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Using the Social Ecological Model to Analyze Population Access to Abortion Care in Costa Rica: A Qualitative Study

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An abstract of
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Abstract

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By Emma Halper

Background: In Costa Rica, abortion is criminalized in all instances except "when the life of the woman is at risk".[1,2] Despite restrictions, individuals living in Costa Rica still seek abortion services outside of the public healthcare system. There is very little published literature that explores abortion access in Costa Rica or on the attitudes and opinions of the medical community and key policy makers, both of whom are involved in both shaping and implementing abortion policy in Costa Rica. No published research is available regarding the vulnerable populations' unique barriers to accessing safe abortion services in Costa Rica.

Methods: We conducted 22 in depth-interviews (IDIs) with OB/GYN clinicians (n=10) OB/GYN medical residents (n=3) and key policy stakeholders (n=8). We coded IDIs and analyzed them for themes using MAXQDA. The lead author completed additional analysis using the Social Ecological Model (SEM) to analyze determinants of abortion access for the general population and for vulnerable populations.

Results: A range of factors across the SEM were identified as impacting abortion access in Costa Rica. Both clinicians and stakeholders described barriers and facilitators to accessing abortion services and unique considerations for vulnerable populations. Themes at each level of SEM included access to comprehensive sexual health education (individual), interpersonal networks and familial support (interpersonal), gender biases and abortion stigma (community), provider abortion training, policy knowledge, stigma, beliefs and fear, and differences between public and private facilities (institutional/health system), migratory status, financial status, and the impact of religion on abortion policy (structural).

Conclusions: This is a unique study that contributes to a gap in published research around social determinants of abortion in Costa Rica, as well as around attitudes and opinions of the medical and stakeholder communities about abortion access and perceived barriers and facilitators to care. The study findings highlight an opportunity for expanded access to comprehensive sexual health education, abortion training for healthcare providers, and increased programming and advocacy efforts for safe abortion care and reproductive healthcare services, more broadly, for populations living in situations of vulnerability in Costa Rica.

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CHAPTER 1: INTRODUCTION

Background

The Latin America and Caribbean (LAC) region (and specifically Central America) is notorious for some of the world's most restrictive laws around abortion.[1] However, over the last two decades, the LAC region has experienced a major shift in reproductive health policies in regards to abortion legislation and contraceptive access.[2] In Costa Rica, specifically, abortion is criminalized in all circumstances except "to save the life or health of the woman".[3,4] In 2019, the President of Costa Rica introduced the *Norma Técnica* protocol (technical standard) to provide clarity to clinicians about when and how legal abortions could be provided under the penal code. Abortion is a contentious and stigmatized topic in Costa Rica, and despite calls for reform of the penal code to expand abortion legality, there remains strong opposition from conservative and religious groups. Little published research exists about opinions and attitudes of populations in Costa Rica who influence abortion policies, including health professionals and policy makers. Additionally, no information is available in published research about the perspectives and needs of Costa Rica's vulnerable populations, who are prominently represented in the population, related to abortion access. This thesis will fill gaps in the literature in these areas, as well as explore the current status of access to abortion services in Costa Rica, and determinants to its access.

Objectives and Significance

<u>Objectives:</u>

- The purpose of this thesis was to explore what clinicians and key policy stakeholders perceive to influence access to abortion services through a social determinants lens.
- The thesis' secondary objective was to explore what clinicians and key policy stakeholders perceive to be unique considerations for vulnerable populations in accessing abortion services in Costa Rica.

Significance:

The study aims to contribute to an understanding of social determinants of abortion access in Costa Rica for both the general population and vulnerable populations. Study findings will inform future programming and policy decisions related to expanding access to safe abortion services in Costa Rica and other restrictive environments in Central America, informing provider training needs, and implementation efforts for vulnerable populations.

A Note About Language

In this analysis, the terms "women" and "people who can become pregnant" or "people with pregnancy capacity" are used in different places. These terms were utilized intentionally to make the distinction between the author's voice and the language included in the literature and codified in Costa Rican and international laws and policies. This analysis also utilizes the term "vulnerable populations" to indicate populations living in situations of vulnerability who have been historically marginalized and may have compounded barriers to services and resources. In this analysis, this terminology is used to describe people with low-income status, refugee/immigrant/migrant status and who are ethnic minorities. There are other populations who are historically marginalized and experience substantial barriers to accessing resources and care (i.e., LGBTQ individuals, sex-workers, people living with disabilities, etc.) who are not included in this analysis given they were not discussed by participants.

CHAPTER 2: LITERATURE REVIEW

**Criteria for the articles included in this literature review were publication in the English or Spanish languages.*

As unintended pregnancy (UIP) is often linked with abortion (and information about access to abortion is limited), understanding larger issues related to UIP could be beneficial for understanding the abortion landscape, more broadly. This review of the literature will cover concepts related to UIP and abortion and will specifically include information about the conceptualization and measurement of UIP, determinants of UIP and abortion access, the context of UIP in the LAC region, and the Costa Rican context, specifically.

Unintended Pregnancy

How is it defined?

The U.S Centers for Disease Control and Prevention (CDC) defines unintended pregnancy as a pregnancy that is either unwanted or mistimed.[5] While the terms are often used interchangeably, 'mistimed' refers to pregnancies that occurred earlier than desired, whereas 'unwanted' refers to when no children, or no additional children, were desired.[6] Unintended pregnancy is an important indicator of the public health of a population and is often used as a proxy indicator of poor sexual health and the degree of autonomy that women have over their reproductive health options, including in determining if and when they want to have children.[7,8]

How is it measured?

Accurate measurement of pregnancy intentions is essential when determining behaviors and unmet needs for contraception. There exist several measures for unintended pregnancy management that have been utilized globally. Traditionally, unintended pregnancy has been measured retrospectively, such as with the National Survey of Family Growth (NSFG), the Pregnancy Risk Assessment Monitoring System (PRAMS), Demographic and Health Surveys (DHS), the Unintended Pregnancy Risk Index (UPRI).[6,9–11]. All of these measures compile a variation of information related to family life, contraceptive use, fertility, maternal attitudes, pregnancy history to assess previous pregnancy intentions. More recently, prospective

measurements have also been utilized more frequently and adapted to different contexts, such as with the London Measure of Unplanned Pregnancies (LMUP).[12–14]

Problems with its conceptualization & measurement

Defining and measuring unintended pregnancy are complex concepts that have been the topic of debate and both conceptual and methodological critiques.[6,9] Critiques are organized into the following elements: Conceptualization, Terminology, Recalling Intentions, Limited Comparability and Significance.

Conceptualization:

There exist several conceptual complexities to the way in which pregnancy intentions are measured and/or reported. Firstly, the majority of data on unintended pregnancy (including PRAMS) related to pregnancy intentions only captures a subset of pregnancies, which are from pregnancies that ended in live births. This leads itself to insufficient information being collected from pregnancies that ended in abortion, miscarriage or stillbirth.[6] Additionally, many of the existing measurement systems only include a single question on fertility intentions, which are then analyzed to determine whether or not a pregnancy was desired or not. This method is insufficient for analyzing the complexity of desires surrounding fertility, and intentions should be viewed and considered on a continuum instead of a dichotomy.[15] Further, the use of a single category to represent pregnancy intentions masks other apparent differences between those with unwanted vs. mistimed pregnancies.[16] In his 2019 paper, Potter et al. further emphasized the conceptual problem with current abortion measurement systems is that abortions and unintended births are often captured as 'equivalent adverse outcomes', which undermines reproductive autonomy of women who seek abortions.[16]

It is also important to note the importance of varying intentions when considering the conceptual assumptions underlying unintended pregnancy measures. For example, data (including from NSFG) has shown that pregnancy intentions between married people can vary greatly, and that discrepancy between partners may have an influence on the other's reported pregnancy intentions and their associated contraceptive behaviors.[6,17] Despite this, most existing measurement systems fail to consider or incorporate the fertility preferences of the partner.[15] A

2018 study on pregnancy decision-making affirmed this notion and emphasized the importance of incorporating the involvement of sexual partners in decision making, by including the men in the data collection. Further, the study characterized men's involvement in pregnancy decisions as "a balancing act between autonomy of decision making and needs of both the women and their partners".[18]

Literature has also included criticism of current unintended pregnancy measures for not fully considering varying contexts and the ways that different cultures characterize and conceptualize pregnancy intentions. For example, the idea that pregnancies are clearly intended or unintended may not be a concept that is universally applicable.[6]This is also relevant to the concept of ambivalence, where people feel conflicted about their pregnancy, which is not well captured in existing measures of pregnancy intention.[16,19] Additionally, the way that unintended pregnancies are viewed and experienced depends greatly on the social, cultural and political context.[13]

Terminology:

The terms "unwanted", and "mistimed" are often used reciprocally to designate unintended pregnancies, and data for the two are typically combined in studies related to pregnancy intentions. However, their meaning and circumstances in which they occur are important to analyze separately, as studies have shown that the risk behaviors and adverse experiences of women with unwanted versus mistimed pregnancies varied substantially. For example, the same study found that women aged 35 and over or pregnant were more likely to report that their pregnancy was unwanted rather than mistimed, likely speaking to the fact that they are more likely than younger women to have already achieved their desired family size.[20] Conflating "unwanted" and "mistimed" pregnancies in one category is common practice, but inadequate, as it obscures the diversity of actual experiences and of underlying factors associated with different situations, such as their differing interpersonal, social and political realities.[6]

In addition to this, studies have shown that women define and interpret the terms ''wanted'' or ''unwanted,'' ''planned'' or ''unplanned,'' and ''intended'' or ''unintended'' differently in relation to their pregnancies, contributing to the complications with its measurement.[7,21] Given the varied interpretations and understandings of these terms, "using these terms alone to discover the circumstances of women's pregnancies would be inadvisable".[7] Further, clarifying and

stratifying the differences in risk between those who identify their pregnancy as mistimed vs. unwanted will help inform decision-making for service provision to women and children.[20]

Recalling Intentions:

Conventional measures of unintended pregnancy are designed to reflect a woman's intentions before she became pregnant.[6] To achieve this, the majority of data collection around pregnancy intentions is collected and measured retrospectively.[22] This includes data collected by PRAMS, NSFG and DHS, among others.[15] Retrospective reporting leads to complications in assessing the data due to the recall bias, which is the systematic error caused by differences in accuracy of recollections from past events. Additionally, pregnancy intention status changes when comparing reports before pregnancy, during pregnancy and following a live birth.[23]

It is highly likely that when you ask people about their pregnancy intentions after having given birth, their opinions (or least reported opinions) will be modified, and the data that is collected is representative of their point of view at the time of data collection instead of their perspective pre-pregnancy.[24] This argument is supported by a 2006 study which illustrated a systematic shift in pregnancy intendedness, as "births originally classified as unwanted or mistimed became, over time, seen as wanted".[15] Further, literature speaks to the 'ex-post rationalization' that occurs in relation to pregnancy intention, where respondents have either accepted the baby and "either adapt to the reality of new offspring or are reluctant to describe existing births as having been mistimed or unwanted, so that births that were initially unintended become subsequently described as having been intended".[15,22,23] This is supported by a 2002 UK-based study by Barrett and Wellings, where they found that women were reluctant to characterize pregnancies that did not end in abortion as "unwanted" and found it overtly harsh to do so.[7]

This ex-post rationalization often looks like people reporting their current happiness with their child, despite their pregnancy being previously identified as unintended. Their satisfaction with their child at the time of data collection may result in a more positive recollection of past intentions and desires.[6] Because of this shift in reporting around pregnancy intentions, retrospective determination is said to be underestimated, further complicating the meaning and measurement of pregnancy intentions.[23]

Limited Comparability:

It is important to note the limitations of having several measurement systems for unintended pregnancies. When surveys utilize different instruments, inclusion criteria, survey questions, and timing of interviews, the comparability between the studies is limited.[25] An example of this is comparing the survey methods between NSFG (national estimate) and PRAMS (state estimates). Some differences include the number of relevant questions and the format of the survey. NSFG utilizes a series of questions related to pregnancy intentions, while PRAMS includes a single question. Also, NSFG is conducted as a face-to-face interview, while PRAMS is primarily a mail survey with follow-up via telephone calls. The method in which participants are asked (in person vs. via mail/phone) can also have an impact on the way that people respond in regard to their pregnancy intentions, with respondents generally more reluctant to answer sensitive questions when asked face-to-face.[20] Research has also found that when comparing NSFG data with PRAMS and other current measures of unintended pregnancies, there exist many contradictions "among assessments of pregnancy intention, contraceptive failure, and a woman's happiness or unhappiness at discovering she is pregnant".[6]

A 2017 study also highlighted the limited comparability between U.S and British measures of unintended pregnancy. Specifically, this study compared the NSFG—which is a timing-based-measure of pregnancy utilized in the US— with the LMUP on the same sample of women. Results found that they are not directly comparable in their current forms, as the US focuses its measures on unintended pregnancy, whereas the UK looks at unplanned pregnancy.[13]

Significance & Summary of Critiques:

Pregnancy planning and intention is a multifaceted and complex concept.[26] Clarifying issues related to meaning and measurement of unintended pregnancies is essential for improving public health and clinical programming efforts, especially in areas "where levels of fertility regulation remain low, contraceptive failure is common, and levels of unintended childbearing may be substantial".[15] Decision-making processes of people with pregnancy capacity around pregnancy are complex, and this complexity should be reflected in the measurement systems. For example, research has shown that these decision-making processes involve many factors, including but not limited to their relationship, plans for the future, moral considerations about abortion and

motherhood, and their living circumstances.[13,18] Modifying measurement systems to account for this complexity will lend itself to more robust data around pregnancy intentions, and by better understanding people's pregnancy intentions and behaviors, the global community will be able to better characterize and make important iterations to programs related to unmet need for family planning.[14,16] Further, incorporating or modifying measures to extend beyond unintended pregnancy will in effect "lessen the stigmatization of fertility among young women, poor women and women of color".[16]

Health Implications & Importance

An updated report from the United Nations Population Fund (UNFPA) included a striking statistic: "nearly half of all pregnancies, totaling 121 million each year throughout the world, are unintended".[27] This translates to an average of 331,000 unintended pregnancies each day.[27] The impact that unintended pregnancies can have on people with pregnancy capacity and their families is substantial-- with several notable health, economic, and social consequences.[22,28]

Maternal Health and Unsafe Abortion

Unintended pregnancies can have significant impacts on the health and wellbeing of the woman. Those who experience unintended pregnancy have been shown to also be at increased risk of mental health issues, including maternal depression, anxiety, and declines in psychosocial wellbeing. These conditions may arise as a direct result of the unintended pregnancy.[22] Studies have also found that unintended pregnancies are a significant risk factor for Self-Reported Postpartum Depressive Symptoms (SRPDS).[29]

In addition to mental health, unintended pregnancies can lead to increased risks for maternal morbidity and mortality.[30] Unintended pregnancy is also linked with maternal mortality in that in some settings may lead to unsafe abortion. The World Health Organization (WHO) defines unsafe abortions when pregnancies are terminated by people without necessary skills and information, or in an environment that does not meet minimal medical standards, or a combination of both[31]. Of the 121 million unintended pregnancies reported globally in 2022 by UNFPA, over 60% of them are reported to end in an abortion, translating to approximately 73 million abortions per year.[27] While abortion in and of itself is not a negative health outcome,

forty five percent of these abortions are estimated to be unsafe, hospitalizing approximately 7 million women a year globally, and causing between 5-13% of all maternal deaths.[27] Frequently reported complications of unsafe abortion include sepsis, hemorrhage, injury to internal organs, chronic pain, infertility, pelvic inflammatory disease, among other complications.[32,33]

Evidence has shown that differences in legal status, accessibility and provision of abortion and post abortion care lead to a significant discrepancy in risk associated with abortions. People with pregnant capacity who live in high-maternal mortality settings or in locations with highly restrictive abortion laws are more likely to have unsafe abortions and have a much greater risk to their maternal health and well-being, sometimes resulting in their death.[22,28] In countries where abortion is illegal and unsafe, unintended pregnancy has become a dominant contributor to maternal morbidity and mortality. Alternatively, countries that have more liberal abortion laws have lower rates of unintended pregnancy reported.[27]

Child Health

In addition to adverse effects on maternal health, literature points to associations between unintended pregnancy and increased risk for poor health outcomes, including considerable negative outcomes for child and family health.[6] Pregnancy intention is also a key determinant of maternal health behavior during pregnancy.[34] Studies have found that there exists a positive interaction between unintended pregnancies and maternal risk behaviors, such as drug and alcohol use, smoking, caffeine intake, as well as less use of daily multivitamins and/or folic acid supplementation during pregnancy.[8,22,35,36] Women with unwanted pregnancies were significantly more likely to participate in these unsafe pregnancy practices, which impact development and wellbeing of the fetus. Additionally, several studies have found that pregnancy intention has an impact on utilization of antenatal care: both in terms of when it is initiated (if at all) and how many visits occurred.[22,37] In addition to this, research has found that unintended pregnancies can have other adverse health impacts on the child, including on their nutritional status and child development.[22,38] This also applies to late recognition of pregnancy often present with unintended pregnancies, where research has shown an association between late recognition with preterm birth and low birth weight, among other adverse events.[36] Further, other studies have found significant associations between unintended pregnancy and risks of negative childcare outcomes and parenting difficulties, which can lead to child abuse and violence.[22]

Determinants of Unintended Pregnancy

Analysis of Determinants through the Socio-Ecological Model

WHO defines the Social Determinants of Health (SDH) as the "nonmedical factors that influence health outcomes", including " the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life".[39,40] SDH have a substantial impact on health outcomes, with research approximating that SDH accounts for between 30-55% of health outcomes.[40] The Social-Ecological Model (SEM) is often utilized as a theory-based framework to understand how SDOH can influence health decisions and behaviors. SEM was first developed by psychologist Urie Bronfenbrenner in the 1970's, and it considers the "complex interplay between individual, relationship, community, and societal factors" and allows for analysis of how factors at one level influences factors at another.[39] The SEM has been utilized across health topics to identify and understand complex health issues and patterns and overlapping levels of influence, and identify points of intervention.[41,42]

While there exist several iterations of the SEM with varying levels and applications, this thesis will utilize a model utilized by Kaufman et al (and a related model by Tirado & Chu, 2020 which makes minor adaptations to Kaufman et al) which builds on Bronfenbrenner's original framework.[43,44] This conceptual framework includes 4 levels. These levels include 1) the individual level, 2) the social and community level, 3) the institutional/health system level and 4) the structural level. Details of the factors at each level include the following table:

Figure 1: Factors at Each Level of the Social Ecological Model

Level	**Definition**
Individual	Knowledge/information, emotions, motivations, personal beliefs
Social and Community	Social networks, social support, family and peer influences, formal or informal social norms, peer pressure, community organizations
Institutional/ Health System	Health services, education/training of health providers, culturally competent environment, confidentiality/privacy, support tools

Structural	Public policies and laws, political context, poverty, access to services (infrastructure), cost of services

Determinants of Unintended Pregnancy

Given the complexity of factors that influence sexual and reproductive health behaviors and decisions, the SEM has long been utilized in the field of sexual and reproductive health, including for topics of contraceptive use, SRHR and pregnancy prevention.[41,44,45]

Looking at unintended pregnancies is no different: unintended pregnancies impose significant burdens on populations globally, and there exist many overlapping, contextual factors that impact the magnitude of unintended pregnancies on individuals. SEM offers a theoretical framework for reviewing unintended pregnancies and their determinants.

