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by

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Abstract

Conscientious objection to abortion provision: developing a survey instrument to measure prevalence

by

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Conscientious objection to abortion – a clinician's refusal to perform abortions because of moral or religious beliefs – is a limited right intended to balance reproductive rights and clinicians' convictions. The first chapter of this thesis argues that conscientious objection policies and debates generally do not take into account the social, political and economic pressures that profoundly influence clinicians who must decide whether to claim objector status. Lack of clarity about abortion policies, high workload, low pay, and social and workplace stigma towards abortion providers can discourage abortion provision. As the only legal way to refuse to provide abortions, conscientious objection can become a safety valve for clinicians under pressure and may be used by clinicians who do not have moral or religious objections. Social factors including stigma also shape how stakeholders and policymakers approach conscientious objection. To appropriately limit the scope of conscientious objection and make protection of conscience more meaningful, more information is needed about how conscientious objection is understood and practiced. Additionally, abortion trainings should include information about conscientious objection and its limits, about reproductive rights, and about how to create an enabling environment for abortion provision. Policymakers and all stakeholders should also focus on creating an enabling environment and reducing stigma.

The second chapter describes the development of a survey instrument to measure conscientious objection to abortion provision. In practice, clinician objection may act as a barrier to abortion access – impinging on reproductive rights, and increasing unsafe abortion and related morbidity and mortality. There is little information about conscientious objection from a medical or public health perspective. A quantitative instrument is needed to assess prevalence of conscientious objection and give insight on its practice. A literature review, consultation with Global Doctors for Choice country lead physicians, and in-depth interviews with stakeholders in Colombia were used to develop a conceptual model of conscientious objection. The model posits three domains of conscientious objection that form the basis for the survey instrument: 1) self-identification as a conscientious objector; 2) beliefs about abortion; and 3) actions related to conscientious objection and abortion. The survey instrument was piloted, and then administered, in Ghana. The instrument can be used to assess prevalence among clinicians trained to provide abortions, and to gain insight on how conscientious objection is practiced in a variety of settings. Its results can inform more effective and appropriate strategies to regulate conscientious objection.

Literature review: the context of conscientious objection

Introduction

Conscientious objection (CO) is an individual's refusal to participate in an activity incompatible with her or his religious, moral or philosophical beliefs. Clinicians' objection to providing abortions is a particularly controversial subject. Ethicists, legal scholars and policymakers delineate a variety of scopes for CO to abortion provision in an attempt to balance women's reproductive rights and health with clinicians' beliefs. Yet in contrast to this ideal of balance, in practice CO often functions as a barrier for women who seek abortions. For example, if objectors don't adequately counsel or refer women who need abortions, women might risk morbidity or death by obtaining unsafe abortions, or might carry unwanted pregnancies to term. And since women with the fewest resources are the most affected by CO, CO increases inequity in reproductive health and rights.

This chapter focuses on two factors that complicate the practice of CO. First, policy and jurisprudence about CO tends to leave key issues unspecified. One of these issues is the question of whether CO can and should be selective (providers can refuse to participate in some types of abortion but not others) or absolute (providers must either participate in or object to all abortions). Second, policies about CO usually assume that conscientious objection occurs in a morally neutral environment among providers who are familiar with the relevant laws and policies; however, these conditions rarely hold. On the contrary, CO is practiced within and is affected by a social environment that usually harbors significant stigma towards abortions, and can be highly polarized. The lack of clarity and specificity in policies regarding CO, and the resulting potential for bias in the interpretation of those policies, magnify the importance of the social environment in the practice of CO.

In this chapter, I first describe conscientious objection through the lenses of bioethics and policies around the world. I then focus on the definition of the legitimate bases for CO and the implications of defining it as absolute or selective, particularly for the regulation of CO. I describe the ways that CO plays out in clinical settings, and analyze some of the social and political forces that shape its practice. I then examine the stakes for women's health and rights, as well as for providers and for health systems. I conclude by discussing strategies to make CO serve its intended function of truly protecting providers' consciences while still upholding women's rights to healthcare.

A note about my own position in this debate: I am a public health researcher and future physician. I am pro-choice. I believe that abortion is a fundamental component of women's rights – part of the right to health and reproductive freedom as well as the right to self-determination. Thus, I believe abortion should be easily accessible to women. I also believe that allowing the practice of conscientious objection is worthwhile for reasons that include epistemic humility: the idea that we cannot know what is morally right with absolute certainty and thus should allow for others to follow deeply held beliefs that are different from our own. However, I believe that the practice of CO must have clear, appropriate scope and limits so that it does not infringe on patients' rights to make decisions about their own bodies and life courses.

Bioethics and conscientious objection

Conscience has many definitions, and legal scholars have argued that "it may be impossible to establish a singular and comprehensive definition of conscience" (Sawiki 2012). And yet, even young children understand what conscience is and can feel its pangs. A working definition of conscience is an individual's "judgment of the moral quality of his or her own conduct" (Sawiki 2012). Long synonymous with religious beliefs, conscience has more recently been extended to the secular realm.

Conscience is considered worth protecting in large part because forcing an individual to go against her conscience would compromise her identity and integrity (Wicclair 2011). The concept of CO to military service has existed since at least the Middle Ages (Wicclair 2011). Objection for reasons of conscience has been part of philosophical debates about religion and morality since that time.

Conscientious objection – also called conscience-based refusal, or conscientious refusal – can be clarified through comparison with civil disobedience. Civil disobedience is "public, nonviolent and submissive violations of the law in protest based on moral-political principles and designed to effect or prevent social, political, or legal change" (Childress 1985). CO is similarly rooted in moral conviction, but it occurs within the law and does not seek to change a broader system or policy.

Conscientious objection among healthcare providers gained popularity in the 1960s and 70s, largely in response to the liberalization of abortion in several countries during this period (Wicclair 2011). Debates about CO in healthcare are part of larger conversations about providers' roles as deliverers of care, and about freedom of religion (Savulescu 2006, Charo 2014, Lawrence 2014).

Some scholars – primarily religious bioethicists – advocate for the unfettered practice of CO; for example, arguing that objecting clinicians need not inform eligible patients about their right to an abortion, or refer patients to another provider (Wicclair 2011). They claim that any limitations on the act of objecting would compromise the moral integrity of providers.

Other scholars – primarily public health and women's rights advocates – argue that CO has little or no place in healthcare. All individuals have a fundamental right to health and autonomy over healthcare decisions, as upheld by UN Human Rights Commission, the UN Committee on Economic, Social and Cultural Rights, and many national constitutions and laws (Cabal 2014). Accessing legal healthcare such as abortion is a fundamental part of these rights. Becoming a clinician is a choice, and these scholars argue that individuals should not become clinicians if they put their own beliefs before patients' rights to access all legal healthcare services because doing so inherently puts patients' rights at risk (Savulescu 2006, Fiala 2014). Medical ethicist Julian Savulescu writes that "the door to 'value-driven medicine' [such as CO] is a door to a Pandora's box of idiosyncratic, bigoted, discriminatory medicine" (2006).

CO is most often framed as a limited right that balances these two positions: the ability to conscientiously object should exist because providers are moral agents, but its practice should be limited because providers are also professionals with duties to their patients (Wicclair 2011). The WHO and most professional societies take this approach, as do most countries around the world that have CO policies or jurisprudence (Chavkin 2013).

The Universal Declaration of Human Rights, article 18, supports this limited right, stating that:

> *"Everyone shall have the right to freedom of thought, conscience and religion… [and] to manifest his religion or belief in worship, observance, practice and teaching…Freedom to manifest one's religion or beliefs may be subject only to such limitations as…are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others" (1948).*

If providers' right to conscientiously object is limited by their duty to patients, then the function – and the tension – of CO is most salient in the context of national health systems, in which doctors who work in public facilities are charged with fulfilling patients' rights to receive legal health services (Chavkin 2013).

Providers around the world object to a variety of services including end of life care, organ removal, and other issues, but reproductive health services are the services most commonly objected to (Wicclair 2011). This thesis focuses on doctors and midwives as conscientious objectors to abortion provision, but many of the same principles discussed here apply to other reproductive healthcare services such as genetic testing, and emergency and non-emergency contraception, as well as pharmacists' fulfillment of prescriptions for medical abortion and contraception (Chavkin 2013). Although most bioethical discussions about CO to abortion provision focus on religion, professional duties, and the right to health, some scholars also recognize that conscientious objection to provision of reproductive health services in particular is consistent with – and socially legitimized by – a long history of religious and moral rationales being used to exert control over women's bodies (Casas 2005, Cook and Dickens 2006, Dickens 2000). I discuss these issues in a subsequent section of this chapter.

Conscientious objection policies: an overview

CO to abortion provision (hereafter simply called CO) is defined and regulated in several arenas, among them international human rights treaties and regional declarations; statements and guidelines by national and international professional organizations; national laws; Ministry of Health standards and protocols; jurisprudence; and institutional policies and practices (Cabal 2014, Chavkin 2013). Guidelines, laws and policies in these arenas delineate varying scopes for the practice of CO (Sepper 2012, McCafferty 2010, Chavkin 2013). In some contexts the scope of CO is derived from a body of jurisprudence about conscientious objection rather than a single policy (Cabal 2014), leading to evolving and potentially inconsistent definitions of the concept.

However, despite these differences, common threads exist. Almost all policies regarding CO include strategies intended to help patients gain access to abortions in a timely manner regardless of their provider's beliefs (Chavkin 2013). For example, nearly all require that conscientious objectors counsel patients on all their care options and refer patients to other providers (Wicclair 2011). Additionally, many policies state that conscientious objectors must provide an abortion in cases of emergency, or when the provider is the only physician present (i.e. when referral is impossible) (McCafferty 2010). Several CO policies explicitly state that the national health system, individual health facilities, or insurance companies collectively must guarantee women's access to abortion

services (Ghana Health Standards and Protocols 2006, Colombia Sentencia T-209/08, McCafferty 2010).

Unbiased, comprehensive counseling on all care options is an essential part of ensuring that patients' needs are met. Most policies and standards state that counseling must include informing patients about all care options, including ones to which the provider objects (ACOG 2007, UK General Medical Council 2013). Some policies require that this counseling include disclosure of the physicians' status as a conscientious objector (McCafferty 2010, Chavkin 2013). Some policies further specify that counseling should be non-biased and non-judgmental (ACOG 2007, Ghana Health Standards and Protocols 2006). Complying with these requirements may be difficult for conscientious objectors. Some objectors transfer the duty of counseling to others because they fear their moral beliefs prevent them from counseling objectively (Nordberg 2014). Other objectors openly encourage patients to keep the pregnancy during counseling (Aniteye and Mayhew 2013). Nonetheless, counseling is a critical component of the balance between patients and providers that CO is supposed to represent.

