrictive abortion laws are typically inversely proportional to the rate of clandestine abortion services which can have adverse effects on women's sexual and reproductive health (SRH) and national SRH indicators (Lavelanet, 2020). The limits on Costa Rican data have prevented in-depth analysis of the human rights landscape related to sexual and reproductive health. This has subsequently contributed to a lack of comparative analysis capabilities between Costa Rica and its Central American counterparts around sexual and reproductive health and human rights indicators and lived experiences.

With the evolution of health and human rights research and program based approaches over the past twenty years, sexual and reproductive health has been at the forefront of human rights analysis. Around the world, abortion laws and health policies have been a major topic of political, social, and human rights discourse and abortion research has revealed the relationship between abortion accessibility and overall accessibility to sexual and reproductive health and rights (SRHR). The World Health Organization (WHO) and other global health bodies have

studied and emphasized the role that restrictive abortion policies play in not eliminating abortion but increasing the rates of unsafe abortion which can result in morbidity or mortality of pregnant people. Current legal restrictions on abortion in Costa Rica have contributed to the minimal data about the full spectrum of abortion care incidence. There is subsequently little knowledge about the rates of public health implications of unsafe and illegal abortion. There is a need to address the gap in abortion accessibility and assess human rights violations as the current Costa Rican abortion law only permits abortion in the cases of physical threat to the mother's life. This study seeks to determine how the current therapeutic abortion law codified in Article 121 of the Penal Code, and further outlined in the Technical Norm, impact human rights.

A Note About Gendered Language:

To study and analyze sexual and reproductive health is to acknolwedge the various components of our identities as individuals and how these identities impact health. As such it would be a disservice to the field and the public we seek to serve to act as though gender identity and expression do not play a part in the acceptability, accessibility, availability, and quality of SRH care. In this analysis the terms "women" and "people who can become pregnant/people with uteruses" are used in different places. These terms were placed intentionally and with the goal of making the distinction between my voice as the author and the language employed by the literature and codified in domestic and international law. In some places I, as the author, use women because I am commenting on literature or legal code which in turn used the term "women." To use "people who can become pregnant" throughout or replace "women"' where it appears in the literature would suggest a universal acceptance to this inclusive language that, unfortunately, has not been applied consistently, or at all, in certain contexts. My distinction with

this language use is not to minimize or exclude, but to acknowledge the role the legal and human rights language has in sexual and reproductive health access and application of law.

Chapter 2: Review of the Literature

For the purposes of this analysis, only sources analyzing topics related abortion care, post-abortion care, contraception, and/or sexual and reproductive health theory in the Latin American and Carribean (LAC) region were considered. This scope was applied in an attempt to focus on countries with similar and/or shared social, cultural, and political values and structures that may affect the aforementioned topics. Furthermore, the focus on the LAC region is designed to further highlight the disparity in research and resources for Costa Rica and its regional counterparts. Sources generally referring to these topics on a global scale, or referencing global themes, were included to provide context for the corresponding phenomena on an international level. This review of recent literature includes a review of: sexual and reproductive health as a human right, relevant human rights treaties and principles, the introduction of the AAAQ framework, and an overview of the gaps in Costa Rican data related to abortion.

Framings of Reproductive Health

In understanding the various legal foundations and State obligations of ensuring the right to safe abortion services, it is crucial to acknowledge the relationships between reproductive rights, reproductive justice, sexual and reproductive health and rights conceptually and in practice. Distinguishing between these frameworks allows for a deeper analysis of the language used and principles employed by activists, policymakers, and healthcare providers (Parker, 2020).

The three models can best be distilled by the ways in which they are operationalized and applied. Reproductive rights, as a subset of human rights, addresses sexual and reproductive health laws and policies that protect or prohibit the realization of reproductive freedom to decide

if, how and when to reproduce (Beracochea et al., 2010). A Sexual and Reproductive Health framing concerns itself with the accessibility of health services that are necessary to attain the highest standard of health defined as

> "the state of complete physical, mental, and social well-being in all matters relating to the reproductive system and implies that people can have a satisfying and safe sex life, the capability to reproduce, and the freedom to decide if, when, and how often to do so." (Amnesty International, 2022)

Reproductive Justice (RJ) incorporates a more sociological view of the intersections of identity that influences the ability to make reproductive decisions freely. Grounded in both human rights and Black Feminist theory, Reproductive Justice calls for improving marginalized people's ability to: have children, not have children, and raise children in safe and healthy environments. The RJ incorporation of social determinants of health/intersectional analysis has resulted in the RR and SRH frameworks adjusting their approach to better address marginalized populations (Ross, 2017).

While the RR, RJ, and SRHR models clearly overlap in their conceptualization of reproductive freedom to decide if and how to reproduce, their methods of attaining these goals depend on politics/legislation, health infrastructure accessibility, and social mobilization respectively (Parker, 2020).

The international acknowledgement of the impact of social determinants of health, particularly the impact on access to stigmatized health services such as abortion, has further propelled the rights based approach (RBA) in place of the needs based models. A key distinction between both models is "the needs-based approach considers the needs of the majority. RBAs

consider the needs of all citizens. In an RBA, it is the people whose rights are not being fulfilled that need to be prioritized."(Beracochea et al., 2010).

Due to the evolving conceptualizations of health and human rights principles over the past 25 years, global intergovernmental treaties, agreements, and documents have begun expanding their incorporation of sexual and reproducutive health into rights frameworks. Agreements such as the International Conference on Population and Development Programme of Action, and Beijing Conference more explicitly introduced "'the human rights of women includ[ing] their right to have control over and decide freely and responsibly on matters related to their sexuality'" (UN, 1996, Kismödi et al., 2014). The intersection of human rights standards/principles and health reflect the evolving understanding of the various ways in which social factors can affect an individual's realization of the 'highest attainable standard of health.' As a result, it becomes the responsibility of the nation state to ensure that domestic law reflects the dimensions of social, economic, and political factors that impact the ability to attain the right to health.

As a result of this holistic view of social, economic, and political identities within the realization of the right to health, it is crucial to consider the principles and language set forth in human rights treaties such as CEDAW (Convention on the Elimination of All Forms of Discrimination Against Women), CAT (Convention Against Torture), CESCR (International Covenant on Economic, Social, and Cultural Rights), CCPR (International Covenant on Civil and Political Rights. A key similarity between all agreements, treaties, and international declarations has been a hesitancy to explicitly declare abortion as a right of people who can become pregnant. This, too, has evolved in recent years as the right to safe, accessible, and

quality abortion care has become a more central indicator or measure of reproductive health, reproductive rights and international development (Kismödi et al., 2014).

As the perception of abortion within human rights frameworks has evolved, so too have the interpretations of existing human rights frameworks to explain the right of people who can become pregnant to access safe and legal abortion care. Central to these arguments are the right to life, freedom from discrimination, health, privacy, and freedom from cruel, inhuman or degrading treatment (CIDT) as outlined in the Universal Declaration of Human Rights and other human rights treaties (United Nations, 1948).

ICPD Programme of Action (1994) and Beijing Conference (1995)

The 1994 International Conference on Population and Development's Programme of Action and the 1995 Beijing Conference made noteworthy progress in its incorporation of reproductive health, and abortion, as a human rights issue. This acknowledgement of the relationship between abortion, particularly safe abortion access, and SRH led the ICPD to outlining specific policy recommendations to protect the right to health. Furthermore, the ICPD discussed and demonstrated the significance of SRH on sustainable development by highlighting the ways in which SRHR indicators demonstrate equal access to rights for women. This approach was a drastic departure from previous analyses from international bodies which relegated the significance of MCH and SRH to population development and control.

However, despite being somewhat ahead of the times in considering of the social determinants of health and the negative impact unsafe abortions have on reproductive health, the ICPD Programme of Action focused heavily on family planning method and service availability as the cornerstone of protecting SRHR. Conversely, abortion was primarily discussed in the

context of how unsafe abortion affected maternal mortality and a strong recommendation against considering abortion as a family planning method. The explicit goal was to prevent the need for abortion without equal considerations for improving abortion accessibility or quality. The ICPD recommends that States where abortion is legal should take all necessary steps to ensure accessibility of services and training of providers. However, these recommendations were not coupled with recommendations around changing abortion legality in order to ensure the availability, accessibility, acceptability or quality of services were guaranteed. The Beijing Conference implicitly supported legal and safe access to abortion services to ensure women have the ability to "decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so" (United Nations, 1995).

CEDAW

The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), signed and ratified by Costa Rica in 1980 and 1986 respectively, outlines the responsibilities of states to ensure protection of women from discriminatory actions and practices (UN General Assembly, 1979). This treaty reflects a global acknowledgement of the ways in which gender impacts access to and realization of human rights. Considered independently, the ability of women to access legal and safe abortion services is covered under the foundational CEDAW protection from all forms of discrimination as only people with uteruses can become pregnant. Limitations on abortion access affect health care access for people who can become pregnant who are already likely to experience other forms of discrimination due to their gender status, gender expression and other social and political identities (Erdman & Cook, 2020).

CEDAW General Recommendation No. 24 (1999) highlighted the relationship between reproductive health and women's overall health and established the obligation of States to ensure equal access to non-discriminatory health care services. This article further emphasized the relationship between social identities for "migrant women, refugee and internally displaced women, the girl child and older women, women in prostitution, indigenous women and women with physical or mental disabilities" and the experience of discrimination in the health care setting (UN CEDAW, 1999). In addition to the social and political identity considerations, General Recommendation 24 stratifies factors that can result in unequal access to or provision of health care including: biological, socioeconomic, and psychosocial factors. The focus on health care access also addresses the State responsibility of ensuring continuity of care in the case of conscientious objection by providers in the case of a procedure the provider refuses to perform.

General Recommendation No. 35 (2017), a continuation of the recommendations established in No. 19, further outlines the legislative, protective, preventative, and punitive measures that should be implemented to eliminate gender based violence. In relation to the realization of sexual and reproductive rights free from violence, No. 35 specifically references the "denial or delay of safe abortion and/or post-abortion care, forced continuation of pregnancy, and abuse and mistreatment of women and girls seeking sexual and reproductive health information, goods and services, are forms of gender-based violence that, depending on the circumstances, may amount to torture or cruel, inhuman or degrading treatment (CIDT)." (UN CEDAW, 2017) The convergence of violence against women (VAW) and CIDT principles represented a pivotal line of human rights analysis as it demonstrated the relationship between women's human rights and the more general human rights.

CAT

This more recent analytical dimension of abortion as a reproductive human right protected under Convention Against Torture (CAT) and Other Cruel Inhuman or Degrading Treatment (CIDT) or Punishment. Signed by Costa Rica in 1985 and ratified in 1993, CAT was traditionally viewed as a protection, under international law, for State detainees to obligate the State to ensure humane treatment during detention. The expanding interpretation of CAT over the past two decades has captured that the State is responsible not only for State actors, but private actors if the State has not adequately prevented or criminalized such CIDT acts. As a result of this emerging view of State responsibility, the denial of abortion care access is increasingly viewed under the CIDT lens as forced continuation of pregnancy can result in severe mental and physical distress.

This emerging interpretation of CAT follows a larger movement of acknowledging gender based differences in the methods of and experiences of torture and further relates denial of abortion access as a form of violence that is further protected against through CEDAW (Zureick, 2015). Thus far, analysis of the right to abortion access under CAT has focused on cases in which the pregnancy was caused by a situation in which there was an ‘autonomy deficit’ (such as young age, mental disability, or sexual violence) of the person who became pregnant or cases in which the continuation of the pregnancy would cause severe physical or mental distress (fetal impairment or threat to the pregnant person’s life (Zureick, 2015). However, feminist and human rights scholars are increasingly proposing that the denial of autonomy to receive an abortion, regardless of reason, is yet another form of CIDT and must be included in the CAT/CIDT analysis of abortion as a reproductive human right.

The evolution of CAT/CIDT within reproductive rights frameworks highlights the relationship and deficits between domestic and international law. As referenced above, States have not only an obligation to ensure domestic abortion laws are effectively and equally implemented, they are also responsible for adjusting abortion restrictions to ensure that CIDT is not being "inflicted." These obligations reflect the issues around international law standards for enforceability (Zureick, 2015).

