Exploring conscientious objection to abortion among health providers in the Eastern and Volta Regions, Ghana

Koku Awoonor-Williams[1]; Peter Baffoe[1], Mathias Aboba, [1]Philip Ayivor[1], Harry Nartey[1], Beth Felker[2]; Dick Van der Tak[2]; Adriana Biney [3]

[1]Global Doctors for Choice, Ghana, Accra Ghana; [2]Global Doctors for Choice, New York, NY, USA; [3]Department of Regional Institute of Population Studies, University of Ghana, Legon, Accra, Ghana

Abstract (150 word limit)
Few studies focus on the role of the clinician and barriers they pose to perpetuating the incidence of unsafe abortion in Ghana. Particularly, the refusal of clinicians to provide legal abortions based on moral or personal beliefs – conscience-based/conscientious objection (CO) – is an important subject to explore. Therefore, using in-depth and group interviews, we explore doctors' and midwives' understanding of the concept, its root causes, practice, and impacts on providers and clients. Results indicate that most clinicians did not understand the term CO. Its root causes originated from anti-abortion religious and cultural beliefs. CO was practiced by referring clients, counselling/convincing them to keep the pregnancy, or directing the client to buy medical abortion drugs. The impacts of CO on clients were complications and sometimes death, while with providers they included annoyance at getting constant referrals and stigma from colleagues. CO must be understood and regulated to reduce unsafe abortion.

Introduction
Unsafe abortion is a major cause of maternal deaths globally [1]. Ghana's maternal mortality ratio is estimated at 310 deaths per 100,000 live births, with 4 to 15 percent of maternal morbidity and mortality being attributed to unsafe abortion [2,3]. In Ghana, specifically, few studies have focused on the role of the clinician and the barriers they pose to perpetuating the incidence of unsafe abortion [4]. Health providers are important gatekeepers to clients receiving safe abortion care in Ghana. Their ability to deny services or discourage or misinform clients impacts access to health services, especially abortion care [5]. Most especially, the refusal of clinicians to provide legal abortions based on their moral or personal beliefs – conscience-based/conscientious objection (CO) – is an important subject to explore [6]. Although conscientious objection preserves the clinician's rights, studies have shown it has negative effects on women receiving the needed safe abortion care [6,7]. Therefore, objectives of this study were to qualitatively explore clinicians' understanding of the concept 'conscientious objection', its root causes, practice, and impacts on providers and clients.

Methods
The selected health facilities for this study were the Tetteh Quarshie Memorial District Hospital and Koforidua Regional Hospital in the Eastern Region (ER) and Sogakope District Hospital and Ho Regional Hospital in the Volta Region (VR). In-depth interviews (IDI) were held with one senior doctor and midwife at each facility resulting in eight IDIs. In addition, focus group discussions (FGD) were conducted with doctors at each regional facility, while the two midwife

FGDs consisted of midwives from facilities in various districts in the two regions. All 12 interviews were conducted in May 2018 and these were audio recorded, transcribed, and analysed using the qualitative data analysis software, Atlas.ti.

Across the regions, the average ages suggest that senior doctors participating in the IDIs were generally younger (in their mid to late 30s) than the midwives who were averagely in their 50s. Doctors in the FGD held in the Volta Region were the youngest group (averagely 27 years), while midwives in the Eastern Region were the oldest group (averagely 53.5 years). All midwives were female and four out of the ten doctors participating in the FGDs were female. The majority of participants were Christian with one doctor identifying as a Muslim.

Results

How do clinicians understand the concept of conscience-based objection to abortion?

Most doctors and midwives did not understand the term CO. Among the IDI participants, only two senior midwives at their respective regional facilities understood the concept. Among FGD participants, doctors in both regions and older midwives in the Eastern Region understood the term. One doctor who understood the concept mentioned the following:

> *"There's the conscience aspect and there's the objective aspect. I understand it as, when within your profession, your conscience isn't allowing you to do something that you are supposed to do as a professional. Then, from your conscience you're objecting to what you're supposed to do. Under certain circumstances you have a right, but not in all circumstances; conscientious objection is not acceptable in emergency situations." (Doctor, ER, FGD)*

They understood that they could object but not under emergency situations, that is, when the woman's life is in danger.

What are the root causes of CO?

