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Conscientious objection to abortion: Zambian healthcare practitioners' beliefs and practices

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ABSTRACT

The potential health consequences of limiting access to safe abortion make it imperative to understand how conscience-based refusal to provide legally permitted services is understood and carried out by healthcare practitioners. This in-depth study of conscientious objection to abortion provision in Zambia is based on qualitative interviews (N = 51) with practitioners working across the health system who object and do not object to providing abortion services in accordance with their cadre. Interviews were conducted in September 2015. Regardless of whether practitioners self-identified as providers or non-providers of abortion services, they presented similar religiously-informed understandings of abortion as a morally-challenging practice that is, or is not, shifted from iniquity to acceptability based on the reasons for which it has been requested or the likelihood of unsafe abortion if services are not provided. These contextual factors presented a series of tipping points for participants, rather than a single justification for providing abortion. Subsequently both groups reported that their decisions about providing services were complex and changeable, rather than clear one-time resolutions. This shaped their practices, both in terms of whether or not they provided services, and when and how they delivered them. Practitioners self-identifying as non-providers, *and* those self-identifying as providers, reported provision, counselling, and referral practices likely to lessen women's access to safe legal abortion. In this way, conscientious objection in practice could be understood as a continuum of behaviours rather than a binary position. Our results suggest that data on prevalence of claims to conscientious objector status may underestimate the impact of practitioners' religious, moral and ethical beliefs on abortion accessibility. In Zambia, eliminating practitioners' right to conscientious objection alone or conducting rights-based advocacy may therefore not significantly increase access to safe abortion.

1. Main text

1.1. Introduction

Conscientious objection to abortion - the refusal to provide legally permitted abortion on the basis of religious, moral or ethical beliefs - is fundamentally about rights: the right to freedom of thought, conscience and religion; the right to health; the right to reproductive freedom. However, in settings in which conscientious objection is highly prevalent and abortion services are limited, conscientious objection is also about public health and equity.

Data on the prevalence of conscientious objection are scarce and problematic. In Sub-Saharan Africa, using a cross-sectional census, Awoonor-Williams et al. (2018) reported prevalence of self-identified conscientious objection among physicians, midwives, nurses, and physician assistants of almost 40 percent in hospital facilities in northern Ghana; more than 25 percent of midwives attending a conference in Ethiopia indicated they would not provide abortion services in Holcombe et al. (2015)'s cross-sectional survey; and an ethnographic study of Senegalese obstetrician-gynaecologists, midwives and nurses reported by (Chavkin et al., 2013) found very few providers were willing to provide abortion services they believed should be available.

Where the practice of conscientious objection significantly reduces the number of providers of safe legal abortion, it is likely that women will experience delays in obtaining safe abortion, seek illegal abortion elsewhere, or continue their unwanted pregnancy. Later abortions increase the risk of complications, limit the choice of appropriate abortion method, are more expensive than earlier abortions and may be beyond legal gestational limits. Illegal abortions performed outside formal health systems are more likely to be performed using unsafe

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methods, by a provider without the necessary skills, or in an environment not conforming to minimal medical standards. More than 25 million unsafe abortions occur annually (Ganatra et al., 2017); estimates of morbidity and mortality from unsafe abortion suggest that around a quarter result in severe complications requiring hospital-based treatment, at least 46,000 result in death, and 3 million in complications that are not treated sufficiently (Singh, 2010).

Widespread conscientious objection is likely to have a disproportionate impact on those with the fewest social or economic resources. Healthcare practitioners carry out their conscience-based objections to abortion inconsistently, and may be more likely to refuse abortion for certain subgroups, such as adolescents (Morrell and Chavkin, 2015). Women who experience provider objection and request abortion from another safe provider must either spend longer within the same facility or travel to another facility to obtain services, incurring economic and social costs that are inequitably distributed. Should women instead seek abortion from elsewhere that is unsafe, post-abortion care may be more costly than accessing safe legal abortion (Leone et al., 2016).

1.1.1. Conscientious objection in Zambia

In Zambia abortion is permitted if continuing pregnancy poses a risk to the life of the pregnant woman, to the physical or mental health of the woman or her existing children, if the child would be seriously disabled by physical or mental abnormalities (GRZ, 1972) or in cases of rape or incest (GRZ, 2005). In determining whether the risk posed by continuing the pregnancy is greater than if the pregnancy were terminated, account may be taken of the pregnant woman's reasonably foreseeable environment and her age. Abortions must be carried out by a registered medical practitioner (a doctor). When the abortion is not immediately necessary to save the life of the woman or prevent grave permanent injury, three registered medical practitioners, one of whom must be a specialist, must give consent (GRZ, 1972).

The Termination of Pregnancy Act (1972) provides for conscientious objection to abortion but notes that it does not extend to practitioners' "duty to participate in any treatment which is necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman" (4.2). The Ministry of Health's *Standards and Guidelines* on abortion (GRZ, 2009), current at the time of our research, aim to balance practitioners' right to conscientious objection with clients' rights to accurate information and access to safe services. With reference to "healthcare providers", rather than the "medical practitioners" permitted to perform the abortion procedure, the *Standards* note (p.9):

- Clients must be "respectfully referred" to healthcare providers willing to assist them in obtaining services;
- With some exceptions, the management of all government-supported healthcare facilities have the obligation to ensure that women have access to the abortion services they are legally entitled to;
- Conscientious objection may only be claimed at an individual level, and not as a group or institution;
- Conscientious objection only applies to the abortion procedure and not broader services;
- Conscientious objection only applies to the abortion provider and does not extend to support personnel.