CCPR

The International Covenant on Civil and Political Rights (CCPR) was first introduced in 1966, and ratified by Costa Rica in 1968, to provide an international acknowledgement of citizens' basic rights that should not be infringed upon during times of conflict as seen during World War II. CCPR further expanded upon the State obligations to protect the right to life and privacy that were outlined in the Universal Declaration of human rights.

General Comment 28 addresses pregnancy and childbirth related deaths of women that States are responsible for not only reporting but preventing through such actions such as aiding in the prevention of unwanted pregnancies. This article refers specifically to the State obligation "ensure that they do not have to undergo life-threatening clandestine abortions" due to unwanted pregnancies. This article goes on to discuss women's right to privacy when seeking reproductive healthcare services. Most importantly, the CCPR discusses the issue of punitive abortion laws through which medical providers can report suspected cases of abortion. While not directly responding to States' restrictive abortion laws, General Comment 28 does provide guidance on the ways in which the right to life and privacy are threatened by laws that prohibit safe abortion services and that punish women who access illegal services.

General Comment 36, article 8, demonstrates a somewhat intriguing balance of a more integrative rights based interpretation of abortion access while acknolwedging the State's right to "regulate voluntary terminations of pregnancy". While proposing required access in circumstances where abortion access is interdependent with other human rights and treaties (right to health, non-discrimination, and freedom from CIDT such as rape, incest, nonviability/fetal impairment, and threat to the "pregnant women or girl"; this section also provides somewhat conflicting guidance regarding other voluntary circumstances (UN Human Rights Committee, 2019).

In a clear example of the human rights standard relative to federal law, Article 8 states that countries should not enact laws that criminalize abortion. The articles goes further and notes that, in accordance with their human rights and treaty duties, States should remove and prevent barriers to abortion access and protect women and girls from the mental and physical side effects of unsafe abortions. The combination of decriminalization and protections from unsafe abortion suggest a more universal system of abortion access given that restriction can contribute to the utilization of unsafe abortion services.

CESCR

The International Covenant on Economic, Social, and Cultural Rights (ICESCR) first written in 1966, and ratified by Costa Rica in 1968, to ensure that particularly marginalized persons are able to enjoy full realization of their economic, social, and cultural rights. Within this document is an expanded conceptualization of the right to health and the first official introduction of the AAAQ framework.

General Comment 14 introduces the AAAQ framework in relation to the right to health as well as the nuances of each component by reiterating States treaty obligations to "respect, protect, and fulfill" (UN CESCR, 2000). Within the context of the right to health, respect from States crucially requires them not to interfere in individual's realization of health, corresponding to the right of people to control their health. These rights include freedom from maltreatment in the healthcare setting and the right to access "a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health." The inclusion of different dimensions of healthcare accessibility (both cognitive accessibility and physical) and quality of care is further stated in this General Comment by the explicit direction to eliminate barriers for women's health. The AAAQ approach as defined here acknowledges that the right and ability to participate in health services is dependent on health policy at all levels in the State further highlighting the interdisciplinary nature of sexual and reproductive health and rights.

Sixteen years after the introduction of the AAAQ framework and analysis provided in General Comment 14, General Comment 22 was published to further cement the position of sexual and reproductive health within the larger human rights framework. This interpretation utilized several examples, including the denial of abortion, to demonstrate the multiple human rights that are violated when sexual and reproductive health is treated as independent from other rights. As such, the CESCR Committee outlines the State obligations to eliminate laws that introduce or maintain barriers to accessibility of health care (goods, services, information, and facilities), actively ensure access to healthcare (including safe abortion care), and ensure all care is evidence based and non-discriminatory (CESCR, 2016). General Comment 22 went further

and acknowledged LGBT+ persons and their right to non-discrimination when seeking SRH care.

AAAQ

There are a variety of frameworks that seek to guide the process of developing human rights based approaches to public health research and the implementation of programs. One of the most effective frameworks is the AAAQ or Availability, Acceptability, Accessibility, and Quality framework for applying human rights concepts to a health topic or issue. In the case of rights-based approaches to sexual and reproductive health, the AAAQ aids in clearly outlining the impact of social acceptability and cultural norms on health service access and quality.

In applying the AAAQ framework to sexual and reproductive health, we must first consider the nuances of the AAAQ criteria, how each component can be legally enforced, and how the criteria can be implemented and measured. The generalizability of the AAAQ and its relationship to the social determinants of health allow for this framework to be applied across contexts by ensuring that the dimensions of the human right to health are captured. This flexibility stems from the criteria not being so specific as to limit any rights that interplay with the right to health to one component of the framework.

AAAQ Methodology

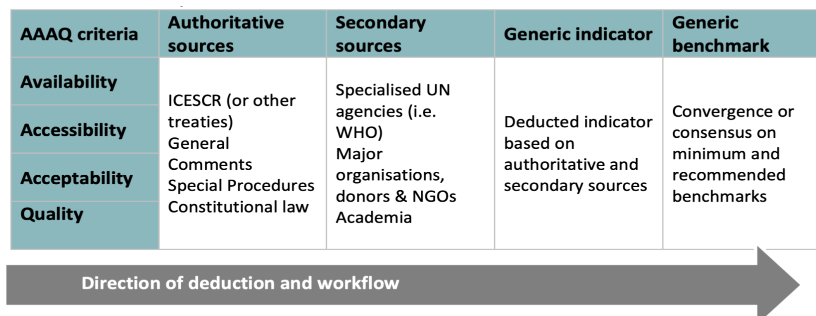
The AAAQ framework or methodology is designed to assess the realization of human rights across four dimensions: Availability, Accessibility, Acceptability, and Quality of people's realization of the right. Human rights mapping utilizes several categories of sources to determine how each of these criteria are defined, how they can be applied, and how they might be measured. Source categories range from binding human rights instruments such as the CESCR,

CEDAW, and CAT to secondary sources such as human rights declarations, tertiary intergovernmental conferences and agendas, and lastly, “soft law” documents such as the General Comments (Jensen et al., 2014).

The AAAQ methodology uses a deductive process of considering the scope of rights as outlined in binding instruments to then establish generic indicators based on the other source categories. Indicators can come from UN subsidiaries such as the Office of the United Nations High Commissioner for Human Rights (OHCHR) and research institutions such as the Guttmacher Institute (Guttmacher Institute, 2015). This deductive approach to the AAAQ is crucial to the application of the universality of human rights as it places all contexts, cultures, and populations at the same starting point of an acknowledgement of the codified human rights (Jensen et al., 2014). From this shared foundation, the indicators and methods of realization can be adjusted in response to population needs and social factors. This allows for increased incorporation of the needs of marginalized communities and re-emphasizes the rights based rather than results-based approach.

Generic indicators are delineated into different interrelated categories that work to evaluate legislative, judicial, programmatic, and outcomes on rights realization. The OHCHR used the categories of structural, process, and outcome indicators to operationalize the process of defining and implementing rights based indicators (United Nations & United Nations. Office of the High Commissioner for Human Rights, 2012).

Table 1: The AAAQ Framework Sources (Jensen et al., 2014)



AAAQ criteria	Authoritative sources	Secondary sources	Generic indicator	Generic benchmark
Availability Accessibility Acceptability Quality	ICESCR (or other treaties) General Comments Special Procedures Constitutional law	Specialised UN agencies (i.e. WHO) Major organisations, donors & NGOs Academia	Deducted indicator based on authoritative and secondary sources	Convergence or consensus on minimum and recommended benchmarks

Direction of deduction and workflow

After establishing the indicators of interest, the generic benchmark of acceptable progress is formed. Benchmarks such as the Sustainable Development Goals (SDGs) maternal mortality rate of <70 maternal deaths per 100,000 live births provide a cross contextual standard of improvement.

AAAQ Criteria

Definitions and scope of the four criteria of the AAAQ vary slightly between organizations. Generally, availability assesses if health services, goods, and facilities are consistently procurable. Accessibility is concerned with the dimensions of physical access, economic access (affordability), cognitive or informational access, and non-discrimination. Acceptability includes consumer acceptance of services across the dimensions of culture, medical ethics, and population needs. Lastly Quality captures both provider training and ability to provide requested services adequately and an overall management of patient needs and risks associated with care (Danish Institute for Human Rights, 2017).

When considering abortion services within the AAAQ, researchers are concerned with the following questions (Jensen et al., 2014):

Availability

- How many clinical providers trained on abortion care methods?
- Is there a national workforce development strategy to assess and improve the availability of trained providers?
- What are legal restrictions around the provision of abortion care (ex: the Norma Tecnica which limits abortion except for cases of morbidity or mortality for the pregnant person)
- Is there funding to ensure abortion services are available at all facilities where pregnant people may seek care?
- Are there continuing education opportunities for providers?

Accessibility

- Physical: Is the geography of facilities that provide abortion services aligned with the populations in need? Is there integration and continuity of care between community and national facilities?
- Economic: Are there financial barriers to accessing care?
- Cognitive/informational: Are people aware of their legal options for procuring abortion services? Do people know where to go to receive abortion and post-abortion care?
- Non-Discriminatoin: Do members of marginalized communities have equal access to abortion care?

Acceptability

- Are clinicians trained to provide care that addresses patients' sociocultural needs?
- Do patients have the ability to choose the abortion method that best aligns with their values and needs?

- Are their monitoring mechanisms to ensure accountability across the dimensions of abortion care?

Quality

- Are the clinicians meeting the licensing and training necessary to perform abortions?
- Are facilities stocked with adequate equipment and medications to perform medical and surgical abortion procedures?
- Are performed induced abortions following scientifically accurate protocols?

Dimensions of Abortion Legality in HRBA

"Human rights standards require access to abortion,at a minimum, on grounds of life and health, rape or sexual crime, and fetal impairment. Procedural protections to safeguard entitlements to lawful care include measures that guarantee timely access to information of the circumstances of pregnancy and grounds for its possible termination, written reasons for denials of care, and mechanisms of appeal and review of denials with an opportunity for persons seeking abortions to be heard and to have their views considered" (Erdman, et al 2020)

Within a human rights based framing, criminal abortion laws demonstrate multi-layered violations of the human rights outlined above. In addition to individual rights violations, criminalization of abortion opposes the international human rights law standards of proportionality and non-arbitrariness. The former seeks to ensure that the punitive harms

inflicted by the law must not be asymmetric to the aim of the law. In other words, the harms and rights violations inflicted by criminal abortion laws exceed, and are disproportionate to, the aim of limiting or decreasing the occurrence of abortion (Erdman, et al (2020).

When we consider frameworks such as the AAAQ, we find that restrictive laws, punitive or not, result in barriers in acceptability, accessibility, availability, and quality, individually or in combination, for abortion services. Restrictive laws further widen the access gap for socially marginalized groups as knowledge and application of the law can become a subjective individual experience rather than an objective universal standard. The result is an individual and context specific realization of the aforementioned human rights contradicting the universality of the human rights treaties member States are responsible for protecting.

Furthermore, the human rights treaties outlined above provided the basis for State obligations to ensure legal access to abortion under the allowance of “life and health, rape or sexual crime, and fetal impairment” as minimum standards. Countries such as Costa Rica, which limit the allowance to life and health are not meeting their full treaty obligations. This has been further emphasized by Inter-American Commision for Human Rights rulings which found Colombia, Nicaragua, Bolivia, and Paraguay responsible for causing harm to rape survivors who were denied abortion care under the right to health (Erdman, et al 2020). A crucial component in the rulings related to sexual violence and abortion access was the acknowledgement that laws that permit abortion in cases of sexual violence cannot in turn incorporate barriers such as medical or legal documentation into the protocol for accessing care.

Latin American and Caribbean Context

The Latin American and Caribbean region, the Central American sub-region in particular, houses some of the most restrictive abortion laws in the world (Bergallo & Ramón Michel, 2016). The restrictive nature of the regional abortion laws have drawn further scrutiny in the past 20 years due to the integration of these abortion laws within the national criminal code resulting in criminalization and punitive measures for those seeking and providing illegal abortion services. All countries in the region, with the exception of Mexico, have abortion codified in the criminal code. A few countries including: Bolivia, Ecuador, and Honduras have also incorporated constitutional amendments related to abortion. The combination of the two legal approaches makes changing abortion law a much more challenging process that is further subject to political influence rather than health or human rights principles.

