

**What's a Girl to Do:**  
**Repatriarchalization and Croatian Women's**  
**Reproductive Freedom**

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Thank you, Dr. Falen. Without your guidance and assistance during the formative stages of this research the whole process would have been infinitely more painful. Thank you to the two wonderful young women who served as my key informants. Without such active and enthusiastic help, this project could have taken me months. Thank you, Dr. Jelavić. Without your timely refresher in gender theory, I might not have regained my focus and direction. And finally, thank you to my two wonderful roommates back at Agnes Scott College. If they hadn't taken the time to discuss various fine points and theories with me (at great length, many times), I might never have figured out what I really wanted to research.

MAP OF THE REGION

## **INTRODUCTION TO THE RESEARCHER**

Despite our best efforts to the contrary, no researcher can ever be completely objective. Regardless of how much conscious effort we expend to be fair and even in the treatment of our data, our own perceptions will invariably color our findings. Since I believe this to be true, I will start my research with a few key facts about myself and my perceptions of reproductive freedom which may have influenced this research.

In the United States, I am involved in reproductive freedom and fighting domestic violence. I absolutely believe in a women's right to choose to have an abortion. I encourage all of my sexually active friends to start taking oral contraceptives. I am a Women's Studies major, and a self proclaimed feminist. All of these things impact the way I view the reproductive freedom situation in Croatia.

Were I to have been born and raised in Croatia, I could have been a participant in this research. Actually, I would have been the third youngest participant. My participants related to me in a friendly, informal way. Our interviews were conducted with much laughter, smoking, and side conversations. However, I am an American, and a native English speaker. Many of my participants agreed to be interviewed because they wanted a chance to practice their English with a native speaker (which are still relatively rare for young women to meet here), or because they wanted to ask me questions about the USA afterwards. All these things impacted the information I received during the interviews.

## **INTRODUCTION TO THE RESEARCH**

Croatia is a country in transition. After decades of officially minimizing differences between itself and the rest of the former Yugoslavia, Croatia is now fiercely fighting to establish its own unique identity. As part of that battle, Croats have embraced their folk traditions, and they have brought the Catholic Church back into prominence. Approximately 85% of Croats are Roman Catholic, and the Croatian government and the Catholic Church have very strong ties (Drakulic 1993: 125). As is the case in many transitional countries, the embracing of folk culture and its norms, coupled with the resurgence of the Catholic Church has brought about a period of intense repatriarchalization. With it has come an intense pressure for women to conform to traditional gender roles. For example, many experts believe that “the content of the educational system is gender biased, reinforces traditional views of family and sexuality” (ASTRA Network 23: 2006).<sup>1</sup>

One main arena of repatriarchalization has come been that of reproductive rights. Croatia’s reproductive policies are pronatalist, due in large part to the upsurge in ethnic nationalist in the region that started during the Balkans war. Pronatalism, with its deeply nationalistic roots, has profoundly shaped ethnicity and gender relations in Croatia. In an effort to consolidate their numerical superiority within their “home territory,” as well as to compensate for high wartime death rates and overall low birthrates, most former Yugoslavian countries embraced policies that increased birthrates. The Catholic Church’s strong presence in Croatia also promotes pronatalism. This has led to a series restrictions on contraceptives and abortions, along with systematically under-educating young Croats about contraceptives and STDs.

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<sup>1</sup> The ASTRA Network is the Central and Eastern European Women’s Network for Sexual and Reproductive Health and Rights. The ASTRA Network is composed of NGOs throughout the Central/Eastern European region and the Balkan countries.

Reproductive freedom is central to gender equality and a high standard of living. Women who cannot control when they reproduce are unable to make meaningful long term plans. Understanding how women feel about and actually use the current reproductive health system is crucial to being able to provide better services and create better policy in the region. This research addresses questions regarding Croatian women's attitudes towards and experiences with contraceptives and the reproductive health system. It seeks to determine how the government's church led pronatalist policies impact Croatian women's conscious control of their reproductive lives, given that "reproductive rights imply informed choice on family planning, birth and birth spacing" (Lancker 2007: 1). This topic involves women's agency in choosing how to regulate their reproductive lives, and their actual experiences making those choices within the current system.

For the purpose of this research, conscious control over reproductive choices is defined as having enough information to make intelligent choices, having the social backing to make those choices and having the resources readily available to support those choices (potentially changing from sexual encounter to sexual encounter) to have or to not have children over the course of fertility. The primary data will be gained through interviews, and secondary data will be heavily referenced.

## **METHODOLOGY**

This research took place in Zagreb, Croatia, between March 1, 2007 and May 8, 2007. I interviewed 15 non-professionally involved women (NPIW), two gynecologists, and one sexual education activist. NPIW are women who are in no way professionally (or on a volunteer basis) involved in reproductive health. This non-affiliation is important because women who work with reproductive issues are less likely to have typical ideas and behaviors regarding

reproductive health. Moreover, one of the key factors that I was interested in is the level of education about reproductive health the women had received, which being involved in an organization working with reproductive health would obviously skew.

Structured interviews were conducted with the two gynecologists and the sexual education activist. The questions from these interviews can be found in Appendices A and B respectively. Semi-structured interviews with NPIW Croatian women were utilized to collect ethnographic data regarding the women's experiences with contraceptives, abortion, sexual education, and choosing whether or not to have children. Participants were questioned about their experiences with sexual education (both formal and informal), their contraceptive usage, their experiences with gynecologists, the reactions of their families and friends to their reproductive choices, and their perceptions about the general acceptability of contraceptives and abortions within Croatia. I also collected demographic information, including respondents' marital status, age, number of children, place in which they were raised, and religious affiliation. An effort was made to find variety within each of these categories in order to give the research breadth. The interview guide for the NPIW interviews can be found in Appendix C. All interviews were recorded into mp3 format when the respondents permitted. Where necessary, I went to various pharmacies or other places of business to confirm or disprove the information about availability or cost collected during the interviews.

Interview participants were selected through nonrandom snowball sampling, using contacts provided through several key informants I have met throughout her time spent in Zagreb. Dr. Grujić and Sanja Cesar of CESI<sup>2</sup> were introduced to me through the School of International Training. An effort was made to obtain female participants through as many

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<sup>2</sup> CESI is the Center for Education and Counseling of Women. It is a member of the Women's Coalition, the ASTRA Network, and the Coalition to Stop High-Risk Sexual Education. It is based in Zagreb, Croatia.



sources as possible so as to have a range of ages, places of origin, educational levels, marital statuses, and economic statuses, as well as participants with variation in number (if any) of children they have. Since the purpose of this research is to understand the impacts of repatriarchalization on the current situation, the age limits for participants were set between 18 and 35. Women older than 35 would have most likely finished their sexually formative years by the time the former Yugoslavia dissolved. Had there been more time, this research could have been improved by having a larger number of participants.

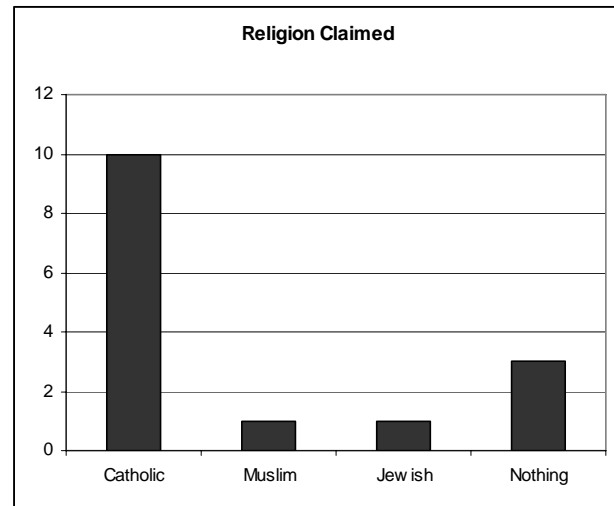
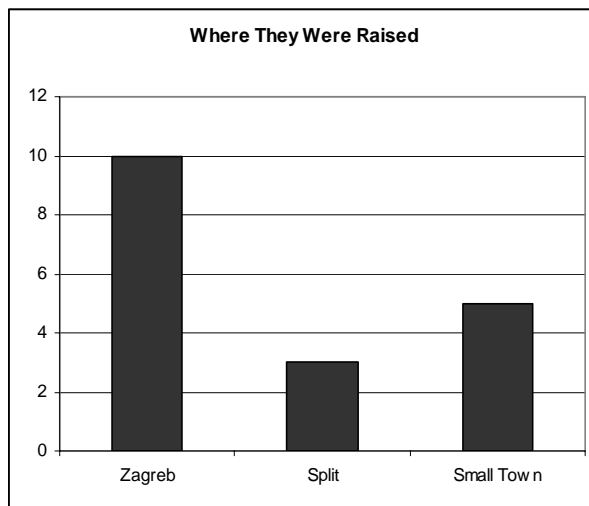
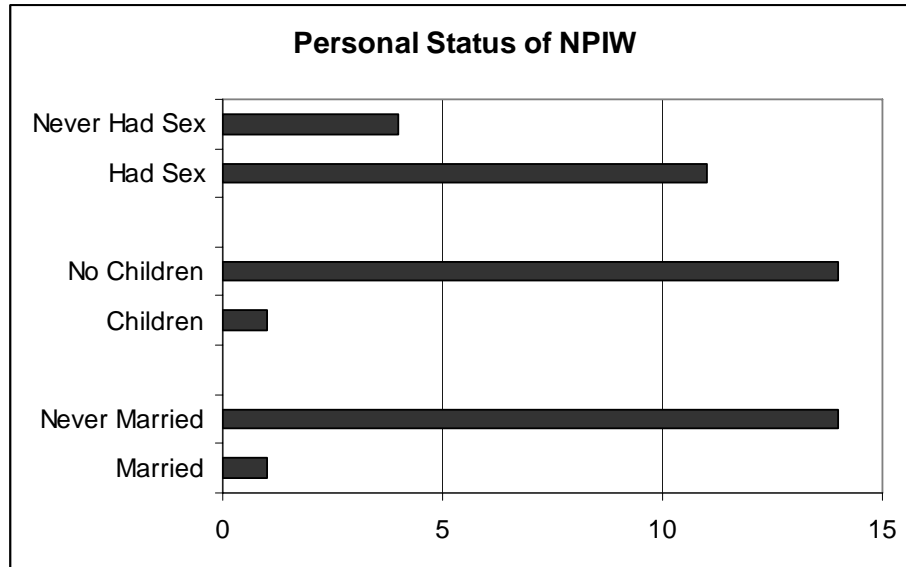
The privacy of all interview participants was maintained by keeping all of the information collected confidential. No names were attached to any of the transcriptions or notes pages, and the master list was destroyed at the completion of this research. Towards that end, a specific interview bibliography is unavailable. All participants were treated according to ethical standards, as determined by the Agnes Scott College IRB and the School for International Training IRB. Research lasted two months and seven days, starting on March 1, 2007.

