On the waves of feminism

AN ACTIVIST PRIMER BY THE PLATFORM FOR REPRODUCTIVE JUSTICE

CONTENT

6 INTRODUCTION

9 REPRODUCTIVE VIOLENCE

19 SEX EDUCATION

28 REPRODUCTIVE HEALTH OF ROMA WOMEN

31 COUNSELING

40 HISTORY OF ABORTION RIGHTS

43 REPRODUCTIVE JUSTICE OF TRANS, INTERSEX AND GENDER VARIANT PERSONS

55 MENSTRUAL POVERTY

63 CLITERACY

72 PLATFORM'S DEMANDS

76 IMPRESSUM

WHY DID WE JOIN FORCES?

The Platform for Reproductive Justice was established in March 2017 at the initiative of the **fAKTIV Feminist Collective** and **PaRiter Human rights and civic participation association**. We joined forces when the Constitutional Court issued a Decision on the constitutionality of the Act on Health Measures for Exercising the Right to Free Decision-Making on Childbirth (commonly known as the "Abortion Law"). Through this Decision, the Constitutional Court mandated the Croatian Parliament to adopt a new law that will regulate abortion, including abortion on demand, within two years. In light of the ongoing decline in the accessibility of abortion on demand, and the fact that it is gradually becoming unavailable, we found it extremely important to react timely. As a result, we formed a broad platform and actively engaged in addressing the new legislative proposal.

A number of organizations, collectives and activists participate in the activities of the Platform. Through our work, we aim to gather a wider coalition of allies, as we achieved through the *#Pravdazadjevojčice* [#Justiceforgirls] campaign, that brought the problem of sexual violence to the attention of the general public, and culminated in a series of protests in 15 cities.

WHAT IS REPRODUCTIVE JUSTICE?

The concept of reproductive justice was developed in 1994 by activists gathered in the **Women of African Descent for Reproductive Justice** collective in Chicago. Their goal was to establish a link between reproductive and social rights, and to assess the actual accessibility of these rights to the larger part of the population.

Reproductive rights include the right to terminate, as well as to plan a pregnancy, the right to gynecological care, dignity in childbirth, medically assisted reproduction, contraception and sex education,

health protection during menopause, and other rights related to reproductive health.

Reproductive rights are inseparable from the socio-economic conditions in which women exercise them. A fight for social rights in this context implies a fight for free, accessible, and quality public healthcare, as well as for free, accessible, and quality public education including preschool education, secure workplaces, solidarity—based pension and housing policies, and socialization of housework.

IS THERE REPRODUCTIVE JUSTICE IN CROATIA?

The availability of reproductive rights in Croatia has been hindered on every level of the healthcare system. At the time of this publication, Croatia is facing a deficit of 104 gynecologists in primary health care, resulting in approximately 250.000 women without access to a gynecologist. The shortage of gynecology teams means that women are less likely to prevent problems related to reproductive health. It also means they do not have access to adequate health information, they do not undergo regular gynecological examinations, or they have to pay for them in private practices. Private gynecologist care is too expensive for the majority of women, so they either cannot resort to it, or they use it only if they have more severe health issues, by which they often endanger their own health. In addition to this, the public health system has been under-staffed and facing budget cuts for years, resulting in reduced accessibility and quality of services related to reproductive health.

Abortion remains inaccessible in Croatia for two main reasons: firstly, the introduction of the so-called conscientious objection has led to a lack of healthcare providers willing to perform it, and secondly, women are not able to afford it.

Women who decide to have an abortion are subjected to lengthy and distressing processes to access basic information on this legal medical procedure.

That's patriarchy

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Reproductive violence as a form of gender-based violence

WRITTEN BY: LANA BOBIĆ

Both the brave testimonies of women and numerous regional initiatives and campaigns (#spasime [#saveme], *Pravda za djevojčice* [Justice for girls], *Nisam tražila* [Didn't ask for it], *#ženeujavnomprostoru* [#womeninpublicspaces], *#nisamprijavila* [#didntreport]) have in recent years pointed to the problem of gender-based violence against women. Besides indicating the scale of this social problem, they shed light on numerous prejudices and deeply ingrained stereotypes that perpetuate the prevalence of such violence. Firstly, we should define gender-based violence and explain what it entails.

Gender-based violence is violence which affects a person based on their gender/sex or which disproportionately affects persons of a particular sex/gender. It is one of the most widespread forms of human rights violations in all societies.

Cultural and structural violence facilitate gender-based violence, as they are rooted in gender inequality, abuse of power, sexism, gender stereotypes, imposed gender roles, etc. Cultural and structural violence do not pertain to individual perpetrators of violence but to violence embedded within different social, cultural, and religious norms and institutions. We can view them as social mechanisms that place others at a disadvantaged position thereby exposing the power imbalance in social relations and facilitating direct violence. Structural and cultural violence can be so deeply internalized that they go unnoticed and are falsely no longer recognized as violence, which is why they are often socially accepted.

Considering the fact that gender-based violence primarily targets women and girls, and the gendered nature of violence is acknowledged in the fight against violence against women, the term is often used interchangeably with violence against women. However, we must keep in mind that gender-based violence does not only affect women. It also impacts men, trans, inter and gender variant persons, persons of homosexual, bisexual and heterosexual orientation, as well as persons of all races, classes, nationalities, ethnicities, religions, or any other statuses.

FORMS OF GENDER–BASED VIOLENCE

- Domestic/Intimate Partner Violence
- Psychological Violence
- Stalking
- Physical Violence
- Sexual Violence (from Sexual Harassment to Rape)
- Economic Violence
- Forced Marriages
- Genital Mutilation
- Honor Crimes
- War and Post-War Violence
- Reproductive Violence
- Obstetric Violence

REPRODUCTIVE VIOLENCE

In the broadest sense, reproductive violence is defined as prevention to exercise reproductive rights and preserve reproductive health. We are talking about "violence that includes a violation of reproductive autonomy or that is directed at people because of their reproductive capacity", as defined by **Ciara Laverty** and **Dieneke de Vos** in the scientific article „Reproductive Violence as a Category of Analysis: Disentangling the Relationship between 'the Sexual' and 'the Reproductive'" from 2021. Reproductive violence is a form of gender-based violence that remains insufficiently acknowledged, both at the interpersonal and institutional levels.

REPRODUCTIVE COERCION

When we talk about reproductive violence at the interpersonal level, we are referring to reproductive coercion, which is an inadequately recognized, even concealed form of intimate partner violence. In their article „A conceptual re-evaluation of reproductive coercion: centering intent, fear and control" from 2021, **Laura Tarzia** and **Kelsey Hegarty** define reproductive coercion as all behaviors intended to control reproductive autonomy for the purpose of either preventing or promoting pregnancy, or all behaviors that use some form of coercion to interfere with person's autonomous decision-making regarding their reproductive health. The behaviors in questions are perpetrated by intimate partners or family members with the intention of gaining or maintaining power and control over a person's reproductive health. Reproductive coercion intersects with other forms of intimate partner violence, such as psychological, physical, sexual, and economical violence.

Tarzia and Kelsey argue that "there is a lack of conceptual clarity around reproductive coercion" which poses a problem when understanding and proving this type of violence. They believe that there is still insufficient research on how the reproductive coercion intersects with other forms of violence — intimate partner and sexual violence — within which the reproductive violence happens. This has severely affected the studies, policies, and healthcare practices, especially since reproductive coercion can happen even in relationships where the partner was never reported for physical or sexual violence.

FORMS OF REPRODUCTIVE COERCION

- coercing or pressuring a person to become pregnant or give birth (including shaming a person for their decision whether or not to have children)
- coercing or preventing abortion
- coercing or pressuring a person to use contraception, preventing, or denying contraception (e.g., removing contraception without partner's knowledge, contraceptive sabotage, lying about using contraception or vasectomy, withholding financial means for purchasing contraception...)
- coercing or pressuring a person to use contraception, preventing sterilization
- intentionally transmitting a sexually transmitted disease (STD)
- preventing access to reproductive healthcare
- forced menstrual suppression
- coercing or pressuring a person to surgically remove parts of their genitalia
- preventing or restricting access to services or information related to sexual health
- stopping or discouraging informed and consensual sexual expression
- intercourse without active consent

DENIAL OF REPRODUCTIVE HEALTHCARE

At the institutional level, reproductive violence is most commonly understood as denial of reproductive healthcare. But we should call things by their proper names, and the laws, policies and practices that restrict access to reproductive rights should be understood as violence against persons whose access to reproductive rights is hindered. "When women do not have access to quality information about their reproductive health, when there is an insufficient number

of gynecologists, when they experience humiliating treatment in hospitals, and when they are denied healthcare services, these are not just shortcomings but acts of reproductive violence perpetrated against them by the state", the **Platform for the Reproductive Justice activists** warned this year on National Day of Combating Violence against Women, observed on September 22.

When healthcare institutions authorized to perform abortion on demand deny healthcare to their patients, that is considered reproductive violence. Structural reproductive violence also occurs when a person cannot access hormonal contraception due to pharmacist's conscientious objection, and the pharmacy does not ensure that there is another pharmacist available at that time to dispense the prescribed medication (whether for contraception or medical purposes). It also occurs when curettage is performed on women without anesthesia, which prompted the #*prekinimošutnju* [#breakthesilence] campaign within which hundreds of women shared their experiences related to this form of reproductive violence.

Although scholarly literature may refer to discrimination or denial of rights in the healthcare sector, it is becoming more and more clear that it constitutes structural violence, a systemic way to prevent access to healthcare to certain groups of people. Reproductive violence should be studied within the field of reproductive justice, with particular focus on how gender, class, race, ethnicity, nationality, or disability status affect the access to reproductive healthcare.

Marginalized groups are multiply discriminated, and they have even less access to reproductive health and rights. According to the World Health Organization data, persons with disabilities are three times more likely to be denied healthcare due to stigmatization and prejudice, or because health services are not accessible to or adapted for them. Healthcare facilities are not always adapted for persons with disabilities — for example, gynecological offices are often not accessible for persons with disabilities. It may be worth mentioning that gynecological examination tables designed for

persons with disabilities can also be used by person without disabilities, which brings us to conclusion that such gynecological tables should become the standard. Women with disabilities face discrimination, prejudice and stigmatization when they decide to become pregnant or become mothers. Forced sterilization, forced abortion and forced contraception are practices that women with disabilities still face today.