The application of criminal abortion laws has varied from outright bans to legal acceptions such Costa Rica's therapeutic abortion provision. Legal acceptions have been a key step in the mounting liberalization that has swept the region as constitutional provisions are increasingly legalizing abortion in cases of rape, incest, fetal deformity, and threats to the woman's physical health/life. With shifting legal contexts such as Nicaragua, which originally had therapeutic abortion allowance, further restricted their law resulting in full criminalization of abortion.

Another gap emerges when abortion legality is considered. In a country such as Costa Rica where abortion is not only restricted but criminalized, the likelihood of post abortion care seeking in public or private facilities further decreases (Rasch, 2015; Bergallo, 2014). Per the Costa Rican Penal Code, both the person administering an abortion and the person receiving an abortion can be criminally charged and serve time in prison which further stigmatizes the procedure and makes surveillance and estimation more challenging. This chilling effect on both

abortion service seeking and provision results in further skewing of abortion estimates, particularly across social and economic groups.

Within the context of global health literature on post-abortion care (PAC), the Costa Rican Penal Code's criminalization of the administration or receipt of abortion care would suggest there is a high level need for PAC to manage complications in those who seek unsafe clandestine abortions. Across low- and middle-income country (LMIC) settings, the implementation of non-punitive PAC programs have worked to bridge the gap between abortion legality and mortality from unsafe abortions (Storrengand & Ouatarra, 2014; Suh, 2018). The lack of existing data regarding PAC accessibility significantly limits analysis of the spectrum of abortion care accessibility and is something this study seeks to address.

Costa Rican Abortion Estimates

Over the past 20 years, the Latin American and Caribbean (LAC) region has witnessed a drastic shift in sexual and reproductive health policies and rights particularly around contraception and abortion access. However, some LAC countries including Costa Rica have minimal data about current or historical rates of abortion, both safe and unsafe, and subsequently lack the data necessary to evaluate the impact of unsafe procedures on maternal mortality, morbidity, and other facets of sexual and reproductive health and rights (Guttmacher Institute, 2018). Furthermore, the limited availability of data has prevented in-depth analyses of the human rights landscape related to sexual and reproductive health in Costa Rica, thus reducing capability to comparatively analyze between Costa Rica and its Central American and, more broadly, Latin American regional counterparts.

As a small upper-middle income country (World Bank Country and Lending Groups – World Bank Data Help Desk. (2022) with a historically stable political and health system, Costa Rica is largely overlooked by global health organizations. The evolving, but largely conservative, domestic discourse has resulted in little research about sexual and reproductive health topics for people who can become pregnant. Surveillance tools and research studies utilized and conducted by international bodies such as the WHO, UN (and its subsidiaries), and the Guttmacher Institute frequently do not include Costa Rica based on exclusion criteria such as the maternal mortality rate (MMR) and GDP. USAID's Demographic Health Survey (DHS), first launched in 1984, prioritizes countries receiving USAID support or funding from organizations such as UNICEF and UNFPA. Tools such as the DHS and the WHO's Multi-Country Survey on Abortion Related Morbidity and Mortality in Health Facilities capture quantitative and qualitative data about family planning access and SRH indicators. The exclusion of Costa Rica from such research efforts combined with the lack of domestic political will has contributed to limited knowledge about the current accessibility and acceptability of SRH topics such as abortion (Berer, 2017) . Although there is a lack of domestic and international interest in SRH research in the country, Costa Rica is an active member in the global human rights community, ratifying the majority of international treaties over the past 3 decades without objection or alteration (WHO, 2020).

The prioritization of SRH indicators such as maternal mortality has contributed to global tunnel vision on maternal health issues by distilling the complex relationship between women's sexual and reproductive health including access, quality, acceptability, etc) and human rights to single indicators that do not provide the full context (Brunson & Suh, 2019).

Due to the aforementioned limitations of the maternal mortality indicator and abortion research, estimates of abortion in Costa Rica are difficult to ascertain. A joint study by several

global health and research organizations such as the WHO, UNFPA, Guttmacher Institute, and World Bank (among others) estimate that from 2010-2014 45% of all abortions were unsafe with three of four abortions in the LAC and Sub-Saharan African regions being unsafe (WHO, 2017). However, country specific estimates for Costa Rica are not included in such joint analyses; unaided by international tools such as the UNICEF Multiple Indicator Cluster Surveys (MICS) which do not include questions about abortion use or seeking behaviors (Minsterio de Salud Costa Rica, 2018).

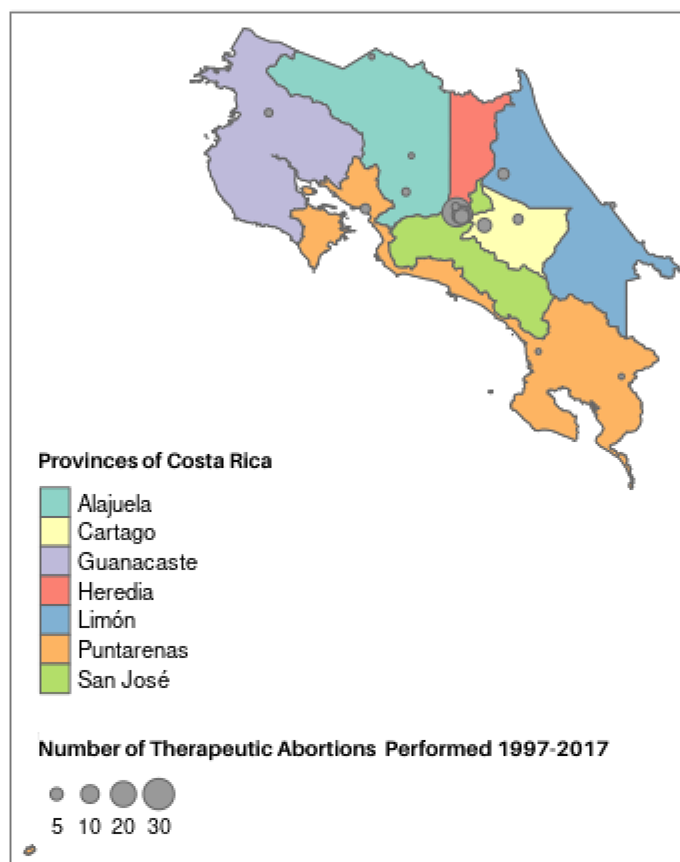
The National Poll of Sexual and Reproductive Health initiated by domestic organizations such as the Costa Rican Ministry of Health, Demographic Association of Costa Rica, and the University of Costa Rica do not include any questions about pregnancy termination, spontaneous or induced. The 2010 and 2015 iterations of this survey only address the desire for the most recent pregnancy and inquiries about the surveyed populations opinions of sexual health education (Costa Rica. Ministerio de Salud, 2010 and 2015). The introduction section to both surveys discuss the role of government in ensuring the protection of sexual and reproductive health and rights based on the human right to health. Nevertheless, the only question about to rights in both the 2010 and 2015 surveys was related to sexual violence experienced by women:

The most recent domestic survey to include abortion was a 2010 study by the Costa Rican Ministry of Health which surveyed 3197 people (50.5% men, 49.5% women) about their opinions of different dimensions of sexual and reproductive health. Across the seven provinces of the country 70 of 81 cantons were surveyed with equal numbers of men and women ages 15-80 being included (Costa Rica. Ministerio de Salud. et al., 2012). With regard to abortion, the survey questionnaire solely asked about acceptable reasons for abortion and stratified the results by gender, education level, and region. Despite acceptance of some reasons behind seeking an

abortion, many people were not aware of Article 121 of the Penal Code which protects therapeutic abortion.

A 2018 article, based on Caja Costaricense de Seguro Social (CCSS) data, revealed that 80 therapeutic abortions were performed from 1997-2017 (Ruis Espinoza, 2018). However, the exact CCSS data this article was based on was not able to be found or accessed. These therapeutic abortion estimates fail to capture the motivations behind, experiences with, or incidence of illegal and unsafe abortion service use.

Figure 1: Map of Therapeutic Abortion Procedures by Facility 1997-2017



The technical norm refers to the Costa Rican Social Security agency data which states common reasons therapeutic abortion is utilized. According to this reference, ectopic pregnancies, placental and/or amniotic fluid infections (chorioamnionitis), and hydatidiform moles (uterine tumors) are the most common followed by pregnancy related hypertension, cardiac conditions, neurologic conditions, or neoplasms (Ministerio de Salud CR, 2019). However, the data referenced by the Costa Rican Social Security agency are not cited in the technical norm; these data do not appear to be publicly available on the *Ministerio de Salud or Caja Costarricense de Seguro Social* websites and databases.

As outlined in the Technical Norm, data about therapeutic abortions should be captured by the Ministry of Health based on, and for reporting to, the International Classification of Diseases (ICD) surveillance tool. One of the limitations of this method of surveillance is that it is only accounting for legally approved therapeutic abortion procedures. Around the world, estimates of abortion prevalence and incidence have attempted to use rates of post abortion care for complications as a proxy measure for determining frequency of abortion provision. This approach, while helpful given the overall lack of data globally, and in Costa Rica specifically, still falls short of capturing the scope of abortion, clandestine abortion, and unsafe abortion (Singh et al, 2015). One of the many challenges in using post abortion care as a proxy measure is that studies are typically limited to data in the ICD database which is only collected from public healthcare facilities, whereas unsafe and/or illegal abortions do not take place in such settings. Furthermore, the focus of data collection on public facilities fails to capture the role of private facilities and providers in safe abortion provision.

The IACHR's influence in Costa Rica became most significant through its ruling on Aratavia v Costa Rica which sought allowances for in vitro fertilization which was previously

prohibited. The IACHR's interpretation of the right to life in this case altered previous conceptualizations by focusing on implantation of fertilized cells rather than fertilization itself (Jesus, 2014). As such, the Aratavia ruling has been coupled with abortion rights legal procedures and interpretations. Two other seminal IACHR cases were those of A.N. and Aurora (both pseydonyms) who were subjected to prolonged denials of abortion care despite receiving diagnoses of fetal abnormalities incompatible with life (CIDH, 2020). These cases became the impetus for the Costa Rican Norma Tecnica which through its incorporation of human rights language sought to meet the "mechanisms of appeal and review of denial" standards required by human rights law by clearly outlining steps for patients and clinicians.

Costa Rica's Abortion Policy and the Norma Technica

Article 121 of the Costa Rican Penal Code, written in 1970, defines the national abortion law which only permits abortion care in cases in which the pregnant woman's life or health are in danger as a result of the pregnancy. This legal form of abortion is more commonly known as *'aborto impune'* or 'unpunished abortion.' In 2019, the *"Norma Técnica"* (or Technical Norm) was passed to establish clear protocols about how medical personnel, specifically physicians, are to evaluate and determine threats to the pregnant woman's life that warrant abortion care according to Penal Code standards (Ministerio de Salud CR, 2019). The original law allows for a termination of pregnancy "to avoid a danger to the life or health of the pregnant women if this danger cannot be avoided by other methods" (Ministerio de Salud CR, 2019).

Almost fifty years after the establishment of Article 121, the Technical Norm was written to ensure medical professionals have clear steps about how to authorize therapeutic abortions to guarantee "the right to life and health of women, in light of the state's duties in regards to human

rights" (Ministerio de Salud CR, 2019). Despite the justifications stated in the technical norm and on the Ministry of Health website, the protocol does not change or expand upon the legal allowances established by Article 121 of the Penal code. Furthermore, mental health is not referenced, discussed, or included in any aspect of the norm.

The Technical Norm is divided into 13 sections to address: the general purpose of this new legal norm, where therapeutic abortions can be performed and by whom, how to access a therapeutic abortion (physician responsibilities and patient rights), informed consent and protections against forced procedures, reporting processes, and monitoring bodies. This document was written for institutions and clinical providers whose roles or scope of practice relate to therapeutic abortion. In essence, although the document furter details the mechanisms through which pregnant women can appeal for an abortion, they were not the primary audience of interest. Significantly, only pregnant "women" are mentioned and protected in this document.

