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Global Public Health

An International Journal for Research, Policy and Practice

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/rgph20

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To cite this article: Jasmine Meredith Davis, Casey Michelle Haining & Louise Anne Keogh (2022) A narrative literature review of the impact of conscientious objection by health professionals on women's access to abortion worldwide 2013–2021, Global Public Health, 17:9, 2190-2205, DOI: 10.1080/17441692.2021.2020318

To link to this article: https://doi.org/10.1080/17441692.2021.2020318

GLOBAL PUBLIC HEALTH
2022, VOL. 17, NO. 9, 2190–2205
https://doi.org/10.1080/17441692.2021.2020318

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A narrative literature review of the impact of conscientious objection by health professionals on women's access to abortion worldwide 2013–2021

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ABSTRACT

Conscientious objection to provide abortion has been enshrined in laws and policies globally. Insufficient attention has been paid to the direct and indirect ways in which conscientious objection compromises women's access to a lawful abortion. Using a systematic search strategy, this narrative literature review synthesises the literature exploring conscientious objection's impact on women's access to abortion in a range of countries. This narrative literature review builds on an extensive literature review published by Chavkin et al. (2013. Conscientious objection and refusal to provide reproductive healthcare: A white paper examining prevalence, health consequences, and policy responses. *International Journal of Gynecology & Obstetrics*, *123*, S41–S56. https://doi.org/10.1016/S0020-7292(13)60002-8). Searches were undertaken on the Medline (Ovid), Global Health, CINAHL, Scopus and Science Direct databases. Thirty six papers were included for thematic analysis. Conscientious objection to abortion was found to impact women's access to abortion at three main levels: the practitioner level, the healthcare system level and the sociocultural environment level. Conscientious objection was found to impact access directly through attempts by health professionals to restrict access, and indirectly by exacerbating pre-existing barriers to access. Further research is required to better quantify the extent to which this impacts women and whether interventions are effective in reducing the barriers that conscientious objection creates and exacerbates.

ARTICLE HISTORY
Received 2 July 2021
Accepted 24 November 2021

KEYWORDS
Conscientious objection; abortion; narrative literature review; access; health professionals

Introduction

In the abortion context, conscientious objection occurs when a health professional opposes a patient's request or refuses to participate in the performance of an abortion based on core (religious or secular) moral beliefs or reasons (Card, 2020). Conscientious objection in health care is subject to considerable ethical, legal, and philosophical debate. Regulation of conscientious objection should ideally involve an attempt to balance a woman's right to access a lawful abortion with a health professional's right to exercise freedom of conscience (Chavkin et al., 2013).

Some regulatory approaches try and strike a balance between these competing interests by permitting health professionals to claim a conscientious objection on the proviso they take steps to facilitate access. For instance, policy guidance by the World Health Organisation (WHO) states that individual healthcare providers 'have a right to conscientious objection to providing abortion, but that right does not entitle them to impede or deny access to lawful abortion services' (WHO, 2012, p. 69). The policy guidance stipulates that conscientious objectors must refer the woman, and where referral

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is not possible, they must provide a safe abortion to save the woman's life (WHO, 2012). The International Federation of Gynaecology and Obstetrics (FIGO) echoes these sentiments (FIGO, 2006).

The WHO's and FIGO's guidelines suggest that conscientious objection should not impede women's access to a lawful abortion. However, there is evidence in the literature which suggests conscientious objection does in fact compromise access. Conscientious objection has been found to disproportionately impact women living in rural and low socioeconomic areas, compounding their already limited access (Autorino et al., 2020). Globally, there is little data on the proportion of health professionals claiming a conscientious objection to abortion and its impact on women's access to abortion services (Chavkin et al., 2017).

Utilising a systematic search strategy, this narrative literature review aims to explore how conscientious objection impacts women's access to safe and timely abortion globally.

Methods

An initial search of the literature was completed to examine recent reviews of the literature on this topic. The most recent comprehensive review was by Chavkin et al. (2013). This narrative literature review was designed to build on this review by focussing on peer-reviewed literature published between 2013 and 2021.

Search strategy

A final systematic search was undertaken on 18 February 2021 using keyword searches on the Medline (Ovid), Global Health, CINAHL, Scopus and Science Direct databases. Keywords included 'conscientious objection', 'abortion' and 'terminat*'. MeSH terms were used in the Medline database. Where possible, database searches were limited to the years 2013–2021 and to English. Searches were limited to articles; however, we did not put limitations on the types of studies that could be included. Each included article was hand-searched by CMH, to identify any papers which may have been missed from database searching. Search strategies and results are shown in Table 1.

Table 1. Database search terms and results.

Database	Search terms	Results
Medline (Ovid)	'Conscientious objection'	543
	Abortion	16,566
	'Conscientious objection' AND abortion	101
	Limit to English	68
	Limit to 2013–2020	
Global Health	'Conscientious objection'	60
	Abortio	13,171
	Terminat*	8278
	Abortion OR terminat*	20,489
	'Conscientious objection*' AND ((abortion) or (terminat*))	44
	Limit to English	27
	Limit to 2013–2020	
CINAHL	'Conscientious objection'	314
	Abortion	20,403
	'Conscientious objection' AND abortion	143
	Limit to English	105
	Limit to 2013–2020	
Scopus	'Conscientious objection'	1116
	Abortion	134,230
	'Conscientious objection' AND abortion	353
	Limit to English	215
	Limit to 2013–2020	
	Exclude: 'book' and 'book chapter'	209
Science Direct	'Conscientious objection'	1,056
	Abortion	129,107
	'Conscientious objection' AND abortion	373
	Limit to 2013–2020	147
	Exclude 'book chapters' and 'encyclopedia'	135
Total		544

Study selection

The Preferred Reporting Items for Systemic Reviews and Meta-analyses (PRISMA) guidelines were followed to screen the records using Covidence software (see Figure 1 for the PRISMA flow diagram). Results of the database searching were imported into EndNote and transferred to Covidence. Papers were screened for duplicates by Covidence. An abstract and full-text screen was undertaken by JMD and CMH based on inclusion and exclusion criteria in Table 2 and the relevancy of the article to the research question.