Stigmatization, discrimination, as well as forced sterilization, forced abortion and forced contraception do not only affect persons with disabilities, but also indigenous peoples, ethnic minorities, and refugees, particularly women and girls belonging to these groups. There is a long, global history of these practices which are based on harmful gender, racial, and ethnic stereotypes, and have not yet been eradicated.

In some countries, transgender and often intersex persons are subjected to forced sterilization as a prerequisite for gender affirming treatment and gender marker change. In addition to this, many transgender, intersex and gender variant persons face discrimination and stigmatization within the healthcare system, which results in denial of healthcare. Another example of reproductive violence is "gender normalization" of intersex persons, which consists of subjecting infants and young children to esthetically and medically unjustified reproductive organ surgeries. Such surgeries are often performed without parent's informed consent and routinely without informed consent of the person undergoing the surgery. These procedures can have serious impact on their mental and physical health in the future, including the potential loss of their reproductive capacities.

OBSTETRIC VIOLENCE

The abuse that women experience during childbirth, such as neglect, disrespect of their rights, or verbal, psychological and physical abuse is called obstetric violence. On a global level, women often face disrespect, neglect, and abuse during childbirth. "Reports of disrespectful and abusive treat-

ment during childbirth in facilities have included outright physical abuse, profound humiliation and verbal abuse, coercive or unconsented medical procedures (including sterilization), lack of confidentiality, failure to get fully informed consent, refusal to give pain medication, gross violations of privacy, refusal of admission to health facilities, neglecting women during childbirth to suffer life-threatening, avoidable complications, and detention of women and their newborns in facilities after childbirth due to an inability to pay. Among others, adolescents, unmarried women, women of low socio-economic status, women from ethnic minorities, migrant women and women living with HIV are particularly likely to experience disrespectful and abusive treatment.", the **World Health Organization** explains in their publication "The prevention and elimination of disrespect and abuse during facility-based childbirth".

When a woman is tied to the bed during childbirth, we are talking about obstetric violence. When a woman listens to sexist or offensive comments from medical staff, when her pain and state are demeaned and attributed to "hysteria", we are talking about obstetric violence. When a woman's privacy is not respected, and she is exposed to others in a facility without informed consent, we are talking about obstetric violence. When a laboring woman's wishes are not respected, and she is subjected to medical procedures without informed consent, we are talking about obstetric violence. In addition to the obvious forms of violence such as inappropriate touching, or even physical and sexual violence, obstetric violence also includes denial of pain relief medication, neglect of the person in labor, and denial of companion during childbirth.

Some forms of obstetric violence are so normalized that we no longer perceive them as violence. The Kristeller maneuver, or pushing on the woman's abdomen, may be easier to recognize as obstetric violence. Although it should not be performed, woman's testimonies reveal that this procedure is still often used during childbirth. We still hear testimonies about the "daddy stitch", an additional stitch given to women during the stitching after a vaginal birth, supposedly to increase

pleasure for their partner/husband. Many forms of obstetric violence are procedures claimed to be medically and professionally necessary, although they often are not. Breaking the water, administering IV drips, these are all forms of obstetric violence - unless they are medically justified or the woman in labor wants them. In an interview from 2016 with a feminist website Libela, **Daniela Drandić** from **RODA — Roditelji u akciji** [RODA — Parents in Action] association stated that episiotomy is one of the procedures deemed "medically necessary", even though it often constitutes obstetric violence. Episiotomy is a surgical incision of the perineum performed during childbirth. The procedure became routine in the 20th century and was performed in up to 80 % of the cases. Today the reasons for these routinely performed perineum incisions are considered myths, and we know that episiotomy is necessary only when the newborn is stuck in the birth canal and there is a risk of respiratory distress. According to the World Health Organization recommendations, the episiotomy rate should not be higher than 20 %, while the optimal rate should be 10 %. According to the official data, episiotomy is performed in 35 % of the cases in Croatia, while according to the data collected by the RODA association, it is performed in 60 % of the cases.

In addition to it being especially traumatic, obstetric violence can have negative consequences for the mother and the child, and it can prevent women from seeking prenatal care and using other healthcare services in the future. Obstetric violence is normalized to the point where we often do not perceive it as violence, which significantly complicates coping with the trauma caused by the experienced, but not recognized violence.

Reproductive and obstetric violence are part of our cultural norms and values, as well as our (healthcare) system. Enabled and normalized by patriarchal matrices, according to which men have the right to fully control women, including reproduction, i.e., deciding whether, when and how to conceive. Thus, it is important to name, define and become aware of these still insufficiently recognized forms of gender-based violence, in order to be able to expose, and ultimately eradicate them.

The fight for comprehensive sexuality education continues

WRITTEN BY: SUZANA KUNAC

"Comprehensive sexuality education within the educational system is one of the most important tools in preventing sexual harassment and violence," reads the Petition for the introduction of comprehensive sexuality education as a subject in schools, which was initiated on 01 February 2021 by the **Reci.hr** website focusing on sexual and reproductive awareness. **The Platform for Reproductive Justice** is one of the 15 co-signatories, and the petition has been signed by 13,055 citizens so far, whose voices are still being ignored by the government.

Sex education was supposed to be introduced in schools within the cross-curricular topic of Health. Cross-curricular topics are created by connecting different educational areas and subjects. The topic of Health was introduced in 2019, as one of the seven cross-curricular topics, but this approach to sex education has not proven effective — primarily because teachers were not given specific content to convey to their students.

HOW SCHOOLS HAVE FAILED THE YOUTH

Many young people are forced to educate themselves about sexuality exclusively through the Internet or in conversations with their peers because schools are not fulfilling this critical duty. Young people are therefore exposed to false and/or incomplete information.

According to the results of an online survey conducted by the **PaRiter** association among young people in Croatia between the ages of 15 and 25, 74 % of them have not encountered comprehensive sexuality education in the educational system. Young people believe that topics such as sexual violence, free and informed consent, abortion, gender-based violence, gender identity and sexual orientation are all insufficiently represented in schools. Survey was conducted within the INCORE — Informed, conscientious & responsible project. In an interview with the Reci.hr website, **Tihana Naglić** from PaRiter stated that „in schools, they mostly talk about sexually transmitted diseases and contraception, which is not enough for young people. They believe that education should cover other topics related to sexual and reproductive rights and gender equality, that school should be a place where gender stereotypes are challenged, and gender-based violence is prevented. Young people may come across some form of sexuality education, but there is no systematic implementation of comprehensive education, and a multitude of topics related to sexuality are not covered."

Despite the fact that there are clear scientific evidence demonstrating that comprehensive sexuality education, one of the most important tools in preventing sexual violence, protects children and young people and benefits society, that young people and their parents clearly express the need for it, and despite citizen petitions, it is persistently left out of the educational system. The question is — why?

HISTORICAL OVERVIEW OF SEX EDUCATION IN CROATIA — FROM SCIENCE TO RELIGION

Answers could be found in a brief historical overview of attempts to introduce comprehensive sexuality education to schools, named "health education" by the governing bodies and sometimes called "gender ideology" by the Catholics, who primarily see it as an ideological conflict.

In their publication "Sexuality and youth in Primorje-Gorski Kotar County", the PaRiter association states that during the 1960s in Yugoslavia, some elementary schools in Zagreb introduced Sex Education for one school period a week. The first textbook for Sex Education was published in 1965, but the teachers did not get their manual until 1973. The subject was far from progressive, but it is an undeniable fact that students at the time had the opportunity to learn about topics perceived "sensitive" by today's Croatian society. The topic discussed in the first grade was "I was born of my mother". From second to fourth grade, the students learned about physical growth and development, differences between

sexes, conception, and menstruation. In the fifth and sixth grade, psychosomatic characteristics of puberty and the child's position in the family were covered, while the seventh grade was dedicated to two topics: "Satisfying urges" and "Biological and social needs of a human being". In the final grade of elementary school, young people learned about love, childbirth, marriage, and family, as well as about sexually transmitted diseases and contraception. Although there was a significant interest in this form of education, the topics covered in Sex Education were eventually integrated into other subjects.

Unfortunately, evidence-based sex education was replaced by religious teachings. **TeenSTAR** is an international program of workshops and lectures based on the Catholic teachings on sexuality and theology of the body by **Pope John Paul II**. The program was introduced by Sister **Hanna Klaus** in 1980. It promotes abstinence from sexual intercourse before marriage and the Billings Ovulation Method as the only reliable form of contraception. The Croatian branch of TeenSTAR was founded in 1995. with the purpose of "encouraging young people to be personally inspired by the perspective of human sexuality in the light of Christian and universal values, and fostering their true maturity and ability to experience true love". Two years later, the program received recommendation from the **National Catechetical Office of the Bishops' Conference**, and it was subsequently verified by the Ministry of Education and Sports, led by the HDZ (*Hrvatska demokratska zajednica* [Croatian Democratic Union]) Minister **Ljilja Vokić**, allowing it to be introduced to schools. This move clearly revealed the close collaboration and complete agreement between the Bishops' Conference and the HDZ regarding the content of Health Education that all students, whether Catholics or not, should be taught.

