Exploring Conscientious Objection to Abortion Among Health Providers in Ghana

CONTEXT: *Few studies have explored clinicians' roles in the abortion experience in Ghana. Examining how clinicians understand conscientious objection to abortion—the right to refuse to provide legal abortion on the basis of moral or personal beliefs—may provide insight that could help manage the practice.*

METHODS: *Eight in-depth interviews and four focus group discussions were conducted with 14 doctors and 20 midwives in health facilities in Ghana's Eastern and Volta Regions in May 2018. The semi-structured interview guides covered such topics as clinicians' understanding of conscientious objection, how it is practiced and the consequences of conscientious objection for providers and clients. The data were analyzed using thematic analysis.*

RESULTS: *Most clinicians did not understand the term "conscientious objection," and midwives had more knowledge on the subject than doctors. The main reasons for conscientious objection were antiabortion religious and cultural beliefs. Clinicians who objected referred clients to willing providers, counseled them to continue the pregnancies or inadvertently encouraged unsafe abortions. The negative consequences of conscientious objection to abortion for clients were complications and death from unsafe abortions; the consequences for providers included high patient volume and stigma for nonobjectors, leading some to claim objection to avoid these.*

CONCLUSIONS: *The findings highlight the need for further research on the consequences of conscientious objection, including stigma leading to refusals. Such research may ultimately help to restrict clinicians' misuse of the right to object and improve women's reproductive health care in Ghana.*

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Unsafe abortion involves procedures to terminate a pregnancy performed either by a person lacking "the necessary skills or in an environment that does not conform to minimum medical standards, or both."[1(p.1908)] It is a major cause of maternal deaths globally.[2] In Ghana, the setting for this study, the maternal mortality rate is estimated at 310 per 100,000 live births.[3] The 2017 Ghana Maternal Health Survey estimates induced abortion as the cause of death among 4% of women.[3] This is despite the fact that the abortion law in Ghana is liberal in comparison to the laws in other Sub-Saharan African nations.[4–6] Specifically, the criminal code permits abortion to save a woman's life, to preserve her physical and mental health, when the pregnancy is a result of rape or incest, and in the case of fetal impairment.[4] The clause about preserving the woman's physical and mental health allows for the law's broad interpretation.[4,7] Surgical and medication abortions are legal in Ghana; however, the provider must be a trained medical professional in an appropriately equipped setting.[1]

For more than a decade, various interventions and programs through government and international agencies have made safe abortion and family planning services more accessible to women across public and private hospitals and health facilities in Ghana.[6,8] For example, the R3M (Reducing Maternal Mortality and Morbidity) program, launched in 2006, trained health providers in comprehensive abortion care, postabortion care, and family planning services and counseling in facilities in the Greater Accra, Eastern and Ashanti Regions of Ghana before scaling up to other regions in the country.[8] Despite these efforts, women continue to terminate pregnancies unsafely.[3] National estimates from 2017 indicate that 64% of women resort to unsafe means to terminate their pregnancies.[9] The 2017 Ghana Maternal Health Survey reports that approximately 60% of recent abortions were performed at home, at a pharmacy or chemical shop, or some other nonclinical place.[3] Also, although 70% of women seeking abortion used medication (e.g., misoprostol) or surgical methods (e.g., dilation and curettage or evacuation), approximately 60% sought assistance for the abortion from pharmacists or chemical sellers, friends or relatives, or terminated the pregnancies themselves.[3]

There are numerous studies on abortion experiences from clients' perspectives in Ghana;[10–15] however, few have focused on the role clinicians* play in these experiences.[7,8,16] Health providers are important gatekeepers to clients receiving safe abortion care in Ghana.[16,17] Their ability to deny services, or discourage or misinform clients, limits access to health services–especially abortion care.[18]

*For our study participants, we use the terms clinicians, health providers and service providers interchangeably, referring solely to doctors and midwives.

Therefore, the refusal of clinicians to provide legal abortions on the basis of their moral, philosophical, personal or religious beliefs—that is, conscientious objection to abortion—is an important subject to explore.

Although conscientious objection to abortion preserves clinicians' rights, studies document its negative consequences on clients and other health providers.[19–22] There are national and international guidelines for managing conscientious objection to abortion;[17,19,23] however, these protocols may not always be known or adhered to. The Ghana Health Service and the Ministry of Health recognize that clinicians' right to conscientiously object to providing abortion services may restrict women's access to life-saving health care services. The Ghana Health Service's guidelines on comprehensive abortion care require clinicians who are not willing to provide abortion services to refer clients to other providers who are willing to provide the services. The guidelines aim to respect the right of clinicians to conscientiously object while safeguarding women's rights to safe, legal abortion services.[23]

The concept of conscientious objection has been extensively discussed in relation to provision of reproductive health care, including abortion services, by Chavkin and colleagues.[20,21,24–26] They defined conscientious objection as "refusal to participate in an activity that an individual considers incompatible with his/her religious, moral, philosophical or ethical beliefs."[20(p.S41)] The discussions regarding abortion emphasize that objecting clinicians and their clients have competing interests that may be detrimental to women's health because they limit access to safe abortion.[20,21,24] A literature review by Chavkin, Leitman and Polin identified several implications of conscientious objection that go beyond harm at the individual level to include the loss of health providers, affecting the health systems of countries.[20] Specifically, low- and middle-income countries with high rates of objectors were found to also have high rates of abortion and maternal mortality.[20,27] Thus, conscientious objection is more complex than has been understood, and may have far-reaching implications at the individual and national levels.

