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Navigating the Minefield: Women's Experiences of Abortion in a Country with a Conscience Clause—The Case of Croatia

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Navigating the Minefield: Women's Experiences of Abortion in a Country with a Conscience Clause—The Case of Croatia

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Abstract

Many countries around the world have a conscience clause allowing physicians and health care providers to opt-out of performing abortions. This practice of conscientious objection to abortion care affects both healthcare providers and women's access to abortion care. In Croatia, a conscience clause was introduced in 2003. Nonetheless, women's experiences of abortion after the introduction have not been previously studied. The aim of our study was to explore women's experiences of abortion and conscientious objection in a country with a conscience clause. The study has a qualitative inductive and explorative design. We interviewed seven (7) women in Croatia with experience of an unwanted pregnancy or abortion and analyzed the interviews using thematic content analysis. Our findings revealed one overarching theme: 'Navigating the minefield—women's experiences of abortion in a country with a conscience clause' and three categories: 'Experiencing abortion—to endure a vulnerable situation,' 'The conscientious objection in practice—causing obstacles and stigma,' and 'Views on abortion—socio-cultural and religious influence'. The women perceived the abortion decision as being difficult and expressed feelings of shame, guilt, and fears of being judged in line with the general attitude toward abortion in society. They described the conscientious objection as having consequences in public healthcare by limiting their access to abortion care and affecting treatment in terms of i.e. derogatory comments, limited or lacking information about the abortion procedure and/or absent contraceptive counseling post abortion. According to the women, a shift towards more conservative ideas towards abortion seem to have taken place in the Croatian society. The conscientious objection was believed to reinforce a moralizing view of sexuality, where the women's decisions regarding abortion became a collective concern causing stigma and involuntary social alienation. The conscientious clause made the women feel they had to navigate a 'minefield,' where their dependency situation and vulnerability in the abortion situation were reinforced by social stigma.

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Keywords: Abortion, Conscientious objection, Conscience clause, Sexuality, Women's experiences, Stigma, Croatia.

Introduction

The practice of unsafe abortions is a major public health problem in many countries, often reinforced by resistance toward abortion care due to religious, moral, and ethical objection (Chavkin et al., 2013; Harries et al., 2014). Conscientious objection in healthcare means the refusal to perform or provide certain treatments to patients, based on personal beliefs or reasons of morality or "conscience" (Shanawani, 2016). Twenty-five out of the 27 countries in the European Union (EU) have a statutory right to free abortion; however, in 21 of these 25 EU countries, healthcare providers have the right to refrain from or opting out of performing or participating in abortion care through a statutory conscience clause. This conscientious objection lacks legal support in Sweden, Finland, Bulgaria, and the Czech Republic. However, reference to the conscience clause among health care providers has become increasingly common in Italy, Portugal, the United Kingdom, Austria, Slovakia, and Poland (Kane, 2009; Heino et al., 2013).

Previous research has pointed to the fact that conscientious objection in abortion care mainly concerns women and thereby affects women's reproductive health (Beal & Capiello, 2008; Kane, 2009; Heino et al., 2013; Faundes et al., 2013; Harries et al., 2014; Fiala et al., 2016). Healthcare providers' right to practice a conscientious objection by referring to the conscience clause puts women in an unequal situation, depending on their place of residence, socio-economic status, income, and their opportunity to gain access to abortion care (Beal & Capiello, 2008; Kane, 2009; Heino et al., 2013; Faundes et al., 2013; Harries et al., 2014; Autorino et al., 2020). Conscientious objection also leads to stigmatization and is ultimately a hindrance to women's access to safe abortions (Galic, 2006; Chavkin et al., 2013; Bijelic & Hodzic, 2014; Zaręba et al., 2017).