In 2002, **CESI — *Centar za edukaciju, savjetovanje i istraživanje*** [CESI — Center for Education, Counseling and Research] launched an initiative to introduce sex education in schools, leading to the development of

the program called "Human sexuality and Quality of Life". The program proposal was submitted to the relevant ministry, but did not receive the required approval as TeenSTAR still held a stronger negotiating position. One year later, TeenSTAR received a recommendation from the former **Institute of Education**, and was issued another positive evaluation by the Ministry of Education and Sports led by **Vladimir Strugar** from the SDP (*Socijaldemokratska partija Hrvatske* [Social Democratic Party of Croatia], dismissing alternative proposals such as the one presented by the CESI organization. In 2003, Croatia applied for membership in the European Union, which recommended the implementation of sex education programs in schools. As TeenSTAR program already had two positive evaluations from the relevant ministry, it was introduced into schools. The program was introduced in approximately thirty schools - as an extracurricular activity in elementary schools, and as an elective course in high schools – and later expanded to 60 schools. In 2004, the Ministry of Science, Education and Sports, led by HDZ Minister **Dragan Primorac**, provided a favorable opinion on TeenSTAR's proposal to establish school clubs involving students, teachers, and parents. The Ministry, on the other hand, sent CESI's "Human Sexuality and the Quality of Life" program proposal for further revision, effectively excluding it from further implementation. A large portion of the public opposed the decisions. Advocates of evidence-based sex education warned that the Ministry's actions are delaying Croatia's integration process into the European Union, where sex education is a standard practice. They also expressed concerns that another generation would not acquire the essential knowledge for a healthy sexual development.

In her 2004 report, the first Gender Equality Ombudswoman **Gordana Lukač Koritnik** pointed out numerous discrepancies between certain aspects of the TeenSTAR program and the provisions of the Convention on the Rights of the Child and other relevant laws in Croatia. An interesting description of the case PRS 02—02/04—03

states: “On 26 October 2004, the Legal Team of the Iskorak and Kontra associations filed a complaint regarding the TeenSTAR comprehensive sexuality education program, which, according to the complaint, has been implemented as an elective subject in 35 elementary and high schools since the school year 2003/2004. The complaint states that the program in question discriminates against alternative family forms, namely the unmarried and same-sex couples, as well as single parents, but it also targets homosexuality itself. Furthermore, the complaint also criticizes the program's professionalism, pointing out ‘the encouragement of negative emotions towards sexuality through intimidation, such as bringing up drug addiction and violence as consequences‘. It questions the expertise of program educators, the standpoint on the inefficacy of contraceptive methods, the ideological (Catholic) approach to sexuality, together with the claims about marriage being ‘the foundation of mature life‘, and assertions about a mother’s unemployment being ‘an important factor in preventing risky sexual behaviors‘. The complainants, therefore, argue that the TeenSTAR comprehensive sexuality education program is not in accordance with the Act on Gender Equality, Article 6, Paragraph 2, and Article 14, Paragraphs 1-4, as well as the Same-Sex Union Act, Article 21, Paragraph 1, the Constitution of the Republic of Croatia, Articles 22 and 35, and the Article 12 of the Universal Declaration of Human Rights by the UN.”

Nevertheless, in the first half of 2005, the program continued to be implemented, prompting the ***Iskorak***, ***Kontra*** and ***Ženska mreža Hrvatske*** [Woman’s Network Croatia] associations to address the matter in an open letter to the relevant ministry. At that point, Minister Primorac made the decision that Sex Education will be taught as a part of Health Education. Consequently, TeenSTAR was removed from schools, and it continues to operate as an association named **GROZD**.

Upon the Ministry’s order, the Sexuality Education Assessment Commission was established with Zagreb psychiatrist **Vladimir Gruden** as its head. Gruden

had previously made statements on several occasions about homosexuality being a disease that should be prevented and treated. As a consequence, he was reported to the Medical Chamber, which distanced itself from his statements. By April 2005, the Commission was supposed to decide which of the programs submitted for the competition would be officially implemented in schools. However, in mid-May, Minister Primorac announced the introduction of the Health Education program, with Sex Education as one of its components, and announced a public tender to decide on the program.

The Ministry issued a new tender in February 2006, and clarified in a press release in May that the tender was issued specifically for Health Education, not for Sex Education. The press release revealed that the media and the public interpreted Health Education merely as a way to rebrand Sex Education. According to the tender, the programs would include following topics: health and quality of life preservation, human sexuality, addiction prevention, social communication culture, and prevention of violent behavior. Health Education was to be incorporated into the curriculum of other subjects. CESI warned that this way the program would depend on the willingness of teachers and professors. A total of 24 programs were submitted: 11 for primary schools, eight for four-year high schools, and five for vocational schools. Some of the associations that submitted proposals were ***Forum za slobodu odgoja*** [Forum for Freedom in Education], **Romi za Rome** [Roma for Roma], ***Centar za razvoj ljudskih potencijala Olimp*** [Center for human resources development Olimp], ***Hrvatski crveni križ*** [Croatian Red Cross] and GROZD. The results of the tender were announced in December, and the Commission selected the program submitted by the GROZD association as the best for primary schools. The programs submitted by the GROZD and Forum za slobodu odgoja associations were selected for the four-year and three-year secondary schools. After the results were announced, the selected programs were submitted for approval to the Ministry of Health, led

by HDZ's **Neven Ljubičić**. In early 2007, the Ministry of Health received an opinion from the Ombudswoman for Children, **Mila Jelavić**, whose recommendation was not to accept any of the submitted programs due to two reasons. The first concerned the personnel and evaluation details which were not sufficiently elaborated in any of the submitted programs. The second focused on the lack of scientific foundation and compliance with the Family Act as well as the principle of treating children as subjects, not objects of education, in the modules related to human sexuality proposed by the GROZD association. In 2007, CESI brought legal action against the GROZD program before the Council of Europe. The action was dismissed, but that was not the end of the fight for scientifically-based comprehensive sexuality education in schools.

The plan of the tender and the GROZD and Forum za slobodu odgoja programs were ultimately abandoned in 2008. The reason behind this decision was that the evaluation results after the experimental phase showed no improvement in students' knowledge on these topics. It is worth mentioning that both programs required written parental consent for participation, which was later strongly advocated for by the GROZD association.

SCHOOL FOR WHOSE LIFE?

The year 2012 was supposed to be a turning point. Minister of Science, Education and Sports **Željko Jovanović** announced the introduction of Health Education, which would be taught across different subjects (during Homeroom and Biology classes). The program was created and published one month after the announcement, and the fact that it was not evaluated by any kind of expert panel nor was there any public discussion was concerning to say the least. Schools had very little time to adapt the curriculum. The teachers were not well-prepared, as they only received one-day training and a written manual.

As expected, the fourth module, which covers the topic of sexuality, proved to be controversial. Statements from the church representatives clearly hinted at what was to come. Together with the ***Hrvatska stranka prava*** 1861 [Croatian Party of Rights 1861], ***Udruga za promicanje etike, morala, obiteljskih vrijednosti i ljudskih prava*** [Association for the Promotion of Ethics, Morals, Family Values and Human Rights], as well as several private individuals, GROZD submitted a request to the Constitutional Court to assess the compatibility of Health Education with the Constitution. On 22 May 2013, the Constitutional Court concluded that the Decision on the Introduction, Monitoring and Evaluation of the Health Education Curriculum Implementation in Elementary and High Schools was unconstitutional as the "democratic procedure involving social dialogue on matters of general interest" was not respected.

The Constitutional Court ruled that, in accordance with constitutional and democratic principles, the content of Health Education taught prior to the beginning of the school year 2012/2013 will continue to be taught until the implementation of a new curriculum. Following the Constitutional Court's decision, the Ministry initiated a public consultation, which included four public discussions held in major cities and meetings with interested groups. A total of 254 educational institutions participated, and 1967 comments were submitted by associations and individuals. Following the public consultation, the Ministry presented the results, the Health Education Curriculum, and teaching manuals printed in 30,000 copies and distributed to all schools in printed form and through the website. At the end of August 2013, the Health Education Curriculum for elementary and high schools was adopted. Health Education was not abolished despite the change of government, and numerous studies involving both students and teachers indicate that the implementation of the program is not satisfactory.

The 2013 manual for high school teachers and expert assistants, created by the Ministry of Science, Education and Sports and approved by the Education

and Teacher Training Agency, includes gender equality and sexually responsible behavior. However, in 2019, the Ministry of Science and Education, led by Minister **Blaženka Divjak**, decided to introduce cross-curricular topics as part of the so-called "School for Life" program. One of the topics was Health Education, which no longer included gender equality and sexually responsible behavior.

In this brief overview, we have not included all the initiatives, meetings, protests, teacher training efforts and numerous non-institutional trainings related to sexual and reproductive health.

The fact that the European Union "calls on the Member States to guarantee the right to inclusive education and to ensure access to comprehensive, age-appropriate information about sex and sexuality" in the Resolution on the Rights of the Child from March 2021, suggests that not all is lost and the fight continues. Furthermore, the data that led to the petition is also encouraging: 78 % of Croatian citizens believe that comprehensive sexuality education should be mandatory in schools and that it is the responsibility of the state to implement it. This data comes from the latest study conducted by CESI in March 2021 on whether sex education should be introduced in schools. Therefore, even the parents' wishes, which were frequently invoked by GROZD, can no longer be considered a valid argument to prevent the introduction of comprehensive sexuality education in schools. The study shows that both young people and their parents have not succumbed to intimidation of the right-wing groups that continuously use the term "gender ideology" to create fear. We must persistently demand from the government to finally do its job and implement evidence-based sex education in schools.

REPRODUCTIVE HEALTH OF ROMA WOMEN

— there was a total of 36.753 births in Croatia in 2018, of which 593 or 1.6 % occurred among women of the Roma ethnic group

— the highest birth rates in the general population are in the age group from 30 to 34 years, while the highest birth rate in the Roma population occurs among women in the age group from 20 to 24 years

— according to the data available in the HZJZ (*Hrvatski zavod za javno zdravstvo* [Croatian Institute of Public Health]) records, the number of abortions and pregnancy terminations (on woman's request, for any reason) per year from 2010 to 2016 ranged between 20 and 40 cases among Roma women in the Republic of Croatia. However, there has been a significant increase since 2017 (2017: 90, 2018: 101)

— the reasons for the increase may include improvements in the recording of abortions and pregnancy terminations in healthcare institutions due to changes in abortion and pregnancy termination data collection and aggregation methodologies, changes in the attitude of the Roma ethnic minority regarding ethnic identification, as well as potential changes in attitudes and decisions concerning childbirth, which should be further investigated through a separate health survey. According to provided data, the overall rates of abortion and legally induced pregnancy terminations among the Roma population in Croatia are two to three times higher compared to the general population of women of reproductive age.