Research examining conscientious objection in the Ghanaian context has done so quantitatively—looking at prevalence and attitudes from a broader perspective.[17] Awoonor-Williams et al. assessed the prevalence of conscientious objection to abortion among medical personnel in the three northern regions of Ghana, outlining that "the 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 postabortion care."[17(pp.31–32)] An estimated 43% of doctors and 35% of midwives and physician's assistants self-identified as objectors to abortion. Hypothetical objection among these same providers was 34%, and was based on statements describing hypothetical situations in which they would refuse abortion services. Overall, the providers' knowledge of the abortion law was high, and the majority knew some of the conditions and procedures for objecting. About 86% of self-identified objecting clinicians knew that they were mandated to counsel patients with unwanted pregnancies on all options, including abortion; 90% knew that it was mandatory to refer patients; and 60% agreed that only those directly involved in abortion provision had the right to object. However, only 18% knew that it was mandatory to provide postabortion care.[17]

On the other hand, according to a qualitative study exploring how clinicians in health facilities in Accra "shape and implement" abortion polices,[28] different types of providers (obstetrician-gynecologists, midwives and pharmacists) faced moral conflict in providing abortion care that led to their provision or denial of services. Religious and moral beliefs, stigma and opposition from authorities were some of the barriers to service provision. Although clinicians' fear of stigma as a deterrent to practice and the pathways through which conscientious objection acts as a barrier to reproductive health care have been examined in other settings,[21,24,29,30] few qualitative studies have explored this phenomenon in Ghana, where the topic deserves recognition, given the high levels of unmet need for family planning[31] and unsafe abortion.[3]

This article complements prevalence studies of conscientious objection in northern Ghana by probing more deeply into how clinicians understand and practice conscientious objection to abortion. We qualitatively explore clinicians' understanding of the concept of conscientious objection, as well as their perceptions of the reasons providers object, its practice, and the consequences of it for clients and clinicians in hospitals in two regions in Ghana. We use in-depth interviews with senior clinicians to draw on their knowledge of and experiences with abortion care provision and conscientious objection, as well as focus group discussions with other clinicians to generate a range of shared experiences and attitudes on these issues.

METHODS

Study Setting

Data were drawn from a mixed method research project fielded in May 2018 that sought to address conscientious objection to abortion in Ghana, focusing on health facilities in the Eastern and Volta Regions. The two regions were purposively selected to produce insights into abortion service provision in southern Ghana, as a complement to a study on conscientious objection conducted in the three northern regions of the country.[17] The Eastern and Volta Regions are situated in the southeastern part of Ghana bordering Greater Accra, are geographically similar and their populations largely comprise a mix of ethnic groups, including Akans, Ewes and Guans. The one regional hospital in each region is located in the capitals of Koforidua and Ho, respectively; other lower-level health facilities in these regions include district hospitals and clinics, private hospitals and clinics, faith-based hospitals and clinics, as well as Community-based Health and Planning Service (CHPS) centers. As public health institutions, regional and district hospitals are both highly patronized, and provide

a range of health care services, including abortion-related services provision; however, district hospitals are less endowed with personnel, infrastructure and resources. Faith-based facilities are private health centers and hospitals founded by faith-based organizations, and tend to be built in areas where public health facilities are inaccessible or unavailable. Their institutions' protocols incorporate religious beliefs about the beginning of life and thus discourage access to health care that may prevent conception and childbirth, namely, contraception and abortion information and service provision.

Participant Recruitment

The project used a quantitative survey, and in-depth interviews and group discussions with clinicians working at selected health facilities. In this article, we focus solely on the qualitative data from interviews and group discussions. Study participants were obstetrician-gynecologists and midwives qualified to perform abortion procedures. Sample size was determined pragmatically due to budgetary and time constraints.

Recruitment for the in-depth interviews began with preliminary visits by one of the interviewers to the two regional hospitals, as well as to two selected district hospitals; the district hospital in the Eastern Region was the operational facility with the name closest to the beginning of the alphabet, while the selected district hospital in the Volta Region was the operational facility with the name closest to the end of the alphabet. Managers or administrators in the gynecology, maternity or other related units were informed about the study, and either nominated one senior doctor and one senior midwife or volunteered to participate in the individual interviews. Thus, four senior doctors and four senior midwives were selected for in-depth interviews.

In addition, participants were recruited for four focus group discussions: in each region, one of doctors and one of midwives. Doctors were recruited from the two regional facilities: On the day of the in-depth interviews, the participating doctor informed other doctors in their unit about the focus group discussion, and those who wanted to take part volunteered to do so. A total of 10 doctors participated in the focus group discussions: seven in the Eastern Region and three in the Volta Region.