The Individual Level

On an individual level, knowledge of pregnancy prevention methods is a key determinant to unintended pregnancy prevention. A 2021 study from Ajayi et al also identified lack of knowledge, religious beliefs, and misconceptions of contraceptive safety and effectiveness and leading barriers to under-utilization of contraception to prevent unwanted pregnancies.[46] The same study attributed poor knowledge around pregnancy prevention methods to abstinence-only information and myths and misconceptions around contraception.[46] A 2019 report from PAHO also identified several individual-level drivers of adolescent pregnancy in the LAC region, including: puberty during adolescence, lack of knowledge about sexuality and reproduction, early or forced sexual initiation or union, inconsistent contraception use, misconceptions about contraceptive use, and sense of self/future perspectives.[47]

While not a *social* determinant, age is also a key determinant in unintended pregnancy rates. A 2016 study found that adolescent women experience unintended pregnancies at a rate that is substantially higher than other age groups, and that the highest rate is seen among young women aged 20-24.[48] Literature has also shown that adolescent pregnancies result in social stigmatization, ostracization, and psychological distress for the young mother, among other adverse health, education, social and economic consequences.[49,50]

The Social and Community Level

On an interpersonal level, age can also impact the information that is received by healthcare providers about pregnancy prevention methods. For example, a 2013 study showed that almost 50% of pediatricians prefer to offer abstinence-only information to adolescents.[51] Society and community-level influences are also significant when looking at the impact that family and friends (and their support of or opposition to contraception) can have on contraceptive behaviors and prevention of unintended pregnancies.[46]

The Institutional/ Health System Level

On an institutional level, limited training from health providers about contraceptive counseling as well as insufficient time for consultations with patients can have a substantial impact on contraceptive use and patient knowledge about pregnancy prevention.[46] Additionally, a study focused on SRH services for populations living in vulnerable situations found that at the health system level, lack of confidentiality and adolescent-friendly health services were barriers to access and care for pregnancy prevention and care.[44]

The Structural Level

On a structural level, poverty is widely considered to be a leading driving factor in unintended pregnancy risk around the world, and economically disadvantaged women experience the highest rates of unintended pregnancy.[22,48] Socioeconomic status also plays a large role in a woman's ability to obtain health services, such as adequate antenatal care, thus also increasing the risk of negative maternal and child health outcomes for those experiencing unintended pregnancy.[52] Research found that births that come from unintended pregnancies have an increased risk of various health and social outcomes, "independently or because of their association with women's disadvantaged social and economic status.[9]

The correlation between higher rates of unintended pregnancy and poverty can be explained by lessened access to contraception, worsened educational opportunities, as well as a greater likelihood to live in a rural or underserved environment with less physical accessibility to services.[27] Additionally, a 2014 study found that adolescent girls of lower socioeconomic status living in places with high income inequality exposed them to greater risks of unintended

pregnancy, likely attributable to lower expectations of their future economic success.[49,53] The impact of poverty is also especially relevant in locations where abortion is restricted, as low-income women are much less likely than higher-income women to be able to pay for services or travel to a location where abortion is less restricted.[54]

Another structural, contextual factor includes whether the unintended pregnancy occurred in a conflict setting. Evidence has shown that in conflict settings, people with pregnancy capacity lose access to contraception, and there is a higher unmet need for contraception, causing pregnancy rates to surge.[27] In general, women are denied agency at all levels, including their right to access care and exercise their bodily autonomy.[27] Also in conflict situations, women have increased exposure to sexual violence as there are breakdowns in protective mechanisms. Refugees and internally displaced persons (IDPs) are highly vulnerable to sexual violence during conflict situations, as seen by an estimated prevalence of 21.4% experienced by this population.[55] A 2020 study by Erhardt-Ohren & Lewinger also found that refugee women are more likely to experience unintended pregnancies and have higher need for abortion services.[56] Given their limited access to resources and other barriers experienced such as limited access to contraception and quality SRH care, these populations are also more likely to experience unsafe abortions as a result of their unwanted pregnancy.[56]

Unintended Pregnancy Management & Abortion

The three options for unintended pregnancy management include 1) continuing the pregnancy and raising the child, 2) continuing the pregnancy and selecting adoption, and 3) terminating the pregnancy through an induced abortion.[57] The decision that the woman makes is dependent on many factors, and is greatly influenced by the social, cultural and economic context they live in. Using the SEM, examples of the overlapping levels of influence which contribute to unintended pregnancy management decisions include the following:

The Individual Level

Individual knowledge around options for unintended pregnancy management (and comprehension of SRH information) may also influence their decision-making process.[44] Also at the individual level, one's marital status, economic independence, education level, and/or

whether they are the victim of rape and/or incest all have an impact on decision-making.[58,59] Additionally, people with pregnancy capacity who identify as religious and may not approve of abortion may be more likely to continue their pregnancy and either decide to raise the child or put them up for adoption.[57,60]

The Social and Community Level

At the social and community level, parental/ family support and support from one's partner both play a key role in the decision-making process for unintended pregnancy management.[58,61] A 2018 Mozambique-based study found that lack of support from the partner to continue the pregnancy or 'refusal of paternity' from their partner was frequently identified as the leading wanting to end the pregnancy.[58]

Additionally, studies also show that unintended pregnancy management decisions are greatly influenced by the age of the woman, and that many factors overlap in the decision-making process for young women. For example, a 2012 US-based study highlighted the marginalization and discrimination experienced by young women with unintended pregnancies, which may be further exacerbated by their pregnancy resolution given the stigma around both abortion and childbearing.[53] This was supported by the findings of a 2020 Kenya-based study that highlighted the negative treatment pregnant teen girls receive from their community members, and were often "shunned, disparaged [and] forbidden to talk to other girls because they were considered to be 'girls of loose morals'". This treatment often led teens to utilize several coping strategies, such as moving to a new place, hiding from the public until after their delivery, and planning to put their child up for adoption upon delivery.[49] Studies from both high and lower-middle income countries (LMIC) have also found that adolescents who decide to continue the pregnancy are at a higher risk for longer term social and health consequences, including employment and educational impacts (such as losing their job or being forced to drop out of school), intimate partner violence, and mental health issues.[49,62]

Other societal determinants that influence the decision if and how to terminate a pregnancy include social norms, stigma (around both extra-marital and premarital sex) and autonomy within society.[58] A 2018 Mozambique-based study explored the influence of autonomy in pregnancy decision-making, and found that in most cases, decisions about whether to terminate a pregnancy

were influenced by others, and decisions to keep or end a pregnancy were sometimes made against their will".[58] These study findings emphasize the linkages between abortion decision-making and both power (namely power imbalances) and gender inequality.[58]

The Institutional/ Health System Level

Another factor which influences one's decision-making process is the information that is made available to them by their health provider, and whether they have access to a health provider at all. A 2009 US-based study emphasized the importance of pregnancy options counseling, including providing educational resources to pregnant women, and found that providing such resources may be instrumental in the decision-making process. Further, they found that "cognitive processing is likely to be inhibited by the initial shock of pregnancy status" so providing supplementary resources to women can have a substantial impact on their actions.[57] Another US-based study highlighted the importance of non-judgmental information being provided about pregnancy management options from physicians to their patients. The information they deemed essential to share with pregnant women includes information about financial assistance, adoption options, safe and legal abortion options and locations to access them.[63] In situations where the provider has a moral objection against abortion provision, the authors stated the obligation that providers have in referring their patients to someone else that may be able to provide abortion care in a timely manner.[63] In places where abortion is restricted and there exists stigma around its provision, conscientious objection of providers is more likely to be present, and the provision of non-judgmental information from providers about abortion may not be as likely.

Frederico's 2018 Mozambique-based study supported this notion, and also found that a recurring factor which negatively impacted a woman's decision-making process surrounding their pregnancy was the "overpowering influence of providers on the decisions made". The study also found that in many cases, providers are not sufficiently informed on national abortion laws, which can have a significant impact on what is withheld or offered during consultations.[58]

The Structural Level

Structural factors such as economic and policy forces also shape pregnancy decision making. Kearney and Levine's 2012 US-based study explored the impact of financial status on pregnancy

decisions, and found that adolescent girls of lower socioeconomic status in locations of great income inequality were more likely to continue their pregnancy, in comparison to adolescent girls of higher socioeconomic status in locations of less income inequality, who were more likely to access induced abortions.[49,62]

Another key factor that plays a role in determining one's pregnancy decision-making is related to the legal context surrounding abortion access. For example, in many places where abortion is restricted or illegal, people with pregnancy capacity may not be able to select to terminate their pregnancy, or at least do so under safe circumstances. Locations in which abortion is criminalized or highly restricted are often characterized by strong religious environments where abortion is deemed immoral. In these settings, individuals of higher socioeconomic status may be able to leave the country to seek abortion services in a location where they are accessible or be able to have increased access to abortion medication networks.[58] However, people with pregnancy capacity of lower socioeconomic status may need to opt to have unsafe abortions (which includes pregnancies that are terminated by people with insufficient skills/information and/or in an environment where minimum medical standards are not met) or may be forced to continue their pregnancy.[31]

SRH & Abortion Policy Landscape in Latin America

Pregnancy and Abortion Related Outcomes

According to Guttmacher, there were approximately 11,900,000 annual pregnancies in the Latin America and Caribbean (LAC) region between 2015-2019.[64] Of these, approximately 7,920,000 (67%) were classified as an unintended pregnancy, and around 3,680,000 (31%) ended in abortion.[64] DHS data has shown that as a region, LAC has some of the world's highest rates of unintended pregnancy.[22]

In a 2018 report by PAHO, UNICEF and UNFPA, the LAC region was also reported to have the second highest rates of adolescent pregnancy in the world, second only to Sub-Saharan Africa.[47] Region-wide, the estimated adolescent pregnancy rate was calculated to be 66.5 births per 1,000 girls aged 15-19 years old, accounting for 15% of all pregnancies and approximately 2 million

children born to adolescent mothers each year.[47] The LAC region also comes second only to the East Africa region with regards to unsafe abortion rates. This is likely attributable to the region having some of the world's most restrictive abortion policies, detailed in the following section of the literature review.[47]

Determinants of Abortion Access

While the LAC region is large and varied-- making generalization difficult-- there exist commonalities in terms of the SRH landscape and the factors which influence access to SRH services, and reception towards abortion.[65]

LAC Abortion Access: Individual Level

At the individual level, several factors influence the abortion landscape and abortion-related complications in the LAC region, including personal demographic characteristics such as education level and marital status. For example, a 2021 WHO study found that severe abortion-related complications were associated with being single.[66] The same study found that age, marital status and education all have an impact on whether or not women present at facilities with abortion related complications and seek post-abortion care (PAC).[66] The study found that across Argentina, Bolivia, Brazil, the Dominican Republic, El Salvador and Peru, the women who sought PAC shared many characteristics. For example, the women were predominantly in the 20-29 age group, married (or cohabitating with a partner) and had at least a secondary education.[66]

LAC Abortion Access: The Social and Community Level

Cultural factors in the LAC region also have an influence on high rates of abortion, such as gender dynamics and patriarchal influences. For example, the influence of machismo is pervasive throughout the region, and in many contexts, these social patterns lead to limited acceptance of gender equality and women's reproductive rights, as well as rigid definitions of sexual behavior.[65,67] While female sexuality is generally less repressed than it once was, women are often still considered solely responsible for pregnancy prevention and the consequences of sexual behavior. This is supported by the fact that in the LAC region, men are rarely considered in the design or thinking of sexual and reproductive health services and campaigns, as they often

target only the women.[65]Other socio-cultural barriers exist which impact access to abortion-related services, such as stigma around reporting rape. While some countries do not allow for therapeutic abortions in situations of domestic violence or rape, others do allow for legal abortions in these circumstances. However, the requirements for reporting rape and violence are often taxing and women are deterred from reporting the situation due to fear of public shame.[65] Social taboos also play roles in much of the LAC region in deterring unmarried women from seeking contraception, or discussing pregnancy prevention within their social networks.[65]

A 2021 WHO study also emphasized the role that stigma has on abortion practices in the LAC region. It found that abortion stigma often "leads women to seek delayed care or avoid the health system entirely due to lack of information on how and when to seek post abortion care".[66]

LAC Abortion Access: The Institutional/Health Systems Level

Across the LAC region, the quality of reproductive health care services has been found to be a leading determinant in under-utilization of care, especially for public sector services.[33] Additionally, certain institutional barriers related to privacy risks impact abortion decision making. A Human Rights Watch report found that breaches of patient confidentiality may deter people with pregnancy capacity from seeking consultations or services related to abortion care.[68] Additionally, it found that countries in Latin America that mandate doctors and other health providers to report cases of individuals who have had abortions further infringes on rights to privacy and deter people with pregnancy capacity from seeking care. This lack of privacy, paired with lack of confidentiality and in some cases, parental consent requirements, also poses unique barriers to access to high quality SRH information and services.[68]

LAC Abortion Access: The Structural Level

Socioeconomic Status (SES): Across the LAC region, more widespread socio-economic inequalities exist than in any other region.[69] This disparity lends itself to major differences in health outcomes for people with pregnancy capacity in general, with individuals who seek unsafe abortions experiencing substantially worse health outcomes.[65] Socio-economic status is a key determinant of access to safe, quality health services.[65] In the LAC region, access to services for safe abortion "has never been straightforward" and is even more complicated for people with pregnancy capacity who are poor.[65] While people with pregnancy capacity with more financial

means can anonymously seek abortion services in the private sector or leave the country to access care in a place where the procedure is legal, this is not feasible for low-income people with pregnancy capacity. While family planning and reproductive health services have become more available across the region in general, low-income and marginalized people with pregnancy capacity face compounded barriers to access to these services.[65] A 2006 Guatemala-based study found extreme poverty to be a key barrier in worsened access to contraceptives and health facilities for services related to pregnancy prevention.[33]

People with pregnancy capacity with fewer resources are more likely to resort to unsafe methods for abortion. Criminalizing abortion intensifies inequality and as well as experiences of discrimination for low-income people with pregnancy capacity.[65] Low-income people with pregnancy capacity, for example, who are hospitalized for complications with their abortions are also more likely to be reported to the police by physicians who work in the public sector.[65]

Religion: Catholicism and Protestant Evangelicalism are the predominant religions in the LAC region.[70] The relationship between church and state in the LAC region is considered to be more 'intimate' and 'involved' than in other regions.[71] Both religions are generally opposed to abortion, which has led to social and political clashes, and has brought the topic to the forefront of much of Latin American politics.[65] The opposition of Catholic church leaders and associated political groups to expanding abortion legality is widely considered as a reason for minimal progress in reducing abortion rates in the region.[65] In his 2011 paper, Kulczycki characterized abortion as a 'bargaining chip' between conservative sectors and government leaders and highlighted the church's attempt to limit abortion services in efforts to maintain traditional gender roles, and prevent increased sexual autonomy.[65] This notion was supported by Morgan, who in 2014 stated that the 'recent emergence of Latin America' is the 'locus of the Church's efforts to control reproduction.[72] The role of religion in shaping abortion national policy and political decisions more broadly, is supported by the findings of a 2012 study in Mexico. This study, which aimed to characterize the role of lawyers in shaping the abortion debate, found that stakeholders were most influenced by factors such as level of religiosity and routine church attendance.[72]

Policy: As stated previously, research has found that restrictive national policies in the LAC region can have profound impacts on the provision of quality and safe reproductive health care.[66] A 2021 WHO study emphasized the association between unsafe abortion and restrictive abortion laws, and found that "an enabling environment and legal grounds play a role in abortion safety".[66] The following section will go into detail around the abortion policy landscape in the LAC region and the range of criminalization.

Regional Abortion Policy Landscape

The Latin America and Caribbean region includes a vast range in abortion policy and has experienced notable shifts over in the past decades, with some countries becoming more progressive and others more restrictive with national legislation. Overall, the region has become more liberalized toward abortion policy over the past two decades, with some of the most significant transformations being in countries with substantial feminist activism and grassroots mobilization activities, which will be discussed further below.[65,73] Countries with notable advancements in liberal abortion policy include Colombia, Argentina, Uruguay, and certain states of Mexico. Commonalities in all four countries, include that abortion has been decriminalized with gestational limits, is permitted in the case of rape, there exist national guidelines for abortion (and post abortion care), among others.[74]

In much of the region, however, there still exists great restrictions towards abortion access. In 2018, it was reported that more than 97% of women of reproductive age in the region live in countries with restrictive abortion laws.[76,75] Countries such as Paraguay, Venezuela, Guatemala, Peru and Costa Rica maintain restrictive abortion laws where abortion is not available on the woman's request, but include therapeutic exceptions for access for when the mother's life is at risk.[76] In all of these countries, there also exists no legal provision of abortion in situations of fetal impairment, rape, incest, or mental/physical health.

