Understanding conscientious objection to abortion in Zambia

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Why conscientious objection to abortion matters in Zambia

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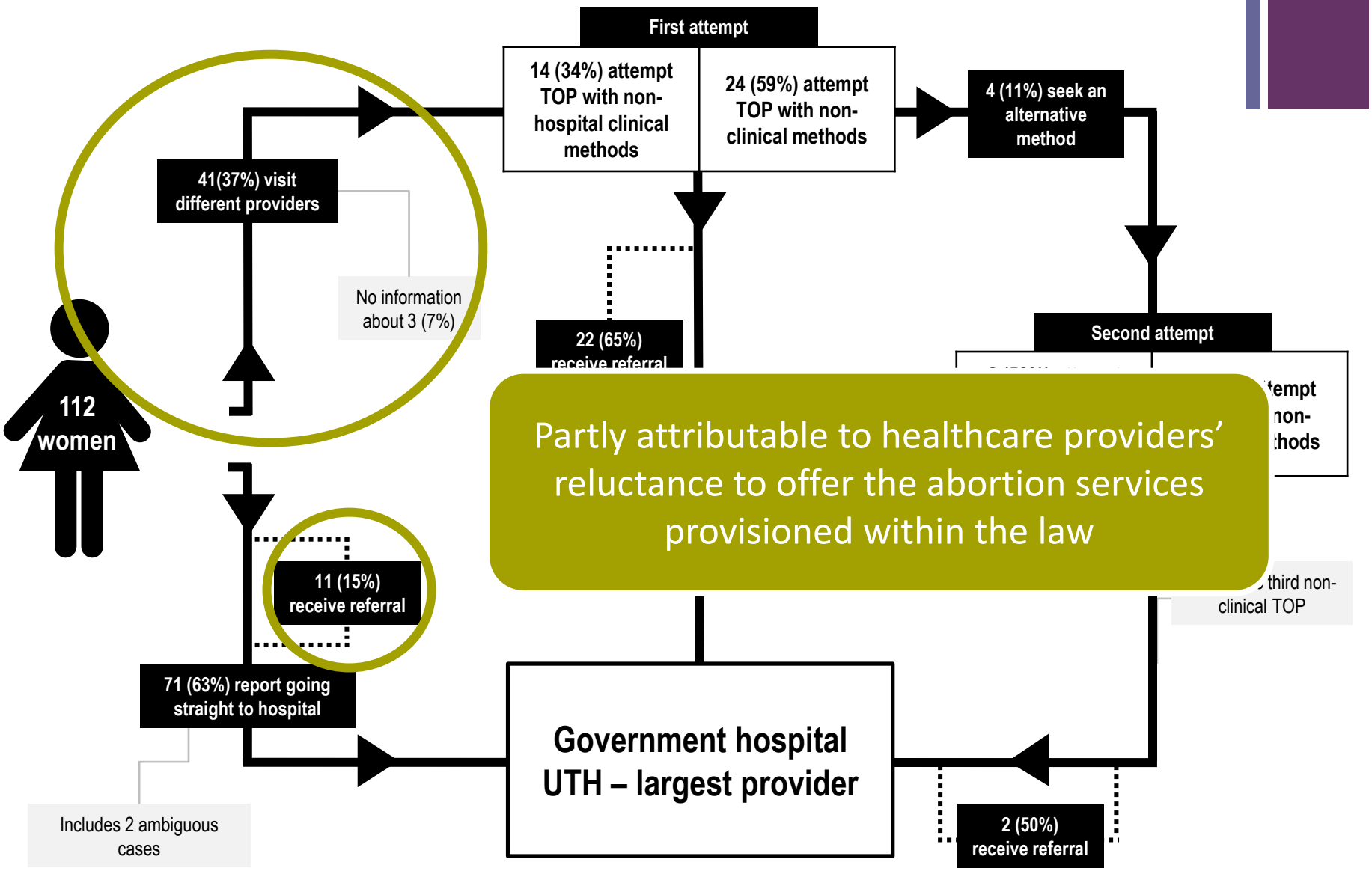