For the midwife focus group discussions, recruitment in the Volta Region was conducted through a research associate at the Regional Health Directorate. The research associate contacted heads of nearby regional facilities and asked them to nominate individuals to participate in the discussion to be held at the Health Directorate. In the Eastern Region, interviewers for a prior survey on conscientious objection contacted midwives in facilities close to the regional hospital and informed them about the group discussion meeting date and time; those who wanted to participate traveled to the regional hospital for the group discussion. In both regions, participants were recruited from facilities across five districts. In the Volta Region, the discussion comprised three midwives from the regional hospital, two from district hospitals, one from a private facility and two from faith-based institutions functioning under the Christian Health Association of Ghana; in the Eastern Region, the discussion included two midwives from the regional hospital, four from district hospitals and two from private centers. Thus, a total of 16 midwives participated in focus group discussions.

Ethical clearance for the study was obtained from the Ghana Health Service Ethical Review Committee in Accra. Informed consent forms were administered to participants prior to the interviews. No incentives were provided to the participants, but refreshments were served to all.

Data Collection

In-depth interviews and focus group discussions were conducted in English, lasted 40–120 minutes and were audio-recorded. Two interviewers—one male and one female, graduate degree holders and researchers well versed in qualitative interviewing—conducted the interviews. The study instruments were semi-structured discussion guides designed and refined by the project's principal investigators, other clinicians and members of the research team. The guides were piloted with two doctors and a midwife in a regional hospital in the Upper East Region, and were revised appropriately prior to the data collection—questions were edited to reduce redundancy and ambiguous questions were clarified. The guides covered questions about clinicians' perceptions about abortion service provision, training received, abortion methods used, perceptions about conscientious objection and attitudes toward abortion stigma, among others. For this study, only questions related to the themes on conscientious objection are discussed. The in-depth interviews provided insights on clinicians' experiences and attitudes toward abortion service provision. Available and willing personnel recruited into group discussions enabled us to gather collective thoughts and experiences on abortion service provision, which is lacking in other studies. The focus group technique generated discussions characterized by rich interactions and shared ideas.

Data Analysis

The recorded interviews and group discussions were transcribed, and the transcripts were checked for accuracy by the two researchers who conducted the interviews. They listened to portions of the recordings as they read the transcripts to ensure that the responses were captured precisely, and then analyzed the transcripts using the thematic analysis approach.[32] The researchers organized, maintained and coded the transcripts in Atlas.ti version 7.1.7. They reread the transcripts and decided on codes jointly using one transcript. Deductive codes were developed on the basis of the interview guides, while inductive codes were generated as the transcripts were studied. Once a list of codes was generated, the remaining transcripts were shared between the two researchers, who coded them separately. For any new codes generated separately, the researchers provided

definitions and discussed them. One researcher later went through each transcript and finalized the codes, using a coding frame to ensure appropriate codes were applied to the content in the transcripts. This coder then merged the eight in-depth interview files and the four focus group discussion files. For each of these files, the codes were unified and grouped into themes.

RESULTS

Participants' Characteristics

Among the in-depth interview participants, the four doctors were male, aged 30–38 and had practiced for 3–10 years; the four midwives were female, aged 55–58 and had practiced for 10–35 years. All eight in-depth interview participants were Christians.

Overall, the group discussions were conducted with 10 doctors and 16 midwives. The three doctors in the focus group discussion held in the Volta Region were the youngest; they were aged 25–29, and all had one year of medical practice. The eight midwives in the Volta Region group were aged 27–34, and had 1–5 years of practice. The seven doctors in the Eastern Region group discussion were aged 28–40, with 1–10 years of medical practice. Finally, the eight midwives in the Eastern Region constituted the oldest group of participants. They were aged 42–69, and had been practicing for 10–41 years. All 16 midwives were female, as were four out of the 10 doctors participating in the group discussions. All focus group discussion participants were Christian, except one female doctor who was Muslim. Five midwives worked at the regional hospitals, six worked at district facilities, two were from faith-based hospitals and three were from private facilities.

Qualitative Findings

We identified five major themes: clinicians have little understanding of "conscientious objection" and practice it somewhat arbitrarily; religious and cultural beliefs are linked to conscientious objection; conscientious objection occurs most often at faith-based institutions; conscientious objection is practiced mainly through referral; and conscientious objection has consequences for clients and clinicians.

• ***Clinicians have little understanding of "conscientious objection" and practice it somewhat arbitrarily.*** Most doctors and midwives did not understand the term "conscientious objection to abortion." Some had never heard the phrase or did not fully understand what it meant. Among the eight senior clinicians interviewed in-depth, only two senior midwives had knowledge of the term. Among participants in the focus groups, a few participants in the doctors' groups and some older midwives in the Eastern Region had heard the phrase. In a focus group, a midwife from a district hospital noted, "[Conscientious objection] is the decision the provider makes whether to give abortion care or not based on his or her conscience." Similarly, a doctor with knowledge of the concept stated:

"There's the conscience aspect and there's the objective aspect. I understand it as when, within your profession, your conscience isn't allowing you to do something that you are supposed to do as a professional. Then, from your conscience, you're objecting to what you're supposed to do. Under certain circumstances, you have a right, but not in all circumstances; conscientious objection is not acceptable in emergency situations. Oh, please, this is just my thought."*–Doctor, focus group, regional hospital*

The general understanding was that clinicians could object to providing a service but not under emergency situations. The majority of doctors and midwives in both the interviews and group discussions emphasized the fact that they were obligated to save lives and must perform terminations when the woman's health is at risk or when there is fetal impairment. They also understood that only the direct providers could object to the service; other staff at the facility had no right to deny abortion care or dissuade clients from accessing it.