Like counseling, referral by conscientious objectors to providers willing to perform abortions is critical to keeping abortion accessible. Nonetheless, some have argued that referral impinges too much on the beliefs of conscientious objectors. For example, Karen Brauer, president of Pharmacists for Life, said that for an objector to refer a patient for abortion is "like saying 'I don't kill people myself, but let me tell you about the guy down the street who does'" (Wicclair 2011). Some providers "pray for forgiveness" after making referrals (Aniteye and Mayhew 2013). Seeking to resolve this dilemma, bioethicists have argued that there is a difference between direct referral, in which the objecting clinician herself connects patients with another provider, and indirect referral, in which the objecting clinician only gives patients information about other facilities or providers (Wicclair 2011). Wicclair argues that if providers feel too directly implicated in the act of abortion through direct referral, providers should at least be required to indirectly refer patients (2011). Different policies require different types of referral, and some do not specify which type must be provided (British Medical Association 2012, McCafferty 2010). Some policies specify that referral should be timely so that women's access to care should not be interrupted (McCafferty 2010). This is essential to ensure that CO does not result in excessive burdens for women. Like counseling, some aspects of referral may be hard to navigate in practice, even by objectors who do their best to comply with the law. For example, in low-resource countries with few health providers, or in contexts where most providers are objectors, referral may not be an easy task.

Laws differ as to whether only clinicians who would perform the procedure are eligible for conscientious objector status, or whether others peripherally involved in patient care such as nurses, or even secretaries, may object to involvement with abortion care. For example, the United Kingdom's Abortion Act of 1967 states that "No person shall be under any duty ... to participate in any treatment authorised by this Act to which he has a conscientious objection." In December 2014, the UK Supreme Court determined that midwives supervising a Labor and Delivery Unit did not have the right to conscientiously object to delegating, supervising and supporting staff who were providing the abortions because this did not constitute "participation" (Brooks 2014). On the other hand, in possibly the most permissive conscience policy in the world, a Mississippi statute protects freedom to refuse participation in "patient referral, counseling, therapy, testing, diagnosis or prognosis"

for any medical treatment (Miss. Code Ann. §§ 41-107-3 & § 41-107-5, discussed in Sepper 2014). This statute has been proposed in 15 other US states.

Some policies and jurisprudence forbid healthcare institutions from claiming "conscientious objector" status (Cabal 2014, Chavkin 2013). For example, the Colombian Constitutional Court affirmed that "the human right to respect for conscience is a right enjoyed by natural human beings, but not by institutions such as hospitals" (Colombia Sentencia T-209/08). However, other CO policies do allow institutional objection. For example, Uruguay allows private institutions such as Catholic hospitals to practice "ideology objection", and Argentina allows for objection by public and private healthcare institutions (Cabal 2014).

Policies' lack of clarity: absolute and selective CO

In addition to varying widely between countries, CO legislation and jurisprudence can be unclear and incomplete (Chavkin 2013, Sepper 2012, Fiala 2014). Some aspects of CO policies that tend to be unclear have been extensively examined in legal literature – for example, the responsibility of conscientious objectors to refer has generated much written controversy. Another important issue that is far less discussed is that CO policies usually do not operationally define what conscience is, and what is – or isn't – a legitimate basis for conscientious objection (Sepper 2012). This is important because different definitions of CO have different implications for the way objection is practiced, and who considers themselves an objector. Without a clear operational definition, it is difficult to determine what constitutes proper CO and thus to regulate the practice of CO.

Most policies do state that CO must stem from moral, ethical, philosophical or religious beliefs; however, few policies actually delineate what this means in practice. In the United States, the American College of Gynecologists statement "The Limits of Conscientious Refusal in Reproductive Medicine" provides a bit more clarity, stating that:

> *"Conscience has been defined as the private, constant, ethically attuned part of the human character. It operates as an internal sanction that comes into play through critical reflection about a certain action or inaction. An appeal to conscience would express a sentiment such as "If I were to do 'x,' I could not live with myself/I would hate myself/I wouldn't be able to sleep at night." According to this definition, not to act in accordance with one's conscience is to betray oneself—to risk personal wholeness or identity."* (2007)

Yet even this definition – one among many that have been used – leaves open the question of what conscience-based objection should look like for a practicing clinician and whether it should be absolute or selective.

The definition and regulation of conscientious objection to military service illuminates by contrast. The US military's policies and procedures are illustrative of many of the regulations about military conscientious objection in many countries. In the current absence of a draft, these policies apply to people who jointed the military voluntarily, and subsequently recognized that they were conscientious objectors. Objection to military service in the US is defined as conscientious objection if it is based on moral, ethical and religious beliefs that are judged to be *sincere* and *consistent* (Galvin 2009). In particular,

military conscientious objection is only considered legitimate if it is towards all wars: an absolute objection (Galvin 2009). Selective objection is prohibited. Individuals serving in the military who recognize that they are conscientious objectors must present a written statement about their beliefs, and then appear before a panel to have a hearing about the sincerity of their beliefs. According to army regulations, "the hearing is to provide the person the chance to establish, by 'clear and convincing evidence,' that he or she is a conscientious objector as defined by this regulation" (Galvin 2009).

CO policies and guidelines rarely have equivalent standards that help providers, health administrators and regulators determine what CO should "look like" in practice. One question seems particularly salient: does legitimate CO permit objection to specific kinds of abortion but not others, or must the objection be categorical towards all abortions? I will discuss this question using Colombia as a case example because of its relatively more developed jurisprudence on conscientious objection. Its constitutional court has developed principles for the practice and regulation of CO through its decisions C-355 (2006), T-209 (2008), T-946 (2008) and T-388 (2009).

Unlike most countries, the Colombian constitutional court has taken an explicit stance on selective conscientious objection: selective objection is not legitimate, and conscientious objectors must object to all abortions to be considered legitimate objectors (T-209). This absolutist understanding has both problematic and beneficial implications from public health and legal perspectives.

One argument for an absolutist definition is that allowing providers to define what specific cases they consider morally objectionable opens the door for heightened provider judgment and further stigma of patients. Wicclair argues that doctors should not be able to practice "invidious" discrimination – the treatment of a class of people unequally in a manner that is malicious, hostile, or damaging – even if this discrimination is based on conscience (2011). UK guidelines have a similar principle:

> *"You must not unfairly discriminate against patients or colleagues by allowing your personal views to affect your professional relationships or the treatment you provide or arrange…this includes your views about a patient's or colleague's lifestyle, culture or their social or economic status, as well as the characteristics protected by legislation: age, disability, gender reassignment, race, marriage and civil partnership, pregnancy or maternity, religion or belief, sex and sexual orientation… and you must not refuse to treat the health consequences of lifestyle choices to which you object because of your beliefs"* (General Medical Council 2013).

This language provides a basis for an absolutist definition of conscientious objection. Refusal to provide certain types of abortions can be inextricable from views of lifestyle choices. For example, in Colombia, abortion is legal in cases of rape and incest, fetal malformation, and the life and health of the mother. If a clinician provides an abortion in cases where the pregnancy affects the woman's health, but does not provide abortions for women who were raped, this can be viewed as stigma against rape victims – some providers believe that rape is partly the woman's fault because of the lifestyle she is living, and thus she is more to blame than a woman who has health issues. What seems at first like a moral

distinction is actually overlaid with questions of stigma and discrimination. Or instead, a provider might simply decide whether to perform an abortion on a case-by-case basis. This would transform each counseling session into a plea for provision of service, and each provider into the judge of morality of each abortion request. Indeed, selective discrimination might appear to open the "Pandora's box of idiosyncratic, bigoted, discriminatory medicine" that Savulescu was worried about.

However, a significant argument against an absolutist definition is that it represents a disconnect between theory and reality. Studies show that most clinicians' beliefs about the morality and acceptability of abortion vary according to gestational age, fetal viability, and other situational characteristics, such as whether the woman seeking the abortion is young, or whether she was raped (Abdel-Aziz 2004). Thus, when faced with an "all or nothing" choice, providers may choose to define themselves as conscientious objectors so as not to participate in the abortions that they do find morally objectionable. This has the potential to dramatically decrease access to abortions, especially in contexts such as Colombia where there is no gestational age limit for legal abortions. In these environments, providers who are not conscientious objectors expose themselves to the risk of being forced to provide later abortions or other abortions they find unconscionable. There are anecdotal reports of abortion providers in Colombia becoming objectors after being confronted with women seeking abortion at late gestational ages. Another potential negative consequence of this disconnect between theory and reality is that providers may disregard the law because it does not correspond with their views, practicing selective objection instead. If CO policy is seen as unrealistic, perhaps its other elements such as proper counseling and referral will also be taken less seriously.

Another, more theoretical, argument against an absolutist definition of CO is that there is no clear ethical basis for determining that absolute CO is more legitimate than selective CO. Perhaps a definition of conscience such as ACOG's, quoted above, does a better job balancing clarity with a degree of epistemic humility. Doctors are left to work out for themselves whether the x in "If I were to do 'x,' I could not live with myself" means all abortions, or only some abortions.

Given these arguments, how can we think about selective vs. absolute CO to abortion provision? One way forward could be to take a middle ground between absolute and selective conscientious objection by specifying a few criteria along which to base one's objection. Gestational age could be one such criterion – providers could declare themselves to be a conscientious objector to abortions after a certain number of weeks. Or, providers might be allowed to declare that they provide abortions only in cases in which the fetus is not viable. By specifying which criteria for bounding conscientious objection are acceptable, and requiring that these criteria be declared up-front and that providers maintain constancy within specified criteria, policies could help providers approximate their beliefs and provide abortions to the extent of their comfort, while allowing their principles to be determined before the visit.

As seen in the above discussion, ambiguity in the definition of CO can have positive and negative implications. A concrete, operational definition of conscientious objection can be quite useful for external verification of conscientious objector status. It can also be important for giving guidance to court cases (Westeson), and it can be good for providers who seek to determine whether they are conscientious objectors. The lack of full definition and regulation of CO gives space for providers' and administrators' own beliefs about

abortion and CO – and the social and political context – to drive how CO is practiced on the ground. However, lack of definition and regulation about CO may have certain advantages: it can allow providers to navigate a morally ambiguous terrain in ways that respond to the complexities, providing the abortions that they feel comfortable providing, while refusing others that they feel, for whatever reason, they cannot provide.

The present discussion has focused on the lack of clarity and under-definition within policies. Yet perhaps even more significant are the differences between how most laws and policies define CO's scope, and how health administrators and providers actually comprehend and practice CO.

Conscientious objection in practice

In contrast to the substantial bioethical and legal literature about CO, relatively little is known from a public health and medical perspective, and most knowledge is anecdotal. What is known complicates the picture significantly. The concept of balance between patients and providers is important but does not do justice to the complexities of abortion provision and access on the ground.