In Croatia, abortion has been legal since 1978 (from the period of socialism) and induced abortions can be performed according to women's wishes and without special permission up until the end of the 10th week of gestation. Since the independence in 1991, religious organizations together with the Catholic Church, have gained strong influence in society and in the early 2000s, the free abortion law was questioned. At the beginning of 2003, the Croatian Government drafted a proposal to amend the law relating to healthcare professionals as well as medical codes. The proposal resulted in the amendment of the Croatian Health and Medical Care Act, whereby healthcare personnel were given the right to abstain from performing work tasks and thereby had the possibility of being exempted from performing abortion care based on personal ethical, religious, or moral opinion. In Croatia, the conscientious objection can be followed only if the woman's life is *not* in danger. If the health care professional does not perform the abortion, then the woman shall be referred to another clinic or doctor, where the woman can get help (Zakon o ljecnistvu, 2003).

After the conscience clause was introduced, the question of abortion turned into a heated topic in the Croatian society and to an emotionally loaded issue for many Croatian citizens (Galic, 2006; Bijelic & Hodzic, 2014). However, research on issues concerning conscientious objection and abortion within the Croatian context is scarce and women's experiences of abortion after the introduction of the conscience clause have not been studied previously. Thus, the aim of our study was to explore women's experiences of abortion and conscientious objection in Croatia.

Method

Study Design

The study has a qualitative inductive and explorative design. Seven women (n = 7) with experiences of an unwanted pregnancy or abortion in Croatia participated in in-depth, semi-structured individual interviews. Women were recruited with the help of two organizations who were willing to gather potential participants: Center for Education Counseling and Research (CESI) and Znaj znanje. CESI and Znaj znanje are two religiously and politically independent organizations whose purpose is to spread knowledge about reproductive and sexual health, contraception, and abortion to the public. During the recruitment process other actors such as health care professionals and heads from private and public abortion care services were asked to participate in the recruitment process. None of them were willing to assist with the gathering of informants.

Participant Recruitment and Data Collection

After obtaining permissions from the heads of the organizations (CESI and Znaj znanje), a web advertisement with information about the study and contact information to the first author was published on the websites. We also used snowball selection to recruit informants. Women who were interested in participating in the study reported their interest via e-mail to the first author and subsequently received written information about the study. The informational letter contained details about the purpose of the study, the voluntary nature of participation as well as confidentiality and anonymity according to ethical principles of the Helsinki Declaration (The Swedish Research Councel, 2011; WMA, 2013). Each participant was informed that the interviews would be audio-recorded. Consent for the study was submitted in writing or orally at each interview session. Those who were eligible to participate were women who had undergone, or wished to have had an abortion after the year 2003, when the country introduced a conscience clause. Eleven women showed interest in participating in the study. Four women who registered their interest were excluded because the abortion took place before 2003. None of the women included in the study had been active members of the organizations from where they were recruited.

The interviews were conducted from October 2015 to January 2016 by the first author Gladoic Hakansson (GH). GH is a bilingual, registered nurse midwife, fluent in Swedish and Croatian with extensive clinical experience in issues concerning sexual and reproductive health. After having performed all the interviews, GH transcribed the full material in the original language (Croatian), resulting in 6–11 pages of text per interview, and subsequently translated parts of the transcripts into Swedish. Information about the informants was anonymized; transcripts were de-identified, and the audio recordings were deleted after transcription so that no informant could be identified.

Due to the sensitive topic, informants could choose between having a personal interview in Croatia, a telephone interview, or a digital interview using Skype. Two informants chose Skype, two chose personal interviews, and three were interviewed by phone. There was a professional readiness within the recruitment organizations if informants required counseling due to difficult emotions arising during or after the interviews; however, such support was not requested by any of the informants.

Interview Guide

A semi-structured interview guide was used, functioning as a checklist of topics and issues that covered relevant areas for the purpose of the study. During the interviews (lasting between 45–60 minutes), the informants were asked to describe their experiences of having an abortion or having an unwanted pregnancy. The interviews started with basic questions (children, family, partnership, contraception use), moving on to pregnancy as well as experiences of the abortion, including experiences at the clinic; easy and difficult aspects of accessing pregnancy termination; attitudes from health care providers, the treatment and the abortion procedure, costs in connection with the abortion, transport, travel distance, support from family, friends or partner; confidentiality or privacy concerns; experiences of stigma; most important aspects regarding the services available, and suggestions for improvements. Some demographic data about the participants were also collected.