As mentioned above, the Latin America and Caribbean region also houses some of the world's most restrictive abortion policies, with several countries maintaining full restrictions on abortion without exception, even in situations where the mother's life is at risk. These countries include El Salvador, Nicaragua, Honduras, the Dominican Republic, and Haiti.[76] Of these, El Salvador, Nicaragua and Honduras are located in Central America, and all have experienced changes to

their abortion policies in the past two decades to make them even more restrictive. In these three countries, there exist several commonalities regarding the restrictions and abortion landscape: including that people with pregnancy capacity are being denied life-saving medical treatments, health care providers are deterred from providing emergency obstetric procedure, and people with pregnancy capacity are experiencing increasing rates of unintended pregnancy (especially among adolescents), unsafe abortions and maternal deaths.[65,77,78] Additionally, in Honduras, both the use and sale of emergency contraception is illegal , further limiting people with pregnancy capacity's options to prevent unwanted pregnancy.[2] All three countries have had several landmark cases that have brought their restrictive legislation to an international audience without resulting in policy changes. Additionally, the three countries share an additional commonality: they experience some of the world's highest rates of violent crime, which when paired with restrictive legislation and decreased access to reproductive health care services and education, render the people with pregnancy capacity living in these countries even more vulnerable and likely to experience unintended pregnancy, contributing to high rates of unsafe abortion. A 2010 study also found that in Central America, fertility rates were substantially higher in comparison to the Latin American average, which was also likely attributable to higher poverty rates and decreased access to resources.[79]

Regional Abortion Activism

Abortion policy is subject to much political activism in the region, including from individual grassroots movements, international bodies, and non-governmental organizations (NGOs), among other groups. One of the most prominent sources of abortion activism across the LAC region is the Green Wave. The Green Wave (or *La Marea Verde)* is a grassroots, feminist advocacy movement that has had a substantial impact on abortion policy in the LAC region. The movement arose from the #NiUnaMenos (*Not One Woman Less*) campaign in Argentina in response to increasing rates of femicide and violence against women.[80] Since its inception, the Green Wave has pushed governments to decriminalize and expand abortion access through mass popular protests.[81] It began in Argentina and has since spread to several additional countries throughout the region and has successfully influenced abortion policies in both Colombia and Mexico. The reforms in these three countries as a result of the movement are groundbreaking, as Argentina, Colombia and Mexico are all traditionally Catholic, conservative countries.[81,82] The

Green Wave movement has been both supported and strengthened by large, international networks of feminist, sexual and reproductive health rights and human rights groups.[81] This advocacy has made substantial progress in many areas related to sexual and reproductive health, including: expanding access to information about the importance of reproductive health care provision, training healthcare workers to provide post-abortion care; increasing access to emergency contraceptives and misoprostol; and providing legal support to protect and expand national policies around safe and legal abortion.[65]

Complementary to the efforts of the Green Wave movement, the Inter-American Commission of Human Rights (IACHR) has led many regional advocacy efforts in relation to increasing access to safe and legal abortion in the region. IACHR is an autonomous organ of the Organization of American States (OAS) dedicated to both promoting and protecting human rights in the American hemisphere. IACHR oversees member states' adherence to human rights, analyzes and investigates petitions regarding human rights violations, refers cases to the Inter-American Court of Human Rights and supports the litigation process and publishes reports on human rights violations, among other duties.[83] IACHR strongly supports the notion that restrictive abortion legislation hinders the dignity of women and their rights, including their rights to life, to health, to personal integrity, and to live a life free of violence and discrimination.[84] Further, in a 2017 press release, IACHR stated that "the absolute criminalization of abortion, including in cases where the woman's life is at risk and when the pregnancy results from a rape or incest, imposes a disproportionate burden on the exercise of women's rights and creates a context that facilitates unsafe abortions and high rates of maternal mortality."[85] IACHR has played a key role in several landmark cases related to abortion in the LAC region, and has supported individuals in filing cases against their country's government. For instance, in 2021, IACHR filed the 'Beatriz case' regarding El Salvador's total abortion ban. Beatriz was a young woman living in extreme poverty who experienced a high-risk pregnancy such that her fetus would not survive out of the womb and sought termination. Despite this, the government of El Salvador did not permit her to terminate her pregnancy. IACHR concluded that in this case, the state was liable for " violating the rights to life, humane treatment, judicial guarantees, privacy, equality before the law, judicial protection, and health held in the American Convention", among others.[85]

NGOs also play a role in applying pressure against states' restrictive abortion policies. For example, in 2011, three Argentinean rights organizations took a case to the UN Human Rights Committee about a young, disabled girl who was raped by a family member, became pregnant and was denied an abortion.[86] Over the last few decades, NGOs have made other gains across the region, such as by submitting shadow reports to UN treaty bodies, filing cases with different courts and human rights bodies, lobbying legislators to improve access to services, holding political leaders accountable during election campaigns, among other actions.[86] This activism has brought about policy changes related to sexual and reproductive rights, as well as with domestic violence, emergency contraception, sterilization and assessed reproductive technologies.[87]

It is also important to highlight both the existence and impact of anti-abortion, religious activism throughout the region. Conservative activists from Catholic and Evangelical churches have used their networks to pressure political leaders to resist reform and sexual and reproductive rights movements, in general. Often, the resistance has claimed that "the movement to liberalize abortion laws 'comes in the guise of reducing maternal mortality'".[88] In her 2017 paper on anti-abortion activism in the LAC region, Morgan describes the impact of 2014's Dublin Declaration on Maternal Healthcare, which states unequivocally that abortion is never necessary in any circumstances. While this argument lacks support from evidence, it has been utilized throughout the region to advocate for keeping abortion bans in place and provides authorities with an excuse to deny requests based on medical need.[88] Another example of anti-abortion regional advocacy can be seen with the OAS General Assembly in 2020, where the Ibero Congress for Life and Family-- an evangelical, pro-life coalition formed by pro-life politicians from Latin America and Spain -- participated and were given the opportunity to spread their messaging. In addition, several conservative lawmakers from the United States have made their contempt known on the topic. In 2016, select Republican Senators banded together to write a letter to the U.S Department of State, in which they claimed that the OAS (and thus, IACHR) is funding 'cultural imperialism' related to abortion in the region which they argued should be halted immediately.[89] These are only a few examples of how anti-abortion, religious activism has been used to advocate for tightening of abortion restrictions.

Costa Rican Context

Population

The United Nations Population Division and the World Bank both estimated the total population of Costa Rica in 2021 to be approximately 5,154,000.[90,91] In 2021, 21% of the population was made up of people 0-14, 69% of the population was made up of people 15-64, and 11% of the population was made up of people ages 65 and above.[92,93] In terms of gender distribution, 2021 data shows a 50-50 split between men and women.[91]

Costa Rica is divided into seven provinces and 84 cantons, and according to the World Bank, in 2021, 81% of the country's inhabitants live in urban areas.[94] Costa Rica does also have a small but present indigenous population, divided among eight different ethnic groups, and making up approximately 2% of the country's total population.[95,96] Costa Rica also has a notable population of foreign-born individuals, which will be detailed in the following sections.

Progressive Social Policy

Costa Rica is acclaimed for having one of the strongest social policy regimes in South America.[97,98] In 1948, Costa Rica abolished their national military and redirected its budget towards healthcare, education and environmental protection measures.[99,100] This decision to demilitarize Costa Rica and its impacts on society have been referred to as their 'peace divided' by some journalists.[101] Since then, Costa Rica has maintained its status as one of the world leaders in progressive environmental policies, and has committed to decarbonize its economy by 2050 and has put into action the policies to achieve its lofty goal.[102] Additionally, they have been able to make landmark investments in protecting its national parks, biological reserves and other land areas.[101] Costa Rica has also made substantial advancements on the immigration front, for which it is considered a world leader in progressive immigration policies. For example, the 2010 Migration Law (Law 8764) which emphasized progressive reforms related to social inclusion of the migrant population, such as facilitating the regularization of undocumented migrants into the country.[103] More information about this important subgroup in Costa Rica is described in detail below:

Refugee, Immigrant, Migrant and Asylum-Seeking Population in Costa Rica

Overall, Costa Rica is renowned for its welcoming reputation and acceptance towards foreigners, as evidenced by its substantial populations of refugees, immigrants, and migrants in the country. In 2016, the United States Ambassador to Costa Rica stated that “Costa Rica is a model for the world on how to treat refugees", and it is often described as a ‘magnet for migrants’ by CNN and other news sources.[104] Costa Rica is one of the few net immigration countries in the Latin America and Caribbean region, and welcomes populations from all over the world, including ‘intra-regional migrants’ (mainly from Nicaragua, El Salvador, Haiti, Colombia, Venezuela and Cuba), as well as from West Africa and Southeast Asia, among other locations.[99,104–106]. In recent years, Costa Rica has also seen much greater rates of migrants and asylum seekers looking to enter the country as violence has spiked in Northern Triangle countries, motivating more people from Honduras, Guatemala and El Salvador to leave their countries of origin and look for better living conditions and employment opportunities elsewhere.[99,107] This is supported by UNHCR's 2023 estimates of approximately 356,000 asylum seekers in the country, with the great majority coming from Nicaragua.[108] Migration Policy Institute reported 64,000 Nicaraguans applying for refugee status between 2018 and 2020, 2016 data also showed that an estimated 150 migrants entered Costa Rica per day, which is likely an understatement of the true amount.[103,104] More recent figures estimate migrants making up between 13-15% of the country’s population.[106]

As mentioned previously, the largest population of foreigners in Costa Rica come from Nicaragua-- Costa Rica’s northern neighbor-- who constitute 75% of Costa Rica’s migrant population.[97] According to Costa Rica’s 2011 census, there were 290,000 Nicaraguans registered in Costa Rica, accounting for 6.7% of its total population. This is also likely an underestimation of the total percentage, given the large population of Nicaraguans that work in the domestic and informal sectors.[109]

Despite its welcoming nature towards foreigners into the country, there exist barriers faced by the population, such as financial hardship, decreased physical access to resources, and discrimination, among others. On a national level, Costa Rica has one of the world’s highest rates of income inequality in the world, which is driven in large part by the informal employment sector. The informal employment sector is comprised mostly of low-income Costa Ricans and the refugee, immigrant and migrant population, for whom the effects of income inequality are

amplified.[99,105] In terms of physical/structural barriers, migrant populations are often concentrated in secluded pockets of the countries, such as with the Nicaraguan population in La Carpio, located in La Uruca district of Costa Rica's capital, San José. According to Costa Rica's 2000 Census, La Carpio was 49% Nicaraguan, and is characterized as the largest binational community in the country, and Central America's largest migrant settlement.[110] Sandoval further emphasized the relationship between symbolic stigmatization and spatial segregation, and highlighted that many migrant communities, such as La Carpio, experience substantial physical factors which prevent their growth and access to other communities and services[110]. The physical and structural barriers faced by migrant populations are also intensified by the immigrant hostility and class stigmatization that this population already experiences. Research points to differing levels of discrimination experienced by Costa Rica's foreign-born community, with Nicaraguans receiving the worst of it. In Costa Rica, Nicaraguans are often colloquially blamed for society's social ills, such as employment and health care shortages and burdens to the social security system.[87,110] Despite this, researchers found little evidence that migrants used more health resources than their share in the population.[97]

Health System

Costa Rica is known to have largely achieved universal health coverage through its system of integrated, socialized medicine, and is one of the few countries in Latin America to do so.[111] Since its inception in the 1940s, the Caja Costarricense del Seguro Social (Costa Rican Social Security Fund, or CCSS) has served as the public institution in charge of the provision of public health care in Costa Rica.[99] The CCSS is an autonomous institution that essentially functions as the single insurer in Costa Rica and both purchases and provides care services. While the Ministry of Health helps set policies around national health priorities, they do not provide direct care and remain external to the processes of CCSS.[111–114] Provision of care does exist outside of the CCSS network with private providers and NGOs for some services; it is limited as evidenced by the approximate 90% coverage rate within Costa Rica.[111]

CCSS has a multi-tiered health system, with primary care at the bottom and tertiary care at the top.[113] Equipos Básicos de Atención Integral de Salud (EBAIS) clinics function as comprehensive primary health care clinics and are the first point of contact for healthcare

services. EBAIS clinics are 'assigned' to the population based on geographic empanelment, which is a foundational component of primary health care and consists of assigning populations to health facilities or providers based on geography.[115] On average, each EBAIS clinic aimed to service around 4,000 people (approximately 1,000 households), and in 2019, there were a reported 1,053 EBAIS clinics operating throughout the country.[113,116,117] According to a 2017 study, Costa Rica has yet to meet its goal of achieving 4,000 people per clinic, and are approximately 295 clinics short of this goal.[118,119] A different report from OECD in 2017 estimated a total of 55,000 employees through CCSS, working across 29 hospitals, 103 health regions and 1,094 EBAIS clinics.[117] Central to the development of the EBAIS clinic model were the government's motivations of enhanced primary care, more active community participation in health programs, increased health care access for the rural and low-income population, and the desire to gain administrative independence from hospitals. Each EBAIS clinic functions as a 'single care delivery unit', with a multidisciplinary team of a doctor, nurse, technical assistant, medical clerk and a pharmacist staffing each clinic.[119]

EBAIS clinics provide comprehensive primary care services, including but not limited to: treatment of disease, rehabilitation, vaccination and family planning counseling and antenatal care, among other services.[119] For more complex health needs people are typically referred to secondary or tertiary care facilities for more specialized care, which are mostly concentrated in San José.[118] The secondary level offers services such as diagnostic support, specialized outpatient consultations and basic surgeries, while the tertiary level offers high-technology medical and surgical services and hospitalization.[96] This is also relevant to pregnancy care, where CCSS has protocols and referral guidelines for categorizing risks of pregnancies, and referring higher-risk pregnancies to secondary or tertiary facilities for more advanced support.[113] It is important to note that patients cannot access secondary care directly, and instead must be referred from the primary level.[117]

While CCSS is often criticized for its long wait times, especially with secondary/tertiary care and elective procedures, it is still known to provide generally affordable care with adequate quality.[117,120]

While Costa Rica's health care system is designed to be inclusive and is often deemed an exemplary model to universal healthcare, there exist barriers to accessing care which make it still inaccessible to many. For instance, EBAIS clinics only offer appointments in the morning and early afternoons, which effectively limits access to primary care, and make it inaccessible for people who cannot afford to miss work.[117]

Additionally, under the current system, migratory status, for example, is considered to be a key determinant for access to health insurance and healthcare services in Costa Rica.[97] In his 2016 study, Voorend highlights the factors that determine immigrants' access to the national healthcare, which in addition to their migratory status, also include their employment conditions and the level of care they require. Costa Rican law stipulates that in order to receive access to health insurance, migrants need to have regular migratory status, which includes having either a residency permit or a permit to work in the country. Voorend describes this as a "legal catch-22 situation", because the law also includes that in order to start the regularization process, migrants need to be affiliated with CCSS.[97] Partially due to this, migrants experience decreased insurance coverage rates under CSSS, as seen by the notable discrepancy of coverage between Costa Rican nationals and Nicaraguans. In 2016, Nicaraguan-born individuals who are either irregular immigrants or have a tourist visa were reportedly 55% and 63% less likely to be insured than their Costa Rican counterparts.[97]

Additional financial barriers for immigrant, migrant and low-income populations exist in accessing care. While CCSS is mostly financed by employers, employees and the government, there exist options for independent workers or those in the informal sector to access 'voluntary' health insurance.[97] However, this requires individuals to pay into the system, which can be a substantial barrier for refugees, immigrants, migrants and low-income nationals, who greatly comprise Costa Rica's informal employment sector. Many foreign-born and/or low-income people are also self-employed in the informal sector, which serves as a determinant of health insurance coverage status. A 2010 study found that the likelihood of having health insurance if an individual is self-employed was substantially lower, pointing to their decision to opt-out of an insurance plan to avoid having to pay payroll taxes, which can be a large financial burden. Other determinants to insurance coverage in Costa Rica were explored in the study, which in addition to nationality and employment status, also included age, marital status and education level.[111]

SRH in Costa Rica

Costa Rica is considered to be a leader in the region on many health indicators, and it ranks in the "very high" category on the United Nations' 2021 Human Development Index (HDI).[100,121] The country's maternal mortality rate has continued to decrease over the last few decades, and is reportedly 24 per 100,00 live births in 2018.[122,123] Costa Rica's maternal mortality rate is also lower than other countries in the region (e.g. Nicaragua- 24 per 100,000 (2017) Guatemala- 107 per 100,000 (2018), Honduras- 71 per 100,000 live births (2014).[124] According to recent estimates, the fertility rate in Costa Rica is 1.6 births per woman, which is a substantial decline from previous decades (e.g. 6.7 in 1960, 3.6 in 1980, 2.2 in 2000).[125] Costa Rica's fertility rate is also lower than other countries in Central America (e.g. in 2020: Guatemala- 2.5, Honduras- 2.4, Nicaragua- 2.3, El Salvador- 1.8).[126] Additionally, infant and child mortality rates have reached historic lows with 7 per 1,000 live births in 2020 (compared to as high as 73 per 1,000 live births in the 1960s, 19 per 1000 live births in the 1980s, 11 per 1,000 live births in 2000).[127] The estimated percentage of women using contraceptive methods is approximately 75%.[128,129]

