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“I’m Not Going to Judge but I’m Not Going to Do it”:
The Implications of Physician Inaction on Abortion Care in Costa Rica

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An abstract of
a thesis submitted to the faculty of the
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2023

Abstract

"I'm Not Going to Judge but I'm Not Going to Do it":
The Implications of Inaction on Abortion Care in Costa Rica

By Whitney Cole

Background

Unsafe abortion accounts for an estimated 10% of maternal mortality in Latin America, though no relevant data are available for Costa Rica. There are much higher rates of unsafe abortion in environments where abortion is restricted. In Costa Rica, induced abortion is only legally permissible to save the life or health of the pregnant individual. Costa Rica's 2019 "Technical Standard" aimed to clarify abortion protocols and gave healthcare professionals the right to opt out of providing abortions for ethical, moral, or religious reasons. Use of conscientious objection creates barriers to legal abortion services and may cause pregnant individuals to procure extra-legal abortions, which are more likely to be unsafe.

Objectives

To understand what influences healthcare practitioners' perspectives on the ethics of abortion, willingness to provide abortions, and, specifically, the use of conscientious objection in Costa Rica.

Methods

Obstetrician-gynecologists and medical residents practicing at public and private hospitals in San José, Costa Rica were interviewed using semi-structured, in-depth interviews. Interviews were coded in pairs and analyzed using thematic analysis.

Results

Most study participants considered abortion to be ethically justifiable in more circumstances than those permitted by law in Costa Rica. Many believed physicians should be the ones to decide whether an

abortion is ethical. Participants discussed a lack of clarity on abortion law, fear of legal repercussions, situational judgment as the main reasons to not provide abortion services.

Conclusion

Physicians may refuse to provide abortions due to fear of legal repercussions even when they believe an abortion to be ethically justified. Initiatives to sensitize and familiarize physicians with current laws could prevent overuse of conscientious objection and may increase participation in the provision of abortion services.

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Acknowledgements & Roles

This study was made possible through a generous grant from Emory Global Health Institute and support from the Global Elimination of Maternal Mortality Fund for Faculty Support. Many thanks to our Costa Rican research partners, who provided invaluable support and direction for this study, and to UCIMED for hosting the study. I am deeply grateful to my two advisors, Roger Rochat and Blake Erhardt-Ohren for their time and guidance throughout this process. I would like to individually thank research team members, Ellyn Pier, McKaylah Hilliard, Daniel Arroyo Solís, Anna Newton-Levinson, Oscar Hidalgo Mora, Sebastián Ospina Henao, Melissa Cobb, Emma Halper, Amari O'Bannon, Fabiola Gamboa Ross, and Adriana Otero Gonzalez, for their contributions to this research. All team members helped design this study. EP and DA conducted the in-depth semi-structured interviews. BEO, MH, and WC coded and analyzed the transcripts in MAXQDA.

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Chapter 1. Background

Terminology

During interviews for this study, researchers referred to abortion as "induced abortion" and to miscarriage as "spontaneous abortion" for clarity. Participants commonly referred to conducting induced abortions as "interrupting pregnancy". The term "post-abortion care" was used to refer to medical care received at a healthcare facility for complications from a miscarriage or an incomplete abortion. Participants often referred to a "therapeutic abortion" as one deemed medically necessary to preserve the pregnant person's life or health and performed in accordance with Costa Rican law, whereas they referred to "clandestine abortions" as those conducted extralegally. The World Health Organization (WHO) defines "unsafe abortion" as "a procedure for terminating an unintended pregnancy carried out either by persons lacking in necessary skills or in an environment that does not conform to minimal medical standards, or both" (WHO, 2011). An abortion is often referred to as "less safe" if only one of these conditions it met and "unsafe" if both are met (Ganatra et al., 2017). Characteristics of an unsafe abortion can include lack of pre-abortion counseling, unhygienic conditions, insertion of foreign objects into the uterus, untrained practitioners, and ingestion of hazardous substances, among others (WHO, 2011). Of note, clandestine and extralegal abortions may be safe, such as with medication abortions or when they occur with the help of a trained provider in hygienic conditions.

Abortion Worldwide

Induced abortion is a common practice throughout the world regardless of legal status. Worldwide, about 73 million induced abortions – 31% of all pregnancies – take place every year. Of those pregnancies that are unintended, 61% end in abortion (Bearak et al., 2022; WHO,

2021). Unintended pregnancy is the main driver of induced abortions and may result from misuse or lack of contraceptives, sexual violence, and threats to the pregnant person's wellbeing from continuing a pregnancy (Singh et al., 2018).

Lack of access to safe abortion services drives pregnant people to seek alternatives, often unsafe abortions. About 25 million unsafe abortions took place annually between 2010 and 2014 (Ganatra et al., 2017). Unsafe abortion is the fourth leading cause of maternal mortality globally and claims the lives of approximately 32,000 people each year (Say et al., 2014). This represents 8% of maternal mortality from all causes, the true burden of which is likely much higher but is notoriously difficult to measure due to misclassification and underreporting (Gerdts et al., 2013; Say et al., 2014). And yet these deaths are almost entirely preventable; the risks associated with unsafe abortions are negligible when performed by a trained medical provider in accordance with medical guidelines (Ganatra et al., 2017; WHO, 2011).

Ensuring pregnant people have access to safe abortion is an important step in meeting United Nations Sustainable Development Goals (SDGs) 3 and 5 related to health and gender-equality. SDG 3 calls abortion services "essential and cost-effect components for any strategy for reducing maternal mortality", urging countries to ensure universal access to sexual and reproductive health services, such as abortion and post-abortion care, and their integration into national health strategies and programs (Ipas, 2015). The World Health Organization considers access to safe abortion and post-abortion care to be essential reproductive healthcare, citing the lack of these services as a primary contributor to maternal mortality (WHO, 2011).

Legally restricting abortion does not lead to fewer abortions. Numerous studies have shown that abortion continues to exist at similar rates in places with total bans, restrictive, and unrestrictive policies. Rather, restrictive policies and laws jeopardize the health and lives of

pregnant people by making it difficult to obtain abortions safely (Ganatra et al., 2017; Sedgh et al., 2014; WHO, 2011). Effective ways to minimize the need for abortions that do not put women's lives at risk incorporate the provision of safe abortions, contraception, and family planning counselling to all married and unmarried women (WHO, 2011).

Methods of unsafe abortion highlight the desperation of women: introduction of foreign objects or substances into the uterus, intramuscular injections, abdominal trauma, ingestion of toxic substances, and the use of off-label medications (Grimes et al., 2006). Pregnant people living where abortion is restricted are more likely to seek abortions from unlicensed, untrained providers and suffer complications such as hemorrhage, uterine perforation, infection, poisoning, and damage to surrounding organs (Singh & Maddow-Zimet, 2016). In contrast, induced abortions conducted in safe conditions and by trained providers are very safe – 14 times safer than carrying a pregnancy to term (Raymond & Grimes, 2012).

The availability of abortion medications has increased the safety and accessibility of abortions in many parts of the world, allowing providers to offer abortions in primary care or outpatient settings (WHO, 2015). Most women have no long-term side effects from safely induced abortions (WHO, 2011).