Data Analysis

The interviews were analyzed using thematic content analysis as described by Burnard, et al. (2008) and with concepts inspired by Graneheim & Lundman (2004). The first author, GH conducted the initial analysis separately; all interviews were carefully listened to following the interview, and notes were made that functioned as initial codes. The transcripts were read several times to get an overall picture of what was stated. All parts related to the aim of the study were retrieved. Meaning units were then extracted, condensed, and sorted into codes. After each coding, the condensed sentences, meaning units, were read again and compared to the original text to check that the essence was not lost. The codes were grouped into subcategories. Thereafter, the second and last author individually read the transcribed parts translated into Swedish and identified codes and subcategories to avoid lone researcher bias (Graneheim & Lundman, 2004). The subcategories were summarized into three categories under one overarching main theme. All researchers took part in discussing the codes, categories and themes until a consensus was reached.

The results have been presented as close to the original interviews as possible; quotations are included for trustworthiness of the analyzed data (Graneheim & Lundman, 2004). The informants were not given the opportunity to provide feedback on the results, but respondent validations were performed at the end of each interview when the first author made an interview summary to make sure the information had been understood correctly. As in all qualitative research, the aim was not to generalize but to provide a better understanding of the participants' perspective (Lincoln & Guba, 1989).

In order to understand the consequences of the conscientious objection and the health care professional's treatment of abortion-seeking women, we used Goffman's (1963) concept of *stigma*. Stigmatization means attributing to someone a deeply discrediting trait, which is considered to be different from the norm. The theory of stigma has previously been used in research involving HIV patients (Chambers et al., 2015), and it has been developed to include a number of aspects such as stamping, stereotyping, status loss, and discrimination, where power relations are crucial for understanding (Link & Phelan, 2001). The stigmatization of women that seek abortion means for example that the health care professionals' derogatory attitudes toward them are made legitimate.

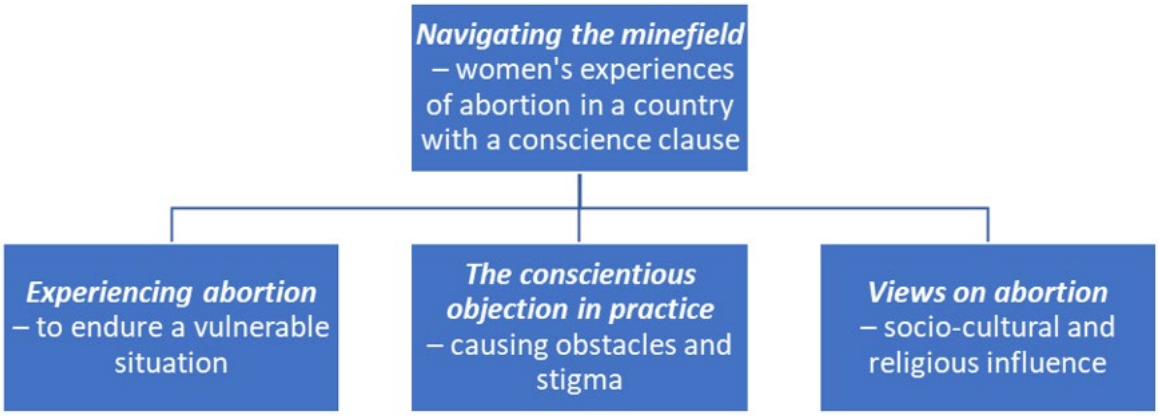
Results

In total, seven women (n = 7), who had an unwanted pregnancy and had decided to terminate the pregnancy, participated in this study. The interviewed women were between 18 and

45 years old at the time of the abortion. The interview took place on average 2 ½ years (ranging from 2 months to 6 years) after the pregnancy termination. Five women had a university education, one had a high school education, and one had a primary school education. Four women were living in a city, two lived in a small town, and one woman came from the countryside. At the time of the unwanted pregnancy, five of the women were pregnant for the first time, while two had children previously. Coitus interruptus was mostly used as the method for protecting against unwanted pregnancy. One woman had used a condom, and one had stopped taking birth control pills. Six of seven women completed the abortion. One woman who had planned to terminate the pregnancy, finally could not go through with the abortion after persuasions from her family. She ended up giving birth to a child.

