Prevalence of Conscientious Objection to Legal Abortion among Clinicians in Northern Ghana

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Synopsis

The study demonstrates that Conscientious Objection to abortion care is highly prevalent in Ghana and constitutes a barrier to care. Provider training on abortion law and clear policy guidelines are needed.

Abstract

Objective

There are few clinicians providing safe abortion services in Ghana. This dearth is aggravated by conscientious objection to provision of abortion, which aggravates maternal morbidity and mortality from unsafe procedures, and leads to escalating healthcare costs from preventable complications. This study assessed the prevalence of conscientious objection (CO) among medical providers in Northern Ghana, their motivations, knowledge of Ghana's abortion law, attitudes and behaviors towards abortion provision, and towards possible measures to regulate CO.

Methods

We conducted across-sectional descriptive study to measure prevalence, knowledge and attitudes of CO among health practitioners trained in abortion provision in Northern Ghana, stratified by facility ownership and provider type. Data were collected from 213 eligible providers using a quantitative survey tool.

Results

Fewer than half (44.1%) of providers trained to provide abortion services were doing so. The prevalence of CO was estimated to be 37.9%. A greater share of physicians (42.5%) compared to mid-level cadres (34.1%) identified as objectors. A high proportion of providers were familiar with Ghana's abortion law and supported regulation of CO.

Conclusion

The study demonstrates that CO based on moral and religious grounds is highly prevalent. However, providers indicated acceptance of policies and guidelines that regulate its application in order to reduce the burden that CO poses for women seeking abortion services.

KEYWORDS: Abortion; Conscientious; Objection; Comprehensive; Care;

Introduction

Unsafe abortion is a major contributor to maternal morbidity and mortality in developing countries, accounting for 13% of maternal deaths worldwide (Åhman and Shah 2011) and at least 15% in Ghana (Mills 2008, Baiden2006). The Ghana abortion law of 1985 permits abortion in situations of maternal and fetal health that pose significant risk to the mother, and for pregnancies that occur as a result of rape, incest or defilement. One barrier to accessing safe abortions is clinicians' refusal to provide legal abortions because of their own moral or religious beliefs, known as Conscientious Objection (CO) (Chavkin 2013).CO involves the competing interests of a patient who wants a safe, legal medical procedure, a provider, with religious or moral opposition to the procedure and the government which wants to reduce maternal morbidity and mortality. Various international agencies and medical bodies concur that CO can be legitimate, but the objector must inform the woman of her legal options, must refer her to a willing competent provider,, must provide the abortion in life threatening circumstances, and cannot object to post abortion care (Chavkin 2013).

Even though there is an extensive rights based literature regarding CO(Cook 2009, Dickens 2001, Dickens 2009, Diniz2011, Lema 2012, Westeson 2013,Zampas and Andión-Ibañez 2012), there is little research about the medical consequences (Bo 2015).Global Doctors for Choice (GDC) – an international network of physician activists with action centers in Latin America and Africa – has been a pioneer in offering a medical and public health perspective on CO, with its 2013 White Paper summarizing the state of knowledge about CO prevalence, health effects, and policy responses, and detailing the

gaps in the evidence. For example, there are few rigorous studies on the prevalence of CO, with estimates ranging from 10% - 70% in various populations (Chavkin 2013). Reportedly, women denied abortions due to CO may seek unsafe abortions, leading to morbidity and increased cost to healthcare systems (Chavkin 2013). CO can increase the workload on overburdened willing providers, and thus threaten quality of care.

Little is known about physicians' attitudes towards potential strategies for regulating CO. CO is presumably most detrimental to women's health in lower income countries, where it can add to existing barriers to safe abortion and lead to morbidity and mortality for women who are turned away (Chavkin2013). A few qualitative studies have demonstrated that CO may vary according to country context, and that it can be complicated by unclear regulations, provider's lack of knowledge about regulations, abortion related stigma and provider's selective disapproval of certain patients and types of abortions (Harries 2014, Faúndes2013, Aniteye and Mayhew 2013).

Determination of the prevalence of CO can provide baseline data for understanding CO as a barrier to safe abortion access. In light of the well-documented harms associated with unsafe abortion, it is critical to assess the magnitude of this issue to allow stakeholders – providers, patients, advocates, program planners and policymakers – to develop ways to ensure safe abortion access. Learning how physicians view CO and their attitudes towards various ways to regulate its application can help inform policies that will be acceptable to clinicians, while allowing women to realize their reproductive rights.