SOURCES: Klasnić, Ksenija; Kunac, Suzana; Rodik, Petra. [2020]. *Uključivanje Roma u hrvatsko društvo – žene, mladi, djeca* [Roma Inclusion in the Croatian Society - Women, Youth and Children]. Zagreb: *Ured za ljudska prava i prava nacionalnih manjina Vlade Republike Hrvatske* [Office for Human Rights and the Rights of National Minorities of the Government of the Republic of Croatia].

Javnozdravstveni pokazatelji zdravlja Roma u Republici Hrvatskoj temeljem podataka javnozdravstvenih baza i registara [Public Health Indicators of Health of Roma in the Republic of Croatia Based on the Data from Public Health Databases and Registries]. [2020]. Štefančić Martić, Vesna [ed.]. Zagreb: HZJZ.

PREPARED BY: SUZANA KUNAC

Mandatory counseling with the indifferent public

WRITTEN BY: ANA LOVREKOVIĆ

It has been almost five years since the Constitutional Court of Croatia rejected the request to review the constitutionality of the Act on Health Measures for the Realization of the Right to Freely Decide on the Childbirth, and thus ruled that the Croatian Parliament cannot ban abortion. Yet, all we currently know about the legislative procedure is that there is a working group responsible for researching and comparing legal models from other countries. According to the vague announcements by **Vili Beroš**, the current Minister of Health, we also know that abortion will not become free of charge, conscientious objection will not be abolished, and there is a clear intention to introduce mandatory counseling before abortion. The Constitutional Court has clearly confirmed that abortion must remain legal in Croatia, which is obvious even to those who advocate for its prohibition, so it is likely that they will continue pursuing measures that will further restrict access to abortion. One of those measures is mandatory counseling.

ABORTION BAN WITHOUT A BAN

The Abortion Law currently in force guarantees women the right to make decisions about abortion without any interference from a third party and without a waiting period, which corresponds to dominant legislative trends in European countries in the past twenty years. According to the interpretation of the Center for Reproductive Rights, mandatory counseling is an existing procedure in abortion-related legal solutions, and although its final form varies from country to country, it involves a counseling process that women must go through before making a final decision regarding abortion. While it is in most countries legally required for counseling to be unbiased, it is noticeable that they frequently serve to discourage women from having an abortion. Stigmatization, exaggeration of potential risks of the procedure, and depicting the healthcare service as "killing an unborn child" are certainly not in line with impartiality that is guaranteed on paper.

When announcing the introduction of counseling, Minister Beroš referred to the above mentioned Decision of Constitutional Court. In the Decision, the legislator has the discretion to regulate certain aspects while modernizing the abortion law, in order to enable women to freely decide on the termination or continuation of pregnancy, but also to define "appropriate period of reflection before making a decision on the termination or continuation of pregnancy, during which women would be provided with comprehensive information about pregnancy and available services (such as counseling centers and healthcare during pregnancy and childbirth, labor rights of pregnant women and mothers, availability of nurseries, centers providing adequate contraception and information on safe sex, as well as centers were counseling can be provided before and after pregnancy)". Consultations are mentioned not only in the final instructions but also in two other sections of the Decision. The first one refers to one of the initiators of the procedure for evaluating constitutionality — ***Hrvatski pokret za život i obitelj*** [Croatian Movement for Life and Family], an organization that has been advocating for the ban on abortion since the 1990s and whose proposal states that one of the numerous deficiencies of the current law is the absence of provisions for mandatory or voluntary counseling before pregnancy termination. The second one consists of expert opinions that analyzed the legislations of European countries, which were taken into consideration by the Constitutional Court. When analyzing "developed European democracies" such as Portugal, Spain, and France, it becomes apparent that in the 21st century, the mandatory counseling was either abandoned as a prerequisite for legal abortion, or counseling was legally allowed but not compulsory. Over the years, an increasing number of countries have abandoned the originally German model of the so-called "discouraging counseling with an 'open outcome'", which forced women to go through a counseling procedure aimed at protecting the fetus i.e. the "unborn child" — a term used by

advocates of abortion ban, which has, under their influence, found its way into legal terminology. The example of Portugal perfectly illustrates this significant change in legislation, as their Constitutional Court confirmed that women, being equal citizens with the right to make decisions about their own lives, cannot be subjected to the German model, which is perceived as extremely infantilizing and paternalistic. With the subsequent law amendment, not only was mandatory counselling abolished and periodic model implemented, but also the payment for this healthcare service was revoked within the public health system. A similar example can be found in Spain: the law amendment shifted away from the discourse of saving fetuses in favor of one that guarantees respect for women's lives. From the mentioned cases, as well as others, it is evident that countries are rejecting the oppressive model that aims to make women's access to abortion more difficult and, ultimately, tries to discourage them from deciding on terminating pregnancies.

DOCTORS AGAINST HEALTHCARE

Let us briefly reexamine the vague information we have on the process of drafting a new abortion law in Croatia, i.e. the working group that does not inspire confidence that they will focus on women's right to abortion when formulating final opinions and proposals. The members of the commission are concerning, as it mainly consists of medical professionals who directly or indirectly advocate the abortion ban and refuse to perform their job, invoking conscientious objection. **Urelija Rodin**, the head of the Department for Research and Monitoring of Maternal and Preschool Healthcare at the Croatian Institute of Public Health, has stated that in the Commission's analysis of abortion criteria in other countries, they did not come across consultations of a religious nature, except in Germany, where it is allowed but not obligatory. Rodin claims that consultations are

carried out by psychologists, psychiatrists, and social workers, emphasizing that psychosocial counseling is mandatory in "developed" countries to ensure that women are provided with comprehensive information about "the abortion procedure, health effects, and future contraception". It is indicative that Rodin considers abortion to be accessible in Croatia, despite the fact that some hospitals do not perform it. While doctor's public announcements in front of the Commission are rare and limited in information, this statement hints at their position and argumentation for introducing mandatory counseling — it is carried out by experts, the practice is present in "more developed" countries, and most citizens do not consider the fact that abortion is not accessible a problem, but rather a situation that needs to be maintained and encouraged.

RELIGIOUS COUNSELING?

If we accept the idea that mandatory counseling is a real concern, the question arises of who will be responsible for providing such counseling in Croatia. The Constitutional Court's decision, for instance, mentions "centers" where counseling can be provided before, during or after pregnancy. It is pretty unclear which centers they are referring to, especially if we take into consideration the local context, where there are only fake centers run by associations aiming to ban abortions, the so-called "life centers". At this moment, there are five centers established by the ***Hrvatska za život*** [Croatia for Life] association which is also known for harassing patients with prayers in front of hospitals in Split, Vinkovci, Vukovar, Zadar and Zagreb. They are called "counseling centers for pregnant women and families" in "collaboration with experts, psychologists, gynecologists, priests, lawyers and social workers". They operate on the principle of spreading unscientific propaganda, such as claims that abortion causes the so-called "post-abortion syndrome" (which does not exist), and they use this as basis to promote the idea that women need counseling after they decide to have one.

In a situation where more and more doctors in public health institutions are invoking conscientious objection, thus denying women healthcare, it remains unclear whether the objectors will also provide counseling. Considering the decreasing number of doctors willing to perform abortions as they believe it falls outside their professional responsibilities, how can the legislator expect to have enough healthcare workers who will provide counseling to women who decide to have an abortion? Will the doctors who are invoking conscientious objection be allowed to provide counseling to women while simultaneously denying them healthcare services? Given the lack of previous efforts to regulate conscientious objection (resulting in entire gynecological teams objecting in some hospitals, which left some cities with no doctors that would perform an abortion), further flavorings of doctors who refuse to perform the tasks they specialize in are a realistic scenario.

In more than ten European countries, including Albania, Belgium, Bosnia and Herzegovina, Germany, Hungary, Italy, the Netherlands, and Slovakia, the law requires women to receive counseling before an abortion. In some countries, such as Hungary and Italy, the counseling is "explicitly discouraging", which means their main purpose is to dissuade women from having an abortion and make it more complicated for them to utilize this healthcare service. The introduction of a counseling model is commonly justified by the goal of protecting women's health and presented as "informed decision-making", which is an argument used in Croatia as well. However, research indicates the opposite outcome. In Macedonia and Slovakia, mandatory counseling is a well-calculated step in restricting the right to abortion. Documented practices, such as stigmatization and questioning women's capabilities and rights to make decisions independently, directly threaten the well-being and health of women. The most vivid example is Macedonia, where an extremely restrictive abortion law was in force from 2013 to 2019. It prescribed the submission of a written request, mandatory counseling on contraception, the benefits of childbirth, abortion risks, as well as a waiting period of three days after the completion of counseling. Mandatory counseling in Macedonian hospitals was also carried out by organizations advocating for abortion bans, thus endangering the lives of multiple women, including a pregnant woman carrying a dead fetus and a pregnant woman with hematoma. Women who decided to terminate their pregnancies were subjected to various forms of psychological pressure, such as ultrasound images of the fetus and its anatomy. With the arrival of the social democratic option to power in Macedonia, this rigorous law was revised and replaced with a periodic model, mandatory counseling and waiting period were abolished, and additional measures were implemented, all aimed at making abortion accessible to as many women as possible.

Although legally mandated waiting periods are not announced in Croatia, mandatory counseling in practice implies a waiting period. In the past years, the patients find it extremely difficult and even impossible to obtain information on whether abortions are performed in a particular hospital, on how to make an appointment and schedule a procedure, on where to go, and who will perform the procedure. Thus, it remains unclear whether scheduling counseling will also entail an exhausting and lengthy process, which will now have to be endured twice. Apart from the time a woman will have to spend waiting from the moment she decides to have an abortion until the counseling, the duration of the counseling itself can also be an issue. If multiple professionals, such as doctors, social workers, and psychologists will be involved in the counseling, the prolongation of the process can be expected. That is very concerning considering the legal timeframe of first 10 weeks of pregnancy within which abortions are allowed. It is still unknown whether this limit will be adjusted to match the standard in most European countries, i.e., the twelfth week of pregnancy. Since the cases where pregnancy is detected right before the legal deadline for abortion are not uncommon, the introduction of mandatory counseling could result

in a certain number of women being forced to continue an unwanted pregnancy because they will simply not have an opportunity to decide on terminating a pregnancy.