Abortion in Latin America

The topic of abortion has been at the forefront of political and social debate in Latin America in recent years as evidenced by policy changes throughout the region (Bergallo, 2011). Uruguay legalized abortion on-request through 12 weeks in 2012, becoming the third Latin American country to do so after Cuba in 1965 and Guyana in 1995 (through 8 weeks) (Center for Reproductive Rights, 2014; Zissis et al., 2022). Then, 8 years later in 2020, Argentina's legalization of abortion on-request through 14 weeks sparked a wave of abortion reform across

Latin America (Zissis et al., 2022). In 2021, Mexico's Supreme Court ruled that abortion could not be considered a crime, which inspired a string of Mexican states to legalize abortion on-request until 12-13 weeks (Tames, 2022). Colombia followed suit in 2022, decriminalizing abortion through 24 weeks to save a woman's life and in cases of incest, rape, and fetal abnormality (Zissis et al., 2022). In 2017, Chile decriminalized abortion to save a woman's life and in cases of fetal incompatibility with life, rape (through 12 weeks), and maternal age under 14 (through 14 weeks) (Ministerio de Salud de Chile, 2017). Meanwhile, other countries have taken steps to tighten restrictions. In 2021, Honduras, where there was already a total ban on abortion, ratified a constitutional amendment that makes the law very difficult to change (Jones, 2022).

Despite recent trends toward derestriction, Latin America remains one of the regions with the most restrictive laws regarding abortion (Guttmacher Institute, 2017). Settings with more restrictive laws have considerably higher rates of unsafe abortions than those with less restrictive laws (Singh et al., 2018). An estimated 44 of every 1,000 pregnancies ended in abortion in the region between 2010 and 2014 of which 76% were considered less safe or unsafe (Ganatra et al., 2017; Sedgh et al., 2016). Nearly 760,000 people are treated for complications from unsafe abortions each year in Latin America (Singh & Maddow-Zimet, 2016). As of 2014, unsafe abortion accounted for approximately 10% of maternal deaths in the region, a proportion higher than any other world region (Say et al., 2014). Given the grim state of maternal mortality due to unsafe abortion and the recent tide of reform in Latin America, it is an important moment to contribute to the body of research that supports access to safe abortion care.

Abortion in Costa Rica

Costa Rica has distinguished itself as a defender of human rights, gender equality, and a safe haven for those in need of refuge. They have ratified 8 out of 9 of the United Nations core international human rights treaties, agreeing to incorporate the tenants into their laws (WHO, 2020). They are the fourth largest recipient of asylum claims and were hosting over 200,000 refugees and asylum seekers as of June 2022 (United Nations High Commissioner for Refugees, 2022). Costa Rica was also the first country in Central American to legalize same-sex marriage in 2018 (Gonzalez Cabrera, 2020). The same year, the country launched the For All Initiative at the United Nations World Assembly to ensure that gender equality and human rights are integrated into global environmental agreements (Human Rights Watch, 2018).

However, Costa Rica remains one of the countries in Latin America with restrictive abortion policies. Costa Rica has not yet complied with the recommendation by the Convention on the Elimination of Discrimination Against Women (CEDAW) to "amend the criminal code to legalize abortion in cases of rape, incest or severe fetal impairment and decriminalize abortion in all other cases" (CEDAW, 2017). CEDAW also expressed concern about the strict interpretation of medical necessity by medical providers in the country (United Nations Geneva, 2017). The United Nations Human Rights Committee (HRC), Committee on Rights of a Child (CRC), and Committee on Economic, Social, and Cultural Rights (CESCR) also urged Costa Rica to make similar law and policy changes to ensure the health and safety of pregnant people (CESCR, 2008; CRC, 2011; HRC, 2016).

There is little evidence available to demonstrate the magnitude of unmet need for abortion care in Costa Rica because of a dearth of research about the topic, a situation that has contributed to the assumption that abortion is uncommon and the need for services is low (Gómez Ramírez, 2008). However, an estimated 59% of pregnancies in Costa Rica were

unintended between 2015-2019, of which 41% were estimated to have ended in abortion (Bearak et al., 2022). The last survey conducted by the Asociación Demográfica Costarricense (Costa Rican Demographic Association [ADC]) estimated that 27,000 abortions occur in Costa Rica each year. This amounts to 38 abortions for every 100 live births – approximately one abortion for every three live births – which is more than triple the figure from their 1991 survey (Gómez Ramírez, 2008). Costa Rica also meets several conditions consistent with high motivation for abortions: there is a low total fertility rate at 1.6 births per woman, a high age at first marriage at 26.4 years for women, and high out-of-wedlock fertility at 73% – the second highest value in Latin America after Chile (Organization for Economic Co-operation and Development, 2022; World Bank, 2018, 2020).

Abortions induced legally by healthcare providers in Costa Rica are similarly difficult to quantify. The Caja Costarricense de Seguridad Social (CCSS), a governmental agency in charge of the public health sector, reported treating 4,359 patients with a primary diagnosis of "abortion". They also reported 2,869 discharged patients and 3,912 hospital stays for dilation & curettage, a uterine evacuation procedure, but did not differentiate between induced abortion and post-abortion care for miscarriage or incomplete abortion (CCSS, 2021). The Costa Rican census by the Instituto Nacional de Estadística y Censos (National Institute of Statistics and Censuses [INEC]) also combines miscarriage, incomplete abortion, and induced abortions into one "abortion" category, which prevents demonstration of the impact of unsafe abortion on maternal mortality (INEC, 2022). A report from the 84th CEDAW convention stated that CCSS had only received eighteen applications for therapeutic abortions and approved six, however a timeframe was not provided and the information was not searchable in the CCSS database (CEDAW,

2023). Lack of data may contribute to the belief that unsafe abortion is not a problem in Costa Rica and may demotivate the medical community's involvement in reform.

The CCSS cites ectopic pregnancy, chorioamnionitis (an infection of the placenta and amniotic fluid), and molar pregnancies as the most common reasons for interrupting a pregnancy, along with maternal hypertension, neoplasms, and cardiac and kidney problems to a lesser extent (Ministerio de Salud de Costa Rica [MSCR], 2019). However, the law does not specify conditions that qualify for therapeutic abortion so establishing medical necessity depends on the judgment of physicians. Cases considered medically necessary remain extremely rare and difficult to obtain compared to countries with similar laws (Carranza, 2007). Strict interpretations of medical necessity limit access to abortions. Therefore, exploration of factors that influence physicians' ethical perspectives on abortion and willingness to practice is necessary as they dictate which patients receive care (González-Vélez et al., 2019).

Abortion Law in Costa Rica

Abortion is illegal in most cases in Costa Rica except when deemed medical necessary to save the pregnant person's life or health. The most recent legislation regarding abortion occurred in 1970 with the passage of Articles 118-122 in the Costa Rican Penal Code and stipulates that induced abortion can be considered exempt from legal consequences if certain conditions are met (MSCR, 2019). Prior to this, abortion in Costa Rica was illegal regardless of the circumstance. Article 121 establishes what is called "abortion impune" or "abortion with impunity" and allows physicians or authorized obstetric nurses to terminate a pregnancy, when the woman consents, to prevent a threat to the woman's life or health that could not have been avoided by other means (Articulo 121, 1970). These are the only conditions under which abortion is currently legal in Costa Rica – there are no exceptions for fetal anomalies, rape and incest, or other social and

economic factors. Medical providers could face one to three years in prison for providing an abortion with the consent of the woman, and up to 10 years for providing an abortion without her consent or on a person under the age of 15. Providers can also be sentenced to 2-4 months of prison time for ending a pregnancy because of neglecting to provide appropriate care to the patient (Articulo 121, 1970).

For nearly fifty years following the limited legalization of induced abortion in Costa Rica, interpretation of the penal code and practice of induced abortion varied due to the lack of standardized protocols (MSCR, 2019). In 2019, the Costa Rican Executive Branch and the Ministry of Health introduced a technical standard to ensure the safe and efficient provision of abortion to those who meet legal guidelines. Technical standards, or "normas técnicas", are regulations that apply to all medical services on a national scale. This step was highly controversial among medical and religious groups, as well as among activists and the general population – some fearing it would enable access to abortion on-demand while others insisting it was necessary to ensure the basic provision of already legalized services (Borbón Quirós, 2019; José Bonilla, 2022). It was ultimately deemed necessary in order to establish medical criteria and clarify legal requirements to regulate medical and nursing interventions related to abortion services and to eliminate barriers to care (MSCR, 2019).