There are few studies of the prevalence of CO. The handful that exist globally have found that between 14% and 80% of providers refuse to provide legal abortions or other health services – 80% being gynecologists in Portugal (Chavkin 2013). In an environment where 80% of providers object to providing legal abortions, one can imagine that a seemingly simple task such as referral to a willing provider becomes difficult to implement for providers. This may pose great burdens on patients in terms of delays or distance to travel, even when a provider can be found. This issue is compounded in countries in which health providers are already rare and overworked. Studies of prevalence of objectors are few and far between; policies are usually made in the absence of information about prevalence, and thus may not appropriately limit the practice of CO or take measures to ensure that women can still access abortion.

In addition, studies in several countries have shown that many providers, health administrators and even health educators are not familiar with the relevant policies about abortion and CO (Aniteye and Mayhew 2013, Harries 2014). This may be compounded by lack of institutional policies and procedures regarding CO; even if a provider knows the national policy, the health facility may not have a policy for how to object or provide within the clinic (Harries 2014). Lack of clarity about the law can cause provider reluctance to engage with abortion, or may result in providers overstepping their boundaries by objecting – for example, they may not understand that referral is part of the proper practice of conscientious objection. This lack of clarity is affected and perpetuated by clinical instructors who may be unsure of their professional duties or whose teaching is biased by religious beliefs (Voetagbe 2010). Further, this dearth of clarity occurs in the context of general lack of provider education about human rights and patient autonomy – principles that form the basis for properly limiting the practice of CO (Chavkin 2013).

On top of unclear laws and unclear understanding, deliberate misuse of CO abounds. Providers can use CO as a strategy to disengage with a morally contentious issue (Dresser 2005, Faúndes 2004, Harries 2014, Milward 2010, Sepper 2012). As a conscientious objector in Colombia described,

"It is easier to say no than to say yes. When you say yes, you are committing to many things. When you say no, you shut a door, and there, no one will bother you," (author's key informant interviews about CO 2014).

Ironically, in this way CO may actually serve as an excuse for providers to avoid grappling with difficult questions of conscience rather than an affirmation of the importance of conscience (Sepper 2012). Using CO as a shield from a contentious issue rather than as a true expression of conscience can result in discrepancies regarding provision; for example, one study in Brazil found that twice as many OB/GYNs accepted abortion as a solution for themselves or their partners as for their patients (Faúndes 2004).

But these sorts of behaviors beg the question: why are providers disengaging in the first place? From what do they want to shield themselves when they claim conscientious objection? Claims of CO can be rooted in – and mask – economic, social and professional pressures for providers. Qualitative studies about conscientious objection have described how some South African providers who identified as conscientious objectors became willing to provide abortions when financial incentives were given (Harries 2014).

It's not only about money. Public knowledge of a clinician's willingness to provide abortions can come with a high price of stigma, discrimination, and even threats of violence in many societies (Hessini 2014). Qualitative studies have found that providers claim status as conscientious objectors to protect themselves from stigma (De Zordo and Mishtal 2011). This phenomenon has been denounced by leadings scholars and advocates for abortion access (Faúndes 2014). In a similar vein, some providers identifying as conscientious objectors in public facilities but provide abortions in their private practice (Fiala 2014, author's key informant interviews about CO 2010). In these cases, CO is being used by providers in multiple ways: to refuse extra workload, gain extra income, and avoid stigma in their public workplace.

Shifting the lens to the social and political context

These misuses of CO are best understood not only in terms of individual provider behavior, but as a function of the broader political and social dynamics around abortion and healthcare provision. If we conceive of CO as practiced by isolated individuals in morally neutral environments, some of the deviations from policy described above may seem puzzling. When we take a perspective informed by political economy – i.e., when we acknowledge that CO is a social act that takes place in an environment fraught with political, economic and social pressures – these deviations are easier to understand. In practice, CO is like a pressure valve: as the only legal reason to object to providing a healthcare service, it acts as a conduit for all the reasons that providers might not want to or feel able to provide this service.

For example, one could imagine that in the context of adequate pay, conscientious objection might not be as prevalent. Clinicians working in the public sector are woefully underpaid and overworked in facilities that often lack basic resources (Astor 2005). In many countries, clinicians must also work a private sector job simply in order to make ends meet. Setting aside abortion as the specific service in question, one can imagine that in this economic context, being able to refuse to provide any service would be tempting. It might even make providers view abortion differently – as an "optional" service. It is ironic that

these economic issues emerge most strongly in the public sector. Public sector clinicians are the ones charged with delivering the full range of health services as part of the right to health, and public health services are the only feasible option for the women with the least resources, those who most need that right protected by external forces.

Considerations specific to the social and religious responses to abortion only compound the problem. The last section briefly touched on CO as a tool for providers to avoid stigma, but stigma and conscientious objection interact in complex ways on multiple levels (Diniz 2011, Faúndes 2013, Hessini 2014, De Zordo and Mishtal 2011). For example, in Colombia the *procurador* – the official in charge of making sure that public servants comply with laws – is strongly anti-choice. Health administrators and activists report that complaints about abuse of CO are unheeded and some people do not provide abortions because of fear of retaliation (author's key informant interviews about CO 2014). In Eastern Europe, churches have pressured providers to publicly declare themselves as conscientious objectors, threatening social and religious sanction if they do not (Fiala 2014). This is a particularly strong example of our social structures actively and explicitly using CO as a tool to achieve their own ends that have nothing to do with an individual provider's conscience, but the same kinds of social pressures exist more implicitly on many fronts.

The social and political context shapes not only the practice of CO, but also attitudes about women, their health needs, their status vis-à-vis the church and the role of abortion in women's lives. For example, a core tenet of Christian thought is that sex is procreative and physical pleasure is sinful; this basic orientation shapes the church's views of sexual behavior, its enforcement of behavior, and women's access to reproductive health care such as abortion (Delamater 1981). These same patriarchal forces underlie how we think about and practice CO. They constitute what anthropologist Laura Nader defines as controlling processes: "the mechanisms by which ideas take hold and become institutional in relation to power" (1997). Indeed, CO is only legible as a socially understood phenomenon: it only becomes acceptable to have a conscientious objection to providing a healthcare service when it is socially understood as controversial. Not only do these forces create a place for conscientious objection, but they help shape what we think a fair "balance" between patients and providers means, even as they delegitimize abortion. They are the more powerful because of how far in the background they are, and thus how natural they seem.

What does it mean to consider oneself a conscientious objector in a healthcare institution that is already strongly anti-choice – whether according to policy, as with Catholic hospitals, or informally, as in a public hospital with an anti-choice administrator? What about if the reason a clinician hesitates to provide abortions is because she has not received adequate training, which may in part be due to administrators and educators' beliefs about abortion (De Zordo and Mishtal 2011)? What is there to object to if the healthcare system has already "objected" to abortions in the place of its providers?

Thus our conceptualization of CO should be seen not only as emerging from debates about religious freedom and provider duties, but as rooted in a strong tradition of patriarchal control over women's bodies that have long operated through religion. As Christian feminist ethicist Beverly Wildung Harrison notes, "much discussion of abortion betrays the heavy hand of misogyny, the hatred of women… [T]he Christian ethos is the generating source of the current moral crusade to prevent women from gaining control over the most life-shaping power we possess" (1983). Social forces thus complicate and problematize the meaning of CO even as they shape it.

Further, it is important to recognize that abortion and CO policies themselves are constructed in the same political and social environment that shapes the practice of CO. This is clearly shown in the lack of support for conscientious provision – providers who are motivated to provide abortions when their patients need them because of their core moral or religious beliefs (Harris 2011, Sepper 2012). Conscience clauses in large part only protect refusal to provide care. Providers in Catholic hospitals who feel a conscience-based duty to provide abortions – especially in emergency situations – do not have conscience-based protection (Sepper 2012). This inequity reveals how our understanding of conscience is shaped by the contextual factors. In addition, several US laws about conscientious objection do not require providers to counsel patients on all of their options, or to refer patients. This is a significant removal of provider responsibility, and it suggests that these CO laws are being used to further restrict abortion (Sepper 2012).

The stakes

CO policies can be under-defined and under-regulated, and the social and political environment can affect the practice of CO in ways that are often not taken into account by CO policies. All of this has effects for women, healthcare providers, and the health system as a whole (Chavkin 2013).

When many doctors are conscientious objectors, or when they don't counsel or refer appropriately, conscientious objection becomes a barrier to accessing safe abortions. This affects women, providers and health systems (Chavkin 2013). Women who are turned away without prompt referral may obtain abortions at later gestational ages, which are more expensive and carry more health risks; they may seek unsafe abortions, risking morbidity or death, or may carry pregnancies to term against their wishes. According to the most recent estimates, 13% of maternal mortality worldwide is due to unsafe abortion, resulting in 47,000 deaths per year (WHO 2008). Women turn to unsafe abortion because of a variety of barriers including cost, transportation, and distance, but the abuse – and sometimes simply the legitimate practice – of conscientious objection is often part of the problem, and it compounds other barriers that are already at play.

The impact for women is particularly concerning from an equity perspective. Women who seek abortions already tend to be among the more vulnerable in society, as many have poor access to contraception or lack control over their reproductive lives (Finer 2011). CO is primarily a barrier for those who are already the most vulnerable, and who have the fewest resources – the women who may not be able to take time off work or afford transportation for a second appointment, or are already dealing with too many burdens to find another provider if the objecting provider puts patients through administrative hassles or does not set up referrals.

The abuse of CO also has effects for clinicians. When many clinicians do not provide abortions, those who do have increased workload and are subject to more visibility and stigma as an abortion provider (Chavkin 2013). They are more susceptible to burnout for these reasons. In addition, healthcare systems must absorb the cost of later abortions and unsafe complications of abortions (Chavkin 2013).

It is imperative to know how many preventable deaths occur due to CO. But what even counts as CO, which providers in which contexts identify as CO, what providers believe, and what they actually do, must be studied before we can understand the role that CO plays in turning women away from safe abortions. The bottom line is that we don't truly

know what's at stake – or the magnitude of the stakes – because there isn't enough research about how conscientious objection operates in practice, or about the effects described above. What we do know is that in many contexts in which abortion is legal, the vast majority of abortions still take place outside the healthcare system because of the many barriers to abortion (Prada 2011, Harries 2014). Among barriers to abortion access, CO is particularly significant because it is sanctioned by law. This makes it even more important to understand what occurs in practice, and whether policies and regulations are adequate.