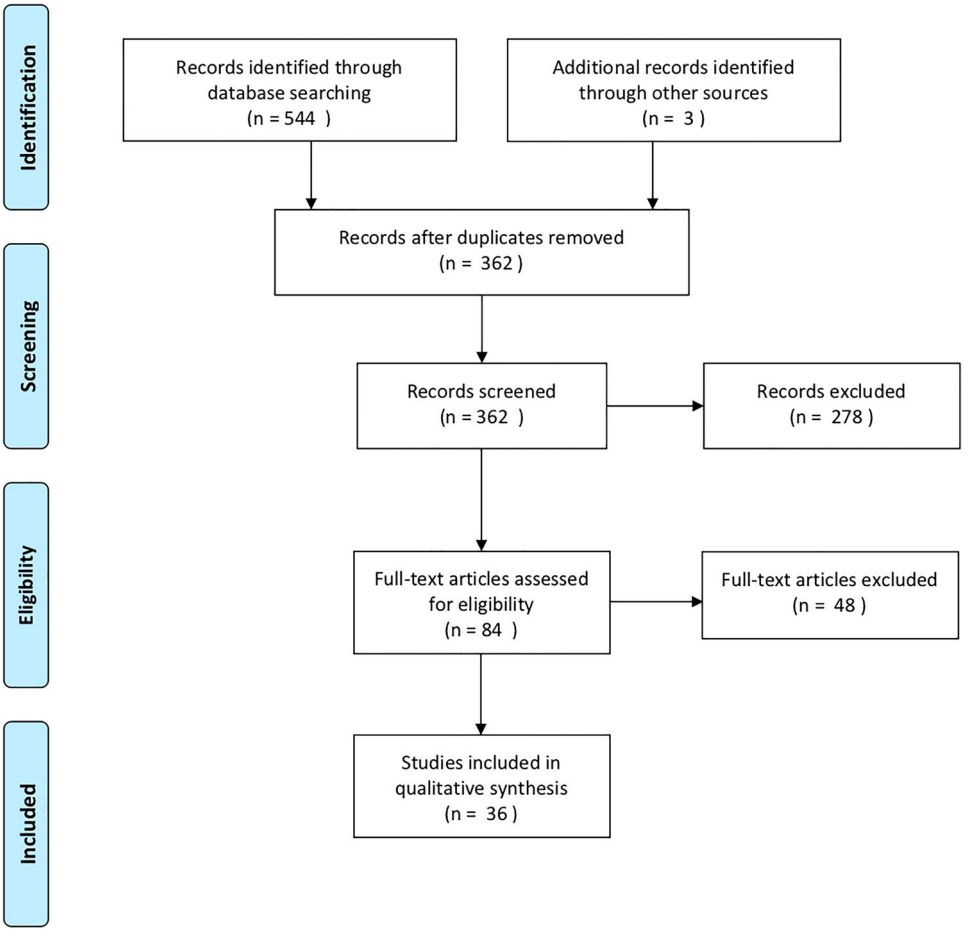

Figure 1. PRISMA flow diagram.

A total of 36 full-text articles were selected for data analysis. Details of the 36 included studies are presented in Table 3. Of the 36 studies, 21 were qualitative in nature, ten were mixed-methods studies, three were quantitative studies and two were case studies.

All included studies were selected and considered relevant by JMD and CMH, who agreed on the relevancy of each paper to the research question and the inclusion and exclusion criteria. Conflicts were resolved by discussion between the two reviewers.

Table 2. Inclusion and exclusion criteria for abstract and full-text screening.

Inclusion criteria	Exclusion criteria
Abstract screen	
• Paper published 2013–2021 • English language • Discussion of conscientious objection and access/provision of abortion services • Journal Articles	• Language other than English • Paper does not mention access or provision of services • Textbook chapters • Broad ethical or legal discussion
Full-text screen	
• Paper published 2013–2021 • English language • Discussion of conscientious objection and access/provision of abortion services	• Comment or editorial • Review of the literature • Paper does not explore conscientious objection and access • Legal or ethical discussion

Data extraction and data analysis

Data was extracted utilising the Covidence Extraction 2.0 Software. Study characteristics were extracted first. Subsequently, an inductive thematic analysis method was utilised to extract major themes and sub-themes from the literature (Braun & Clarke, 2006).

Results

Nature of evidence

The research captured experiences from a variety of nations in all major world regions. The most commonly studied country was Ghana (six studies), followed by Australia and Italy (four studies each), Colombia and South Africa (three studies each). Two studies were conducted in each of the following countries: Brazil, England, Norway, Uruguay and Zambia. One study was conducted in the Argentina, Bolivia, Chile, Ethiopia, Mexico, New Zealand, Portugal, Scotland, South Korea, Spain, Tunisia and United States of America (U.S.A.).