### **NPIW Statistical Breakdown**

The sample for this research was created of women aged 18 to 33, with a mean age of 25.33. Much like in the general population, most of the women questioned were Catholic, and the second largest group was comprised of atheists. While all of the participants are currently living in Zagreb, almost half of them grew up and attended mandatory schooling in Split or from various small towns throughout Croatia. Four of the women interviewed had never had sex<sup>3</sup>, versus 11 who have. Of them women who have, all of them are having sex on a regular basis. Only one woman who was interviewed has been married or has had children.

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<sup>3</sup> For the purpose of the question “Have you ever had sex?” I allowed sex to be self defined. However, it is unclear how the participants were defining sex because those that answered yes have had heterosexual intercourse, while those who answered no had only ever kissed someone else (if that). Neither oral nor anal sex were addressed in the interviews, except in one case where a participant told me a story about the STI she contracted in her mouth. I decided that the topic was outside of the scope of the research.



## **CONTEXT**

### **Pronatalism, the Church, and the Symbolic Role of Women**

“In national quests for airtight, invariant identities,” women are frequently assigned the symbolic position of reproducers of the nation (McClintock 1997: 77). Within the discourse of pronatalism, which was characteristic of the political scene in Croatia throughout the 1990s, women’s bodies are “transformed into national symbols and presented as symbolic battlefields that embody national values” (Bjelic 2002: 314). As ethnic wars killed thousands of Croats, a

new nationalist “iconography of mother as war victim, symbolizing the suffering homeland, replaced the socialist image of women as workers with formal equality to men” (Shiffman 2002: 21; Drakulic 1993: 123). Homemaking and family rearing as primary responsibilities are central to the concept of women-as-only-mothers. Women are under represented in politics in the Balkans because they are expected to assume full responsibility for their families. (Rueschemeyer 1994: 163). Ethno-nationalist discussions saw women “exclusively in the role of mothers” and excluded women from political decision-making (Howell 2005: 42). Catholic leaders propagated the traditional family models (Rueschemeyer 1994: 227). Emphasis on a women’s “proper place” in the home was accompanied by building pressure to remain outside the public sphere (Lobodzinska 1995: 233). More than just that, they propagated women’s “proper roles” within that model. In order to perpetuate the “natural” order of patriarchy, the church stressed the importance of motherhood to womanhood (Lobodzinska 1995: 233). The Church promoted women as “modest, obedient, emotional, and accommodating” (Lobodzinska 1995: 233).

Croatia is said to be ruled “by a national-populist program, by the huge influence of the Catholic Church which seems to be making up for fifty years of socialism, and by a militarization of all segments of life” as opposed to being ruled by sound economic policies (Corrin 1996: 133). As is common in Eastern Europe, an “alarmist discourse” about the low fertility rates impact on national and ethnic survival shaped the reproductive rights discourse in Croatia (Shiffman 2002: 20). Approximately 85% of Croatians are Roman Catholic, and the Croatian government and the Catholic Church have very strong ties (Drakulic 1993: 125). The Catholic Church’s strong socio-political standing in Croatia has allowed it to severely impact reproductive policies in the state. The Church actively opposes sex education, abortion, and

contraceptives besides the rhythm method, and actively supports traditional family models, women's traditional roles, and increased birthrates. Croatia's pronatalist policy, which is inextricably linked to nationalism and the Catholic Church, solidifies the otherness inherent to ethnicity, and propagates traditional gender roles for women.

Many ethnic Croats died in the series of wars and skirmishes fought over the past few decades in Croatia, and the Croatia birth rate was and is significantly below replacement rates. The first Croatian regime that held power after the dissolution of Yugoslavia "used a perceived threat to national survival emerging from warfare and low fertility rates to promote a pronatalist population policy that threatened the reproductive rights of its citizens" (Shiffman 2002: 21). Croatian leaders started to claim that population decline "jeopardized the survival of the nation" (Shiffman 2002: 22). 1989 marked the beginning of the pro-life campaigns in Croatia. These campaigns heavily supported by the Catholic Church. The next serious threat to reproductive rights materialized in 1990 when the new constitution was posted. The constitution left out the clause from the 1974 constitution which guaranteed citizens the right to "free decision-making concerning childbearing" and instead, included a "general 'right to life'" (Shiffman 2002: 23).

The nationalist slant to reproduction makes reproduction by ethnic Croats seem "right, judicious, and necessary," while at the same time it makes reproduction by those not recognized as citizens (minorities, immigrants, etc...) seen as "polluting, dangerous, and out of control." (Gal 2000: 23) The Catholic churches issued dramatic warnings that the national birth rates of Croatia were among the lowest in the world, and that they faced the threat of becoming "minorities in their own countries" (Bjelic 2002: 316). The heavy attention Croatia's pronatalist policies pays to ethnicity has the effect of legitimizing perceived ethnic differences. Or, to put it another way, "If ethnicity is to be mobilized on behalf of national destiny, cultural differences

must be internalized as inbred and inviolate.” (McClintock 1997: 77). Croatia’s ethnic nationalism in the form of pronatalism seems “bent on redrawing the boundaries of nation-states...into more ethnically homogeneous polities” in that the nationalistic pronatalist Croatian policies that encourage the birth of more Croats also discourage the birth of non-Croats.

(McClintock 1997: 69; Gal 2000: 27). It is also important to realize that panic about the decrease of birthrates in a country like Croatia which is not shrinking in physical population, can only exist because the people panicking do not recognize immigration as legitimate growth. (Gal 2000: 28).

### **Legal Context**

Under the Croatian Constitution, family, maternity, and children enjoy special protection, and the state is charged with creating “social, cultural, educational, material and other conditions conducive to the realization of the right to a decent life” (CFRR 2000: 35). Mothers are entitled to special protection at work. Women have explicitly protected rights to paid maternity leave and affordable child care in the constitution. (Flanz 1983: 282). In addition, the Croatian Constitution also “guarantees the right to health care” (CFRR 2000: 35). Aside from the constitution, there are two main pieces of legislature which are supposed to increase the birthrates of and support parenthood by ethnic Croats: the National Program for Demographic Development (NPDD) and the Labor Act.

In May, 1995, the Ministry of Development and Renewal released the National Program for Demographic Development (NPDD) for the Republic of Croatia (CFRR 2000: 38). The program addresses the fears surrounding “depopulation” and the “failure” of women to sufficiently reproduce. The NPDD states that the revaluation of family is “essential for the

restoration of the entire nation and the country” (CFRR 2000: 38). The NPDD is invoked in the support those who attack abortion rights and divorce.