However, conscientious objection in Zambia is unregulated. There is no requirement for medical practitioners to record their refusal to provide abortion, making the management of services difficult. There are no estimates of the prevalence of conscientious objection, but the practice is expected to be widespread, and, along with the secrecy around which doctors do provide abortion, limit women's access to safe services (Ngoma et al., 2017). Given low public knowledge around the legal availability of abortion (Cresswell et al., 2016), women seeking abortion for reasons permitted within the law are unlikely to know that services should be made available to them (Coast, 2016).

The Zambian case is unlikely to be extraordinary. The breadth of Zambia's legal framework for abortion is uncommon, but not unique in Africa. Moreover, the limited accessibility of safe abortion services in public facilities is likely to mirror that identified in countries across the continent, regardless of the legal and policy frameworks in place. While there are no nationally aggregated data on the incidence of (un)safe abortion in Zambia (Macha et al., 2014), and abortion-related deaths are difficult to measure and estimate (Gerdts et al., 2013), the consequences of limiting access to abortion are commonplace: the 31.2% of Zambian maternal mortality occurring in the antepartum period which includes abortion is broadly consistent with other countries in the region (Merdad and Ali, 2018).

1.1.2. Conceptualising conscientious objection

The potential health consequences of conscientious objection for women's access to safe abortion make it imperative to understand healthcare practitioners' motivations for claiming it and how they perform it in practice. However, conscientious objection is understudied and under-theorised. While the definition of conscientious objection is relatively clear, there are no agreed criteria for what it means to be a conscientious objector, and subsequently, how it should be measured so that adequate services can be planned. Must a practitioner self-identify as a conscientious objector for it to count as such? Is a practitioner a conscientious objector if they refuse to provide abortion in every circumstance, or conversely, if they refuse in any circumstance? Is a practitioner a conscientious objector only when their actions align with a country's law and/or policy (e.g. always referring clients in absence of providing the abortion procedure) or should 'illegitimate' objection – that which is not provided for by law or policy (e.g. not providing the abortion procedure and not referring clients) – also be included?

Based on criteria for conceptualising conscientious objection to military service that include establishing that an individual's beliefs are deeply held and applicable in *any* circumstance of war, conscientious objection to providing abortion is often presented as a binary position that ought to be consistently held. Much of the limited research in this area has subsequently reflected on whether practitioners refusing to provide abortion services are exercising 'true' conscientious objection or not. For example, evidence that practitioners in Brazil obtained abortion for themselves or their partners despite reporting religious objection to abortion (Faúndes et al., 2004) and that practitioners in South Africa claiming conscientious objection provided services for additional financial remuneration (Harries et al., 2014) has been used to argue that some practitioners claim conscientious objection for reasons other than deeply held religious, moral or ethical beliefs (Chavkin et al., 2013). Other studies have highlighted practitioners who report objection to abortion based on beliefs that are understood to be genuine, but apply their objection inconsistently or inappropriately. In Colombia, Fink et al. (2016) identify among those who identify as conscientious objectors "partial objectors", who exercise their refusal on a case-by-case basis, along with "extreme objectors", who always oppose abortion and additionally obfuscate care by not providing appropriate information or referral. González Vélez and Urbano (2016) argue that actions of extreme objectors are an imposition of beliefs rather than an exercise of conscience and should not be considered conscientious objection at all.

Harris et al. (2016) have developed a conceptual model of conscientious objection based on three domains: healthcare practitioners' beliefs, actions and self-identification. The model addresses complexity in how conscientious objection is applied by identifying conscientious objection in these domains independently, noting that they may not always align in an individual clinician's practices. For example, the model takes into account practitioners who consistently refuse to provide services on religious grounds, but who do not identify as 'conscientious objectors' because they are unfamiliar with the concept. It

also facilitates reflection on the differences between conscientious objectors who refer clients to another provider, and 'abortion obstructers' who do not.

Debates about the conceptualisation and nomenclature of conscientious objection are extended when the beliefs and practices of healthcare practitioners who provide abortion are considered. One strand of this has been a call to recognise that practitioners' decisions to *not* object to provide abortion are also conscience-based. By associating religious, moral and ethical conscience only with objecting to abortion, policies and laws fail to protect practitioners who feel compelled to provide and abortion providers are vulnerable to stigmatising understandings that their actions reflect having a bad or no conscience (Harris, 2012).

Another, distinct, body of research focusing only on abortion providers' experiences rather than conscientious objectors', suggests that providers' religious, moral or ethical beliefs might also stand in opposition to their decision to provide. In Italy De Zordo (2018) identifies obstetrician-gynaecologists who provide abortion services but remain somewhat uncomfortable with the 'unpleasant' procedure of terminating a potential life. In Ghana, Aniteye and Mayhew (2013) explore how abortion providers navigate tensions they experience between their moral beliefs and their professional obligations. In Scotland, Beynon-Jones (2013) explores how health practitioners who typically framed abortion as a pregnant woman's choice simultaneously distinguished between understandable and problematic abortion requests, based on their personal rather than professional interpretation of the significance of the woman's characteristics. For example, associating successful motherhood with stable partnership, wealth and more advanced age, young women's requests for abortion were constructed as rational and obvious, while the requests of women in their thirties with established careers and families were positioned as irrational and more challenging for practitioners.