Most studies employed a purposive and/or snowball sampling method of recruiting participants. Sample sizes for qualitative research ranged from 7 to 116 and mixed-methods sample sizes ranged from 23 to 1690. The included studies featured a variety of different participants. Twenty eight studies were with healthcare workers (doctors, nurses, midwives and pharmacists), and three papers researched women with lived experience of abortion. Other study populations included policy makers, academics, lawyers, faculty members and hospital administrative staff. Table 3 provides further details about the samples.

Three major umbrella themes were elicited from the literature review as shown in Table 4. Whilst for the purpose of analysis the authors deal with these themes individually, this is not to suggest that these themes are necessarily independent from one another. Indeed, the authors acknowledge that there will be considerable overlap and intersection between the practitioner, healthcare system and sociocultural level impacts of conscientious objection on women's access to abortion as shown in Figure 2.

(1) Practitioner level impacts on abortion access

Practitioners who conscientiously objected to abortion in the literature were found to impact women's access to abortion services in four key ways. Objecting practitioners were found to refuse women mandated referral, obstruct access directly, impose their beliefs in attempt to dissuade

Table 3. Characteristics of the reviewed articles.

Author's name	Year	Countries studied	Study design	Sample description	*n*=
Aborigo et al.	2020	Ghana	Interviews	Individuals in public and private sector who have contributed to the task-sharing policy	12
Aniteye et al.	2013	Ghana	In-depth interviews	Policy makers, NGO staff, academics, journalists, lawyers, and health professionals	76
Autorino et al.	2020	Italy	Prevalence study	Gynaecologists	N/A
Awoonor-Williams et al.	2018	Ghana	Cross-sectional survey	Trained abortion providers working in hospitals	213
Awoonor-Williams et al.	2020	Ghana	In-depth interviews and focus groups	Obstetrician-gynaecologists and midwives in health facilities in Ghana qualified to perform abortion procedures	34
Bo et al.	2015	Italy	Prevalence study	N/A	N/A
Brack et al.	2017	Colombia	In-depth interviews	Women aged 18 or older who had had legal abortions in the past year	17
Casas et al.	2020	Chile	Semi-structured, in-depth interviews	Faculty members of schools of medicine or midwifery who teach obstetrics, gynaecology or related fields.	30
Chavkin et al.	2017	England, Italy, Norway, and Portugal	Multiple case study	Stakeholders including law maker, legal expert, health system official, medical association representative, reproductive health advocate, academic, bioethicist, anti-abortion advocate, and religious advocate	54
Chavkin et al.	2018	Ghana	Semi-structured, in-depth interviews	Key stakeholders and experts: medical practitioners, government officials, NGO staff and academics	8
Cheng et al.	2020	Australia	Survey questionnaire	Fellows and specialist trainees of RANZCOG both in public and private practice	638
Coppola et al.	2016	Uruguay	Case studies	Gynaecologists	N/A
Czarnecki et al.	2019	U.S.A.	In-depth, semi-structured interviews	Healthcare providers working on the labour and delivery unit of a large teaching hospital who find themselves involved in providing abortion care	50
De Zordo	2018	Italy, Spain	Mixed methods: short questionnaires and in-depth interviews	Obstetrician-gynaecologists in public hospitals	54
Diniz et al.	2014	Brazil	Mixed methods: structured questionnaire and in-depth interviews	Physicians affiliated with the Brazilian Federation of Obstetrics and Gynaecology (FEBRASGO)	1690
Favier et al.	2018	South Africa	Semi-structured, in-depth interviews	Medical practitioners, government officials, NGO staff, key stakeholders and experts	9
Fink et al.	2016	Colombia	In-depth interviews	Actors in the abortion debate in Colombia (key informants) and self-identified conscientious objector physicians and nurses	28
Fleming et al.	2019	Scotland	Unstructured interviews	Practising Roman Catholics familiar with the subject of conscientious objection who were either midwives, lawyers or priests	8
Freeman et al.	2019	Zambia	Unstructured interviews	Variety of healthcare workers in both rural and urban settings, both conscientious objectors and non-conscientious objectors	51
Gerdts et al.	2016	United Kingdom	Mixed-methods: survey	Non-resident clients who sought abortion at clinics within the past year	58
Haaland et al.	2020	Zambia	Ethnographic research and in-depth interviews	Rural health bureaucrats and hospital managers	16
Harries et al.	2014	South Africa	In-depth interviews	Abortion related health service providers, managers and policy influentials	48
Harris et al.	2016	Colombia and Ghana	In-depth interviews and pilot survey	Key stakeholders in Colombia; doctors and midwives in Ghana	22
Keogh, Gillam et al.	2019	Australia	Semi-structured interviews	Experts in abortion provision	19
Keogh, Croy et al.	2019	Australia	Mixed Methods: survey and semi-structured interviews	General practitioners	23