To explore variations in the application of conscientious objection, we asked clinicians about their willingness to provide abortion care under differing circumstances. Midwives working in the Eastern Region and interviewed in-depth stated that they would provide abortion for all of the reasons listed in Ghana's abortion law. A few clinicians were unwilling to provide services for reasons of rape and incest, even though these constitute legal reasons to obtain an abortion. Most would refuse if the reason was contraceptive failure, relationship problems and socioeconomic reasons. The results seem to indicate that clinicians employ an ad hoc approach to the delivery of services, as different providers chose variously when they would provide care; this held true in the group discussions as well. One clinician justified providing an abortion to one person over another even though they had the same reason for seeking to terminate:

"That she doesn't have the finances?...That's something I would have to think [about]. Unless she is a teenager...I think teenagers should be given abortion care because they are just not there yet. If it is an adult with a job but she is still saying that she doesn't have the finances to, I think that is a case I would refer."*–Doctor, focus group, regional hospital*

• ***Conscientious objection is linked to religious and cultural beliefs.*** After we identified their level of knowledge about conscientious objection, we provided all study participants with a definition and the meaning of the concept was explained. They were asked to identify some reasons for conscientious objection. Antiabortion religious beliefs were mentioned as reasons for health providers refusing clients care. During a focus group discussion, one doctor from a regional hospital stated, "For most [objectors], it is about their religion; they're Christians and the Bible doesn't allow it. They've bounded themselves with religious protocols."

Culture was cited as another reason for conscientious objection. A doctor described the effects of pronatalistic (probirth) and antiabortion cultural beliefs in Ghana:

"...we live on a continent where cultural beliefs are valued. Okay, and so regardless, we are Ghanaians or we are

different nationalities and once we are Africans, we tend to have this notion about abortion. Okay, so if people naturally are not for abortion, are not proabortion, and you are that one person that is proabortion, they would label you in a way that you might probably not feel right to do it anymore...."–*Doctor, focus group, regional hospital*

Some participants expressed concerns that openly proabortion clinicians would be labeled in a manner that would force them to conform to societal beliefs about abortion. This could result in a discontinuation of abortion service provision.

• *Conscientious objection is most often practiced at faith-based facilities.* Participants discussed how conscientious objection was observed in various health facilities; they mentioned Catholic hospitals as major faith-based facilities practicing conscientious objection. Clinicians working in other public facilities had impressions about these hospitals and compared them to their own institutions. In an interview, a district hospital doctor said:

"[Conscientious objection] is being practiced, especially in the Catholic institutions. Within the Ghana Health Service, I don't think it is as much as in the Catholic institutions. For some of the Catholic institutions...don't even allow normal evacuation."

Two midwives in the Volta Region working at Catholic health facilities discussed the manner in which procedures are undertaken at their facility. They could attest to services being provided only to save the life of the woman or in the case of fetal impairment, as shown in the following exchange:

Participant (P): Because my facility is a Catholic facility and Catholics are warned against the use of contraceptives...they are against abortions. So, [conscientious objection] is heavily practiced in my facility unless the health of the mother [is at stake] or there is some abnormality, then we provide the service. We had a doctor who was a Catholic so she wouldn't start it.

Interviewer: But she will end it?

P: Yes.

–*Midwife, focus group, faith-based hospital*

This exchange highlights the fact that even at faith-based facilities, abortions are provided under some conditions, and women can obtain postabortion care.

• *Conscientious objection is practiced mainly through referral.* Clinicians who felt a personal or moral obligation not to terminate pregnancies referred clients to others. This is the major means by which objecting clinicians are trained to practice conscientious objection. Participants acknowledged that referral was an important process to ensure that clients receive health care without compromising their conscience or the patient's well-being. As a doctor from a regional hospital who was interviewed explained:

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

Interview findings indicate that doctors seemed to object more often than midwives. During group discussions, doctors stated they would perform the service when the indications were medically related, but would refer for any other reasons. In an interview, one midwife from a regional hospital noted:

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

Also, counseling, attempting to convince clients to continue the pregnancy or not discussing abortion as an option were all means through which objecting clinicians could avoid terminating a pregnancy. In one of the group discussions, a midwife from a district hospital provided the following example:

"There is a physician's assistant who used to do the scan and tell the lady straight away to go for antenatal [before the lady could say she wanted to terminate the pregnancy].... So, when some of the clients came to tell me, I sat her down and told her that if she isn't comfortable providing the service, she should just refer them to me, and it is working now."