Ways forward

In their 2014 article, Fiala et al. discuss many of the same issues – lack of clarity in policies, abuses of CO in practice – and conclude that CO is inherently, irredeemably flawed. They advocate for abolishing the practice of CO and changing the term to "dishonorable disobedience" to emphasize that the act of objection is an inappropriate abdication of responsibility by clinicians. While I agree with many of their observations regarding how CO can be misused, I do not think that these abuses are inherent to CO. Rather, they are encouraged by the specific ways that laws are formulated and regulated, as well as the political and social contexts in which the objection occurs. They are not irredeemable if the context can be ameliorated. A contextual perspective not only helps make sense of how CO is currently practiced; it can provide insight into ways to reduce the abuse of CO.

As a first step, more information about CO is sorely needed. Policymakers, public health planners, and other stakeholders have far too little data on CO and its effects. One of the first steps is to gather information about prevalence of conscientious objectors in various countries, in order to understand the magnitude of the issue. However, given the complexities of the practice of CO, the single question of whether a provider self-identifies as a conscientious objector would not give a full picture of the prevalence of conscientious objection. (Even though this data alone would be an improvement on the current state of knowledge about CO in most countries).

In light of the issues brought forward in this literature review – as well as the formative research I undertook for this thesis, described in the subsequent chapter – I propose a three-domain model of conscientious objection: self-identification as a CO, beliefs about abortion, and actions related to CO and abortion. *Self-identification* is whether a provider calls him or herself a conscientious objector. *Beliefs about abortion* refers to whether a provider is morally opposed to no abortions, some abortions, or all abortions and whether the decision to refuse to provide abortions stems from political, moral or ethical foundations or from other sources. *Actions related to CO and abortion* include whether a provider never, sometimes or always performs abortions; what determines whether the provider does or doesn't provide abortions; and whether the participant counsels and refers appropriately. These three domains all are implicitly assumed to align in CO policies, but they may differ in practice. I discuss the model further in the second chapter of this thesis.

In researching CO we also need to gain a better understanding of how providers and administrators view conscientious objection, how it operates within a social context, and its effects on women. With this information in hand, stakeholders can begin to more accurately guide and shape policies and practices to address the realities on the ground.

In addition to research, clearer CO policies and regulations are sorely needed. Importantly, regulations about CO should not punish providers or force them to choose

whether to be a CO without proper knowledge, training and facility-level support for abortion provision. In fact, policies in the absence of such support could dramatically reduce access to abortion provision by forcing providers who currently operate in a gray area of providing some abortions to instead provide no abortions. Instead, regulations should seek to create more feasible opportunities to provide abortions for those who want to – for example, by addressing basic working conditions and reducing abortion stigma. Equally important, policies should encourage and enable providers who are morally opposed to abortions to practice *true* conscientious objection and not obstruction. This involves not only making the regulations themselves clearer (i.e. specifying that nonbiased counseling on all options is mandatory) and encouraging protocols at facilities to help implement them, but pursuing complementary strategies to address the environment as a whole.

One of these complementary strategies is including meaningful trainings about abortion and conscientious objection into pre-clinical education and in-service training. This factual information should also include training on human rights, medical ethics, and provider duties, as well as personal opportunities for values clarification.

The solution cannot only be to better or more clearly regulate CO itself. Policymakers must also try to create a more enabling environment for abortion provision within practice of medicine, and holding meaningful trainings on patient rights, human rights, and medical ethics. Unfortunately, these strategies are the most feasible to achieve in cultural settings that already have the least stigma and opposition to abortion provision. The role of pro-choice activists is to pressure politicians and try to change the culture – no easy feat, but a worthwhile effort.

Conclusion

Bioethical literature describes conscientious objection as a balance between a provider's capacity as a moral agent, with responsibility to her or his own integrity, and the provider's capacity as a professional agent, with responsibilities to patients. This calculus misses that the provider is also a social and political agent, responding to social and political pressures. Policies about conscientious objection are often unclear and under-defined. They usually fail to take these pressures into account, and are themselves created within similar pressures. In practice, divergences from CO policies by clinicians and health administrators have significant consequences for the wellbeing of patients and their providers. Abuses of CO are most impactful for women with least resources, increasing inequity in reproductive health. Further, they undermine the legitimacy of conscience as something worth protecting. Conscience is worth protecting, but must be protected in a meaningful way, and the protection of conscience can only be meaningful in an environment that enables abortion provision.

Developing a survey instrument to measure prevalence

Introduction

Conscientious objection to abortion (CO) is defined as a clinician's refusal to perform abortions because of personal religious or moral beliefs. The practice has generated heated debate about how religious freedom intersects with abortion access (Charo, 2005; Wicclair, 2011), and has been regulated in various policies, jurisprudence and guidelines around the world (Chavkin, 2013). Most policies require that conscientious objectors counsel women on all pregnancy options including abortion, and that they refer women seeking abortions to willing providers (Chavkin, 2013). Policies differ on whether health facilities can be exempted from providing abortions via claims of conscience, and on other aspects of conscience-based objection.

The scope and practice of conscientious objection have important consequences. The recent white paper on conscientious objection-related medical and public health literature by Global Doctors for Choice (GDC) posited that CO affects clinicians, patients, and health systems (Chavkin, 2013). The objection of some clinicians may increase workload for clinicians who do provide abortions (Chavkin, 2013). It also subjects abortion providers to more visibility and stigma, likely increasing their risk of burnout (Chavkin, 2013). CO affects patients by creating barriers to abortion access when objectors refuse service, especially when they don't counsel or refer patients appropriately. In some settings, patients who are denied abortion care due to CO may seek unsafe abortions instead, contributing to the more than 44,000 abortion-related deaths that occur each year (Chavkin, 2013; Kassebaum, 2014). CO likely presents the largest barrier for patients who don't have time or money to obtain another medical appointment with a provider; this increases inequity in reproductive health and rights. Finally, CO affects healthcare systems that must absorb the cost of later abortions and unsafe complications of abortions (Chavkin, 2013). It is thus critically important to assess the prevalence of CO and to understand more about how CO works in practice.

In contrast to the substantial bioethical and legal literature, and despite its importance, relatively little is known about conscientious objection from a public health and medical perspective. The handful of studies on prevalence that exist globally have found that between 14% and 80% of clinicians refuse to provide legal abortions (Chavkin et al, 2013). As discussed in the previous chapter, qualitative work has revealed complexity and variation in how clinicians understand and practice CO, including lack of clinician knowledge about abortion and CO laws, lack of clear protocols at an institutional level, and clinician deviation from CO policies (Harries, 2014; Fiala, 2014; Diniz, 2014; Aniteye and Mayhew, 2013).

Global Doctors for Choice (GDC) is an international network of physician-activists committed to promoting exchange, support, and collaboration among physicians around the world so that they can actively work toward ensuring that all people have the information, access to high quality services, and freedom of choice to make their own reproductive health decisions. GDC physicians called for more research on CO as it increasingly became an issue of concern in member countries, and more rigorous and systematic knowledge about the phenomenon was needed. Although a few quantitative studies have assessed prevalence of self-identified conscientious objectors as one component of a larger survey, to our

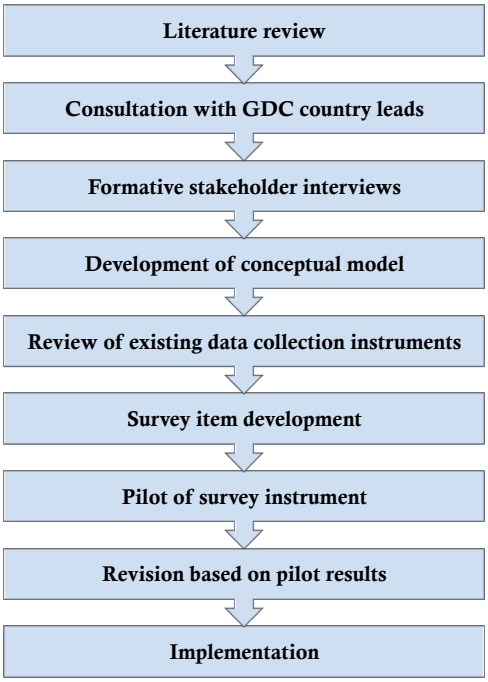
knowledge no quantitative survey instrument exists that focuses on CO. There is a need for a quantitative instrument that assesses the complexity of CO in clinical practice, because the practice and understanding of CO have implications for how it should be regulated.

To this end, with support from GDC, I (LH) developed a survey to measure the prevalence of CO and to give insight into how CO is practiced. The instrument can furnish data to inform effective and acceptable regulation of CO, for the benefit of patients, clinicians, and health systems. It was designed for multi-country usage, and was initially administered in Ghana by Global Doctors for Choice. This paper describes the survey instrument's conceptualization and development and discusses the strengths and limitations of the instrument.

Methods

Please see Figure 1 for an overview of the methods used to develop this instrument.

Figure 1: Process of survey development



Literature review

The literature review included original research, opinion, and bioethics articles published in peer reviewed journals, books, and newspapers, as well as unpublished work and gray literature. Literature on bioethical, policy, public health, and medical aspects of CO was included. Relevant literature on related subjects such as abortion stigma and the social and political context of abortion provision was also included.

GDC lead and co-lead physician consultation

LH spoke with GDC lead and co-lead physicians from four of the five GDC country action centers about the content areas of CO research that they thought were most important, how research could relate to their advocacy efforts, and their methodological and logistical considerations in conducting this research. These conversations and the literature review were used to design stakeholder interview guides.

Stakeholder interviews

LH conducted semi-structured, in-depth interviews with key stakeholders in Colombia, including objectors, providers, psychiatrists, activists, health administrators, and legal experts. Psychiatrists were included because when patients seek an abortion for mental health reasons, OB/GYNs sometimes request that psychiatrists affirm these patients' claims even though this second opinion is not needed according to law. Interviewees were recruited via email from the professional networks of Global Doctors for Choice/Colombia country lead and co-lead physicians. The respondents were purposively selected to ensure variation in profession, place of work, and known opinions about CO. Interviews were conducted in Spanish or English depending on the respondent's preference. Interviews conducted in

Spanish were facilitated by a Spanish language interpreter. Interviews were audio recorded and transcribed. Interviews differed from previous qualitative work on CO in that they involved multiple types of stakeholders, and in addition to exploring participants' views of CO and abortion they directly asked about respondents' perspective on issues associated with measuring CO. Transcripts were analyzed in NVivo using thematic analysis. This study received IRB approval from UC Berkeley (CPHS # 2014-03-6178), and all respondents gave verbal informed consent prior to being interviewed.

Development of conceptual model

A conceptual model of conscientious objection was formulated from the themes of the interviews and literature review. Domains for the survey were based on the conceptual model as well as themes from the interviews and literature review.