This study aimed to determine the prevalence of CO to legal abortion and related components of reproductive health care (RHC), such as post abortion care, in northern Ghana. As Ghana has too few clinicians, particularly in the northern regions, the loss of providers trained in abortion to CO is a serious concern.

The study's objective was to determine the prevalence of CO among clinicians trained to provide abortion in the Northern, Upper West and Upper East Regions of Ghana and to examine the knowledge and attitudes of these providers towards abortion and CO,

MATERIALS AND METHODS

This cross-sectional descriptive study was conducted in the three northern regions of Ghana to measure the prevalence of CO and related variables among trained abortion providers.

Study sample and participant recruitment

Eligible providers included doctors, midwives, nurses, and physician assistants (PAs) who had been trained in Comprehensive Abortion Care (CAC) and were working in one of the 48 hospitals in northern Ghana. The Ghana CAC guidelines was developed to guide training and provision comprehensive abortion services including counselling, abortion, post-abortion care and family planning. These providers were identified using records from the Ghana Health Services (GHS), which maintain the most up-to-date records of service providers in the country. Using a census approach, we aimed to survey all eligible physicians and midwives to obtain a sufficiently powered sample to estimate the true prevalence of CO in northern Ghana. Providers were recruited from hospitals by GDC/Ghana-trained interviewers, who—after obtaining written consent from each eligible

provider--administered a 48-question survey or provided instructions to providers to self-administer the survey. When eligible providers were identified but could not be reached due to schedule conflicts or absences, interviewers returned to the hospital within 1-2 weeks or rescheduled a visit to suit provider availability.

Survey tool and data collection

The CO Provider Survey assessed provider knowledge, beliefs, practices, and self-identification as an objector, using both closed- and open-ended questions (Harris 2016). The survey design and content were informed by extensive literature review, formative interviews, pilot testing, and incorporated validated abortion stigma scales such as the Abortion Provider Stigma Survey (APSS) (Martin 2014) the Stigmatizing Attitudes, Beliefs, and Actions Scale (SABAS) (Shellenberg 2014). Findings from the survey's pretest indicated that some providers preferred interviewer-administered surveys, while others found self-administration more compatible with clinical workflow. Therefore, we asked providers to choose their preferred mode of survey administration.

There were two rounds of data collection between June and December 2015. During both rounds, survey data were collected anonymously and all responses were reviewed for quality and completeness. Although both quantitative and qualitative data were collected during the interviews, this paper only presents the quantitative analysis.

Measures

Outcome measures included two novel composite measures of CO : Hypothetical Objection (where participants conveyed their comfort providing abortion care in hypothetical scenarios such as an adolescent seeking abortion in order to complete school, a woman with pulmonary hypertension, or a woman who was pregnant as a result of rape seeking abortion and answers were categorized based on composite scores) and Self-Identified Objection, which asked if a person considered themselves to be an objector or would be so defined by Ghanaian law. These types of objection were not mutually exclusive; providers could be classified as both self-identified and hypothetical objectors. Provider knowledge of abortion law and their attitudes toward CO-related policy were measured using their response to direct questions on the Ghana abortion law (PNDC law 102) and their acceptance or rejection of suggested policy measures to regulate CO.

[Ethical approval was obtained from the Navrongo Health Research Center Institutional Review Board (NHRCIRB). Participation in the study was voluntary without any direct benefit and all study participants provided written informed consent. All participants' data and responses were collected anonymously and kept safe and secured. Participants were reminded of their right to skip any survey questions they were not comfortable with at any point.

Analysis

Basic descriptive statistics were generated for the entire sample, and then by provider type. Overall point prevalence of conscientious objection was calculated as the proportion of objectors among all respondents at the time of the survey. Prevalence was stratified by provider type and facility type. The proportion distribution of provider knowledge on abortion law and attitudes towards incorporating CO into current and future policies was also calculated among objectors and non-objectors. Other variables examined included socio-demographic characteristics, provider type, facility ownership status, facility location, and measures of clinical practice. Where meaningful, results by provider type were compared using chi square tests. All analyses were conducted using Stata Version 14.0.