The Labor Act fashioned a unique legal status called “mother-nurturer” for mothers of four or more children. An employed or an unemployed woman with a status of mother-nurturer “is entitled to financial reimbursement, pension and disability insurance, health insurance and other rights in accordance with special regulations” (CFRR 2000: 42). The Labor Act “protects maternity” and “offers special rights for pregnant employed women,” such as an employer cannot based on a woman’s pregnancy, refuse to hire her, fire her, or “discriminate against her in any way” (CFRR 2000: 42). The Labor Law’s chapter on motherhood, called “Protection of Maternity” gave a wide range of rights to working mothers. These included “mandatory maternity leave during the first six months of the child’s life for the mother and an optional six months of additional leave that could be used by mother or father,” and the “protection of pregnant women against firing and a paid breast-feeding break of two hours daily” (Shiffman 2002: 26). Under the Labor Act, women are required to take a mandatory maternity leave that lasts from at least 28 days prior to giving birth, until at least 42 days after giving birth. Although the Labor Act promised women with four or more children professional status and monetary recompense, the government has been unable to deliver on either account. Women who believed the NPDD and Labor Act’s guarantees and had four or more children are now testifying about the terrible situation — financial and social —in which they have found themselves, without a job or any hope to get one” (CFRR 2000: 42). Additionally, while employers are not suppose to be able to fire women based on their pregnancies, “it is common in small private enterprises that women are fired as soon as their employer finds out about their pregnancy” (CFRR 2000: 42). The slow and complicated nature of the legal proceedings to combat the illegal firing makes

most women reluctant to prosecute. In addition, in the 1997 state budget “no resources were allocated for full payment of the second six months of the promised maternity leave to employed women, and thus many women received two to three times less money than guaranteed by law” ( Shiffman 2002: 28).

## **RESULTS**

The results of these interviews have been analyzed with other literature to prove that young Croatian women have insufficient conscious control over their own reproductive lives. The definition of conscious control calls for three necessary elements in order to establish or disprove its presence. Social attitudes and resources are inseparable except on the most superficial level, so they will be addressed together. Therefore, the results will be broken down into two categories: information and social availability.

### **Information**

Human beings have been successfully reproducing for as long as there have been human beings. Most of those people never had a sexual education class, or visited a gynecologist at all. It is arguable that most of those people never even knew how they were reproducing. Clearly, a good understanding of reproductive health is not a prerequisite for the survival of the species. So then, why is it important? Understanding reproductive health is important for maintaining public health and for the existence of gender parity.

Societies can no longer afford to ignore STIs. We live in the age of HIV, Herpes, Hepatitis C, and Chlamydia, to name a few. Some STIs are treatable with simple antibiotics. However, someone has to recognize the signs, be getting regular tests, and know what to do when they notice something is wrong to get these simple antibiotics before his or her STI becomes something more serious. Other STIs are incurable, and will change and potentially

radically shorten the life of whoever contracts them. Here, the only defense is to take sound preventative measures. If for no other reason than STIs, mandatory scientific sexual education would be a sound investment.

However, there is another reason which is equally if not more important: gender parity. To boil it down to its simplest terms, women who cannot control when they will have children cannot make long term plans for their lives. This is not about the occasional accidental birth, we are talking about women who do not know enough about contraceptives to be able to correctly list which methods will prevent pregnancy. Information about reproductive health is a key aspect to conscious reproductive control. According to my research, the majority of women between the ages of 18 and 35 lack at least some the information necessary to make responsible choices in regards to their own reproductive lives for at least part of their sexual careers.

### **Sexual Education**

When discussing sexual education, it is important to remember that there are two distinct and largely separate kinds. The first type is formal education. This type includes anything about sex, contraceptives, STIs, etc... which is learned in a formal educational setting. For example, a 9<sup>th</sup> grade health class is a source of formal sexual education. Formal sexual education is given more weight than the second type of education, informal sexual education, because the information is dispensed by authority figures in an environment that students have grown accustomed to trusting for factual information. Informal sexual education covers everywhere else someone might learn about sex, contraceptives, STIs, etc... Popular sources of informal education are television, magazines, parents, friends, and the internet.

#### *Formal Sexual Education*



Formal sexual education is important because “the lack of sexuality education has resulted in an incomplete understanding of sexual behavior, underdeveloped communication skills and fragmented knowledge of sexuality and SRHS<sup>4</sup> issues. For young people, this means a greater exposure to risky sexual behavior, unrealistic expectations and distorted view of ones own sexuality” (ASTRA Network 24: 2006). The formal sexual education system in Croatia is in a transitional phase right now. Objections from the Catholic Church have largely kept scientific programs out of the schools, and made room for church based pilot programs like Teen Start and GROZD. However, the fight is not over; the Women’s Coalition has launched a campaign against “High Risk Sexual Education” and is appealing for international aid.

#### *The Role of the Catholic Church*

Recently Croatia has signed an agreement with the Holy See, obliging it to “ensure the teaching of Catechism in pre-schools, primary and secondary schools” (ASTRA Network 24: 2006). This religious education encapsulates a program taught over the last three grades which educates on issues of sexuality. The information disseminated is in keeping with the official Catholic doctrine, “meaning that sexuality is placed only within the context of marriage with the exclusion of correct information on condoms, oral contraceptives, STIs, abortion, sexual orientation, and abortion (which is rendered as ‘child murder’)” (ASTRA Network 24: 2006). The Catholic Church’s strong socio-political standing in Croatia has allowed it to severely impact reproductive policies in the state. The Church actively opposes sex education, abortion, and contraceptives besides the rhythm method, and actively supports traditional family models, women’s traditional roles, and increased birthrates. Croatia’s pronatalist policies, which are inextricably linked to nationalism and the Catholic Church, solidify the otherness inherent to ethnicity, and propagates traditional gender roles for women.

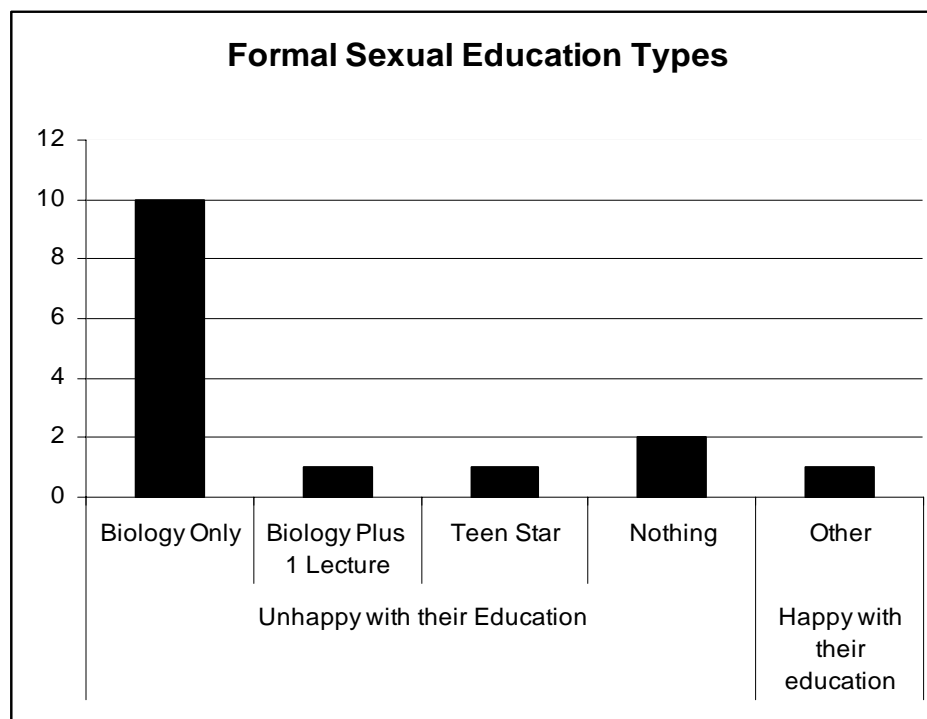
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<sup>4</sup> Sexual and Reproductive Health Issues

Historically, Croatia had “never had a systematic and comprehensive school-based national program for sexuality education” (ASTRA Network 24: 2006). While there have been several attempts to institute a scientific sexual education program, the Church has successfully blocked them from becoming widespread. The Catholic Church has repeatedly tried to end sex education (and has been fairly successful) (Einhorn 1993: 87). There is no formal sex education in Croatian public schools at either the primary or the secondary level. The lack of contraceptive education is linked to the Catholic Churches endorsement of only natural family planning methods, such as the rhythm method (CFRR 2000: 39). There have been a few attempts to pilot other sexual education programs focusing specifically on contraceptives or STIs, but negative Catholic Church reactions and a lack of governmental support has severely undermined these efforts (ASTRA Network 24: 2006).

#### *Programs Available Now*

There is no widespread sexual education program in Croatia right now of any kind. Anyone attending public compulsory school in Croatia right now might end up experiencing any of the following: sexual anatomy in Biology class, sexual anatomy in Biology class plus one or two seminars about some other facet of reproductive health, Teen Star or GROZD, one of the few local scientifically based sexual education programs or nothing at all. Of the 15 women interviewed for this research, ten had only Biology class, one had Biology class plus one additional seminar about STIs, one had completed the Teen Star program, one had a local scientifically based program, and two had nothing at all. Out of all of these women, the only one who was satisfied with the amount, quality, and timing of what she learned was the one who attended the local scientifically based program.