"COUNSELING"? MORE LIKE "CANCELLING"

If we look at mandatory counseling in potential correlation with the other two factors that currently make abortion inaccessible in Croatia, i.e., cost and conscientious objection, it is evident that its introduction further limits the number of women that have access to abortion. Based on the announcements of the Minister of Health, the legislator has no intentions to make abortion more accessible, either by abolishing fees in public health system hospitals or regulating or abolishing conscientious objection. If counseling becomes a legal requirement, it will significantly complicate the process of freely deciding on pregnancy termination. For instance, if a woman lives in a city where abortion is not available, she is forced to travel 50 or more kilometers just to reach a hospital that can provide her with a legally guaranteed healthcare service. Therefore, the expenses of travel and accommodation should be added to the cost of abortion. The cost of abortion keeps increasing: over the last five years, it has gone up by 500 — 1300 Kunas (65 to 170 Euros) in public hospitals, and the highest cost, according to data from 2020, was 3000 Kuna (400 Euros). If a woman is required to attend counseling at the same hospital before an abortion, possibly multiple times, travel expenses will rise significantly, and the overall cost of preserving her health will exceed her monthly income. Since there are two private hospitals in Croatia authorized to perform abortions, it remains uncertain how counseling will be regulated within private healthcare institutions. Women's testimonies tell us that patients with higher socioeconomic status mostly choose to have abortions in private hospitals because public hospitals obstruct their right to healthcare and because they do not encounter condemnation and neglect in private hospitals — just a higher bill. Ironically, while the cost of abortion in public healthcare institutions is generally lower than in private clinics, private clinics often offer installment plans, which could also mean that women of lower socioeconomic status, who cannot gather the necessary funds for abortion quickly, may opt to go to private clinics and ultimately end up paying more for the procedure. Taking everything into account, it is not impossible to presume that the introduction of mandatory counseling may prompt even more women seeking unbiased counseling to choose private hospitals to carry out their decision to terminate their pregnancies, the same way they currently seek more humane treatment before, during, and after the abortion.

Another year has gone by and there is still very little information on the new abortion law, but the announcements are alarming. We know enough about mandatory counseling — it is a model designed to dissuade women from having abortions and to make abortions even less accessible to the decreasing number of women who can still say they have a right to abortion in Croatia. We know enough to say we will do whatever is necessary to prevent its legalization.

THE HISTORY OF ABORTION RIGHTS: DIGEST

THE YUGOSLAVIAN EXPERIENCE

1951 Criminal Code: Abortion is allowed if a woman's health is at risk; women are not penalized, but those who perform abortions.
1960 Regulation on conditions and procedure for authorizing abortion: medical reasons, challenging personal circumstances, financial difficulties.
1974 The working group comprised of Mira Alinčić, Nevenka Petrić, and Milan Bosanac proposed a formulation intended to be included in the new Constitution of SFRY. "In order to ensure women's personal freedom, women's right to terminate pregnancy is guaranteed. This right may only be limited in the interest of protecting the life and health of the woman." This proposition was rejected, and instead, in paragraph 191, the wording is as follows: It is a human right to freely decide on childbirth. This right may only be limited for the purpose of protecting health."
1978 Law on Health Measures for Exercising the Right to Free Decision-Making on the Birth of Children: Termination of pregnancy is a medical procedure that can be performed up to the 10th week of pregnancy.

THE CROATIAN EXPERIENCE

1991 Abortion is no longer part of the new Constitution, and the law from 1978 is still in force.

> "We included the right to freedom of choice in the draft of the Constitution, but by the time we arrived from Krk to Zagreb, that provision vanished. It was excluded due to certain influences, and from 1991 until today, we have been facing a series of ideological questions, either in favor or against", commented lawyer Krunoslav Olujić.

1995 A special commission of the Ministry of Health prepared a Draft Proposal for the Abortion Law, which never entered into a parliamentary procedure.
1996 Hrvatska stranka prava [The Croatian Party of Rights] proposed a law to ban abortion, but it did not pass.
2017 The Constitutional Court of Croatia issued a decision in 2017 that compels the legislator to adopt and modernize the Act on Health Measures for Exercising the Right to Free Decision-Making on Childbirth within two years. The Constitutional Court unequivocally made it clear that abortion cannot be banned, but it left considerable leeway for restrictions in practice, such as potential counseling, waiting periods, and similar measures.
2018 Minister of Health Milan Kujundžić established a working group to draft a proposal for a new law.
2020 Minister of Health Vili Beroš declared: "The Ministry of Health has taken preliminary steps towards adopting a new law and established the 'Commission for the Evaluation of Legal Criteria and Experiences of European Union Member States concerning the Right to Pregnancy Termination'". The minister insinuates in the media that mandatory counseling will be incorporated into the law.
April 2022 as of the release of this publication, there is still no draft of the new law, which was supposed to be adopted in 2019 as per the Constitutional Court decision.

Reproductive justice of trans, intersex, and gender variant persons

WRITTEN BY: ARIAN KAJTEZOVIĆ

In this text, we will clarify who TIGV persons are, outline the basic terminology, and summarize the most relevant topics and problems related to the reproductive health of TIGV persons.

WHO ARE TIGV PERSONS?

TIGV is an abbreviation for trans, intersex, and gender variant persons. In order to better understand what TIGV entails, we will start from the list of relevant terms and refer to the glossary of **Trans Network Balkan**, as well as to the information collected by **kolekTIRV (formerly known as Trans Aid)**, associations dealing with these topics in the region.

ON GENDER

Gender identity is a person's intrinsic, inner feeling about their gender. "Male" and "female" gender identities are most frequently mentioned as they are in accordance with current social norms. Identities that do not fit the norms are treated as inferior and less real, and attempts are made to describe them through the socially accepted norms of "masculine" and "feminine." That is why it is important to emphasize that there are numerous gender identities and many of them cannot be attributed to socially accepted male and female identities.

Gender can also be seen as a "space" in which male and female identities are only two of many existing identities and not the two endpoints. The term gender is often used to describe the social aspects of gender identities and sexes. The experience of others may or may not be in accordance with a person's real identity. Gender role is a socially defined role, i.e., a set of expectations that persons "should" fulfill based on the gender assigned to them at birth. Gender expression includes characteristics of personality, appearance, and behavior that are defined as masculine or feminine (thus typical of a male or female social role) in a certain culture and historical period.

ON SEX

Male and female sexes are most often assigned to persons immediately at birth, depending on the appearance of the genitalia. Sexual characteristics also include internal reproductive organs (uterus, ovaries, fallopian tubes, vas deferens...), chromosomes, and sex hormones, but these characteristics are only considered if a person's genitals do not fall within the given norms established by agreement, and not by some natural demarcation between the two sexes.

There are attempts to forcibly divide sexual diversity into two clear categories and sexual diversity is often based on only one of several sexual characteristics. Therefore, natural sexual diversity remains invisible, and society only accepts the male and female sexes.

Sex identity is a person's own sex identification, which is not necessarily in accordance with the sex assigned to them at birth. Regardless of what "parts" a body has, it is neither "male" nor "female" on the basis of those parts, but on the basis of the person to whom it belongs.

TRANS, GENDER VARIANT, AND CIS PERSONS

When a person identifies as trans, they may need to take steps to find harmony and alignment with their gender. In this case, "transition" may include a change in one's social and legal identifiers, body, and/or appearance. Trans people are often mistakenly said to be "trapped in someone else's body". The bodies in which trans people live, in which they were born, are their own, not someone else's. They do not belong to other persons, they are not stolen, borrowed, or mistakenly "taken" from others. In the broadest sense, gender dysphoria is a feeling of unhappiness, discomfort, or dissatisfaction related to one's gender. Gender dysphoria, which can occur in relation to any gender dimension, can include a wide

range of feelings, from mild discomfort to excruciating pain. The intensity, comprehensiveness, frequency, and triggers of gender dysphoria vary widely from person to person, and feelings of gender dysphoria can change over time. Gender variant people (or non-binary, queer, gender nonconforming persons) are persons whose gender identity and/or gender expression differ from the norms that society attaches to the gender assigned to that person at birth. These norms differ between cultures, religions, and throughout history.

Cis persons are persons whose gender identity fits (sufficiently) into the social gender norms associated with the gender they were assigned at birth. As socially prescribed gender norms are very rigid, exclusive, and limiting, not many persons completely fit into them. It is often said that most of the population is cis (not trans). The question, however, is: if a deviation from the norm was not stigmatized in society, how many people would truly identify as a cisgender person? If society was in accordance with the real diversity of sexes and genders, we probably wouldn't even need terms like "trans" and "cis".

Cisnormativity is a view of the world that treats cisgenderism as "normal" and "natural," and considers deviations from social sexual and gender norms as disorders. From cisnormativity comes cissexism, which is reflected in attributing lesser value to persons whose identities and expressions do not fit into social norms, as well as in stigmatization and discrimination of those persons. Cissexism often results in violence against trans and gender variant persons, in discrimination in all spheres of life, and in deprivation of those who do not fit into social gender norms of basic human and civil rights. The cis privilege of a person whose gender identity and expression do not deviate from social norms to such an extent that they suffer discrimination and violence because of it implies that cis people are often unaware of the problems that trans and gender variant people face on a daily basis.

INTERSEX AND ENDOSEX PERSONS

Intersex is an umbrella term for all innate variations in sexual characteristics that encompass the experiences of persons whose bodies, according to medical norms, cannot be classified into typical male and female bodies based on their chromosomal, gonadal, or anatomical sex. Intersex is not the same as transgender, and an intersex person can be transgender, cisgender, LGB, straight, asexual, etc., just like any other person.