The evidence points to a complicated picture of abortion care delivery that involves healthcare practitioners influencing women's access to safe, legal services based on their conscience to varying degrees. This is the first study in Zambia to explore healthcare practitioners' abortion-related beliefs and decision-making in depth. We consider the experiences of practitioners who conscientiously object to abortion alongside those who do not in order to investigate divergences – or similarities. In doing so, we contribute evidence to support the conceptualisation of conscientious objection to abortion in Zambia needed to plan adequate abortion care.

1.2. Methods

While Zambian law around conscientious objection applies exclusively to doctors, in practice access to abortion is shaped by the beliefs and professional behaviours of all the healthcare practitioners a woman may encounter in seeking services: clinical officers (mid-level clinicians equivalent to nurse practitioners in North America and Europe who provide the majority of first-line health care in Zambia), community healthcare workers (lay members of the community trained to provide basic health services and advice), midwives, nurses, as well as doctors. Non-doctors may facilitate or obstruct a woman's access to abortion by their pre-abortion counselling or (non-)referral to doctors. We considered all cadres of healthcare practitioners involved in women's trajectories from entering the public healthcare system seeking abortion, to exiting having either received or not received it. To juxtapose and examine factors we expected to influence practitioners' understandings and practices, we considered both rural and urban settings, and two provinces (Lusaka and Eastern) that are better and less well served by doctors permitted to perform abortion (Ferrinho et al., 2011).

Potential participants were identified by a practitioner gatekeeper with considerable knowledge of the public healthcare system and access to a wide range of practitioners working in different settings, having been involved in the delivery of obstetrics and gynaecology training for many years. Participants worked at the country's main teaching hospital, urban and rural district hospitals, a mission hospital, urban and rural health centres, and within two rural communities. While we visited many of these facilitates to recruit participants, on one visit to an urban facility in Eastern province we discovered a training event was being hosted, attended by practitioners from health facilities across the province. This presented an opportunity to further expand our sample.

Table 1
Sample description.

Characteristics	N = 51
Sex	
Male	31
Female	20
Occupation	
Clinical Officer	3
Community Health Worker	8
District Medical Officer	3
Doctor (non-specialist)	6
Midwife	12
Nurse	5
Specialist obstetrician gynaecologist	14
Setting	
Rural	21
Urban	20
Not clear	10
Reported position	
Conscientious objector	21
Non-conscientious objector	26
Not clear	4

We present qualitative data generated using audio-recorded interviews with 51 of these purposefully and opportunistically sampled healthcare practitioners (Table 1), conducted in September 2015. Since so little is known about how practitioners understand abortion and deliver or do not deliver abortion services, we designed the relatively unstructured interviews to maximise our opportunities to uncover unexpected relationships and concepts. We carried out most of the interviews in English, and a research assistant, guided by a list of topics we prepared for her, conducted the eight interviews with community healthcare workers in Nyanja.

The content of interviews varied between participants, but typically covered whether or not participants identified as providers of the abortion services that would be expected relative to their role, how they came to their decisions, their thoughts about abortion and those who seek abortion, how they deliver services, and their understanding of the law and policy around abortion and conscientious objection. Since our gatekeeper knew whether doctors working at the same facility as him objected to or provided abortion, we were able to sample accordingly. We discovered the position of all other participants during the interviews. Concepts and experiences we identified in earlier interviews were explored with participants we interviewed later. Participants were encouraged to discuss their understandings of abortion and care, giving insight into the normative lenses through which they perceived the world around them, as well as descriptions and examples of actual events and interactions. Our analysis takes both into account.

Interviews were all conducted at the participants' place of work during breaks within their shifts or the training event. This typically dictated the length of interviews, which ranged from around 20 min to just over an hour. Shorter interviews covered the key themes but in less depth.

1.2.1. Analysis

We conducted a highly inductive analysis using many of the analytical tools of constructivist grounded theory (Corbin and Strauss, 2008). All interviews were transcribed verbatim, and those with

community health workers were simultaneously translated into English. We used NVivo 11 Plus (2017) to facilitate our analysis.

To prepare data for in-depth analysis, EF read each transcript, grouping data line-by-line into fluid concepts and themes according to the perspectives, experiences and practices identified within and across them (coding). Using the codes EF had developed, but remaining open to refining or producing new codes, EC coded a 50 percent random sample of the transcripts. This double coding ensured we did not overlook any key themes and that each code collected together all the data pertaining to it. This exercise did not identify any further themes or data that had not already been assigned a code.

Cases were categorised by role, place of work, gender and position on providing abortion services to allow subsequent analyses to take account of these differences between participants. We did not ask all participants whether or not they were "conscientious objectors" since many were not aware of the concept or its legal provision. However all were asked whether or not they provided abortion services, and we categorised them depending on their answers. In the analysis and the results presented, we use the term 'non-providers' to describe participants who self-identified as practitioners who refuse to provide abortion services pertaining to their role (for clinical officers, nurses, midwives and community health workers, delivering counselling and referring to a doctor for abortion; for doctors, providing abortion), and 'providers' to describe participants who self-identified as practitioners who provide abortion services pertaining to their role. The positions of a small number of participants (n = 4) were difficult to ascertain: their narratives either oscillated between descriptions of practice that implied they did not provide abortion services or did provide abortion services, or between reports that they had never been approached by women seeking abortion or that they had – or might have been. We categorised these cases as having 'unclear' provider/non-provider status and the contradictory nature of their narratives is reflected in our analysis.

