Providers' attitudes and experiences with referral for legal abortion in light of conscience-based objection to abortion care in Ghana

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Abstract (150 word limit)

In Ghana, unsafe abortion is a relevant maternal health issue; however, the topic is sensitive and stigmatized. This notwithstanding, referral procedures for abortion care are subsumed under the country's National Referral Policy Guidelines. Considering that clinicians are gatekeepers of abortion services, their referral attitudes could increase unsafe abortion levels. Using in-depth and group interviews, we explore referral attitudes and experiences of doctors and midwives from health facilities in the Eastern and Volta Regions of Ghana, in light of the high conscience-based objection to abortion prevalence among clinicians. Findings show both doctors and midwives' work involves referrals and most were happy to work in a facility with abortion referral services. Referrals were carried out for personal, client-based and facility-based reasons. Providers also discussed difficulties with following up on referred clients. Considering that providers' personal beliefs interfere with referrals for abortion there may be implications for maternal mortality and morbidity.

Background

One of the major contributors to maternal mortality and morbidity in low and middle-income countries is the lack of an effective referral system that links access to timely and appropriate maternal health care, including services for safe abortion (Kumar, Baraitser, Morton, & Massil, 2004; Murray & Pearson, 2006; Ngmenenso, 2009). In Ghana, unsafe abortion is a maternal health issue of relevance. Unsafe abortion contributes to at least 15% of maternal morbidity and mortality cases in the country (Awoonor-Williams et al., 2018), although the country's law permits a woman to have an abortion under a wide range of circumstances including cases of rape, incest and grounds of health risks to either the mother or the baby or both (Morhee &

Morhee, 2006). Abortion is a sensitive topic and an issue that is stigmatized in Ghanaian society. This notwithstanding, referral procedures for abortion care are subsumed under the Ministry of Health's National Referral Policy Guidelines launched in 2012.

The National Referral Policy Guidelines state that "All health care providers shall refer patients appropriately to ensure continuous provision between all levels of health care in the country" (Ministry of Health, 2012). However, it falls short in spelling out clearly the roles, responsibilities and limitations of health care providers at various referral levels, and perhaps referral types. The system describes how a maternal health case, for instance, should be referred under the Gate Keeper System but this is only for the reason of health insurance processing. In addition, the type and reason for referral may be sensitive and/or frightening which means that it is important for health workers to demonstrate high professionalism by showing empathy to clients. Women seeking abortion services may be justifiably afraid of being stigmatized, in addition to the fear of getting complications or even dying. They could also be concerned about meeting the cost of treatment, transportation and other related expenses. Considering that doctors and midwives are gatekeepers of women seeking medical care for the purpose of abortion, which is both a specialized type of care and a sensitive topic, the referral attitudes of these gatekeepers could lead to an increase in unsafe abortion. This is especially a concern considering the high prevalence of conscience-based objection to abortion among clinicians in the parts of the country (Awoonor-Williams et al., 2018). As a result, the generalization of the referral system in Ghana has implications for maternal mortality and morbidity.

Therefore, we aim to explore the referral attitudes and experiences of doctors and midwives in light of considerable prevalence of conscience-based objection to legal abortion among clinicians in Ghana. Specifically, the study seeks to identify the role of referrals in health providers' work, attitudes to facilities with referrals services, reasons for referrals, and challenges associated with providing these referral services.

Methods

Focus group discussions (FGD) and in-depth interviews (IDI) were conducted with doctors and midwives in two District Hospitals and two Regional Hospitals in the Eastern and Volta Regions. In the Eastern Region (ER), the two facilities were Akwapim North District Hospital (Tetteh

Quarshie Memorial Hospital) and Koforidua Regional Hospital whilst Volta Regional Hospital and South Tongu District Hospitals were the study facilities in the Volta Region (VR).

All doctors and one senior midwife each from the district and regional facilities were staff working at the same facilities and were referred by their supervisors or personally volunteered for the study. In the case of midwives who participated in the FGDs in both regions, they were recruited from various facilities within the two regions. Personal details of the willing and eligible persons were collected. Table 1 summarizes key characteristics of the participants.

Table 1: Socio-demographic and work characteristics of participants

	Eastern Region				**Volta Region**			
	Doctors IDI	**Midwives IDI**	**Doctors FGD**	**Midwives FGD**	**Doctors IDI**	**Midwives IDI**	**Doctors FGD**	**Midwives FGD**
Avg. ages	38.0	55.0	31.3	53.5	32.0	58.0	27.0	29.4
Sex								
- Female	0	2	2	8	0	2	2	8
- Male	2	0	5	0	2	0	1	0
Avg. duration of practice	10	26	3.7	18	4	18	1	3.5
Number of participants	**2**	**2**	**7**	**8**	**2**	**2**	**3**	**8**

Senior doctors recruited for the IDIs were younger than the senior midwives in both regions. Midwives recruited for the FGDs were also older than the doctors, with a larger difference in the Eastern Region (31.3 years versus 53.5 years). The age differences also reflected in the average years of practice in their professions since midwives generally had higher average years of practice than doctors did. All midwives were female and most doctors were male – out of the 14 doctors participating in the study, four were female.