Review of existing data collection instruments

Survey instruments and interview guides from related fields and topics of study were collected for review. Research tools included instruments or portions thereof that accompanied published articles, instruments that were publicly available online, and unpublished instruments and guides used in both published and unpublished research (collected with authors' permission). 14 data collection instruments were included in the database. Instruments were in English, Spanish, French, and Portuguese. Six were close-ended survey instruments; eight were open-ended, in-depth interview guides. The tools were entered into a database for comparison, with emphasis placed on identifying phrasing that could be used for the present survey.

Survey item development

Items were developed within the survey domains based on interview and literature review findings. When possible, questions from other surveys were used as written or in adapted form, in order to maximize questions that had already been field-tested and validated, and to provide opportunities for comparisons between survey instruments. The survey was tested for face validity and comprehension with colleagues from the Upper East Regional Health Bureau in Ghana, who suggested some wording changes.

Pilot testing of survey instrument

The survey was piloted with doctors and midwives who were currently practicing in hospitals in the study area of three regions in northern Ghana. Pilot respondents were recruited in person from hospitals in the Upper East and Northern Region, both of which were part of the planned study area for eventual survey administration. Respondents were purposively selected for variation between clinician type (physicians or midwives) and ownership of health facility where employed (public, private, or Christian Hospital Association of Ghana). In Ghana, some midwives have received training in comprehensive abortion care (CAC); others have received other abortion training, might participate more peripherally in abortion services, or might not have received any training. Both CAC-trained and non-CAC-trained midwives were interviewed, in order to understand these differences and to determine whether non-CAC-trained midwives should be included in the study sample. Respondents completed the survey instrument via one of three methods: self-administration using a tablet, self-administration using paper, and administration via

interview by LH. After completing the survey, LH asked respondents open-ended questions about their thoughts on the survey's content and phrasing. These post-survey interviews were audio-recorded and transcribed. Transcripts were analyzed in NVivo using thematic analysis, and were triangulated with survey instrument responses. The pilot-test was covered under the same UC Berkeley IRB protocol, and all respondents gave verbal informed consent prior to participating in the pilot.

The survey instrument was modified based on results from the pilot study. A team of experts reviewed this modified instrument; their feedback was incorporated. As a pre-test, the modified survey was administered to a midwife who was working at a hospital in the survey area, to check comprehension of items. Small modifications were made to instrument wording based on the results of this pre-test.

Survey implementation

The survey was administered in Northern Ghana to 186 clinicians providing sexual and reproductive health services and trained to provide abortions: general physicians, OB/GYNs, CAC-trained midwives, and non-doctor, non-midwife clinicians who were trained in abortion (response rate of 94%). Analysis of survey data is pending.

Results

Literature review

The literature review, described in the first chapter, highlighted the potential for differences between CO policies and the practice of CO. To summarize, the review found that CO policies were often unclear in that they left key issues open to interpretation (Sepper 2012), and there was evidence of poor knowledge and/or understanding of CO and abortion policies among clinicians and health administrators (Voetagbe 2010). Further, the review found that contextual pressures can affect the practice and understanding of CO. High workload, low pay and disapproval from health administrators can discourage abortion provision (Harries 2014). As the only legal way to refuse to provide abortions, CO can become a safety valve for clinicians under pressure and may be used by clinicians who do not have moral or religious objections (Harries 2014). Social factors including stigma also shape the ways that stakeholders and policymakers approach CO (Faúndes 2012).

Stakeholder interviews

In Colombia, abortion was legalized in 2006 for rape or incest, fetal abnormality, and physical or mental health of the pregnant woman (Colombia Sentencia C-355/06). CO is a limited right; objecting clinicians must counsel patients on all options and refer to a willing provider (Colombia Sentencia T-209/08). Health facilities cannot claim consciences or conscientious objections; abortions must be available at an institutional level. Despite abortion's legal status the vast majority of abortions take place outside the legal health system (Prada 2011). Only physicians are authorized to perform abortions, and OB/GYNs perform most abortions. Abortion is strongly stigmatized, in part because of Colombia's Catholicism (Prada 2011).

Eleven interviews were conducted with a total of 13 respondents. Two of the interviews were conducted with two respondents; the paired respondents were colleagues in both cases. The 13 respondents consisted of three conscientious objectors (two OB/GYNs,

one generalist), three abortion providers (OB/GYN), two psychiatrists, two public health researchers, a constitutional court expert, a health administrator, and a reproductive rights activist. Analysis revealed the following themes:

Regulation vs. practice of CO

Interviewees thought that Colombia's jurisprudence related to CO had created a fairly strong and clear legal framework, but that CO practices varied by clinician and institution, and often differed from the practices mandated by policy and court decisions.

> *"Colombia is a country of laws, but they are not enforced,"* (OB/GYN, abortion provider, interview 1).

Further, laws did not translate into clear regulations at the clinical level. Speaking about the legal requirement that objectors refer patients to other providers, a respondent stated:

> *"None of this is regulated, so then we know that in practice, nothing happens. The doctor simply says to the patient 'I am an objector, so look for someone else.' It doesn't happen as it should,"* (Health administrator, interview 4.)

Several respondents mentioned that an unsupportive regulatory environment helped to enable these deviations between CO in law and in practice. For example, in Colombia the *procurador* is a civil office charged with ensuring health system and clinician compliance with the law; the current *procurador* is strongly pro-life:

> "[*The procurador's] personal agenda intersects with his public responsibility. It is very serious, because his office also has powers to investigate and dismiss public officials, and service providers. It is a very complex situation, because apart from the difficulties involved in changing [abortion] from a crime to a right and all that transition, providers are afraid to act, because of course, they are monitored by an entity that does not agree with this issue [of abortion],"* (Reproductive rights activist, interview 2).

Beyond laws and regulations, respondents discussed multiple ways that context affected the practice and understanding of CO. They characterized its practice as affected by contextual factors at all levels – from broad social views to health administration policies to institutional characteristics.

> *"[CO] mixes many things – it mixes psychological factors, social factors, religious factors,"* (OB/GYN, abortion provider, interview 9).

Respondents stated that CO would be difficult to isolate from these other factors.

While respondents considered most laws about abortion and CO to be adequate, regulation around gestational age and CO was considered problematic by several. There are no gestational age limits for abortion in Colombian law. CO is only considered legitimate if

a clinician objects to all abortions, not certain types. If a clinician is not a conscientious objector, he or she is considered responsible for providing abortions at all gestational age limits. Respondents stated that some clinicians claimed objector status even though they would be willing to provide earlier abortions, simply because they did not want to perform later abortions.

Beliefs related to CO

All respondents thought that beliefs about abortion, and motivations for refusal, were of central importance to CO. They described that stigmatizing or paternalistic beliefs could fuel clinicians' refusal to provide abortions, and all but one thought that these beliefs should be distinguished from conscience-based beliefs. That respondent – an objector – thought that clinicians' beliefs were not important as long as they self-identified as conscientious objectors and practiced appropriately.

> *"An objector says, "I will not perform [abortions]," based on whatever reasons that she has. Cultural, religious, philosophical, doesn't matter. But this is very different from denying patients their rights,"* (Generalist doctor, conscientious objector, interview 11).

Most respondents described skepticism about the basis for much of so-called CO, given that physicians faced multiple factors that discouraged performing abortions: training about abortion provision was often lacking, abortion providers face stigma, and a general culture of paternalism fed into the belief that it was proper for a doctor to influence reproductive decisions.

> "*Much of what we think of as in CO in Colombia is actually the ignorance of doctors, it's fear,*" (Health administrator, interview 4).

> *"It is easier to say no than to say yes. When you say yes, you are committing to many things. When you say no, you shut a door, and there, no one will bother you,"* (Generalist doctor, conscientious objector, interview 11).

Interviewees also consistently mentioned human and reproductive rights as important principles that influenced provision of abortion, as well as the proper exercise of CO in ways that would not affect abortion access. Conversely, lack of knowledge about human rights was considered to fuel improper use of CO.

> "*Few Colombian doctors know about human rights…this is a subject which is unfortunately not discussed in universities. Here there is much disrespect for human rights, and obviously the result are these doctors [who abuse CO],"* (OB/GYN who provides abortions, interview 1).

Actions related to CO

Interviewees recognized that actions were important, as well as beliefs.

> CO is *"not only about opinions, talk, saying 'I don't want to do this' or 'I don't agree'. It's also about behavior,"* (Public health researcher, interview 5).

Refusal to provide abortion was the primary action associated with CO, but counseling and referral were also mentioned. Respondents discussed how some clinicians would not counsel or refer patients appropriately, or would create unnecessary administrative tasks for patients who sought abortion. To respondents, these actions de-legitimized these clinicians' status as conscientious objectors, even if the clinicians identified as objectors and believed providing abortions was a sin.

> *"They [some physicians] try to hinder women from obtaining abortion. And they put up barriers and barriers and barriers. That to me is no conscientious objection. I think some of them consider themselves conscientious objectors, because of the simple fact that they think it is wrong to interrupt a pregnancy,"* (Health administrator, interview 4).

One respondent, a conscientious objector, stated that he was respectful of reproductive rights but that he would try to dissuade patients from obtaining abortions.

> *"Objecting doctors should simply ask the patient if she desires [an abortion] or not, and then send her to doctors who will do it, but in my case I try to dissuade them a bit because it shouldn't be done, in my religion,"* (OB/GYN who identifies as a conscientious objector, interview 9).

The other conscientious objectors did not comment on counseling.

Self-identification as CO

Most respondents thought that CO would be difficult to measure because objection means different things to different clinicians, and they thought that the concept was unclear to many clinicians.

> *"In reality, many who think they are conscientious objectors are unaware of the laws, unaware of abortion practices, unaware of women's rights, especially. When we talk to them and tell them what [CO] is, many of them understand that they are not conscientious objectors really, they simply don't know the law,"* (OBGYN, abortion provider, interview 1).

As described above, respondents described how clinicians might call themselves conscientious objectors, but act more as obstructers – for example, by not making a referral or setting up unnecessary administrative hassles. Additionally, respondents described how some clinicians call themselves conscientious objectors even though they aren't eligible to object. For example, secretaries might call themselves conscientious objectors if they refuse to schedule abortions, but Colombian policy states that only those who could perform abortions are able to claim conscientious objector status.

"Starting with administrative levels there are those who claim status as conscientious objectors, be they secretary, receptionist, or gatekeeper. Those levels of barriers arise long before the medical contact," (Health administrator, interview 4).

Finally, some respondents mentioned that there could be resistance to categorizing oneself either as an objector or as a non-objector due to different expectations at places of work.