Further in-depth analysis, which constitutes the most substantive part of our analytical method, was carried out by EF and began by producing sets of memos about individual topics (e.g. referral). These memos posed and answered a series of questions of the coded data, moving from more simple questions (e.g. 'What are the reasons providers give for providing abortion services?') to more evolved questions based on the answers (e.g. 'What discourses are being used to explain provision of abortion?'). Answering questions involved referencing individual cases, allowing EF to see the range of perspectives, experiences and practices represented in the data and guard against selectivity in its use. Each memo additionally included a summary of EF's analytical thoughts on what the data suggest about the memo topic and subsequent questions to ask of the data in further memos. Memos continued to be (re)written to document the increasingly elaborated and abstracted analysis and the evidence for it. The final stage of our analysis was to sort the successive memos in the way that best presented the relationship between the various analytical ideas. This emergent central analytical 'story' was then refined by reviewing its internal consistency and testing it against the raw, uncoded data to check that it could explain most cases. EC independently reviewed each memo and the analytical story as a final check that both were grounded in the evidence.

Data generation and our analysis were reflexive, taking account of the questions participants had been asked and how we asked them, as well as the influence of our own perspectives on abortion. The anonymised quotations presented below are from a wide range of participants; pseudonyms are used. Non-doctors quoted are speaking about providing abortion services corresponding to their role.

Independent ethical review was carried out and granted by ERES Converge (Zambia) and the London School of Economics (UK).

1.2.2. Limitations

We present practitioners' reports of their understandings and behaviours. While these are rich and give us insight into how their practices might influence women's ability to access safe services, they cannot represent women's experiences. Our assumptions about the likely impact of the counselling, referral and provision practices they report are supported by research from elsewhere (Chavkin et al., 2013). However we have no evidence about how the interactions healthcare practitioners reported were experienced by their clients, and how those interactions influenced their clients' subsequent care-seeking.

Our purposive and opportunistic sample was designed to maximise variation in participants' roles, settings and, where known before interview, conscientious objection. Our study was not designed to estimate the prevalence of, or make generalisations about, conscientious objection-related understandings or behaviours, but to elucidate explanations for them and explore the mechanisms through which they operate. The iterative, relatively unstructured, interviews were designed to prioritise what was salient for participants, rather than answer pre-determined questions based exclusively on existing frameworks for understanding conscientious objection to abortion, such as those around understandings of professionalism or person-centred care.

1.3. Results

1.3.1. Beliefs about abortion

Christian religious beliefs were at the heart of non-providers' reasons for not providing or assisting with abortion; their narratives unambiguously present abortion as the unjust act of killing a living being. Other reasons for objecting to abortion – for example, that a woman should have used contraception or that a participant's professional role is to prevent harm – were the articulation of this religiously-informed resistance.

> "I'm a Christian … if we are going to say that we are Christians, what is wrong, is wrong, it doesn't become good sometimes … I am a Christian … I can't give people anything other than what I am." [Doctor, female, non-provider]

Providers typically did not use the same explicitly religious language to describe abortion. However, the way non-providers and providers, of all cadres and working in all settings, presented their motivations for either not providing or providing abortion was remarkably similar. Both understood their personal religious convictions to be at odds with abortion. Both anchored our research conversations around the reasons women sought abortion and the consequences of unsafe abortion. Both discussed these reasons as being either "not enough" or "enough" for them to provide services in light of their beliefs.

Non-providers highlighted clients who sought abortion because they had not used contraception, were in school, had had extra-marital sex or had been raped, and offered counter-arguments to the need for abortion in these circumstances. For example, a pregnancy must have been wanted if contraception was not used, an adolescent could return to school after the birth, a sexual sin would not be alleviated by committing the additional sin of abortion, and a rape victim should be spared the additional trauma of abortion:

> "The trauma, the child goes through [when raped], it is terrible but you know, still, if we do terminate that pregnancy … You're not solving the problem … trauma will still be there: 'I aborted, I aborted!' you know?" [Senior midwife, female, non-provider]

Non-providers reported that reasons for seeking abortion like these were "not convincing". Only abortion with clear medical indications, such as eclampsia, was widely considered to be morally acceptable:

> "We can have some exceptions … there are mothers who have medical conditions which may not support that pregnancy. You end up losing the mother and having lost the mother, the baby also." [Doctor, male, non-provider]

Self-identified providers discussed many of the same reasons clients

seek abortion - not using contraception, wanting to continue education, socially-unsanctioned sex, rape - but additionally lacking choices in society, lacking education about contraception and contraceptive failure. Although a small minority of providers presented these reasons as the reality that underpins why some women need abortion that is their right regardless of their reasons for seeking it, the most dominant narrative, echoing that of non-providers, was that these reasons were or were not "convincing enough" to justify their providing abortion services.

> "[Whether or not I provide] is more to do with the reasons that they have, especially if they are obstetric reasons … or if they can manage to convince me that they cannot cope with this baby. We cannot just [provide abortion]." [Doctor, male, provider]

However, abortion providers' discussion of these socially-oriented reasons for abortion was far less frequent than their discussion of medically-focused reasons for abortion. Almost all offered preventing physical ill-health or death from pregnancy and preventing the possibility of unsafe abortion as the key reasons for providing abortion services. These medically-focused reasons are presented as being less ambiguous than socially-oriented reasons, making their decision to provide abortion more straightforward:

> "I'm Catholic, my religion and what I believe they tend to differ at some point. I look at things in a medical and humanitarian way. Medically if this pregnancy would kill the woman then why keep it? … I've seen women dying out of pregnancy … So I try to match [religious] belief with what happens if we live in the reality." [Clinical officer, male, provider]

1.3.1.1. Tipping points. Participants' shared conceptualisation of the reasons women and girls seek abortion as being "enough" or "not enough" to warrant abortion, and their apparent ease discussing medically-indicated abortion compared to all other reasons for abortion, suggests that both non-providers *and* providers understood abortion as a challenge to their personal morally-informed beliefs. In their common narrative, the contextual factors surrounding abortion (from why a woman sought abortion to the likelihood she would seek unsafe abortion if refused) function as a series of tipping points that shift, or do not shift, abortion from iniquity towards moral acceptability. The difference between non-providers' and providers' narratives is not whether or not abortion is morally wrong, but the extent and variety of reasons for abortion that they consider a tipping point. Both non-providers and providers reported that in light of these tipping points, their decisions about whether or not to provide abortion services were complex.