Participation in the study was strictly voluntary and all participants duly signed consent forms. In all twelve (12) individual and group interviews were conducted. All interviews were audio recorded, transcribed, and analyzed using the qualitative data analysis software, Atlas.ti.

Results

The findings are presented under four themes: 1) referrals as doctors and midwives' work; 2) providers' attitudes to working in a facility that offers referrals for abortion; 3) reasons for referrals; and 4) challenges to referral services and follow-ups.

Referrals as work

Generally, both doctors and midwives alluded to referral as part of their work; providing referrals was an important aspect of this. Health providers who felt a moral or personal obligation to not carry out legal abortion services for reasons other than to save the life of the mother were willing to refer; the following was mentioned:

> *"…I gave you an example where a place I worked, there were two groups of doctors, some were doing it and others were not doing it. But those who were not doing it, if they have a case; they refer to those who were doing it." (Doctor, ER, IDI)*

Among midwives, counselling was provided on the following topics: the different abortion procedures, antenatal care, family planning, reproductive rights, counselling to keep pregnancy, and getting mothers of teenagers involved in the pregnancy in addition to advising teenagers. Counselling was described to represent a clinician who accepts to offer abortion services and provides information on available options. However, it also depicts a situation where a clinician objects to provide abortion services based on his or her conscience and sees him or herself as obligated to prevent the client from aborting the pregnancy. Thus, the provider goes ahead to provide information that persuades clients to change their decision to terminate the pregnancy. Here is the case of a midwife who uses counselling to prepare a client to receive abortion care:

> *"We counsel them and then refer them to a doctor. If you don't counsel them and they go and see a different thing, it will create problems for them. So we counsel them but they always insist so you can't prevent the person. You have to refer them to the next level" (Midwife, ER, FGD)*

In another case, midwives described how they provide counselling upon objecting to clients' requests for abortion:

> *"On so many occasions, the young ladies walk in and they tell me they want to terminate their pregnancies, most of the time I only talk to the MA [medical assistant] and encourage them to keep it no matter what is going on because it is always a personal*

reason, either they are schooling or they are learning a trade so they can't be pregnant. I counsel them to keep the pregnancy and I send them back home." (Midwife, VR, FGD)

"[At] my place when we realize you are a teenager, we try as much as possible to involve their mothers. We talk to them and their mothers and they can go back to school after delivery. We follow up on them and they come for antenatal. Even when they come for antenatal and they are sick, they are treated in a special way. At my facility for instance we have a day for teenagers that come for antenatal and we have special treatment for them. After delivery, we make sure that their parents are involved in taking care of the baby so the girl can go back to school." (Midwife, VR, FGD)

This aspect of some clinicians using counselling sessions to dissuade clients from seeking abortion care and also not referring them to the appropriate place for the service was mentioned in both regions. One midwife from an Eastern Region health facility gave the following experience:

"There is a physician assistant who used to do the scan and tell the lady straight away to go for antenatal before the lady would say she would want to terminate the pregnancy. Then she will try to guilt (counsel) the lady out of it. So some of the clients came to tell me and I went to sit her down and talked to her to not be doing that. If she isn't comfortable providing the service, she should just refer them to me; and it is working now." (Midwife, ER, FGD)

Doctors mentioned that they could refer clients to those they had networks with and knew their specialties.

"It is possible and we do that. Some doctors call doctors from other facilities and describe the case they have and if the other doctor is willing then the doctor would give the other doctor's number to the client." (Midwife, VR, FGD)

One doctor noted that there may be a standard referral procedure for health facilities in Ghana.

"I think there's a referral system in every district or area." (Doctor, ER, FGD)

The general rule for clients seeking abortion was to provide a service or refer. Participants mentioned only three instances where they would not provide services and not refer: if the client

changes her mind after counselling, if the health provider has no reliable person to refer client to, and if the client offers no good reason for wanting the abortion. A quote discussing this last reason is presented below:

> *"Interviewer: What will be the important influence in you neither providing nor referring the patient?*
> *Participant: Before you perform an abortion, you will have to find the reason from the person. If you don't give me any tangible reason, I will not even give you a referral. You have to know the reason why the person wants to terminate" (Midwife, VR, FGD)*

Providers' attitudes to facilities with referral services

Most health providers were happy to work in a facility with abortion referral services. They responded with various positive comments about this:

> *"I personally think it is not a bad thing that we work in a hospital where they provide those services because people actually need it." (Doctor, VR, FGD)*

> *"I don't have a problem with it because it makes my work easier. If I don't do it and somebody does it and I need to refer somebody to the person, it would be easier if it is done in my hospital." (Doctor, ER, IDI)*

> *I always want to play safe according to the first rule, do no harm. That is the first rule I was taught in school. If I know I am not going to do something for you, I prefer you go somewhere else where you will get the service. There is no way I will not do something for you and keep you there; I will just refer you to a different facility." (Doctor, VR, IDI)*

Reasons for referring clients

Referrals were carried out for personal, client-based and facility-based reasons. Personal reasons were associated with conscience-based objection to abortion and the provider's personal or moral beliefs not to provide the service.