Intersex variations can be chromosomal, which means that the chromosomes can be something other than XX or XY. An intersex characteristic or variation can also be gonadal. Gonads are sex glands like ovaries or testicles. Thus, a person born with a vulva may later in life discover that they have internal testicles and not the (expected) ovaries. Likewise, the gonad sometimes does not develop into any type (it is called an "undeveloped gonad") and does not produce any hormones.

Even the external genitalia, or genital tissue, can vary in spectrum at birth: the same tissue can become the labia or the scrotum through surgical intervention, and another can become the clitoris or the phallus. If, for example, the size of the tissue is somewhere between the clitoris and the phallus, the doctor decides whether to intervene surgically. In a large number of cases, combinations in the spectrum of intersex children do not have any health consequences. Surgical interventions are generally not performed due to medical necessity, but are of an aesthetic nature – they are performed solely to classify the child as "male" or "female". Urgent intervention is only necessary when the child cannot urinate. Since children cannot give informed consent, their physical integrity is violated, so such procedures often carry physical and psychological risks and consequences. They are therefore referred to in the same way as clitoris removal procedures, i.e., they are called intersex mutilation.

Unlike intersex persons, endosex persons have innate sexual characteristics that can be classified according to all the mentioned categories (chromosomal, gonadal,

genital) into a typical male or female body, that is, they are called that according to social and medical norms. In other words, endosex persons are persons who are not intersex. Many persons assume they are endosex without necessarily knowing all aspects of their sexual characteristics and the extent to which they fit into their assigned gender (e.g., most people never find out what chromosomes they have). However, both endosex and intersex bodies are generally healthy and complete as they are.

REPRODUCTIVE HEALTH OF TIGV PERSONS

TIGV persons may have the same reproductive health needs as cis and endosex persons, especially if they have not started a legal nor medical transition, or if they have an intersex variation not directly related to their reproductive organs. In addition, TIGV people sometimes have specific needs related to reproductive health that endosex and cis people do not have.

Let us take the menstrual cycle for example: some TIGV people have it, some do not, while some have a non-normative cycle. Trans men and other persons perceived as men often face the prejudice that they shouldn't menstruate in order to be masculine enough, and some are simply not bothered by their menstrual cycle. On the other hand, it is often not believed that trans women can have almost all aspects of the menstrual cycle with the help of estrogen hormone therapy.

Another example of discrimination is the performance of certain examinations, depending on the day of the menstrual cycle, and medical professionals often do not take into account TIGV persons and their existing, irregular, or non-existent menstrual cycles. Likewise, many TIGV people encounter numerous inconveniences when going to a gynecological office or a gynecological department - from medical staff refusing to provide them health care, through verbal violence and discrimination, all the way to painful, abusive examinations and inappropriate touching. For many, even when not discriminatory, this experience is a source of

gender dysphoria. These are all reasons why TIGV persons often neglect their reproductive health.

When it comes to planned parenthood, trans, gender variant, and intersex persons are often and in various ways forcibly sterilized. In the case of trans and gender variant persons, forced sterilization most often occurs if the system is arranged in such a way that a certain sterilizing medical intervention is necessary for the person to be able to change the gender designation in the documents (e.g., the condition that they have been taking hormonal therapy for a certain period of time, which can cause sterility, or that they have undergone surgical procedures resulting in sterility). In Croatia, sterilizing interventions in case of document change were necessary until 2014, when the Constitutional Court issued a historic verdict ordering a new regulation on the procedure for changing documents. Until 2016, there was a pause in the procedures for changing documents until the implementation of a new legal framework, according to which it is possible to change gender designation without obligatory medical interventions.

TIGV persons are often not sufficiently informed on the possibilities for family planning or the consequences of a certain therapy. It is often considered that trans and gender variant persons should not have children at all or it is assumed that they need certain sterilizing interventions even when this is not the case. On the other hand, intersex children, not old enough to give informed consent, are often subjected to medical interventions that can result in sterility.

On the other hand, there are cases where a TIGV adult does not want to have children but is approached under the assumption that this is tragic and that everything possible should be done to prevent such an outcome. There are attempts to force intersex people into cycle-regulating therapy, and to convince trans and gender-variant people not to start the necessary interventions until they are at least 25, 30, or some other apparently appropriate age. Another important point when it comes to planning

a family for many TIGV people is that the procedure involves medically assisted reproduction. Trans and gender variant persons often need to inform themselves on their own about the possibility of storing their reproductive cells (sperm, egg cells, or embryos) if they are planning to take hormonal therapy or undergo surgery to remove their gonads. This is sometimes possible and sometimes not, depending on the health system of a particular country. For some trans men and gender variant persons, pregnancy causes acute gender dysphoria. These persons need a lot of support to get through the pregnancy or find other ways to plan a family.

Pregnancy and abortion on demand are situations that clearly reflect the attitude of the medical profession toward TIGV people. In addition to many problems that cis or endosex women have during childbirth and in exercising their right to abortion, TIGV people also have to deal with minority stress (a chronic level of stress caused by prejudice, discrimination, violence, lack of social support and other forms of stigmatization accompanying members of marginalized groups) and trauma experienced in the health system, all due to a non-normative body, intersex body or the fact that they have undergone some form of medical transition.

Here are some of the examples of attitudes towards TIGV persons within the healthcare system: medical staff does not trust an intersex person about experiences during childbirth or abortion because the experiences are not typical; a person is called a mother or a pregnant woman even though, for example, it is a man or a gender variant person; ignorance of whether a parent should be registered as mother or father and the like. Sometimes, due to lack of information on the part of the healthcare staff, necessary medical care is delayed until significantly less urgent matters such as whether a man can be admitted to the gynecology department are resolved. Due to lack of information and lack of awareness of the medical staff, TIGV persons are often left out of programs for the prevention of, for example, breast or prostate cancer.

Thus, a person who has breasts, and whose documents indicate male gender, will not be called for a mammogram. In addition to this, 56% of TIGV persons postpone going to the doctor because of the traumas they have experienced in the healthcare system (Transgender Europe, *Overdiagnosed but Underserved*, 2017).

Personal experiences of trans and gender variant people in the healthcare system in Croatia are available in research of the **kolekTIRV** association on legal recognition of gender from 2020, in which people reported experiences such as "*I had an unpleasant experience in a private polyclinic where I was insulted, humiliated, and ultimately kicked out, because I am trans*".

As part of the 2020 research on menstrual poverty in Croatia by the **PaRiter** association, as many as 60 trans people took the survey (about 1% of the total surveyed) — most likely thanks to an inclusive approach, which did not exclusively mention women in the context of menstruating persons.

The stories of intersex persons in Europe are documented in detail in **OII Europe's** 2019 *#MyIntersexStory* publication.

TIGV AND WOMEN'S REPRODUCTIVE JUSTICE

I am deliberately writing "TIGV and women's reproductive justice", and not, for example, "gender and sexual reproductive justice". This way, I give visibility to different experiences that are often left out or forgotten. At the same time, we have to be careful that inclusion does not result in unintended harm — inclusion must imply expansion. So, for example, I think that when talking about reproductive justice, we should not talk about "women's justice" or "justice for gender and sexually oppressed people", but precisely about "women's and TIGV reproductive justice". As can be concluded from all of the above, TIGV reproductive health and women's reproductive health are inseparable because they are

dealing with the same issues and the same or similar experiences. However, TIGV and women's experiences may differ depending on the experiences or identities that a woman or TIGV person has. For example, experiences of gender variant persons with disabilities are different from those of gender variant persons without disabilities; experiences of endosex Roma women are different from those of intersex white women, etc. Reproductive justice is based on universal principles — we must all have the inviolable right to bodily autonomy and bodily integrity, to informed consent, to free, accessible, and quality health services, and it is important to equally trust our experiences. In practice, this means, among other things, that all our similarities and differences should be visible and that the approach in the process of ensuring these universal principles must be individualized in order to have true justice for all and not mere equality that only suits some.

Drop by drop

WRITTEN BY: MARINELLA MATEJČIĆ

Until recently, menstrual poverty was a completely overlooked topic in Croatia. This changed in February 2021, when Human Rights and Civic Participation Association **PaRiter** published alarming study results: over 10 % of Croatian women cannot afford to buy enough menstrual pads to change them regularly, and the same percentage cannot afford pads at all. Many victories have been achieved since then at the level of local and regional authorities, but the main battle — the fight for free menstrual supplies in Croatia — is ongoing.

INVISIBLE PROBLEM

The data was collected through an online survey from mid-September to early October 2020. The research involved 6084 participants aged 16 and older who had menstruated in the past year, regardless of their gender identity. Responses from participants who completed the questionnaire were included in the analysis. It is important to note that an online questionnaire as methodology excludes people without internet access, which implies that the scale of this issue could potentially be even larger.

"The objective of the study was to collect data on the usage, spending, and accessibility of menstrual supplies, conditions for menstrual hygiene maintenance, and the shame associated with menstruation", explained **Maja Močibob**, psychologist and author of the questionnaire, in the analysis of study results.

Ana Marija Sikirić Simčić, PhD, who wrote the recommendations based on study results, commented on the topic of menstrual poverty: "The importance of menstrual health has historically been disregarded, mainly due to taboos and misconceptions about menstruation and androcentrism within medical knowledge and healthcare systems worldwide.

The concept of androcentrism takes the male body as reference, norm, and example for all people, leading to the invisibility of women, female bodies,

and women's health in healthcare science, politics, and practice. Consequently, the problem of 'menstrual poverty', which refers to financial, social, cultural, and political obstacles in accessing menstrual products and education, is overlooked."

STUDY RESULTS

One third of women in Croatia are forced to economize on menstrual pads as they are too expensive. Some of them buy lower-quality menstrual supplies due to overly high prices, and more than 10 % of women cannot afford to purchase enough pads to change them regularly. An equal proportion of women cannot afford pads at all.

Over a third of participants (36.4 %) reported that they occasionally have to buy lower-quality menstrual products due to high prices, with 8.3 % stating it happens frequently and 28.1 % occasionally. More than 10 % of participants responded that sometimes they do not have enough menstrual supplies to change them whenever they want (11.9 %) or they cannot afford them at all (11.9 %).