Because of this physician assistant's discomfort with providing abortion services, she failed to listen to her clients' thoughts on their pregnancy resolution. However, once the option to refer was available, she changed her approach to those clients.

Participants also shared how health providers could encourage clients to use other methods to terminate and then come back to the facility to complete the process. One way this was done was for doctors to direct clients to buy drugs to induce abortions:

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

Although the exact drugs were not mentioned in this instance, doctors talked about the availability of misoprostol, Medabon (a combination of misoprostol and mifepristone) and Cytotec at pharmacies and dispensaries with and without prescription.

Other ways of practicing conscientious objection include clinicians refusing to begin the pregnancy termination process but agreeing to complete abortions for clients in distress. One midwife in a focus group noted that although her faith-based health facility did not do terminations, "if you come and you are willing to terminate it, we can't terminate it for you, but when you start and you come, we would complete the process for you."

• *Conscientious objection has consequences for clients and clinicians.* Clinicians' decisions to object and the manner

in which they approach this has implications for clients, as well as for objecting and nonobjecting clinicians. Clinicians understood that their decisions could result in complications, incomplete abortions and possibly death for their clients. In an interview, a district doctor described the dilemma:

"[Conscientious objection] has a huge impact...most of them, when you refuse, they come back to you with complications. And as I said, managing complications is more difficult than tackling the problem from onset. So, it has a huge impact on us."

A doctor from a regional hospital who was interviewed said:

"People have declined patients [manual vacuum aspiration] services and later saw those patients worse off and regretted not helping the person when the person needed that service. I have personally seen young ladies who came in to do abortion and were denied the service, but later went to take some medications and ended up losing their lives."

Also, clinicians were affected by colleagues who chose to object in various ways. Some midwives felt that being nonobjectors made them targets for extra provision of services, which overwhelmed them and made them want to stop performing abortions. As a midwife from a regional hospital explained in a focus group:

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

Nonobjecting clinicians sometimes refused to provide abortions because of stigma. In a focus group, a doctor from a regional hospital stated the following:

"If people are judging you for providing the care, it might influence your decision to give the care, because you are worried about what people would think about you. It shouldn't, but I think it might influence other people's decisions."

Issues of fear and stigma regarding abortion service provision were particularly a concern when supervisors were objectors. A doctor from a regional hospital who was interviewed explained his thoughts in such a situation:

"Mostly if the one who was supposed to provide the service is your superior, you tend to be a little bit reluctant because you...question why the person didn't do it for her...he is more experienced than me and he might have his reasons for not wanting to do it, so I will not want to touch such a case."

A major cause for concern for the health system is the refusal of objecting health providers to undergo general training in abortion procedures. Objectors may avoid all abortion services and therefore be inadequately trained, even for cases in which the procedure is necessary to save a woman's life. As a district hospital doctor discussing clinicians refusing to undergo abortion training stated in his interview: "It impacts negatively because they will not be trained. They would like to distance themselves from anything related to abortion. They will not learn the procedures."

Finally, the only positive impact on providers discussed was their ability to choose to provide the service or not. Ultimately, clinicians understand that their rights protect them from having to perform procedures that may compromise their moral, ethical or religious beliefs. Their acknowledgement of the right to object promotes the well-being of both the patient and the health provider. The patient can be referred to a willing provider, and, thus, will receive appropriate treatment without feeling stigma or shame or suffering abuse or harm from an unwilling clinician. As a doctor from a regional hospital explained in a focus group:

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

It must be noted that a few clinicians suggested that conscientious objection should not affect other providers because everyone has their own agency and, as individuals, can decide to provide abortion services or not. In a focus group discussion, a doctor from a regional hospital stated, "[One's choice to object] shouldn't impact other providers. Your decision is yours; I mean if you don't feel good about it, it doesn't mean that I don't have to feel good about it."

DISCUSSION

This study sought to explore clinicians' understanding of conscientious objection to abortion, where and how it is practiced, and its consequences in two regions in southern Ghana. The findings indicate that conscientious objection to abortion is not fully understood by most clinicians, including the core requirement that objection must stem from "deeply held beliefs," as described by Chavkin.[25] Conscientious objection is seemingly being practiced in an ad hoc manner, and not according to Ghanaian or international guidelines. These guidelines state the conditions under which objections can be made; however, in offering reasons, some clinicians gave views at variance with the law and guidelines, while others suggested their personal judgement would determine their provision of abortion services. A study conducted among clinicians and administrators in South Africa also found that many did not truly understand the concept, nor did they have clear guidelines to follow to manage conscientious objection at their facilities.[29] Fink et al. describe objection in Colombia as existing in a range from extreme to moderate to partial.[30] Extreme objectors opposed abortions and birth control, and refused to refer patients, while moderate objectors referred patients; both of these objectors would try to prevent clients from undergoing abortions. Partial objectors, however, refused for reasons that varied with the

circumstances.[30] None of the objectors in our study were extreme objectors because they always referred clients; they fell into the moderate and partial categories.

