

# Prevalence of conscientious objection to legal abortion among clinicians in northern Ghana

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## Abstract

**Objective:** To assess the prevalence of conscientious objection (CO), motivations, knowledge of Ghana's abortion law, attitudes, and behaviors toward abortion provision among medical providers in northern Ghana, and measures to regulate CO.

**Methods:** Between June and November 2015, the present cross-sectional survey-based descriptive study measured prevalence, knowledge, and attitudes about CO among 213 eligible health practitioners who were trained in abortion provision and working in hospital facilities in northern Ghana. Results were stratified by facility ownership and provider type.

**Results:** Approximately half (94/213, 44.1%) of trained providers reported that they were currently providing abortions. The overall prevalence of self-identified and hypothetical objection was 37.9% and 33.8%, respectively. Among 87 physicians, 37 (42.5%) and 39 (44.8%) were categorized as self-identified and hypothetical objectors, respectively. Among 126 midwives, nurses, and physician assistants, 43 (34.7%) and 33 (26.2%) were coded as self-identified and hypothetical objectors, respectively. A high proportion of providers reported familiarity with Ghana's abortion law and supported regulation of CO.

**Conclusion:** CO based on moral and religious grounds is prevalent in northern Ghana. Providers indicated an acceptance of policies and guidelines that would regulate its application to reduce the burden that CO poses for women seeking abortion services.

## KEYWORDS

Abortion; Comprehensive care; Conscientious objection; Northern Ghana

## 1 | INTRODUCTION

Unsafe abortion is a major contributor to maternal morbidity and mortality in low-income countries, accounting for at least 15% in Ghana.<sup>1-3</sup> The Ghana abortion law—the Provisional National Defends Council law (PNDC law 102<sup>4</sup>) of 1985—permits abortion both in situations of maternal and fetal health conditions that pose significant risk to the mother and for pregnancies that occur as a result of rape, incest, or defilement.

One barrier to accessing safe abortions is a clinician's refusal to provide a legal abortion because of their own moral or religious beliefs, known as conscientious objection (CO).<sup>5</sup> CO involves the competing interests of a patient who wants a safe legal medical procedure, a provider who has religious or moral opposition to the procedure, and the government, which wants to reduce maternal morbidity and mortality. Various international agencies and medical bodies concur that CO can be sincere, but that the provider's primary fiduciary responsibility is to the patient; therefore, an objector must inform the woman of her legal



options, refer her to a willing competent provider, provide the abortion in life-threatening circumstances, and cannot object to postabortion care.<sup>6</sup>

Despite extensive rights-based publications on CO,<sup>7-12</sup> there is little research about the medical consequences.<sup>11,13</sup> Global Doctors for Choice (GDC)—an international network of physician activists—has offered a medical and public health perspective on CO via its 2013 White Paper,<sup>5</sup> which summarizes the status of knowledge about CO prevalence, its health effects, and policy responses, and details gaps in the evidence. For example, there have been few rigorous studies on the prevalence of CO, and estimates range from 10% to 70% in various populations.<sup>14</sup> It has been reported that women who are denied abortions because of CO might seek unsafe abortions, leading to morbidity and increased costs to healthcare systems.<sup>15</sup> Additionally, CO can increase the workload on overburdened willing providers and thus threaten quality of care.

Little is known about physicians' attitudes toward regulating CO. A few qualitative studies have demonstrated that CO might vary by country, and that it can be complicated by unclear regulations, providers' lack of knowledge about regulations, abortion-related stigma, and providers' selective disapproval of certain patients and types of abortion.<sup>16-19</sup>

Ghana has too few clinicians, particularly in the northern regions, and the loss of trained providers to CO is a serious concern. The aim of the present study was therefore to determine the prevalence of CO among clinicians trained to provide abortion in the Northern Region, Upper West Region, and Upper East Region of Ghana, and to examine the knowledge and attitudes of these providers toward abortion and CO.