Despite significant reductions in adolescent pregnancy rates in Costa Rica over the last several years, rates still remain high, with an approximate 56 per 1,000 women aged 15-19 and 65 per 1,000 women in rural areas.[105,130] These rates are even higher for indigenous and migrant populations. In 2016, the National Institute of Statistic and Census in Costa Rica estimated approximately 14,000 adolescent pregnancies per average each year.[130] According to the United Nations Population Fund, approximately 69% of adolescent mothers in Costa Rica do not attend school and are behind in comparison to non-mothers, which both impacts their job prospects and their financial sustainability. Costa Rica is also criticized for inadequate comprehensive sexual education in school systems, which likely contributes to high rates of adolescent pregnancy reported.[105]

Estimates for unintended pregnancy and abortion are more limited. Most recent estimates indicate that Costa Rican women experience similar rates of unintended pregnancy as other countries in the region. The most recent 2015-2019 model-based estimates from Guttmacher and WHO fill some of the data gaps by estimating several rates for women of reproductive age in Costa Rica. Firstly, the estimates include the country's annual unintended pregnancy rate as 52 per 1,000 women of reproductive age, with an estimated 41% of those unintended pregnancies

ending in abortion.[131] This estimated unintended pregnancy rate is a substantial decline from previous data from 1990-94, but the percentage of unintended pregnancies ending in abortion rose significantly from 26% to 41% from the 1990s data. They also estimate the total abortion rate in the country as 21 per 1,000 women.[131] It is important to note that outside of these model-based estimates, recent statistics for abortion in Costa Rica are virtually nonexistent. A 2007 report by the Costa Rican Demographic Association estimated 27,000 clandestine abortions each year, but there exists little-to-no data on *confirmed* procedures in public or private facilities.[132] The 2007 study found that approximately 27,000 abortions were performed per year in Costa Rica, with approximately 25 treated for induced abortion per day in health institutions.[32] The study also estimated that 20% of women who have induced (clandestine) abortions end up in a health institution due to complications with their unsafe abortion procedures.[32]

The most recent information available on legal, therapeutic abortions provided by the public health system is quite dated (from 1984 to 2003). During this time, the most therapeutic abortions provided in a single year was 7, with an average of 2 per year in all of Costa Rica.[133] Older statistics from CCSS show that from 1990-1994, 12.4% of maternal deaths were attributed to clandestine abortions, and from 1984-1991, 8,669 women were hospitalized due to complications from them as well.[134]

Determinants

Similar to the determinants presented above (organized through SEM) that influence the SRH landscape at both a global and regional level, there exist overlapping social determinants that influence the SRH environment in Costa Rica which shape abortion attitudes, access and experiences. For example:

Costa Rica Abortion Access: The Individual Level

At the individual level, the 2007 report from the Costa Rican Demographic Association (ADC) included that the majority of women who reportedly sought abortion services in Costa Rica shared similar characteristics. According to the health professionals surveyed in the report (which compiled information and medical records from providers and health centers), 85.2% of women seeking abortion services in Costa Rica were under the age of 25, 66% had at least a secondary education, 83% were single, and 62.5% were without other children.[32] The study also

found that women who had a higher education level, increased personal access to technology, access to the labor market were less likely to suffer complications from induced abortions.[32]

Costa Rica Abortion Access: The Social/Community Level

It is also important to highlight the cultural factors in Costa Rica which contribute to the sexual and reproductive health landscape.

Firstly, a culture of 'machismo' persists, which both tolerates and sustains gender-based violence across the country.[105,135] This notion is supported by Costa Rica's rates of violence, which while lower than its neighboring Central American countries, is still notable. A report found that sexual violence is reported every 80 minutes in Costa Rica, which has an impact on the SRHR landscape.[136]

Additionally, there are several issues that are related to sexual and reproductive health that are divisive in Costa Rican society. One of the most prominent issues is related to induced abortion for medical necessity, which according to a 2018 study by the University of Costa Rica, reported 55% of the population in favor of it and 45% of the population against it.[137] Public opinion around abortion in Costa Rica has changed to become more progressive over the last few decades, but not significantly. In 1999, 51% of women who were surveyed about their abortion stance were opposed to it in all circumstances, and only 37.7% approved of it when the mother's life was at risk or in the case of incest.[133] There also exists taboos around topics such as emergency contraception and in-vitro fertilization in Costa Rica, despite recent progressive policy movement, and both remain poorly promoted.[65,138] The human rights community has further emphasized the impact of interference from powerful, conservative forces on progress towards women's rights.[129]

Costa Rica Abortion Access: The Health System/Institutional Level

Research shows that women from rural areas had decreased access to both abortion medication acquisition and to high quality healthcare services, both of which lend itself to increases in risks related to abortion.[32] This population also experiences difficulties in accessing 'safe' providers and post-abortion care.[32] For lower-income people with pregnancy capacity, they can seldom

afford private providers, whereas higher income people with pregnancy capacity may be able to access private clinics and have easier access to post abortion care.[32]

Also relevant to institutional barriers are the legal barriers associated with migrants seeking healthcare and receiving access to CCSS services as presented in the previous section.

Costa Rica Abortion Access: The Structural Level

In terms of human rights related policy, Costa Rica has also ratified several international human rights instruments, and played a large role in establishing the Inter-American human rights system.[129] In 2018, Costa Rica received further praise for being the first country in Central America to legalize gay marriage.[139] Despite these advancements, Costa Rica has still been criticized for its limited integration of human rights instruments into national programs-- especially ones relevant to sexual and reproductive health and rights-- and its fragmented and insufficient implementation of others.[90,105] In their 2017 Annual Report, UNFPA also shared that while Costa Rica does have widespread access to various sexual and reproductive health services, there are issues surrounding quality and cultural sensitivity which impact the effectiveness of SRH services.[90,105]

Also at the structural level, poverty and unemployment disproportionately affect people with pregnancy capacity who are young, immigrants/migrants, afro-descendants, and from rural areas. These populations have lessened access to SRH services and information, which is likely connected to higher rates of unintended pregnancy.[90,105] The 2007 ADC report showed that non-poor women were much more likely than poor-women to seek “safe” induced abortion services. Among the non-poor women, safer practices were also reported in urban areas versus rural areas.[32] Socio-economic status also played a role when looking at choice of service provider and available economic resources to access high-quality care.[32]

The abortion policy landscape in Costa Rica is also an important determinant to abortion access and attitudes. As has been discussed at both the global and regional level, the illegality of the procedure motivates people with pregnancy capacity, especially low-income people with pregnancy capacity, to resort to unsafe and clandestine abortion methods.[32] The impact of Costa

Rica's abortion policy that will be reviewed in depth in the following sections of the literature review.

Policy and Activism

Activism in Costa Rica in response to various SRH policies has brought these national policies to an international stage.

In-Vitro Fertilization

One of the issues that garnered international attention and a strong activist response was surrounding the in-vitro fertilization (IVF) debate. Despite a short stint from 1995-2000 where it was legal, it was greatly opposed by religious influences, who argued that artificial reproduction was immoral, as was any action that eliminates or discards of leftover embryos.[129] The Constitutional Chamber of the Supreme Court of Costa Rica agreed with this argument and the procedure was banned in 2000, which attracted the attention of feminists and human rights advocates as it "dramatically heightened the subjectivity of a new class of human rights claimants: human embryos".[87,109,129] In 2012, the Inter-American Court condemned Costa Rica's IVF ban, and after several years of legislative battles, it was ultimately made legal in 2018 with the first IVF birth through the CCSS in over two decades, reported in 2020.[129,140,141]

Therapeutic Abortion

Following the IVF dispute, Costa Rica faced additional reproductive rights violation claims, this time related to therapeutic abortion access.[129] Several high-profile cases have caused the current legal definition of therapeutic abortion into question on the national stage. Two notable cases include A.N vs. Costa Rica (2008), and Aurora vs. Costa Rica (2012). In both cases, two women were denied therapeutic abortions despite being diagnosed with pregnancies incompatible with life outside of the uterus. Also in both cases, it was argued that the physical and mental wellbeing of the mothers was neglected which left them with trauma and long term complications.[142] Both in the case of A.N and Aurora, the government was accused of 'unspeakable cruelty' by the Center for Reproductive Rights and other international activism groups, who stated publicly that the government "gave more consideration to an ideological stance than the dignity and health of its people".[143,144]

These highly-visible cases were brought by advocates, including the Center for Reproductive Rights, to the Inter-American Commission on Human Rights for review, and the Inter-American Commission continued to put additional pressure on the government of Costa Rica in the years that followed.[123,129]. While Costa Rica was not explicitly named, the Inter-American Commission of Human Rights included in a 2017 press release the urge for "states that still lack an adequate regulatory framework to adopt legislation designed to ensure that women can effectively exercise their sexual and reproductive rights", which included Costa Rica.[129,142]

Costa Rica's lack of a technical document (or 'Norma Técnica') outlining the situations which merited therapeutic abortion had long been the focus of attention for human rights and feminist activists. Calls for a Norma Técnica had existed for decades, since the passing of the 1970 Penal Code.[145] Without this document, the procedure was virtually inaccessible as there was no regulatory clarity; people with pregnancy capacity did not know their rights and clinicians did not know when it was permissible to offer.[146] In many cases, doctors in public hospitals refused the procedure regardless of the circumstances due to the lack of clarity and fear of facing prison time or losing their medical license.[132,143] Without the standard detailing terms and scope of the legal exceptions, there existed no due process, and life-saving medical decisions were left up to the particular clinician's interpretation of the law.[133,145] Often, people with pregnancy capacity did not ask for therapeutic abortions in the first place because they knew it to be illegal. Further, the lack of standards or protocols perpetuated inequalities, as some people with pregnancy capacity who had pregnancies where the fetus could not survive outside of the womb had access to the procedure, while others were denied.[145]

Several activists took on the fight for a Norma Técnica on therapeutic abortion in Costa Rica, including the Acceder Citizen Association *(La Asociación Ciudadana Acceder)* who litigated with the Inter-Commission for Human Rights. Acceder decided to do so after a Norma Técnica had been stalled for years, despite years of empty promises from the Costa Rican government to develop one and de-prioritization from different administrations.[146] Acceder's founder Larissa Arroyo directly accused the president at the time, Luis Guillermo Solís, for breaking the promises made to A.N and Aurora in their lawsuits, and for prioritizing his reelection campaign over the human rights of Costa Ricans.[146,147]

Through Acceder's activism, they emphasized that they were not talking about free access to abortion or expanding legislation; instead they wanted technical standards that people with pregnancy capacity and providers can rely on and use to advocate for their rights.[148] Costa Rica's National Institute for Women (INAMU) supported Acceder in advocating for a Norma Técnica to be passed. The Minister for Women's Affairs, Patricia Mora, described the importance of the situation and the 'setback of women's rights' in the country, and publicly denounced the actions of the lawmakers who have repeatedly blocked passage of a Norma Técnica. Other activist groups in Costa Rica closely involved with the fight for expanded sexual and reproductive rights in Costa Rica include the Colectiva por el Derecho a Decidir (Pro-Choice Association), the Feminist Information and Action Center (CEFEMINA), among others.[134]

Abortion Policy & The Norma Técnica

As mentioned above, while abortion is not available upon the woman's request and there remains restrictions to abortion provision and access, there have been modifications to national policies to allow for therapeutic exceptions for abortion. In Costa Rica, Article 121 of the 1970 Penal Code includes a ban on abortion in all cases except in situations where "there is danger to the life or health of the mother that could not be prevented by other means", which is classified as "unpunishable abortion".[4] This criteria caused confusion as it was not widely understood the situations which constituted grounds for unpunishable abortion and caused "a lack of regulatory clarity at hospitals" which has meant that the law could not be applied in practice.[149] Despite the official legality of therapeutic abortions since 1970, they are very rare, even in extreme and highly-publicized cases as mentioned previously.[133]

In response to the confusion surrounding Costa Rica's therapeutic abortion policy, and the widespread scrutiny received from the international community as the result of tremendous activism efforts, in 2019, Costa Rica's President Carlos Alvarado, together with the head of the Ministry of Health, issued a technical decree ('Norma Técnica'). This Norma Técnica was issued to establish clear, mandatory protocols for physicians to evaluate risk and determine if therapeutic abortions are warranted given the situation. The Norma Técnica stated that therapeutic abortions are permissible if four requirements are met: 1) That the woman gives her consent for the abortion to happen; 2) That it is carried out by a medical personnel or an

authorized obstetrician (when there is no medical personnel available); 3) That it is practiced to avoid endangering a woman's life or health, and 4) That the danger to the life or health of the woman could not have been avoided by other means. In this document, said 'danger' was defined as the 'the affectation of the woman who during her pregnancy presents an underlying pathology that compromises the health and life of the mother, based on medical evidence, the health professional must act'.[150] In total, the Norma Técnica includes 13 distinct sections, which information related to: the procedure to assess whether or not the interruption of pregnancy is appropriate, the place where the abortion can be performed; the time requirements for doctors to respond to assessment results; the next steps if the doctors deem the interruption of pregnancy unnecessary; the information that the patient seeking abortion services must receive; the woman's consent; and comprehensive care and supervision requirements.[151] More detailed information about the Norma Técnica and key sections (5-13) including the following:

Section 5: General Considerations: In addition to the process guidelines, the Norma Técnica also establishes the supervisory role of the Ministry of Health (MOH) to act as the regulatory body that monitors compliance with this procedure. This role includes that the MOH will ensure 'proper application and compliance' with the Norma Técnica, as well as carry out inspections related to the Norma Técnica as they deem necessary. Also included in this section is specific guidance about the location of care. The Norma Técnica includes that therapeutic abortions that meet all criteria must take place in hospitals or clinics that have the necessary infrastructure, equipment and human resources. These hospitals or clinics must also previously comply with the current authorizations for complex service provision, in accordance with the MOH. Additionally, the Norma Técnica also states that this technical standard is mandatory for all public and private institutions in Costa Rica, including for any health professionals 'linked to the medical procedures' regulated in the guidelines.

Section 6: Generality of the Procedure: In terms of who may be impacted by this policy, the Norma Técnica explicitly states that every pregnant woman has the right to a medical assessment to avoid danger to her life or health, and that each case must be assessed individually due to the diversity and potential complexity of medical situations. (SCIJ, 2019) This section also states that the woman has the right to receive objective information based on scientific evidence regarding her diagnosis and the procedure.

Section 7: Development of the Medical Procedure: This section outlines the requisite of having 3 health professionals conduct a mandatory evaluation to determine if the situation merits a therapeutic abortion and meets all criteria. This evaluation must also be completed within 3 business days of the request for assessment. The woman will be informed immediately of the assessment results, and if the recommendation is to interrupt the pregnancy, they must collect the informed consent from the woman. This section also includes the right of the woman to request another assessment with a new group of medical professionals, as well as robust documentation requirements for record maintenance.

Section 8: The Medical Procedure: This section includes information about the standard of care that is required for the procedure. The Norma Técnica calls for the procedure to be done with the highest levels of safety and non-invasive procedures possible, based on scientific evidence. Further, it includes that they must refer to the World Health Organization (WHO)'s international health standards for quality assurance.

Section 9: Conscientious Objection: This section includes the right of the medical professional to exercise their conscientious objection to the termination of the pregnancy and waive their participation in the procedure, without discrimination for doing so. It also states that in the case of an obstetric emergency when that medical professional is the only one available to complete the procedure, they may not invoke conscientious objection, as the priority is given to the woman whose life is at immediate risk.

Section 10: Informed Consent: This section of the Norma Técnica includes detailed information about what constitutes informed consent. This includes that the woman must give her consent before the procedure is performed and may revoke that consent at any time. Additionally, the woman must have the cognitive capacity to make that decision, and it must be voluntary and free of coercion. If the woman has cognitive disabilities, it is the obligation of the health facility to ensure that the woman receives objective and evidence-based information and that it be given to her in a way that is comprehensible to them and their condition.

Section 11: Comprehensive Care: After receiving the procedure, all women must receive access to comprehensive care, which includes SRH care and therapeutic support. It also states that

‘special care’ must be taken so that the woman is not subject to discrimination, but details are not provided as to what that special care includes.

Section 12: Case Registry: This section includes the data that must be reported to the MOH. This includes the following information: the national ID card of the woman, the number of pregnancies, the weeks of pregnancy, and the methods used to terminate the pregnancy. The MOH must collect all information that is submitted to them so that the procedures are ‘traceable’ to the woman and for quality assurance purposes.

Section 13: Care Protocols in Health Establishments: It is explicitly stated that the MOH will lead the initial training process for the implementation of the Norma Técnica. Additionally, health facilities are obligated to establish their own care protocols in accordance with the Norma Técnica, and the Caja Costarricense de Seguro Social (CSSS) was mandated to establish a protocol for the national health system to implement these modifications within six months of the Norma Técnica being published. It is important to note that there was no pre-created template or toolkit for implementation of the Norma Técnica, which likely contributed to variation and discrepancy among facilities.