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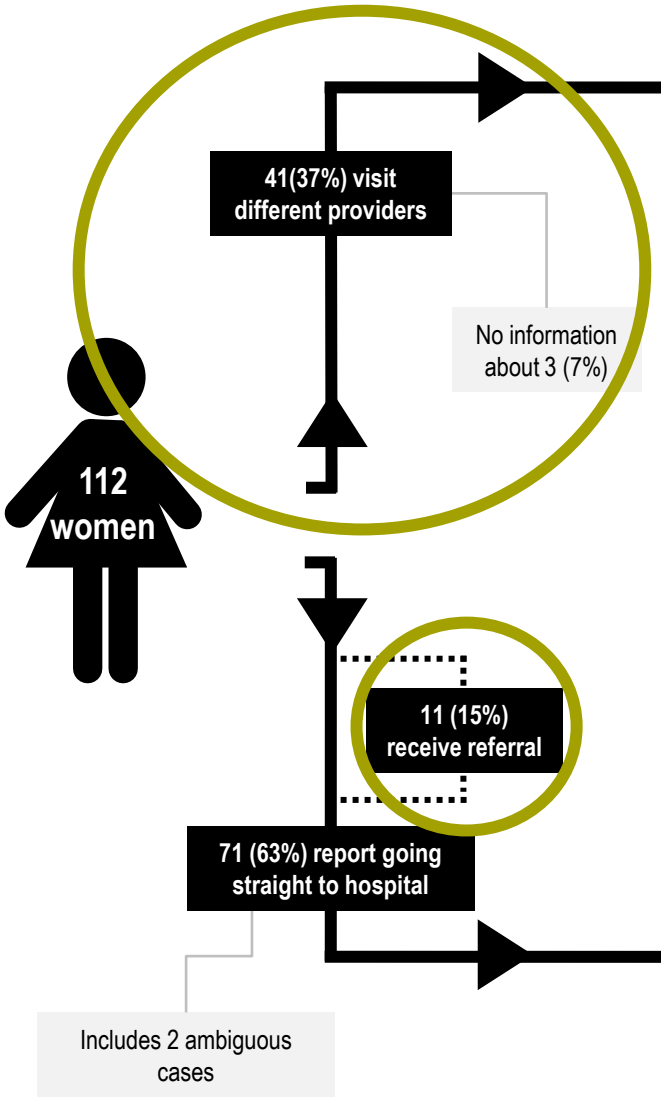

Mercy went to a licensed clinic:
"So they told my grandmother that they couldn't deal this problem here so you have to UTH, because here we may not do the right thing and she could end up dead"

After a lot of dangerous advice, Thandi decides to go to a major NGO provider:
"Actually they gave me a referral [letter], saying they do not have that service. They actually encouraged me to keep, coz they deal with planning parenthood. Yes so it's like an association, and of which as for me I had already decided to have a [termination] and of which, ok they don't provide that service, so we would rather transfer you to UTH and that's how I was transferred"

Why conscientious objection to abortion matters in Zambia

- Conscientious objection is likely to make delivery of abortion care complex and fragmented – even where it's legal
- Whether or not women receive safe abortion seems to be chance, dependent on which individual healthcare worker they confide in

Conscientious objection matters for unsafe abortion

Why conscientious objection to abortion matters in Zambia

Methodology

- We need to hear from conscientious objectors
  - understand barriers to safe abortion
  - inform strategies to engage potential providers
- In-depth interviews (n=55) with health professionals
- Explored participants' day-to-day practices, their beliefs and the legal, professional, moral, ethical and religious influences shaping their practices

Methodology

Role	Facility	N
Senior health administrator	Rural and urban	4
Specialist obstetrician gynaecologist	Large urban hospital	15
Doctor (non-specialist)	Rural hospital	6
Clinical Officer	Rural hospital or clinic	4
Midwife	Rural hospital or clinic	13
Nurse	Rural hospital or clinic	5
Community health worker	Rural community	8

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Known in advance
8 providing; 7 refusing

Position of all other participants explored during interviews

Conscientious objection in this study

- Following previous research:

  Defined as any healthcare worker who feels that "her or his moral, ethical, or religious beliefs precluded her or him from being willing to perform or assist abortions in some or all situations" (Fink et al. 2015)

- Reflecting participants' understandings:

  Definition extended to healthcare workers who feel that their own or their community's objection to abortion preclude them from being willing to refer for abortion in some or all situations

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Findings

Confused understanding of abortion law

- What the law says:

Conscientious objection does **not** make provision for practitioners to opt out of performing abortions when pregnancy poses a "grave, permanent" risk to the mental or physical health of a woman (GRZ 1972) or for those who are not licenced to carry out abortions (e.g. reception staff, pharmacists) to refuse to make referrals or to obstruct a woman from seeking an abortion elsewhere (e.g. by giving misinformation) (MoH 2009)

- What participants understood:

- Either that abortion wasn't legal, or -
- Providing **or referring** for care was their **choice**

Influences on practitioners' "choice"

1. Christian faith
2. Empathy
3. Others' perceptions

- Some practitioners performed/referred for abortion and some did not
- How they referred for abortion