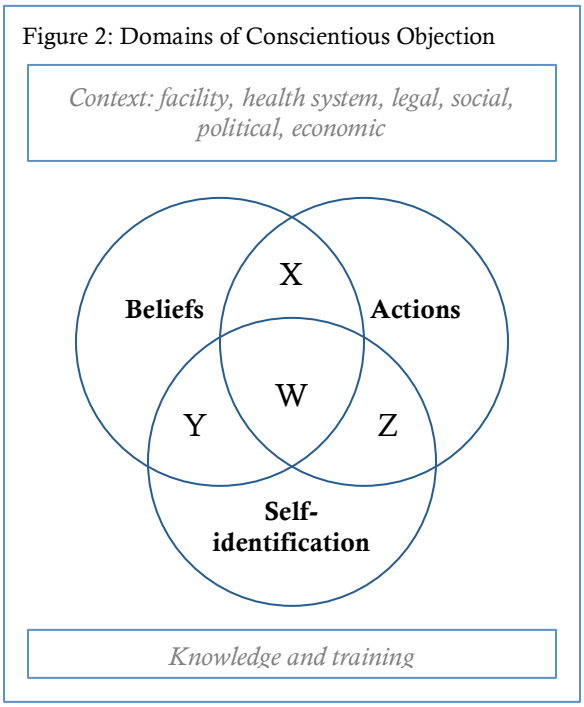
"Nobody wants to be identified as a non-objector or objector or because in the morning you can work in a religious institution, and in the afternoon [in a non-religious institution]. In order to manage the double work, nobody really wants to be identified as objector or not. It changes," (OBGYN who provides abortions, interview 1).

Conscientious objection: conceptual model

Based on the stakeholder interviews in Colombia and the literature review, LH developed a conceptual model of CO. This model posits three primary domains of CO: *beliefs, actions, and self-identification*. The domain *beliefs* includes whether a clinician is morally opposed to abortion, and related beliefs such as abortion stigma and reproductive rights. The domain *actions* includes whether a clinician performs abortions, whether the determining factor regarding provision is moral beliefs or other factors such as lack of training or protocols, and whether he or she counsels and refers patients appropriately. The domain *self-identification* is whether a clinician calls him or herself a conscientious objector.

The definition of conscientious objector – a clinician who does not provide abortions based on moral or religious beliefs – implicitly assumes that the three domains align for individuals who object (W, on diagram). However, they may not align in practice. A clinician may believe that abortions are morally wrong and refuse to provide them, but not identify as a conscientious objector because she is unfamiliar with this concept, or it is not how she thinks about herself (X). Alternatively, a clinician might identify as a conscientious objector and believe that providing abortions is a sin, but might be an obstructer of abortion access if he does not refer appropriately (Y). All three domains contribute to the understanding and practice of CO, but each domain has different implications for interventions about and regulation of CO.

Figure 2: Domains of Conscientious Objection



Prerequisites for the practice of abortion provision – or meaningful objection to it – are adequate training to provide abortions, and adequate knowledge of abortion and CO laws. Thus, assessing training and knowledge is

important in understanding prevalence. Institutional context also affects CO. Assessing clinician views about potential regulations of CO can also directly inform efforts to improve CO policy.

Creation of survey items

Within the domains, survey items were created based on the interview and literature results, using items from previously field-tested and validated survey instruments when possible. Items were used from three close-ended surveys: the Ghana Health Providers Survey component of an evaluation of the program Reducing Maternal Mortality and Morbidity (R3M), which included questions on abortion provision (Sundaram et al 2014, http://www.abortionresearchconsortium.org/extra/Ghana-Questionnaire.pdf); Stigmatizing Attitudes, Beliefs and Actions Scale (SABAS), a scale that measures stigmatizing attitudes, beliefs and actions of the respondent related to abortion, and was developed in Ghana and Zambia (Shellenberg et al 2014), and the abortion provider stigma survey (APSS), a scale that measures the stigma experienced by abortion providers and was developed in the United States (Martin et al 2014). The survey instrument is included in the appendix.

Pilot of survey instrument

Abortion in Ghana was legalized in 1985 for similar indications as Colombia: rape, incest or "defilement of a female idiot"; fetal malformations; or risks to the life or physical or mental health of the woman (Ghana Health Service 2012). However, widespread provision started as recently as 2006, when the Ministry of Health and Ghana Health Services released guidelines that operationalized safe abortion provision. Doctors and CAC-trained midwives are authorized to provide abortions. As in Colombia, CO is a limited right; according to the Ghanaian Standards and Protocols, clinicians who object must counsel patients on all pregnancy options including abortion, and must refer patients to a willing provider. Maternal death is the second most common cause of death for women in Ghana; unsafe abortion is responsible for 11% of maternal deaths (Guttmacher 2011).

The nine interview respondents consisted of two doctors and seven midwives who were offering sexual and reproductive health services at hospitals the study area, and who thus would have been eligible to take part in the study. More midwives than doctors were interviewed because of the small number of doctors in the recruitment region, which would eventually be used for the study. Three of the seven midwives were CAC-trained. Practitioners worked at five hospitals: one MD and one midwife worked at a CHAG hospital; one midwife worked at a private hospital, and the other respondents worked at three different public hospitals. Four of the nine providers did not want the post-survey interview to be audio-recorded; notes were recorded about these interviews instead. Interviews lasted between 15 and 30 minutes, with additional conversation occurring during the survey administration.

Overall, respondents said that the domains and survey items were relevant to the concept of CO, although most said the survey took too long. The subsequent themes are those that differed from the Colombia interviews and that added nuance to the conceptual model of CO.

Framing abortion as safe/unsafe, rather than legal/illegal

Most respondents spoke about "safe vs. unsafe" as the major distinction between abortions, whereas Colombian respondents spoke often about "legal vs. illegal" abortions as well as "safe vs. unsafe". Most Ghanaian respondents said they lacked clarity about abortion law and CO policies, but all had vivid understandings of the health consequences of unsafe abortion – most from personal experiences caring for patients facing post-abortion complications or death. Clinicians' focus in terms of abortion counseling, provision, and referral was whether the woman was likely to seek an unsafe abortion.

> *"[Whether abortion is provided] depends on the reason they give. If it is convincing enough then you do it and if you think that if you don't do it the person can end up doing something unsafe to cause her death then you do it for them,"* (midwife who provides abortions, interview 7).

> *"When you have a law that is so loose such that you can always find a reason around the law to carry out the process then it looks like there is literally no law. And you have people carrying out the procedure in so many places and they come in here complicated. Personally, my reason for carrying out abortion will be if I don't do it for her she is going out to see a quack who will have it done,"* (doctor who provides abortions, interview 8).

For most respondents, abortion seemed to be important primarily because it was a means to prevent maternal mortality, rather than because of principles such as reproductive rights or patient autonomy. It seems as though most respondents who provide abortions take a harm-reduction approach to abortion provision: whether or not the respondent thinks an abortion is legal or moral, if the woman going to have an abortion it should be safe.

Counseling vs. provision

According to most CO policies, including Ghana's, an objector is expected to exercise his or her conscience through refusing to perform abortions, but must provide unbiased counseling. However, some respondents' expression of conscience was through biased counseling rather than provision: they would provide abortions that they considered immoral if they were worried about the patient seeking unsafe abortion, but would do their best to dissuade patients who they thought were unsure about their decision. This theme was much more pronounced than it was in Colombia.

For example, when discussing the survey item *have you ever refused to provide a legal abortion (*a Yes/No question), one respondent stated, "well, I don't refuse totally" – and explained that she would provide if she couldn't convince the woman to keep her pregnancy. However, this respondent identified herself a conscientious objector, although she was only "somewhat clear" about whether she fit this definition (midwife, interview 6). Prior interviews with Ghanaian clinicians have found similar patterns: "Midwives in particular shaped the content of their counseling as a way of 'coping' with the professional need to counsel which conflicts with their religious beliefs that abortion is a sin," (Aniteye and Mayhew; 2013).

Moral beliefs and stigma

Most respondents were highly religious, and most provided abortions. These clinicians reported that their religion looked negatively on abortions, but separated their religious and professional identity.

> *"Religion can't taboo [abortion provision] – it's my work,"* (midwife who provides abortions, interview 4).

However, some clinicians' moral beliefs about abortions seemed highly connected with stigmatizing beliefs. For example, one clinician marked on the survey that religious/moral beliefs were the reason she did not perform abortions for some indications. During the post-survey interview, she clarified that women should use family planning instead of becoming pregnant because it is easily available, and said that sometimes she wouldn't perform abortions for or refer some women as "punishment" because they ought to have known better. When this clinician referred to her "moral beliefs", she wasn't speaking about her moral beliefs about her personal involvement in providing the abortion or not, but a moral judgment of others. It appeared that stigma interacted with moral beliefs by shifting the moral calculus - i.e. it is acceptable to not provide abortion for this woman because the pregnancy was her fault, or because she would be able to parent.

Clinician reactions to the instrument:

Most respondents said that they had learned new things from the survey or that it had refocused their thinking about CO, counseling, and abortion provision. According to one respondent,

> *"[The survey] wants to find out our approach towards people who come to seek for help concerning abortion. I think it is a good thing because we haven't actually thought about that for a long time as to whether or not the person believes in it, though some object when they come but we haven't really taken it so serious,"* (midwife who provides abortions, interview 1).

Some respondents said that the survey would not change the way they practiced; others said it would. Respondents said that they would like to receive information about CO and abortion law after taking the survey.

Based on these results the conceptual framework and survey items were revisited and the survey was shortened. The revised survey was pilot tested with one midwife in Ghana, and was revised to clarify wording.

Discussion

The literature review and interview results were used to develop a conceptual model of CO and survey instrument to measure CO's prevalence and furnish information about its practice. The instrument was created to reflect the three domains of action, belief, and self-identification. The instrument is not intended to be analyzed as a scale; the three different domains of CO should each be considered in their own right. The instrument also includes sections on training, knowledge about CO and abortion law, and on opinions about potential policies to regulate CO. The data from this instrument can be used to deepen understanding

of CO; to inform policy, advocacy and public health strategies; and to understand how clinicians might respond to regulations around CO.

Nuanced and varied rationales for CO

In most policies, CO is defined as objection that stems from moral, religious or ethical beliefs. This simple statement belies the complex and varied set of factors that clinicians consider when deciding whether they identify as conscientious objectors. Interview findings suggest significant variation – between individuals, and between cultural contexts – in how morality is conceptualized in relation to medical practice. The extent to which morality is intertwined with stigma and judgment seems particularly striking in this regard. Further, CO is derived from a Western bioethical framework, and is usually understood as a balance between individual liberties: of the clinician, and of woman to determine her reproductive fate (Wicclair 2011). While this framing is implicit in the policies of countries around the world, as well as the guidelines of some international organizations, clinicians from non-Western countries may not share this lens. For example, some respondents valued abortion primarily as a means to prevent maternal mortality rather than a means to ensure reproductive rights. Additionally, some respondents thought of medical work as entirely separate from their personal moral or religious belief system.

