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Conscientious objection and reproductive health service delivery in sub-Saharan Africa

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Abstract

Lack of access to quality reproductive health services is the main contributor to the high maternal mortality and morbidity in sub-Saharan Africa (SSA). This is partly due to a shortage of qualified and experienced health care providers. However conscientious objection amongst the available few is a hitherto undocumented potential factor influencing access to health care in SSA. Provision of certain reproductive health services goes counter to some individual's religious and moral beliefs and practices. Health providers sometimes refuse to participate in or provide such services to clients/patients on moral and/or religious grounds. While the rights to do so are protected by the principles of freedom of religion, among other documents, their refusal exposes clients/patients to the risk of reproductive health morbidity as well as mortality. Such providers are required to refer the clients/patients to other equally qualified and experienced providers who do not hold similar conscientious objection. Access to high quality and evidence-based reproductive health services by all in need is critical to attaining MDG5. In addressing factors contributing to delay in attaining MDG5 in SSA it is instructive to consider the role of conscientious objection in influencing access to quality reproductive health care services and strategies to address it (*Afr J Reprod Health 2012; 16[1]:15-21).*

Résumé

Objection de conscience et la dispensation des services de santé de la reproduction en Afrique subsaharienne : Le manque d'accès aux services de santé de la reproduction de bonne qualité contribue le plus à la mortalité et morbidité élevée en Afrique subsaharienne (ASS). Ceci est dû en partie à un manque de dispensateurs des services médicaux qualifiés et expérimentés. Néanmoins, une objection de conscience qui existe parmi les quelques-uns disponibles est un facteur potentiel non documenté qui influence l'accès aux services médicaux en ASS. La dispensation de quelques services de santé de la reproduction va à l'encontre des croyances et pratiques religieuses de certaines personnes. Les dispensateurs des services médicaux refusent parfois de participer à l'assurance de tels services aux clientes / patientes pour des raisons morales et /ou religieuses. Alors que les droits qui permettent de le faire sont protégés par les principes de la liberté de la région parmi d'autres documents, leur refus expose les clientes /patientes au risque de la morbidité de santé de la reproduction aussi bien qu'à la mortalité. Il faut de tels dispensateurs pour envoyer les clientes /patientes aux dispensateurs aussi qualifiés et expérimentés qui n'ont pas une objection de conscience pareille. L'accès aux services de santé de la reproduction qui sont basés sur les constatations pour tous ceux qui les désirent est crucial pour l'accomplissement de l'OMD-5. En s'occupant des facteurs qui contribuent au délai dans l'accomplissement de l'OMD -5 en ASS, il est instructif de considérer le rôle de l'objection de conscience dans l'influence de l'accès aux services de santé de la reproduction de qualité et les stratégies permettant de s'en occuper (*Afr J Reprod Health 2012; 16[1]:15-21).*

Keywords: Conscientious objection, reproductive health service delivery, impact, sub-Saharan Africa

Introduction

Maternal health has been the subject of numerous international forums over the past four decades or so. Efforts to address it continue at international, regional, sub-regional as well as national levels across the globe. Acknowledging the disparities among developed and developing regions and countries and across social strata the safe motherhood conference (Nairobi 1987) called on nations to develop programs to reduce maternal mortality and by extension morbidity as well [1]. The ICPD (Cairo 1994) endorsed the decision of the SMI conference and called for reduction of maternal mortality ratio (MMR) by 75% between 1990 and 2000. The ICPD also brought to global prominence the concept of sexual and reproductive health [2]. The Millennium Summit [3], which gave birth to the historic Millennium Development Goals (MDGs) highlighted the linkage between reproductive health and socio-economic development of people and societies. MDG5 calls for improvement of maternal health and some of its key indicators include maternal mortality, contraceptive prevalence rates, and skilled birth attendance [4].

Mid-term review of progress made by member states in attaining the MDGs (2008) showed that SSA lagged behind especially with regards to MDG5. In some countries the situation had worsened instead of improving [5]**.** Lack of SBA has been identified as the main factor contributing to maternal morbidity and mortality in SSA [5, 6, 7.] This is in turn determined by availability of and access to quality and appropriate health services and availability of qualified and experienced health care providers.

In sub-Saharan Africa, majority of the population lives in the rural areas and depend on public health facilities for reproductive health care. Whereas many governments have made efforts to increase the number of health facilities and reduce the population: facility ratio in line with the UN guidelines [8]**,** lack of qualified and experienced health providers remains a major challenge. Health care providers' attitudes have been cited as one of the factors hindering access to quality reproductive health care. The role of provider's moral and/or religious beliefs and practices which have been shown to affect access to health care in the developed world [9,10,11,12,13,14], have not been documented in SSA apart from South Africa in connection with access to safe abortion [15].