> *"Even at the hospital level, some doctors don't do it so you have to refer the client to a medical officer who does it." (Midwife, VR, FGD)*

Client-based reasons include characteristics about the client that warrant referrals such as high gestation period (especially for midwives), clients' persistence despite unfavorable conditions for termination and disagreement over termination between client and partner.

Facility-based reasons involved providers' availability or attitude, the facility's protocol, and when pregnancy is beyond facility's capacity. A few of these reasons are discussed below:

> *"Maturity. We were trained to handle only cases up to twelve weeks. (Midwife, ER, FGD)*

> *"Another thing is logistics. If you don't have the logistics you would have to refer." (Midwife, ER, FGD)*

> *"Participant: The facility comes in because if it is being done where you are then you don't have to refer but when it is not been done at the facility then you may have to refer." (Midwives, VR, FGD)*

Challenges with referrals services and follow up

Superiors were sometimes in charge of the referral process. They generally put measures in place to ensure referrals were carried out, as one midwife mentioned:

> *"If you send a client away without referral and the management gets to know about it, you can lose your job." (Midwife, ER, FGD)*

However, at times superiors could create challenges for some clinicians who would want to provide the service but would have to refer.

> *"A new doctor was posted to our facility. And he said since he's now there, I shouldn't do any abortion care. I was trying to explain that if is above me, I will refer to him but he said no. So now, I am not doing it. So now he has taken over everything. When the case comes, he only makes me prepare the place for him." (Midwife, ER, FGD)*

Finally, providers also discussed difficulties with following up on referred clients. This process is not adequately outlined in the guidelines as discussed by participants.

> *"The follow up system is a problem. If it is a doctor you know, you can call to find out whether the patient reported. But if it is a hospital you're not used to, if you direct*

somebody it is really difficult to trace if the person really reported there or not. For the referral system, I think it is outlined but for the follow-ups you wouldn't know." (Doctor, ER, FGD)

For patients seeking abortion, while some midwives kept referral books with contact details and called referral points to follow up on patients, others physically went with the patients, while others were also not able to do so. Some midwives had a rapport with clients so got feedback from them directly. Midwives at CHAG facilities that referred clients for abortion and family planning services elsewhere also discussed their procedures for following up.

"When we are referring, it means we know the person we are referring to, we have the number so we give the number to the client and call them, I am referring this case to you, and then we let the patient go. They give us feedback. Even the clients themselves, when they see us, they say 'ooh the other time you referred me I went and now everything is successful'. So they give us feedback." (Midwife, VR, FGD)

"You call the referral point to ask if the person is there. But if you realize the person won't find where you're referring her to… for me, I personally go with them. They also have a referral note. They also call that they're bringing a client." (Midwife, ER, FGD)

Doctors also discussed the procedures used to follow up which included calling the doctors they referred clients to or simply scheduling weekly reviews with clients. The ease of referring clients to units in the same facility was also discussed.

"The follow up system is a problem. If it is a doctor you know, you can call to find out whether the patient reported. But if it is a hospital you're not used to, if you direct somebody it is really difficult to trace if the person really reported there or not. For the referral system, I think it is outlined but for the follow-ups you wouldn't know." (Doctor, ER, FGD)

"The follow-up is what we're not doing so honestly, you cannot ensure. With the kind of system we're running now… I don't even write any formal consult for you to go to the Family Planning Unit when you come to me in the consulting room; I just show you the direction and that is the end. So I don't know if you really found the place or even

changed your mind along the way. For now, there's no way of following up. Except the person is a family member or someone I know in the society. Or maybe after a month or two, you meet the person and ask if she was able to do it. But asides that, for complete strangers it is difficult following up." (Doctor, ER, FGD)

"For that one, I have no idea. But what I know is that when you perform TOP [termination of pregnancy], the woman comes back after a week for a review. Then you repeat the scan to be sure that everything is out." (Doctor, VR, IDI)

From their responses it is clear that there was no one method for following up on clients; it was based on the facility, the health provider and their relationship with the client.

Conclusion

Considering that abortion, a sensitive maternal health issue, is subsumed in the general referral guidelines in Ghana where providers' personal beliefs interfere with referrals, there may be implications for maternal mortality and morbidity. The findings point to the fact that health facilities have no clearly spelled out roles, responsibilities and limitations for clinicians regarding referral for abortion, and abortion does not have its own specific procedures therefore its generalized nature may leave the process to the doctors' and midwives' discretions. In addition, with a sensitive situation as induced abortion, following up is something that needs to be streamlined and perhaps made uniform. Awoonor-Williams et al. (2018) discuss how clients may be lost once referred and this is where following up becomes important.

The results also indicate that providers practicing CO were happy about being able to refer, and this dispels the notion that most would not want to refer. However, the lack of clear counseling guidelines for abortion allows for clinicians to substitute the professional process of providing education and information on options, risks and effects of the services the clients are seeking with personal and religion influenced information.

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