Taking effect on December 10th, 2019, the Technical Standard for Therapeutic Interruption of Pregnancy (hereafter referred to as the Technical Standard) addressed a range of topics related to the clinical evaluation and the provision of abortion services such as:

- Criteria for evaluating whether a pregnant person qualifies for an abortion
- Types of medical establishments that can provide abortions
- Timeline for determinations of eligibility and provision of services

- Evaluation requirements and procedures
- Rights and limitations of providers to decline to provide an abortion due to conscientious objection and subsequent referral requirements
- Requirements regarding informed consent and the registry of cases
- Obligation to inform parents of minors (Ministerio de Salud de Costa Rica, 2023)

The Technical Standard stipulates that two physicians specializing in obstetrics and one specializing in the pathology requiring the abortion must deem an abortion medically necessary. Medical providers may cite conscientious objection to decline to evaluate a pregnant person for appropriateness of an abortion or to provide an abortion. They must submit written documentation of their objection to the director of the medical facility, who should then identify another provider that can assume care of the patient according to pre-established institutional protocols. Conscientious objection cannot be invoked in the case of obstetric emergencies when the life of the pregnant person is at stake if they are the only qualified professional available (MSCR, 2019). The *Clinical Practice Protocols related to Article 121* published in 2020 further explain the rights and responsibilities of Costa Rica medical personnel who wish to conscientiously object (CCSS, 2020).

Chapter 2. Literature Review

Conscientious Objection

Though common throughout the world, conscientious objection is not an inalienable right of healthcare professionals. The countries of Finland, Bulgaria, and Lithuania prohibit all conscientious objection in healthcare settings to safeguard patients' right to autonomy and nondiscrimination (Ramón Michel et al., 2020). When permitted, conscientious objection allows medical providers to refuse to provide abortions based on moral, ethical, or religious beliefs. In Costa Rica, the Technical Standard, which standardized protocols about abortion care, explicitly gives healthcare professionals the right to invoke conscientious objection to opt out of conducting induced abortions (MSCR, 2019).

International law aims to regulate and limit conscientious objection to avoid causing harm to patients; unregulated conscientious objection can pose significant barriers to accessing safe and timely abortion care (Carranza, 2007; WHO, 2022). The International Federation of Gynecology and Obstetrics (FIGO) has included the topic of conscientious objection in their ethical standards for abortion, recognizing the importance of regulating conscientious objection in removing barriers to reproductive healthcare (FIGO, 2021). Conscientious objection has been cited as one of the primary barriers to induced abortion by studies in Argentina, Brazil, Uruguay, Guyana, Trinidad and Tobago, India, Poland, Australia, South African, Uganda, Zambia, Indonesia, Ireland, Israel, the Philippines, and South Korea (International Reproductive and Sexual Health Law Program [IRSHLP], 2020).

Conscientious objection creates barriers to care when abortion providers are scarce or unevenly distributed, when there are no accountability mechanisms for objectors who do not follow protocols, and when objectors are discriminatory or do not refer patients to providers who

are willing to perform abortions (Galli, 2020; IRSHLP, 2020; Küng et al., 2021; Ramón Michel et al., 2020). A study in Argentina found that providers experience virtual impunity when refusing to participate in abortion care. The same study described mechanisms to hold objectors accountable for ensuring prompt and appropriate referrals as "weak" and "scarce" (Ramón Michel et al., 2020). To address these problems, the World Health Organization, summarizing international human rights law, issued updated recommendations in 2022 to guide countries in the development of conscientious objection regulations related to abortion care, including:

- Organizing the health system to ensure that sufficient, non-objecting providers are employed and distributed fairly across the country;
- Putting in place clear and enforceable regulation of conscientious objection;
- Ensuring adequate enforcement of the regulation of conscientious objection, including identifying, addressing, and sanctioning non-compliance;
- Outlining clearly who may object to what components of care;
- Prohibiting institutional claims of conscience;
- Requiring objectors to provide prompt referral to accessible, non-objecting providers;
- Requiring conscientious objection to be exercised in a respectful and non-punitive manner; and
- Prohibiting conscientious objection in urgent or emergency situations (WHO, 2022)

Proponents of conscientious objection describe it as a necessary protection for healthcare providers, allowing them to practice free from discrimination due to personal convictions. In a 2021 bill in Costa Rica called *La Ley de Objeción y Libertad de Conciencia* (Conscientious Objection and Conscientious Freedom Law), conscientious objection is called a "pillar of

democracy, freedom, independence, and pluriculturalism". Professional obligation to participate in an abortion procedure against one's ethical code is compared to religious discrimination (Diaz Mejías, 2021). The authors point to Article 1.1 in the United Nations *Declaration on the Elimination of All Forms of Intolerance and Discrimination Based on Religion or Belief* that states that "everyone shall have the right to freedom of thought, and conscience, and religion" (Diaz Mejías, 2021). Justifying conscientious objection this way implies a link between practice and ethical stance. However, interviews with gynecologists in Uruguay revealed that some providers are able to detach from the moral weight of the abortion by mentally separating their role as facilitators from the patient who chooses to have an abortion (EtShalom, 2015).

Reasons for invoking conscientious objection to abortion often extend beyond conflicts with moral, ethical, or religious beliefs. Studies in Mexico, Bolivia, Brazil, and Argentina found that important motivators included political, social, and personal reasons such as lack of knowledge and training, fear of legal consequences, or stigmatization (Diniz et al., 2014; Küng et al., 2021; Ramón Michel et al., 2020). Healthcare leadership may use conscientious objection to impose personal ideologies on their departments, wielding it as a political tool to deny access to reproductive healthcare (Ramón Michel et al., 2020). In some cases, providers may decline to perform an abortion on a case-by-case basis, such as in Brazil where providers doubted victims' testimony in cases of sexual assault (Diniz et al., 2014; Galli, 2020). In Argentina, providers also expressed concern that conducting abortions in an environment where many others would decline services would leave these providers with disproportionately heavy workloads (Ramón Michel et al., 2020).

Conscientious Responsibility

In contrast to conscientious objection and rarely the focus of public attention, some individuals feel they have a conscientious responsibility to provide abortions for moral, personal, or religious reasons. For example, a physician may feel that providing a safe abortion is necessary to prevent the pregnant person from putting their life at risk by seeking care in an unsafe context (WHO, 2012). FIGO recognizes these individuals as "conscientious providers" for conducting abortions despite facing stigmatization or threats to personal safety, having little professional support, and dealing with potential negative impacts on their careers (FIGO, 2021).

Participation of the medical community in abortion policy

As trusted medical experts, physicians are well-positioned to influence community attitudes and health policy that could improve access to safe abortion care (Higgins et al., 2021). Physicians in Uruguay were instrumental in reframing abortion as a public health imperative which ultimately supported policy reform and streamlined service implementation after decriminalization (Stifani et al., 2018). Conversely, the American Medical Association played a major role in the criminalization of abortion in the United States until 1970, when it reversed its stance and became influential in subsequent abortion reform (Halfmann, 2003). FIGO recognizes the important role that member societies have in influencing policy, and, on their website, lists "advocacy by national societies to their local policymakers and communities" as one of their primary strategies to prevent unsafe abortion (Shaw, 2010). As a participating member society, the Asociación de Obstetricia y Ginecología de Costa Rica (AOGCR) created an action plan in 2014 to address unsafe abortion; however, it lacks a commitment to advocacy work (Table 1) (Padilla de Gil, 2014). The AOGCR has not issued a position statement on abortion as they have with salpingectomies (fallopian tube removal) and emergency contraception, two other controversial reproductive health issues (AOGCR, n.d.).