Conscientious objection in medicine is the notion that a health care provider can abstain from offering certain types of medical care with which he/she does not personally agree. This includes care that would otherwise be considered medically appropriate. It is reported to be particularly wide-spread in reproductive health care [10,11,13,16]. Health care providers involved in the provision of reproductive health care services which go counter to their moral and religious beliefs and practices find themselves in a dilemma. This is particularly so in emergency and life-saving situations in SSA.

This article discusses the potential impact of health care providers' refusal to participate in or provide reproductive health services on moral or religious grounds in SSA using case scenarios from some facilities in a number of countries in the region. Some strategies which may be implemented to ensure women have access to needed reproductive health services in the light of conscientious objection are proposed.

Cases

1. A 16 year old high school student was brought to the university teaching hospital in one Southern Africa country requesting termination of an eight weeks pregnancy, a result of sexual assault by her step-father. She was seen by the consultant on duty on the material day, who refused and sent her and the mother away. He never bothered to discuss with another consultant or refer them. Four days later the young girl was admitted to the gynaecological ward in the same facility with severe postabortal sepsis. Unfortunately for her and her mother the same consultant was on duty that day as well. The girl was not offered appropriate treatment the whole night. She was seen by the consultant on duty the following day during his morning ward round. By then she was so septic with features of renal failure and shock. All attempts to save her life failed. She died a week later of multi-organ failure. The case was discussed during a departmental morbidity and mortality meeting at which appropriate

recommendations were made to avert similar calamities in the future.

2. A 36 year old gravida 4 with 4 living children, who had had a caesarean section in her third pregnancy due to a twin pregnancy three years priorty, was admitted in labour at 40 weeks gestation at a high-premium private hospital in a capital city of one Eastern Africa country. Her obstetrician had recommended trial of scar as there was no indication for repeat caesarean section then. She progressed, albeit slowly and delivered a 3.8 kg live healthy male infant, vaginally. She however developed severe postpartum haemorrhage and abdominal pains and after assessment was thought to have a ruptured uterus. This was successfully repaired by her obstetrician who for personal religious reasons did not do bilateral tubal ligation. Post natally she was not put on any contraceptives. She conceived eighteen months later. I was called one night to see her after she had been admitted with severe abdominal pains and loss of foetal movements at about 36 weeks of gestation. Upon examination a diagnosis of ruptured uterus was made. After resuscitation and stabilisation haemodynamically, an emergency laparotomy was performed, which confirmed the diagnosis. A total hysterectomy was carried out and the patient made uneventful recovery thereafter. She was discharged home seven days later.

3. An obstetrician at a provincial hospital in one sub-Saharan Africa country wanted to do bilateral tubal ligation (BTL) during caesarean section on a 42 year para 5+0 lady, who had had two previous caesarean operations which she had requested and consented to. Unfortunately the anaesthetist in attendance flatly refused to continue administering anaesthesia. He threatened to wake up or abandon the patient if the obstetrician continued with the surgery. As it was in the middle of the night and it would have been difficult to get the anaesthetic clinical officer to take over, the obstetrician decided to abandon the tubal ligation and closed the abdomen. The patient had mini-laparotomy during which bilateral tubal ligation was done three months later.

4. A 28 year old school-teacher, mother of two boys was sexually assaulted by two men during a house break in at night, while her husband was away on duty. She presented at the near-by provincial hospital the following day and was referred to the gynaecologist at the hospital. She was worried about possibility of infections such as HIV and STIs and pregnancy as she was not on any contraception. The gynaecologist offered her prophylaxis for HIV and STIs as well as examined her for any genital injuries, but flatly refused to give her emergency contraception (EC) for personal religious beliefs. She conceived as a result. At about six weeks gestation she went back to the same hospital and requested termination of the pregnancy. The medical officer on duty referred her to the gynaecologist, the same one she had seen earlier. He refused and instead gave her a lecture on morality and sanctity of life. She eventually sought the help of a retired local nurse/midwife who procured an abortion. Fortunately she never sustained any complications.