1. Importance of Christianity

- Conscientious objectors **and non-Conscientious objectors**' perspectives informed by their religious beliefs
- Participants were members of Pentecostal, Jehovah's Witness, Roman Catholic, Anglican and Seventh Day Adventist Christian fellowships. **None of their religious communities collectively interpreted Christianity so as to permit abortion**

Conscientious objectors

- Conscientious objectors reported asking clients to go away and think on their (*life-changing*) decision
- Situated pre- *and* post-abortion counselling within broad Christian teaching or specific Bible verses

> *"Yes I tell them! Abortions are like killing. I refer them to the Bible. It is there: Thou shalt not kill. I tell them, despite being a school girl you have killed."* [Nurse midwife, rural facility]

- Some reported that they believed they could, and had, changed the minds of those seeking abortion
- More believed it was their duty to try regardless of outcome

Conscientious objectors who referred women

- Many COs open to – or grateful for – colleagues performing abortions so that women had an option beyond unsafe abortion
- Nevertheless referring women was to "facilitate" abortion, and difficult
- COs responded by:
  - Avoiding meeting clients who want abortion (only possible in large hospitals)
  - Advising clients to "keep the child" before beginning the referral process. Understood as part of their obligation as health professionals to offer "counselling" for women seeking abortion, and as Christians to protect both the life of "the baby" *and the client*
- Some participants invested considerable time and effort in their attempts protect client and pregnancy

Non-conscientious objectors

- Non-conscientious objectors found ways to reconcile their practice with their religious belief
  - For a minority, straightforward separation of roles as Christians and healthcare professionals
  - For many, more complex decision made over time and informed by having witnessed the consequences of unsafe abortion and the circumstances of those seeking safe abortion

2. Importance of empathy

- Identification with or the 'othering' of those seeking abortion key distinguishing theme in participants' narratives

Providers discussed:

- girls' limited opportunities should they continue pregnancies and drop out of school
- married women who could barely afford to feed their existing children
- girls frightened of their violent fathers
- girls and women pregnant following rape

Objectors discussed:

- school-going teenagers
- adulterous women

Distanced themselves from their clients' experiences

Abortion provides forgiveness without penance

e.g. the power of stories

Dr Katongo, specialist obstetrician gynaecologist had always been firm in objection to abortion. She had recently re-evaluated her position following a national conference at which a respected colleague had "borne witness" to having an abortion that allowed her to complete her medical training, marry and have children at the right time for her. Dr Katongo had never heard of anyone "like [her]" having an abortion; she had previously believed that all women would regret their decision to have an abortion. She reported subsequently reflecting on her own life and what decisions she might have made had she found herself in a similar position, and significantly, changing her opinion on abortion. She was now willing to perform an abortion when she was next asked.

3. Importance of others' perceptions

- Participants additionally motivated by the beliefs of those around them:
  - Conscientious objectors who would have performed or referred for abortion did not for fear of being stigmatised by their colleagues and communities
  - Non-conscientious objectors performed abortions clandestinely in order to protect their careers and social standing

Conscientious objectors

- In rural facilities perceptions of communities' attitudes prevented providers referring for abortion or carrying out emergency procedures

Mrs Phiri, a midwife at a rural health care centre, not currently providing abortion services but thought that safe services should be available. She was preoccupied with the case of a pregnant 12 year old girl, brought to the health centre by her father and the police after she was defiled by an older neighbour. The girl was too small to carry a pregnancy to term. On learning she could carry out the abortion she thought was necessary, she admitted that since the local police, the girl's family and her colleagues did not know abortion was possible, she probably would not raise the option with them.

Non-conscientious objectors

- Obstetrician gynaecologists who were providing abortion care reported systematic discrimination from senior doctors who objected to abortion
- Junior doctors who did provide abortion used a variety of strategies to ensure abortion care was available without their senior doctor's knowledge:
  - referring clients to doctors with supportive consultants
  - providing abortions outside of usual consulting hours
  - recording an obfuscated treatment plan on clients' files (e.g. spontaneous abortion)
  - noting on prescriptions another reason the drugs were required in order to prevent "*pharmacists refusing to dispense the medicine or else verbally assaulting the client*"

Conclusions

- Personal and shared beliefs about abortion meant that practitioners in this study variously provided abortion, but clandestinely, provided abortion in some circumstances but not others, referred clients for abortion, refused to refer clients, and gave misinformation about the safe abortion services legally and geographically available
- The result is complex and fragmented delivery of abortion care
- Whether or not women and girls seeking abortion care receive it in Zambia, especially rural settings, appears to be luck, dependent on which practitioner they confide in