## 2 | MATERIALS AND METHODS

The present cross-sectional study surveyed trained abortion providers working in hospitals located in the three northern regions of Ghana between June 1 and November 30, 2015. Ethical approval was obtained from the institutional review board of the Navrongo Health Research Center. Participation in the study was voluntary without any direct benefit and all study participants provided written informed consent. Participant data and responses were collected anonymously and kept securely. Participants were reminded of their right to skip any survey questions with which they were not comfortable at any point.

The three northern regions were selected on the basis of their poor health indicators. Hospitals were also selected because, according to abortion law in Ghana,<sup>4</sup> a medical practitioner who works only in hospitals must perform the procedure. Eligible participants included doctors, midwives, nurses, and physician assistants (PAs) who had been trained in comprehensive abortion care<sup>20</sup> and provided services in one of the 28 public, 8 private, or 8 Christian Health Association of Ghana (CHAG) hospitals in northern Ghana. Providers were identified using information from the Ghana Health Service (GHS), which maintains the most up-to-date records of service providers in the country.

A census approach was used to survey all eligible providers to obtain a sufficiently powered sample to estimate the true prevalence

of CO in northern Ghana. Trained interviewers obtained written consent from each eligible provider and administered a 48-question survey or provided instructions to providers to self-administer the survey.

The survey assessed provider knowledge, beliefs, practices, and self-identification as an objector, via both closed and open-ended questions.<sup>21</sup> Survey design and content were informed by an extensive literature review, formative interviews, and pilot testing in the Kassena-Nankana West District of the Upper East Region,<sup>21</sup> and incorporated validated abortion stigma scales such as the Abortion Provider Stigma Survey<sup>22</sup> and the Stigmatizing Attitudes, Beliefs, and Actions Scale.<sup>23</sup> Findings from the survey's pilot indicated that some providers preferred interviewer-administered surveys, whereas others found self-administration more compatible with clinical workflow. Therefore, providers were asked to choose their preferred mode of survey administration.

Survey data were collected anonymously and all responses were reviewed for quality and completeness. Although both quantitative and qualitative data were collected during the interviews, the present study was based only on the quantitative analysis.

Outcome measures included two novel composite measures of CO: hypothetical objection and self-identified objection. The two types of objection were not mutually exclusive: providers could be classified as both self-identified and hypothetical objectors.

Hypothetical objectors were those who said that they would refuse to perform an abortion in response to hypothetical situations because of personal religious or moral beliefs. The situations were described as follows: (1) "At your current job, you see a patient who is 17 years old and pregnant, and does not want the pregnancy because she is worried that she will not be able to continue her studies if she has a baby"; (2) "You see a 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"; and (3) "You see a 25-year-old woman who has become pregnant as a result of rape." Provider responses to the three questions were combined into a composite score of 0–2, where 0 represented "not at all" and 2 represented "a great deal"; participants with scores of 1 or 2 were considered hypothetical objectors.

Self-identified objectors were those who answered yes to one or both of two questions: (1) "Do you consider yourself a conscientious objector to abortion provision—in other words, someone who refuses to provide abortions based on personal moral or religious beliefs?" and (2) "Conscientious objection refers to clinicians who are trained to provide abortions but refuse to provide abortions because of their religion or their moral beliefs—do you fit the definition of a conscientious objector according to Ghanaian policy?"

Provider knowledge of abortion law was evaluated using providers' responses to direct questions on the Ghana abortion law.<sup>4,24,25</sup> Respondents were also asked two primary questions to understand their attitudes toward regulating CO in Ghanaian policy. The first question provided respondents with four aspects of CO and participants were asked whether these components should be incorporated into current Ghanaian policies. The second question provided a list of eight potential policies related to CO and respondents were asked whether the regulations should be implemented as future Ghanaian policy.