Findings from a study among medical students in South Africa mirror the lack of understanding of abortion laws and policies observed among the clinicians in this study. The South African study showed that the students had varying perceptions about the abortion law and practice, further highlighting a need to orient all clinicians (and soon-to-be clinicians) on guidelines and practices pertaining to their discipline.[33] Increasing awareness of the guidelines on conscientious objection is required to curb its current unregulated use. Once the guidelines are clearly understood by practitioners and clients, the manner through which conscientious objection is used can be regulated. Clinicians' refusal for reasons other than moral or personal beliefs and sporadic objection has consequences ranging from nonobjecting clinicians' fatigue to clients' death. Sporadic objection suggests that clinicians have mixed feelings about abortion provision that can change depending on the circumstances. According to Chavkin and colleagues, this can be regulated through laws and policies that ensure appropriate use of objection.[19]

Also, conscientious objection is practiced by certain institutions, particularly described as Christian, faith-based or Catholic, according to our participants, although international medical and human rights covenants state clearly that only individuals can object, not institutions.[25] In addition, abortion stigma can play a role in influencing some clinicians to adopt conscientious objection status to defend their reputations, not because of conviction. Sensitization and other forms of training are needed to reduce stigma for those willing to receive referrals. Conscientious objection cannot be regulated without an effective referral system. The referral process is a central component under the comprehensive abortion care and conscientious objection guidelines, and thus, proper procedures must be enforced.

It is important to highlight that no providers objected to providing care to women for medical indications, an essential criterion in the conscientious objection guidelines.[17,22] However, that clinicians refuse to perform elective abortions may suggest to women that they should terminate pregnancies themselves to get access to safe services. Midwives and doctors alluded to their hospital policies giving clients this impression.

Finally, objection appeared to be more prevalent among doctors than midwives, which was also observed in another study conducted in Ghana.[17] We found that objection by superiors can adversely affect the confidence of midwives and doctors. Because there are certain types of abortions that only doctors can perform (such as those performed using surgical methods or after 12 weeks' gestation), it is necessary to explore if this has a role in why more doctors than midwives object. Perhaps the training in value clarification and assessment transformation midwives receive positively affects their willingness to provide services. The current study also found that the midwives are the most knowledgeable about abortion issues and the most willing to perform abortions for any reason. It would be useful to assess if this is because of their extensive training in abortion and family planning–related topics,[8] their extensive years of practice in the region or both.

Limitations

The study has limitations that require mentioning. First, we interviewed only midwives and obstetrician-gynecologists and, thus, do not know if medical assistants or other health staff have different experiences or opinions. Second, some providers were not available or willing to participate because of their busy schedule. For example, the doctors' group discussion conducted in the Volta Region only had three participants because others were too busy to volunteer. Also, the three participants were needed at different points during the group interview, so the discussion was not carried out in a typical leisurely manner. Third, our recruitment strategy entailed senior staff recruiting their junior colleagues and this may be a possible source of bias; however, participants were informed of the voluntary participation clause, and a few did drop out without fear of being penalized. Despite these limitations, we were able to obtain perspectives on the subject of conscientious objection from clinicians with a wide range of experience.

Conclusions

Findings from this study contribute to the literature on conscientious objection and barriers to safe abortion services in Ghana. They indicate the means through which clinicians are gatekeepers to safe abortion services and how they can influence clients' use of unsafe abortion. The findings also highlight the need for further research on the identified implications of conscientious objection, especially the nature of the referral system and stigma leading to refusals. Understanding these complex mechanisms may ultimately help to restrict clinicians' misuse of the right to object and improve women's reproductive health care in Ghana.

REFERENCES

1. Grimes DA et al., Unsafe abortion: the preventable pandemic, *Lancet*, 2006, 368(9550):1908–1919, http://dx.doi.org/10.1016/S0140-6736(06)69481-6.

2. Sedgh G et al., Induced abortion: estimated rates and trends worldwide, *Lancet*, 2007, 370(9595):1338–1345, http://dx.doi.org/10.1016/S0140-6736(07)61575-X.

3. Ghana Statistical Service (GSS), Ghana Health Service (GHS) and ICF, *Ghana Maternal Health Survey 2017*, Accra: GSS, GHS and ICF, 2018.

4. Morhee R and Morhee E, Overview of the law and availability of abortion services in Ghana, *Ghana Medical Journal*, 2006, 40(3):80–86, http://dx.doi.org/10.4314/gmj.v40i3.55256.

5. United Nations Department of Economic and Social Affairs, Population Division, *Abortion Policies and Reproductive Health Around the World*, 2014.

6. Chavkin W, Baffoe P and Awoonor-Williams K, Implementing safe abortion in Ghana: "We must tell our story and tell it well," *International Journal of Gynecology & Obstetrics*, 2018, 143(Suppl. 4):25–30, http://dx.doi.org/10.1002/ijgo.12674.

7. Payne CM et al., Why women are dying from unsafe abortion: narratives of Ghanaian abortion providers, *African Journal of Reproductive Health*, 2013, 17(2):118–128, https://www.jstor.org/stable/23485926.