## BIOLOGY CLASS

Of the fifteen participants interviewed, ten only learned about physical anatomy in biology. This is the most common exposure to sexual education in Croatia. Throughout compulsory school education, students are usually exposed to between one and three lessons about reproduction, designed to transmit “basic factual knowledge about human bodies and the reproductive dimension of human sexuality” (ASTRA Network 24: 2006). These classes cover such basics as “this is a penis, this is a vagina” (Participant 3). Often, there is never even a clear description of how insemination occurs. There is definitely no mention of contraceptives or STIs. “We only talked about it for a day. By the end of the class, we had giggled a lot, but I was more confused than ever” (Participant 15). The biology only approach is “not good because it misses vital information. It’s important for kids to learn correct information about STDs and contraceptives before they start having sex” (Gynecologist 1).

Once participant had Biology Class plus one seminar on reproductive health. This is what she remembers from the seminar: “We had a doctor come in once when I was in primary school. He told us about STIs and contraceptives, but it was only once for like, an hour. I don’t remember what he said. Actually, I don’t think that anyone was really paying attention. We were only 12 or 13, you know? We were embarrassed to be talking about it, and we laughed a lot. No, I really don’t remember anything he said, sorry” (Participant 5). Programs like this, while well intentioned, are often ill timed and too short to be really effective. “Young people must be repeatedly exposed to information about reproductive health in order for them to learn anything from it. They are embarrassed by it, and they want to look cool in front of their friends. They have to be exposed long enough to get past that” (Gynecologist 2).

#### TEEN STAR AND GROZD

Right now, there are two Catholic based sexual education programs being tested in public schools. One is called Teen Star, and the other is called GROZD. CESI has found that GROZD and Teen Star are essentially the same: “During the last two years Government has designed a reactive, irresponsible, inefficient, and non-transparent policy, whose result is the extremely problematic, irrational and non-professional proposal for introduction of an experimental health upbringing and education program in primary and secondary schools” (CCSHRSE 1: 2007). Teen Star was a “very strange class. They told us about contraceptives, but they made them seem really dangerous and complicated.” The basic message of the class was “don’t have sex, because if you do before marriage you will get a lot of nasty diseases. I don’t know, the whole thing really confused me” (Participant 4). These programs contain information about human sexuality that is “in its substance and methodology counter to the contemporary principals of public health, standards of human and children’s rights, and therefore to scientific knowledge” (CCSHRSE:

2007). The programs propagate Catholic Church teachings, and disseminate information that is not scientific, safe, or even always accurate.

The programs are designed to correspond with “Catholic morals.” They teach abstinence before marriage, that abortion and contraceptives are morally wrong, and that masturbation is unhealthy. Teen Star is referred to as the “Catholic program based on and promoting sexual abstinence” (ASTRA Network 24: 2006). Both programs take traditional Catholic teachings, like the ban on abortion or contraceptives, and teach them to students as though they were based in science as opposed to faith. For example, the “GROZD Association suggests that responsible parenthood has to do with values and readiness for love, rather than with material circumstances. But even in the Papal *Humanae Vitae* discourse, “physical, economic, psychological and social conditions” are cited as possible reasons to avoid a pregnancy” (Lancker 2007: 1). The result of this unmarked mixing of papal doctrine and scholastic authority is a dangerous combination of half truths and omissions throughout the curriculum.

Teen Star and GROZD are programs “that supply medically inaccurate and incomplete information about sexual and reproductive health and family planning, as well as about available and legal contraceptive methods” (Lancker 2007: 1). “In the curriculum, natural family planning methods are recommended and deemed more appropriate and safer than artificial contraception, since, it is alleged, the latter interfere with the human body and the harmony of the physical union. However, Dr. Jean Marc Olive (WHO) indicates that ‘the failure rate of natural family planning is much higher than other modern contraceptives. Many studies exist and the results are very similar.’ Mr. Olive quotes a study showing that, even if used consistently and perfectly, the failure rate is still of 12.5%, compared to modern contraceptives, which have a failure rate of less than 1%” (Lancker 2007: 1). Moreover, natural family planning methods

such as the kinds recommended within the programs “involve self-observation, temperature, external and internal mucus, and cervical observations , all recorded daily, and some methods require up to six months of research and observation (and abstinence) in order to collect baseline data” (Lancker 2007: 1). These methods are complicated and onerous in the best circumstances. They are especially unreliable during adolescence, since the body is undergoing so many changes as to make the readings undependable. Research has also suggested that “ unprotected intercourse in the infertile periods of the menstrual cycle may still result in conceptions, but create unviable embryos 3, and that pregnancies resulting from failure of natural contraception present an increased risk of miscarriage and birth defects” (Lancker 2007: 1). Equally troubling is the curriculum's support of faithfulness as a “fail-proof mechanism.” Sadly, “the fact that one partner stays faithful does not imply reciprocity, thus making way for the transmission of diseases and infections, including HIV/AIDS, if proper protection is not used” (Lancker 2007: 1). Moreover, this insistence on abstinence does not take in to account victims of sexual assaults (rape, pedophilia, incest etc), who “need to be informed of and have access to contraception and prevention methods” (Lancker 2007: 1).

While it is hard to know all of the consequences of the current sexual education program (GROZD) because of the previously mentioned poor data collection, there are a few patterns worth mentioning:

“We have catechism classes in our high schools and a big part of this is also sexuality education. The way they talk to young people about sexuality is actually the same as this GROZD program is offering. It's the same values. It's the same way in which they talk about masturbation, and it's a sin. Its not healthy, you should wait until you are married to have sex, and even in marriage it's not good to have it to often. About contraception, its just natural methods [which are] acceptable. That abortion is absolutely unacceptable even though it's regulated by law here in Croatia. So, and I can see that these kinds of attitudes actually effect young peoples behavior; they actually hear some things and they don't want to take other things. So, they have sex before marriage, but they think

that using contraceptive is a sin, so they don't use it. They pick some information which they want to follow and some others not so it's very risky for their health.” (Cesar: 2007)

Clearly the sexual education programming is promoting unhealthy choices among many of its students. That is why the Coalition calls it “High Risk Sex Education” (CCSHRSE: 2007).

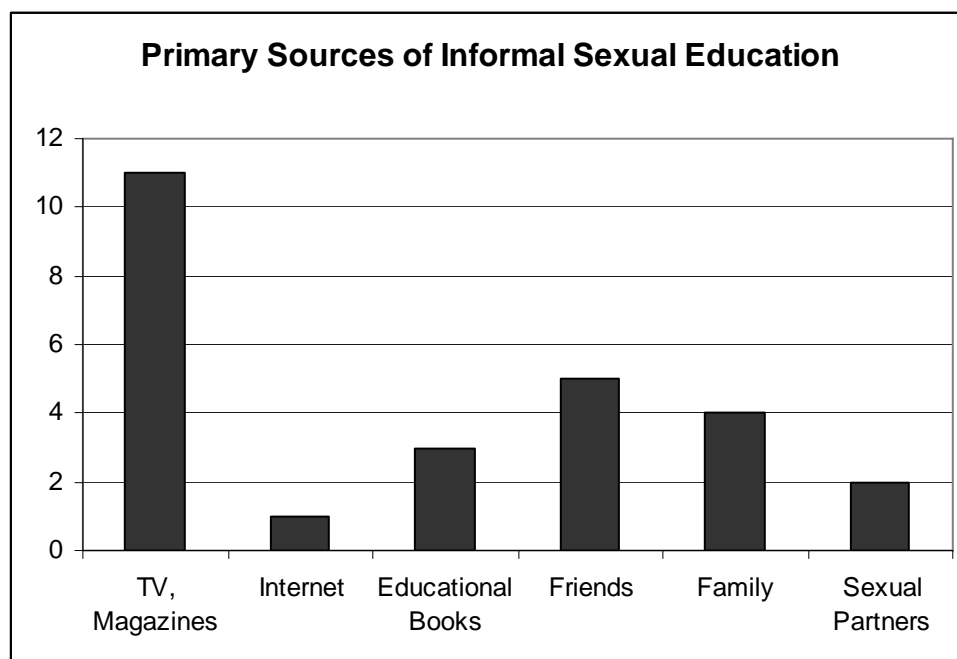
In the end, their opponents believe that GROZD and Teen Star will ultimately cause great damage. Dr. Grujić put it best when she said: “They will see in ten or 20 years, they will see, that many complications, that many infections, that they are guilty for this. I am sure. Its, in 21<sup>st</sup> century, it's a comedy, I think. The information is crucial. Information about such bacteria, such viruses. Everybody has to know about. If someone is religious, ok, then they won't perform sexual life before the marriage. Ok, then they wont, but statistics are showing another percentage, you know. I don't know why [sex education is so bad here], it's nothing very complicated. The sex is part of every life, the sex is wonderful. Every biological education, especially in adolescence, should have it” (2007).

#### OTHER KINDS OF EDUCATION

The other two categories of formal sexual education in Croatia are nothing at all, and other. Nothing at all is exactly what it sounds like: over the entire course of their compulsory education, these women learned nothing at all about reproductive health. They did not even learn about the different body parts involved in the reproductive process. In the other category, there was one young woman whose school had a series of lectures led by doctors within the community addressing various facets of reproductive health. She was the only participant who felt like she had received a thorough and timely education about reproductive health. She is also one of only four women out of the fifteen interviewed who claim to consistently use some form of modern contraception.