The survey includes items about the respondents' perspective on stigma, reproductive rights, and similar issues, in an effort to probe for some of these nuances. However, a quantitative instrument will be unable to capture many of the variations and nuances found in the interviews.

Qualitative work

Quantitative data is useful in understanding the magnitude of CO and major trends in the way that it is practiced. However, given complexity of the subject, this survey should be paired with qualitative research to understand the connections between the concepts. This qualitative work can help to validate findings or suggest improvements for future iterations of the survey, and can give insights on the conceptual model's strengths and limitations.

Other strategies for validation

The abortion field has too few survey instruments with transparent, validated development processes. More insight will be gained on this instrument once its results have been analyzed, and there will be complementary qualitative work done in the study area to contextualize findings. Further work should be done to validate this survey, and to investigate capacity for translation into other settings. However, validation is challenging because the very concept of CO is still under-theorized. For example, one strategy for validation could be to pair this survey with the full SABAS (Stigmatizing Attitudes, Beliefs and Actions Scale) and assess overlap. However, a high degree of overlap might have multiple interpretations. It could be seen to imply that the CO instrument is mistakenly assessing abortion stigma instead of "true" CO, or could be taken to indicate that stigmatizing beliefs and CO do indeed have a great deal of overlap, as was discussed in several interviews.

Administration of instrument in other settings

The survey was developed in Colombia and piloted in Ghana – two countries with different contexts for CO. For example, legal regulations are more elaborated in Colombia. Maternal mortality and morbidity are higher in Ghana. While it seems reasonable that basic domains of the conceptual model – actions, beliefs, and self-identification – would be relevant everywhere, the domains may look very different in different places, and some

items may need to be adapted. The different contexts of the interview and pilot sites may help increase the likelihood that the instrument's items are more widely applicable, but this may not be true for every context. Additionally, the most contentious CO-related issues in Ghana and Colombia seemed to arise from the interface of abortion and CO policies, and these policies' interactions with social opinion and clinical environment. These factors are each likely to differ between contexts, which amplifies differences in their interactions. Gestational age was one example of difference; many Colombia respondents characterized it as a major point of tension in abortion provision and CO, while few respondents mentioned it in the Ghana pilot.

Because of these differences, we recommend that the instrument be adapted based on formative qualitative research in the area of interest if possible, or at minimum with the consultation of local stakeholders who are familiar with CO in policy and practice, and the major issues related to CO in their particular context. Adaptations of the survey should be particularly attentive to local CO-related policies and jurisprudence, and their potential effects on practice.

Pedagogical implications

The survey may function as a values clarification exercise for some respondents. If most or all clinicians on a unit take the survey at the same time, it presents an opportunity to start a unit-level conversation about CO from a more informed position – all the more so if clinicians are presented with a fact-sheet afterwards. However, it is important to note that taking advantage of the pedagogical opportunities may change the very phenomenon that the survey is measuring. Once clinicians gain more understanding of CO, they may change their minds about whether they identify as objectors or not. This survey instrument attempts to gain an estimate of CO from at least minimally informed clinicians.

Political implications

Attention should also be given to the instrument's potential political implications. For example, the respondent pool for this instrument has been restricted to clinicians who are trained to provide abortion. While useful knowledge might be gained from surveying professionals who cannot legally be conscientious objectors, such as psychiatrists or medical secretaries in most countries, doing so may imply that it is legitimate for these professionals to conscientiously object.

Some researchers may have concerns that simply administering the survey might change respondents' behavior – perhaps in ways that reduce abortion access. For example, the survey might induce clinicians who had not previously considered or been aware of CO to take advantage of this legal option. Of special concern is the study's potential to polarize the situation around CO. For example, several interviewees and pilot participants stated that some survey respondents may have difficulties identifying themselves as conscientious objectors – if they work at a Catholic hospital they may 'need' to identify themselves as a conscientious objector, and then if they do other work elsewhere they may be able to perform abortions there. Requiring a firm declaration may push them towards one side or another, and they may choose to identify as a conscientious objector because it is less politically fraught. This identification could potentially influence their actions in the clinic.

We contend that it is worthwhile to gain more information about the practice of CO despite the potential for changes in behavior. Refusals to provide legal abortions happens in most contexts, and if clinicians aren't aware of the right to conscientiously object then they also aren't aware of its limits. Further, it is ethical to make clinicians aware of the range of

practice options available to them, including CO. The survey should be administered in the context of appropriate complementary education that underscores the importance of CO's limited scope. The survey instrument asks questions about CO and abortion policy, and can be followed with a fact sheet of country or region-specific "answers" to these questions.

Strengths of the development process

This is the first quantitative instrument of which we are aware that assesses CO in a robust manner. The development process benefited from the feedback from the GDC team, and a variety of perspectives from expert stakeholders to thesis advisors. There was breadth in the locations and perspectives considered in the interviews and pilot, although this meant that there was not as much depth in any single location. A challenge of the development process has been to isolate CO from the many other factors that affect abortion provision, while still assessing contextual factors as needed because CO does not operate in a vacuum. It is hoped that attention to this challenge throughout the development process has resulted in a survey instrument that balances these aims.

Asking about the CO within the context of a specific measurement project had pros and cons. One potential drawback is that respondents may have been too focused on measurement, and might not have spent as much time as they otherwise would have on talking about the concept of CO, which would not have allowed for as deep a look into the phenomenon in all its forms. On the other hand, speaking directly about measurement allowed for an interesting way to ask again "what *is* CO," in its essence. Enlisting the respondents' collaboration in distilling the concept of CO for the purposes of measurement was another way for them to clarify and express their thoughts about it. Often, questions about measurement would lead back to fruitful discussion about scope of CO. Moreover, the instrument development process furnished a conceptual model of conscientious objection that may be useful for research beyond the specific survey instrument.

Limitations of the survey

A quantitative survey about CO is necessarily limited in several ways. According to respondents, some important aspects of CO are unlikely to be captured directly through a self-reported survey instrument. For example, some providers may identify as objectors in some practice settings but not others – they may identify as an objector in a public institution but provide abortions in their private practice. These types of deviations from policy are unlikely to be disclosed by respondents because of social desirability bias. Additionally, objection can occur at many stages before abortion provision: for example, a clinician who harbors negative views towards abortion may refuse to participate in abortion training or simply not seek it out, she may choose to work at a hospital that does not provide objections per policy; she may instruct secretaries not to schedule appointments with patients who seek abortion; she may put patients through administrative hassles rather than denying them abortions outright; and/or she may effectively remove herself from participation in abortion without actually refusing. The instrument could not reasonably ask about them all due to length as well as concerns with social desirability bias.

Further limitations were introduced by the instrument's development process. Only one person (the interviewer) analyzed the formative interview data and the pilot data. However, there was feedback at key points from the GDC team working on the study. Another limitation was that the respondents in Colombia were all professional contacts of the GDC country lead physicians. This recruitment method meant that even the conscientious objectors were more likely to recognize the importance of reproductive rights,

which limited the range of viewpoints considered in the study. During the pilot in Ghana, the same person administered surveys and conducted post-survey interviews. This may have increased social desirability bias from the respondents, leading them to give more favorable reviews of the survey and to be more reluctant to discuss aspects that they found were lacking.

As discussed earlier, the survey instrument is not validated, and should be validated through future work.

Conclusion

Measurement of CO deepens understanding of this complex phenomenon. Moreover, it is a necessary part of formulating effective regulations that protect both reproductive rights and clinicians' beliefs. CO is under-theorized and under-researched. More qualitative and quantitative work is needed to understand how CO operates and is understood by clinicians. It is hoped that this survey will be useful to those who seek to measure and understand CO.

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Supplementary material: Survey instrument

TITLE: Prevalence of conscientious objection to legal abortion among clinicians in Northern Ghana

Thank you for filling out this survey. We value your opinions and are interested in hearing what you think. There is no "right" answer for many of these questions, so please answer from your own knowledge and opinions to the best of your abilities. Moreover, please be assured that your responses are confidential.

Section 1: Demographics

1.01 Are you:
- ☐ Male
- ☐ Female

1.02 How old were you on your last birthday?_____ (years)

1.03 What is your title at this hospital?
- ☐ Ob/Gyn
- ☐ Medical Officer
- ☐ Midwife, trained in Comprehensive Abortion Care
- ☐ Midwife trained on the job in abortion care
- ☐ Other (please specify) _____

Section 2: Training and provision

2.01 Please mark whether you have been trained to perform the following types of abortion:

Type of abortion	**Yes**	**No**
Medication abortion (with misoprostol or mifepristone/misoprostol)	□	□
Manual and/or electric vacuum aspiration	□	□
Dilation and Curettage (D&C)	□	□

2.02 Up to what gestational age were you trained to provide abortions? _____ weeks

2.03 Have you ever been selected for an abortion-related training but not participated?
- ☐ Yes
- ☐ No →***skip to 2.05***

2.04 If you were selected for an abortion-related training but did not participate, why not? (**Check all that apply.)**
- ☐ Training time didn't fit with my schedule
- ☐ Providing abortions is against my moral or religious beliefs
- ☐ Fear of being stigmatized by my colleagues

- ☐ Fear of administrators/management' disapproval
- ☐ Fear of my family's/community's disapproval
- ☐ Not wanting to add another responsibility to my workload
- ☐ Not interested in providing abortion
- ☐ Other (please specify) _____

2.05 Have you ever personally provided an abortion?

- ☐ Yes
- ☐ No→***skip to 2.07***

2.06 Do you personally currently provide any abortions in this hospital?

- ☐ Yes
- ☐ No

Please indicate what you personally would do in the following clinical scenarios:

Scenario 1 At your current job, you see a patient who is 17 years old, pregnant, and does not want to keep the pregnancy because she is worried that she will not be able to continue her studies if she has a baby.

2.07 Do you counsel her on all options regarding the pregnancy, including abortion?

- ☐ Yes
- ☐ No

2.08 Do you try to convince her to keep the pregnancy?

- ☐ Yes
- ☐ No

2.09 After counseling, this patient wants an abortion. Do you perform the abortion?

- ☐ Yes→***skip to 2.11***
- ☐ No
- ☐ Not sure

2.10 If no or not sure, which factors contribute to your response?

	Not at all	**Somewhat**	**A great deal**
a) My personal religious or moral beliefs about abortion	□	□	□
b) The patient should have known better	□	□	□
c) My hospital administration does not support abortions	□	□	□
d) I am worried that my family or community would disapprove	□	□	□
e) Other (specify)_____	□	□	□

_	

2.11 If you do not provide the abortion, do you refer to a clinician who will provide one?

- ☐ Yes
- ☐ No
- ☐ Not sure

Scenario 2 You see another pregnant patient who is 33 years old, does not want to be pregnant and has pulmonary hypertension, which has a 50% mortality rate during pregnancy.