Table 1. Strategies included in Costa Rica's plan of action for the prevention of unsafe abortion for FIGO (Padilla de Gil, 2014)

Strategy	Costa Rica
Sex education	X
Family Planning	X
Facilitate adoption	X
Access to safe legal abortion	X
MVA incomplete abortion	
Misoprostol incomplete abortion	
Postabortion contraception	X
Sensitize politicians	
Advocacy law reform	
Improved data on abortion	X

Abortion providers in settings where abortion is unrestricted and restricted may experience harassment and stigma which can lead to compassion fatigue (emotional distress leading to decreased ability to empathize with patients) and burnout, potentially threatening the abortion provider workforce (Martin et al., 2014). Research among abortion providers from seven Latin American countries in which abortion is legally restricted found that stigma can contribute to amplified fears of criminal prosecution and hesitancy to participate in legal advocacy due to feelings of powerlessness. Such "legal disengagement" reflects justified concerns about safety and prosecution (Mosley et al., 2020). Research in Sub-Saharan Africa and Latin America showed that engaging providers in Provider Share Workshops – a group intervention focusing on abortion providers' personal experiences of stigma – decreased anxieties about disclosing their

professional role and perceptions of judgment, discrimination, and isolation. They found that by reducing feelings of stigmatization, fear of legal repercussions decreased even when legal restrictions on abortion remain the same. It also fostered a sense of community that improved willingness to participate in advocacy (Mosley et al., 2020).

Research Gaps

There are no recently published data on provider opinions related to the ethics of abortion and willingness to practice in Costa Rica. Despite a commitment by AOGCR to improve data on abortion in the 2014 action plan for FIGO, there has been no updated research on abortion incidence in Costa Rica since 2007 (Gómez Ramírez, 2008; Padilla de Gil, 2014). Little information is available about the extent of training provided to health personnel after the Technical Standard took effect and about physician awareness of current laws and policies regarding abortion in Costa Rica. Costa Rican delegates at the 2023 Convention on the Elimination of all Forms of Discrimination Against Women stated that a training course on the Technical Standard was offered in May of 2022 followed by training and awareness courses on approving therapeutic abortions later that year. The number of participants and geographic areas reached was not disclosed (CEDAW, 2023). In February of 2023, CEDAW urged Costa Rica to provide mandatory training to healthcare personnel, suggesting that this had not yet occurred broadly (United Nations Human Rights Office of the High Commissioner, 2023). There is no information about consequences or accountability mechanisms to ensure providers are complying with the requirements outlined in the Technical Standard. There is no publicly available information about the number of therapeutic abortions practiced per year or about the number of providers who have been prosecuted for providing abortions. Research about the

extent to which physicians are aware of the details of the Technical Standard and clinical protocols for abortion and their willingness to participate would provide essential insight for policy makers, advocates, and the medical community. This thesis fills a gap in the research about providers' ethical decision-making on abortion and identifies barriers that negatively affect providers' willingness to practice abortions in Costa Rica.

Problem Statement

Unsafe abortion is responsible for at least 8% of maternal mortality globally and is almost entirely preventable (Gerdts et al., 2013; Grimes et al., 2006; Say et al., 2014). Places where abortion is restricted have considerably higher rates of unsafe abortions than those with less restrictive laws (Singh et al., 2018). In Costa Rica, abortion is only permitted to save the life or health of the mother, but cases considered medically necessary remain extremely rare and difficult to obtain compared to countries with similar laws (Carranza, 2007). The Costa Rican Ministry of Health aimed to address some barriers to abortion access by outlining protocols in the 2019 Technical Standard.

As trusted medical experts, physicians are in the unique position to influence community attitudes and health policy that could improve access to safe abortion care (Higgins et al., 2021). They function as medical gatekeepers because judgment regarding medical necessity and willingness to participate in abortions determines which patients receive care. However, there are no data about Costa Rican physicians' perspectives on abortion care, current laws, and factors that affect their willingness to provide abortions.

Purpose Statement

The purpose of this study was to explore the perspectives of obstetrician-gynecologist (OB/GYN) physicians and medical residents related to abortion care in public hospitals in San

José, Costa Rica. This thesis focuses on factors that influence physicians' ethical stance on abortion and willingness to perform abortions.

Significance

The results of this study are significant because they provide new information about the perspectives of physicians and medical residents about abortion in restricted settings, filling a gap in understanding about why providers are hesitant to perform abortions and participate in advocacy in Costa Rica. Their views provide valuable insight into barriers to care and help identify areas for training and policy change. Understanding physician perspectives can also facilitate their participation in abortion care, policy, and advocacy, and ensure the appropriateness and relevance of future interventions. With increased provider participation in abortion care and advocacy, pregnant people may have improved access to safe abortion care, preventing maternal morbidity and mortality from unsafe abortion.

Chapter 3. Methods

Introduction

Researchers from Emory University, the University of Medical Sciences (UCIMED) in San José, Costa Rica, and the University of California, Berkeley, designed this study to explore OB/GYN physician and medical resident perspectives regarding unplanned pregnancies and abortion care in Costa Rica. This thesis focuses on understanding the factors that influence physicians' and residents' ethical stances on abortion, their willingness to participate in abortion care, and their use of conscientious objection as a way to opt out of providing abortions. The author of this thesis contributed to the design of inductive and deductive codes, assisted with translation, and coded and analyzed interview data.

Population and Sample

All practicing OB/GYNs with over five years of experience and medical residents at any stage of training in Costa Rica were eligible to participate in this study. We recruited fifteen participants in total, ten OBGYNs and five medical residents, all of whom primarily worked in urban, public hospitals. We sampled this population due to their knowledge of and involvement in reproductive healthcare in Costa Rica and potential to be abortion providers. Sampling both residents and established physicians allowed researchers to explore generational variations in opinions of abortion care as well as current training in reproductive health topics. OB/GYNs with five years of experience or less were excluded to ensure there was a distinction between physicians and residents. The research team recruited participants by posting electronic fliers on UCIMED's social media pages. The team also purposively sent fliers, targeted emails, and WhatsApp messages to practicing OB/GYNs and residents. We then utilized snowball sampling to identify additional participants: following their interviews, we asked participants to share

names of others who may be interested in the study. No individuals that we approached directly declined to participate.

Procedures

Researchers from Emory University, UCIMED, and the University of California worked collaboratively to design the study, recruit participants, conduct in-depth interviews (IDI), and analyze data. Semi-structured IDIs were utilized to facilitate personal reflection and provide privacy in the discussion of a stigmatized subject. Together, the research team established project goals, drafted a memorandum of understanding, and developed and translated interview guides into Spanish. The interview guides focused on understanding physicians' and residents' perspectives about unplanned pregnancies, abortion, and current laws and beliefs about the future of comprehensive abortion care in Costa Rica. The finalized proposal was approved by the Emory University Institutional Review Board (#STUDY00002394), the Costa Rican Consejo Nacional de Investigación en Salud (CONIS), and UCIMED's ethics committee to ensure adherence to the host country's ethical standards for human subjects research. All members of the data collection team completed a 30-hour research ethics course by the Instituto de Investigación en Ciencias Médicas UCIMED (IICIMED) in compliance with Costa Rican law 9234 that regulates biomedical research (IICIMED, n.d.; Ley Reguladora de Investigación Biomédica, 2014).