Data analyses were conducted using Stata version 14.0 (StataCorp, College Station, TX, USA). The distribution of facility location and ownership, sociodemographic characteristics, and measures of clinical practice (e.g. level of abortion training) was calculated for the whole sample and for provider type (physicians vs midwives, nurses, and PAs). Overall point prevalence of CO was calculated as the proportion of objectors among all respondents at the time of the survey. Point prevalence of self-identified and hypothetical objection was also calculated and the results were stratified by provider type and facility type. The proportional distribution of provider knowledge about abortion law and attitudes toward incorporating CO into current and future policies was also calculated.  $\chi^2$  tests were used to identify significant differences in prevalence of CO between provider types and facility ownership types.  $P < 0.05$  was taken to be statistically significant.

### 3 | RESULTS

In total, 213 providers were interviewed: 87 (40.8%) were physicians, and the remaining 126 (59.2%) were midwives, nurses, or PAs. Table 1 provides the provider distribution across facility and key provider characteristics. More than three-quarters (162/213, 76.1%) of respondents worked in public facilities. Most (187/213, 87.8%) reported that they were proficient in safe abortion provision; however, only 94 (44.1%) reported that they currently provide abortion services, of whom 53 (60.9%) were physicians.

Table 2 presents the prevalence of CO by provider type and facility ownership. The prevalence of hypothetical objection and self-identified objection was 33.8% (72/213, 95% confidence interval [CI] 27.7–40.5) and 37.9% (80/213, 95% CI 31.6–44.7), respectively. Nearly half (37/87, 42.5%) of all physicians self-identified as objectors as compared with approximately one-third (43/126; 34.7%) of midwives, nurses, and PAs; the difference was not significant. Significantly more physicians identified as hypothetical objectors as compared with midwives, nurses, and PAs (44.8% vs 26.2%;  $P = 0.005$ ). There was also a significant difference between the prevalence of self-identified objectors by facility type: 57.6% of CHAG providers, 50.0% of private providers, and 32.5% of public providers were self-identified objectors ( $P = 0.014$ ). Similarly, 54.5%, 38.9%, and 29.0% of providers from CHAG, private, and public hospitals, respectively, were categorized as hypothetical objectors ( $P = 0.016$ ).

In total, 94 (44.1%) of the 213 respondents were coded as objectors: 22 (23.4%) were categorized as self-identified objectors only, 14 (14.9%) were categorized as hypothetical objectors only, and the remaining 58 (61.7%) respondents were coded as both hypothetical and self-identified objectors. All but 5 (2.3%) providers said that they would provide abortion-related referrals even if they would not provide abortion care themselves (data not shown).

Table 3 presents data on the knowledge of Ghanaian abortion law. Most non-objectors (110/119, 92.4%) were confident that they knew the situations under which abortion could be provided legally, and their responses to the specific circumstances confirmed this. Both self-identified (63/80, 78.8%) and hypothetical (60/72, 86.3%)