#### *Informal Sexual Education*

“Right now kids learn from magazines, TV, and each other. It would be better to learn from schools. Right now, kids start having sex before they learn anything about it” (Gynecologist 2). The worst thing about not having a comprehensive sexual education program is that young people are forced to rely on informal sexual education, which is scattered, unreliable, and often unguided.



Programs that dispense incomplete or misleading information only make the informal education process harder. Informal sexual education is comprised of three main sources, media, friends, and family.

### *Media and Friends*

“My friends and I learned about sex together. We would read about it in magazines or see something on TV.” Her mother died when she was 15, and she “would rather dies than ask my dad about sex. It’s been hard for all of us, but we just figure it out as we go.” Some of her friends have gotten STDs or become pregnant but “at least we all learned from it” (Participant 7). Eleven out of the fifteen participants in this study listed TV or magazines as one of their primary



sources of knowledge about reproductive health. Seven out of fifteen participants said that their friends or boyfriends were crucial to their reproductive education.

When asked what kinds of information they got out of watching TV or reading magazines, they usually answered sex tips. When pressed about how they had learned about contraceptives or STIs, most of them said they had heard something about HIV (or some other STI) on the news, and that they learned about contraceptives from the boys they were sleeping with. When asked how their friends or boyfriends knew what they did, the answers were fairly evenly divided between the “media,” “their families,” and “I don’t know.” Clearly the channels of communication here are a little murky.

### *Family*

“I think my situation is different because my mom talked about it [sex] a lot with me. Most people can’t talk about that with their moms.” Their discussions started when she was about 6 years old. Her mom came into her room one day, and explained the basics of anatomy and sex using her Barbie and Ken dolls. “I was so embarrassed, I didn’t know whether to laugh or cry, but we kept talking. Now I can ask her about anything. My friends think it is so weird that I talk to my mom about sex, but I think they are a little jealous too” (Participant 10). When asked directly, most participants said they could never talk to their parents about sex. Only four participants said they had discussed sex with their parents. “I couldn’t ever talk to my parents about sex; that would be way too embarrassing. Still, I had to learn about it somewhere. I was lucky because I have two older sisters who are both doctors. They never gave me any advice or warnings; they just answered questions. For the most part, I would learn about something from magazines, TV, or the boys I was sleeping with, and then afterwards I might go ask my sisters about it. I didn’t really understand how you could keep from getting pregnant until I had already

had a few sexual partners. I didn't even know to ask questions about STDs until I was in my late 20s" (Participant 1).

### Sustaining Problems

The current reproductive health situation is sustained primarily through a lack of information and through stigmatization. One powerful motivator to establish better sexual education anywhere has historically been high instances of STIs or teenage pregnancy. However, these statistics are hard to gather in Croatia because "according to law in the last 15 years, medical institutions are not obliged to take information about how many patients came in with STIs. We have it for HIV/AIDS but not for Chlamydia and some other diseases" (Cesar: 2007). The problem this poses is two fold. First, without statistics on STIs it is hard to know which STIs are a problem at any time, and who they are primarily affecting. Without this information, it is almost impossible to formulate a strategy to help alleviate the problem (if there is one). Secondly, without statistics on STIs, there is no public incentive to have better programs. The argument "X% of teenagers have syphilis, we need to do Y to combat that" is reasonable and fundable. The argument "some people probably have a lot of STI problems because we don't really cover prevention in sex Ed" is less persuasive. However, you can find "some research here and there, like we have some data on Chlamydia, we get it from students' medical clinic. And they collect it like first year girls, for example. That's all we have and we say ok, it's like this for whole population. Of course its not" (Cesar: 2007).

Clearly neither the current formal nor the informal sexual education processes in Croatia are desirable. Comprehensive, scientific sexual education must be made widely available if young women in Croatia are going to have the ability to exercise conscious control over their

reproductive lives. However, there is one more avenue through which women potentially gain information about reproductive health: the gynecologist.

### **Gynecological Experiences**

Though they are living in a primarily capitalist economy now, Croatians still enjoy public health insurance. This insurance covers most routine doctor and dentist visits and medications. There are two kinds of gynecologists in Croatia: public gynecologists and private gynecologists. Public gynecologists are covered by this insurance, as are some kinds of high dose birth control pills. However, citizens must present a co-pay for each visit or medical service. This negatively impacts reproductive health because “nearly half of all rural women live in poverty”, and therefore the “majority of rural women come in contact with a gynecologist only during pregnancy” (CFRR 2000: 36).

There is currently a shortage of public gynecologists. According to the Center for Reproductive Rights, as of 1996 there was “one gynecologist for every 7,338 women of fertile age,” and those providers were not distributed evenly (CFRR 2000: 35). Gynecological health units “tend to be part of larger health centers, and these are found only in larger urban areas” (CFRR 2000: 35). Oftentimes, women in rural areas have no nearby gynecological practices. Some places, like the town of Poreč, have no public gynecologists at all. Therefore, “travel and other impediments prevent many women from consulting gynecologists for their reproductive health needs” (CFRR 2000: 35).

Although the gynecologists that are available do provide advice and information to women upon request, “their counseling is neither uniform nor up-to date, because Croatian gynecologists do not receive continuing education” (Katzive 2001: 2). Women generally have to wait “three to five months for a mammography exam,” and the long wait often causes women

to “skip preventive check-ups” (Katzive 2001: 2). Those public gynecologists who are available have very little time with each of their patients, and they are not in the habit of explaining anything to their patients (including their illnesses or what they are doing) nor answering questions. Private gynecologists can be quite expensive.

### Public Gynecologists

“I hate going to the gynecologist. I wouldn’t ever go, but I have too.” She has been having ovarian cysts since she was 16, so missing her yearly gynecological appointment is out of the question. “I go to a public gynecologist because it’s all I can afford. Sometimes I wish there was time for me to ask questions, though” (Participant 6). For the most part public gynecologists are available (though pressed for time) in Zagreb, the largest city in Croatia. Here, women have grown accustomed to having the quickest possible examinations, knowing that their doctor has far more patients than time. How do they maintain speed, when doctors’ offices the world over seem to be running perpetually late? They have cut out questions and explanations. “I am sure my gynecologist would answer me if I asked him a question, but he is so busy that none of my questions seem important enough” (Participant 11).

The shortage also makes it difficult to switch gynecologists. One participant who goes to a public gynecologist described her gynecologist as “really, really terrible.” Apparently, she had contracted Hepatitis B. First she had to insist that he test her for STDs. Then he misdiagnosed her. Eventually she had to go to the hospital because the prescription he gave her was causing her so much pain. By that time, her Hepatitis B was in a very advanced stage. However, she still uses that same gynecologist because “it’s really difficult to switch, and I just can’t afford a private gynecologist.” Women simply aren’t getting much information from public gynecologists. They seem to feel like their gynecologists are doing the best they can, but there

just aren't enough of them. "I only go to the gynecologist in years when I have a lot of sex. If I only sleep with a few guys, what is the point, you know?" She usually goes to a public gynecologist, but once she went to a private gynecologist because she "had a problem and she needed to know fast." Her public gynecologist can take up to a month to get test results back, but her private gynecologist only takes two days.

### Private Gynecologists

The situation with private gynecologists seems to be a little better. Their turn-around times are faster with test results, they are more flexible with appointment times, and their appointments are longer. The two private gynecologists I spoke with averaged about forty minutes per appointment. The general satisfaction level participants had with their gynecologists seemed higher among those who used a private gynecologist. So, if one has the money to go, a private gynecologist seems to be the better choice.

However, the amount of advice and information about contraceptives private gynecologists dispense varies considerably from one to the next. The first gynecologist interviewed said that she "always asks about contraception, the 5<sup>th</sup> question I am posing to them is what kind of birth control they are using" (2007). The second gynecologist interviewed said that she "discusses contraceptives only if they ask" (2007). Using a private gynecologist is no guarantee that women will be exposed to information about contraceptives or STIs. Women usually have to ask if they want that information. "My gynecologist has never mentioned contraceptives or STIs before, but I think she just assumes I know" (Participant 1).

The problem, as has already been seen when discussing sexual education, is that women who know very little about contraceptives (and so would benefit the most from a discussion about them) are the least likely to know the correct questions to ask. Clearly gynecologists are

not a place where reproductive health information is frequently being dispensed either.

Therefore it must be concluded that most young women in Croatia are not reliably receiving the information they need to have conscious control over their reproductive lives unless they actively pursue the information on their own.

### **Social Availability**

The second key factor in having conscious control over one's own reproductive choices is living in a social climate that has room within its norms and values for a range of reproductive choices. Social availability is comprised of legality, social acceptance of a practice, and physical availability. For example if oral contraceptives are legal, socially accepted to the point to where taking them does not impair the recipients relationships or social standing in any significant way, and they are physically available for purchase at a reasonable price in a given area, then oral contraceptives are socially available in that area. If any of these three contentions is not true (for example, if the taking of oral contraceptives is illegal), then contraceptives are not socially available in that area. So then, for women in Croatia to have conscious control over their reproductive choices, there must be a variety of contraceptives socially available to them, as well as abortions. Furthermore there must be several different socially viable lifestyle choices in regards to childbearing.