Data Collection

Data collection occurred between September 2021 and March 2022. Interviews were conducted in Spanish by two researchers – one interviewer from Emory University and one notetaker from UCIMED. Due to health considerations during the Covid-19 pandemic, we conducted all interviews using Zoom online video conferencing software. Researchers from

UCIMED collected written consent in person at the beginning of each interview. Interviewers collected subsequent verbal consent prior to beginning the interview. All interviews were audio recorded. Audio files were transcribed by bilingual student researchers as well as by HappyScribe, a professional transcription service. The transcripts were subsequently translated into English by GMR, a translation company familiar with Costa Rican vernacular. Accuracy of translations was verified by Costa Rican research team members. Audio files were destroyed following transcription and transcribed data were kept in a password-protected online server. The complete interview guide can be reviewed in Appendix A. The primary research questions included in the interview guide regarding ethical decision-making and factors that influence willingness to provide care were:

In what situations do you think it is ethical to perform an abortion?

What influences your opinion about abortion?

If laws and policies made induced abortion more accessible, how do you think providers would feel about providing care to women seeking an abortion?

Other interview questions yielding pertinent information included:

What do you think abortion-related medical practice will be like in Costa Rica in ten years?

What do your colleagues think of the future of abortion in Costa Rica?

Is abortion an issue you can discuss with your colleagues?

How do you feel about providing post-abortion care?

How do doctors feel about the current reproductive health-related policies?

Data Analysis

All interviews were de-identified prior to analysis. Data was analyzed using thematic analysis, which involved the iterative process of familiarization, coding, theme generation and

review, interpretation of themes, and writing up results (Castleberry & Nolen, 2018). Familiarization with the data occurred during the revision of translations and transcriptions. The research team developed the initial codebook prior to beginning interviews; it was reassessed after the first three interviews and additional codes were added based on salience of the topic. The team utilized MAXQDA software for coding and analysis. English transcripts were coded simultaneously by two to three researchers to ensure concordance and completeness. Coded segments were reviewed for repeating ideas, which were organized into subcategories and summarized to identify themes. Individual coders developed detailed descriptions of themes that stood out from the data and presented them to the team for group assessment and feedback; revisions were made based on this input. Themes related to ethical decision-making and willingness to practice abortions were summarized for this thesis and presented with illustrative quotations pulled directly from translated transcripts.

Chapter 4. Manuscript

Obstetrician-Gynecologist Perspectives on Conscientious Objection and Barriers to Providing Abortions in San José, Costa Rica, 2021-2022

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Abstract

Objectives

To understand what influences healthcare practitioners' perspectives on the ethics of abortion, willingness to provide abortions, and, specifically, the use of conscientious objection in Costa Rica.

Methods

Obstetrician-gynecologists and medical residents practicing at public and private hospitals in San José, Costa Rica were interviewed using semi-structured, in-depth interviews. Interviews were coded in pairs and analyzed using thematic analysis.

Results

Most study participants considered abortion to be ethically justifiable in more circumstances than those permitted by law in Costa Rica. Many believed that physicians should be the ones to decide whether an abortion is ethical. Participants discussed religion, culture, a lack of clarity on abortion law and resulting fear of legal repercussions as the main reasons to not provide abortion services.

Conclusion

Physicians may refuse to provide abortions due to fear of legal repercussions even when they believe an abortion to be ethically justified. Initiatives to sensitize and familiarize doctors with current laws could prevent overuse of conscientious objection and may increase participation in the provision of abortion services.

Keywords

Physician attitudes, perspectives, ethics, unplanned pregnancy, abortion, conscientious objection, Costa Rica, law

Unsafe abortion is the fourth leading cause of maternal mortality globally and claims the lives of approximately 32 000 people each year (1). Multiple studies have shown that settings with more restrictive abortion laws and policies have considerably higher rates of unsafe abortions than those with less restrictive laws (2–4). Additionally, legally restricting abortion does not lead to fewer abortions; abortion rates are similar in places with total bans, restrictive, and unrestrictive policies. Rather, restrictive abortion laws and policies jeopardizes the health and lives of pregnant people by making safe abortions harder to access (3–5). Despite recent regional trends toward abortion derestriction, Latin America remains one of the world's regions with the most restrictive abortion laws and, at 10% of maternal deaths, it has the highest proportion of maternal deaths due to abortion of any region in the world (1,6).

In Costa Rica, abortion is only legal when medically necessary to save the pregnant person's life or health. Costa Rican law states that "abortion, practiced with the consent of the woman and by a doctor or authorized obstetric nurse, is not punishable if it has been done to avoid a threat to the life or health of the mother and cannot be avoided by other means"(7). Despite this exception, those abortions provided legally are extremely rare and difficult to access compared to countries with similar laws (8). And yet, an estimated 41% of all unintended pregnancies in the country end in abortion (9,10). In 2019, in response to the recommendations of the Committee for the Elimination of Discrimination Against Women (CEDAW) and several other United Nations international human rights committees, the Costa Rican Ministry of Health established technical guidelines to standardize abortion care and attempt to ensure appropriate referrals in cases where the doctor refuses to provide care (11–15). The guidelines explicitly give healthcare professionals the right to invoke "conscientious objection", which allows them to opt out of providing induced abortions for ethical, moral, or religious reasons (15).

Proponents of conscientious objection describe it as a necessary protection for healthcare providers, allowing them to practice free from discrimination due to personal convictions. However, unregulated conscientious objection can pose significant barriers to safe and timely abortion care (16,17). Conscientious objection is sometimes overused for reasons which are not strictly matters of conscience; these can include political, social, and personal concerns such as a lack of knowledge and training, fear of legal consequences, or stigmatization (18–20). Studies exploring the factors that influence physicians' willingness to provide abortions are necessary since they dictate which patients receive care and which do not (21). In this manuscript, we seek to fill the gap in data about conscientious objection among potential abortion providers in Costa Rica. We conducted semi-structured in-depth interviews with obstetrician-gynecologist (OB/GYN) physicians and medical residents to understand what influences their opinions on the ethics of abortion and their willingness to provide abortions in public and private hospitals in Costa Rica.

Methods

Researchers from Emory University, the University of Medical Sciences (UCIMED) in San José, Costa Rica, and the University of California, Berkeley, designed this study to explore OB/GYN physician and medical resident perspectives regarding unplanned pregnancies and abortion care in Costa Rica. This manuscript focuses on understanding the factors that influence physicians' and residents' ethical stances on abortion, their willingness to participate in abortion care, and their use of conscientious objection as a way to opt out of providing services.

All practicing OB/GYN physicians with over five years of experience and medical residents in Costa Rica at any stage of training were eligible to participate in this study. The research team recruited fifteen participants by purposively sending fliers, emails, and WhatsApp

messages to OB/GYNs (n=10) and medical residents (n=5) at UCIMED. We then utilized snowball sampling to identify additional participants: following each interview, we asked participants to share names of others who may be interested in the study. No individuals approached directly declined to participate.

Researchers worked collaboratively to design the study, recruit participants, conduct in-depth interviews (IDI), and analyze study data. Semi-structured IDIs were utilized to facilitate personal reflection and provide privacy in the discussion of a stigmatized subject. The interview guides focused on understanding physicians' and residents' perspectives about unplanned pregnancies, abortion, and current laws and beliefs about the future of comprehensive abortion care in Costa Rica. The finalized proposal was approved by the Emory University Institutional Review Board (#STUDY00002394), the Costa Rican Consejo Nacional de Investigación en Salud (CONIS), and UCIMED's ethics committee to ensure adherence to Costa Rica's ethical standards for human subjects research. Additionally, all members of the data collection team completed a 30-hour research ethics course by the Instituto de Investigación en Ciencias Médicas UCIMED (IICIMED) in compliance with Costa Rican law 9234 that regulates biomedical research (22,23).

Data collection occurred between September 2021 and March 2022. Interviews were conducted in Spanish by two researchers. Due to health considerations during the COVID-19 pandemic, we conducted all interviews using Zoom online video conferencing software with audio only. Researchers from UCIMED collected written consent in person prior to interviews. Interviewers collected subsequent verbal consent at the beginning of each interview. Audio file recordings were transcribed by bilingual student researchers as well as by a professional transcription service. The transcripts were then translated into English by a translation company

familiar with Costa Rican vernacular. Accuracy of transcriptions and translations was verified by Costa Rican research team members. Transcribed data were kept in a password-protected online server and audio files were destroyed following translation.