Reception of the Norma Técnica

Since its adoption, the Norma Técnica has received mixed reception from national and international audiences. Substantial misinformation and ‘fake news’ promptly circulated across Costa Rica through social media networks and included information such as the Norma Técnica allowed for free access to abortions nationwide, and that the government was actively promoting the intervention.[152] In efforts to dispel misinformation, government officials have spoken publicly about the Norma Técnica and clarified that instead of expanding any legislation, the document simply clarifies the situations in which it was previously accessible under the law.[153] President Alvarado urged the public to ‘not use this issue to generate harmful polarization’ in Costa Rica, and also spoke about the importance of the Norma Técnica in terms of respecting the rights of women in the country and ‘repaying a historic debt’ to them.[154]

White the Norma Técnica does not expand the situations in which abortion is legal, it has received praise from the international community for clarifying policies and theoretically making

the procedure more accessible to those who meet the criteria.[155] Human rights activists have expressed their satisfaction with the decree in the additional agency it affords people with pregnancy capacity in Costa Rica's restrictive SRHR environment. While sign off and consensus from medical professionals is still required to receive a therapeutic abortion, the Norma Técnica explicitly allows a woman to request the review of her own case, which the doctors must agree to review.[155] This does not, however, indicate any guarantee that the medical providers will approve of the procedure. Other activists, however, commend the decree but acknowledge that it is just an initial step with substantial room for improvement. For example, the decree has received some criticism for its poor roll-out and limited advertisement to both people with pregnancy capacity, and medical personnel in health facilities. ACEDER's founder Larissa Arroyo highlighted the impact of this subpar dissemination, by sharing that 'women who do not understand their rights cannot demand their rights'.[155] Further, she highlighted that while the Norma Técnica does permit therapeutic abortion in some circumstances, it falls short in many others. For example, situations where an unintended or high-risk pregnancy may impact the physical and emotional health of a woman or girl, but they are not 'on the verge of death' would still be excluded from receiving approval under the stipulations of the Norma Técnica.[155] While Costa Rica relies on the WHO's comprehensive definition of health for most health areas, when it comes to therapeutic abortion, the policy is instead limited to situations where there is documented risk of the mother's imminent death.[156] This overtly narrow definition of health needs in the context of the Norma Técnica is criticized for its unjustified, differential treatment, and has been deemed by many activists as inadequate, as it will continue to cause doubts of medical providers about when they can and cannot apply the standard in other situations of health impacts.[153,156]

Unsurprisingly, the Norma Técnica has received negative backlash from conservative and religious groups in the country, who believe that this decree could be a window for increased abortion access. After the president announced his intention to sign the document, select groups organized a March for Life event to publicly oppose the decree, which was attended by thousands.[157]. The Colegio de Medicos-- a professional body that all doctors in Costa Rica must be affiliated with to practice legally-- publicly opposed the Norma Técnica by declaring that the decree was unnecessary, given that they were 'well aware of the rules surrounding abortion'.[148] Additionally, the Norma Técnica received substantial criticism from over 23 conservative lawmakers in Parliament, who threatened legislative boycotts and other actions.[158] In 2020, the

National Restoration political party filed an action before the Chamber stating that the Norma Técnica is unconstitutional and should be reviewed further.[159]

It is also significant to highlight that Costa Rica's current president, Rodrigo Chaves Robles, has made his opposing stance on the Norma Técnica known and has worked closely with the Catholic Church to 'review' the document and 'close loopholes'.[160] Many doctors who support the Norma Técnica have spoken out against this action, and have stated that it is 'unnecessary' and 'inappropriate' for the government and church to do so.[161] Further restricting the Norma Técnica and the abortion landscape in Costa Rica was emphasized throughout his presidential campaign, and many believe that abortion restrictions may intensify under his leadership.[162] President Chaves' has received backlash from human rights activists on this issue and others, who are concerned that his leadership will both thwart and actively undermine progress in Central America's most progressive nation and have significant impacts on women's rights.[160]

Given the current administration's skepticism towards the Norma Técnica and conservative calls for its reform, the future of abortion policy in Costa Rica remains a divisive and a hotly debated topic. Costa Rica's abortion landscape is 'complex' and 'ever-evolving', and the international community continues to track the situation closely.[88] While conservative groups continue to rally behind the "evolution of transnational pro-life and pro-family movements and strategies across Latin America", abortion and women's rights activists around the world remain hopeful that the landscape in Costa Rica will not tighten its restrictions and instead move towards expanded access to therapeutic abortion care.[88]

Gaps in the Literature

There exist many gaps in literature about social determinants of abortion access in Costa Rica that make the case for future research needs.

Globally: Regarding unintended pregnancy research more broadly, researchers have stated the need for additional studies that focus on determinants (including social determinants) of unintended pregnancy in developing countries to help fill important gaps in data.[22] This need is amplified when looking both at the needs of adolescents and other vulnerable populations in

LMIC, and their unique barriers to access, and the needs of people with pregnancy capacity in countries where abortion is restricted.

LAC Region: These research gaps are amplified when looking specifically at the LAC region. Several researchers have emphasized the need for more research about sexual and reproductive health attitudes and have cited substantial knowledge gaps and underrepresentation of the LAC region in global health literature.[163,164] Many gaps in reliable, representative data in the LAC region can be attributed to the restrictive legal landscape related to abortion and associated sensitivities/stigmas with discussing the topic.[65] The limited studies on abortion attitudes that *are* available in the LAC region are mostly limited to Mexico, Colombia, Brazil and Argentina, the abortion landscapes of which vary greatly from that of Central America and represent countries with a more liberal abortion policy context.[164] The lack of Central-America focused studies on abortion attitudes highlights the need for additional research in that subregion, with particular focus on attitudes and access in restrictive legal environments.[164]

Another abortion-related research gap that has been identified in published literature is related to data on rural populations in the LAC region and their unique health needs. In general, the LAC region is considered to be highly urbanized, and studying the attitudes and access of rural populations can be costly and logistically challenging.[164] In much of the LAC region, these rural areas are inhabited by indigenous populations that likely have unique needs and barriers to access of services, which are not being captured in research and should be considered in the context of other factors.[164]

Costa Rica: In Costa Rica, there exist major gaps in abortion data. As mentioned previously, the most recent estimates come from a 2007 study conducted by the Costa Rican Demographic Association. Due to the restrictive abortion legislation in Costa Rica, getting data on abortion incidence is far from straightforward. Both the 2007 study and the 2015-2015 Model Based Estimates from WHO and Guttmacher use *estimates*, and not patient or practice generated surveillance data on the incidence of induced abortions (either from the public, private health services or self-administered) in Costa Rica.[32,132]

There is also a dearth of data from Costa Rica pertaining to important subgroups who may have influence on policy and practice. For example, no information is available in published literature

about the perceptions and experiences of Costa Rica's medical community (including doctors and residents) as well as from key policy makers and stakeholders about access to unintended pregnancy management services-- both of which are important populations when looking at the national abortion landscape. Research has shown it to be necessary to "build a critical mass of support and work together" with these populations for abortion-related policy change to be possible.[165]

Additionally, while few public opinion polls around the acceptability of therapeutic abortion exist, data is lacking in relation to the perspectives of community members around issues of values & preferences and access to care for abortion and unintended pregnancy management, more broadly.[166] Additionally, there exists very limited comprehensive information regarding how restrictive abortion policy affects the lives of individuals living in Costa Rica.

Data is also especially lacking for populations living in situations of vulnerability (e.g., indigenous populations, refugees, immigrants, migrants) who face compounded barriers to access and are prominently represented in Costa Rica's population. In their 2017 report, UNFPA reported that there is "insufficient qualitative and quantitative information about these populations".[105] Further, UNFPA emphasized knowledge gaps for data on how these vulnerable groups experience gender-based violence and SRHR in Costa Rica, which can be utilized to make programming and public policy decisions.[105] While Costa Rica does have some guidelines in place in the health sector specifically aimed at the indigenous and afro-descendent populations, there are no immigrant or migrant-specific policies.[105] Generating more data about the unique healthcare needs and barriers experienced by this population will allow SRH-related care to be made more accessible.

The gaps identified in this section of the literature review, with particular focus on the social determinants of unintended pregnancy management and abortion access of people living in Costa Rica, will be further investigated in the following manuscript.

CHAPTER 3: MANUSCRIPT

Abstract

Individuals still seek abortion services outside of the public healthcare system of Costa Rica, despite strict laws criminalizing abortion except in cases to save the woman's life. This study explores the determinants of abortion access in Costa Rica through the perspectives of OB/GYN clinicians, medical residents, and policy stakeholders. The study identifies limited access to comprehensive sexual health education, support from interpersonal networks, provider knowledge and training, financial and migratory status, and both provider and community stigmas as substantial barriers to abortion access. This study addresses a gap in published research around the social determinants of abortion in Costa Rica and sheds light on the attitudes and opinions of the medical and stakeholder communities about abortion access. Moreover, it provides insight into unique considerations for vulnerable populations regarding determinants of abortion access. The study highlights the need for expanded access to comprehensive sexual health education, abortion training for healthcare providers, and increased programming efforts to ensure safe abortion care and reproductive health services, especially for vulnerable populations in Costa Rica.

Introduction

The World Health Organization (WHO) defines access to comprehensive abortion services as a human right and identifies that a lack of access to safe abortion care "poses a risk to not only the physical, but also the mental and social, well-being of women and girls" globally.[167]

The Latin America and Caribbean (LAC) region includes a vast range of abortion policies and has experienced notable shifts over the past decades.[65] Some of the most significant transformations have occurred in countries with substantial feminist activism and grassroots mobilization activities through the Green Wave, which have resulted in more progressive national abortion legislation in countries like Argentina, Mexico, and Uruguay.[81,82] In much of the region, however, there still exist many restrictions to abortion access. In 2018, the

Guttmacher Institute estimated that more than 97% of women of reproductive age in the LAC region live in countries with restrictive abortion laws.[75]

Central America, in particular, has some of the world's most restrictive abortion policies, and abortion in most countries is mostly illegal, even in cases of rape, incest, and when the life of the pregnant individual is at risk.[78,168] In addition to the policies themselves, high levels of poverty, limited access to healthcare, and conservative societal attitudes around sex and gender make it extremely difficult for women in Central America to prevent unwanted pregnancies and access safe and legal abortion services, even when permissible under law. Consequently, many women in these settings are forced to seek unsafe and clandestine abortions, which can result in serious health consequences.[65,169]

Costa Rica is one country in Central America with a unique situation: On one hand, the country is acclaimed for having one of the strongest social policy regimes in the LAC region, and is considered an "exemplary democracy", and a "distinguished champion of inter-American human rights law".[129] On the other hand, it has a complex abortion landscape, with highly restrictive access to abortion, and has been the focus of several highly-visible abortion cases that have captured the attention of the international human rights community.[129]

In 1970, Costa Rica's Penal Code criminalized abortion except in limited circumstances ("to save the life or health of the woman").[3,4] While Costa Rica relies on the WHO's comprehensive definition of health for most health areas, when it comes to therapeutic abortion, the policy is instead limited to situations where there is documented risk of the mother's imminent death.[156] In 2019, the *Norma Técnica* protocol (technical standard) was introduced by the Costa Rican government to provide clarity to clinicians about when and how to provide abortion services.[151] An estimated tens of thousands of women seek extra-legal abortions each year in Costa Rica, and the Guttmacher Institute estimated that between 2015-2019, 41% of all unwanted pregnancies in the country ended in induced abortion.[131] A 2007 study from the Costa Rican Demographic Association (ADC) reported that approximately 27,000 abortions were performed per year in Costa Rica, with approximately 25 treated for induced abortion per day in health institutions.[32] In recent years, there has been increasing debate around whether to derestrict abortion in Costa

Rica, but it has been met with fierce opposition from conservative groups, including the Catholic Church.

Despite the increasing attention to abortion access and policy in the LAC region, there are major gaps in the literature related to the abortion policy landscape in Costa Rica specifically. There is minimal data on abortion access and abortion opinions in Costa Rica, especially pertaining to populations who may lack access. To our knowledge, no information is available in published literature about the abortion perceptions and experiences of Costa Rica's medical community or key policy stakeholders, both of whom are critical to service delivery and influence national abortion policies. Additionally, the United Nations has identified that abortion data is especially lacking for populations living in situations of vulnerability in Costa Rica (i.e. refugees, migrants, ethnic minorities, low-income individuals) who face compounded barriers to abortion access and are prominently represented in Costa Rica's population.[90,106] These populations make up significant percentages of Costa Rica's population, with an estimated 356,000 asylum seekers in the country, and migrants comprising approximately 15% of the total population.[106,170]

This study sought to identify social determinants of access to abortion services in Costa Rica and identify additional considerations that exist for vulnerable populations from the perspective of clinicians and key policy stakeholders. Generating more information about the barriers and facilitators of access to abortion services in Costa Rica will allow us to characterize the unique needs experienced by different populations and advance the debate around abortion policy and access in Costa Rica.

Methods

This qualitative study was conducted between September 2021 and March 2022 in a partnership between Emory University, Universidad de Ciencias Médicas (UCIMED)-- Costa Rica's largest private medical university-- and the University of California, Berkeley. The purpose of the study was to understand the perceptions of obstetrician-gynecologist (OB/GYN) clinicians and medical residents, and policy stakeholders about abortion in Costa Rica. These populations were identified for their involvement in both shaping and implementing abortion policy in Costa Rica.

Given the sensitive nature of the topic, semi-structured in-depth interview guides were selected for this study. The guides were created for each study population separately and were reviewed by UCIMED to ensure cultural acceptability and relevance. The guides were initially authored in English translated into Spanish, and back translated into English as a quality assurance measure. The guide for the clinicians and medical residents included questions about their views and perspectives on women seeking abortion care, any relevant training they had received on abortion provision and reproductive ethics, and the impact of the national abortion policy on the health and well-being of their patients. The stakeholder guide focused on the impact of current abortion laws, the accessibility of abortion services, and the relationship between health policy and women's sexual and reproductive rights. The study protocol and all materials were approved by the Emory University Institutional Review Board (#STUDY00002394) and the UCIMED Ethics Committee (#586-06-2021) in August 2021.

First, clinician and medical resident participants were recruited through a virtual announcement distributed through UCIMED listservs. Then, we employed snowball sampling for additional recruitments. Clinicians were eligible to participate in the study if they currently practiced as an OB/GYN in Costa Rica. Residents were considered eligible if they were within the OB/GYN specialty. For the stakeholders, a key informant versed in Costa Rica's legal and policy environment provided an initial list of connections to the research team, and then snowball sampling was utilized to recruit additional participants. Stakeholders were eligible to participate if they had worked in the past five years with an organization or in a role that addressed reproductive health laws, policies, or access to health services. These positions could include activism, counseling, research, legislation, and non-governmental organization (NGO) employees. Across both study groups, there were no exclusion criteria related to age, race, or gender.

Prior to interviews, verbal and written informed consent was collected by UCIMED for all study participants. All interviews were conducted virtually using Zoom conferencing software and audio was recorded. The interviews were transcribed in Spanish and then translated into English using a professional translation company. Once transcribed and translated, the

transcripts were reviewed by Spanish-speaking research team members for quality assurance and modifications to the English translations were made as necessary. A codebook was developed which included both inductive and deductive codes, and definitions were refined through discussion with the full team. The transcripts were then coded by two groups in the research team for all de-identified transcripts using MAXQDA software. Thick descriptions were then developed, which captured the key patterns and illustrative quotes for each code to generate themes and were shared with the entire research team for feedback. For this manuscript, we will refer to both clinicians and medical residents as "clinicians" throughout the paper. Also for this manuscript, the lead author further reviewed the coded segments and categorized themes according to the Social Ecological Model (SEM) Framework.[43] The lead author also completed additional analysis on vulnerable populations, which is defined in this manuscript as populations who have been historically marginalized, and experience compounded barriers to healthcare access, such as populations with migratory status, low-income status or people who identify as ethnic minorities.

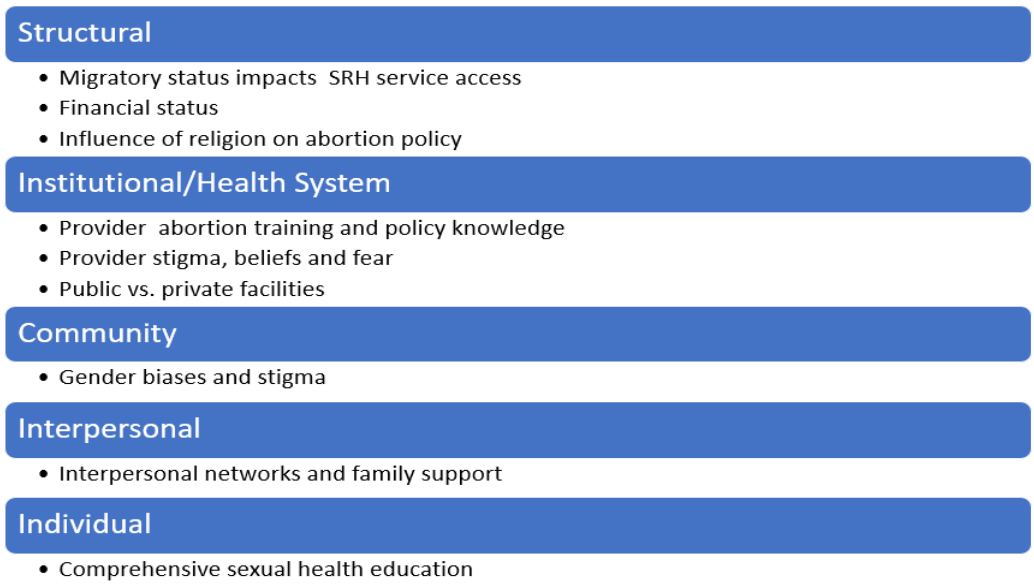
Results

In total, 23 interviews were conducted, including fifteen clinicians (n=15; 10 clinicians and 5 medical residents) and eight stakeholders (n=8) (Table 1). As depicted in Figure 1, the determinants of abortion access in Costa Rica were influenced by factors across all levels of the Social Ecological Model (SEM). Themes are presented across 5 levels of the Social Ecological Model, including those associated with 1) the individual level, 2) the interpersonal level, 3) the community level, 4) the institutional/health system level and 5) the structural level. In total, we identified eight themes across the SEM. Thematic findings are presented in terms of the factors influencing the general population, and then factors that are specifically influential for vulnerable populations.