**TABLE 1** Characteristics of the study facilities and providers.<sup>a</sup>

Characteristic <sup>b</sup>	All providers (n=213)	Physicians (n=87) <sup>c</sup>	Midwives, nurses, PAs (n=126)
Facility region			
Northern Region	115 (54.0)	42 (48.3)	73 (57.9)
Upper West Region	51 (23.9)	16 (18.4)	35 (27.8)
Upper East Region	47 (22.1)	29 (33.3)	18 (14.3)
Facility ownership			
Public	162 (76.1)	60 (69.0)	102 (81.0)
Private	18 (8.5)	11 (12.6)	7 (5.6)
Christian Health Association of Ghana	33 (15.5)	16 (18.4)	17 (13.5)
Provider age, y	40.2 ± 11.6	37.0 ± 8.4	42.2 ± 12.9
<30	45 (21.1)	18 (20.7)	27 (21.4)
30–39	73 (34.3)	36 (41.4)	37 (29.4)
40–49	36 (16.9)	21 (24.1)	15 (11.9)
50–59	42 (19.7)	5 (5.8)	37 (29.4)
≥60	10 (4.7)	1 (1.1)	9 (7.1)
Provider sex			
Male	87 (40.9)	70 (80.5)	17 (13.5)
Female	125 (58.7)	16 (18.4)	109 (86.5)
Provider religion			
Islam	55 (25.8)	22 (25.3)	33 (26.2)
Catholic	83 (39.0)	32 (36.8)	51 (40.5)
Presbyterian	21 (9.9)	11 (12.6)	10 (7.9)
Pentecostal/Charismatic	34 (16.0)	13 (14.9)	21 (16.7)
Other or no religion	16 (7.5)	7 (8.1)	9 (7.1)
Abortion provision			
Ever provided	137 (64.3)	71 (81.6)	66 (52.4)
Currently provide	94 (44.1)	53 (60.9)	41 (32.5)
Proficient in safe abortion provision <sup>d</sup>	187 (87.8)	86 (98.9)	101 (80.2)
Trained for type of abortion			
Medical abortion	158 (74.2)	83 (95.4)	75 (59.5)
Aspiration	200 (93.9)	85 (97.7)	115 (91.3)
Dilation and curettage	99 (46.5)	68 (78.2)	31 (24.6)
Trained for gestational age, wk			
<12	146 (68.5)	38 (43.7)	108 (85.7)
13–24	41 (19.3)	27 (31.0)	14 (11.1)
≥25	18 (8.5)	17 (19.5)	1 (0.8)

Abbreviation: PA, physician assistant (including nurse practitioners, community health nurses, and one community health worker).

<sup>a</sup>Values are given as number (percentage) or mean ± SD.

<sup>b</sup>Data were missing on age for 7 providers; sex for 1 provider; religion for 4 providers; current provision of abortions for 76 providers; training in medication abortion, aspiration, and dilation and curettage for 7, 2, and 13 providers, respectively; and gestation for 8 providers.

<sup>c</sup>Physicians included obstetricians and gynecologists.

<sup>d</sup>Proficiency in safe abortion provision was self-reported.



**TABLE 2** Prevalence of conscientious objection by provider type and facility ownership.<sup>a</sup>

Characteristic	Total number	Self-identified objectors (n=80), % (95% CI)	Hypothetical objectors (n=72), % (95% CI)
<b>Provider type</b>			
Physicians	87	42.5 (32.5–53.2)	44.8 (34.6–55.5)
Midwives, nurses, physician assistants	126	34.1 (26.3–42.9)	26.2 (19.2–34.6)
<b>Facility ownership</b>			
Public	162	32.5 (25.6–40.2)	29.0 (22.5–36.5)
Private	18	50.0 (27.8–72.2)	38.9 (19.3–62.9)
Christian Health Association of Ghana	33	57.6 (40.1–73.3)	54.5 (37.3–70.7)
Overall prevalence	213	37.9 (31.6–44.7)	33.8 (27.7–40.5)

Abbreviation: CI, confidence interval.

<sup>a</sup>All percentages are by row. Self-identified objectors included those who classified themselves as either self-identified objectors or objectors based on Ghanaian policy. Hypothetical objectors included respondents who reported feeling either slightly or a great deal of moral or religious objection to the three situations in the survey.

objectors were also knowledgeable about national abortion law. Most non-objectors seemed aware of the aspects of CO that are currently required and mandated by law; however, more than half (79/119, 66.4%) thought that only abortion providers can conscientiously object. Practitioners reported that they would provide appropriate counseling (defined as informing a patient about all legal options and not trying to persuade them against termination) for women seeking abortion due to maternal health (151/213, 70.9%); physicians were significantly

more likely than midwives to appropriately counsel women in cases of serious maternal health risk (80.5% vs 64.3%;  $P < 0.05$ ). A smaller proportion of respondents (118/213, 55%) said that they were willing to appropriately counsel women who had been raped.