### **Contraception**

The social availability of contraception is of primary importance because modern society is structured in such a way that being heavily involved in the public sphere is dependant on being able to anticipate and regulate childbirth. Only modern contraceptives such as birth control pills and condoms have the success rates (95-99.9% effective when used correctly) that women need for meaningful control. Since conscious control of reproductive choices is all about the ability

choose whether or not to conceive, determining the social availability of contraceptives is crucial to determining the overall levels of conscious control women have.

### Legality and Physical Availability

The 1978 Family Planning Law defines contraception as “temporary prevention of unwanted pregnancy for the purpose of family planning” (CFRR 2000: 39). This law guarantees the right to contraceptives for all citizens. However, contraceptives are not as available as their legal status might lead one to assume. Even though citizens are guaranteed “the right of free use and choice of medical aids for temporary prevention of conception,” only some contraceptives are available in pharmacies (CFRR 2000: 39). This lack of physical availability is demonstrated with painful clarity in a story related by one of the participants: “There are only 7 kinds of pills in Croatia, and they are all high dose pills (lots of hormones). They really aren’t good for younger women. I tried them all, but they made me gain a lot of weight really fast, like 10 kilos in a month. I decided I wanted to try a diaphragm because I wanted something I was in control of, and I had seen them on *Sex and the City*. You can’t buy diaphragms in Croatia at all. My gynecologist had never sized one before. I learned all about how you do it on the internet, and then I explained it to him. After that, I spoke with all the pharmacies in Zagreb. Only one did foreign imports, and could import me a diaphragm, just one pharmacist in all of Zagreb. It took 3 months for the diaphragm to arrive, and I had to pay three times as much for it as you normally would. When I got in, I realized that they we don’t have the right kind of spermicide here, and I had to wait another three months for that to be imported. Six months later, I am probably the only woman in Croatia who uses a diaphragm. At least I am the only one I know of” (Participant 14). In order to verify the problems with accessibility presented in this story, I visited four pharmacies near the center of Zagreb. In each pharmacy, I walked up to counter and asked if

they sold diaphragms there, if so how much they cost, and if not where could I buy one in Zagreb. The first pharmacy did not sell them, and could not tell me where I could get them. The second pharmacy did not understand what I was talking about, and I had to describe a diaphragm to them in great detail before they realized what I meant. Then they said that they did not sell diaphragms, and that I would need to go to an orthopedic store to get one.<sup>5</sup> The third place I went was a combination orthopedic store and pharmacy. They also did not sell diaphragms, but they did know of a place off the main market that imported foreign medicines, so they suggested I try there. The final pharmacy I visited was the foreign imports pharmacy, which was at the top of an old building near the market. A pharmacist there told me that they do import diaphragms from Germany, that it would cost between \$20 and \$50USD, and that it would take approximately a week to arrive. While it normally shouldn't take three weeks for the diaphragm to arrive, it is certainly not out of the question that a one week international delivery could take that long. Moreover, it was very difficult to find somewhere willing to import a diaphragm for me. Finally, while the pharmacists were very polite and generally good natured when I first entered the shop, once they found out why I was there, they became much colder.

When prescribed by a doctor, the state offers only one contraceptive pill – Trinovum – that is covered by insurance at all (and it is only partially covered); “all other contraceptive products are paid for in full by the individual” (CFRR 2000: 39). In addition to birth control pills, “condoms are available in pharmacies as well as in shops, grocery stores and at newsstands” and other contraceptives on the market include “spermicidal foam, hormonal pills, vaginal diaphragms and IUDs” (CFRR 2000: 39). While emergency contraception is legal and

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<sup>5</sup> At this point I called one of my key informants to find out what an orthopedic store was, and why I would go there for a diaphragm. She told me that an orthopedic store is a place where you can buy hospital gowns and orthopedic shoes and such. Her guess was either that the woman behind the counter was confused, or that she was joking with me. However, she told me where to find an orthopedic store just in case, and that is where I went next.



physically available, “it is not widely publicized, and its expense is borne by the consumer” (CFRR 2000: 39).

Even though some kinds of contraceptives are more widely available now, their prices can be prohibitive. The high costs of the contraceptives that actually are available have led to “income stratification” in birth control practices (Gal 2000: 35). Contraceptives are no longer partially subsidized by the government; consequently, the range of available contraceptives in the pharmacies is narrow. Health care providers push oral contraceptives and IUDs over other methods of birth control, and there is no organized effort to find the most appropriate method of birth control for each person (Katzive 2001: 6). As was mentioned earlier, condoms are available, but “their cost, at 4KN each [USD \$.71], is a deterrent for some people (the average salary is 3,800KN per month [USD \$678])” (Katzive 2001: 6). It is estimated that “twice as many couples in the Balkans use no contraceptives at all in comparison to Western Europe.” (Rueschemeyer 1994: 170). One result of this is a very high abortion rate. As a matter of fact, “more than half of all the women who had abortions in 1991 had practiced no form of contraception” at the time of conception (Rueschemeyer 1994: 170).

### *Social Acceptability*

We must ask ourselves why Croats can easily buy pornography in half a dozen languages from street side kiosks when is it almost impossible to buy a female condom or a diaphragm. In talking to the participants, it quickly became clear that all but two of the women held one or more of the following three basic assumptions: contraception is embarrassing to talk about or be caught owning, contraception is only necessary for promiscuous behavior, or birth control pills are unhealthy and condoms are men’s business. All of these assumptions impair a woman’s ability to effectively use birth control.

The idea that contraception is embarrassing to talk about or be caught owning is especially prevalent with women in their late teens or early twenties. This assumption is revealed through statements like: “I hate asking for condoms in the pharmacy. When you buy them at the drug store, you can mix them in with everything else so no one really sees, but at the pharmacy you have to ask for them. As soon as you say it out loud, everyone stops what they are doing and looks at you. It’s so embarrassing” (Participant 12). Several participants said they could not buy condoms because “people look at you weird if you try to buy them” (Participant 15). When pressed further, one participant said “You just don’t talk about contraceptives with 80% of people, especially your parents. It’s embarrassing, and a lot of people are really against them. Instead, everyone talks about natural methods, and wanting kids and ‘silent murder’” (Participant 14).

Women who are too uncomfortable to discuss contraception with each other or to allow strangers to see them buying condoms or filling birth control prescriptions are also to uncomfortable to ask their gynecologist questions about contraceptives or STIs. Since it has already been established that asking their gynecologist questions might be the only way for them to receive information from an education professional, this effectively limits many women who hold this assumption to acquiring their information from the media. Moreover, it sometimes keeps them from physically purchasing contraceptives: “My friends say they would not be comfortable buying condoms or filling a birth control prescription. People don’t want others to know they are having sex. I think it’s sad that you should be ashamed of what you are doing” (Participant 7). However, it does not keep them from having sex.

The second common assumption is that contraceptives are only necessary for promiscuous behavior. Nice girls who only sleep with their boyfriends do not need any kind of

protection. “I don’t ever use anything [contraceptives]. But, I have a boyfriend, so I don’t need too. I mean, I probably would use a condom or something if I had a one night stand. Well, maybe [laughter] if I wasn’t too drunk. No seriously though, you don’t need condoms with your boyfriend.” This sentiment was echoed by every participant who has a steady boyfriend right now, or is married. Apparently contraceptive free sex is a reward of temporary monogamy, because “everyone hates contraceptives, everyone hates condoms” (Participant 9). This attitude has direct roots in the catechism classes, as well as Catholic based programs like Teen Star and GROZD,<sup>6</sup> which teach that faithfulness makes contraceptives superfluous. However, faithfulness in one partner does not guarantee it in both partners, leaving the way open for STIs. Moreover, faithfulness in no way protects against pregnancy. This association of contraceptives with promiscuity also makes the believers less likely to ever want to use contraception, and to think less of those who do.