8. Sundaram A et al., The impact of Ghana's R3M programme on the provision of safe abortions and postabortion care, *Health Policy and Planning*, 2015, 30(8):1017–1031, http://dx.doi.org/10.1093/heapol/czu105.

9. Boah M, Bordotsiah S and Kuurdong S, Predictors of unsafe induced abortion among women in Ghana, *Journal of Pregnancy*, 2019, 2019:9253650, http://dx.doi.org/10.1155/2019/9253650.

10. Gbagbo FY, Amo-Adjei J and Laar A, Decision-making for induced abortion in the Accra Metropolis, Ghana, *African Journal of Reproductive Health*, 2015, 19(2):34–42.

11. Biney AAE, Exploring contraceptive knowledge and use among women experiencing induced abortion in the Greater Accra Region, Ghana, *African Journal of Reproductive Health*, 2011, 15(1):37–46.

12. Schwandt HM et al., A comparison of women with induced abortion, spontaneous abortion and ectopic pregnancy in Ghana, *Contraception*, 2011, 84(1):87–93, http://dx.doi.org/10.1016/j.contraception.2010.10.011.

13. Glover EK et al., Sexual health experiences of adolescents in three Ghanaian towns, *International Family Planning Perspectives*, 2003, 29(1):32–40, http://dx.doi.org/10.2307/3180999.

14. Adjei G et al., Predictors of abortions in rural Ghana: a cross-sectional study, *BMC Public Health*, 2015, 15:202, http://dx.doi.org/10.1186/s12889-015-1572-1.

15. Bleek W, Did the Akan resort to abortion in pre-colonial Ghana? Some conjectures, *Africa*, 1990, 60(1):121–131, http://dx.doi.org/10.2307/1160430.

16. Loi UR et al., Health care providers' perceptions of and attitudes towards induced abortions in sub-Saharan Africa and Southeast Asia: a systematic literature review of qualitative and quantitative data, *BMC Public Health*, 2015, 15:139, http://dx.doi.org/10.1186/s12889-015-1502-2.

17. Awoonor-Williams JK et al., Prevalence of conscientious objection to legal abortion among clinicians in northern Ghana, *International Journal of Gynecology & Obstetrics*, 2018, 140(1):31–36, http://dx.doi.org/10.1002/ijgo.12328.

18. Tavrow P, Promote or discourage: how providers can influence service use, in: Malarcher S, ed., *Social Determinants of Sexual and Reproductive Health*, Geneva: World Health Organization, 2010, pp. 15–36.

19. Chavkin W, Swerdlow L and Fifield J, Regulation of conscientious objection to abortion: an international comparative multiple-case study, *Health and Human Rights Journal*, 2017, 19(1):55–68.

20. Chavkin W, Leitman L and Polin K, Conscientious objection and refusal to provide reproductive healthcare: a White Paper examining prevalence, health consequences and policy responses, *International Journal of Gynecology & Obstetrics*, 2013, 123(Suppl. 3):S41–S56, http://dx.doi.org/10.1016/S0020-7292(13)60002-8.

21. Johnson BR, Jr., et al., Conscientious objection to provision of legal abortion care, *International Journal of Gynecology & Obstetrics*, 2013, 123(Suppl. 3):S60–S62, http://dx.doi.org/10.1016/S0020-7292(13)60004-1.

22. Chavkin W et al., Balancing freedom of conscience and equitable access, *American Journal of Public Health*, 2018, 108(11):1487–1488, http://dx.doi.org/10.2105/AJPH.2018.304711.

23. GHS, *Prevention and Management of Unsafe Abortion: Comprehensive Abortion Care Services, Standards and Protocols*, third ed., 2012.

24. Faúndes A, Duarte GA and Osis MJD, Conscientious objection or fear of social stigma and unawareness of ethical obligations, *International Journal of Gynecology & Obstetrics*, 2013, 123(Suppl. 3):S57–S59, http://dx.doi.org/10.1016/S0020-7292(13)60003-X.

25. Chavkin W, Conscientious objection to the provision of reproductive healthcare, *International Journal of Gynecology & Obstetrics*, 2013, 123(Suppl. 3):S39–S40, http://dx.doi.org/10.1016/S0020-7292(13)00601-2.

26. Zampas C, Legal and ethical standards for protecting women's human rights and the practice of conscientious objection in reproductive healthcare settings, *International Journal of Gynecology & Obstetrics*, 2013, 123(Suppl. 3):S63–S65, http://dx.doi.org/10.1016/S0020-7292(13)60005-3.

27. Freeman E and Coast E, Conscientious objection to abortion: Zambian healthcare practitioners' beliefs and practices, *Social Science & Medicine*, 2019, 221:106–114, http://dx.doi.org/10.1016/j.socscimed.2018.12.018.

28. Aniteye P and Mayhew SH, Shaping legal abortion provision in Ghana: using policy theory to understand provider-related obstacles to policy implementation, *Health Research Policy and Systems*, 2013, 11:23, http://dx.doi.org/10.1186/1478-4505-11-23.