All interviews were de-identified prior to analysis. English transcripts were coded simultaneously by two or three researchers to ensure concordance and completeness. Coded segments related to provider opinions on abortion and abortion law were reviewed for repeating ideas, which were organized into subcategories and summarized to identify themes. Coders developed detailed descriptions of themes that stood out from the data and presented them to the team for group assessment and feedback; revisions were made based on this input and a final coding manual was created.

Results

Demographics

Of the ten physicians and five medical residents that participated in this study, most practiced in urban (n=14), tertiary medical facilities (n=12). Most participants (n=8) provided care in private clinics in addition to their work in the public sector. About half of study participants identified as Catholic (n=8) and another third as agnostic or having no religion (n=5); the remaining two participants identified as “Evangelical”, referred to in this manuscript as “non-Catholic Christian”. Seven participants identified as female and eight as male. About half of the study participants were 30-39 years old (n=6), and only three participants were aged 50+ years. Physicians averaged 20.0 years of medical practice while residents averaged 2.2 years. *Table 1* illustrates the demographic characteristics of study participants.

Table 1. Demographic characteristics of participants

	Physicians (n=10)	Residents (n=5)
Gender		
Male	4	4
Female	6	1
Other	0	0
Age		
20-29	0	2
30-39	3	3
40-49	4	0
50-59	1	0
60-69	2	0
Religion		
Catholic	5	3
Non-Catholic Christian	2	0
No religion/Agnostic	3	2
Years in Practice		
0-9	2	5
10—19	4	0
20-29	1	0
30+	3	0
Health Facility location		
Urban	9	5

Rural	1	0
Health Facility sector		
Public	2	5
Private	0	0
Both	8	0
Health Facility Sector		
Primary	2	0
Secondary	1	0
Tertiary	7	5

Circumstances in which healthcare providers consider abortion to be ethical

Most of the study participants considered induced abortion to be ethical in some situations (n=13) and supported expanding abortion policy to include situations of rape and fetal malformations (n=12). One participant expressed this by saying:

> "[…When] a patient became pregnant by rape [or] in stories of incest, seems terrible to me... I think the patient has the right to request it if she knows that the fetus is not viable… one knows has hours that they will live and the patient is exposed to all the dangers of three trimesters. It seems to me that that should also be allowed since they are things that can be diagnosed early." - Female physician, 30-39 years old

Only two participants felt there were no ethical reasons to perform an abortion. One of whom stated, "it would only be [ethical] for an early gestational loss, nothing more", referring to performing post-abortion care after a miscarriage (Female physician, 40-49 years old). When

asked if depression would justify an induced abortion, nearly half (n=6) of participants felt that it would. As one resident responded:

> "I think that [depression] could definitely be a justified reason to do it, definitely. But I don't think most people agree with that." - Male resident, 30-39 years old

Few participants (n=3) considered "personal choice" alone to be sufficient reason to obtain an abortion. More commonly, participants expressed a desire to make ethical determinations about abortion on a case-by-case basis (n=5). One participant explained that they would:

> "... Probably individualize the cases. If it is a patient who… is already on the third [surgical abortion] that is done because she does not want to take care of herself, I will probably refer her to another colleague, but a patient who tells me '"I have studied all my life, I had a slip and right now I do not want to [give birth] because I am in a very good professional stage, I don't have the financial means'" or whatever reason, I'm probably going to [provide an abortion]. So, I would be like very picky, honestly." – Male physician, 30-39 years old

Formation of ethical perspectives about abortion

Commonly cited reasons for disagreeing with abortion were religion (n=9) and culture (n=5). Several participants stated they had become more open to abortion in certain cases, crediting medical education (n=2) and experience seeing patients in need of abortions (n=3). One participant explained the evolution of her perspective as follows:

> "I was raised religious. So, I thought that one should not have an abortion in any way. And after, when I went to medical school, I learned about therapeutic abortion, but all the same, I only supported therapeutic abortions. In recent years, my perspective has been

opened a little more… with what I see in people and I've seen that it is a right." - Female physician, 40-49 years old

All interviewees described doctors' opinions about abortions as varied. One participant stated that she "…Think[s] that there are mixed opinions and it depends a lot on the personality and cultural aspects, religious aspects of each physician" (Female physician, 30-39 years old). Most felt that the issue was quite polarized (n=13) though analyzing all interviews together revealed more nuanced perspectives among participants. One participant explained that:

"There are two sides. Those of us who want there to be a little more access, or for the law to change, for women to have more access to this. And those who are very conservative or religious who are totally against abortion." - Female physician, 40-49 years old

When asked to describe their colleagues' perspectives on abortion, half of interviewees (n=7) described their colleagues' willingness or aversion to practicing abortions rather than their ethical stance. Most believed that their colleagues would not perform abortions (n=8). For example, one participant asserted that he "…Do[es] not believe that the health professional of this country is prepared mentally and personally to perform an abortion in situation where the product is still alive" (Male resident, 30-39 years old). Several participants did not comment on their colleagues' opinions and only one, a resident, felt that most of their colleagues would be willing to perform abortions. Several described a concern among physicians that permitting abortions in more cases could open the door to broad, unrestricted legalization (n=5). As one participant put it:

"Many people, what they say is that it will be a justification for doing a lot of abortions, to say that, "Oh no, I did not want it", or to say "it makes me sad" or "it makes me worry,

I am going to abortion it". But it seems to me that yes, each case should be considered separately in that sense." – Female physician, 30-39 years old

Nonparticipation of the medical community in abortion policy

Several participants perceived a tendency of the medical community to avoid participation in the discussion about abortion policy (n=4) for reasons such as conflict avoidance and taboo. One participant explained that:

"The vast majority of doctors, we do not participate in that discussion. I think it has been the politicians, the Legislative Assembly, the religious societies that have participated the most actively. In general, generally speaking, doctors have not participated, and the Association of Gynecology and Obstetrics has not participated either. It has had a spectator aspect, we don't participate." - Male physician, 50-59 years old

Another participant elaborated on the effect taboo has on physicians' involvement in abortion discussions by explaining that:

"This is an issue that people don't want to talk about, they don't want to express an opinion, they don't want to get involved. It's a taboo subject, just like religion, it's a subject that nobody wants to talk about publicly, it's a secret subject" – Female physician, 60-69 years old

One participant described a disconnect between doctors and activists/politicians, stating that "the operational part is divorced from the law", whereby those involved in the practical aspect of providing abortions, who risk prosecution, are not the ones making laws and "feminist groups, all the people who promote this, are not the ones who end up doing the procedure" (Female physician, 40-49 years old).

Several participants (n=3) believed abortion is not a problem that warrants attention in Costa Rica. One participant observed that:

> "No one discusses [abortion], not at congresses, not in grand rounds, not in restaurants, not in our informal meetings. It's not a major issue for us right now and I don't think it's a country issue right now. It's an important issue for people who are involved in religions, in things like that, but for us it's not an important issue" - Male physician, 50-59 years old

Factors influencing medical provider attitudes toward participation in abortion care

Participants described a lack of clarity about laws regulating abortion care (n=12). As one participant explained:

> "One thing is the politics and that it has passed this guideline, and another thing is what happens in hospitals; we do not have the guide. The law was passed, but in the field, we have not received any training, we do not know, we have not received any information about the process to be able carry out the therapeutic abortion guide" - Female physician, 40-49 years old

Another participant explained that doctors are afraid to perform abortions "because, there is still much that is unknown about that. There still isn't a law that supports doing it. And there is much unknown regarding that" (Female physician, 40-49 years old).