Table 4 presents data on provider attitudes related to CO policy. The majority of both non-objectors and objectors reported being open to including most aspects of CO into current policy, although 34 (28.6%) of 119 non-objectors reported interest in regulating CO related to postabortion care. Approximately half of non-objectors believed that policies were needed to require mandatory confidential registration of objectors with the GHS (56/119, 47.1%) and within their facility (60/119, 50.4%). Additionally, 68.9% (82/119) of non-objectors thought that abortion providers should be compensated, and 86.6% (103/119) thought that abortion training should be mandatory. Most also endorsed facility-level guidelines about CO (85/119, 71.4%).

## 4 | DISCUSSION

Well-trained clinicians must be available to provide safe abortion care. The present study found that most professionals trained to provide abortion services in northern Ghana were mid-level healthcare workers, reflecting the decision of the GHS to train mid-level clinicians to provide safe abortion services according to international recommendations.<sup>20,25</sup> However, fewer than half of the providers surveyed said that they currently provided abortions, which raises questions about both the systemic translation of training into practice and the reasons why individuals are not providing the service. Possibly, the criteria for selecting trainees for abortion services and their conditions of service should be reviewed, or additional content is needed

**TABLE 3** Knowledge of national abortion law by objector type.

Knowledge of national abortion law <sup>a</sup>	Non-objectors (n=119)	Self-identified objector (n=80)	Hypothetical objector (n=72)
Certain when abortion can be provided legally	110 (92.4)	63 (78.8)	60 (83.3)
Consider abortion legal under the following circumstances			
Rape	114 (95.8)	69 (86.3)	61 (84.7)
Incest	112 (94.1)	67 (83.8)	61 (84.7)
Fetal risk	117 (98.3)	75 (93.8)	67 (93.1)
Maternal risk <sup>b</sup>	112 (94.1)	68 (85.0)	61 (84.7)
Socioeconomic reasons	55 (46.2)	23 (28.8)	20 (27.8)
All circumstances	50 (42.0)	15 (18.8)	13 (18.1)
Consider the following practices mandated by law			
Objectors must counsel patients with unwanted pregnancies on all options, including abortion	105 (88.2)	69 (86.3)	63 (87.5)
Objectors must refer abortion patients elsewhere	109 (91.6)	72 (90.0)	67 (93.1)
Only abortion providers can conscientiously object	79 (66.4)	48 (60.0)	47 (65.3)
Providers cannot conscientiously object to postabortion care	22 (18.5)	14 (17.5)	11 (15.3)

<sup>a</sup>As per Ghanaian law, abortion is legal under circumstances of rape, incest, fetal risk, and maternal risk. Conscientious objection practices mandated by Ghanaian Standards and Protocols include the following: objectors must counsel patients with unwanted pregnancies on all options including abortion; and objectors must refer abortion patients elsewhere (to clinicians who are willing to provide abortions).

<sup>b</sup>Maternal risk includes risk to the woman's life, mental impairment of woman, and risk to psychological and/or physical health of woman.

**TABLE 4** Provider attitudes toward incorporating conscientious objection into current and future Ghanaian policy.<sup>a</sup>