RESULTS

According to Ghana Health Service (GHS) records, there were 91 physicians capable of providing abortions in northern Ghana at the time of the study, and 25% of the 374 midwives (96) had received training in abortion provision. In line with these estimates, we identified 200 providers in northern Ghana who had been trained in abortion care at the time of this study. An additional 13 eligible providers, including physician assistants and nurses, were also identified during data collection, resulting in a total sample size of 213 providers. The majority of respondents worked in public facilities. One hundred and twenty six (59.2%) were midwives and nurses/physician assistants (nurse/PAs), whilst 87(40.8%) were physicians. Even though almost 88% of respondents said they were proficient enough to provide CAC services, the results suggest that less than half (94 out

of 213; 44.1%) of the sample currently provided abortion services; more than half (n=53; 56.3%) of these were physicians as indicated in Table 1 below.

[Insert Table 1 Here]

The prevalence of hypothetical objection and self-identified objection was 33.8% and 37.9%, respectively. Nearly half (42.5%) of all physicians self-identified as objectors and 44.8% identified as hypothetical objectors. This proportion was lower among midwives/nurses/Pas, 34.1% of whom self-identified as objectors and 26.2% as hypothetical objectors. More than half of CHAG-based respondents (57.6%) self-identified as objectors compared to 50.0% of respondents from private facilities and 32.5% from public facilities.

[Insert Graph 1: Here Prevalence of Conscientious Objection by type]

Nearly all respondents knew the exceptions (rape, incest, and to protect maternal health) under which abortion could be performed legally (see Table 3). Similarly, almost 90% of respondents were aware that objectors must counsel patients with unwanted pregnancies on all legal options, including abortion, as enshrined in the Ghana Comprehensive Abortion Care (CAC) Guidelines.

[Insert Table 3 Here]

Practitioners were willing to provide appropriate counseling (defined as informing a patient about all legal options and not trying to persuade them against termination) for women seeking abortion due to maternal health (71%), although physicians were

significantly more likely than midwives to appropriately counsel women in cases of serious maternal health risk (80.5% vs 64.3% p, <.05) A much smaller proportion of respondents were willing to appropriately counsel women who had been raped (55%)

While the Ghana abortion law does not include continuing education as ground for legal abortion, it is one of the main reasons for adolescents and young girls to seek abortion. Roughly one-quarter of providers overall, and less than 10% of practitioners in CHAG facilities, provided appropriate counseling for such patients as indicated in table 4 below.

[Insert Table 4 Here]

In general, both objectors (87% among hypothetical and 82% among self-identified) and non-objectors (89%) agreed that providers must counsel clients on all legal options and approximately 90% of respondents agreed that objectors should provide referral for patients seeking abortion care. However, 29% of objectors respondents overall thought that clinicians should be permitted to object to providing post abortion care. The majority endorsed the development and dissemination of guidelines on CO for clinicians and patients at the health facility level. Nearly all (96%) of respondents rejected any form of punishment for objectors even when the objectors had not complied with the CAC guidelines.

[Insert Table 5 Here]

DISCUSSION

Well-trained clinicians must be available in order to provide safe abortion care. These results show that the majority of professionals trained to provide abortion services were mid-level cadres, which affirms the decision of the Ghana Health Service to train mid-level cadres to provide safe abortion services according to international recommendations (WHO 2008). Unfortunately, fewer than half of trained professionals were providing abortions, which raises questions about the systemic translation of training into practice, as well as the reasons why individuals were not providing the services. Perhaps, the criteria for selecting trainees for abortion services and their conditions of service require investigation and attention; perhaps additional content is needed.

The prevalence of CO was sizeable enough to restrict access to safe abortion services, and appears to be in the mid-range of estimates in other populations (Chavkin 2013). Since the number of clinicians trained to provide CAC is limited, further reduction of this pool because of CO restricts access even more. The higher prevalence of CO amongst physicians compared with mid-level provider's raises concern about quality of care as high-risk cases needing highly skilled management may not receive it if only middle level cadres are available. This difference in prevalence of CO by provider type requires deeper investigation as there are policy implications regarding training priorities and content.

Providers demonstrated knowledge about the circumstances under which abortion is legal, and their obligations to counsel and refer. - although these self-reports do not indicate whether such counseling and referral occur in practice. The exception is that they

did not understand the obligation to provide Post Abortion Care, regardless of personal opinion about abortion. Several factors may have contributed to this generally high level of knowledge: GDC Ghana in collaboration with other stakeholders, has been advocating since 2011 for women's right for safe abortion services in the three Northern regions based on the Ghana abortion law and the Ghana medical and dental council have organized mandatory continuous professional development programs on ethical and legal issues for all registered providers. Future investigations can probe the contribution of societal stigma on the judgement of objectors in their daily practice. Even though the majority of objectors claim that they refer women, the inconvenience of travelling long distances and the associated increased costs may deter women from following through and lead them to patronize more easily available abortion methods in their communities, even when these are unsafe.

Whilst practitioners disagreed with punishment for objectors who do not follow the law, they endorsed policies to regulate the use of CO in the interest of the health and safety of women who seek abortion services. Respondents supported policies to ensure that objectors provide appropriate counselling and referral to clients, and agreed that there should be effective ways to monitor compliance. They also support policies to require health facility management to display guidelines on CO in their facilities so that users of the facility can make informed decisions whenever they need abortion services.

Conclusion

In Northern Ghana, we found that more than half of health professionals trained to provide safe abortion services are not doing so and that prevalence of CO to abortion care is

notable, particularly amongst physicians. However, there are opportunities to regulate the application of CO to improve access to quality abortion services for women and girls considering that clinicians support the introduction of some form of regulation.

Author contributions

JKAW, PB, CF, and WC conceived and designed the study. JKAW, PB, PA participated in the study planning and conducted the data collection. SD, WC, JKAW and PB did the analysis, initial draft and revision. All authors reviewed and approved the final version.

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Conflict of Interest

None declared

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Table 1: Facility and provider characteristics

		Provider Type	
Characteristic[a]	**Total Providers (N=213) N (%) or Mean±SD**	**Physicians[b] (n=87) N (%) or Mean±SD**	**Midwives/Nurses/PAs[c] (n=126) N (%) or Mean±SD**
Facility region			
Northern Region	115 (54.0)	42 (48.3)	73 (57.9)
Upper West Region	51 (23.9)	16 (18.4)	35 (27.8)
Upper East Region	47 (22.1)	29 (33.3)	18 (14.3)
Facility ownership			
Public	162 (76.1)	60 (69.0)	102 (81.0)
Private	18 (8.5)	11 (12.6)	7 (5.6)
CHAG	33 (15.5)	16 (18.4)	17 (13.5)
Provider age -- yr	40.2±11.6	37.0±8.4	42.2±12.9
<30 yr	45 (21.1)	18 (20.7)	27 (21.4)
30-39 yr	73 (34.3)	36 (41.4)	37 (29.4)
40-49 yr	36 (16.9)	21 (24.1)	15 (11.9)
50-59 yr	42 (19.7)	5 (5.8)	37 (29.4)
≥60 yr	10 (4.7)	1 (1.1)	9 (7.1)
Provider sex			
Male	87 (40.9)	70 (80.5)	17 (13.5)
Female	125 (58.7)	16 (18.4)	109 (86.5)
Provider religion			
Islam	55 (25.8)	22 (25.3)	33 (26.2)
Catholic	83 (39.0))	32 (36.8)	51 (40.5)
Presbyterian	21 (9.9)	11 (12.6)	10 (7.9)

Pentecostal/Charismatic	34 (16.0)	13 (14.9)	21 (16.7)
Other or no religion	16 (7.5)	7 (8.1)	9 (7.1)
Abortion provision			
Ever provided	137 (64.3)	71 (81.6)	66 (52.4)
Currently provide	94 (44.1)	53 (60.9)	41 (32.5)
Proficient in safe abortion provision[d]	187 (87.8)	86 (98.9)	101 (80.2)
Trained in which type(s) of abortion			
Medication abortion	158 (74.2)	83 (95.4)	75 (59.5)
Aspiration	200 (93.9)	85 (97.7)	115 (91.3)
Dilation and curettage	99 (46.5)	68 (78.2)	31 (24.6)
Trained up to what gestation			
Up to 12 weeks	146 (68.5)	38 (43.7)	108 (85.7)
13-24 weeks	41 (19.3)	27 (31.0)	14 (11.1)
25+ weeks	18 (8.5)	17 (19.5)	1 (0.8)

[a]Data on age missing for 7 providers; data on sex missing for 1 provider; data on religion missing for 4 providers; data on current provision of abortions missing for 76 providers; data on training in medication abortion, aspiration, and dilation and curettage missing on 7, 2, and 13 providers, respectively; and data on gestation missing on 8 providers.

[b] Physicians include obstetricians/gynecologists

[c] PAs=Physician Assistants; includes nurse practitioners, community health nurses, and one community health worker

[d] Proficiency in safe abortion provision was self-reported

Table 2: Prevalence of conscientious objection by provider type and facility ownership (N=213)

Characteristic[a]	**Self-identified Objectors (n=80)**	**Hypothetical Objectors (n=72)**
	% (95% CI)	**% (95% CI)**
Provider Type		
Physicians	42.5 (32.5, 53.2)	44.8 (34.6, 55.5)
Midwives, Nurses, & PAs	34.1 (26.3, 42.9)	26.2 (19.2, 34.6)
Facility ownership		
Public	32.5 (25.6, 40.2)	29.0 (22.5, 36.5)

Private	50.0 (27.8, 72.2)	38.9 (19.3, 62.9)
CHAG	57.6 (40.1, 73.3)	54.5 (37.3, 70.7)
Overall prevalence, N (%)	37.9 (31.6, 44.7)	33.8 (27.7, 40.5)

[a]All percents are row percents. Self-identified objectors included those who classified themselves as *either* self-identified objectors *or* objectors based on Ghanaian policy. Hypothetical objectors included respondents who reported feeling either somewhat or a great deal of moral or religious objection to the three scenarios.

Table 3: Knowledge of national abortion law by objector type and among all providers

		Type of Objector	
	Non-objectors (n=119) N (%)	**Self-identified Objector (n=80) N (%)**	**Hypothetical Objector (n=72) N (%)**
Knowledge of national abortion law[a]			
Certain when abortion can be provided legally	110 (92.4)	63 (78.8)	60 (83.3)
Consider abortion legal under the following circumstances			
Rape	114 (95.8)	69 (86.3)	61 (84.7)
Incest	112 (94.1)	67 (83.8)	61 (84.7)
Fetal risk	117 (98.3)	75 (93.8)	67 (93.1)
Maternal risk[b]	112 (94.1)	68 (85.0)	61 (84.7)
Socioeconomic reasons	55 (46.2)	23 (28.8)	20 (27.8)
Under all circumstances	50 (42.0)	15 (18.8)	13 (18.1)
Consider the following practices mandated by law			
Objectors must counsel patients with unwanted pregnancies on all options, including abortion	105 (88.2)	69 (86.3)	63 (87.5)
Objectors must refer abortion patients elsewhere	109 (91.6)	72 (90.0)	67 (93.1)
Only abortion providers can conscientiously object	79 (66.4)	48 (60.0)	47 (65.3)
Providers cannot conscientiously object to PAC	22 (18.5)	14 (17.5)	11 (15.3)

[a]As per Ghanaian law, abortion is legal under circumstances of rape, incest, fetal risk, and maternal risk. CO practices mandated by Ghanaian Standards & Protocols include: objectors must counsel patients with unwanted pregnancies on all options, including abortion; and objectors must refer abortion patients elsewhere (to clinicians who are willing to provide abortions).

[b]Maternal risk includes: risk to woman's life, mentally impaired woman, risk to psychological health of woman, risk to physicial health of woman.

Table 4: Practices and beliefs related to abortion provision by scenario, distributed across provider type and facility ownership

		Provider Type			Facility Ownership
Scenarios, practices, and beliefs[a]	**Total Providers (N=213) N (%)**	**Physicians[f] (n=87) N (%)**	**Midwives, Nurses, PAs[g] (n=126) N (%)**	**Significance Level**	**Public (n=163) N (%)**
Patient's desire to postpone childbearing in order to continue education					
Provide appropriate pregnancy options counseling[b]	60 (28.2)	23 (26.4)	37 (29.4)		53 (32.7))
Refuse to provide abortion[c]	77 (36.2)	37 (42.5)	40 (31.7)		49 (30.1)
Personal religious or moral beliefs	65 (84.4)	34 (91.9)	31 (77.5)		39 (79.6)
Provider disapproval/community stigma/other[d]	43 (55.8)	20 (54.1)	23 (57.5)		18 (36.7)
Refuse to provide abortion-related referrals[e]	5 (6.5)	2 (5.4)	3 (7.5)		3 (6.1)
Serious maternal health risk					
Provide appropriate pregnancy options counseling[b]	151 (70.9)	70 (80.5)	81 (64.3)	*	24 (72.7)
Refuse to provide abortion[c]	57 (26.8)	18 (20.7)	39 (31.0)		36 (22.2)
Personal religious or moral beliefs	35 (61.4)	16 (88.9)	19 (48.7)	**	20 (55.6)
Provider disapproval/community stigma/other[d]	29 (50.9)	10 (55.6)	19 (48.7)		11 (30.6)
Refuse to provide abortion-related referrals[e]	4 (7.0)	0 (0.0)	4 (10.3)		2 (5.6)
Rape					
Provide appropriate pregnancy options counseling[b]	118 (55.4)	50 (57.5)	68 (54.0)		16 (48.5)

Refuse to provide abortion[c]	57 (26.8)	24 (27.6)	33 (26.2)		35 (21.6)
Personal religious or moral beliefs	38 (66.7)	20 (83.3)	18 (54.6)	**	23 (65.7)
Provider disapproval/community stigma/other[d]	32 (56.1)	13 (65.0)	19 (57.6)		13 (37.1)
Refuse to provide abortion-related referrals[e]	4 (7.0)	1 (4.2)	3 (9.1)		2 (5.7)
* p ≤ 0.05; ** p ≤ 0.01; *** p ≤ 0.001					

[a]Scenarios are indicated by bold print.
[b]Appropriate counseling defined as providing all-options counseling including abortion and not trying to convince patient to keep pregnancy.
[c]Reasons for refusal to provide listed below. Providers who refused to perform an abortion in the hypothetical scenario were asked for each of the reasons listed: "How much do these factors contribute to your response?" The proportion of providers who responded "somewhat" or "a great deal" are combined and shown here. Cumulative proportions for the reasons will not sum to 100 as respondents were asked to provide a response to each type of reason.

[d]Other includes lack of support from hospital administration

[e]Provision of referrals measured among those who refused to provide an abortion, but would refer patient to a clinician/department where they could receive abortion services.

[f]Physicians include obstetrician/gynecologists

[g]PAs=Physician Assistants; includes nurse practitioners, community health nurses, and one communityhealth Worker

Table 5. Provider attitudes toward incorporating conscientious objection into current and future Ghanaian policy

	Non-objectors (n=119) N (%)	**Self-identified Objector (n=80) N (%)**	**Hypothetical Objector (n=72) N (%)**
The following aspects of conscientious objection <u>should</u> be in *current* Ghanaian policy:			
Objectors must provide all-options counseling to patients with unwanted pregnancies	106 (89.1)	66 (82.5)	63 (87.5)
Objectors must provide referrals to patients seeking abortions	111 (93.3)	71 (88.8)	65 (90.3)
Only a clinician who perform the abortion can conscientiously object	86 (72.3)	55 (68.8)	50 (69.4)
Clinicians can be conscientious objectors to PAC	34 (28.6)	22 (27.5)	16 (22.2)
The following aspects of conscientious objection <u>should</u> be implemented as *future* Ghanaian policy:			

Mandatory confidential registration of objectors with GHS	56 (47.1)	28 (35.0)	27 (37.5)
Mandatory public registration of objectors with GHS	35 (29.4)	17 (21.3)	12 (16.7)
Mandatory confidential registration of objectors within their facility	60 (50.4)	33 (41.3)	29 (40.3)
Additional compensation for providers who perform abortions	82 (68.9)	39 (48.8)	32 (44.4)
Alternative service for providers who are objectors	20 (16.8)	11 (13.8)	5 (6.9)
A penalty for providers who are objectors	5 (4.2)	4 (5.0)	0 (0.0)
A requirement that Ob/Gyns learn how to provide abortions	103 (86.6)	64 (80.0)	59 (81.9)
A mandate that health facilities develop and disseminate guidelines about conscientious objection	85 (71.4)	55 (68.8)	52 (72.2)