Ko et al.	2020	South Korea	Survey	Perioperative nurses working in a large tertiary care hospital	168
Küng et al.	2021	Mexico and Bolivia	In-depth interviews and focus groups.	Health professionals, legal, data, administrative personnel working in public sector hospitals.	116
Lee et al.	2015	Australia	Semi-structured interviews	Registered pharmacists working in community or hospital pharmacies in Sydney	41
Macfarlane et al.	2019	New Zealand	Questionnaire	New Zealand Fellows and trainees of RANZCOG	131
Magelssen et al.	2020	Ethiopia	Semi-structured interviews	Healthcare professionals involved in abortion provision.	30
Makleff et al.	2019	Uruguay	Quantitative survey	Women seeking abortion services at a high-volume public hospital	207
Mendes et al.	2020	Brazil	Questionnaire	Coordinators of services accredited to assist victims of sexual violence in Minas Gerais	35
Müller et al.	2016	South Africa	In-depth interviews and focus groups	Nurses providing sexual and reproductive healthcare services in rural and urban health facilities	28
Nordberg et al.	2014	Norway	Semi-structured interviews	Christian general practitioners	7
Raifman et al.	2018	Tunisia	In-depth interviews	Providers at maternity hospital or family planning clinics – physicians, midwives, nurses, gatekeepers	23
Ramón Michel et al.	2020	Argentina	Mixed methods: survey and in-depth interviews.	Sexual and reproductive health providers in the public health system, provincial managers and heads of department of sexual and reproductive health programmes	280

Table 4. Themes and sub-themes elicited from literature review.

Theme	Sub-themes
(1) Practitioner level impacts on abortion access	(a) Refusal of referral (b) Direct obstruction of access (c) Imposition of practitioner beliefs (d) Non-legitimate claims of conscientious objection
(2) Healthcare system level impacts on abortion access	(a) Insufficient providers (b) Overburdening of abortion providers (c) Increased waiting times (d) Increased geographical and financial barriers
(3) Sociocultural environment level impacts on abortion access	(a) Community stigma (b) Religion

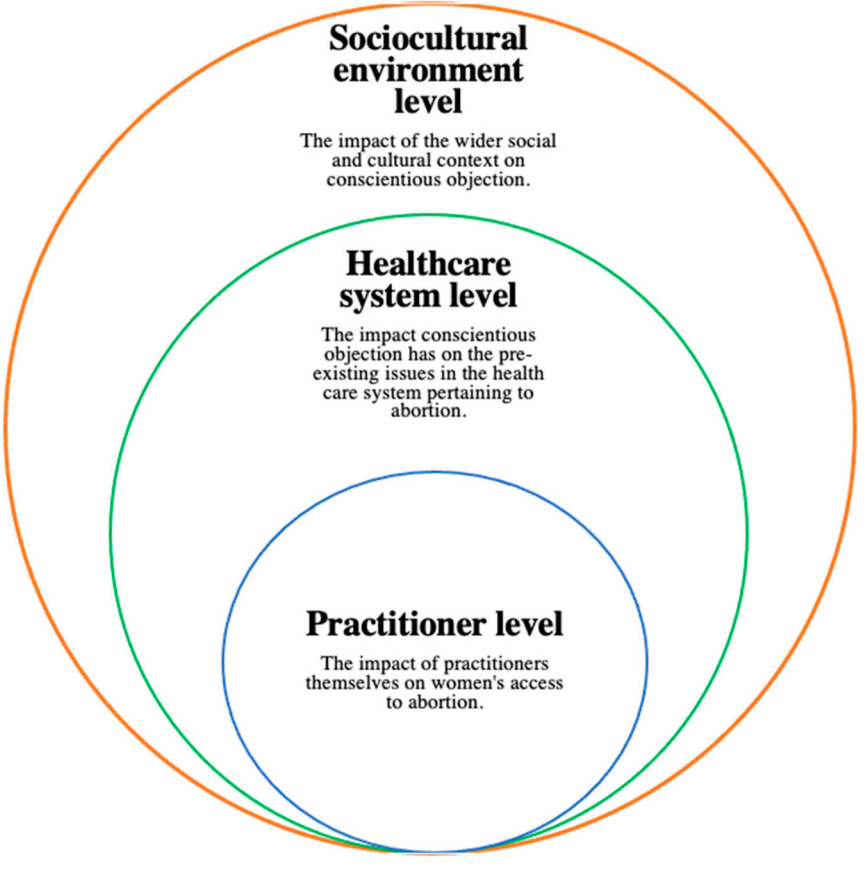

Figure 2. Interrelationship between the levels of impact on women's access to abortion.

women, and claim conscientious objection for unlawful reasons. Practitioners were found to use some, or all, of these tactics to hinder women's access to lawful abortion.

(a) Refusal of referral

In attempt to prevent conscientious objection becoming a barrier to abortion access, many jurisdictions have introduced referral requirements in law and/or policy that mandate conscientious objectors to refer patients on to health professionals who do not object. Based on the included

articles, referral obligations imposed by policy and/or law on the individual objecting practitioner existed in Argentina, some Australian states (such as Victoria), Chile, Colombia, Ghana, Portugal, South Africa and Zambia (Aniteye & Mayhew, 2013; Awoonor-Williams et al., 2020; Casas et al., 2020; Chavkin et al., 2017; Fink et al., 2016; Freeman & Coast, 2019; Harris et al., 2016; Keogh et al., 2019a, 2019b; Müller et al., 2016; Ramón Michel et al., 2020).[1] Despite such a requirement, some of the studies suggested that objectors refused to refer based on the belief that doing so would constitute a form of active participation and would, therefore, make them complicit in the provision of abortion (Aniteye & Mayhew, 2013; Fink et al., 2016; Harris et al., 2016). Despite a legal obligation to refer, refusal of referral has been evident in Victoria, Australia (Keogh et al., 2019a, 2019b). In one of the studies, not referring patients was described as 'common practice' by participants working in rural areas (Keogh et al., 2019b).