For example, Dr Phiri identified himself as a provider of abortion but reported "mixed feelings" that echoed non-providers' reports. For him abortion is "help[ing] someone to kill someone", an act that "borders in someone's conscience". However, unsafe abortion was his tipping point and the reason that he now provides abortion as part of a "complete service" for women. Nevertheless he continued to question his decision, emphasising that the service he provides is selective, not "grab[bing] anyone because she's pregnant" but responding to an expressed need in a way that will save his clients' lives:

> "I look at myself and am I doing something right, am I normal or am I not normal?"

While some non-providers and providers reported firm and static beliefs about the provision of abortion, collectively the interview narratives suggest that for the majority of participants, decision-making about the morality of abortion in particular circumstances and subsequently whether or not to provide abortion services, is a process. Non-providers and providers reported that their reflections on abortion had varied over time in response to their perceptions of requests for abortion that they received or had heard about, and for some, appeared to be on-going and non-linear, dependent on the circumstances of each new request.

Dr Mulenga illustrates the dynamic nature of decision-making. She notes that while providing abortion when a woman presents bleeding is morally straightforward, being called upon to decide whether to offer abortion to a woman who is "healthy and she says, 'I want one'" is the "moment that most of us struggle". However, like Dr Phiri, she had recently decided to provide abortion in order to prevent women seeking unsafe abortions. This tipping point had crystallised for her at a conference, hearing a doctor discuss her own abortion and calling on colleagues to consider the consequences of not providing safe services. Nevertheless, the decision had been difficult and despite pushing herself towards finality in her decision-making ("the decision has been made") she was unconfident that it would remain consistent if tested by a request for abortion for reasons she did not think were 'enough'.

> "My husband's a doctor so we've had this discussion. We've struggled with it because of my faith. I have struggled, struggled, and in that moment I did not make a religious decision. I did not make a moral decision. I made a decision of, 'If I'm in the ER, then a woman comes to ask for it and I say I can't and the one who can is in tomorrow and maybe tomorrow she's over 12 weeks, she doesn't come back. She loses her courage and in the evening she's gone to see some hocus-pocus woman somewhere who's given her something and she comes in bleeding. I'm still in the ER. I will still have to attend to her and Lord forgive me, if that woman dies because that's something I could have done for her safely, properly and under controlled circumstances.' So, for me it's still a lot of processing but the decision has been made. I want to provide it safely. I don't want to meet the woman who sleeps around all the time and then gets pregnant and she has a history of [abortions], Lord forgive me because then I might be able to say, "Okay, I am not taking part in this because this is a woman who should be responsible with her contraception" …. For me the biggest thing was, 'Am I killing and are my reasons for killing justified?'"

1.3.2. Practices of delivering abortion care

Almost all participants described themselves as either providers or non-providers of abortion services. However practitioners in both groups reported professional practices not wholly aligned with that positioning. Rather, their changing and context-dependent behaviours are fluidly positioned along a spectrum, from non-provision and obfuscation to consistent provision of services. Only a small minority of participants reported behaviour consistently positioned at these extremes. More commonly the complexity participants experienced in their beliefs about abortion appeared to underpin complexity in how they delivered abortion services. Participants across all cadres and facilities reported shared practices in relation to evaluating grounds for abortion and delivering it, pre-abortion counselling, and referral, that are likely to lessen women's access to legally-permitted abortion.

1.3.2.1. Evaluating reasons for abortion and delivery. The majority of participants reported making their abortion care decisions on a case-by-case basis depending on the reasons abortion had been requested. Rather than reflect Zambia's legal framework, their narratives suggest that these decisions were more commonly based on participants' personal, morally-informed, positions:

> "Depending on your personal perception of the problem, you may agree or not agree with the reason the woman is seeking a termination and therefore based on that you might be able to offer or refer to a colleague who might take a different position …. we evaluate the patient according to case by case." [Doctor, male, provider]

In the case of non-providers, this meant that not all women were refused abortion services. The very widely shared "exception" made of

abortion to save a woman's life has been noted; one self-reported non-provider additionally reported providing abortion in cases of congenital abnormality and others were accepting of abortion in cases of pregnancy resulting from rape. However, it also meant that for a sizable minority of participants who self-identify as providers of abortion services, the reverse was true: not all women seeking abortion on grounds that align with the law were provided services.

There are several examples of the conditionality of provision by self-identified abortion providers in their interview narratives. For the doctor quoted above, having recently given birth, having been left by one's partner, and wanting to continue tertiary education were all "not enough". His reluctance to accept continuing education as a reason for abortion was shared by other self-identified providers of all cadres whose nuanced views were based not only on how far the woman had got in the education system but also their personal expectations of her future career opportunities. For example, Community Healthcare Worker Mrs Mwale, working in a rural setting, reported advising a schoolgirl to return to school after birth and refusing to refer her to colleagues, and conversely, referring a university student for abortion "because [the client] wants to succeed in life".