The final assumptions seem to always go together: condoms are men’s business, and birth control pills are unhealthy. Throughout the interview, there was an overwhelming consensus that men should take care of having and deciding to use condoms. As one participant explained it to me, this makes things tricky when you start having sex with a new partner. “If he is a gentleman he will take care of it, you know?” If he has a condom with him, then it’s not a problem. However, if he doesn’t, that would create a very awkward situation because she really did not feel comfortable asking him to wear one, and she definitely did not feel comfortable bring some along because he might think she was promiscuous. She didn’t see the condom issue as being inside her control, and said that “you just have to hope [that he brings one]” (Participant 1). This story was echoed by several women, who mentioned that men don’t really like

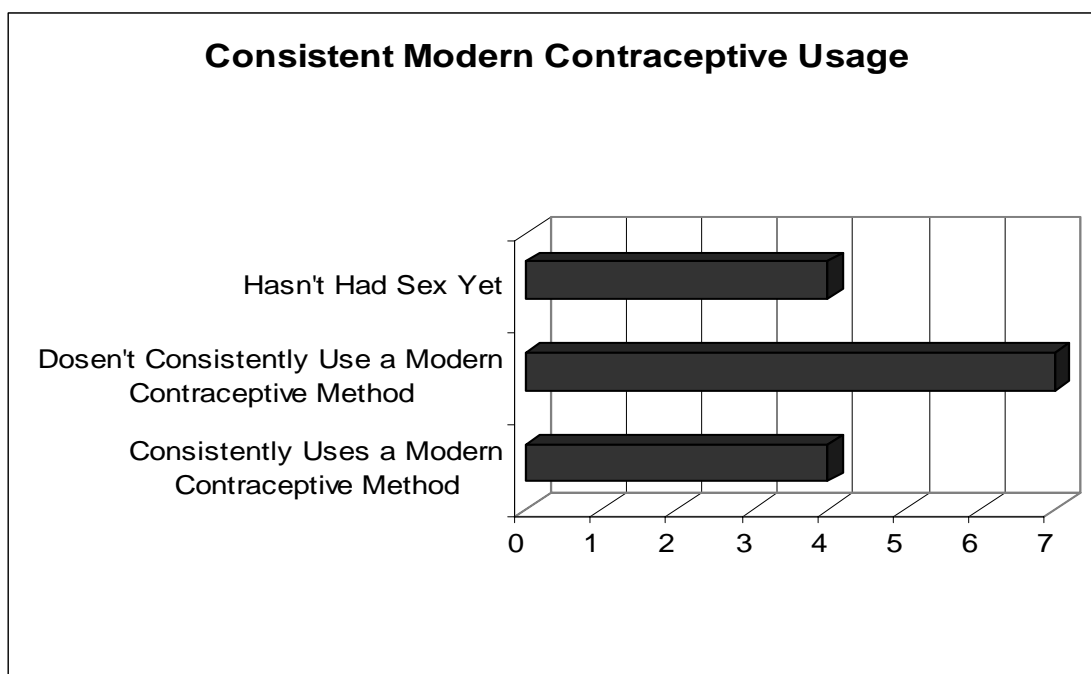
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<sup>6</sup> Teen Star and GROZD are two sexual education programs which are being piloted in Croatian public schools right now. They are both based on Catholic teachings, and they have both been accused of disseminating untrue or misleading information. GROZD was designed in part by Teen Star educators.

condoms. This was dismissed easily, with each woman saying some version of “boys are usually like that” (Participant 3).

Condoms, besides being an excellent way to lessen the risk of pregnancy, are also one of the very few methods of contraception that protect against STIs. The fact that so many women seem willing to leave it entirely up to their male partners to decide if they should be used or not is problematic in and of itself. When this assumption is coupled with the assumption that hormonal birth control (most commonly the pill) has negative health impacts, women are left with very few options that are inside their control. Statements like “birth control makes girls less attractive or healthy,” “pills make girls fat,” or “pills aren’t natural” were common throughout the interviews (Participants 4 and 12).

With all of these assumptions forecasting such negative levels of contraceptive usage, it is important to see what the actual practices of the participants are:



For the purposes of this study, modern contraceptives are defined as contraceptives with a success rate of 95% or higher with perfect use. More specifically for this graph, modern

methods are hormonal birth control, condoms, and diaphragms with spermicide. Participants who are included in the category “doesn’t consistently use modern contraceptives” most commonly use nothing, natural methods, withdrawal, or a combination of one of these methods with occasional condom usage. Seven of the eleven participants who are sexually active do not consistently use a modern contraceptive method. The two participants who did not seem to hold one of the three base assumptions discussed consistently use modern contraception. That means that only two of the women who hold one or more of the assumptions and are sexually active are using modern contraceptive methods consistently. Since only the one woman who is married right now wants children right now, and none of the participants want STIs, it seems clear that these assumptions are an impediment to conscious control of one’s reproductive choices.

### **Abortion**

Abortion seems to be a complicated and highly charged subject across the world. Croatia is no exception. Due to various social and economic factors, women in Croatia have a long history of using abortions as their primary means of birth control. At the same time, the Catholic Church has a strong influence in the country. These two seemingly contradictory facts do not always live comfortably with each other, as this story demonstrates. When asked how she felt about abortions, one participant responded by telling a story about her ex-boyfriend. He had paid for one of his ex-girlfriends to have an abortion before he met the participant. One day they were snuggled up on the couch telling each other secrets, and he told her about the incident. She immediately stood up, broke off their relationship, and walked out the door. She hasn’t spoken to him since. When asked if that meant she was very strongly opposed to abortions, she replied in a surprised voice “no, I think the right to an abortion is very important.” None of the participants in this research have ever had an abortion.

Abortions are an important part of having conscious control of reproductive choices. Contraceptives can and sometimes do fail. Condoms break, hormones fluctuate, on rare occasions even morning after pills can fail to work. Moreover, rape victims and victims of incest are not usually given the chance to use birth control. Abortions represent absolute control over reproduction. Whether or not a woman chooses to have an abortion is immaterial; what is important is that she has the choice. Abortions must be socially available for women to have conscious control of their own reproductive choices.

### Legal and Physical Availability

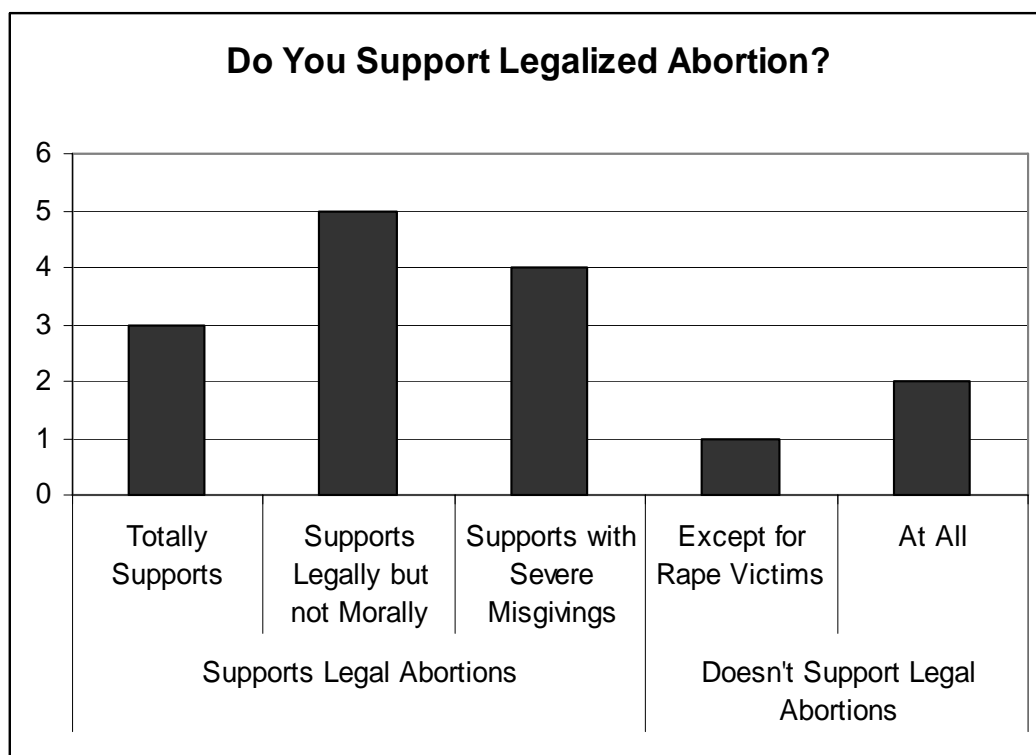
Before 1990, the cost of legal abortions (minus anesthesia) was paid by the Health Insurance Fund. Today, an abortion in Zagreb costs approximately USD \$180 (including anesthesia), and since “the average monthly salary of most employed women is USD \$390,” the cost of the procedure is often prohibitive (CFRR 2000: 40). Another estimate puts the fee for abortion at “twice the average monthly wage” (Lobodzinska 1995: 241). As a result, for many women, including the poor and unemployed, legal abortions are inaccessible. The high cost of abortions and traveling to them (as it is often some distance to a gynecologist for rural women) has led to “income stratification” in legal abortion practices. (Gal and Kligman 2000: 35)

Lately, serious efforts have been made to curtail the actual availability of abortion. Even though it is still legal to have an abortion within the first ten weeks of pregnancy under law, doctors and others in the field are starting to challenge that right as a part of the larger pro-life movement under the protection of Article 45 of the Croatian constitution, called the “contentious objection” article (Drakulic 1993: 124). This article came into play in Zagreb in November 1991, “when the largest hospital there prohibited its doctors from performing abortions” (Drakulic 1993: 123). The Zagreb case is not unusual. There is evidence that between 1996 and

2001, “in at least five hospitals, gynecologists have refused to perform abortions on the basis of ‘conscientious objections,’ thus making the procedure unavailable in these institutions” (Katzive 2001: 2).

### Social Acceptability

In spite of its long history in the region, abortion is losing support, and not just legally. Out of the fifteen participants interviewed, none have had an abortion, and only three participants unequivocally supported legalized abortion.



“I think that every woman has a right to decide for herself, but for example I now have a job, I have everything, I wouldn’t have a reason now, so I wouldn’t do it. I don’t know about before, but this is how I think, I would be careful not to be in that situation” (Participant 15). As the largest two categories suggest (Supports Legally but not Morally and Supports with Severe Misgivings) many people are pretty confused about the whole issue.