Table 1: Demographic Characteristics of Study Participants

Participant Group	Clinicians (n = 10)	Medical residents (n = 5)	Stakeholders (n=8)
Gender			
Male	4	4	0
Female	6	1	8
Age			
20-29 years	0	2	1
30-39 years	3	3	3
40-49 years	4	0	0
50+ years	3	0	4
Religion			
Catholic	4	3	4
Non-Catholic Christian	2	0	1
Agnostic	2	1	2
No religion	2	1	1

Figure 1: Factors Influencing Access to Safe Abortion in Costa Rica



Individual Level

Access to Sexual Health Education Influenced SRH Knowledge, Agency, and Abortion Decision Making

General Population: At the individual level, the most prominent theme that emerged was related to the significant gaps in knowledge of sexual and reproductive health and national abortion policies among women. Most clinicians and stakeholders discussed the impact of insufficient general education and a lack of sexual health education as key contributors to experiencing barriers to prevent unintended pregnancies, to communicate and advocate for themselves with healthcare providers, and to make informed decisions about unintended pregnancy management options. Additionally, several respondents from both clinician and stakeholder groups discussed that in general, there is a very poor understanding of Costa Rica's abortion policy among the general population, leading to misinformation. The majority of clinicians and stakeholders explicitly stated a need for enhanced sexual education for adolescents and young girls in Costa Rica so that they could better prevent unintended pregnancies. For example, one clinician stated the following about the need for greater access to sexual health education in schools:

> *"...The young population should be more educated on the subject because they are the most prone to try to interrupt a pregnancy. I think there should be more access to birth control and family planning in school... and a more effective sexual education for them"- Clinician, female*

Vulnerable Populations: Both clinicians and stakeholders spoke to the unique barriers experienced by vulnerable populations in accessing a quality general education, as well as sexual education. Some clinicians cited that most unintended pregnancies they saw were women with low education levels that had received little-to-no sexual education, and that issues of literacy as well as language barriers impacted their ability to counsel women effectively about their pregnancies. Some stakeholders spoke specifically about how certain populations with migratory status have interrupted access to education, and even less access to sexual education than the general population. These stakeholders emphasized the impact of insufficient sexual education and information on vulnerable populations' ability to exercise their rights and advocate for

oneself with health care professionals, as well as seek services. For example, a stakeholder shared this about vulnerable populations' access to abortion information:

> *"...if you are a refugee, you probably don't even know what a therapeutic abortion is...even if you need it, you probably won't know how to ask for it or you won't know that you need it" - Activist, female*

Similarly, another stakeholder noted how people with greater access to information and resources can hold clinicians accountable for therapeutic abortion services:

> *"... Women with better socioeconomic status and from metropolitan areas definitely at least have access to more information to hold the health professionals who are treating them accountable and [ensure] that this element, abortion, is considered among the decisions they can make." - Legislative Advisor, female*

Interpersonal Level

Interpersonal networks impact women's decisions to terminate their pregnancies and who they turn to for support.

General Population: Both clinicians and stakeholders spoke about the influence of interpersonal networks, such as family and friends, on women's decisions to terminate their pregnancies, and who they turn to for support. A few clinicians and stakeholders spoke about how women with supportive families tend to accept their unwanted pregnancy and may be less inclined to look for options to terminate it if there are guarantees for social support. Some stakeholders also mentioned how women with unwanted pregnancies may be more likely to discuss their situations with their close friends, and through these friendships, may be better connected to abortion networks. A stakeholder emphasized the influence of being connected to abortion networks:

> *"There are also networks of women who are very hidden who help other women to have abortions, or people who are able to gestate and, with the same thing, perhaps have access to pills or have brought them from abroad. But that's a little less common and it's*

harder to get because you have to be in the right circles... Have your friends know your friends, have those friends who do the abortions"- Activist, female

Vulnerable Populations: Additionally, both clinicians and stakeholders spoke about how vulnerable populations and those with migratory status, such as migrants and refugees, often do not have access to social networks of support in Costa Rica, which they perceived to impact their decision-making process and ability to seek abortion services. For example, a stakeholder spoke about how vulnerable populations have less access to abortion networks and familial support:

"It is much more likely that if you are a refugee, you have even less money to be able to do it, even less support networks, because here you are not living in your territory. Maybe you don't have your family... you don't have friends. So, all of that of course is going to make it even more difficult for you" - Activist, female

Community Level

Gender biases and stigma impact the way that abortion access is discussed in society, as well as restricts people's ability to seek and use abortion services.

General Population: Many study participants discussed the impact of traditional gender norms on access to reproductive health services, more broadly. Both clinicians and stakeholders mentioned how gender biases and 'machismo'-- or exaggerated masculine pride-- impacts the way that abortion access is discussed in society, as well as the quality of health care that women have access to. For example, a few stakeholders discussed the impact of gender biases on physician behaviors, and how women are often confronted by cold, biased reproductive healthcare service providers when they seek services.

Another consensus among clinicians and stakeholders was that in general, the topic of abortion is highly stigmatized in society and not discussed openly. For example, a clinician shared the following about general stigma towards abortion in Costa Rican society:

"I think that pregnancy termination is a subject that just mentioning it makes some people's hair stand up, but I also think this is due to misinformation." - *Clinician, female*

Other participants spoke about how the stigma around abortion restricts people's ability to seek and utilize abortion services. Both clinicians and stakeholders discussed how abortion stigma has led people who want to terminate their pregnancies to do so in secret, using potentially dangerous methods, so as to minimize the social ostracization associated with the illegal procedure. For example, one clinician shared this about how women have clandestine abortions and do not discuss it with others:

"The process is 'get pregnant, get scared, I don't want to have this pregnancy, I Google it, I look for misoprostol, I put it in myself, without knowing the dose, without knowing anything; I have the abortion, I get scared a lot, where I see the bleeding, and I come for emergencies; I don't tell anyone.'"- Clinician, female

Additionally, a few respondents spoke about how this stigma around abortion builds on other taboos in Costa Rican Society, such as stigma towards contraception or same-sex marriage.

Vulnerable Populations: Some participants also spoke about how societal stigma surrounding abortion and fear of the restrictive abortion policy may especially deter women living in rural or underserved areas without access to more progressive social support systems from seeking to terminate their pregnancies at all. For example, women living in more rural areas may be subject to more intense community oversight and religious stigma. One stakeholder responded to the question of why women often do *not* terminate their pregnancies with the following:

"...Fear. Fear of ending up in prison or dying... I think fear is one of the biggest factors. And religious fear too. Or social punishment. I also think that this is going to vary a lot, depending on the area or the region in which you are asking. Because I live in the capital. Maybe in some rural or remote areas, the punishment or the spiritual and family repercussions could be greater than what I perceive here. It's like in the villages everything is known, everybody knows everything about everybody, it's very small." - *Non-Profit Executive, female*

Institutional/Health System

Provider abortion training and policy knowledge impacts access to abortion services.

General Population: Several institutional barriers to abortion access were identified at the health system level, with the most prominent theme being provider knowledge and understanding of abortion policy impacting access to services. This theme was raised by all clinicians and only one stakeholder, and most clinicians cited little-to-no training on the national abortion policy or therapeutic abortion provision in their health center. When probed about their level of training on induced abortion, almost all clinicians shared that they learned very little in their medical training about abortion and some offered anecdotes about how they had to make difficult medical decisions in the wake of insufficient training on abortion. One clinician shared this about how they received no training on abortion provision during their OB/GYN residency:

> *"There were no regulations to discuss anything. I didn't follow any rules, you practically followed your intuition and your basic training that you had to be able to deal with that type of situation. There was really no training, no regulations, no nothing" - Clinician, female*

Additionally, a few clinicians shared that while they received information about how to remove fetal remains after stillbirths, they were never trained on how to terminate a live pregnancy.

In addition to insufficient training on abortion provision, several clinicians also mentioned a lack of familiarity with the *Norma Técnica.* Some clinicians shared that they had never read the policy so were unsure of the situations which allowed for a legal induced abortion.

Vulnerable Populations: Only a few study participants discussed provider knowledge of abortion policy in relation to the access of vulnerable populations. However, some respondents did speak to differences in rural facilities regarding comprehension of the national abortion policy and its impact on abortion access for rural populations. For example, one stakeholder shared the following about how provider understanding of abortion policy may be strained in certain areas:

"... Particularly in indigenous areas, coastal and rural communities that do not have enough information and there are physicians who are not as up to date, shall we say, on what they should be doing." - Legislative Advisor, female

Stigma, personal beliefs and fear leads to provider hesitancy to engage with patients on the topic of abortion.

General Population: Many clinicians acknowledged the lack of regulatory clarity of the national abortion policy in facilities and overall misunderstanding of the abortion policy as drivers of hesitancy for clinicians, who were thus less inclined to provide therapeutic abortions for fear of criminalization and losing their medical license.

Clinicians acknowledged there was very limited or no discussion on the topic among peers given the stigma surrounding abortion and thus there was not much space for sharing knowledge on the topic. Many clinicians shared that a woman's access to legal abortion is up to the individual belief system of the doctor given the lack of standardization with national policy and limited policy-focused training in facilities. Participants also cited conscientious objection, and a doctor's ability to refuse to perform a therapeutic abortion if it is against their belief system, as a barrier to accessing legal abortion and a contributing factor to abortion stigma. One clinician shared this about how a woman's abortion access is influenced by general stigma and the stance of the treating physician:

"...I feel that the first level where they face obstacles is in the access to health services; and 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." - Clinician, female

Additionally, almost all clinicians who spoke about conscientious objection supported it and praised the ability for providers to exercise their personal beliefs. No clinicians shared direct

experiences where they have utilized conscientious objection to refrain from participating in a legal, induced abortion on religious grounds. However, one clinician shared this about their what their thought process would be if a woman came in seeking an induced abortion:

> *"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 ... If someone wants to abort, let them abort. I'm not going to judge her, but I'm not going to do it ... That problem is hers."- Clinician, male*

It is important to note that in every instance where a clinician expressed desire to refrain from providing induced abortions due to moral objections, they were reportedly comfortable with providing post-abortion care.

Vulnerable Populations: No study participants spoke explicitly about the impact of provider hesitancy to engage on abortion policy in relation to vulnerable populations. However, one clinician shared a nuance of conscientious objection legality, by acknowledging that in rural areas where there are less OB/GYNs available, clinicians are not legally allowed to exercise their conscientious objection if they are the only specialist available.

Public and private facilities present vastly different options for abortion access and care quality

General Population: Another theme that was mentioned by both a few clinicians and stakeholders was the difference in abortion access between public and private institutions. Several participants from both groups discussed their awareness of clandestine abortion service availability at private facilities for those with access to private sector services. One stakeholder highlighted the long-standing availability of abortion in private facilities:

> *"It has always been done here in private places ... Here, in Costa Rica, there have always been private clinics that have performed abortions on demand and with pay ... Without even resorting to Article 21" - Research Consultant, female*

Another clinician confirmed that therapeutic abortion services are not accessible in public facilities, but are at select private facilities:

> *"Now, if they didn't plan it and didn't want it and want to end the pregnancy, they can't access the public institution because the public institution does not offer services of this type. From what I have heard, they're generally private institutions or private doctors who, in an illegal or hidden way, could offer to terminate the pregnancy. - Clinician, male*

Vulnerable Populations: When probed about differences in abortion access in public and private settings, a few clinicians responded in the context of larger SRH services for vulnerable populations. Specifically, clinicians spoke about the differences in access to reproductive health care services in public facilities located in rural, underserved locations. This included fewer facilities, less medical personnel in general, and shortages of gynecologists.

> "I think that in the rural areas ... we have fewer resources in these places. From a health resources perspective, sometimes there are laboratories, devices, or technology that we don't have ... Rural hospitals have only a few specialists, there are fewer specialties, fewer nurses, just fewer people in general."- Clinician, female

Structural

Migratory status impacts people's ability to access reproductive healthcare services.

General Population: Study participants did not discuss the issue of migratory status inherent to specific groups in Costa Rica other than vulnerable populations.

Vulnerable Populations: While there was general consensus between clinician and stakeholder groups that socioeconomic status impacts abortion options, there was a notable discrepancy between clinicians and stakeholders about access to services specifically for women with migratory status. When probed about differences in abortion access, the majority of clinicians responded about SRH services, more broadly. They stated that refugee, migrant and immigrant populations have the same access as the rest of the population to reproductive healthcare

(including access to contraception and post-abortion care). These clinicians referred to Costa Rica's Universal Healthcare System to support this claim. For example, a clinician shared:

> *"There are laws that protect the woman who does not have public healthcare, the state protects her ... Women are protected during pregnancy and childbirth without the need for them to be insured and without difference in treatment due to ethnicity, nationality or immigration status."* - *Clinician, male*

However, a few clinicians and mostly all stakeholders acknowledged substantial differences in access to reproductive health care services among populations with migratory status. Specifically, they cited discordance between the national health care policy and actual ability to access care. These participants emphasized that while all populations have rights "on paper", in reality, certain populations are not able to access public or private services due to financial barriers or lack of documentation. Several respondents mentioned that if women seek reproductive health services but lack citizenship papers or a permanent residence and cannot pay the fee to access the most basic level of health insurance, they are unable to receive care.

One clinician shared this about the barriers for low-income and migratory populations in Costa Rica in seeking reproductive health services:

> *"We say solidarity, well, but when there is no support for this type of insurance, then you have to pay a fee that some consider to be very high ... If you have no papers. If no one knows what your name is except you, you don't have access to the services."* - *Clinician, female*

A stakeholder also said this about the nuances of immigration and financial status on access to legal and clandestine abortion services in Costa Rica:

> *"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, on your immigration status ... if you are a refugee or not"* - *Activist, female*

Financial status is considered the primary determinant for access to abortion services.

General Population: At the structural level, financial status was identified by clinicians and stakeholders as the leading determinant of abortion access. Both groups acknowledged that one's socioeconomic status determines not only if one is able to access abortion, but how. One stakeholder shared this about the impact of financial resources on abortion method selection:

> *"Well, like so many other things, I would say that this has a lot to do with access to economic resources and that then there will be different ways of doing it for different people, depending on their economic possibilities."* - *Judge, female*

Nearly all clinicians and stakeholders emphasized that those who have financial resources have the option to leave Costa Rica and seek abortion services in other countries where it is accessible and are often counseled by clinicians to do so. Several clinicians shared that when women come to their facility with an unwanted pregnancy, they share information with the women about other countries where they can seek abortion services, including Mexico and the United States. One stakeholder shared this anecdote highlighting the compounding resources, including financial capacity and family support, necessary to leave the country to seek abortion services:

> *"She had the means to be able to travel ... which implies not only having money, but also having a United States visa, in her case ... it's not just any person ... being ready at the moment needed, with a current visa, with the money to be able to go. And with a support network. So, she travels with her stepmother and her mother-in-law and goes to Miami ... she has a spectacular treatment, they treat her very well. She completes her abortion, it's a matter of two, three days and they come back here."* -- *Non-Profit Executive, female*

Other clandestine abortion options available for women with resources that were mentioned by participants included accessing private facilities for abortion services or self-managed medication abortion through pills provided by clandestine sellers. Both of these options were acknowledged by respondents from both groups to be costly, and not accessible for the majority of the population. One stakeholder shared this about a woman's experience discreetly accessing abortion medication from a private provider:

"Her private gynecologist recommended that she get pills ... pretending he didn't say anything ... and told her he will wait for her in his office after she takes them. In other words, the private gynecologist was okay with her having an abortion, but he said, 'I can't do it by law. I'm too afraid of losing my license' ... And he sent her to buy her pills clandestinely. - Non-Profit Executive, female

Vulnerable Populations: Many clinicians and stakeholders acknowledged that financial resources directly impact the ways in which women can access information about abortion seeking, as well as the abortion services themselves. Both participant groups believed that the common options for clandestine abortion in Costa Rica mentioned above, including leaving the country, receiving abortion care in private facilities, or accessing abortion pills, are not financially possible for the majority of the population, which leaves women from vulnerable populations or low-resource settings with a harsh reality: they either need to continue their unwanted pregnancy and have the child, or terminate the pregnancy under unsafe conditions, which often lead to poor health outcomes. One clinician spoke about the lack of agency women with limited resources have in accessing abortion services:

"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. If you leave, you don't have resources, nothing, unfortunately it's going to be a fetus, a person more unsuitable for society. "- Clinician, female

A few clinicians and stakeholders also spoke to the impact of limited resources on inability to access medication abortion. A stakeholder shared this about the disparity of access to abortion information and abortion pills among low-income populations:

"I also believe that there are many differences among women. First, that they have access to information ... and secondly, that they can afford it because both the pills or the drugs and the medical procedure are expensive. So, definitely women in a disadvantaged socioeconomic situation ... I don't think they have access to these practices."- Legislative Advisor, female

Religion influences reproductive health care policy in Costa Rica

General Population: Participants frequently cited the influence of religion on sexual and reproductive health care and specifically abortion policy in Costa Rica as particularly influential on abortion access. Approximately a third of clinicians and stakeholders acknowledged that the political climate in Costa Rica is quite conservative, which impacts open discussion around both abortion and general women's health issues. Both clinicians and stakeholders cited the impact of Catholicism on Costa Rican politics and attributed religious beliefs of policymakers to limited conversations around abortion. One stakeholder shared this about the conservatism of the Costa Rican congress and how they avoid political discourse around abortion:

> *"It's a subject that they're [Congress] afraid of, that they don't want to touch. "Oh, no. Don't talk about abortion". It's still a taboo subject" - Lawyer, female*

Vulnerable Populations: Across all interviews, the impact of religion on abortion policy was not discussed in the context of vulnerable populations.

Discussion

Little research has been conducted in Costa Rica on access to abortion and reproductive health care services, and this study fills several gaps in the literature. This unique, qualitative study found that a range of factors across the socio-ecological model influence access to abortion care for people with pregnancy capacity in Costa Rica, and it included analysis of determinants at the individual, interpersonal, community, institutional/health system, and structural levels. The most prominent findings included insufficient access to sexual health education, little-to-no training on induced abortion provision for healthcare providers, and structural barriers associated with financial and migratory status.