Question	Non-objectors (n=119)	Self-identified objector (n=80)	Hypothetical objector (n=72)
The following aspects of conscientious objection should be in current Ghanaian policy			
Objectors must provide all-options counseling to patients with unwanted pregnancies	106 (89.1)	66 (82.5)	63 (87.5)
Objectors must provide referrals to patients seeking abortions	111 (93.3)	71 (88.8)	65 (90.3)
Only a clinician who perform the abortion can conscientiously object	86 (72.3)	55 (68.8)	50 (69.4)
Clinicians can be conscientious objectors to postabortion care	34 (28.6)	22 (27.5)	16 (22.2)
The following aspects of conscientious objection should be implemented as future Ghanaian policy			
Mandatory confidential registration of objectors with Ghana Health Service	56 (47.1)	28 (35.0)	27 (37.5)
Mandatory public registration of objectors with Ghana Health Service	35 (29.4)	17 (21.3)	12 (16.7)
Mandatory confidential registration of objectors within their facility	60 (50.4)	33 (41.3)	29 (40.3)
Additional compensation for providers who perform abortions	82 (68.9)	39 (48.8)	32 (44.4)
Alternative service for providers who are objectors	20 (16.8)	11 (13.8)	5 (6.9)
A penalty for providers who are objectors	5 (4.2)	4 (5.0)	0 (0.0)
A requirement that obstetricians and gynecologists learn how to provide abortions	103 (86.6)	64 (80.0)	59 (81.9)
A mandate that health facilities develop and disseminate guidelines about conscientious objection	85 (71.4)	55 (68.8)	52 (72.2)

<sup>a</sup>Values are given as number (percentage).

on value clarifications during the selection of healthcare providers for training on abortion care.

The prevalence of CO among both types of provider (physicians and nurses/midwives/PAs) in this population was notable and seems to fall in the mid-range of estimates from other populations.<sup>5</sup> Because the number of clinicians trained to provide comprehensive abortion care is already limited in northern Ghana, further reduction of this pool as a result of CO might lead to even more restricted access to safe abortion services. The higher prevalence of CO among physicians as compared with mid-level providers raises concern about the quality of care, because high-risk cases needing highly skilled management may not receive appropriate care if only mid-level workers are available. The difference in prevalence of CO by provider type requires deeper investigation because it has implications for policy regarding training priorities and content.

Providers demonstrated knowledge about the circumstances under which abortion is legal and their obligations to counsel and refer, although the self-reports did not indicate whether such counseling and referral occur in practice. Several factors might have contributed to this generally high level of knowledge. Since 2011, GDC Ghana in collaboration with other stakeholders has been advocating women's rights for safe abortion services in the three northern regions based on the Ghana abortion law, and the Ghana medical and dental council have organized mandatory continuous professional development programs on ethical and legal issues for all registered providers. A worrying exception is failure to understand the obligation to provide postabortion care.<sup>20</sup> Even though most objectors claimed that they refer women, the inconvenience of travelling long distances with associated increased costs could deter women from following up the referral and lead them to resort to more easily available abortion methods in their communities, even when these are unsafe.

The study has some limitations. First, provider responses were all self-reported and it is possible that social desirability bias might have affected the providers' decision to report their discomfort with abortion, meaning that the prevalence of CO in this study could have been under-reported. Second, although we attempted to survey all eligible providers in northern Ghana, it is possible that a proportion of providers were missed owing to incomplete GHS records and persistent scheduling conflicts.

Although the practitioners disagreed with punishment for objectors who do not follow the law, they endorsed policies to regulate the use of CO in the interest of the health and safety of women who seek abortion services. Respondents supported policies to ensure that objectors provide appropriate counselling and referral to clients, and agreed that there should be effective ways to monitor compliance. They also supported policies to require health facility management to display guidelines on CO in their facilities so that users of the facility can make informed decisions whenever they need abortion services.

#### AUTHOR CONTRIBUTIONS

JKA-W, PB, CF, and WC conceived and designed the study. JKA-W, PB, and PKA participated in study planning and conducted data collection. SD designed the sampling strategy and analytic plan. JKA-W, PB, SD, and WC analyzed the data, and contributed to the initial draft and manuscript revision. PKA and CF contributed to the initial draft and manuscript revision. All authors reviewed and approved the final version of the manuscript.

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## CONFLICTS OF INTEREST

JKA-W is the Lead of Global Doctors for Choice (GDC) Ghana, and a member of GDC's (Global) Board of Managers. He is also a member of the Ghana Medical Association, the American Public Health Association, the Population Association of America, and the Global Health Council, and is a Fellow of Ghana College of Physicians and Surgeons. The other authors have no conflicts of interest.

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