The general consensus seems to be that abortions are OK on a don't ask don't tell basis. "One girl from my school talked about her mother having an abortion, it isn't something people wouldn't say. I've just heard of one girl having an abortion. He boyfriend wanted her to. Between friends people do talk about. My friends usually decide to have the baby" (Participant 7). While this does not bode well for the future of abortions in Croatia, right now the social acceptability situation does not seem bad enough to cause serious impediment to having an abortion. However, the rising costs and the increasing number of doctors who refuse to perform abortions is potentially a problem.

## **CONCLUSION**

Sex and reproduction had been major sources of women's social power for centuries. Most of the female saints either gave birth to someone important, or refused to sacrifice their virginity. In traditional Croatian folk culture, women were not accepted as full member of their husbands' houses until they gave birth. The single most important woman in all of Catholicism bears the title "mother of g-d." Women are said to use sex appeal to attract potential husbands, and the mystical "feminine wiles" by which women are said to always get their way with men are comprised primarily of innuendos and half-promises for future sexual encounters. Wherever women are systematically othered, and forced to access power and stability through men this equivocation of women's power with sex exists.

The single attitude that was prevalent not only in the interviews with all but one of the participants, but also in my casual discussions with Croatian men and women about sex was that sex is not a serious matter. There was an overwhelming perception that ultimately sexual education, or contraceptive use, or even pregnancy didn't really matter. Sex was not representative of a serious moral, ethical, or even health related decision; it was mostly a game.



“Sex is something teenagers do when they are bored.” “Sex is something a girl does when she wants a boyfriend.” “Sex is fun.” “G-d, don’t mention sex. Do you know it’s been three whole weeks for me? I’m dieing here.” “If I could just sleep with him, then I could stop obsessing about everything he says.” “So, are you going to sleep with me or what?” “Sex, it’s just not such a big deal.” I heard these statements or hundreds more like them almost every single time the subject of sex came up.

In an atmosphere where young adults are constantly hearing two opposing messages, “sex is a sin” and “you need sex to be happy,” it is almost impossible to develop a responsible attitude towards sex. Moreover, in a transitional society that is experiencing intense repatriarchalization, women are not supposed to be taken seriously. Since sex is largely regarded to be the key to all women’s power, sex cannot be taken seriously. By devaluing sex while upholding it as the central power of women over men, the importance of women is diminished.

When women are diminished, and sex is unimportant, reproductive freedom is unimportant. When reproductive freedom is unimportant, then scientific sexual education is not valued. When scientific sexual education is not valued, then kids are forced to learn about sex from the church (which has been systematically devaluing women for years) or from the media (which has been systematically devaluing women for years). When the population has learned about sex from the media, which showcases women as primarily sexual, and the church, which portrays sex as sinful, women are diminished and reproductive freedom seems unimportant. Clearly this problem is both cyclical and troublesome.

Right now, young Croatian women do not have conscious control over their own reproductive choices unless they make great personal efforts to have that control. Since most young Croatian women do not learn about reproductive health from an authoritative,

scientifically based source, most of them do not know enough to make that effort. Moreover, the influences of the media and the church on their ideas about sex make most of them unlikely to ever have clear opinions on many of the issues that must be faced when one decides to make strong, unconventional decisions about their own reproductive lives (such as the decision to be the only woman in Croatia who uses a diaphragm).

The situation seems to be worsening rather than getting better right now, but repatriarchalization, like many conservative forces, seems to operate on a pendulum like schedule. However, the reproductive situation in Croatia for young women is unlikely to improve without some serious changes in sexual education and the social availability of contraceptives.

## **REFLECTIONS**

It is hard to resist the temptation to spend this section whining about how there is so much more I would have liked to do with this research, but I didn't have time. In retrospect, I could have made things a lot easier by simply picking a smaller and less demanding topic. If I didn't have plans for this research already, I probably would have. That said conducting this research was an amazing experience. I had read about key informants before, but I never really understood how you could just meet someone and they would be willing to go out of their way to help you conduct research that means very little to them. However, having had two or three amazing key informants myself during the course of this research, I cannot doubt their importance any longer. I can't say that I completely understand why they do it (and I know that it changes from person to person) but I might never have been able to do this research without them (and definitely not in the time allotted), so I have decided to stop worrying about why and just be grateful.

At the beginning of the research period, I had pin pointed my biggest potential problem as being my tendency to judge contraceptive irresponsibility and under-education very harshly. I was so conscious of avoiding this predisposition to judgment that went quite far in the other direction. For the majority of my interviews (from the 2<sup>nd</sup> to the 14<sup>th</sup>, to be exact), I was so focused on just hearing what my participants were saying and not passing judgment that I forgot what I was looking for in the interviews. I had a very tense night after the 14<sup>th</sup> interview when I realized that I no longer knew what information I was trying to get, and where my paper was going. Luckily, I had designed my interview guide precisely enough that I got what I needed anyway. I dug back up some old notes I had been writing myself, and the research process was able to resume. I hope that next time I can find a more middle ground. I knew this balance would be hard to achieve because I picked a subject that is very important to me, but I couldn't see myself spending so much time on something that wasn't.

Finally, I really enjoyed collecting this data. I never disliked interviewing before, but it wasn't exactly fun. How much difference it makes when you are interviewing for your own project, about something you find very interesting! I thoroughly enjoyed myself, especially when I was interviewing the NPIW. Admittedly, the paper writing part was less fun, but even that was exciting in that I was finally putting everything together.

### **IDEAS FOR FURTHER RESEARCH**

I really don't feel like I had enough time to conduct the research I originally laid out. There are several directions I would consider going in if I was given another month (or six). First, I would expand my own research sample, because while 15 NPIW is a good sample size given my time restrictions, I think that more participants would be better. Then, I would do the whole thing over again in a few small villages. Everyone I have talked to keeps telling me that

all these negative feeling about contraception and abortions are vestiges of a simpler time in the villages. I'm not sure if that's true, but it would be a very interesting look at how people distance themselves from their past.

Another interesting comparative study, which my mentor suggested, would be a comparison of the community I've studies with a lesbian community in order to compare the effects of hetero-normative education on people who are not heterosexual. I believe that this comparison would be particularly interesting in Zagreb because the queer community seems to be, in the words of one of my fellow researchers "so activist based."

Most people I've talked to (and studies I have read) confirm that young women in Croatia (and presumably young men) get the majority of their information about STDs, contraceptives, and sex in general from the media (TV, magazines, etc...). The majority of that media comes from the United States or Western Europe. If I had more time, I would look into this further. I think there is probably something interesting here.

As was previously mentioned, oral and anal sex were not addressed in this research. I have reason to suspect that the ideas surrounding and practices utilized in regards to STI prevention during oral or anal sex are less than ideal by conventional medical standards. There is a lot of interesting research ground here.

Finally (and only because I am tired of thinking up ideas that I cannot use, not because the subject has been the least bit exhausted) I have had a number of young men be around when I was introducing my topic to potential participants, or discussing some question that had arisen during the interview with a participant afterwards. They all seemed very interested, and I was hard pressed to turn them away. A comparative study with young men in the region would

illuminate a lot of things. I would ask them about contraceptive responsibility and condom usage. I would also love to interview them about their views on vasectomies.

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## **INTERVIEWS**

Cesar, Sanja. Personal interview. CESI Offices, Zagreb, Croatia. March 1, 2007, 1:00PM.

Gynecologist 1. Personal interview. Gynecological Office, Zagreb, Croatia. March 17, 2007, 3:00PM.

Gynecologist 2. Personal interview. Gynecological Office, Zagreb, Croatia. April 16, 2007, 4:00PM.

Participants. 15 personal interviews. Various locations in Zagreb, Croatia. April 14 – April 27, 2007.

## **Appendix A**

### Gynecologist Interview Questions

- Why do most of your patients first come to see you?
- What common characteristics do most of your patients share?
- What is the most common birth control method employed by your patients?
- Do you discuss contraceptives with your patients? When?
- What kinds do you recommend?
- Is coitus interrupts popular? What do you tell your patients about it?
- When do your patients request birth control prescriptions?
- Are STD's common? Among which groups?
- What do you think about the current reproductive education program?
- Do you perform abortions? On whom, primarily?
- Do you perform sterilizations? How often? When?



**Appendix B**

## Sexual Education Activist Interview Questions

- What is your current project in regards to sex education?
- So, what do you think are the most important things that should be included in a sexual education program?
- What do you think the impact is that so many kids are going through school without ever getting a good, comprehensive sex education?
- So, do you think that if there were better sex education in the schools people would be more aware of their options and use them more?
- What do you think is the most important thing that could be done right now to make the climate more hospitable to mandating the kind of sex education CESI is proposing in public schools?

**Appendix C**

## NPIW Interview Guide

Rose in:

Religion:

Age:

Married:

Children:

Contraceptive method of choice:

Sex Ed:

    Formal:

    Informal:

Gynecologist experiences:

Contraceptive responsibility/stigma:

Abortions:

Family hopes: