

## **Policy Brief to Regulate the Application of Conscientious Refusal of Care for Legal Abortion Services**

**From: Global Doctors for Choice, Ghana**

**To: Minister of Health**

### **Executive Summary**

Unsafe abortion is a major contributor to maternal morbidity and mortality. One barrier to accessing safe abortions is clinicians' refusal to provide legal abortions based on moral or religious beliefs, known as conscientious objection. Global Doctors for Choice/Ghana conducted a cross sectional study to determine the prevalence of conscientious objection among 213 medical providers in Northern Ghana, their motivations for objection, and their attitudes towards regulation of objection..

In all, 87 physicians, 102 midwives and 24 nurses/physician assistants (PAs) were surveyed. Fewer than half (44.1%) were currently providing abortion services. The prevalence of objection among health providers in the three northern regions was 37.9%, with physicians more likely to object than other cadres and higher rates of objection in CHAG facilities than in private and Ghana Health Service health facilities. The majority of clinicians supported regulation of conscientious objection into current policy.

Policy implications of these observations are Objectors do not provide all available options for abortions, do not refer patients seeking abortion to where they can access the service, may not see or provide services for post-abortion clients and morbidity and mortality associated with abortion and its complications may increase. However, both objectors and willing providers support regulation of conscientious objection to the provision of legal abortion

### **Introduction**

Unsafe abortion is a major contributor to maternal morbidity and mortality, accounting for 13% of maternal deaths worldwide<sup>1</sup> and at least 15% in Ghana<sup>2</sup>. One barrier to accessing safe abortions is clinicians' refusal to provide legal abortions based on moral or religious beliefs, known as conscientious objection (CO)<sup>3,4</sup>. There are few clinicians providing abortion services and conscientious objection to provision of abortion or other reproductive health services puts additional burden on willing clinicians, increases health risks for women who may resort to unsafe abortion. The consequences are high morbidity, mortality, and escalating healthcare costs due to preventable complications<sup>5</sup>.

There is dearth of public health research about conscientious objection in sub-Saharan African and Ghana. Global Doctors for Choice (GDC), an international network of physician activists has been a global pioneer in offering a medical and public health perspective on conscientious objection<sup>3</sup>. The study was conducted by GDC, to highlight the burden associated with conscientious objection in Ghana.

The study aimed to determine the prevalence of conscientious objection among medical providers in Northern Ghana, their motivation for objection and explore objector's knowledge



on Ghana’s abortion law, their attitudes and behavior towards abortion provision and possible measures to regulate conscientious objection.

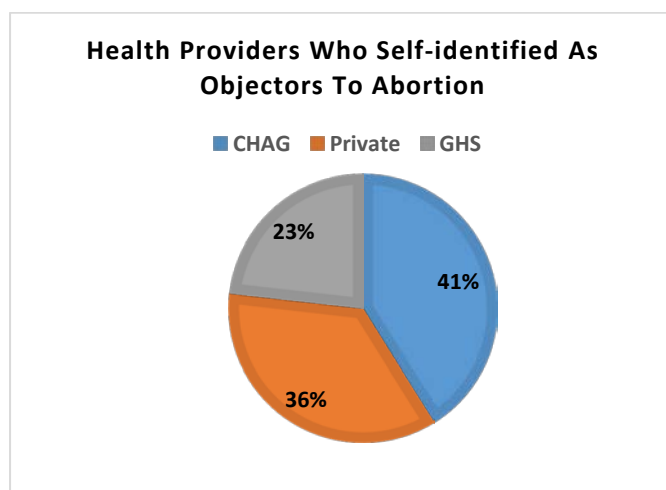
**Approaches and Results**

A cross-sectional descriptive study was conducted to measure the prevalence of, knowledge on, and attitudes toward conscientious objection among health practitioners trained in abortion provision in Northern Ghana. Data were collected anonymously from the 213 eligible providers using a quantitative survey tool (47 from 9 facilities in Upper East Region; 51 from 14 facilities in Upper West Region; and 115 from 35 facilities in Northern Region). These providers included in the survey had been trained either formally or informally in abortion provision and were working in a public hospital facility (Ghana Health Service or Christian Health Association of Ghana, CHAG) and private facilities within the three regions.

In all, 87 (40.6%) physicians, 102 (47.7%) midwives and 24 (11.2) nurses/physician assistants (PAs) were surveyed. These providers were from Ghana Health Service i.e. health facilities 163 (76.2%), CHAG facilities 33 (15.4%) and Private health facilities 18 (8.4). Most of the health providers were either Christians 110 (51.9%) or Muslims 83 (38.8%).

It was observed that, less than half of trained providers 94 (44.1%) were currently providing abortions services; among these, more than half were physicians. All physicians surveyed had been trained in both medical means of abortion (95.4%) as well as surgical methods-aspiration (97.7%). However, relatively higher proportions of the midwives/nurses/PAs (85.2%) were trained to provide abortion for up to 12 weeks gestation. In both physicians and midwives/nurses/PAs, relatively lower proportions have been trained to perform dilation and curettage (78.2% of physicians; and 24.6% of midwives/nurses/PAs).

The survey indicated the prevalence of self-identified objection among health providers in the three northern regions to be 37.9%. Among the physicians, 42.5% self-identified as objectors, with a lower proportion among midwives/nurses/PAs, of 34.1%.



Interestingly, relatively higher proportion of health providers in the CHAG facilities self-identified as objectors compared to health providers in private facilities (57.6% vs. 50.0%). Overall, health providers in Ghana Health Service (GHS) health facilities had the lowest proportion self-identified as objectors, 32.5%.

The majority of both objectors and willing abortion providers 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 supported 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

The study demonstrates that conscientious objection based on moral and religious grounds is prevalent among providers in both public and private health facilities in the three northern regions of Ghana. Less than half of trained health providers were currently providing abortions services. More than a third of all the health providers surveyed in the three northern regions indicated objection to abortion care.

The majority of health providers however indicated willingness to accept policies and guidelines that regulate conscientious objection and reduce the burden that is imposed on women seeking abortion services.

CO involves the competing interests of a patient who wants a safe legal medical procedure, a provider who has 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 may be sincere, but that the provider's primary fiduciary responsibility is to the patient; therefore, an objector must inform the woman of her legal options, refer her to a willing competent provider, provide the abortion in life-threatening circumstances, and cannot object to post-abortion care<sup>6</sup>

Models in other countries exist which indicate that health providers comply with their national laws that permit individuals to exercise CO to abortion, while still fulfilling their obligations to provide and fund access to abortion care. In these models, the ingredients that appear necessary for a functional health system that guarantees access to abortion while still permitting CO include clarity about who can object ( only direct providers) and to which components of care; ready access by mandating referral or establishing direct entry; and assurance of a functioning abortion service through direct provision or by contracting services These models illustrate that it is possible to permit CO to abortion and still ensure that women have access to care<sup>6</sup>.

### Implications

- ✚ Objectors do not provide all-options including counseling to patients with unwanted pregnancies,
- ✚ Objectors often do not refer patients seeking abortion to where they can access the service
- ✚ Objectors may not see or provide services for post-abortion clients
- ✚ Morbidity and mortality associated with abortion and its complications may increase

## Recommendations

- i. Sensitization drive and advocacy for policy directions on conscientious objection for health workers by key players at all levels by the Ministry of Health (MOH), Ghana Health Service (GHS), CHAG and partners in the field of reproductive health, should be a key consideration
- ii. National sensitization programme on abortion laws in Ghana as a way of reducing stigmatization by (MOH, GHS, CHAG and partners)
- iii. The need for a policy change at the MOH/GHS level through discussions with Family Health Division (FHD) and Policy, Planning, Monitoring and Evaluation Division (PPMED) of the GHS.
  - o Physician Assistants and other nurses (apart from midwives) were identified to be providing abortion care. The current policy only allows this service to be rendered by doctors and midwives.
- iv. Provide sensitization and refresher onsite training for objectors to counsel patients with unwanted pregnancies on all options, including abortion and refer patients seeking abortions to a qualified provider/facility.
- v. Selection for training on comprehensive abortion care in health facilities should be targeted. Health providers who clearly self-identify as objectors should not be the targeted for such training.
- vi. Train more nurses and physician assistant to provide comprehensive abortion care service
- vii. The need for a mandate that health facilities create and disseminate facility-level guidelines about abortion care including conscientious objection.

## References

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