The analysis resulted in one overarching theme: 'Navigating the minefield—women's experiences of abortion in a country with a conscience clause' and three sub-categories: 'Experiencing abortion—to endure a vulnerable situation,' 'The conscientious objection in practice—causing obstacles and stigma,' and 'Views on abortion—socio-cultural and religious influence' (Figure 1).

Figure 1. Themes in the Study



Experiencing Abortion: To Endure a Vulnerable Situation

All women in this study felt bad, surprised, and shocked when they had found out about their pregnancy. Some had not told their partner, friends, or family that they had become pregnant. The women perceived that the community viewed them as unreliable and irresponsible. Some suffered from depression as a result. Feelings of guilt were recurring elements in the women's stories. All of the women thought abortion was a difficult decision.

I'm not against abortion, but it's not an easy decision. It felt like deciding whether a life should be allowed to continue or not. It is not a good feeling. (1)

Bad mood, insomnia, anxiety, and depression were commonly expressed feelings related to the abortion and the descision making process preceeding the pregnancy termination. Some women felt traumatized and were afraid of becoming pregnant again. Feelings of shame and guilt, fear of judgment, powerlessness, and pronounced vulnerability in relation to the abortion descicion were commonly expressed and in line with the perceived general attitude toward abortion in society.

When discussing reactions on the abortion descision among friends and family in their surroundings, the women reported how the others judged them as being unreliable and irresponsible because of their unwanted pregnancy and for wanting to abort. Some described the feeling of total helplessness. One woman felt strongly pressured by her social network to give birth to the child.

I only wanted help, nothing else, but everybody just criticized me. They said straight to my face that I was worse than a killer because murdering a child is worse than murdering an adult!

I wanted nothing but to have an abortion, but nobody wanted to help me. I got no help from the hospital. I didn't get any help at all. Think about a leashed dog that has gotten itself tangled into chains and that cannot get loose by itself: a stuck dog that is seeking help. A helpless dog that cries for help and no one wants to help it. That's how I felt. (3)

I was lying on the operating table, had a syringe in my arm and felt like my hands and legs were being strangled. (2)

Because of the perceived vulnerability, the women wanted the abortion to be performed anonymously, to avoid moral judgments. Some were able to get the abortion registered as spontaneous or as being performed due to medical reasons.

Any receipt? They didn´t give any. I think the doctor did not register it in the journal. Of course, I wanted to do it discretely. (4)

We did an early ultrasound, and the fetus was very small. My mom knew the doctor. He pretended that the fetus was undeveloped, which was a reason for the medical abortion. We did not pay, and the abortion was not registered like intentional abortion. (5)

Some women with a partner felt support in the abortion decision but the opposite was also revealed. One woman described that her partner ended the relationship because of the pregnancy, others, without stable relationship at the time felt alone and lacked psychosocial support.

The lack of support and feeling of being judged was evident also after the abortion procedure. One woman having tried to seek support from her friends recalled;

When I told my friends, I saw immediately how they changed toward me and kept a distance. One even said that it [the abortion] actually was the reason, because she thought what I was doing was wrong. No one asked me what I thought. It was insignificant in the context. (1)

The Conscientious Objection in Practice: Causing Obstacles and Stigma

According to the interviewed women, the conscientious objection became a factor to consider when they sought abortion care. Some knew where to get help, while others searched randomly on the Internet or tried to get information over the phone. The women had two options: public or private abortion care. The women hoped to encounter abortion friendly health care personell, but it was often difficult to find out since there were wide differences in how hospital staff sometimes explicitly and openly refered to the conscience clause, whereas at other times their statements were cloaked. In some hospitals it was impossible to have a legal abortion because all

of the health care professionals referred to the conscience clause and clearly demonstrated the agenda with anti-abortion propaganda.

There were folders and posters against abortion in the waiting room. It said abortion is murder and children are the gift of God. My partner and I were in shock! (2)

Other health care settings had health care professionals that performed abortions but also those who did not. Women who sought public care described difficulties in accessing abortion care due to lacking information on hospital websites on wether conscience objection was applied or not. The women claimed that the most important factor in getting help to have an abortion was to navigate correctly in the healthcare system. Several stressed the importance of using social networks and contacts to avoid facing moralization and stigmatization from health care professionals and others.