The root causes of CO were thought to originate from religion and culture. Anti-abortion religious and cultural beliefs were the main reasons health providers refused clients care except in cases they consider they are doing so to save the woman's life. During the two doctors FGDs they mentioned the following:

> *"For most them it is about their religion; they're Christians and the bible doesn't allow it. They've bounded themselves with religious protocols. (Doctor, ER, FGD)*
>
> *"... we live on a continent where cultural beliefs are valued. Okay, and so regardless we are Ghanaians or we are different nationalities and once we are Africans, we tend to have this notion about abortion. Okay, so if people naturally, are not for abortion, are not pro-abortion, and you are that one person that is pro-abortion, they would label you in a way that you might probably not feel right to do it anymore..." (Doctor, VR, FGD)*

Where and how is CO practised at health facilities?

Doctors and midwives discussed how CO was practiced most at Christian Health Association of Ghana (CHAG) facilities.

> *"Interviewer: So how do you think conscientious objection is being practiced in other health facilities?*
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> *Participant: It is being practiced, especially in the Catholic institutions. Within the Ghana Health Service I don't think it's as much as in the Catholic institutions. For some*

of the Catholic institutions, they don't even allow normal evacuation. The same in the Muslim communities.
Interviewer: So the religious based facilities…
Participant: …yes. In the Catholic institutions, even the use of contraceptives is a problem there." (Doctor, VR, IDI)

CO was practiced in various ways: referring clients, counselling or convincing them to keep the pregnancy, or directing the client to buy medical abortion drugs. Clinicians who felt a personal or moral obligation not to terminate pregnancies referred to other.

"…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)

Doctors seemed to practice this more than midwives, as one midwife notes:

"We have some doctors who are not into comprehensive abortion. But as I said, when the patient's life is threatened they can never object; they help. For my facility, it is solely those who come in for the comprehensive abortion that they [doctors] refuse to come into contact with them." (Midwife, ER, IDI)

Some clinicians would also counsel (or attempt to convince) their clients to keep the pregnancy as a way to not deal with terminating the pregnancy.

"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 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)

Health providers may also prescribe a drug for the clients to go and buy in order not to initiate the procedure.

"I have seen it happen before. When a clinician didn't want to provide the service based on religious beliefs. Most people like I said will not want to do the surgical procedure for the person but will direct you to buy medication and take to terminate the pregnancy." (Doctor, VR, IDI)

What are some impacts of CO on clients and health providers?

The impacts of CO on clients were complications and sometimes death.

"It has a huge impact… most of them, when you refuse they come back to you with complications. And as I said, managing complications is more difficult than tackling the problem from onset. So it has a huge impact on us." (Doctor, VR, IDI)

"Since we're all midwives and we have been sensitized, we are committed to do it. But if as a midwife you refuse to provide services to someone and another time you hear that the client is dead…" (Midwife, ER, IDI)

With providers, the impacts ranged from feeling annoyed by the extra loads because of constant referrals to refusing to provide services due to stigma from colleagues. CO could also impact other providers' provision of services. The ensuing quotes highlight some of these impacts.

> *"Sometimes when a particular provider keeps referring clients to you and you know for sure in some of the cases that she can definitely handle it herself, it becomes a bit annoying. Because money was spent to train all of us and yet you are refusing to provide the service. (Midwife, ER, FGD)*

> *"… sometimes in a facility, you don't know of any doctor who would be willing to do it. You may want to do it but because you don't know anyone else doing it, you will also not want to do it." (Midwives, VR, FGD)*

One positive impact on providers was the ability to exercise their right to provide the service or not.

> *"I think it also gives them the freedom to exercise their rights. If you're working and you're doing something you do not like, it can have a negative impact on your life. So if you have that right object at the right time, I think it frees us in a way to do what you want to do without causing harm to yourself or your patient." (Doctor, ER, FGD)*

Discussion and Conclusion

Conscientious objection to abortion is practiced by health providers and can have negative impacts on clients as well as other clinicians. It is important to note that providers did not object to providing care to women for medical indications. However, elective abortions, whether legal or not, were denied clients and this is mostly by doctors. Doctors' practice of CO was discussed in another study conducted in northern Ghana [2]. Providers need a better understanding of the CO concept and sensitization to reduce stigma among those willing to provide services.

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