Other self-identified providing practitioners discussed women seeking multiple abortions as presenting them with a "very, very big [moral] challenge" (Doctor, male). Likewise, some providers noted that if a woman does not agree to using contraception in future it was difficult for them to provide services "because she'll come back again pregnant." (Doctor, male, provider).

1.3.2.2. Counselling. The provision of pre-abortion counselling presents a similarly mixed picture. Non-providers typically described counselling as a conversation in which their aim was to dissuade clients from seeking abortion. Some commented that successfully changing a client's mind about abortion was an indicator of quality in counselling. Most reported delivering counselling that makes direct reference or allusion to religious teaching. Some non-providers reported that they would be willing to refer clients to a providing practitioner following 'unsuccessful' counselling in order to avoid the client seeking unsafe services elsewhere. Neither cadre nor facility location seemed to influence the nature of non-providers' counselling, creating a consistent narrative across these interviews. Interviews with a doctor working in a large urban hospital and rural community health worker illustrate this shared approach to counselling:

> "We just try to tell them to just keep the pregnancy. First of all, you know, religiously 'it is a life that you have' … 'if you abort it means you kill' … and 'if you don't kill the child there will be someone who could support the child' things like that … we are different in terms of convincing people, counselling people to keep it, maybe I am not that good, maybe [another doctor] is better." [Doctor, male, non-provider]

> "I would say to her keep it, or if you don't want to keep it better give it to me – I will keep the child for you … [If you insist] then I think I can just surrender out of your case because only you will be judged [by God] … Mostly, when you advise someone in that way they [understand] you and opt to keep the child." [Community health worker, female, non-provider]

While self-identified providers' descriptions of their counselling were far more heterogeneous than non-providers', many reported putting a similar emphasis on encouraging clients to continue their pregnancies, as well as encouraging longer reflection on their decision or return for counselling with their partners or families. Two providers dissuaded clients from proceeding with abortion by emphasising the logistical and administrative burden involved, especially in rural areas. Again, the narratives of self-identified providers working across cadres and facility settings indicate that only if women had capacity to insist on abortion following this explicitly or implicitly dissuasive counselling, would the practitioner continue to facilitate it. As Dr Phiri, discussed earlier, commented:

> "Those who come in for seeking [abortion], they really knock for a long time for them to have it … They should insist and show the reason why they need it, for me to provide it."

The moral tensions about abortion these self-identified providers experienced are reflected in apparent contradictions within their descriptions of the counselling they provide:

> "We just counselled her, we said we can talk to your relatives, you can bring them we can talk about it together rather than terminating the pregnancy you can just keep it … It depends on my assessment of the history that she has given me … if this woman says that she cannot keep that child of course I can explain to her the advantages of keeping that baby and then the advantages of terminating that pregnancy … I think my beliefs [about abortion], I think they are not very important because as I have said it is the law so my beliefs have got nothing to do with that." [Senior midwife, female, provider]

1.3.2.3. Referral. Referral to a doctor constitutes the core abortion service all non-doctors are required to carry out. Doctors who claim conscientious objection to providing abortion must refer clients to another doctor. Participants from all cadres, identifying as non-providers and providers of abortion services, discussed referral processes that add further complexity in abortion care services.

As with provision of abortion and counselling, some participants reported behaviours aligned with national policy and law: a few non-providers and providers reported making clear, timely referrals to providing doctors and were concerned not doing so would increase the likelihood of their clients seeking unsafe abortion. However, a continuum of conscience-based objecting behaviours was reflected in other participants reporting referral practices that are likely to increase barriers to safe abortion care. Participants from across the spectrum, including almost all self-identified providers who discussed it, described making vague referrals: rather than written or verbal communication to link clients with a named providing practitioner, they recommended their clients repeat their requests for abortion to another practitioner or at another health facility.

Frequently participants appeared to have not considered any implications of these vague referrals for the risk of unsafe abortion. Nurse Nyirenda for instance, who considered herself a provider of abortion services, offered no reflection on any possible causal links in her account of having told a client she must return to her clinic with her husband before a referral could be made and the client later returning to the clinic needing post-abortion care. In participants' illustrations, clients are likely to have understood the tentative nature of the referrals as an indication that their requests for abortion were inappropriate. For example, the clients of non-doctors who reported telling them to effectively 'take their chances' with another provider are unlikely to have left the consultation reassured that the abortion they sought was their legal right. Similarly, the reports of vague referrals by doctors who publically self-identify as providers but who nevertheless sometimes refused clients' requests, suggest that clients are likely to receive this referral as a negative moral judgement on their request for abortion which may dissuade them from trying another safe provider.

The emphasis on the verb 'to try' elsewhere in the referrals reported by a minority of non-providers may have been used by them explicitly as a tool to communicate to clients that abortion services may *not* be available elsewhere.

> "Sometimes, we just tell them that they should go to the big hospital and try to find out if they do that. Because I know that the general hospital conducts those procedures." [Nurse, female, non-provider]

Indeed, two non-providers commented that the vague referrals they had

made are likely to have prevented clients from obtaining safe abortion. Their descriptions of referral practices are shared by providers, suggesting that in some circumstances, practitioners from both groups may have used vague referral as a deliberate strategy to prevent abortion they had moral or religious reservations about.