Some objectors have found ways to circumvent referral requirements. Studies of healthcare providers in South Africa and Zambia found objectors deliberately made vague or impractical referrals, for example referring women to a service that is far away, or having women attend multiple unnecessary appointments with different practitioners, inevitably causing delays (Freeman & Coast, 2019; Müller et al., 2016).

Given the paucity of the studies examining lived experiences of women seeking abortions, the exact impact of practitioners refusing referral on women's ability to access abortion is unclear. However, Fink et al. (2016) theorise that such actions put women at a higher risk of seeking out unsafe, illegal abortions in Colombia. Similarly, drawing on their research with healthcare workers in Zambia, Freeman and Coast (2019) postulate that women may interpret a refusal of referral as their legal request for abortion being inappropriate.

(b) Direct obstruction of access

Research with nurses in South Africa and health bureaucrats in Zambia found that some nurses and clinicians were 'actively obstructionist' to women's attempts to access abortion by directly refusing women abortion care, despite knowing it was legal (Haaland et al., 2020; Müller et al., 2016). Multiple studies also reported that objectors directly obstructed women's access by not discussing their options for unplanned pregnancy (Aniteye & Mayhew, 2013; Awoonor-Williams et al., 2020; Keogh et al., 2019a; Macfarlane & Paterson, 2020; Müller et al., 2016); falsely telling women that they did not meet the legal criteria for access when they did (Fink et al., 2016; Keogh et al., 2019b); and causing delays, for example, by making women attend additional appointments and requesting that they come back at a later time (Keogh et al., 2019b). Research in Ghana, Colombia, Mexico, and Brazil reported that some objectors would often create unnecessary administrative tasks to delay or obstruct women's access (Diniz et al., 2014; Harris et al., 2016; Küng et al., 2021). However, given these studies were not reporting on women's experiences, rather they are the perspectives of other personnel, it is not clear whether or not women were eventually able to access a legal abortion.

Direct obstruction of access is not limited, however, to doctors and midwives. Participants in focus groups and interviews in Mexico and Bolivia reported that they had observed social workers, reception and security staff impeding abortion access by telling patients abortion was not available or by asking for incident reports, despite them no longer being a legal requirement (Küng et al., 2021). Obstruction was also exhibited by Australian pharmacists, who refused to stock or dispense medications such as mifepristone, a medication that induces abortion, usually used in early pregnancy (Keogh et al., 2019b; Lee et al., 2015). However, some Australian pharmacists in Lee et al. (2015) suggested that their unwillingness to supply mifepristone was associated with a lack of education and guidelines, rather than of an attempt to deliberately obstruct access.

It is unclear in the literature how such actions by health professionals impact women who are seeking an abortion. However, Favier et al. (2018) and Haaland et al. (2020) suggest attempts to obstruct women's access to abortion has resulted in women unsafely procuring their own abortions.

Similarly, a respondent in a study by Keogh et al. (2019b) recalled a case where a doctor falsely misled a patient, forcing her to continue with an unwanted pregnancy.

(c) Imposition of practitioner beliefs

There was evidence in the literature of practitioners imposing value judgements on women by classifying their requests to access abortion services as either 'worthy' or 'unworthy' (Aniteye & Mayhew, 2013; Czarnecki et al., 2019; Freeman & Coast, 2019; Magelssen & Ewnetu, 2020; Müller et al., 2016). Requests for abortion which fell into the 'worthy' category were commonly medical indications such as eclampsia or fetal abnormalities. Women presenting for abortion who had not used contraception, who wanted to pursue education or who were seeking a subsequent abortion were often deemed 'unworthy' (Freeman & Coast, 2019; Küng et al., 2021; Müller et al., 2016; Raifman et al., 2018). In Mexico, Brazil and Bolivia, in cases where women seek an abortion as a result of rape (one of the limited circumstances where abortion is lawful in these jurisdictions), health professionals have been found to mistrust patients' claims of pregnancy resulting from sexual assault (Diniz et al., 2014; Küng et al., 2021). This personal ethical stratification of women's worthiness of abortion access was also reported among some abortion providers who considered themselves pro-choice in the U.S.A. (Czarnecki et al., 2019). Fink et al. (2016) define this subjective assessment by individual practitioners as a case-by-case approach. Such an approach is thought to lead to health professionals determining access, rather than the law, resulting in inconsistent practice and fragmented access (Fink et al., 2016).

In-depth interview studies in Australia and Ghana revealed that some doctors with a conscientious objection would actively try to deter or convince women not to have abortions (Aniteye & Mayhew, 2013; Awoonor-Williams et al., 2020; Keogh et al., 2019b). Some Tunisian conscientious objectors admitted that they had attempted to convince patients not to have an abortion (Raifman et al., 2018). Two studies in Colombia had similar findings (Fink et al., 2016; Harris et al., 2016).

Health professionals have been found to leverage their position to emotionally manipulate women to not pursue abortion. Most notably, a study of women who had accessed legal abortion in Colombia found that nurses who did not approve of their decision were cruel and threatening (Brack et al., 2017). Other study participants gave examples of objectors making false claims about the dangers of abortion (Fink et al., 2016), attempting to make women feel guilty for requesting abortion (Keogh et al., 2019b), and utilising scare tactics such as showing patients images of developing foetuses (Müller et al., 2016).