The norm requires women to receive scientifically accurate information about their diagnosis and that recommendations in favor of therapeutic abortion by physicians must be in response to a medical threat to the life or health of the woman that cannot be prevented by any other means. This requires that the group of physicians that review each case must agree that abortion is the sole option to avoid morbidity or mortality from the pregnancy. Physicians and medical facilities are required to consider the highest standard of health as a criteria for evaluating the threat to the pregnant person's life, using WHO standards and guidelines for reference.

Physicians have the right to conscientiously objection to performing an abortion procedure can remove themselves from the patient's case. The medical facility will be responsible for ensuring that the objection does not delay or create a barrier to completion of the

approved therapeutic abortion. Furthermore, physicians who have a conscientious objection may not participate in the panel that considers and approves a patient's need for a therapeutic abortion. The norm goes on to state that medical facilities are responsible for ensuring non-discrimination protections for providers who participate in the medical evaluation panels, perform therapeutic abortions, or who decline to perform a therapeutic abortion under conscientious objection.

Despite the lack of clarity about the development of the medical panels, the norm prohibits conscientious objection in the case of an obstetric emergency when no other qualified physician is present or available.

The informed consent section outlines the rights of the pregnant woman to receive objective scientific evidence, right to decline a recommended therapeutic abortion, and the right to decline the procedure after signing the consent form. This section also details the information about the patient that should be collected with the informed consent. In the case of pregnant minors, the opinions of the parents or caregivers are taken into consideration but a physician may make the final decision to protect the life or health of the pregnant minor in accordance with the Penal Code on Childhood and Adolescence. This legal framework also protects the right to information and the right to the realization of human rights except political rights that depend on age as outlined by the Constitution.

Although Section 11 does prohibit discriminatory care for pregnant women seeking or receiving therapeutic abortion services, Section 12 outlines the data that should be reported to the Ministry of Health. This information includes: the patients national ID number, number of pregnancies, number of terminations, and more.

Hospitals are responsible for establishing care protocols that outline these processes in accordance with the Technical Norm. The national health system, CCSS, was charged with developing a protocol for its hospital within six months of the publication of the Technical Norm. Although the Technical Norm states that the hospital protocols must align with the standards established in the Technical Norm, the exclusion of a pre-created norm allows for variation between facilities, particularly between the public and private facilities

Vague wording of abortion laws contributes to arbitrary protections and applications resulting in uneven access. Countries such as Costa Rica, Peru, and Colombia have been positively highlighted for developing standards like Costa Rica's Norma Técnica which provide step by step explanations for accessing therapeutic abortion care. These standards theoretically diminish cognitive accessibility concerns from patients and providers seeking to navigate the therapeutic abortion process. One line of inquiry of this qualitative study was the familiarity of physicians and residents with the Technical Norm and their ability to guide patients through the process.

This thesis will utilize data collected from qualitative interviews with OB/GYN physicians, residents, and community stakeholders to assess the human rights effects of Costa Rica's current abortion law. Utilizing the AAAQ human rights framework, this analysis will primarily focus on the concepts of Acceptability and Accessibility related to abortion care in the Costa Rican context with brief discussions of how these two components impact Availability and Quality. Before beginning this study, it was expected that social perceptions, and therefore cultural acceptability, coupled with cognitive accessibility, in terms of people's knowledge and comprehension of the current abortion law, are the driving factors of abortion care availability and quality. In essence, cultural acceptability and cognitive accessibility of abortion policy and

methods are the cornerstones of abortion access as they drive the legislative, financial, and informational resources that influence availability and quality of care.

Chapter 3: Methods

Study Design

The study utilized a qualitative methodology including in-depth interviews with clinicians and community stakeholders in San Jose, Costa Rica to assess their views onf abortion accessibility from legal, social, and health infrastructure perspectives. This study was conducted remotely from the United States between September 2021-March 2022 in a collaborative effort between Emory University (Atlanta, GA) and Universidad de Ciencias Médicas (UCIMED) in San Jose, Costa Rica. The research questions we considered for this study were as follows:

1. How do individuals define their sexual and reproductive rights? How do these definitions compare with the current Costa Rican political climate, legal code, and international human rights standards? (Stakeholders)
2. What is the understanding of abortion among healthcare workers? How do healthcare workers feel about their role as potential abortion providers? (Clinicians)
3. Does the reason to end a pregnancy affect the perception of abortion among different Costa Rican populations? (Stakeholders and Clinicians)

Study Team

The two Principal Investigators and project mentors were Emory University Global Health Department faculty and a post-doctoral fellow in the Behavioral, Social and Health Education Sciences Department. The team was supported by a former Emory University Hubert H. Humphrey Fellow who is a Costa Rican native and lawyer in women's rights. The student data collection team included two Emory University Master's of Public Health students, one Emory University Master's of Development Practice student, and a medical student from our

research partner, UCIMED. The data analysis team consisted of: the data collection team, an Emory University dual degree MPH/MBA student, two additional MPH students, and MPH alumni currently pursuing their Doctorate in Public Health (DrPH).

The PIs guided the student team through the proposal development, IRB, and MOU writing processes with Emory University and UCIMED. They provided additional support during data collection and analysis through weekly meetings to assist the team in adapting the project timeline as necessary. The team's Humphrey Fellow assisted with navigating the UCIMED ethics committee process, provided recommendations for study participants, and translated all study and recruitment materials. All members of the student team were involved in the creation of the interview instruments to confirm all population specific research questions were addressed in the guides. The data collection team, in collaboration with our UCIMED contacts and Humphrey Fellow, scheduled and completed all participant interviews in pairs. Once interviews were translated, all students worked on analysis.

Study Population

The study population consisted of two groups, clinicians and community stakeholders, which were subdivided by professional roles and professional and/or personal engagement with the topic or delivery of abortion care. The clinician group included OB/GYN physicians and OB/GYN current medical residents. Participants from the physician group were eligible to participate if they had a minimum of five years of medical practice post-residency as an Obstetrician/Gynecologist. The community stakeholders included community activists, legal activists, and current/former members of the Costa Rican legislature and Ministry of Health who work, or have worked in the past five years, with an organization or in a role that addresses

reproductive health laws, policies, or health access. These positions could include: activism, counseling, research, legislation, non-governmental (NGO) employees, and more.

Instrument

Two original structured interview guides were created— for the clinician and stakeholder interview groups, respectively. The clinician guide included open-ended questions about the providers' views and experiences about women seeking abortion care, the level of abortion training they received in school or after, and the effect of abortion laws on the health of their patients. The stakeholder guide included open-ended questions to assess the impact of the current abortion laws and accessibility of legal abortion on the health and human rights of people who can become pregnant. Both instruments included questions about the participants' knowledge and understanding of the *Norma Tecnica*, perceptions of how people manage unplanned pregnancies, and their opinions about their ethics of abortion under varying circumstances. Each of the interview guides was translated to Spanish and back-translated to English to ensure consistency and clarity in language use.

Participant Recruitment

The physician and resident populations were recruited using advertisements through the UCIMED listserv, formal networks through our UCIMED contacts, and snowball sampling as we completed interviews. Participants were contacted via Whatsapp and/or email to introduce the study and to schedule interviews.

We purposively sampled our stakeholder population using informal professional networks to identify participants. We used informal network recommendations from our Humphrey Fellow

and UCIMED contacts to initiate recruitment and combined this with snowball sampling by asking participants for referrals.

Data Collection

The data collection team consisted of three Emory University students with professional proficiency in Spanish, a Costa Rican medical student, and intermittent support from the Humphrey Fellow. All interviews were conducted in pairs with one research team member functioning as the primary interviewer asking all questions and responding to the participant, and the other team member managing the recording process and taking notes. All interviews were conducted in Spanish to ensure full comprehension of the research questions by study participants to prevent any barriers to their communication and maintain data quality. All interviews were conducted and were recorded on Zoom. The audio files were temporarily saved to the primary interviewer's computer before being uploaded into the team's encrypted drive after which the files were deleted from local storage on personal computers. Three pilot interviews were conducted with members of our target population to compare participant responses with the population specific research questions and to identify gaps in data richness due to interview guide quality. Both guides were updated to ensure alignment with the research questions.

Data Analysis

All interviews were immediately uploaded to HappyScribe's human generated transcription service and automatically translated from Spanish to English. The verbatim transcripts were then reviewed and corrected by the primary and secondary Spanish speaking interviewers to allow for immediate adjustments to the interview guides and to ensure accuracy

of the translation. The native Spanish speakers of the research team were contacted for any areas where the native English speaking reviewers were divided on translation.

After the first three interviews for each population were completed, two groups of three team members jointly completed a close reading of three transcripts from the clinician and stakeholder populations to develop an initial codebook in MAXQDA. Initial codebook development started with deductive codes based on the population-specific research questions and interview guide.

After preliminary codes were defined and added to MAXQDA, the three transcripts were reviewed for inductive codes. This involved an exploratory reading for possible codes and a second reading for code application. This process was done with a team of three researchers for the stakeholder and clinician transcripts respectively.

Once these codes were created, the definitions were shared with the entire team, including the project mentors. Codes that overlapped between the initial stakeholder and clinician codebooks were compared by the full team and synthesized into a single definition with shared inclusion and exclusion criteria. To be considered overlapping, codes had to be similar in the definitions, inclusion/exclusion criteria, criteria for how the code would be used, and interview guide questions that related to the code. This was done to allow for flexibility based on how the interview guides addressed certain topics and to allow for nuance in code use where appropriate.

After the full team review, two additional transcripts were reviewed and a final set of new inductive codes were introduced for both codebooks where appropriate. The two new codes, “Clandestine Abortion” and “Religion” were incorporated into the clinician codebook. Once the codebook was finalized, the remaining transcripts were coded and memoed by pairs or triads of

student researchers. After initial coding was completed, demographic variables were added to MAXQDA to aid in comparative analyses.

For the analysis, the author segmented and further memoed all transcripts. One member of the stakeholder and clinician coding teams to discuss emerging themes and areas with co-occurring codes. The author then proceeded to review all sections with co-occurring codes and memo these areas for themes relevant to the research questions. All transcripts were then summarized in brief descriptions to capture the main themes and patterns.

The AAAQ framework and human rights principles were used to identify codes that would explore relevant concepts. As the codebook was developed, inductive questions were added to the comparative analysis plan to assess differences in opinions of abortion ethics, influence of health personnel on abortion care/stigma, and socioeconomic differences in unplanned pregnancy management. Comparisons were conducted between years of medical practice (Clinicians), and activist versus legislative/judicial professional experience (Stakeholders).

Using MAXMAPS, segments were separated into their corresponding components of the AAAQ framework. If segments appeared in multiple sections of the framework, brief quotes were copied from the segment for inclusion in the Results and Discussion. Themes were organized by the overarching structure of the AAAQ framework.

Ethical Approval

This project was approved by the Emory University Institutional Review Board and the Universidad de Ciencias Médicas (UCIMED) Ethics Committee. All members of the data

collection team completed the UCIMED ethics training, similar to the U.S. CITI training, prior to conducting in-depth interviews.

This study was conducted remotely from the United States to eliminate the risk of COVID-19 transmission between the data collection team and study participants.

The UCIMED Ethics Committee oversaw the informed consent process which required signatures from all participants. Costa Rican law requires the inclusion of a copy of participant identification cards with the informed consent documentation, however, given the sensitive nature of the study topic, the team developed an MOU that clearly outlined who had access to participant information. The UCIMED research collaborators in conjunction with the Emory Humphrey fellow, managed the in-country signature collection and filing of all hard copy informed consents. A digital copy of the informed consents were saved to the encrypted team drive.

Chapter 4: Results

Eight stakeholders (n_S) and fifteen clinicians (n_C—ten physicians, five residents) participated in in-depth interviews. Due to delays in recruitment, only three of the five residents were included in this analysis. The clinician group included OB/GYN medical residents who had been in the clinical setting for five years or less and OB/GYN physicians ranging from 7 to over 30 years of experience. All clinicians worked in both private and public health facilities in an urban setting. Only two of the physicians reported experience working in a rural setting at the time of the interview or in the past. Of the thirteen clinicians, five identified as male and eight identified as female. The stakeholder group included pro-choice/pro-abortion social activists who participated in local advocacy and/or SRH research, a retired judge, former legislators, and a non-profit founder who provided pregnancy support services. Of the eight stakeholders, four were in favor of full liberalization of abortion, one supported increased allowances, and the remaining three described themselves as pro-life and did not support non-therapeutic abortion. All stakeholder participants identified as female.