Around 10 % of them experienced situations where they could not afford pain relief medication during menstruation, and 8.8 % reported that sometimes they do not change their pad/tampon for longer than 6-8 hours because they cannot afford more menstrual supplies. A smaller portion of the participants had to obtain menstrual supplies from a friend or someone else because they could not afford them (4.7 %).

In addition to the accessibility of menstrual supplies and pain relief medication, the study also examined menstrual hygiene and conditions at home, work, high schools, and universities that (do not) allow proper menstrual hygiene maintenance. The study also covered the issue of stigma and shame associated with menstruation. The study indicates a high level of dissatisfaction, namely due to the lack of basic sanitary conditions in workplaces, high schools, and universities. These are just few of the findings obtained

from research, and you can find more details in the publication "Menstrual Poverty and Destigmatization", available on PaRiter's website.

SOCIAL IMPACT

Currently, Croatia has one of the highest taxes on menstrual hygiene products, a staggering 25 %. Although the "luxury tax" category no longer officially exists in Croatia, menstrual pads and tampons are taxed as if they were luxury items rather than essentials.

The study results were published in February 2021, at the time when **Anka Mrak-Taritaš**, a member of the parliament, submitted a proposal for tax law amendment, aiming to introduce a minimal 5 % tax rate for menstrual products. The Parliament and the Government rejected the proposal to reduce the tax rate on menstrual products, but many high schools, as well as local and regional authorities, decided to take action. Free menstrual supplies are provided in Rijeka, Karlovac, Lepoglava, Varaždin, Sisak, and Čavle (local level), in Krapina-Zagorje, Split-Dalmatia, Osijek-Baranja, and Šibenik-Knin Counties, as well as in "Vladimir Gortan" High School in Buje, Buzet High School, Pula Gymnasium, Varaždin School of Mechanical Engineering and Traffic, and Ruđer Bošković Technical School in Vinkovci. The Pula Student Dormitory, the Institute for Social Research in Zagreb, and all constituents of the University of Rijeka, also joined this initiative.

The Initiative of Female Members of Croatian Parliament has also taken action and, in cooperation with the Initiative to Reduce Taxes on Menstrual Supplies (consisting of about fifteen civil society organizations from Croatia),has started a petition and collected 23,777 signatures over the course of two weeks.

This study has made an impact beyond the borders of Croatia: The Faculty of Philosophy in Novi Sad became the first educational institution to provide

free hygiene products to female students, all thanks to brave women and the initiative of female students who recognized the issue and addressed it adequately.

MENSTRUATION AS A POLITICAL ISSUE

Is menstruation a political issue? As long as menstruation is a word, we whisper due to drama and stigma, it remains a political issue. As long as we live in an androcentric world that taxes menstruation at the highest rate, menstruation is a political issue. As long as it is problematic to discuss menstruation as a physiological occurrence in public space simply because it concerns a portion of the public that has no right to set topics — it is a fundamental political issue. Even though menstrual poverty has always been present, the accessibility of menstrual products was not a topic of public discussion until recently, and proposals for tax law amendments that would reduce the tax on menstrual products were quietly dismissed without the public's knowledge and, more importantly, without its interest.

As long as we live in a world where women's needs are consistently ignored and met with ridicule and mockery, menstruation is and will remain a political issue that needs to be resolved to the satisfaction of those for whom it is a biological reality.

IN SEARCH FOR A SOLUTION — HOW TO TAKE ACTION IN THE LOCAL COMMUNITY?

Study results were presented to the Gender Equality Committee of the Croatian Parliament, which gave several recommendations: the first is to reduce the tax on menstrual products, the second is to introduce education on menstruation, and the third is to encourage schools to provide free menstrual supplies to their students. Finally, if you are wondering what you can do in your local community to help solve this issue, we have some suggestions. You can be

proactive, reach out to existing civil society organizations dealing with related issues, collaborate with them, or with individuals willing to donate menstrual supplies to those who cannot afford them. You can contact local authorities that have the capacity to provide menstrual supplies in schools that are under their jurisdiction. You can appeal to the Government to reduce the tax on menstrual supplies to the lowest possible rate. Budgets should not be filled with bloody pads, that is, discriminatory and sexist legal provisions, but with smart economic policies. It is time to stop being silent about this problem. It is time to stop ignoring the needs of over half the population because the patriarchy has forced us to either keep quiet or speak about our problems in whispers.

Cliteracy

WRITTEN BY: KARLA HORVAT—CRNOGAJ

Cliteracy is a word coined by American artist **Sophia Wallace** for her project dedicated to dismantling taboos related to female genitalia. Over the past ten years, the term was used in numerous other projects worldwide with a shared mission to increase public visibility of the complete anatomy of the clitoris. I launched the Croatian version of the project in 2018, and since then, in collaboration with numerous activists, artists, and organizations, we have been spreading the mission of cliteracy throughout Croatia.

While you probably haven't heard it before, the meaning of the word is clear, isn't it? It sounds dramatic because the word "clitoris" is seen so rarely that it appears a bit exotic. It feels good to bring the clit back into all the spaces where she belongs — including language. We can play with the clit linguistically in different ways — the word "clitastic" for example, sounds so brilliant! One of my favorite versions was created when, while seeking a way to vividly illustrate the importance of having information about the complete anatomy of the clitoris in order to understand female corporeality, we came up with a superhero and named her Super Klita.

WHY DO WE NEED CLITERACY?

The history of studying the clitoris did not progress simultaneously with that of external female genitalia and reproductive organs. However, it is not true that nothing was known about the clitoris until modern times. On the contrary, Greek medical scientists named the clitoris as early as the first century, but the issue arose because previous knowledge of clitoral anatomy was overlooked in the history of its examination. Moreover, we come across bizarre cases, such as the ones from the mid—16th century where two scientists (one of them being Fallopio, after whom the fallopian tubes were named) almost had a dispute over which one of them discovered the clitoris — as if it were a new continent or chemical element.

Already by the mid-19th century, **Georg Friedrich Kobelt** (a brilliant guy, be sure to remember his name) described all the parts of the clitoris that we know today. How and why do we now learn about the anatomy of the clitoris from obscure corners of the internet?

A couple of years after Kobelt's publication, two crucial moments influenced the expert's approach to the clitoris. First, the realization that it does not affect fertility made it far less important to many anatomical experts, while a dubious focus on female masturbation gained a forward momentum from some of the experts, since it was blamed for causing various problems, from epilepsy to (of course) lesbianism. The second moment (1905) was the publication of three essays on sexuality by Freud, in which he divided orgasms and women into, brace yourselves — mature genital and immature clitoral.

The entire 20th century was characterized by waves of censorship or at least neglecting the facts about the complete anatomy of the clitoris. The magnitude of this tragedy is evident from the example given by Vincent Di Marino and Hubert Lepidi, authors of the pioneering publication "Anatomic Study of the Clitoris and the Bulbo-Clitoral Organ" from 2014, who present the results of a study in which, out of 376 surveyed female 9th—grade students, 23 % did not know they had a clitoris, and 65 % were unaware of its function. The study was carried out in 2009, and the country in question is located in the heart of the Western European Union — France.

HOW DID THE CONVERSATION ABOUT THE COMPLETE ANATOMY OF THE CLITORIS BEGIN?

In the 1970s, a myriad of feminist collectives focusing on health were founded in the USA. They published various publications (often in form of pamphlets) in which they promoted self-examination, awareness of one's anatomy, and denial of the distinction between clitoral and vaginal orgasm. In 1976, American sexologist Shere Hite published

a report revealing that 70 % of several thousand anonymous participants state that they cannot achieve orgasm solely through penetration. However, this information does not affect the overall knowledge about clitoral anatomy, nor does it spark interest among the experts.

A slightly more significant breakthrough of the complete anatomy of the clitoris into the public and media space happened at the very end of the 20th century, in late 1998, when Australian urologist Helen O'Connell once again drew attention to Kobelt's forgotten sketches while describing the complete anatomy of the clitoris. It is significant that she simultaneously disproved the traditional distinction between clitoral and vaginal orgasm because vaginal stimulation includes stimulation of the internal parts of the clitoris.

Just like other knowledge, clitoral anatomy has also benefited from the advent of the internet. This particularly applies to visual representations, which have an especially strong potential to become viral. And so, just over a decade ago, several medical researchers began using new imaging technologies. Consequently, illustrations based on sonograms started circulating the internet, revealing that the clitoris is significantly larger than previously thought — larger than the button some struggle to locate.

In 2016, French sociologist Odile Fillod launched a project to create the first 3D printed model of the clitoris for the educational website Matilda. The image of the model gained a certain amount of media exposure, especially among media outlets specialized in 3D printing. Afterward, Fillod was interviewed in the renowned Guardian, and the article (with a somewhat sensational and partly inaccurate headline) featuring an illustration of the model was picked up by numerous media outlets around the world — including several in Croatia. Thanks to the combination of media hype and interest in 3D technology, the anatomy of the clitoris has sparked more interest than ever before.

MS. CLITORIS IN ALL HER GLORY — AND SIZE

So, what are we talking about when mentioning the complete anatomy of the clitoris? The clitoris is a female sex organ present in mammals, ostriches, and a limited number of other animals. In the animal kingdom, one interesting example is the spotted hyena, which, unlike most animals, has a notably large clitoris, and uses this organ for urination, mating, and giving birth.

If you Google "glans", the internet will inform you that there is a glans penis and a glans clitoris. In Croatian, it would be "glavić" — the only visible, external part of the clitoris. The entire length of the external and internal parts can measure from 6 to 12 centimeters. The body of the clitoris is composed of the socalled cavernous, or porous, erectile tissue, and below it are the bulbs filled with spongy tissue. If the terminology sounds familiar, it is because the clitoris is homologous to the penis — at least morphologically. Thus, similar to the penis, the clitoris fills with blood and becomes erect. The physiological aspect of clitoral erection is based on a dynamic interaction of enzymes, neurotransmitters, and nerve activity, involving both cavernous and spongy parts.