(d) Non-legitimate claims of conscientious objection

Another predominant theme in the literature is individuals claiming conscientious objection out of convenience rather than on the basis of legitimate beliefs. This has been termed 'convenient objection' (Chavkin et al., 2017), or 'pseudo-objection' (Coppola et al., 2016). Multiple studies saw practitioners use conscientious objection protections as an opportunity to opt-out of abortion, despite not having a legitimate conscientious objection to the abortion (Coppola et al., 2016; Czarnecki et al., 2019; Favier et al., 2018; Harries et al., 2014; Harris et al., 2016; Keogh et al., 2019b). Practitioners were seen to pick and choose which parts of abortion care they participated in an ad-hoc manner, rather than in accordance with the law (Awoonor-Williams et al., 2020; Czarnecki et al., 2019; Diniz et al., 2014; Favier et al., 2018; Harries et al., 2014). Such behaviour creates difficulties for ensuring adequate staffing of abortion and postabortion care units (Czarnecki et al., 2019; Harries et al., 2014).

Few nations have found a way to monitor non-legitimate use of conscientious objection. Countries such as Italy, Norway and Uruguay require health professionals claiming a conscientious objection to submit a written declaration of their objection to their employers and/or local

healthcare authority; however, some studies revealed that this is rarely enforced and/or done correctly (Chavkin et al., 2017; Coppola et al., 2016).

Non-legitimate use of conscientious objection may not always be a result of voluntary exploitation of the law. For instance, non-legitimate use of conscientious objection is thought to be partly the result of inadequate staff education and ineffective translation of the law into practice. Research by Harris et al. (2016) in Ghana and Columbia found clinicians had different understandings of conscientious objection. Health professionals have consistently been found not to understand their legal obligations in relation to what they can or cannot object to, and the term conscientious objection (Awoonor-Williams et al., 2020; Chavkin et al., 2017; Czarnecki et al., 2019; Ko et al., 2020; Küng et al., 2021). Additionally, research in Argentina found that providers of sexual and reproductive healthcare sometimes claim a conscientious objection due to community stigma (Ramón Michel et al., 2020).

(2) Healthcare system level impacts on abortion access

(a) Insufficient providers

Having high proportions of practitioners conscientiously objecting exacerbates pre-existing abortion provider shortages (Aborigo et al., 2020; Awoonor-Williams et al., 2018; Favier et al., 2018). This has led to shortages of willing abortion providers in many countries (Bo et al., 2015; Czarnecki et al., 2019; Fleming & Robb, 2019; Harries et al., 2014; Müller et al., 2016), which cause delays and reduces women's access to lawful abortions (Autorino et al., 2020; Awoonor-Williams et al., 2018).

Participants of studies in South Africa, Uruguay, Chile, Brazil and Italy reported knowing of services that had no willing providers at all (Casas et al., 2020; Chavkin et al., 2017; Coppola et al., 2016; Favier et al., 2018; Haaland et al., 2020; Makleff et al., 2019; Mendes et al., 2020). Mendes et al. (2020) was the only aforementioned study that quantified this impact, finding that of the surveyed 49 institutions authorised for abortion care in Brazil, 60.6% of the institutions do not perform legal abortion because their whole team conscientiously objects to the procedure. Importantly, the mandatory referral requirement may not assist in facilitating abortion access in regions where there are limited providers, as a health professional may be unable to put a woman in contact with a willing provider within a reasonable geographic proximity. Furthermore, whether access is facilitated by the referral requirement is unknown, as a result of the lack of feedback post-referral (Freeman & Coast, 2019).

There are also shortages of opportunities for trainees to learn abortion skills (Cheng et al., 2020; De Zordo, 2018; Freeman & Coast, 2019; Keogh et al., 2019b; Raifman et al., 2018). This is compounded by objecting superiors who discouraged medical personnel from receiving training in abortion provision (Aniteye & Mayhew, 2013). Freeman and Coast (2019) found Zambian objectors denied juniors training opportunities, implying there will be penalties on career progression if they participate. Ramón Michel et al. (2020) found that one in three participants they surveyed believed that hospital leadership influenced the use of conscientious objection among younger professionals. Keogh et al. (2019a) reported that rural health professionals seeking to provide medical termination lacked support from colleagues which was necessary to fulfil their training requirements, such as a surgical colleague agreeing to be available in the region if surgical abortion is required.

(b) Overburdening of abortion providers

Many abortion providers reported feeling overworked, overwhelmed and frustrated with the lack of support (Autorino et al., 2020; Awoonor-Williams et al., 2020; Cheng et al., 2020; Harries et al., 2014; Ramón Michel et al., 2020). Performing abortions was found to come with personal and professional sacrifices. Personally, abortion providers were often confronted by community stigma and discrimination (Aniteye & Mayhew, 2013; Chavkin et al., 2017; Cheng et al., 2020; Favier

et al., 2018; Küng et al., 2021; Ramón Michel et al., 2020). Professionally, non-objectors have been found to be disadvantaged in career development opportunities compared with objectors (Autorino et al., 2020; Chavkin et al., 2017; Ramón Michel et al., 2020). This has instilled fear within professionals, with many reporting of being afraid of becoming 'abortion doctors', becoming de-skilled in other areas and not having time to dedicate to career progression (Chavkin et al., 2017; Cheng et al., 2020; De Zordo, 2018; Küng et al., 2021; Ramón Michel et al., 2020).