My mom knew the doctor and she was with me the whole time and talked to the doctor whom she knew well. You know how it is in a small town; you know what to do and with whom. Contacts are important. (5)

The consequences of not being able to navigate this 'minefield' were that the women did not get satisfactory help with having the abortion. The help was dependent on the staff's attitude toward abortion. Consequently, the woman's access to abortion care was left to chance.

We went to the hospital that had abortion friendly doctors. But then we met staff that were dismissive when we wanted information. We felt that something was wrong; they were against abortion. I just wanted to leave. (6)

The attitudes from health care professionals varied. Some women felt questioned after having been declared as being irresponsible because of having become pregnant unintentionally. It was described how health care professionals sometimes made it clear what they thought about the woman as a person, especially if the woman chose to have an intentional abortion instead of having an abortion for medical reasons. One woman explained:

The staff showed no respect. They performed abortions with the door open, so we could hear everything. I heard the woman before me scream and cry, and I heard all the talk when they did her abortion. I'm sure it was to lecture us. When they came out, I was absolutely appalled.
[…]
The doctor asked me how old I was and if I was unemployed. I was in total shock. I am quite sure that they do it to frighten those of us who choose to have an abortion, while being friendly to others who do it for medical reasons. It was clearly a moral judgment. (2)'

At other times less pronounced insinuations and ethical objections to the pregnancy termination were made;

Even though the doctor and everyone there was very nice, I was completely paralyzed after I heard the doctor say several times: the heart beats already! (7)

Information about the use of contraception after an abortion was rare in public hospitals. One woman requested strilization, but this was not obeyed. After the abortion, she continued to renounce sex because of the fear of pregnancy, but also because of a lack of desire.

The staff at the private clinics, on the other hand, were described as helpful and professional in all stages of the treatment. Three women had a health check-up after termination of pregnancy privately and received contraceptives after the abortion. None of the interviewees who went to the private clinics encountered the conscientious objection to abortion. The private clinics were however economically more expensive than public alternatives since abortion is not subsidized by the health insurance. The women paid between 1500-3000 HRK depending of the choice of hospital/clinic or choice of analgesic, which is equivalent to half of an entire average monthly income. If needed for medical reasons, however, the abortion was free of charge. Women who had economic resources chose private alternatives to avoid meeting staff making moral and ethical objections to abortion and to avoid moralization and stigmatization.

My experience with the staff was fantastic because I had private care. It costs money, you pay, and you get the care you need without being moralized. (4)

The women's experiences reveal a large spectrum of healthcare facilities where abortion care was conducted. Being able to navigate in the healthcare system was an important factor in being able to access abortion care. The staffs' use of and reference to the conscience clause as well as their perceptions greatly influenced the women and their experieces of their possibilities to accessing abortion sevices.

Views on Abortion: Socio-cultural and Religious Influence

Social norms in Croatia – including attitudes towards abortion—were perceived to have changed over the last few decades into a more conservative paradigm. The informants believed a shift towards more conservative ideas had taken place, possibly affected by the growing influence of the Catholic Church. As reflected by the conservative social norms, the women felt that sexual and reproductive health matters did not primarily belong to them as individuals, but was rather a matter for the whole community.

Actually, no one sees you as a person and listens to what you want. You have to do what others say even though they don't live your life. It means you have to live your whole life in sorrow. (3)

It was further discussed how the influence of the Catholic Church had increasingly affected all parts in society, such as healthcare, schools, and public spaces – often in a negative way. One informant expressed how religious ideas influenced attitudes towards contraceptives.

The religious influence is everywhere. A teacher [nun] in my daughter's school told me about how contraception is murder and everyone who uses contraceptives are killers, and that I had to look after my daughter [18 years] so she doesn't use contraception. (3)

The women sensed that views on abortion seemed more accepting among middle-aged and older generations, while younger ones were perceived as being more judgmental. Some therefore

found it easier to talk about the abortion with their mothers or older female friends instead of friends of the same age.