Table 1: Participant Role and Gender

Participant Group	Total	Gender—Female	Gender—Male
Stakeholders	8	8	0
Clinicians—Physicians	10	7	3
Clinicians—Residents	3	1	2

Under the four components of the AAAQ framework, the following corresponding themes emerged:

1. **Availability:**
    1.1. Clinician Hesitancy
    1.2. Independence of private providers
2. **Accessibility:**
    2.1. Ambiguity of the Technical Norm
    2.2. SES influences on abortion seeking
3. **Acceptability:**
    3.1. Physicians as decision makers
4. **Quality:**
    4.1. Limitations on physician training

1. Availability—The AAAQ as applied to abortion allows us to analyze the availability of the abortion health care infrastructure and provider workforce. The availability of abortion is influenced by clinician hesitancy to discuss and provide abortion services and the perceived independence of clinicians in the private care setting.

1.1 Clinicians are hesitant to discuss or perform abortion due to fears of criminalization and religious views. Religion operates on both the personal and cultural levels.

Both clinician and stakeholder groups provided perspectives of the current reasons for clinician hesitancy around discussing and providing abortion services. The dimensions of clinician hesitancy included: the influence of criminalization and perceptions of the influence of religion on hesitancy. Manifestations of clinician hesitancy were limitations on unintended pregnancy counseling and willingness to discuss abortion with colleagues.

1.1.a—Influence of Criminalization on Clinician Hesitancy

When asked about how they counsel patients on unintended pregnancies, all clinicians referenced the impact of abortion being not only illegal but criminalized. The majority of clinicians stated they try to make it clear to patients that abortion is not legal in their country. Some clinicians mentioned telling patients that they could access abortion services outside the country, emphasizing that it is not legal in Costa Rica, but these discussions would not include direct referrals to abortion providers or networks. Several clinicians further noted that they viewed their role as "sensitizing" the patient to or "accompanying" the patient through accepting an unintended pregnancy because they could not personally perform or directly refer a client to abortion services. Within the national hospital system, "accompaniment" refers to coordination with other departments such as mental health and social work services to support patient needs for unintended pregnancies. However, this service was reportedly not available at all facilities. Clinicians commented that due to criminalization, accompaniment is the main resource they are able to offer. Although several physicians indicated while making clear that they are not legally able to provide abortion services, they tell patients they can seek care outside of Costa Rica. One participant shared,

> "Try to sensitize the patient with the pregnancy so that she tries to respect that life and that being that is there before teaching or telling her about alternatives for the termination…We always advise her on what are the best options and recommend that she go outside the country. Usually Nicaragua, United States, which are the closest countries to the area where they can go to terminate the pregnancy…Patients who cannot leave the country have to live with their cruel and sad reality - which is to continue with pregnancy

> - that they don’t have a way to terminate, that there is no other way. ” (Physician 3, Female—61)

Clinicians were split on their perceptions of how open their colleagues were to discussing abortion, including legal therapeutic abortion. Some clinicians felt they were able to discuss their abortion opinions with colleagues, while others viewed discussions of abortion to be silenced within the medical community. Physicians expressed the sense that due to the legal limitations, there was not much to discuss regarding abortion since only therapeutic abortion cases are permitted as a part of their practice. Few physicians had personal experiences of being involved in a therapeutic abortion case, and due to their rarity did not feel a need to discuss them with colleagues. Hesitancy around therapeutic abortion specifically was difficult to discern among the experienced physician (non-resident) sub-group. In interviews, the majority of physicians did not make their opinions of, or willingness to perform, the procedure clear and instead focused discussion on the permitted medical indications and protocols established in the Technical Norm. Residents in particular expressed having very little knowledge of how physicians viewed abortion. None of the residents had any personal experiences with therapeutic abortion and all of them mentioned having few conversations about the topic with their instructors and colleagues. Both clinician sub-groups’ limited experiences with therapeutic abortion, and abortion more broadly, suggested an overall invisibilization of abortion within the medical community. Commenting on the culture around discussing or performing abortions, one physician highlighted:

> “But here it is suppressed, it is silenced and it is illegal. I mean, it's an issue, as I tell you, regardless of whether I as a person feel comfortable doing it or not, it's illegal for me. I

can end up in jail for practicing this medical procedure. We are suppressed." (Physician 4, Male—31)

While the clinician group discussed the influence of criminalization on both physicians and their patients, stakeholders primarily discussed the fear of criminalization of abortion seeking rather than clinician hesitancy. Among the stakeholder participants, the pro-choice participants (n_S= 5) perceived clinician hesitancy to perform therapeutic induced abortion as a deliberate and/or institutionally supported mechanism to prevent therapeutic abortions from occuring. In contrast, the stakeholders against expanded abortion access (n_S = 3) expressed support for the current health system personnel and their application of the Technical Norm which they viewed as protecting women's lives and health.

1.1.b—Influence of Religion on Clinician Hesitancy

Both clinician and pro-choice stakeholder participants shared a perception that physicians and their colleagues are increasingly conservative, or hold more traditional values in a way that may prevent them from administering abortion services. Religion was considered to be a reason for more conservative views in the physician community and subsequently emerged as a sub-theme of clinician hesitancy. Several clinicians viewed their colleagues, and the physician community in general, to be split on their views about administering abortion services and abortion ethics. For clinicians, religion, and Catholicism in particular, was discussed (with few specifics) as a broad mechanism within the Costa Rican cultural context that influenced physicians and their practice as expressed by one participant,

> “What they [physicians] themselves report is a concern about conservatism in the training of health professionals. There was a "shift" at some point and health professionals, here at least, began to have much more conservative positions than they used to. And that can be seen now in the access to health care.” (Stakeholder 2, Female—33)

All stakeholders who supported expanded abortion access attributed current clinician hesitancy to perform therapeutic abortions to increased conservative or traditional views about the “defense of life” or pregnancy. Stakeholders, both pro-choice and anti-abortion, repeatedly used “conservative” and “traditional” interchangeably with “religious.”

Intriguingly, when considering the other facets of full spectrum abortion care, namely post-induced abortion care and spontaneous abortion (miscarriage) management, all clinicians and stakeholders agreed that patients should, and do, have unobstructed access to these forms of care. The sources and manifestations of clinician hesitancy reportedly did not apply to the provision of post-induced abortion care or miscarriage management. However, all clinicians, and some stakeholders, noted that suspected induced abortions were required to be reported to authorities. A gap emerged between the requirements outlined in the Penal Code and personal experiences of clinicians, with less than half knowing of cases where judicial authorities were contacted for suspected abortion.

A sub-theme of clinician hesitancy due to criminalization was the perception among clinicians of how hesitancy could or would change if a more liberalized abortion law were passed. Due to the perceived split in clinician opinions about abortion, mentioned above, perceptions of the impact of a law change on hesitancy were also split. However, there was a consensus among clinicians that if the law were to change and expand legal abortion access, the

ability to conscientiously object (defined as recusing themselves from procedures they do not want to perform) would be important for physicians. One participant shared,

> "And yes, many colleagues commented to me that they were going to make conscientious objection, so I feel that... At the end of the day I'm going to tell you what happens, on a more political level, you can say everything you want, but at the end of the day, and I'm going to tell you, the politician is not the one who gets his hands dirty…Feminist groups, all the people who promote this are not the ones who end up doing the procedure."
> (Physician 5, Female—48)

Among stakeholders, half (n_S= 4) viewed conscientious objection as a manifestation of current clinician hesitancy, and as current and future barrier to abortion provision. For several activist stakeholders, conscientious objection was discussed in the context of concerns about how this would interrupt or decrease availability of abortion care. More conservative stakeholders (those who would not support more expansive abortion allowances), wanted future laws to ensure the right of clinicians to conscientiously object to procedures they did not want to perform. Clinicians echoed these views with all clinician participants expressing doubt about the willingness of their colleagues to provide an abortion if the law were expanded. For many of the clinicians, their current or future willingness to perform abortion services was not explicit as many focused their responses on the realities of how they practice medicine under the current law or their perceptions of the views of their colleagues.

Clinician hesitancy manifested in the forms of providing limited counseling to patients with unintended pregnancies and minimal discussions about abortion with colleagues. The degree to which clinicians felt they could openly discuss abortion varied and reflected the reported split in opinions within the physician community as a whole. Both participant groups

viewed conscientious objection as a likely response to the removal of criminalization, and/or increased allowances for abortion, through a more liberalized law. Clinician hesitancy due to the influence of personal and societal religious values were discussed as another reason for limitations on abortion opinion sharing and patient counseling.

1.2—Independence of Private Providers

Another influence on the availability of abortion services was the pereceived independence of private clinicians compared to clinicians and services within the national health system. For both stakeholders and clinicians, the independence of private facilities was connected with an increased availability of providers willing to perform abortion services. Though not explicitly stated, both participant groups alluded to private facilities having different protocols in place that increased provider independence with managing patient cases. What was explicit, was the perception from both participant groups that it is widely known that private physicians perform abortion services. The majority of physicians reported personal relationships with and/or anecdotal of accounts of private providers who perform abortion procedures. No physicians personally disclosed providing these services, and no residents knew of specific private physicians who performed illegal abortion services. Private providers were referenced as aiding in both medication and surgical abortion. A few physicians suggested that private providers had a different level of oversight that allowed them to perform such services, therapeutic abortion included, more easily. One participant shared,

> "I work in a hospital, also private, in San Jose and a statement was sent out that every patient who was going to be admitted for a curettage for an abortion [miscarriage], had to have two ultrasounds. One from the professional who was going to operate on her and

> another ultrasound from another professional. What that means is that probably someone was doing abortion curettages of viable pregnancies, and they found out." (Physician 4, Male—31)

However, the degree of oversight in private and public facilities was not mentioned by enough physicians to draw any conclusions. Stakeholder references to the willingness of private physicians to perform abortion services was anectdotal but was viewed as an expensive option available to only a subset of patients.

A sub-theme of the independence of private providers was the reported increase in self-managed abortions using misoprostol. Both participant groups shared scenarios of how private providers may instruct patients in advance on how to self-manage the abortion and when to seek post-abortion services in either public or private care facilities. Private providers were not reported to be a source for misoprostol for patients, and were only perceived to provide counseling on misoprostol use and when to seek post-abortion services. Both stakeholders and clinicians identified the internet and informal vendors as a main source for misoprostol. Stakeholders did not report on the reasons for why clinicians are able to practice differently between private and public settings. Stakeholders, in turn, perceived provider independence as more of an issue of accessibility (e.g. financial, information, and physical accessibility) rather than availability which will be discussed later.

Availability of abortion services, including therapeutic abortion, was reportedly influenced by current and future clinician hesitancy to perform and discuss abortion as a result of criminalization and religiosity. Concerns about criminalization reportedly limits the breadth of unintended pregnancy counseling that clinicians provide to their patients as they are not able to

provide abortion services without medical indications permitted in the Technical Norm. Criminalization also raised concerns about the proper application of the Technical Norm for therapeutic abortion, resulting in clinician and facility hesitancy to perform the procedure.

Consequently, the rarity of therapeutic abortion provision compounded with criminalization results in a reported suppression of abortion provision and discussions. Religion was perceived as a factor to current and future hesitancy as religion was viewed as influencing both individual and cultural values and behaviors about abortion. Both participant groups reported that they see religion as a source of conscientious objection among clinicians, particularly if a law change expanded legal abortion access. Availability is further affected by the ability of private providers to practice more freely than those in the public care settings. The primary explanation for the increased independence of providers included differences in the oversight of therapeutic abortion, and general obstetric consultation, services. This was viewed by participants as both a method of increasing availability in different healthcare contexts and simultaneously decreasing accessibility.

2. Accessibility

The AAAQ framework includes four dimensions or sub-categories of accessibility: cognitive/informational, economic, physical, and non-discriminatory. Clinician and stakeholder participants viewed the current law as ambiguous in a way that impacts informational accessibility or comprehension of the law for both physicians and patients. An additional theme that arose was the relationship between socioeconomic status and financial, informational, and physical accessibility. In participant's views, socioeconomic status (SES) drove how people access information, what information they have, where they seek abortion services, and how they

pay for these services. The ability to access illegal abortion services (abortion that is not classfied as therapeutic and is therefore illegal) was tied to specific informational, financial, and physical accessibility issues.

2.1—Ambiguity of the Technical Norm: Informational Accessibility

Stakeholders and clinicians viewed the legal language of the Technical Norm for therapeutic abortion as vague, particularly around the definition of health. The majority of participants, from both stakeholder and clinician groups, were aware of and specifically mentioned the Technical Norm. These participants referenced the same component from the guidelines: the requirement that a pregnancy must pose an imminent risk to life or health in order for a therapeutic abortion to be granted. For both participant groups, conceptualizations of what constitutes an imminent health risk due to pregnancy was open to interpretation. However, there were mixed perceptions of how the ambiguity impacts abortion accessibility. From the perspective of pro-choice stakeholders (n_S=5), the ability to interpret "health" places abortion decision making more firmly on physicians. These stakeholders viewed the Technical Norm's requirement that a panel of physicians review therapeutic abortion cases, and subsequently granting or denying the service, as a bottleneck of accessibility. Conversely, the other, more conservative stakeholders (n_S=3), emphasized that the vague interpretations could "open a door" for patients to access abortion services upon request by using a wide interpretation of health. Another concern for both stakeholders and clinicians, was the lack of clarity about mental health as a viable medical indication of an imminent health risk when doctors review patient cases. Several clinicians viewed mental health as a valid reason for the administration of therapeutic abortion services, even though the law does not explicitly support this. One participant shared,

> "But it does seem to me that the definition remains super open, that it is interpreted however each doctor wants to interpret it, and that is the only reason. It also does not allow for, which for me is important, the concept of the patient's mental health, it allows for only when there is imminent physical danger to the patient, what the woman thinks is completely left out, if you have any serious pathology that is going to be aggravated in the background, anything psychological or psychiatric, that is practically left out of the context." (Physician 1, Female—38)

Informational accessibility thus directly affected physicians and their understanding of how to correctly administer therapeutic abortion under the Technical Norm. Despite being aware of the Technical Norm in concept, the majority of clinicians expressed feelings that therapeutic abortion is still rarely administered and not incorporated into their practice. Informational accessibility was also perceived to be driven by geographic location. Both participant groups referenced how the level of information/education among clinicians is likely different for those away from the capital of San Jose. Ambiguity about proper application of the norm, combined with the aforementioned clinician hesitancy to perform therapeutic abortions, affects patient's ability to access therapeutic abortion services.

Among all participants there was minimal discussion of knowledge of the law among people who can become pregnant. The majority of clinicians, and more than half of the stakeholders', referenced the population's knowledge of contraceptives rather than abortion laws or services. Participants focused on informational accessibility about things, such as sex education and contraception, that could prevent unplanned or unwanted pregnancies that result in abortion seeking. The lack of clarity among patients around the Technical Norm was discussed in

the context of a general lack of knowledge about sexual and reproductive health and health services. More notably, stakeholders viewed informational accessibility about pregnancy management options as a direct result of a patient's socioeconomic status.

2.2—Influence of Socioeconomic Status on Abortion Seeking

Socioeconomic status was discussed as a reason for and barrier to abortion seeking among people who can become pregnant. In addition to the broad connections clinicians and stakeholders described between SES and information about the therapeutic abortion law, participants noted financial and physical accessibility gaps for accessing both therapeutic and illegal abortion services. Among stakeholders (n_S=5), physical accessibility in conjunction with informational accessibility was perceived as a cause of disparities in therapeutic abortion care for people who can become pregnant. When considering illegal abortion access, stakeholders viewed physical, financial, and informational accessibility as the cause of disparities between those with different socioeconomic statuses. Although both participant groups referenced the decreased forms of access.

Interplay Between Informational, Physical, and Financial Accessibility

Physical accessibility, or the ability to safely reach health services within a reasonable distance, was discussed in the context of accessing the following services/forms of care: therapeutic abortion services, illegal abortion services, and out of country abortion services. There was a perception that the informational accessibility of patients is influenced by their physical location, a phenomena that also reportedly affects physicians. Stakeholders broadly referenced how the relationship between physical accessibility and informational accessibility for low SES women decreases the likelihood they are aware of therapeutic abortion as an option.

The ability to use therapeutic abortion services is reportedly dictated by both the patient and the physician's level of information. Additionally, illegal abortion seeking was viewed as a point of informational, physical, and financial accessibility driven by socioeconomic status. Clinicians did not provide as many details about the impact of SES on abortion seeking behaviors. One area where both participant groups were in agreement, was the view that high SES people travel out of the country for abortion services. As seen with the perceptions around private providers, stakeholders and clinicians did not mention specific foreign facilities or clinicians who provided abortion. However they shared the perception that it is well known that high SES people travel for abortion services. Seeking illegal abortion services in Costa Rica, both medical and surgical abortion, requires physical access to services according to stakeholders. Stakeholders highlighted that illegal services are expensive and thus prevent lower SES people from accessing medical and surgical abortion services. For medical abortion, which uses misoprostol pills, several stakeholders added that being of lower SES increased the risk of pregnant people purchasing fake, potentially harmful, misoprostol pills. One expressed,

> "People who have less information, fewer resources, fewer contacts, they find out, they go to the central market here, they buy some pills that are out of date, they don't know what to do with them, they don't know anything and they don't have a doctor they can trust to say, a doctor, to say: "Look, I'm going to do this, keep an eye out to see what happens to me."There, the class difference is abysmal. And the class difference, not only in purchasing power, is that there is also a class difference when you have more information, when you have more contacts, when you have more international and national relations. These differences and these exclusions act totally in situations like these." (Stakeholder 5, Female—72)

Stakeholders felt that this gap in financial accessibility and physical accessibility was widening the SES related gap in health.

> "If you're upper middle class, and "melia", sometimes, right? If you're upper class you can get out of the country and most likely you're going to make it or you're going to be able to pay someone to bring you the pills. Melia class, as we call it here, you might be able to get out of the country too. But the reality is that most women can't leave the country to do it and they can't afford to pay for the pills at that high a price, let's say. So, there is a class gap in terms of access to abortion in Costa Rica, which in itself is not possible, but when you do it clandestinely there is another gap, because it is not universal, because it also depends on how much money you have." (Stakeholder 1, Female—21)

For people of lower SES, access to physical, financial, and informational therapeutic, illegal, and out of country services are not viewed as generally attainable. Socioeconomic status was listed as the main cause for decreased access to resources necessary for abortion seeking, and SRH care more generally. The foundational disparities created by SES resource gaps are reportedly worsened by the ambiguity of the Technical Norm which affects both patients and providers. Clinicians and stakeholders viewed the ambiguity of the Technical Norm to be a contributor to physical accessibility problems for patients due to the perceived subjectivity of providers allowed under the Technical Norm.

3. Acceptability: Medical Culture of Physicians as Sole/Primary Decision Makers

3.1— Acceptability Among Physicians

Typically, the AAAQ approaches acceptability of health services from the patient perspective to evaluate how services meet a patient's values and needs. However, both participant

groups reported ways in which the medical system and institutions are just beginning to shift to allow for increased patient autonomy and decision making; and instead emphasized that it was physicians who were often the sole decision makers. According to the majority of clinicians, people who can become pregnant historically have not been the decision makers during sexual and reproductive health care service provision. This extends to therapeutic abortion care under the Technical Norm which requires panels of physicians make the decision to grant or deny therapeutic abortion. Both participant groups reported that the acceptability of abortion for a physician influences therapeutic abortion decision making. Acceptability of abortion for physicians was perceived to be influenced by religious or conservative views that reject abortion. One participant expressed,

> "Well, I think there is a great limitation there. In spite of the fact that there is this regulation that I mentioned in 2019, in this country, the medical profession has some very particular characteristics. They, from my perspective, naturally, are a very united guild and I think that in these issues, very traditional, very attached to the traditional ideas of defense of life, because in addition to this the Hippocratic oath is entangled with this. And all these things become so entangled that doctors are very reluctant to take on the responsibility of doing this, of providing a therapeutic abortion. Not even protected by this norm of the Penal Code, they don't feel safe or feel capable of doing this type of procedure, with all the limitations that it has." (Stakeholder 4, Female—61)

Related to the aforementioned issue of clinician hesitancy, stakeholders and clinicians discussed the central role physicians have in abortion decision making under the Technical Norm. The acceptability of therapeutic abortion, and abortion more broadly, was just one component of the influence of clinician acceptability on patient care. Stakeholders (n_S=4) and

clinicians (n_C=5) discussed the history of clinician influence on health service access as a part of a larger medical culture that places physicians as the primary decision maker. Physicians were described as being the gatekeepers for sexual and reproductive health services including salpingectomies (fallopian tube removal for sterilization) and childbirth delivery position or method by both participant groups. These trends in obstetric and gynecologic care were reportedly not solely a result of provider opinions, some protocols (such as opting for cesarean section) are codified in medical institutions in a way that does not allow for patient choice. Extending this broader medical culture to abortion, stakeholders and clinicians reflected on the level of physician subjectivity which can dictate therapeutic abortion care provision. Clinicians echoed this perspective acknowledging how individual physician opinions can determine patient care and counseling. While participants noted the medical culture is shifting in regards to patient decision making, including the more recent inclusion of informed consent requirements for medical interventions, therapeutic abortion is still perceived as firmly under physician discretion. The acceptability of abortion among physicians, as previously mentioned in Availability, is impacted by individual and societal religious values as shared by one participant,

> "After the woman gains access to the system, she is left up to the will of the treating doctor, because there is no uniformity in approach for these women. Then, if she is lucky enough, it will be someone who validates her felt need, then she will do well. If it was someone very conservative or someone who is not open minded, then it will not go well. So, yes there is some degree of difficulty, because we are depending almost on the individual perception that each doctor has and as I tell you, there is a very conservative sect." (Physician 5, Female—48)

Despite perceiving a split in acceptability among physicians, the majority of clinician participants expressed the belief that abortion access should include allowances for fetal anomaly. Among clinicians there was a perception that physicians in general would support this allowance. Among stakeholders, only those in favor of expanded access to abortion viewed physician acceptability as a problem in therapeutic abortion administration.

3.2—Acceptability Among Patients

Patients in turn, have limited involvement in decision making and are only able to deny therapeutic abortion administration, not request it. For stakeholders, the acceptability of abortion among patients is affected by religious fear which was perceived to drive abortion seeking behaviors. Stakeholders further discussed how acceptability of abortion for patients was equally influenced by religion and social factors which affect care seeking behaviors. When asked why patients may not seek an abortion, the majority of stakeholders referenced a religious "fear" that they would be punished for the "sin" of getting an abortion. One participant expressed,

> "Depending on the socioeconomic status of the person or many women who also have a religious debate within themselves. "That no, I'm going to feel bad and I'm going to feel guilty and God doesn't allow it" and so on, because society reinforces a lot. Let's remember that Costa Rica is a confessional state, Costa Rica is not even a secular state. And the Catholic Church has had a lot of influence. And all of us have been educated in the Catholic religion in schools." (Stakeholder 3, Female—56)

Physician acceptability is seen as a part of a larger medical culture that positions physicians as the primary decision maker with participants noting a slow progression in SRH healthcare to incorporate patient informed consent and autonomy. Participants viewed clinician acceptability

as a source of subjectivity in the therapeutic abortion care seeking process. Acceptability was explained as resulting from religious and conservative views that reject abortion as acceptable care. For patients, abortion seeking behaviors among patients are reportedly influenced by a fear of religious and/or social reprisal and can be further affected by the influence of physicians.

4. Quality: Limited clinical training on abortion limits quality of care

Quality, as outlined by the AAAQ framework, is considered to be the adequate training of the healthcare workforce and adequate stocking of equipment and medications in health facilities. All clinicians discussed their personal, as well as their work settings', management of spontaneous abortions (miscarriages) but had limited personal experiences with administering therapeutic abortion services. The limitations on training were perceived to affect both technical skills and the ability to provide unbiased or non-stigmatizing care. Stakeholder views about the quality of care provided by physicians focused on cultural factors, such as religion, that influence quality of care rather than technical training or knowledge.

The limited experiences with therapeutic abortion, and induced abortion more generally, extended to clinician's reported training in medical school and residency. Half of clinicians (n_C=7) reported feeling that they had received no training on induced abortion, while others described their training as minimal due to the focus on spontaneous abortion (miscarriage) management and fetal anomalies. Explanations for the perceived constraints on medical training included the perception that due to criminalization, training on induced abortion was unecessary and that the taboo nature of abortion led to its exclusion in training curricula. Among clinicians a sharp delineation emerged between their comfort with their technical skills for spontaneous abortion provision and management compared with induced abortion provision. Although

technically the same procedures, providers seemed to view their ability to provide induced abortion care as distinct from their ability to manage miscarriages. Some clinicians (n_C=5) discussed the limitations of their training as a result of the restrictions of the Technical Norm which they viewed placing implicit and explicit restraints on their training. This was particularly expressed among residents who are still in the process of completing their medical education who perceived a greater emphasis on understanding the legal repercussions of induced abortion than the medical process itself. One provider shared,

> "I think that when I went through medical school the focus was a lot on spontaneous termination and I also think part of the fact that the professors were older, perhaps the issue of induced abortion, and since it was not legal, then they're issues that are best left undiscussed. I think that when I went through legal medicine we were told, and in a very punitive way, about the induced termination of pregnancy because it's something that is punishable." (Resident 3, Male—33)

A sub-theme of the issue of training limitations was a perception that the technical knowledge for how to perform medical and procedural abortions is not sufficient for adequate care. Clinicians (n_C=5) emphasized the desire for/necessity of training on sensitivity for how to address the topic of induced abortion with patients. Discussion of desired training topics included bioethics of abortion and stigma training. It was noted that this training would also benefit clinicians who may be uncomfortable with the concept of participating in the provision of abortion care. Some clinicians referenced continuing education requirements as an opportunity to increase their technical and bio-ethical knowledge of abortion. However, these participants noted

that clinicians would have to use resources from international medical and public health agencies, and have enough personal interest to research abortion. Few clinicians referenced hospital stocking of medications such as misoprostol so the quality of facility management from an equipment and medication perspective is still unclear.

Quality of therapeutic abortion care was thus perceived to be affected by limitations on provider training during medical school and continuing education interests/motivations. Explanations for the limitations on training included: suppression of abortion within medical institutions due to criminalization, stigmatization of the topic as a result of socio-cultural factors, and the influence of the Technical Norm which focuses on therapeutic abortion. Clinician training desires suggest an interest in abortion ethics/bioethics and stigma training. Clinicians reported a perceived need to increase training if abortion access were legally expanded.

Study Limitations

The remote nature of this study prevented us from interviewing participants without Zoom access limiting our assessment of perceptions of abortion accessibility from lived experiences. Among clinicians, our recruitment was hindered by the severe scheduling constraints of this population which may have been aided by in-country access to participants. As is typically the case with abortion research, the sensitive nature of this subject may have prevented people from our identified populations from participating despite their relevant or unique perspectives. As a result of our recruitment barriers, our study population size is relatively small which caused some potential themes to be excluded from this analysis due to lack of saturation.

When considering certain facets of the data, there were some limitations with the data collection tools. The main issue arose from not defining, or probing participants to define, certain

terms such as unplanned pregnancy, unwanted pregnancy, and the interchangeable use of abortion to refer to spontaneous and induced procedures. This change during data collection would have allowed for a deeper understanding of nuances in clinician views of their role in regards to pregnancy management and induced abortion. Lastly, this study was designed to assess stakeholder and provider perceptions of abortion and the Technical Norm. As a result, we did not explicitly structure our data collection tools assess the relationship between illegal and unsafe abortion and maternal mortality. Future studies will need to more closely analyze the differences between public and private facilities, post-abortion care, and illegal abortion methods.

Chapter 5: Discussion

Availability

Clinician hesitancy was perceived as both an individual phenomena and the result of larger contextual factors such as the influence of religion and the legal environment created under the Technical Norm. Our findings regarding clinician hesitancy align with findings from a study in Chile after legalization for rape, fetal anomaly, and therapeutic reasons (Biggs et al, 2019). Conversely, the universal acceptance of post-abortion care (PAC) emerged as a counterpoint to the overall level of abortion hesitancy among both clinicians and more conservative stakeholders. Participants discussed the medical community's dedication to protecting life, a topic referenced as a cultural factor, which may lead them to ensure medical care is available for all patients no matter the impetus.

While decriminalized post-abortion care is a documented harm reduction strategy in contexts that criminalize induced abortion, this approach is not in effect in the Costa Rican context (Stifani et al, 2018). Clinicians acknowledged that health facility protocols require reporting any suspected induced abortion to judiciary services. However there appears to be a gap in the knowledge and implementation of this protocol. Therefore, despite the legally codified basis for criminalization it appears post-abortion care is more generally available than would be expected (Galli, 2020). This finding could explain the low maternal mortality rate (27 per 100,000 live births) in Costa Rica (UNICEF, 2020). Another explanation is that the combination of the availability of PAC coupled with the reported increase in self-managed abortions (SMA) using misoprostol is resulting in minimal morbidity and mortality (Dzuba et al., 2013). Self-managed abortion using misoprostol, sometimes in combination with mifepristone, has become a safer replacement for more invasive clandestine services (Zamberlin et al., 2012).

However, future mixed methods studies determining the incidence of post-abortion care, with a focus on suspected induced abortions, would be necessary to understand a potential relationship between PAC for complications from induced abortion and maternal mortality in Costa Rica. Unfortunately, the benefits provided by this implicit support for PAC appear to at least mildly be undone by the accessibility barriers described later.

Participant discussions of the independence of private providers raised more questions than they answered about current and future availability of a clinician workforce that provides abortion services. Only public facilities, which are part of the national health system (CCSS), are specifically referenced in the Technical Norm as being beholden to the protocol requirements it outlines. Based on our results, variability in the level and forms of oversight between public and private care centers is unclear. There is a thematic tension between the majority of participants who perceive clinician hesitancy, in all its dimensions, and the majority of participants who acknowledge that there is a group of physicians willing to provide abortion services despite the risk of criminalization. While these two concepts are not mutually exclusive, future studies will need to determine if, given the proper training, physicians who were previously deterred by criminalization would be willing to provide abortion services in a legalized environment. Studies in Chile and Argentina indicate there may be generational differences in future willingness to provide abortion, however due to the minimal range in clinician ages this conclusion can be drawn from our data (Biggs et al, 2019). Our results did not provide insight into the reasons why some private physicians may be willing to perform abortion services clandestinely. Our results suggest that private physicians provide counseling for self-managed abortion with misoprostol, as seen in other studies, and in the Uruguyan model which lead to legalization (Stifani et al, 2018). However, as with post-abortion care, private counseling for SMA is not currently an

official, or broadly implemented, harm reduction strategy in Costa Rica and health outcomes from this form of care are difficult to assess.

Accessibility

The Technical Norm was written decades after the implementation of Article 121 in an attempt to alleviate confusion about the proper administration of therapeutic abortion. For many participants, the Technical Norm maintained uncertainty and potentially worsened access. Informational accessibility not only dictates if people know their legal options for abortion and where to go for services, it also appears to limit clinician understanding of how to grant or deny access to the procedure. Despite the norm referencing the WHO definition of health ("Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." WHO, 2022) participants perceived a gap in the application of the norm for mental health risks due to pregnancy. The language of the Technical Norm, despite the inclusion of the definition above, requires imminent threat to the woman's life that cannot be resolved by other interventions. The perceived difficulties interpreting and applying the therapeutic abortion norm mirror the challenges experienced in Peru prior to the intervention by international human rights bodies, who called for clarification of the law (CEDAW, 2011). This further adds to the subjectivity of how health is defined and applied as there is no guidance about what, or how many, interventions are considered acceptable to prevent the need for a therapeutic abortion (CESCR, 2016). Conversely, the ambiguous interpretations could allow for increased access if providers and health institutions support expanded interpretations.

For clinicians, the vague language around the definition of health coupled with criminalization makes access difficult to maneuver. A barrier to care arises as facilities and physicians may seek to evade legal repercussions and apply the norm more narrowly than

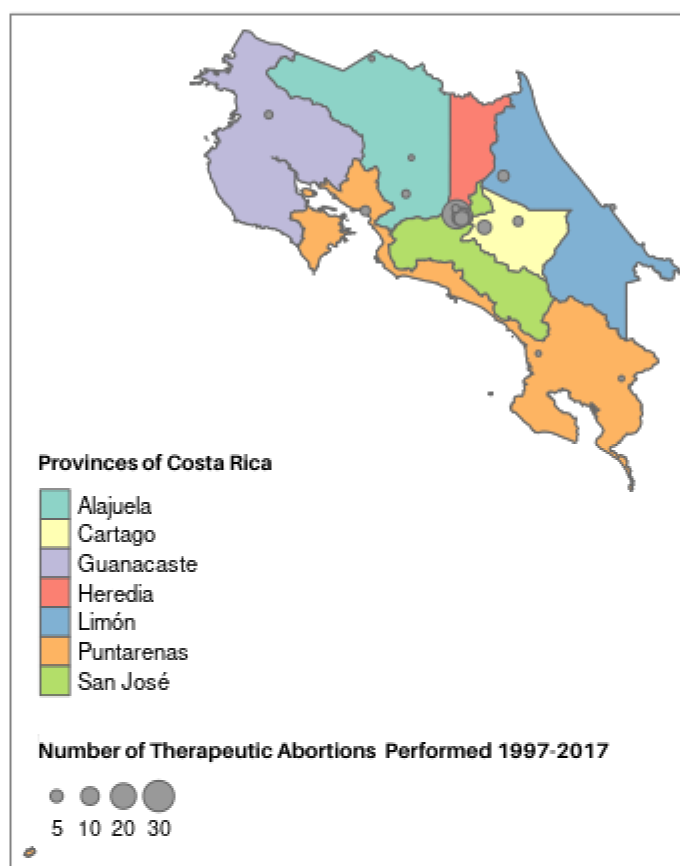
scientific evidence would allow for. Although the Technical Norm allows patients to appeal a denied therapeutic abortion, once, this requires an increased level of informational accessibility among people who can become pregnant (Ministerio de Salud, Costa Rica, 2019).

Regarding informational accessibility for people who can become pregnant, the priority of all interviewed participants was a broad need for SRH education. Participants presented sex education and knowledge about contraceptives as a higher concern than the population's knowledge of the Technical Norm. Human rights recommendations, such as CESCR General Comment 22, hold informational accessibility for all SRH services, including abortion, in tandem rather than prioritizing one form of health service (CESCR, 2016). No recent studies have assessed sexual health or sexuality education programs in Costa Rica so it is difficult to determine the current relationship between contraceptive use and sexual education. This sub-theme appeared repeatedly for clinicians and could be a contributing factor for clinician hesitancy and abortion opinions, as contraception is viewed as readily available among physicians. Participants did not discuss perceptions of knowledge of the Technical Norm among people who can become pregnant with any depth. However, our results, and other studies suggests that knowledge that abortion is criminalized reportedly leads to the misperception among the general population that abortion is illegal in all cases, including health risks to the pregnant person (Costa Rica. Ministerio de Salud, 2010 and 2015). This contributes to a gap in information about abortion services that affects accessibility and may impact abortion care seeking.

In alignment with the literature, and general global health trends, socioeconomic status is an underlying factor that determines all points of access in the case of therapeutic and illegal abortion (UN CESCR, 2000). As noted by participants, economic and informational access are

drivers for physical accessibility to abortion services out of the country. They also determine a person's ability to access resources such as misoprostol or private providers within the country. Informational accessibility about therapeutic abortion is influenced by economic resources and physical accessibility to services. As seen in the map below using CCSS data of therapeutic abortions from 1997-2017, the majority of procedures were performed closer to urban areas. This may be the result of a combination of informational accessibility for both physicians and patients, although future studies would need.

Figure 1: Map of Therapeutic Abortion Procedures by Facility 1997-2017



Acceptability

Acceptability is generally utilized to capture how health services meet the sociocultural values and needs of patients. When considering the human rights impacts of the therapeutic abortion law, the acceptability of abortion among clinicians is a more relevant measure as abortion acceptability within the workforce serves as a determines how other components of the AAAQ function. The legal language of the Technical Norm places decision making power regarding therapeutic abortion in the hands of a panel of physicians. The result is a medical protocol that makes therapeutic abortion a subjective decision based on its acceptability to clinicians (World Health Organization, 2012). While the Technical Norm does use language requiring scientific evidence to be employed in decision making, there is no discussion of how this is monitored. Furthermore, there is no standard that explicitly states how abortion perceptions are assessed or considered before physicians are assigned to a panel for case review. While patients do have the ability to appeal the panel decision, once, or deny the procedure if they choose, they are otherwise excluded from the discussion of the impact of the pregnancy on their health and life.

This has negative implications for the broader view of acceptability because it prevents patients from being able to choose the medical intervention that best aligns with their values and needs. This implicates not just the language of the Technical Norm but the existence of the norm itself, in conjunction with Article 121, as a barrier to acceptable care for people who can become pregnant (UN Human Rights Council, 2019). The issue of patient exclusion in decision making also appears to be a larger contextual issue related to sexual and reproductive health that is slowly beginning to evolve for other interventions and health process such as labor and delivery and sterlization. The occurrence of provider control over sexual and reproductive health

decisions on a broad scale suggests cultural factors, such as stigma towards sexual freedom and reproductive decision making, that may be contributing to abortion acceptability. However, clinicians did

Quality

The acceptability of abortion among not only current clinicians but medical institutions themselves is directly impacting the level and quality of abortion training providers receive. Our findings of the clinician perception they received little to no information about how to oversee induced abortion procedures follows trends seen in another studies and across global contexts (Freedman et al., 2010). As participants noted, the education gaps included the lack of guidance of how to discuss the subject. The invisibilization of abortion within training is likely affecting the current quality of therapeutic abortion services and has negative implications for the likelihood of a trained healthcare workforce should abortion access be legally expanded (Biggs, 2019).

There was no mention by the clinicians of the stocking or availability of misoprostol or mifepristone for medication abortion provision. This could be due to the legal environment which requires alternative medical interventions to be attempted before a therapeutic abortion is granted resulting in higher gestational ages that are contraindicated with medication abortion. Future studies will need to assess in more detail where providers perceive gaps in their education related to abortion and determine destigmatization methods that could be employed to engage the workforce.

AAAQ in Costa Rica

The 2019 Universal Periodic Review Working Group Report of Costa Rica recommended increased protections of the right to health. The recommendations included: expanded abortion access in cases of rape/incest and fetal impairment and the immediate creation and implementation of clear guidelines for therapeutic abortion. The therapeutic abortion Technical Norm was publicly released in December 2019 (UN Human Rights Council, 2019). However, as discussed previously the language in the norm is still ambiguous and does not appear to clarify issues that arose under Article 121 of the Penal Code, such as how to interpret health. Additionally, the Swiss recommendation regarding the technical norm specifically referenced its implementation in the public health system. This may account for the currently perceived gaps in oversight in private care settings as no other countries provided guidance on implementation. The recommendations for Costa Rica follow UPR trends for the LAC region, particularly countries with restrictive abortion laws such as Nicaragua (UN Human Rights Council, 2019). The second and third review cycles for countries with restrictive policies included increased endorsements for legalization for rape, incest, and fetal anomalies.

The interplay between the components of the AAAQ provides us with a more holistic view of abortion access in Costa Rica. The availability of clinicians willing to provide therapeutic abortion services is influenced by the accessibility of information about the legality of the procedure based on the protocols set forth in the Technical Norm. The combination of these two factors directly influences the accessibility of services and information about services for patients as their access is directly tied to subjective views and knowledge levels of clinicians. In turn, accessibility is directly determined by the acceptability of abortion within the medical institution and the cultural context more broadly. The result of restricted acceptability is a

constrained training environment that hinders clinicians from fully engaging with abortion from a technical and social care perspective. In whole, the ability to access care and the care environment created under the Technical Norm negatively influences the human right to health, life, freedom from non-discrimination, freedom from cruel, inhumane, or degrading treatment. More studies will need to be done to better understand each of the themes that appeared under the components of the AAAQ. As qualitative data increases and the dimensions of perspectives are better understood, quantitative tools should be designed to attempt to estimate the current incidence of therapeutic abortion and illegal abortion.

The findings from this study indicate that the human right to life, health, privacy, freedom from non-dscrimination, and freedom from CIDT are negatively impacted by the current therapeutic abortion law and Technical Norm in Costa Rica. Our results suggest that barriers to therapeutic abortion care exist across the dimensions of care Availability, Accessibility, Acceptability, and Quality. These barriers interrupt the full realization of the aforementioned rights and contradict State obligations and recommendations outlined in the following treaties: CEDAW, CESCR, CIDT, and CCPR. It is important to note that the AAAQ framework itself, and the findings from this study, present overlapping principles that demonstrate the interrelatability between the components of the AAAQ and their corresponding themes.

Chapter 6: Public Health Implications/Recommendations

Over the past 30 years, particularly after the 1994 ICPD Program of Action, abortion has primarily been viewed in relation to maternal mortality when unsafe abortion procedures are performed. In countries like Costa Rica, where the maternal mortality rate is low, concerns about abortion accessibility are less pressing as they are not resulting in the more obvious impacts on the population such as morbidity and mortality. This is further strengthened by the, reportedly unspoken, acceptance of post-abortion care within Costa Rican health facilities despite the legal code prohibiting non-therapeutic abortion procedures. Costa Rica has seemingly managed to restrict abortion access without experiencing a rise in maternal mortality and without sentencing those who seek abortion care. Furthermore, all of this has been accomplished under a 50+ year old abortion law and a new Technical Norm that utilizes and relies on human rights language and principles.

Since the development of the Millenium Development Goals (MDGs) in 2000, international focus has centralized on eliminating disparities in low- and middle-income countries. As Costa Rica's economy has expanded over the past 25 years and the country became an early success for family planning, infant mortality, and maternal mortality indicators, international attention appears to have shifted elsewhere. However, it is important to note that these historical research and programmatic efforts prioritized health system delivery and modern contraceptive access in an effort to increase family planning options and accessibility, not to directly research or address safe or unsafe abortion. Furthermore, gaps in sexual education were, and continue to be, a barrier to pregnancy prevention.

When it comes to maternal health, abortion seems to be considered only insofar as the unsafe practice of abortion, or subsequent inaccess to post-abortion care, contributes to maternal

mortality and morbidity. The rejection of abortion from the umbrella of maternal health reflects and further intensifies the stigmatization of abortion that results in low international and domestic political will to study the subject as a SRH concept in its own right (Rance, 1997). As self-managed abortion continues to evolve as the chosen abortion method, our definition of and subsequent approaches to unsafe abortion need to evolve with it.

Maternal mortality has transformed into a gold standard indicator of health system success and women's health. The prioritization of indicators such as maternal mortality has contributed to global tunnel vision on maternal health issues by distilling the complex relationship between women's sexual and reproductive health across the AAAQ and human rights principles to single indicators that do not provide the full context (Brunson and Suh, 2019). Brunson and Suh highlight an important relationship between SRH indicators and international support:

> "Maternal health governance occurs as governments are ranked according to their MMR, and in the case of poor performance, receive technical guidance and financial support from a bevy of bilateral and multilateral donors and NGOs to assist them in lowering their MMR. On the one hand, evidence-based governance can galvanize or even"shame" (Merry, 2016) governments into investing more seriously in maternal health. On the other hand, results-based governance can lead to a "fetishization" of indicators like the MMR, which say very little about the context in which women seek and receive pregnancy and delivery care (Wendland,2016), but through their very production and circulation convey accountability to the global health community that something (or not enough) is being done to address maternal death and disability." (Brunson and Suh, 2019)

It is therefore important to question what happens when a country is meeting these criteria. Is the attainment of these indicators enough to absolve nation states of international monitoring and research? By the Millenium Development, and now Sustainable Development Goal standards, countries with a maternal mortality rate (MMR) below 70 maternal deaths per 100,000 live births are categorized as very low on the MMR scale. When compared with low income and developing countries exceeding a MMR of 500 or even 1000, countries with 'low' MMRs such as Costa Rica's appear to be receiving a level of disengagement from the global health community.

USAID's Demographic Health Survey (DHS), first launched in 1984, prioritizes countries receiving USAID support or funding from organizations such as UNICEF and UNFPA. Tools such as the DHS and the WHO's Multi-Country Survey on Abortion Related Morbidity and Mortality in Health Facilities capture quantitative and qualitative data about family planning access and SRH indicators. What Brunson and Suh capture in their analysis of SRH indicators, is that measurements such as the maternal mortality rate have been designed for surveilling the Global South. Articles referenced and written by Brunson and Suh further demonstrate the focus of the global health community on the Global South and colonial institutions' views of population control. While further highlighting some of the benefits of indicators on international accountability, these analyses also reveal the perpetuation of this cycle of focusing on the more extreme cases while neglecting those in the middle, such as Costa Rica (Suh, 2020).

This calls into question the need for surveillance tools and indicators for the so-called Global North. For upper-middle income countries like Costa Rica, what are the next steps in sexual and reproductive health accountability when these 'key indicators' have been achieved?

How are governments held to account when their competence and perceived health system strength are tied to quantitative measures of healthcare access, morbidity, and mortality? Furthermore, how are such indicators impacting the study of the more stigmatized aspects of sexual and reproductive health such as abortion? One answer is the evolving use of health and human rights frameworks. The integration of human rights norms and evaluation frameworks, such as the Universal Periodic Review, with our approach to measuring health, provides an opportunity for all countries to be assessed for how they protect the nuanced components of health, not just major indicators.

The concept of indicators such as MMR being used to shame countries is not a phenomena unique to public health, maternal health, or SRH research. The human rights community heavily relies on this approach of calling out 'bad actors' for violations of human rights. However, as rights-based approaches to global public health evolve, it is becoming essential to identify where nation states that are 'successful' from a health indicator perspective may fail to meet their obligations in protecting or improving the realization of human rights for their citizens. Upon recognizing gaps in human rights related to health, specific steps must be taken to ensure relevant improvements to health service delivery and infrastructure are implemented.

The convergence of public health and human rights frameworks better allows us to analyze the impact of health laws and policies on health access, social acceptability of care methods, and health outcomes. If we view health policy from a systems thinking perspective, its impact on sociocultural norms, health infrastructure, financing, training and research has direct health implications that are easily traceable to outcomes outside of just maternal mortality and morbidity. That is, restrictive abortion laws have not only direct effects on the human right to

health; but they also contribute to a policy system that influences multiple facets of sexual and reproductive health care and service provision.

It is therefore the recommendation that the following stakeholders take the steps outlined below to address the barriers to abortion availability, accessibility, acceptability, and quality in Costa Rica:

- USAID/WHO—Conduct a mixed methods study of abortion acceptability among people who can become pregnant, sexual partners of people who can become pregnant, and women's health physicians. This study should consider if acceptability differs across the dimensions of: abortion reason, personal acceptability compared with societal acceptability, and State sponsored compared with privately accessible care.
- The Costa Rican government and Ministry of Health— Must consider increasing allowances for abortion to include cases of rape and incest and fetal anomaly. These legislative expansions should be combined with educational campaigns, created in collaboration with community stakeholders, clinicians, and patients to disseminate this information with the general population. All clinicians in CCSS facilities should be trained on the new protocols related to abortion, both from a legal and medical perspective. Women's health clinicians should also be guided through de-stigmatization training prior to the implementation of the new law. Lastly, in collaboration with USAID or WHO, the national government should conduct a mixed methods study of clinician willingness to perform abortion after de-criminalization or in the case of increased legal allowances.

- Medical Institutions (Universities and Licensing Monitoring Agencies)—Incorporate de-stigmatization trainings such as values clarification exercises and bioethics modules to accompany technical skills trainings for full spectrum abortion services. Licensing bodies should provide evidence-based abortion education resource

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