There are also few financial benefits for healthcare workers to provide abortions, including in developed nations such as the United Kingdom (Chavkin et al., 2017). There is a fear that overburdening abortion providers may compound staff shortages, as it may cause burn-out or drive career changes (Awoonor-Williams et al., 2020; Chavkin et al., 2017; Harries et al., 2014; Ramón Michel et al., 2020). Staff shortages in Argentina have led to professionals subsequently not wanting to become a provider due to the heavy workload, causing a toxic cycle of shortages (Ramón Michel et al., 2020).

(c) Increased waiting times

Research by Autorino et al. (2020) found that a high prevalence of conscientious objection is associated with longer waiting times, given that women are unable to receive an abortion from the first professional they see, and the few non-objecting personnel are likely to have very high caseloads. Bo et al. (2015) found that the increased workload for non-objectors in many Italian regions due to the high percentage of objectors was inversely correlated with the proportion of women who had their abortion request met within 14 days. Both of these studies were undertaken in Italy, which is one of the limited countries that collects data on conscientious objection, due to the legal obligation to register their objection (Autorino et al., 2020). Health professionals have reported increased waiting times at abortion point-of-care, and long waiting lists being linked to high proportions of conscientious objectors (Brack et al., 2017; De Zordo, 2018; Freeman & Coast, 2019; Küng et al., 2021; Ramón Michel et al., 2020). It is possible that long waiting periods may result in women surpassing the gestational threshold for legal access to abortion – as reported in one small study of key stakeholders in South Africa (Favier et al., 2018).

(d) Increased geographical and financial barriers

Autorino et al. (2020) found that high numbers of objectors in a region in Italy led to a higher probability of women travelling elsewhere to seek abortion, with some regions having up to 85% of practitioners registered as conscientious objectors. Health professionals in the literature often recalled times where patients had to travel for abortions especially in rural and remote areas (Chavkin et al., 2017; De Zordo, 2018; Gerdts et al., 2016; Keogh et al., 2019a). In a study examining women's lived experience of travelling to England for abortion access, four women reported having to travel for abortion due to clinician refusal in their own country (Gerdts et al., 2016). When health professionals refuse abortions on the basis of their conscientious objection and fail to provide an adequate referral within a reasonable geographic proximity, women may resort to unsafe abortion methods, especially if they do not have access transport or the financial means to travel to access a lawful abortion (Aniteye & Mayhew, 2013; Awoonor-Williams et al., 2018; De Zordo, 2018; Magelssen & Ewnetu, 2020).

Autorino et al. (2020) found that conscientious objectors in Italy were clustered in low-income areas, meaning women who needed to travel to access abortion were less likely to have the financial resources to do so. Governments in middle income countries such as South Africa have not provided adequate funding to abortion services, resulting in an unsustainable reliance on non-government organisations (NGOs) and the privatisation of abortion clinics, compounding access for women of low socioeconomic status even further (Favier et al., 2018).

(3) Sociocultural environment level impacts on abortion access

The sociocultural environment in which practitioners and healthcare systems sit, was found to impact the likelihood of health professionals claiming conscientious objection. Community stigma impacts both clinicians' decisions to conscientiously object, and patients experiences of abortion seeking. Multiple conscientious objectors cited stigma as a reason not to perform abortions (Awoonor-Williams et al., 2020; Diniz et al., 2014; Harris et al., 2016; Mendes et al., 2020). A participant in Aborigo et al. (2020) reflected that some midwives in Ghana became non-providers if their relatives did not approve. Segregation of abortion services from mainstream hospitals has been utilised in an attempt to improve access (Macfarlane & Paterson, 2020). However, some clinicians believe that segregation increases professional stigma (Favier et al., 2018; Macfarlane & Paterson, 2020). Integrating abortion service into existing sexual and reproductive health and primary health services and improving education may help to reduce the stigma associated with abortion amongst health professionals (Favier et al., 2018; Macfarlane & Paterson, 2020).

(a) Community stigma

In a study by Makleff et al. (2019) of women in Uruguay with lived experience of abortion, found that 85% of participants reported worries about being judged. Community stigma may reduce service utilisation and prevent women speaking out about negative experiences, including those with conscientious objectors (Brack et al., 2017; Chavkin et al., 2017; Favier et al., 2018; Makleff et al., 2019). Community stigma, therefore, influences conscientious objection, and conscientious objection exacerbates the reduction in access the stigma creates.

(b) Religion

Alongside community stigma, a religious sociocultural context was found to influence conscientious objection. Given religion is viewed as a legitimate reason to claim conscientious objection, it is unsurprising that objectors frequently cite religion as their reason for objecting (Aniteye & Mayhew, 2013; Autorino et al., 2020; Awoonor-Williams et al., 2020; Brack et al., 2017; Casas et al., 2020; Chavkin et al., 2017; Czarnecki et al., 2019; De Zordo, 2018; Fink et al., 2016; Freeman & Coast, 2019; Keogh et al., 2019b; Lee et al., 2015; Nordberg et al., 2014). Autorino et al. (2020) found a correlation between the percentage of objectors and the religiosity of a population in Italy. Ko et al. (2020) found being Protestant was a predictor of nurses' intentions to utilise conscientious objection. Conversely, in a study of 50 healthcare workers in the U.S.A., multiple nurses cited their Christian religion as motivation to participate in compassionate and non-judgemental abortion care (Czarnecki et al., 2019). A small number of abortion providers in a study by Aniteye and Mayhew (2013), cited biblical texts of forgiveness and compassion as their reasons for being conscientious providers of abortion care.