This study validated existing global literature about the relationship between access to sexual health information and access to informed decision-making and abortion services. Research in several other low-and-middle income countries found similar results about the association between SRH knowledge and abortion access.[44,58,59] The overwhelming sentiment from both clinicians and stakeholders about inadequate sexual health education in Costa Rica highlights the

opportunity for increased engagement with local and regional organizations that promote expanded SRH information access. This study found that in the Costa Rican context, support from family and friends was instrumental for either connecting women to abortion services and networks, or as motivators for continuation of pregnancy. This finding was validated by global and regional literature on the influence of social support in determining one's access to abortion services.[44,58,61,65] This study also found that abortion is highly stigmatized in Costa Rica across multiple levels, which although not surprising given the legal context surrounding the procedure and existing literature on abortion stigma in the LAC region, fills gaps in published literature about the nuances of stigma in the Costa Rican context.[65,66] A relevant implication of abortion stigma that the study validates is suggested in a 2021 WHO study that found abortion stigma to lead to an avoidance of the health system in many cases.[66]

This study provided unique information about the knowledge and attitudes of Costa Rica's medical community. It found that clinicians received little-to-no training on abortion provision and had limited discussions with their medical peers about the topic, effectively limiting their ability to share knowledge and learn from one another. This finding is not discussed elsewhere in the literature on Costa Rica or on other countries in Central America but does validate a 2020 Jamaica-based study which found insufficient training and knowledge of nation abortion policy among medical students.[171] While Costa Rica's 2019 *Norma Técnica* was introduced to bring clarity to therapeutic abortion provision and establish clear, mandatory protocols for physicians to evaluate pregnancy risk, it has been criticized for insufficient roll-out and poor standardization in health facilities.[150,155]. Our study validated this criticism as evidenced by a general sense of unfamiliarity with the policy among clinicians and reported insufficient training on induced abortion provision years after the *Norma Técnica* was introduced. The study findings indicate an urgent need for abortion training and clarification of the policy for clinicians. This study highlights the opportunity for further research that could investigate the stigma that currently exists within clinical environments in Costa Rica, as well as potential for stigma reduction through training programs.

The study's findings on financial barriers to abortion were clear: safe abortion services are only accessible to those who have adequate financial resources and can afford to either clandestinely visit private facilities or pay for medication abortion pills or can leave the country and seek services where it is not restricted. This supports existing global and regional literature around financial status as a leading determinant of abortion access, and adds additional information on the Costa Rican context.[49,53,65] For example, Kulczycki found that across the LAC region, wealthy people can leave the country for abortions, or access private facilities. This study found this to be the same in Costa Rica, with particular nuances offered about common destinations for abortion travel and access to medication abortion specifically for wealthier women. Additionally, this study highlighted the linkage between finance and geography in Costa Rica, with several mentions of increased access to reproductive health services and resources in urban locations and more disparate access in the rural, coastal areas of the country.

Across the SEM, factors were disproportionately influential for vulnerable populations, who experience disparate access to sexual health information, support networks, reproductive health infrastructure and financial resources. The study findings corroborate existing literature on general health access barriers for vulnerable populations globally, as well as in Costa Rica, specifically.[44,97,99,172] Despite Costa Rica's alleged universal healthcare system and praise from the human rights community for integrating all populations into their health system, unique barriers exist that continue to exclude specific populations-- such as requirements for legal migratory status-- from accessing most insurance options.[97,172] This finding is supported by literature such as Voorend's 2021 paper, which found substantial difficulties for migrants in accessing healthcare and staggeringly low insurance coverage rates for this population.[97] This is especially relevant for vulnerable populations' access to abortion and sexual and reproductive health services in Costa Rica. Both the United Nations Population Fund (UNFPA) and the Costa Rican Demographic Association have issued reports that state that vulnerable populations have worsened access to sexual and reproductive health services, and that poor women were more likely to receive unsafe abortion services in comparison to people with adequate financial resources.[32,90] This study built on these findings and challenged the notion of a truly accessible, universal health care system in Costa Rica, with many participants emphasizing documentation status as a structural barrier to accessing healthcare services in general, as well as reproductive healthcare services, specifically.

Also notable, while secondary to the focus of this study, many participants mentioned existing barriers to other preventative reproductive health care, such as limitations to contraceptive access for vulnerable populations, thus further reducing the abilities of these populations to access preventative reproductive health care and undermining their bodily autonomy. Vulnerable populations' unmet need for contraception has been widely researched in the LAC region, with poverty identified as a key barrier in accessing resources and care.[173] This study also highlighted a significant discordance in the understanding of access to healthcare services for vulnerable populations. While most stakeholders acknowledged that vulnerable populations experienced strained or disparate access to health services and resources, most clinicians identified equal access for these populations without any differences or hardships in accessibility. This contrast in understanding about the unique health needs of vulnerable populations emphasizes the need for future sensitization of Costa Rican OB/GYNs on the compounded barriers experienced by vulnerable populations in accessing reproductive health services. It also leads us to believe that there may be opportunities for Costa Rican OB/GYNs to develop culturally-specific reproductive care health tools and information which can be provided to this population about accessible resources.

Limitations: This study is limited by its relatively small sample size and lack of participant diversity. In both stakeholder and clinician groups, most respondents worked in urban areas, so their perspectives should be interpreted within that context. Due to the recruitment method of snowball sampling, participants may have recommended others with similar political or religious beliefs, which may have contributed to limited perspectives shared in the interviews. Additionally, information about the needs of general and vulnerable populations was collected through clinician and stakeholder interviews and this manuscript does not include data from people that are low-income and/or have migratory status.

Strengths: This is the only study to analyze the social determinants of abortion access in Costa Rica. Additionally, this exploratory study is the first of its kind to assess both provider and stakeholder attitudes around abortion access in the country. Lastly, it is the only study to include distinctive considerations for vulnerable populations in the context of abortion access in Costa Rica.

Conclusion: This study addresses a gap in research related to the knowledge and opinions of clinicians and stakeholders on abortion access in Costa Rica, for both general and vulnerable populations. Study participants identified that abortion access is determined by multilevel, overlapping factors. The study found that cultural norms in Costa Rica perpetuate abortion stigma, which functions across all levels. Additionally, the study highlighted the need for more education on abortion, including with the general public and with clinicians. Efforts should be made to increase access to reliable information about abortion services and comprehensive sexual health information for the general population, as well as for vulnerable populations, specifically. The study found that vulnerable populations face compounded barriers and more complicated access to information and care for both abortion services, as well as general reproductive healthcare services, more broadly. Improving access to safe and legal abortion services in Costa Rica is an urgent public health priority, and further research is necessary, especially with vulnerable populations, to further characterize their needs and barriers to reproductive health care and safe abortion. The study also highlights a significant need for abortion training for clinicians, so they are informed about how to induce abortions in cases of medical necessity, are familiar with national policies, and can work towards minimizing abortion stigma. Costa Rica is considered by many as a human rights exemplar and this research reveals opportunities for changes within the healthcare system that would continue to bolster the human right to health and to specifically enhance access to reproductive health services for all people, while enhancing the bodily autonomy of people with pregnancy capacity in Costa Rica. This study also presents opportunities for human rights organizations to further engage and advocate for expanded access to safe and legal abortion services in Costa Rica at national and international levels, so all people in Costa Rica can realize their human right to health.

CHAPTER 4: PUBLIC HEALTH IMPLICATIONS

In recent years, more research has been conducted around abortion in the LAC region, in part due to tightening restrictions in some countries and growing activist movements in support of expanded abortion legality in others. However, in Costa Rica specifically, very limited published literature is available regarding access to access to abortion and reproductive health care services, more broadly. This study is the first of its kind to assess social determinants of abortion access in Costa Rica. It found that a range of factors across the socio-ecological model influence

access to abortion care for people with pregnancy capacity in Costa Rica, and it included analysis of determinants at the individual, interpersonal, community, institutional/health system, and structural levels. The most prominent findings included insufficient access to sexual health education, little-to-no training on induced abortion provision for healthcare providers, and structural barriers associated with financial and migratory status.

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facilities.[150,155]. Our study validated this criticism as evidenced by a general sense of unfamiliarity with the policy among clinicians and reported insufficient training on induced abortion provision years after the *Norma Técnica* was introduced. The study findings indicate an urgent need for abortion training and clarification of the policy for clinicians. This study highlights the opportunity for further research that could investigate the stigma that currently exists within clinical environments in Costa Rica, as well as potential for stigma reduction through training programs.

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accessing healthcare and staggeringly low insurance coverage rates for this population.[97] This is especially relevant for vulnerable populations' access to abortion and sexual and reproductive health services in Costa Rica. Both the United Nations Population Fund (UNFPA) and the Costa Rican Demographic Association have issued reports that state that vulnerable populations have worsened access to sexual and reproductive health services, and that poor women were more likely to receive unsafe abortion services in comparison to people with adequate financial resources.[32,90] This study built on these findings and challenged the notion of a truly accessible, universal health care system in Costa Rica, with many participants emphasizing documentation status as a structural barrier to accessing healthcare services in general, as well as reproductive healthcare services, specifically.

Also notable, while not the focus of this study, many participants mentioned barriers to contraceptive access for vulnerable populations, thus further limiting the abilities of these populations to access preventative reproductive health care. Vulnerable populations' unmet need for contraception has been widely researched in the LAC region, with poverty identified as a key barrier in accessing resources and care.[173] This study also highlighted a significant discordance in the understanding of access to healthcare services for vulnerable populations. While most stakeholders acknowledged that vulnerable populations experienced strained or disparate access to health services and resources, most clinicians identified equal access for these populations without any differences or hardships in accessibility. This contrast in understanding about the unique health needs of vulnerable populations emphasizes the need for future sensitization of Costa Rican OB/GYNs on the compounded barriers experienced by vulnerable populations in accessing reproductive health services. It also leads us to believe that there may be opportunities for Costa Rican OB/GYNs to develop culturally-specific reproductive care health tools and information which can be provided to this population about accessible resources.

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through clinician and stakeholder interviews and this manuscript does not include data from people that are low-income and/or have migratory status.

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Synthesis of Recommendations:

Following the results of the study and the priorities highlighted by participants, it is recommended that the following stakeholders take the steps outlined below to address the barriers to safe abortion care and reproductive health services, more broadly:

1. <u>The Costa Rican Government/ the Ministry of Public Health:</u>
    a. Partner with relevant stakeholders, such as the National Institute for Women (INAMU), to institute abortion policy trainings for all OB/GYNs in Costa Rica, or family medicine doctors that see pregnant patients. These trainings should be mandatory for all clinicians within the public health system (CCSS) to participate in so everyone is informed about the national policy, and there should be enforcement, where possible, to private sector providers as well for participation. This training should include a comprehensive overview of the national abortion policy and the 2019 Norma Técnica.
    b. Collaborate with relevant stakeholders to implement training to destigmatize the topic of abortion in medical facilities and encourage more dialogue and open discussion among medical faculty, students, and in training programs.
    c. Implement educational campaigns in collaboration with relevant stakeholders to spread information about the national abortion policy and the 2019 Norma Técnica so the general population is better informed about their rights and what they can request.
    d. Expand access to comprehensive sexual health education in schools, and partner with local organizations involved in health education to partner on the

provision of youth-friendly sexual health information nationwide. Resources/tools should also be created that are migrant-friendly and include unique considerations for accessible services for populations that cannot pay for health insurance.

2. Non-governmental and human rights organizations:
    a. Participate in increased advocacy efforts for vulnerable populations so that populations with compounded barriers to access in Costa Rica may have enhanced ease of accessing health services. The Center for Reproductive Rights and the Interamerican Commission of Human Rights have already been involved in several landmark abortion cases in Costa Rica and should consider involving themselves in advocacy efforts aimed at vulnerable populations.
    b. Organizations located in areas with high percentages of migrant, refugee, or low-income populations should consider implementing additional programming efforts aimed at reproductive health services.
    c. Mobilize funding to expand access to sexual and reproductive health resources for the population and provide financial support to aid vulnerable populations who cannot access public health services.
    d. Collaborate with the government and other relevant stakeholders to hold stigma-reduction workshops for the general public, the medical community, and other relevant professional groups to help decrease society-wide abortion stigma.

Future Study Directions:

While this study filled many gaps in literature related to abortion access, opinions and attitudes in the Costa Rican context, more research is needed. Based on the findings of the study, priorities highlighted by study participants, and remaining gaps in knowledge, the following future study directions are recommended:

1. Vulnerable Populations: This study included unique considerations for vulnerable populations from the perspectives of clinicians and key policy stakeholders. Additional qualitative research should be done *directly* with the communities with compounded barriers to access to directly highlight the voices and experiences of those most

marginalized so they may provide nuances about their barriers and facilitators to accessing abortion care. Data should be collected from locations in Costa Rica with high volumes of migrant, refugee, and low-income populations. This may include La Carpio, which is located west of San Jose and is marked by lack of basic services, poverty, overcrowding, and a majority migrant population[110,174]. It would also be valuable to conduct qualitative research with organizations or individuals that work with vulnerable populations directly. This would allow for an organization-level perspective to complement first-hand experiences that are collected directly from individuals.

2. Medical Community:

    a. Further studies with medical providers outside of San José would fill gaps in literature and would shed light on attitudes and experiences of clinicians in rural areas. These findings may provide unique understandings and nuances to the health realities and needs of populations living in rural, low-resource areas. It may also inform training needs and tools of providers working outside the capital city. Future research should also conduct studies with private sector providers to better understand their attitudes and experiences with providing abortion services.
    b. More research should be done to analyze the impact of abortion stigma on medical practice in San José. Additionally, in response to frequency of conscientious objection being raised by providers and stakeholders in relation to abortion accessibility, further research is needed to explore the willingness of clinicians to perform legal abortions in Costa Rica. It may also be interesting to assess providers through self-reporting or qualitative research on whether or not their views on abortion provision changed pre-and post- passing of the 2019 Norma Técnica, which may lend itself to analysis on the impact of domestic policy change on abortion attitudes.

Conclusion: This study addresses a gap in research related to the knowledge and opinions of clinicians and stakeholders on abortion access in Costa Rica, for both general and vulnerable populations. Study participants identified that abortion access is determined by multilevel, overlapping factors. The study found that cultural norms in Costa Rica perpetuate abortion

stigma, which functions across all levels. Additionally, the study highlighted the need for more education on abortion, including with the general public and with clinicians. Efforts should be made to increase access to reliable information about abortion services and comprehensive sexual health information for the general population, as well as for vulnerable populations, specifically. The study found that vulnerable populations face compounded barriers and more complicated access to information and care for both abortion services, as well as general reproductive healthcare services, more broadly. Improving access to safe and legal abortion services in Costa Rica is an urgent public health priority, and further research is necessary, especially with vulnerable populations, to further characterize their needs and barriers to reproductive health care and safe abortion. The study also highlights a significant need for abortion training for clinicians, so they are informed about how to induce abortions in cases of medical necessity, are familiar with national policies, and can work towards minimizing abortion stigma. Costa Rica is considered by many as a human rights exemplar and this research reveals opportunities for changes within the healthcare system that would continue to bolster the human right to health and to specifically enhance access to reproductive health services for all people, while enhancing the bodily autonomy of people with pregnancy capacity in Costa Rica. This study also presents opportunities for human rights organizations to further engage and advocate for expanded access to safe and legal abortion services in Costa Rica at national and international levels, so all people in Costa Rica can realize their human right to health.

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Appendixes

Appendix A. English In-Depth Interview Guide: Clinicians and Medical Residents

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 the audio recorder if the 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?

Policies related to reproductive health

Now we would like to learn more about your perspective on policies related to women's health.

3. Do you think women's rights are protected in Costa Rica?
    a. If yes: what protects them?
    b. If not: why not? How could they be better protected?
4. How do current policies affect how women in Costa Rica access reproductive healthcare?
5. How do clinicians feel about these current policies?
6. How do current abortion laws affect women's health?
7. If laws and policies made induced abortion more readily available, how do you think providers would feel about providing care to women seeking an abortion?

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

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.

9. 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?
10. What training did you receive regarding contraception, prevention of unwanted pregnancy, unintended pregnancy, and abortion in your medical residency?
11. How are induced abortions discussed at your institution?
12. 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.

13. 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?
14. 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?
15. How do doctors provide induced abortions to women?
    a. How do you feel about the doctor's role in providing care to these women?
16. What is your experience providing post-abortion care to women?
    a. How do you feel about your role in providing care to these women?
17. In which situations do you think providing an abortion is ethical?
    a. Do you think that most clinicians think depression should be a reason to obtain a therapeutic 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. Spanish In-Depth Interview Guide: Clinicians and Medical Residents

Guía de Entrevistas: Personal Sanitario

Introducción

Gracias por acompañarnos el día de hoy y dedicarnos su tiempo. Nuestros nombres son _____ y _____. Somos estudiantes de maestría en salud pública en la universidad Emory en Atlanta, Georgia, EEUU y estamos llevando a cabo una investigación (de verano) como parte de nuestro programa. También nos acompaña Daniel que es un estudiante de medicina y representante en la investigación de la UCIMED.

Este es un estudio que están llevando a cabo la Universidad Emory, en Estados Unidos, y la UCIMED, sobre las políticas y las prácticas de salud relacionadas con el embarazo no planeado y el aborto en Costa Rica. El término, "embarazo no planeado", hace referencia a los embarazos que no se esperaban y que no son deseados. Nuestra expectativa es que, al comprender mejor los comportamientos, conocimientos y percepciones actuales sobre el embarazo no planeado y el aborto, podamos proporcionar a los legisladores y a los médicos más información sobre las necesidades de salud de los costarricenses y ayudar a informar en la práctica médica futura y el desarrollo político. Nos interesa escuchar lo que tiene que decir y lo que cree que es más importante. No hay respuestas correctas ni incorrectas.

La entrevista es voluntaria y puede elegir omitir preguntas o terminar la entrevista en cualquier momento y por cualquier motivo. La entrevista será confidencial, y su nombre y otros datos de identificación no serán grabados. Compartiremos los resultados del estudio con la UCIMED y con los funcionarios del Ministerio de Salud de Costa Rica. Estos resultados pueden ser publicados en revistas académicas, pero no incluiremos ninguna información de identificación en nuestros informes.