5. As the consultant gynaecologist on duty at one private hospital in a SSA country, I was called one night to attend to a 24 year old university student who had been admitted with severe post-abortal haemorrhage. A decision was made to do an emergency uterine evacuation (MVA). As is the policy of the hospital I called the anaesthetist on duty. He refused to attend the patient claiming that this must have been an induced abortion as she was a university student. He could not therefore give her anaesthesia for moral –religious reasons. He was informed that this was an emergency and the procedure was life-saving but he still refused. As the only other anaesthetist with admission and practice rights at the hospital was out of the country, I had to perform the procedure myself using sedation with diazepam and pethidine. The patient made an uneventful recovery. She is now a successful lawyer, married and a mother of two beautiful children.

Discussion

Medical doctors are bound by ethics in their clinical practice – health service delivery. They often discharge their contractual responsibilities under the provisions of their professional ethical code and personal morality. Ethical principles in clinical care include i) Respect for patient's autonomy ii) Doing good (beneficence) and what is right, iii) Doing no harm (non-malficence), iv) Just distribution of finite resources (justice) [17]. The Declaration of Geneva states that "the health of my patients will be my first consideration" [18].

Brody et al (1998) assert that by virtue of entering the medical profession doctors accept a set of moral values and duties that are central to the medical practice [19]. The oath taken by each graduating medical student is meant to guide the professionals and service delivery. However despite all these doctors have been known to refuse to provide or participate in health care services to which they hold religious or moral objection.

Conscientious objection is said to be wide spread in clinical practice. Dickens et al (2000) state that this denies patients access to treatment of their choice [20,] or one they desperately need as the cases referred to above. By virtue of the nature of related services reproductive health is said to attract the most conscientious objection in medicine [10-12,15,16,21]. Abortion holds the unenviable top position as far as conscientious objection is concerned. There are numerous publications and court proceedings on it. Even in countries where abortion is legal they are not spared. An example is often given of Southern Italy where despite abortion being legal women in need of the service are not able to access it as very few doctors are willing to provide it [22]. Closer home, Boegarts (2002) stated that one of the obstacles to accessing safe abortion in South Africa despite the constitutional right is providers' conscientious objection/refusal [15]. Induced abortion is a major contributor to the high maternal mortality ratios in SSA [6, 7], most of the women dying as a result of sepsis or haemorrhage. Doctors refuse to provide safe abortion on the pretext of moral obligation to promote foetal well-being or that it increases risk of breast cancer [23]. It is however argued that doctors' basic obligation in such circumstances is to protect the safety of the woman who is primarily and unarguably their client [13, 24, 25]. The presented young girl died as a result of septic abortion which could have been averted had the attending consultant acted professionally. The second one was lucky. She did not sustain any serious complications following the induced abortion.

Ill-timed and unwanted pregnancies are major predisposing factors to maternal ill-health and deaths. These result from lack of or poor contraceptive use. Many countries in SSA have family planning programmes either as stand alone vertical programmes or as apart of the larger sexual and reproductive health programmes. The related services are readily available and providers trained and equipped to offer them. Despite that the unmet need for contraception still remains unacceptably high [5-7]. Contraceptive uptake is one of the indicators for attainment of MDG5 [4]. The refusal by the anaesthetist, a staunch Roman Catholic to give anaesthesia for tubal ligation on moral grounds in the presented case goes against the Roman Catholic religious principle of "Double Effect" which states that "no wrong is involved in performing a legitimate procedure for proper reason when an effect follows that is improper to achieve for it's sake" [26]. One wonders whether he should even give anaesthesia for caesarean sections at all as he may never know what the obstetrician may need to do on top of the caesarean section such as tubal ligation or hysterectomy. It is also not certain if he'd give anaesthesia for treatment of un-ruptured ectopic (tubal) pregnancy, as some refuse to do on the pretext that it amounts to abetting murder.

High parity and scarred uteri are two common factors predisposing to rupture of the gravid uterus, a leading cause of maternal deaths in SSA. It is disheartening to see even senior doctors refuse to avert such potential causes. The refusal by the anaesthetist in the presented case exposed the patient to unplanned pregnancy, with a potential of ruptured uterus and maternal mortality. She was however one of the lucky few as she could afford to have another surgery soon thereafter to realise her desire. The majority of women in such situation in SSA may not be so lucky. In my practice to date I continue to receive patients who have been denied surgical contraception either by their attending obstetricians or health facilities on religious grounds. This therefore is not an isolated case!

Emergency contraception (popularly known as the morning after pill) has attracted its share of controversy globally. This is now quite popular among sexually active women single and married likewise in large cities in SSA. Health care providers who refuse to provide EC do so because of the belief that this leads to interference with implantation of fertilised ovum [27]. However

published evidence does not support that view [28]. Continued refusal by health care providers as the case presented which was genuine and which is not an isolated case is invalid cognisant of scientific evidence and more importantly of the woman's situation. The presented patient got pregnant from the sexual assault resulting in double punishment. The gynaecologist "rubbed salt to her wound" by denying her needed services twice. Fortunately she survived the induced abortion!