Participants explained why they or their colleagues would conscientiously object or otherwise decline to perform abortions. In addition to the factors listed above that influence clinicians' reasoning about whether abortion is ethical, nearly half (n=7) identified the illegal status of abortion as a major inhibiting factor to participation in cases of medically necessity, indicating that many of their colleagues are unwilling to perform abortions due to lack of legal protection and fear of prosecution. Referring to physicians' participation in abortion care, one participant explained that:

> "What's scariest is a type of sanction because since it's still not legalized here, in Costa Rica… so the majority of people are afraid, of course. The matter of abortion here, in

> Costa Rica, is still penalized by law, so there still isn't a legislation that supports it or protects it." - Female physician, 40-49 years old

One participant also pointed to social pressures from colleagues and family, stating that "many people do not do it because the rest of the colleagues see it as bad or because their wife sees it as bad, their mother sees it as bad." (Female physician, 30-39 years old).

Several interviewees (n=4) – all of whom felt abortion is ethical in some situations and would support liberalization – mentioned they would decline to perform abortions even in legal situations. One participant elaborated by saying:

> "I have nothing against abortion. I mean, if someone wants to have an abortion, it's their decision, but I wouldn't do it. It's a personal issue for me as well. That is, if someone wants to abort, let them abort. I'm not going to judge her, but I'm not going to do it… I am not obligated and there is no law that obliges me to practice it" - Male physician, 50-59 years old

Irrespective of their stance on abortion, several interviewees (n=8) believed that medical professionals' ability to choose whether to participate should be protected. As one resident expressed:

> "They should give the health professional the option of whether to do it or not, even if the woman requests it. As a professional, I believe that it is necessary for one to be able to make the decision to do it or not. And if one does not want to do it, that it should not be penalized, in some way." - Female resident, 20-29 years old

The only two participants who felt that the majority of physicians supported or would practice abortion were residents; otherwise, no differences were found between physicians and residents by gender, age, or years of medical practice.

Discussion

This study represents a small but significant contribution to research on medical provider perspectives on abortion in restricted settings and, specifically, in Costa Rica. Studies show that doctors may base decisions about which patients deserve abortions on highly subjective assessments of individual patients such as compliance with medical advice, contraceptive behavior, and the woman's perceived credibility (8,18,24). In contrast, abortion providers with patient-centered perspectives describe their role as supportive to women who make the decision for herself (20). We found that many participants thought physicians should be the ones to decide whether abortion is ethical in specific cases, not simply whether it is medically necessary. When doctors function as judges of social morality, they have the power to restrict access to abortion based on factors unrelated to medical necessity (8). Clear guidance on circumstances in which abortion is legal is essential to ensure consistent access across health systems.

Physicians and medical associations worldwide have been influential in both the liberalization and restriction of abortion when they participate in advocacy and policy reform (25–27). Most participants in this study considered abortion to be ethical in circumstances beyond what is currently permitted by Costa Rican law but described a lack of participation of the medical community in abortion policy. This study reveals an opportunity for medical associations and other physician groups in Costa Rica to be engaged in discussions about abortion policy.

Participants identified a lack of understanding and training around current abortion law as a reason physicians may be unwilling to provide abortions in the Costa Rica. These participants felt that the heavily restricted status of induced abortion generates fear of prosecution among doctors and an unwillingness to provide services irrespective of ethical stance. This aligns with

research conducted in Argentina, Bolivia, Brazil, and Mexico, which also found that providers without clear policy guidance feared the potential repercussions associated with service provision (18,20,28). Conducting trainings with healthcare providers to clarify these policies could improve their willingness to provide abortion services to individuals that qualify for abortion services under Costa Rica's laws.

Strengths & Limitations

This study benefited from the collaboration of a multinational research team with diverse areas of expertise in qualitative research and healthcare. One limitation was the use of conferencing software rather than face-to-face interviews; there were some few periods of poor signal and difficulty ensuring interviewees were in a private setting. These issues were mitigated by reconvening with improved conditions when possible. Additionally, because all participants worked at urban, tertiary, public health facilities, perspectives about abortion care in smaller clinics and rural settings was limited.

Conclusion

Conscientious objection is sometimes used to refuse to provide abortions even when physicians believe the service to be ethically justified. Participants identified lack of understanding of the law, fear of legal repercussions, situational judgement as important factors that influence medical providers' willingness to provide therapeutic abortions. Initiatives to support, sensitize, and familiarize physicians with current laws could help prevent overuse of conscientious objection, normalize a taboo topic, and increase participation in abortion care and advocacy. Updated data on the incidence of abortion in Costa Rica could motivate providers who view abortion as unimportant to participate in the conversation.

Acknowledgements

This work was made possible through a generous grant from Emory Global Health Institute and support from the Global Elimination of Maternal Mortality Fund for Faculty Support. Many thanks to our Costa Rican research partners, who provided invaluable direction and support for this study, and to UCIMED for hosting the study. Finally, a word of appreciation for research team members, Melissa Cobb, Emma Halper, Amari O'Bannon, Adriana Otero Gonzalez, and Fabiola Gamboa Ross, for their contributions throughout the research process.

Contributors

All authors designed this study in collaboration with research team members listed in the acknowledgements. EP and DA conducted the in-depth semi-structured interviews. BEO, MH, and WC coded the transcripts in MAXQDA. WC led interpretation of the data and wrote this manuscript. All authors reviewed this manuscript.

Conflict of Interest

None declared.

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Chapter 5. Public Health Implications

This study found that most participants were supportive of therapeutic abortion and even believed it should be allowed in cases of rape and fetal malformations. However, supporting abortion ethically does not always equate to willingness to provide abortions. Physicians may invoke conscientious objection due to lack of understanding of the law, fear of legal repercussions, and situational judgment irrespective of their ethical stance. Such overuse of conscientious objection can create significant challenges to abortion access when healthcare providers are unfamiliar with or do not follow referral protocols and there are no accountability mechanisms to support compliance. Conscientious objection can create barriers to care if there are insufficient or unevenly distributed personnel to conduct a three-physician abortion review as is required by the Technical Standard, or if physicians object to providing services based on their personal assessment of whether an abortion is ethically justified.

The Caja Costarricense de Seguridad Social (CCSS) provided an optional three-hour "refresher" training course for public healthcare employees on the topic of therapeutic abortion . The course was held online in September, 2022 and included discussion of clinical practice protocols and conscientious objection ethics (CCSS, 2022). This is an excellent starting point to providing continuing education about abortion in Costa Rica. Conducting periodic, widespread, and accessible trainings could help to clarify the law and increase physicians' willingness to provide abortions or referrals. Orienting medical students to the law on therapeutic abortion, the Technical Standard, and clinical protocols could also help clarify misconceptions and dispel fears that create barriers to abortion access. Finally, the World Health Organization recommends adding values clarification exercises to abortion education to mitigate the effect of physicians' beliefs and attitudes on quality of care and professional judgment (WHO, 2012). Values

Clarification and Attitude Transformation (VCAT) has been shown to reduce abortion stigma among healthcare providers and improve knowledge and attitudes toward abortion care (Turner et al., 2018). Additional recommendations for abortion training content from WHO can be found in Appendix B.

Physicians and the larger medical community have a unique opportunity to influence the opinions of policy makers, religious leaders, and the public around abortion access and care. Their participation in policy and advocacy is crucial to move the abortion access conversation forward. However, lack of data on induced abortion may contribute to the perception that abortion is not a significant issue in Costa Rica and may prevent providers from taking action. Most study participants felt that induced abortion remains a taboo subject, several referencing this to explain why it is not a part of their formal medical education and why abortion is not frequently discussed among colleagues. These participants shared that the medical community largely avoids taking a stance on abortion because opinions are quite varied and the topic is taboo. Physicians who perceive abortion as unimportant or would rather avoid the discomfort of violating a taboo are unlikely to attend optional professional development workshops or participate in advocacy efforts to decriminalize abortion.