However, it appears that religious conscientious objection may be reducing women's access at an institutional level. Despite FIGO guidelines only permitting individual health professionals to conscientiously object (FIGO, 2006), many Christian institutions claim a 'conscientious' objection (Awoonor-Williams et al., 2020; Awoonor-Williams et al., 2018; Chavkin et al., 2018; De Zordo, 2018). This may result in employees who would otherwise be willing to provide the service being unable to do so (Chavkin et al., 2017).

Discussion

Over the last nine years, there have been multiple high-quality studies on the topic of conscientious objection. There were many consistent findings in the literature examining how conscientious objection impacts women's access to safe and timely abortion.

This literature review elicited three key areas in which conscientious objection reduced women's access to abortion. These included at the practitioner, healthcare system and sociocultural environment levels. Conscientious objection was found to both impact women's access directly by creating barriers to obtaining services, and indirectly, by exacerbating pre-existing barriers to access.

The findings in this review at the healthcare system level are similar to that of the Chavkin et al. (2013) review, with paralleled discussion of insufficient providers, overburdening and burn-out of providers significantly impacting women's access. This review builds upon the Chavkin et al. (2013) review by diving deeper into practitioner level factors, exploring how some practitioners utilised their position of power to impose their individual beliefs on abortion to women seeking access.

This review also has wider consideration of the sociocultural factors which often influence how conscientious objection operates in a particular setting. Importantly, however, how sociocultural factors directly impact a health professional's refusal is not always clear cut, with each individual practitioner having their own complex ethical considerations either compelling them to provide abortion services or leading them to conscientiously object. It is also important to recognise that some whilst some objectors claim a conscientious objection on religious grounds, others may rely on religion as a reason to provide an abortion and non-judgemental care to their patients (Czarnecki et al., 2019).

The literature reviewed revealed potential solutions for managing conscientious objection in practice. England and Norway have recognised the referral process as a barrier, enabling women to self-refer to abortion clinics (Chavkin et al., 2017). South Africa has used mobile teams of abortion providers (Favier et al., 2018). Hospital units in the U.S.A. and Portugal roster and hire practitioners based on their willingness to provide abortions to ensure staff availability (Chavkin et al., 2017; Czarnecki et al., 2019). The effectiveness of these methods, however, is currently unknown and warrants further exploration.

Limitations

Overall, despite limited research on this topic, the literature was of good quality and represented a wide range of countries and populations. The majority of studies were purposively sampled, which may induce selection bias, although this is common for qualitative research in a specialised field. In two studies the authors were also participants in the study, which may be a conflict of interest (Chavkin et al., 2017; Favier et al., 2018). The majority of studies did not declare any conflicts of interest.

This literature review was unable to quantify the extent to which abortion access is compromised as a result of conscientious objection due to limited quantitative research. This is due to sparse quantitative data collection on conscientious objection to abortion worldwide. A situation that can, and should be, addressed. Furthermore, the literature currently contains limited studies exploring women's lived experiences and their views about barriers to accessing abortion services.

With regards to the review methodology adopted by the authors, selection bias was reduced by the use of two researchers screening each paper. Whilst using an inductive thematic analysis method for data extraction may introduce researcher bias, this was mitigated through a systematic approach which utilised the standardised data extraction tool 'Covidence Extraction 2.0'. The decision to exclude data prior to 2013 may also have excluded significant research in this field. Similarly, the authors restricted this literature review to studies available in English, due to resource limitations. As a result, the authors acknowledge that this decision may mean some countries may not have been captured by this narrative review and identify this a limitation.

Conclusion

This review of the literature elicited clear ways in which conscientious objection by health practitioners impacts women's access to abortion services worldwide. However, it is evident that further quantitative and lived experience research is required in order to quantify the impact of

conscientious objection and to determine how such impacts can be reduced in order to ensure women have access to safe and timely abortion services. Four key recommendations for further research have emerged from this review. Firstly, governments and health services should collect data on conscientious objectors and abortion service utilisation, to increase quantitative data on the prevalence of conscientious objection and its impact on abortion service access. Secondly, further research into women's lived experience of abortion access is needed to examine their views on how conscientious objection impacts their access. Thirdly, research exploring health professionals' understandings of conscientious objection laws and policies are needed to identify areas where further education and policy translation is required. Finally, further research focused on younger trainees in midwifery and obstetrics and gynaecology is needed, to examine their willingness to perform abortions and identify any barriers to their training. Such findings are critical to determining the sustainability of future workforces.

Note

1. The authors have relied on background sections of the relevant included articles to provide this insight. It may be the case that the law and/or policy has subsequently changed. Additionally, referral requirements may not exist in emergency circumstances. With respect to Argentina, the article by Ramón Michel et al. (2020) does not explictly refer to the referral requirement in their paper, but does reference Argentinian abortion guidelines from 2019 (Guía nacional para la atención integral de personas con derecho a la interrupción legal del embarazo) that include a referral requirment.

Acknowledgements

The authors would like to thank the anonymous reviewers for their thoughtful and constructive comments.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

The author(s) reported there is no funding associated with the work featured in this article.

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