¿Tiene alguna pregunta en este momento?
¿Acepta ser entrevistado/a? Si acepta, por favor firme el formulario de consentimiento.

Nos gustaría grabar nuestra sesión para asegurar capturar con precisión lo que comparte con nosotros. Solo los miembros del equipo de investigación tendrán acceso a la grabación para asegurarse de que no se pierda información importante. Además, sólo grabaremos su voz en esta entrevista; no se utilizará ningún video. Eliminaremos la grabación después de transcribir la entrevista. ¿Está de acuerdo si grabamos el audio de la sesión de hoy?

Encender la grabadora de audio si el participante consiente ser grabado.

Datos demográficos

Antes de comenzar la entrevista, me gustaría confirmar algunos detalles de la información que usted compartió cuando hablamos por teléfono.

- ¿Se identifica como hombre, mujer u otro género? _____
- ¿Cuántos años tiene? _____
- ¿Cómo describiría su religión? _____
- ¿Cuánto tiempo lleva usted trabajando como [enfermero / médico / médico residente]? _____
- ¿Trabaja en un centro de salud público o privado? _____
- ¿Trabaja en un centro de salud primario, secundario o terciario? _____
- ¿Describiría el establecimiento de salud en el que trabaja como rural o urbano? _____

Preparación

Ahora, comencemos con algunas preguntas sobre usted y su profesión.

1. ¿Cómo describiría su rol profesional actual?
2. ¿Cómo es un día típico de trabajo para usted?

Políticas relacionadas con la salud reproductiva

Ahora nos gustaría conocer más de su perspectiva sobre las políticas relacionadas con la salud de las mujeres.

3. ¿Cree que los derechos de las mujeres están protegidos en Costa Rica?
    a. En caso afirmativo: ¿qué los protege?
    b. Si no, ¿Por qué no? ¿Cómo podrían estar mejor protegidos?
4. ¿Cómo afectan las políticas actuales el acceso a la salud de las mujeres de Costa Rica?
5. ¿Cómo se sienten los médicos acerca de estas políticas actuales?
6. ¿Cómo afectan las leyes actuales sobre el aborto a la salud de las mujeres?

7. ¿Puede describir los detalles de la norma técnica del aborto terapéutico?
8. Si las leyes y las políticas hicieran que el aborto inducido estuviera más accesible, ¿cómo cree que se sentirían los proveedores al brindar atención a las mujeres que buscan un aborto?
9. Si las leyes y las políticas hicieran que el aborto inducido estuviera más disponible, ¿cómo cree que se sentirían otros proveedores al brindar atención a las mujeres que buscan un aborto?
10. ¿Piensa que los cambios en política en países como Argentina y México afectaran las políticas en Costa Rica?

Entorno laboral y formación profesional

Ahora me gustaría hacerle algunas preguntas sobre su formación médica y el entorno en el que trabaja. Como recordatorio, por "embarazo no planeado", nos referimos a embarazos que no se esperaban ni se deseaban. Cuando hablo de abortos inducidos, me refiero a abortos que se realizan en un centro de salud por un médico capacitado. Cuando hablo de atención post aborto, me refiero a cuando una mujer tiene un aborto espontáneo o intenta inducir el aborto sin un médico capacitado y acude a un centro de salud debido a complicaciones.

11. ¿Qué le enseñaron acerca del embarazo no deseado y el aborto en la facultad de medicina?
    a. ¿Qué aprendió?
    b. ¿Hay más que desearía haber aprendido en la facultad de medicina?
12. ¿Qué capacitación recibió sobre anticoncepción, prevención de los embarazos no deseados, los embarazos no deseados y los abortos en su residencia médica?
13. ¿Cómo pueden los médicos aprender de la norma técnica de aborto terapéutico?
14. ¿Cómo se discuten los abortos inducidos en su institución?
15. ¿Es el aborto un tema que puede discutir con sus colegas?
    a. Si es así, ¿qué tipo de conversaciones tiene sobre el aborto?

Práctica actual con embarazos no planeados

Me gustaría preguntarle por su experiencia al brindar atención a mujeres con embarazos no planeados.

16. ¿Qué sucede típicamente en Costa Rica cuando una mujer se entera de que tiene un embarazo no planeado?
    a. ¿A dónde acuden las mujeres para recibir atención cuando tienen embarazos no planeados?
17. ¿Cuál es su experiencia en asesorar a mujeres que tienen un embarazo no planeado?
    a. Cuando asesora a mujeres con embarazos no planeados, ¿Qué clase de preguntas plantea usted a la mujer?
18. ¿Cómo proveen los médicos abortos inducidos a las mujeres?
    a. ¿Qué opina del rol del médico en la atención de estas mujeres?

19. ¿Cuál es su experiencia en brindar atención post aborto a mujeres?
    a. ¿Cómo se siente con respecto a su rol en la atención de estas mujeres?
20. ¿En qué situaciones cree que es ético realizar un aborto?
    a. ¿Cree que la mayoría de los médicos consideran que la depresión debería ser una razón para obtener un aborto terapéutico?

Para concluir

Muchas gracias por compartir sus perspectivas hoy. ¡Hemos aprendido mucho de usted! Tenemos solo un par de últimas preguntas antes de terminar la entrevista.

21. ¿Cómo cree que será la práctica médica relacionada con el aborto en Costa Rica en 10 años?
    a. ¿Cómo espera que sea?
22. ¿Hay algo más que crea que deberíamos saber antes de que terminemos la entrevista?

Ahora hemos llegado al final de la entrevista. Queremos agradecerle nuevamente que haya hablado con nosotros hoy y que haya compartido su experiencia. Apreciamos que haya dedicado su tiempo para ayudarnos con nuestra investigación y esperamos compartir nuestros resultados pronto. Si desea hacer un seguimiento con nosotros por cualquier motivo, puede llamarnos o enviarnos un mensaje de texto al [WhatsApp / Google #] o comunicarse con nosotros al [insertar correo electrónico del equipo].

Appendix C: English In-Depth Interview Guide: Stakeholders

Introduction

Thank you for coming today and sharing some of your time with us. Our names are _____ and _____. We are graduate 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. It is important that we hear a range of perspectives on the topic. 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 the audio recorder if the 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? _____
- What is your age today? _____
- What religion do you practice? Pentecostal, Catholic, Evangelical, None, Other (please list)
- How religious are you on a scale of 1-5 (1-not religious at all 5-very religious)

Warm Up

Let's start a few questions about you and your professional role

1. What is your current profession?
2. What organization do you work for?
3. How long have you been working at this organization?
4. Can you tell me about how your work intersects with or addresses sexual and reproductive health?

Perspectives on SRHR

Thank you for sharing some information about your professional background. Now I would like to ask you about sexual and reproductive health and rights in Costa Rica.

5. How would you define sexual and reproductive rights?
    a. Probe: Are abortion rights included?
6. How would you describe the relationship between sexual and reproductive rights and human rights?
    a. Probe: What about the relationship between abortion rights and human rights?

7. How do you think people's sexual and reproductive rights are protected in Costa Rica?
    a. Probe: In what ways are sexual and reproductive rights unprotected?
    b. If yes— Who or what currently protects sexual and reproductive rights?
    c. If not—Why would you consider them not protected?
8. In which situations, if any, is providing an abortion ethical?
    a. Probe: When is it unethical?
9. In your opinion, when should people be able to access post-abortion care?
    a. Probe: Should people be able to access post-abortion care if they access abortion illegally?
10. In your professional community, when do people think accessing abortion and post-abortion care is ethical?

Current access and practices related to abortion

Thank you for providing your perspectives on sexual and reproductive health and rights. I would like to ask you about current access to abortion in Costa Rica and ways that it is practiced.

11. What do women in Costa Rica do when they have unintended pregnancies?
    a. Probe: what services (legal and illegal)
    b. Probe: How does that differ by groups i.e., economic class, refugee status, region of country, etc.?
12. How would you describe current healthcare access to legal abortion in Costa Rica?
    a. Probe: How would you describe current access to therapeutic abortion in Costa Rica?
    b. Probe: How does that access differ by groups i.e., economic class, refugee status etc.
13. What are the most common reasons Costa Ricans seek abortion?
    a. Probe: Which of these reasons are ethical? unethical?
14. Can you describe the common reasons why people will not seek an abortion?
15. To your knowledge what are the most common methods of inducing abortion for those who do not qualify for a legal abortion (in your community/in Costa Rica)?

Abortion Laws and Policy

That was very helpful, thank you. I would now like to ask you about current abortion laws and policies in Costa Rica:

16. What is your current understanding of abortion laws in Costa Rica?
    a. Probes: cases when it is legal, when it is not
17. How is reproductive health and rights affected by Costa Rica's current abortion law?
18. Can you give me an example of a time when a therapeutic abortion was not granted despite a legal justification?

a. Probe: Do you think the current abortion law has any effect on pregnant people's physical and mental health?

Influences and future of abortion policy

Great, thank you! We are almost to the end of our interview and before we conclude I would like to ask about the future of abortion policy:

19. What abortion advocacy or pro-life movements currently exist in Costa Rica?
    a. Probe: What are the strengths of these movements?
    b. Probe: How have these social movements influenced policy change?
    c. Probe: Have you/How have you been involved in these movements?
20. How have policy changes in other parts of Latin America, including the recent legalization in Argentina, impacted policy in Costa Rica?
    a. Probe: How do you foresee regional policy changes impacting Costa Rica's abortion laws in the future?

Wrap-up

Thank you so much for sharing your perspectives today. We are learning a lot from you! We have just a few last questions before we close.

21. Do you believe that attitudes about removing abortion restrictions have changed over the past 20 years?
    a. Probe: If yes, how have attitudes changed?
22. What do you think abortion policy will look like in Costa Rica in 10 years?
    a. What do you hope it will look like?
23. Is there anything else that you think we should know before we close?

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 D. Spanish In-Depth Interview Guide: Stakeholders

Guía de Entrevistas: Legisladores

Introducción

Gracias por acompañarnos el día de hoy y dedicarnos su tiempo. Nuestros nombres son _____ y _____. Somos estudiantes de maestría en salud pública en la universidad Emory en Atlanta,

Georgia, EEUU y estamos llevando a cabo una investigación (de verano) como parte de nuestro programa.

Este es un estudio que están llevando a cabo la Universidad Emory, en los Estados Unidos, y la UCIMED, sobre las políticas y las prácticas de salud relacionadas con el embarazo no planeado y el aborto en Costa Rica. El término, "embarazo no planeado", hace referencia a los embarazos que no se esperaban y que no son deseados. Nuestra expectativa es que, al comprender mejor los comportamientos, conocimientos y percepciones actuales sobre el embarazo no planeado y el aborto, podamos proporcionar a los legisladores y a los médicos más información sobre las necesidades de salud de los costarricenses y ayudar a informar en la práctica médica futura y el desarrollo político. Nos interesa escuchar lo que tiene que decir y lo que cree que es más importante. No hay respuestas correctas ni incorrectas.

La entrevista es voluntaria y puede elegir omitir preguntas o terminar la entrevista en cualquier momento y por cualquier motivo. La entrevista será confidencial, y su nombre y otros datos de identificación no serán grabados. Compartiremos los resultados del estudio con la UCIMED y con los funcionarios del Ministerio de Salud de Costa Rica. Estos resultados pueden ser publicados en revistas académicas, pero no incluiremos ninguna información de identificación en nuestros informes.

¿Tiene alguna pregunta en este momento?
¿Acepta ser entrevistado/a? Si acepta, por favor firme el formulario de consentimiento.

Nos gustaría grabar nuestra sesión para asegurar capturar con precisión lo que comparte con nosotros. Solo los miembros del equipo de investigación tendrán acceso a la grabación para asegurarse de que no se pierda información importante. Además, solo grabaremos su voz en esta entrevista; no se utilizará ningún video. Eliminaremos la grabación después de transcribir la entrevista. ¿Está de acuerdo si grabamos el audio de la sesión de hoy?

Encender la grabadora de audio si el participante consiente ser grabado.

Datos Demográficos

Antes de comenzar la entrevista, me gustaría confirmar algunos de los datos que compartió cuando hablamos por teléfono.

- ¿Se identifica como hombre, mujer u otro género? _____
- ¿Cuántos años tiene? _____
- ¿Qué religión practica? Pentecostal, Católica, Evangélica, Ninguna, Otra (Por favor, indíquela)
- ¿Qué grado de religiosidad tiene usted en una escala del 1 al 5 (1 - nada religioso, 5 - muy religioso)

Preparación

Empecemos con algunas preguntas sobre usted y su profesión.

1. ¿Cuál es su profesión actual?
2. ¿Para qué organización trabaja?
3. ¿Cuánto tiempo lleva trabajando en esta organización?
4. ¿Puede comentarnos cómo su trabajo se relaciona o aborda la salud sexual y reproductiva?

Perspectivas sobre la salud y los derechos sexuales y reproductivos

Gracias por compartir información sobre su trayectoria profesional. Ahora me gustaría preguntarle sobre los derechos sexuales y reproductivos en Costa Rica.

5. ¿Cómo definiría usted los derechos sexuales y reproductivos?
    a. Indagar: ¿Están incluidos los derechos de aborto?
6. ¿Cómo describiría la relación entre los derechos sexuales y reproductivos, y los derechos humanos?
    a. Indagar: ¿Qué relación existe entre el derecho al aborto y los derechos humanos?
7. ¿Cómo cree que se protegen los derechos sexuales y reproductivos de las personas en Costa Rica?
    a. Indagar ¿De qué manera están desprotegidos los derechos sexuales y reproductivos?
    b. Si están protegidos, ¿quién o qué protege actualmente los derechos sexuales y reproductivos?
    c. Si no están protegidos, ¿por qué considera que no están protegidos?
8. ¿En qué situaciones, si es que hay alguna, es ético realizar un aborto?
    a. Indagar: ¿Cuándo no es ético?
9. En su opinión, ¿cuándo debería la gente poder acceder a la atención postaborto?
    a. Indagar: ¿Deberían las personas poder acceder a la atención postaborto si acceden al aborto de forma ilegal?
10. En su comunidad profesional, ¿cuándo cree la gente que es ético acceder al aborto y a la atención postaborto?

Acceso y prácticas actuales relacionadas con el aborto

Gracias por aportar sus perspectivas sobre la salud y los derechos sexuales y reproductivos. Me gustaría preguntarle sobre el acceso actual al aborto en Costa Rica y las formas en que se practica.

11. ¿Qué hacen las mujeres en Costa Rica cuando tienen embarazos no deseados?
    a. Indagar: ¿A qué servicios acceden? (legales e ilegales)

    b. ¿Cómo difiere esto por grupos: por clase económica, por condición de refugiado, ¿o región del país?
12. ¿Cómo describiría el acceso sanitario al aborto legal en Costa Rica?
    a. Indagar: ¿Cómo difiere ese acceso por grupos: por clase económica, por condición de refugiado, ¿región del país?
13. ¿Cuáles son las razones más comunes por las cuales las costarricenses buscan un aborto?
    a. Indagar: ¿Cuáles de estas razones son éticas? ¿poco éticas?
14. ¿Puede describir las razones más comunes por las que la gente no buscan un aborto?
15. ¿En su conocimiento cuáles son los métodos más comunes para inducir un aborto para las mujeres que no pueden recibirlo legalmente?
    a. Indagar: ¿En su comunidad? ¿En Costa Rica en total?

Leyes y Políticas de Aborto

Esto fue muy provechoso, gracias. Ahora me gustaría preguntarle sobre las leyes y políticas de aborto en Costa Rica.

16. ¿Cuál es su conocimiento actual de las leyes sobre el aborto en Costa Rica?
    a. Indagar: ¿En cuales casos es el aborto legal, y cuando no?
17. ¿Cómo se ven afectados los derechos reproductivos por la ley de aborto actual en Costa Rica?
18. ¿Puede dar un ejemplo de un caso en que la ley no haya funcionado, es decir, en el que el aborto haya sido inaccesible a pesar de una justificación legal?
    a. Indagar: ¿Cómo afecta la actual ley de aborto a la salud física y mental de las personas embarazadas?

Influencias y la futura de la política de aborto

Bueno, ¡gracias! Estamos casi al fin de esta entrevista y antes de concluir, me gustaría preguntar sobre el futuro de la política del aborto:

19. ¿Cuáles movimientos de advocación u oposición al aborto existen actualmente en Costa Rica?
    a. Indagar: ¿Cuáles son las fortalezas de esos movimientos?
    b. Indagar: ¿Cómo han influido estos movimientos en el cambio de políticas?
    c. Indagar: ¿Ha participado usted en estos movimientos? ¿Como?
20. ¿Cómo han influido los cambios de política en otras partes de América Latina, incluida la reciente legalización en Argentina, en la política de Costa Rica?
    a. Indagar: ¿Cómo prevé que los cambios en las políticas regionales impactarán en las leyes de aborto de Costa Rica en el futuro?

Para concluir

Muchas gracias por compartir sus perspectivas hoy. Estamos aprendiendo mucho de usted. Tenemos solo unas preguntas más antes de que terminemos.

21. ¿Cómo han cambiado las actitudes sobre la eliminación de las restricciones al aborto en las últimas 20 años?
22. ¿Cómo cree que será la política del aborto en Costa Rica dentro de 10 años?
    a. ¿Cómo espera que sea?
23. ¿Hay alguna cosa más que piense que debamos saber antes de que terminemos?

Ahora hemos llegado al final de la entrevista. Queremos agradecerle nuevamente que haya hablado con nosotros hoy y que haya compartido su experiencia. Apreciamos que haya dedicado su tiempo para ayudarnos con nuestra investigación y esperamos compartir nuestros resultados pronto. Si desea hacer un seguimiento con nosotros por cualquier motivo, puede llamarnos o enviarnos un mensaje de texto al [WhatsApp / Google #] o comunicarse con nosotros al [insertar correo electrónico del equipo].