2.12 Do you counsel her on all options regarding the pregnancy, including abortion?

- ☐ Yes
- ☐ No

2.13 Do you try to convince her to keep the pregnancy?

- ☐ Yes
- ☐ No

2.14 After counseling, this patient wants an abortion. Do you perform the abortion?

- ☐ Yes→***skip to 2.17***
- ☐ No
- ☐ Not sure

2.15 If no or not sure, which factors contribute to your response??

	Not at all	**Somewhat**	**A great deal**
a) My personal religious or moral beliefs about abortion	□	□	□
b) The patient should have known better	□	□	□
c) My hospital administration does not support abortions	□	□	□
d) I am worried that my family or community would disapprove	□	□	□
e) Other (specify)_____ _	□	□	□

2.16 If you do not provide the abortion, do you refer to a clinician who will provide one?

- ☐ Yes
- ☐ No
- ☐ Not sure

Scenario 3: You see another patient, a 25-year-old woman who has become pregnant as the result of rape.

2.12 Do you counsel her on all options regarding the pregnancy, including abortion?
- ☐ Yes
- ☐ No

2.13 Do you try to convince her to keep the pregnancy?
- ☐ Yes
- ☐ No

2.14 After counseling, this patient wants an abortion. Do you perform the abortion?
- ☐ Yes→***skip to 2.17***
- ☐ No
- ☐ Not sure

2.15 If no or not sure, which factors contribute to your response??

	Not at all	**Somewhat**	**A great deal**
a) My personal religious or moral beliefs about abortion	□	□	□
b) The patient did not provide evidence for rape	□	□	□
c) My hospital administration does not support abortions	□	□	□
d) I am worried that my family or community would disapprove	□	□	□
e) Other (specify)_____ __	□	□	□

2.16 If you do not provide the abortion, do you refer to a clinician who will provide one?
- ☐ Yes
- ☐ No
- ☐ Not sure

2.17 Do you know of a clinician to whom you can refer patients for abortion?
- ☐ Yes, in this facility
- ☐ Yes, in another facility
- ☐ No

2.18 Until what gestational age do you perform abortions? _____ weeks

2.19 Why is this the latest gestational age you perform abortions?
- ☐ I was only trained to provide abortion services up to this gestation
- ☐ It is against my moral or religious beliefs to provide abortion past this gestation
- ☐ Other (specify)_____

2.20 Have you ever advised a woman to take misoprostol and then seek postabortion care?
- ☐ Yes
- ☐ No

2.21 Have you ever refused to provide abortions at one facility, but provided them in another?
- ☐ Yes
- ☐ No

Section 3: Perspectives

3.01 Are you uncertain about the circumstances under which you can legally provide abortion?
- ☐ Yes
- ☐ No

3.02 Are you uncertain about how to perform a safe abortion?
- ☐ Yes
- ☐ No

3.03 Please indicate whether you personally disagree with, have mixed feelings about, or agree with the following statements.

	Disagree	**Mixed feelings**	**Agree**
a. The needs of a patient are more important than the beliefs of a clinician.	□	□	□
b. Clinicians have a responsibility to counsel patients against having an abortion.	□	□	□
c. Every woman has the right to access safe abortion to the full extent of the law.	□	□	□
d. Providing abortions is a positive contribution to society.	□	□	□
e. I feel that providing abortions is morally wrong.	□	□	□
f. I feel guilty about providing abortions.	□	□	□
g. I do/would worry about telling people that I provide abortions.	□	□	□
h. A woman who has had an abortion brings shame to her family.	□	□	□
i. A woman who has an abortion is committing a sin.	□	□	□

	Disagree	Mixed feelings	Agree
j. The later the gestational age, the more sinful the abortion.	□	□	□
k. I would continue to be friends with someone if I found out that they had an abortion.	□	□	□
l. Most abortions could be provided under the legal ground of "mental health".	□	□	□

Section 4: Policy

4.01 Please mark whether abortion is legal or illegal in Ghana in the following cases:

In the case of…	Legal	Illegal	Don't know
Rape	□	□	□
Incest	□	□	□
Serious fetal malformations	□	□	□
Risk to woman's life	□	□	□
Mentally impaired woman	□	□	□
Risk to psychological health of woman	□	□	□
Risk to physical health of woman	□	□	□
Socioeconomic grounds	□	□	□
Under any circumstances	□	□	□

4.02 Sometimes clinicians who are trained to provide abortions refuse to provide abortions because of their religion or their moral beliefs. Such refusal is called conscientious objection, because they are *objecting* to providing a medical service because of their *conscience.* Have you heard about conscientious objection?

- ☐ Yes – I have heard about the term
- ☐ Yes – I have heard about the idea, but not the term
- ☐ No – I have not heard about the idea or the term → ***skip to 4.04***

4.03 In what settings have you learned about conscientious objection to abortion provision? **(Please check all that apply)**

- ☐ Pre-service education
- ☐ In-service training session
- ☐ From supervisors/management
- ☐ From colleagues
- ☐ Religious organization (e.g. Church, Christian association, Mosque)
- ☐ Other (specify) _____
- ☐ I have not received education about conscientious objection

4.04 The following statements present different aspects of conscientious objection. For each, please indicate whether or not the statement is currently true according to the Ghanaian Standards and Protocols, **and** whether or not you think it should be true. Remember we are interested in knowing your personal opinion.

	The case in Ghanaian Standards & Protocols?			**Do you think it should be the case?**	
Aspect of conscientious objection	**Yes**	**No**	**Don't know**	**Yes**	**No**
Clinicians who conscientiously object must counsel patients with unwanted pregnancies on all of their treatment options, including abortion.	□	□	□	□	□
Clinicians who conscientiously object must refer patients eligible for a legal abortion to a clinician willing to provide it.	□	□	□	□	□
Only a clinician who would be performing the abortion is eligible to conscientiously object – i.e. secretaries, assistants cannot conscientiously object.	□	□	□	□	□
Clinicians can be conscientious objectors to postabortion care.	□	□	□	□	□

4.05 Do you consider yourself a conscientious objector to abortion provision (i.e. someone who refuses to provide abortions based on personal moral or religious beliefs?)?

- ☐ Yes
- ☐ No

4.06 Do you fit the definition of a conscientious objector, according to Ghanaian policy?

- ☐ Yes
- ☐ No
- ☐ Unsure

4.07 Do you conscientiously object to taking care of a woman with complications after an abortion (i.e. postabortion care)?

- ☐ Yes
- ☐ No

Section 5: The workplace

5.01 Are abortions ever performed at this hospital?

- ☐ Yes
- ☐ No

5.02 Does this hospital have a formal policy prohibiting abortion, due to moral or religious grounds?

- ☐ Yes
- ☐ No

5.03 Does this hospital have a formal policy about conscientious objection (i.e. a policy about the rights and responsibilities of trained clinicians who refuse to provide abortions because of moral or religious beliefs)?

- ☐ Yes (specify the policy) _____
- ☐ No
- ☐ Don't know

5.04 Please indicate whether you disagree with, agree with, or have mixed feelings about the following statements.

	Disagree	**Mixed feelings**	**Agree**
a. I/My colleagues don't have the support of the administration of my health facility to provide safe abortions.	☐	☐	☐
b. I feel that the people who provide Comprehensive Abortion Care counseling at my health facility encourage women to keep the pregnancy.	☐	☐	☐
c. In my facility some professionals treat women badly for seeking an abortion.	☐	☐	☐
d. In my facility, women seeking an abortion who are seen by a service provider who is opposed to abortion are never referred to another doctor.	☐	☐	☐
e. The supplies to perform abortions (e.g. misoprostol, MVA syringes) are usually or always available.	☐	☐	☐
f. My supervisor believes that abortions are morally wrong.	☐	☐	☐
g. Clinicians refusing to provide abortions because of moral or religious beliefs is one of the main barriers to women accessing safe, legal abortion.	☐	☐	☐

5.05 Do you know any clinicians who are trained in abortions, and who…

	Yes	No
Don't provide abortions because of their moral or religious beliefs	□	□
Refuse to provide abortions in one health facility, but provide them in another facility	□	□
Charge clients money besides what the facility charges, to provide abortion	□	□

Section 6: Possible policies

We are interested in your opinions about possible ways to regulate conscientious objection so that women can access legal abortion services, while abortion providers and conscientious objectors alike feel able to do their jobs in a fair environment. Some of the following regulations are used in other countries.

6.01 In your personal opinion, would the following regulations be a good idea to implement in Ghana?

Potential policy	No	Unsure	Yes
a. Mandatory **confidential** registration of conscientious objectors with GHS	□	□	□
b. Mandatory **public** registration of conscientious objectors with GHS	□	□	□
c. Mandatory **confidential** registration of conscientious objectors with the facility in which they work	□	□	□
d. Additional compensation for providers who perform abortions	□	□	□
e. Alternative service (for example, working additional hours at other clinical tasks) for providers who are conscientious objectors	□	□	□
f. A penalty (for example, a monetary fine) for providers who are conscientious objectors	□	□	□
g. A requirement by the Medical and Dental Council that OB/GYNs learn how to provide abortions	□	□	□
h. A mandate that health facilities create and disseminate facility-level guidelines about conscientious objection	□	□	□

6.02 In your personal opinion, how should the Ghana Health Service regulate the practice of conscientious objection?

_____
_____
_____

6.03 In your personal opinion, what are some ways that the Ghana Health Service could encourage providers to perform abortions when needed?

_____
_____
_____

Section 7: Religion

7.01What is your religion?

- ☐ Catholic
- ☐ Methodist
- ☐ Presbyterian
- ☐ Pentecostal/ Charismatic
- ☐ Other Christian. Specify_____
- ☐ Muslim
- ☐ Traditional/ Spiritualist
- ☐ Hindu
- ☐ Pagan
- ☐ No religion
- ☐ Other (specify) _____

7.02 How much does your religion influence your everyday life?

- ☐ In few areas
- ☐ In many areas
- ☐ In everything I do

Section 8: Conclusion

8.01If you have other thoughts you would like to share about conscientious objection, legal abortion, or postabortion care, please add them here.

_____
_____
_____

This concludes the survey. Thank you very much for your time and your responses.

TO BE COMPLETED BY GDC/GHANA

9.01 Is this facility urban or rural?
- ☐ Urban
- ☐ Rural

9.02 In which region is this facility located?
- ☐ Northern Region
- ☐ Upper West Region
- ☐ Upper North Region

9.03 What type of facility is this?
- ☐ Public
- ☐ Private
- ☐ CHAG