Conscientious objection is enshrined in international documents and national constitutions as a basic individual human right. The Universal Declaration of Human Rights (1948) recognised freedom to behave in accordance with ones conscience as central to individual liberty and integrity [29]**.** The International Covenant on Civil and Political Rights states that "Everyone shall have the right to freedom of thought, conscience and religion .... and to manifest his/her religion or belief in worship, observance, practice and teaching" [30]. It is argued though this right is not absolute. Limitations on the power of conscientious objection were addressed in a case resulting in an important judgment of the Constitutional Court of Colombia in February 2008, which is of considerable significance nationally, regionally, and internationally [31]. Those who invoke it should and must demonstrate the same respect for other's rights and freedoms as they require for their own and that a balance between providers' rights of conscientious objection and patients' rights of access to health care is necessary to avoid harm. The right to conscientious objection has its limits [9, 13, 15, 31, 32]**,** especially so in emergency situations like the ones presented above. It inherently takes the decision-making power away from the patient and places it in the hands of the physician. This denies patients or clients access to needed and at times life-saving health services as the cases presented above.

Access to quality and evidence-based reproductive health services is key to reducing reproductive morbidity and mortality. When it is obstructed by health providers' refusal to provide and/or participate in required services as cited above, it exposes the concerned persons to avoidable morbidity and mortality. Each of the above presented cases sustained some degree of reproductive morbidity and one died. It may also discourage other would potential patients/clients from accessing the same or related services. Such scenarios may only serve to escalate MMR in SSA.

Conscientious objection has not been documented in SSA except for the article by Bogaert (2002) on safe abortion in South Africa [15]. This does not mean that it does not exist. Indeed as observed in the cases presented in this article it does. Dickens et al (2000) stated that claims of conscientious objection are so wide spread as to deny patients access to treatment of their choice [20]. With the widening democratic dispensation globally we should expect increased instances of conscientious objection, which may obstruct access to reproductive health care leading to increased reproductive morbidity and mortality. The SSA can not afford this if it is to attain MDG5 and realise the ICPD PoA.

Several strategies have been proposed to address conscientious objection in health care service delivery. Some of them are controversial and not easily attainable in SSA. These include i) compelling doctors to provide the services despite their moral and/or religious beliefs and practices [12, 32,33]; ii) governments required to ensure availability of health care providers who are prepared to and equipped to undertake a full range of care [20]; iii) health care providers being expected to put their patients rights and interests before their self interests[34]**;** iv) advocate and lobby for the ratification and implementation of international conventions and protocols [42,43] as well as national constitutions (44) that impact on sexual and reproductive health, disseminate the same to reproductive health care providers while holding all relevant stake holders to account for violation of women's sexual and reproductive rights. Others strategies include medical doctors with conscientious objection to make their stand clear to clinic and health administrators, co-workers and patients alike in good time, or to consider practicing in disciplines where conscientious objection may not be an issue [20, 33, 35, 36]. It is universally agreed that doctors with conscientious objection are legally required to refer clients/patients to equivalent practitioners who do

not share such objections [12, 18, 20, 35, 37, 38]. It is also agreed that in emergency situations as obtain in most cases in SSA conscientious objection should not be allowed [18, 20, 39].

Ethically, health professionals are required not to impose their beliefs upon patients and to guarantee their right to adequate, quality care, otherwise it is considered an infringement of women's reproductive rights or a violation of the bioethics principle of non-maleficence. True conscientious objection requires that a balance be struck between the rights of the objector and the health rights of patients, in this case women. Health care providers are entitled to their beliefs and to have those beliefs accommodated, but it is neither viable nor ethically acceptable for conscientious objectors to exercise this right without regard for the right to health care of others, or for policy and services to be rendered ineffectual because of individual objectors.

Whereas the above strategies sound laudable, they may not be practical especially in rural areas of SSA where the majority of populations live due to a perennial shortage of qualified and experienced practitioners. To address the above concerns policy makers and programme managers in SSA need to be aware of the existence and potential impact of conscientious objection on reproductive health care as well as be innovative in addressing it. One possible strategy is to train and delegate key services such as anaesthesia and minor surgical procedures e.g. MVA and family planning to non-physicians as has been done in some countries [37, 40, 41].

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