Abortion is generally not acceptable here, especially among younger people. The older generations are more liberal; they accept abortion more than the younger ones. There is a generational issue. […] My generation, the young people, think that it's terrible and wrong if someone has an abortion. (1)

Discussion

Discussion of Results

This study highlights womens experiences of deciding on, and performing abortion in Croatia after the introduction of a conscientious clause in the year of 2003. Our results reveal a wide range of challenges that women had to fight against when seeking to have an abortion. By the term 'Navigating in a minefield landscape' we mean a societal landscape where women, in trying different strategies, navigate to escape moralizing views and stigma. Our findings showed that deciding on abortion was difficult and mentally stressful for the women, who all wrestled with various negative emotions. Feelings of vulnerability and stigma turned out to be a recurrent theme during the interviews in which the women also revealed how the conscientious objection contributed to poor abortion services, lack of information and judgemental attitudes among health care providers. Our findings are in line with previous research in which conscientious objection in abortion care have been found to reduce access to safe abortions, and contribute to stigmatization of the woman (Beal & Capiello, 2008; Kane, 2009; Faundes et al., 2013; Heino et al., 2013; Harries et al., 2014; Fiala et al., 2016).

All informants were more or less aware of how abortion care in Croatia worked, but still, information on where and how to seek help, or wether or not the health care professionals would assist with the abortion or refer to the conscience clause, were often unclear. This uncertainty made it difficult for the women to navigate in the health care system and it caused stress for the women to access abortion services in time. It also caused them emotional stigma. An obvious drawback for women in this sense is the time, since women who want to get an abortion have a limited time frame to undergo such a procedure. Consequently, negative attitudes toward abortion and possibilities for health care professionals to refer to conscientious objection had negative imact on the women's reproductive health and rights, even when abortion was formally legal.

According to an NGO-report, Croatian physicians often referred to conscience objection without regulations by any standardized procedures (Bijelic & Hodzic, 2014). The lack of clarity about how one can express conscientious objection when it comes to abortion in the Croatian context therefore leaves room for the suspicion that this 'privilege' of conscientious objection is being misused (Borovečki & Babić-Bosanac, 2017). There are numerous examples in the literature of situations when so called 'double standards' are being practiced in abortion care and causing stigma for abortion seeking women. In Poland for example, treating physicians have been detected to support the decision of their patient when at the same time they refuse to perform the procedure themselves (Zareba et al, 2019). In South Africa unclear abortion legislation and uncontrolled practices of the conscientious objection have formed a 'double standard' where doctors are able to perform abortions for extra compensation, but can refer to the conscience clause if this additional profit is not included (Harris et al., 2014). In Croatia, problems have been raised of situations where the same person may rely on conscientious objection in public health care institutions, but

perform abortions in private health care facilities after working hours (Borovečki & Babić-Bosanac, 2017).

Stigma can also extend to health personnel and result in healthcare providers opting out of abortion services entirely. Fear of being judged or discriminated against by colleagues can then result in physicians' referring to conscientious objection in order to camouflage their own fear of stigma (Faundes et al., 2013; Singh et al., 2017). Whether or not this is something that occurs in the Croatian context could be a question for future research to explore. However, the women in our study did not report any situation where staff in the private care settings had invoked conscientious objection. On the contrary, the informants clearly stated that private options, albeit far more costly, were expected to be less stigmatizing and women who had financial resources therefore sought private care from the beginning. Another advantage with private options was that the women could remain anonymous.

Our findins are in line with previous research concluding that conscientious objection has a stronger impact on women living in lower-income regions, with lower socio-economic status in terms of seeking care and having access to abortion (Beal & Capiello, 2008; Kane, 2009; Heino et al., 2013; Faundes et al., 2013; Harries et al., 2014; Autorino et al, 2020).