The main difference is the functions. The clitoris in humans does not contain the distal part (or opening) of the urethra, so it is not used for urination, and it does not serve a reproductive function. It is the only known organ whose sole function is pleasure, leading us back to the comparison with the penis. Indeed, while some authors disagree on whether the clitoris has more or fewer nerves than the penis, the indisputable fact is that the clitoral glans has 50 times higher innervation density, i.e., an extensive nerve network, with an impressive 8000 nerve endings. The clitoris is significantly more innervated than the vaginal wall. Therefore, during penetration, simultaneous pressure on the internal parts of the clitoris stimulates a much larger number of nerves within the clitoris compared to the vaginal tissue. This finally dismantles

the entire foundation of Freud's mythology but unfortunately, it was long overdue. In 2010, Buisson and Foldès studied female orgasm and performed the first ultrasound of the clitoris during vaginal penetration. They documented the interaction between these tissues and observed the mobility of the clitoral parts that arch during sexual intercourse, further stimulating the nerve endings. So, merely a decade ago, we managed to prove that the distinction between clitoral and vaginal orgasm is obsolete, as they differ only in the specific area of the clitoris that is most intensely stimulated. It is likely that we will also slowly leave behind the boring, old discussions about G-spots, A-spots, and the rest of the alphabet.

HEROINES OF THE CLIT

Many women, experts in different areas, fought for the visibility of the clitoris - we have already mentioned the pioneers such as Shere Hite and Helen O'Connell, whose contributions you have read about in the historical overview of the clit. In our context, Jasenka Grujić, PhD, passionately advocates for matters related to female corporeality and has been participating in designing the first cliteracy workshops in Croatia.

The engaged work of artists and activists has also significantly contributed to the visibility of the clit. An animated documentary "Le clitoris" by Canadian filmmaker **Lori Malépart-Traversy** won a bunch of well-deserved awards in 2017. A French group **Les Infemmes** published a fanzine designed like a cheat sheet for the clitoris — it was where I first learned most of the information about the history of perspectives on the clitoris. Australian artist **Alli Sebastian Wolf** came up with the concept of "Glitoris": a giant, sparkling clitoris with a mission to challenge narrow-mindedness.

The clitoris is boldly represented by numerous artistic and activist social media profiles, allowing for the rapid spreading of visual content. Instaclits gather

under hashtag #cliteracy, and there are lovely and informative platforms such as @iamtheclitoris and @clitoriscious. You can find engaged artwork at @yescliteracy — it is the above-mentioned Sophie Wallace, a multimedia artist whose artwork ranges from street art to massive surfaces like mega billboards or several square meters large neon installations. There is also @clitorosity — **Laura Kingsley**, who draws clitorises with chalk on asphalt across the globe, explaining the enigmatic motif to passersby. Her Instagram showcases drawings from the streets from New York to Brighton. Of course, for all information on cliteracy in Croatia, be sure to follow @Klitopismenost.

The clit, you see, is sweeping Croatia. After the pilot project in 2018, we enthusiastically continued spreading the mission of cliteracy in different cities — programs took place in Zagreb, Rijeka, Pula, Čakovec, Šibenik, etc. The reactions are almost exclusively positive — the charm of this extremely optimistic organ dedicated solely to pleasure wins hearts wherever it appears. In cahoots with an Australian artist, we created the Croatian version of Glitoris, which made a grand appearance at the Zagreb Pride Parade with a rainbow flag hanging like a cape around its "neck". Performance artist Sendi Bakotić designed a costume to disguise herself as Super Klita and walked like that through the streets of Rijeka, bringing great joy to passersby, especially children. The **Paprat Kolektiv's** installation bloomed with great pride, reaching a height of two and a half meters, adorned with live plants in full bloom, located in the heart of Zagreb, in front of the Academy of Music. During workshops, we drew, 3D printed, embroidered, illustrated, and crafted the clitoris from recycled materials — and truly, it's an inspiring model!

CLITCLUSION

The history of the study on the clitoris and its anatomy is a story of how prejudices shape knowledge about one's body and sexuality. This particularly applies to

visual representations, as images circulate widely, even beyond the internet. When it comes to knowledge about anatomy, which is mostly transmitted through models, charts, and similar illustrations, the motifs are simplified into stylized and highly similar drawings that are then (often unknowingly) shared by a large portion of the society. These drawings then become symbols for the anatomic elements they illustrate, and we interpret them automatically and without questioning: when we think of a kidney, we visualize a bean-shaped image from the anatomical chart — this image becomes the representation of a kidney for us.

In the study "Clitoral Conventions and Transgressions: Graphic Representations in Anatomy Texts, c1900-1991" from 1995, **Lisa Jean Moore** and **Adele E. Clarke** refer to **Bruno Latour's** concept of "regimes of (re)presentation" warning that the context determines what will be considered a legitimate depiction. The history of anatomy vividly reflects such processes and articulates political background behind decisionsconcerning the representation (or sometimes withholding) of knowledge about the human body constitution.

This pictographic imagery of anatomy will further have a direct impact on (again, not always consciously) shaping the understanding of corporeality and identities related to gender and sex. This, of course, especially applies to genital anatomy, where, for centuries, the depiction has emphasized dichotomies that are not in line with the diverse reality of human morphology. Overly simplified depictions lacking folds, protrusions, hair, and blood, already move far away from everything that is characteristic of human bodies. Then, presenting them as universally applicable and equal gives a false sense of uniform morphology, leaving out a significant portion of a wide range of anatomical variations, including the entire area between the fictional dichotomy of sex and gender.

Finally, the anatomical interpretation of genitals as (exclusively) reproductive organs serves as one way of controlling women by confining them within the domain of reproductive capabilities. It would be a huge shame to (continue to) let that happen — but there is no need to because the tools we have developed, such as cliteracy, are slowly but effectively reshaping public narratives. We have the responsibility to utilize them and motivate others to do the same. Experience has shown there is an interest, which comes as no surprise — the clitoris is the most optimistic aspect of the corporeality for all individuals who possess it.

DEMANDS OF THE PLATFORM FOR REPRODUCTIVE JUSTICE

1. PUBLICLY FUNDED AND ACCESSIBLE CONTRACEPTIVES

Everyone must have access to various contraception methods and, based on provided scientifically sound information about contraception, choose which method to use. Denying contraceptives (in hospitals and pharmacies) is not acceptable. Contraceptives should not be a luxury. We demand that the new law requires coverage of the expenses by the Croatian Health Insurance Fund.

2. EVIDENCE–BASED SEXUALITY EDUCATION

It is crucial that children and young people learn about responsible sexual life from school age within health education that is based on relevant information and up-to-date scientific knowledge. The competent ministries are responsible for implementing sexual and reproductive health education programs at the national level within the education system, starting from elementary school age.

3. FREE ABORTION

Abortion must be accessible to everyone – regardless of their economic and social status. Currently, it is only accessible to those who have enough money to exercise their right, and it is important to highlight that in some hospitals the cost can reach the amount of minimum wage. We demand that the new law requires coverage of cost of pregnancy termination by the Croatian Health Insurance Fund.

4. RIGHT TO AN INFORMED DECISION WITHOUT COUNSELING, WAITING PERIODS, AND COMMISSIONS

There is no room for consultations or waiting periods in the process of deciding about pregnancy termination. Access to scientifically sound information is a prerequisite for making an informed decision. This information can only be provided by a gynecologist who performs abortions, and the competent ministries must develop a standardized procedure for providing information about pregnancy termination.

5. RIGHT TO CHOOSE THE ABORTION METHOD

In the process of informing about the procedure of pregnancy termination, gynecologists must provide information about different methods: surgical and medical. The decision regarding the method of pregnancy termination must be made by the pregnant person in question. The Ministry of Health must create standardized instructions to explain the specifics of each method. All healthcare institutions that perform abortions must ensure access to both surgical and medical abortion. The law should also permit medical abortion at home until the ninth week of gestational age, following the guidelines of the World Health Organization.

6. RIGHT TO STERILIZATION BASED ON AN INFORMED DECISION

Sterilization should be accessible to all adults. Neither can the minimum or maximum number of children be used as a criterion for accessing sterilization, nor can consent from a partner be demanded. We demand legally guaranteed sterilization with informed consent for every person of legal age based on their informed and voluntary decision.

7. FINANCIAL PENALTIES FOR THOSE WHO DISREGARD THE PROVISIONS OF THE LAW

We demand financial penalties for institutions that disregard the provisions of the new law and refuse to provide a safe and as painless as possible pregnancy termination procedure. We also demand financial penalties for institutions that fail to perform pregnancy termination procedures within the specified time limits. Penalties should be imposed on both the institution and the responsible person within the institution.

After all, the new law cannot completely resolve the issue of denial of care, namely conscientious objection, as this right is regulated by multiple laws and subordinate legislation. However, the introduction of a new abortion law provides a chance to revise those laws and regulations; therefore, we demand:

8. ABOLISHMENT OF THE RIGHT TO DENY CARE OR THE SO-CALLED CONSCIENTIOUS OBJECTION

By invoking the so-called conscientious objection, over half of the gynecologists deny us care without facing any consequences. Women are also denied care by medical staff, as well as pharmacists. In Croatia, anyone can invoke conscientious objection under any conditions. The only ones facing the consequences are the patients. In practice, the regulation of the so-called conscientious objection has not been successful. There is simply no room for “conscientious objection” in medicine or laws concerning medical practices. It should be removed from the Law on Medical Practice and all related laws because it represents an abuse of power by a privileged minority exploiting their position to deny women their right to make independent decisions about childbirth.

IMPRESSUM

ON THE WAVES OF FEMINISM
An activist primer by the Platform for Reproductive Justice

Editors: **Vedrana Bibić, Ivana Živković**
Illustrations: **Ena Jurov**
Graphic Design: **OAZA Collective**
(**Nina Bačun, Roberta Bratović**)
Proofreading: **Nikolina Janković**

Translators: **Eva Fućak, Andrea Rudan**
Proofreading: **Mia Uzelac**

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