Healthcare providers need improved data on the magnitude of abortion in Costa Rica to justify and motivate participation in discussions and advocacy. Offering physicians a forum to engage in discussion about their concerns and experiences of stigmatization such as by offering Provider Share Workshops, could alleviate hesitancy to violate the taboo around abortion. By reducing perceptions of judgment and isolation, providers may be more willing to participate in discussions about abortion (Mosley et al., 2020).

Conclusion

Matters of conscience may lead physicians to form any ethical stance on abortion and may compel them to provide or refuse to provide abortion care. Conscientious objection can present barriers to abortion access and may be overused when physicians refuse to provide abortions even when they believe the service to be ethically justified. Participants identified lack of understanding of the law, fear of legal repercussions, and situational judgement, as important factors that influence physicians' willingness to provide therapeutic abortions in Costa Rica. Initiatives to support, sensitize, and familiarize physicians with current laws could help prevent overuse of conscientious objection, normalize discussion of abortion, and increase participation in abortion care and advocacy. Workshops to help physicians reflect on their beliefs about abortion may help reduce stigma and hesitancy to provide care. Updated data on the incidence of abortion in Costa Rica could motivate physicians who view abortion as unimportant to participate in conversations about advocacy and decriminalization. With improved data, training, and participation of the medical community, Costa Rica has an important opportunity to remove barriers to safe abortion care, reduce maternal morbidity and mortality, and strengthen their position as a champion for human rights.

Appendix A. Clinician Interview Guide

Introduction

Thank you for coming today and sharing some of your time with us. Our names are _____ and _____. We are public health master's students at Emory University and we are conducting summer research as part of our program.

This is a study that is being conducted by Emory University, in the United States, and UCIMED, on policies and healthcare practices related to unintended pregnancy and abortion in Costa Rica. By "unintended pregnancy", we mean pregnancies that were not expected and are not wanted. Our hope is that by understanding more about current behaviors, knowledge, and perceptions of unintended pregnancy and abortion, we can provide policymakers and clinicians with more information about the health needs of Costa Ricans and help inform future medical practice and policy development. We are really interested to hear what you have to say and want to know what you think is most important. There are no wrong or right answers.
This interview is voluntary, and you may choose to skip questions or end the interview at any time and for any reason. This interview will be confidential, and your name and other identifying information will not be recorded. Findings from this research will be shared with UCIMED, Costa Rican Ministry of Health officials, and may be published in academic journals, but we will not include any identifying information in our reports. Do you have any questions at this time? Do you consent to be interviewed? If so, please sign the consent form.
We would like to record our session to make sure we accurately capture what you share with us. Only members of the research team will have access to the recording to ensure that no important information is missed. We will also only record your voice from this interview; no video will be used. We will delete the recording after the interview is transcribed. Is it okay if we record the session today?

Turn on audio recorder if participant consents to recording.
Demographics
Before we begin the interview, I would like to confirm some of the information you shared when we spoke over the phone.

- Do you identify as male, female, or another gender? _____
- How old are you? _____
- How would you describe your religion? _____
- How long have you been working as a [nurse/physician/medical resident]? _____
- Do you work in a public or private health facility? _____
- Do you work at a primary, secondary, or tertiary health facility? _____
- Would you describe the health facility where you work as being rural or urban? _____

Warm-up
Now let's start with a few questions about you and your professional role.

1. How would you describe your current professional role?
2. What does a typical day look like for you at work?

Training and work environment

Now I would like to ask a few questions about your medical training and the environment where you work. As a reminder, by "unintended pregnancy", we mean pregnancies that were not expected and are not wanted. When I talk about induced abortions, I mean abortions that are provided at a health facility by a trained clinician. When I talk about post-abortion care, I am referring to when a woman has a miscarriage or tries to induce abortion without a trained clinician and comes to a health facility because of complications.

3. How were you taught about unintended pregnancy and abortion in medical school?
    a. What did you learn?
    b. Is there anything else you wish you had learned in medical school?
4. What training did you receive regarding contraception, prevention of unwanted pregnancy, unintended pregnancy, and abortion in your medical residency?
5. How are induced abortions discussed at your institution?
6. Is abortion a topic that you can discuss with your colleagues?
    a. If so, what kinds of conversations do you have about abortion?

Current practice with unintended pregnancy

I would like to ask some questions about your experience providing care to women with unintended pregnancies.

7. What typically happens in Costa Rica when a woman finds out that she has an unintended pregnancy?
    a. Where do women go for care when they have unintended pregnancies?
8. What is your experience counseling women who have an unintended pregnancy?
    a. When you counsel women with unintended pregnancies, what types of questions do you ask the woman?
9. What is your experience providing induced abortions to women??
    a. How do you feel about your role in providing care to these women?
10. What is your experience providing post-abortion care to women?
    a. How do you feel about your role in providing care to these women?
11. In which situations do you think providing an abortion is ethical?
    a. What influences your opinion on abortion?
    b. Do you think depression should be a reason to obtain a therapeutic abortion?

Policies related to reproductive health

Thank you for your insight on your work in reproductive health. Now we would like to learn more about your perspective on policies related to women's health.

12. Do you think women's rights are protected in Costa Rica?
    a. If yes: what protects them?
    b. If no: why not? How could they be better protected?
13. How do current policies reflect the healthcare needs of women in Costa Rica?
14. Who in Costa Rica is eligible to receive an induced abortion?
15. How do current abortion laws affect women's health?
16. How do doctors feel about the current reproductive health-related policies?

17. If laws and policies made induced abortion more accessible, how would you feel about providing care to women seeking an abortion?
18. If laws and policies made induced abortion more accessible, how do you think other providers would feel about providing care to women seeking an abortion?

Wrap-up

Thank you so much for sharing your perspectives today. We are learning a lot from you! We have just a couple of last questions before we end the interview.

18. How do you think medical practice related to abortion will look in Costa Rica in 10 years?
    a. What do you hope it will look like?
19. Is there anything else that you think we should know before we end the interview?

We have now reached the end of the interview. We want to thank you again for speaking with us today and sharing your experience with us. We really appreciate you taking the time to assist us with our research and we look forward to sharing our findings. If you would like to follow-up with us for any reason, you can call or text us at [whatsapp/Google #] or reach us at [insert team email].

Appendix B

WHO's Recommended Training Content for Abortion Service Providers (WHO, 2012)

Background for abortion service delivery:

- legal, regulatory and policy provisions;
- health effects of unsafe abortion;
- ethical responsibility to provide abortion (or to refer women when the health-care professional has conscientious objection to providing abortion) and to treat complications from unsafe abortion;
- national standards and guidelines for abortion care; y human rights related to safe abortion.

Counselling and provider–patient interaction:

- clarification of health-care provider attitudes and beliefs regarding abortion;
- confidentiality and privacy;
- interpersonal communication and counselling skills;
- information on abortion and contraception;
- issues and risks associated with HIV and other STIs;
- consideration of needs of all women, including adolescents, poor women, women from ethnic minorities, displaced women and refugees, women with disabilities, survivors of rape, women living with HIV or other STIs;
- recognition of signs that the woman has been subjected to violence, and guidance in helping her obtain additional counselling and services;
- informed decision-making.

Clinical skills:

- anatomy and physiology relevant to pregnancy and abortion;
- pre-procedure assessment (e.g. medical history, examinations, pregnancy dating);
- STI screening;
- cervical dilatation;
- uterine evacuation;
- infection prevention;
- pain management;
- recognition and management of complications of abortion;
- management and care following the procedure, including provision of contraceptive information, counselling and methods;

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