However, structural stigma about abortion within the health system also contributed to and facilitated nebulous referral processes. Self-identified non-providers and providers in our sample had low levels of knowledge about the availability of abortion even when making referrals to a specific doctor or team. Poor or non-existent feedback mechanisms from receiving doctors to referring practitioners left referring practitioners with little idea about whether they had referred clients to the right place or person, or whether they ought to have made a referral at all.

> "Others cannot manage to come to the hospital. They go back [home], then they do their own [abortion]. You see them coming back bleeding and you ask them "Did you go to the hospital?" … But the problem [is] with the feedback … we don't know whether they've been attended to … There's no follow up." [Senior nurse, male, provider]

The lack of feedback mechanisms in the referral chain additionally meant that participants had no exposure to the consequences of the nature of their referrals for women's health.

Structural stigma within hospital facilities also extended the influence of conscientious objection on providers' referral processes. Doctors reported that senior doctors who oppose abortion prevent more junior doctors working within their teams from providing abortion either directly, by refusing to allow abortions in their clinics, or more commonly indirectly. Indirect tactics were publically questioning the motives and morals of providing colleagues, implying there would be career penalties for doctors who provide abortion, not building capacity of junior colleagues to provide abortion by denying them the training opportunity of observing and assisting abortion procedures, or making it impossible for junior doctors to perform surgical abortion by refusing to assist them in the event of an emergency. Several doctors noted that the strength of expression both for and against abortion among senior doctors dissuades junior doctors from discussing abortion – including who provides abortion and challenging poor service provision – so as to avoid conflict.

> "[Speaking about providing abortion] is not something that … you can just do openly, especially in our setup or when you are also training. So they will think 'this is one of the people doing this.'" [Doctor, male, provider]

As a result, some doctors self-identifying as providers reported making referrals for abortion they would otherwise have provided themselves. Referrals typically involved instructing a client to return to the hospital at a time or day medical teams headed by consultants who provide abortion are scheduled to work. These participants were aware that such referrals introduce delays to providing abortion care, may communicate to clients that what they have requested is problematic and could dissuade clients from returning for safe abortion care.

Our analysis suggests that the influence of senior non-providing doctors on less senior potentially-providing doctors in large health facilities may inform the vague referrals and lack of feedback noted by participants working across the health system. By encouraging providing practitioners in large facilities to hide or at least not openly discuss their provision, referring practitioners of other cadres working outside large facilities are especially limited in their ability to make clear referrals to them.

1.4. Discussion

1.4.1. Continuum of conscience-based care practices

We set out to explore how healthcare practitioners working across the Zambian health system understand abortion and how they report their abortion care practices in light of this. We found remarkably similar discourses about abortion and reported behaviours among practitioners who presented themselves as non-providers and providers of abortion services. These similarities were consistent across genders, roles and facilities, contrasting previous research that has identified distinct differences in conscientious objection according to cadre and associated training and exposure to international debates and messages (e.g. Aniteye and Mayhew, 2013).

In our data, participants *share* a narrative in which abortion is a morally challenging procedure that is – or is not – to varying degrees shifted towards moral acceptability by the reasons for abortion or the potential consequences of not providing abortion safely. For the majority of participants these contextual factors presented a series of tipping points, rather than a single decisive argument for providing abortion. Subsequently, some non-providers, as identified by Fink et al. (2016), but significantly, many who identified as providers, reported that their decisions about whether or not to provide abortion services were sometimes difficult and were changeable, both over time and in response to the circumstances of a pregnancy or abortion.

Participants in our study reported delivering abortion services in light of their complex moral beliefs about abortion. Rather than simply providing or not providing abortion services according to their role, participants additionally expressed their conscience-based discomfort with abortion under certain circumstances in *how* they delivered care. In this way, conscientious objection in practice could be understood as a continuum of behaviours rather than a binary position. While a few participants reported static practices positioned at either end of the spectrum (always objecting or never objecting to abortion and delivering services accordingly), participants identifying themselves as both non-providers and providers of abortion services reported practices that are more accurately conceptualised as being fluidly placed along it.

Our analysis suggests that the presence of a continuum of conscience-informed practices is likely to be responsible for considerable complexity in the delivery of safe abortion in Zambia. We found that both self-identified non-providers and providers do not permit or permit abortions inconsistently, dependent on their personal evaluations of the reasons abortion has been requested rather than the law; that both non-providers and providers deliver counselling designed to dissuade clients from abortion; and that both non-providers and providers' make referrals for abortion care that are vague to the extent that women seeking abortion may conclude that the safe, legal abortion they had requested is unlikely to be provided by any practitioner, increasing the possibility that they will obtain unsafe abortion outside the formal health system.

There is no evidence as to how typical lack of formalised referral patterns for abortion care is. In this research setting, vague referral practices were facilitated by structural stigma. The limited pool of practitioners who will provide abortion, especially in rural settings with fewer doctors, the influence of non-providers within urban hospital's hierarchies, and the reluctance of doctors who provide abortion to openly discuss their practices at work, all underpinned inappropriate referral practices and meant practitioners had limited knowledge of the consequences of their referrals.

The likely result of the practices our participants reported is that obtaining safe abortion is a matter of luck. Whether or not the healthcare practitioner a woman meets identifies as being a conscientious objector/non-provider or provider of abortion may not predict the treatment they receive.

1.4.2. Conceptualising conscientious objection in Zambia

How then should we conceptualise conscientious objection to abortion in the Zambian context? The continuum of conscience-based practices rather than binary status of objector and provider we identified, fits well with Harris et al.'s (2016) model delineating the three

domains of practitioners' beliefs, actions and self-identification. In our study, practitioners self-identified as non-providers based on moral beliefs about abortion, but reported counselling and referral practices that are not aligned with the legal and policy framework for conscientious objection; other practitioners self-identified as providers of abortion but, based on their moral beliefs about abortion, did not consistently provide the abortion services expected of their cadre in accordance with the law.