The enactment of a conscience clause in Croatia, together with neo conservative movements and the growing prominence of the Catholic Church during the past decades, seem to have influenced social norms about abortion and possibly other issues concerning sexual and reproductive health. For example, the women perceived older generations to have a more permissive view of abortion, while younger generations were seen as more judgmental, which may endorse theories of how religious and neo-conservative forces, through public and political campaigns, can change norms and socio-cultural scripts (Totter et al., 2015). B & B (2017) argues that the current discourse regarding abortion within the Croatian context primarily stems from ideology, culture, and traditionalism, with laws and bylaws being far less present (Borovečki & Babić-Bosanac, 2017). Aditionally, the conscientious objection within abortion care is based on individual conviction from a religious context where conception equates a child and an abortion with the murder of a child (www.katolik.nu). Thus, religious influences create a discourse that controls the individual's sexuality, access to information, the use of contraceptives, and abortion services. The women in our study felt accused of being irresponsible or stamped as depraved due to the abortion decision, or for wanting to use contraceptives. Sexual behavior that falls outside "the good sexuality", defined as sex for reproductive purposes in a heterosexual relationship, can thus be seen as deviant and distasteful (Rubin, 1984). In concordance with such norms, the use of contraceptives or having an abortion is being viewed as wrong and immoral. Consequently, being labelled as immoral for having become pregnant while not having the possibility of using contraceptives puts women in a paradoxical situation, which negatively affects both their sexual and reproductive health and rights.

According to Gagnon & Simon (2004), norms of sexuality may be changed, transformed, and questioned based on social context. The women in our study described issues concerning sexuality and childbirth as a collective concern where people in their surroundings believed they had the right to have opinions about, and influence over the women's actions and decisions. Since there was no organized or regulated social support, the women felt isolated from their social environment. In this sense, stigma was symbolized by the people's moral status (Goffman, 2011), and the women were burdened with guilt and shame. By deviating from the prevailing norms, the women were punished by stigmatization and retaliation, for example in terms of social exclusion.

This study did not explore the staff's attitudes toward performing an abortion in a country with conscience clause. This could be an area of further research. Another interesting topic would be to gain a better understanding of the differences between public and private abortion care in a country with a conscientious clause. How abortion is experienced in a country with a conscience clause is a topic that is not easily explored, nevertheless, important to highlight in order to gain knowledge about womens situations, experiences and access to abortion related health care services.

Strenghs and Limitations

The study was based on a relatively small number of informants, even for a qualitative study. This may be seen a disadvantage. On the other hand, the collected material was rich with a variety of perspectives addressed. It is also important to note that abortion in Croatia is a morally and ethically charged issue and it was therefore difficult to get actors to assist with the recruitment of participants. Nevertheless, the recruited women were willing to share their stories extensively and in detail – also when several years had passed between the abortion occation until the interview took place.

The informants were recruited via advertisements on websites linked to organizations working with abortion issues, as well as with the help of snowball selection. The advantage of the sampling methods used was that it enabled enough informants to be recruited and the study could be carried out. Women having experienced stigma tend to withdraw to groups where they can meet with people having similar experiences or stigma and where they can feel safe (Goffman, 2011). In a neo-conservative society, organizations like the ones used for recruitment in the present study play an important role in promoting women's rights regarding sexual health and abortion. Hence, it may be argued that these organizations have become important actors in highlighting the complexity of the abortion situation in countries where conscientious objection is being practiced.

Conclusion

The effects of practicing conscientious objection in abortion care, despite a free abortion law, legitimized moralization and caused women to feel emotional and social stigma. The women found themselves having to navigate in a ‘minefield’, where their dependency situation and vulnerability were reinforced. Unregulated application of the conscientious objection caused obstacles for accessing abortion services and contributed to unequal care depending on the womens geographic location and social-economic conditions. There were no reports on the use of conscientious objection in the private sector. Social norms and attitudes towards abortion were influenced by religious views and conservative ideas, which generally had negative impact on the womens sexual and reproductive health and rights.

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Disclosure statement

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Appendix 1. Interview guide

Warm-up questions

- Age, partnership.
- Have you been pregnant before?
- Have you been using contraception?
- Do you have children? Family?

Pregnancy

- How did you find out about your pregnancy? How did it feel?
- Do you want to tell me about the treatment seeking process?

Experience and reception during the abortion

- How was the reception by the health care system, your social circle, and family?
- What was your experience with received treatment?