29. Harries J et al., Conscientious objection and its impact on abortion service provision in South Africa: a qualitative study, *Reproductive Health*, 2014, 11:16, http://dx.doi.org/10.1186/1742-4755-11-16.

30. Fink LR et al., "The fetus is my patient, too": attitudes toward abortion and referral among physician conscientious objectors in Bogotá, Colombia, *International Perspectives on Sexual and Reproductive Health*, 2016, 42(2):71–80, http://dx.doi.org/10.1363/42e1016.

31. GSS, GHS and ICF International, *Ghana Demographic and Health Survey 2014*, Rockville, MD, USA: GSS, GHS and ICF International, 2014.

32. Braun V and Clarke V. Using thematic analysis in psychology, *Qualitative Research in Psychology*, 2006, 3(2):77–101, http://dx.doi.org/10.1191/1478088706qp063oa.

33. Wheeler SB et al., Attitudes and intentions regarding abortion provision among medical school students in South Africa, *International Perspectives on Sexual and Reproductive Health*, 2012, 38(3):154–163, http://dx.doi.org/10.1363/3815412.

RESUMEN

Contexto: *Pocos estudios han explorado los roles del personal clínico en la experiencia del aborto en Ghana. Examinar la forma en que el personal clínico comprende la objeción de conciencia al aborto –el derecho de rehusarse a proveer servicios de aborto legal sobre la base de la moral o creencias personales– podría aportar conocimientos que ayuden a gestionar la práctica del procedimiento.*

Métodos: *Se realizaron ocho entrevistas en profundidad y cuatro discusiones de grupos focales con la participación de 14 médicos y 20 parteras en instituciones de salud en las regiones de Ghana oriental y del Volta en mayo de 2018. Las guías de entrevistas semiestructuradas cubrieron temas como la comprensión del personal clínico acerca de la objeción de conciencia, la forma en que se practica y las consecuencias de la objeción de conciencia para proveedores de servicios y clientes. Los datos se analizaron mediante análisis temático.*

Resultados: *La mayor parte del personal clínico no comprendió el término "objeción de conciencia" y las parteras tuvieron más conocimiento del tema que los médicos. Las principales razones para la objeción de conciencia fueron las creencias religiosas y culturales contrarias al aborto. El personal clínico que practicó la objeción refirió a sus clientes a proveedores dispuestos a dar el servicio, les aconsejó continuar*

con los embarazos o inadvertidamente les motivó para tener abortos inseguros. Las consecuencias negativas de la objeción de conciencia al aborto para las clientas fueron complicaciones y muerte debidas a abortos inseguros; las consecuencias para los proveedores incluyeron un alto volumen de pacientes y el estigma para los no objetores, lo que condujo a que algunos se identificaran como objetores para evitar dichas consecuencias.
Conclusiones: *Los hallazgos destacan la necesidad de mayor investigación sobre las consecuencias de la objeción de conciencia, incluido el estigma que conduce a negar los servicios. Esa investigación podría ayudar, en última instancia, a restringir el uso indebido del derecho a objetar por parte del personal clínico y a mejorar los servicios de salud reproductiva para las mujeres en Ghana.*

RÉSUMÉ

Contexte: *Rares sont les études qui examinent le rôle des cliniciens dans l'expérience de l'avortement au Ghana. Il peut être utile d'examiner comment les cliniciens comprennent l'objection de conscience à l'avortement – c.-à-d. le droit de refuser la prestation d'un avortement légal sur la base de croyances morales ou personnelles –, afin de mieux gérer la pratique.*
Méthodes: *Huit entretiens en profondeur et quatre discussions de groupe ont été menés avec 14 médecins et 20 sages-femmes de structures sanitaires des régions Orientale et de la Volta au Ghana, en mai 2018. Les guides de ces entretiens semi-structurés couvraient des questions telles que la compréhension du concept d'objection de conscience par les cliniciens, sa pratique et ses conséquences pour les prestataires et les patientes. Les données ont été analysées par analyse thématique.*
Résultats: *La plupart des cliniciens ne comprenaient pas l'expression « objection de conscience »; les sages-femmes étaient mieux informées sur la question que les médecins. Les principales raisons de l'objection de conscience étaient les croyances religieuses et culturelles opposées à l'avortement. Les cliniciens objecteurs aiguillaient les patientes vers les prestataires qui ne l'étaient pas, leur conseillaient de poursuivre leur grossesse ou les encourageaient par inadvertance à recourir à l'avortement non médicalisé. Les conséquences négatives de l'objection de conscience à l'avortement étaient, pour les patientes, les complications, parfois mortelles, de l'avortement non médicalisé; pour les prestataires, ces conséquences se révélaient dans le grand nombre de patientes et la stigmatisation des non-objecteurs, en conduisant certains à invoquer eux aussi l'objection pour les éviter.*
Conclusions: *Les constats de l'étude mettent en lumière la nécessité d'une recherche approfondie sur les conséquences de l'objection de conscience, y compris la stigmatisation menant au refus d'assurer le service. Cette recherche aidera peut-être, en fin de compte, à limiter l'abus du droit d'objection des cliniciens et à améliorer les soins de santé reproductive des femmes au Ghana.*

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