The crux of Harris et al.'s conceptualisation of conscientious objection is to encourage consideration of the overlaps and importantly, voids, between the three domains, for the measurement and regulation of conscientious objection. Indeed, our results urge evaluation of the utility of focusing solely on self-identified conscientious objection if our aim is to assess and measure the impact of practitioners' conscience-based beliefs on the accessibility of legally permitted safe abortion services. In this study, had we considered only healthcare practitioners who report to object to providing abortion services, we would have missed the ways those who identified themselves as providers of abortion services also limited women's access to care. By considering both types of practitioner in our study, and exploring the relationships between their self-identification and their reported practices, we exposed a series of unexpectedly shared access-limiting behaviours. The fact that practitioners saw themselves as providers of abortion services, even when reporting practices that would limit services, suggests that those managing healthcare facilities in Zambia may need to look beyond the legally permitted exercise of conscientious objection to meet the obligation of ensuring women have access to abortion set out in the Ministry of Health's *Standards and Guidelines*.

Harris et al. propose that their model of conscientious objection, offered as a basis for prevalence survey tools, should be refined as new data on the way conscientious objection is practiced comes to light. Our data suggest that the model and subsequent tools could be usefully expanded to include healthcare practitioners who are not legally permitted to perform abortions, such as the community health workers, nurses, midwives and clinical officers in our study. In Zambia these cadres are often the first point of contact for women seeking abortion and influence whether, how and when they obtain one. Including them would not change the components of the model, just who is considered within it.

Finally, given participants' changing and non-linear positions on abortion and reported practices, our data supports the value of longitudinal approaches to considering their prevalence. Doing so in Zambia would lead to better identification of conscientious objection in practice. As noted by Harris et al., survey tools developed from their conceptual model could be used to measure change in individual practitioners' position in the three domains over time.

1.4.3. Relevance for interventions

Our results highlight two important considerations for interventions to increase access to safe abortion.

Firstly, the study underlines the importance of context for understanding conscientious-based abortion care practices. In Zambia, constitutionally a "Christian nation", while the social, political or economic pressures identified elswhere (Harris at al. 2018) may have influenced healthcare practitioners' provision of abortion care, the continuum of conscience-informed practices we identified most strongly reflect entrenched and widely shared religiously-informed norms about the moral status of abortion. As observed in other African settings (e.g. in Ethiopia by Holcombe (2018)), healthcare practitioners in our study most commonly made their decisions about providing abortion services in light of competing concerns to protect women's health and around their understandings of the morality of abortion. However discourses employed in their interview narratives cannot easily be divided into moral discourses about the ethics of abortion employed by non-providers/conscientious objectors on one side and medical discourses about women's health employed by providers on the other. Some non-providers were concerned about the public health consequences of non-provision and while some providers did draw on a medical discourse to explain why safe abortion was necessary, their overarching discourse was frequently moral: that preventing maternal morbidity and mortality from unsafe abortion is the 'right' thing to do.

Very few participants of any cadre discussed the provision of abortion as a means to reproductive rights. However it is an emphasis on rights – of physicians to abstain from providing abortion and for women to receive it – that underpins the Zambian legislation and policy on conscientious objection. Similarly, international research, policy and advocacy all situate the need for accessible safe abortion services within rights-based development paradigms (Unnithan and de Zordo, 2018). For example, there has been heightened attention and commitment to emphasising professional ethics and the importance of respectful woman-centred care in recent international midwifery education (UNFPA, 2014). These discourses were not present in the narratives of practitioners in our study. Rather, our findings suggest that in Zambia at least, different ways of situating this agenda may be needed if it is to have salience for the practitioners called upon to operationalise it.

Secondly, our results make clear that in Zambia, removing or limiting conscientious objection may not significantly decrease barriers to safe abortion services since healthcare practitioners who self-identified as providers also reported practices that limit service availability and quality. Instead, in lieu of longer-term social change towards gender equity, interventions could usefully consider advice and guidance for all practitioners – including those not legally permitted to carry out abortion – on how their beliefs about abortion should be reflected in the abortion services they are called upon to provide. Such guidance could be underpinned by formalised procedures for managing conscience-based objections to delivering or referring for abortion services within the health system.

1.5. Conclusion

In Zambia, providing and non-providing healthcare practitioners' understandings of abortion as a morally-challenging procedure is likely to have significant impacts not just on whether or not women receive safe abortion care, but the nature of services that are delivered. If the evidence we present from Zambia is not unique, it is likely that existing or future prevalence data focused exclusively on the binary position of conscientious objection, practitioners who self-identify as objectors, and/or those legally permitted to enact conscientious objection, will underestimate the extent of conscience-based influences on accessing safe legal abortion.

Our research suggests three further research agendas related to conscientious objection. First, while there is prospective evidence from a range of settings about the consequences for women denied abortion care, much less is known about the actual practices of directive counselling. Second, our research highlights the importance of non-providing gatekeepers, such as community healthcare workers, for accessing abortion and the need to better understand how they are implicated in practices of conscientious objection. Finally, although there is a sizable evidence base describing practitioners' knowledge and understanding of abortion laws, our study suggests that research on the implications of these understandings for practices of conscientious objection, and the outcomes for women, are needed.

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