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What makes a likely abortion provider? Evidence from a nationwide survey of final-year students at Ghana's public midwifery training colleges

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Abstract

Background: Even in countries where the abortion law is technically liberal, the full application of the law has been delayed due to resistance on the part of providers to offer services. Ghana has a liberal law, allowing abortions for a wide range of indications. The current study sought to investigate factors associated with midwifery students' reported likelihood to provide abortion services.
Methods: Final-year students at 15 public midwifery training colleges participated in a computer-based survey. Demographic and attitudinal variables were tested against the outcome variable, likely to provide comprehensive abortion care (CAC) services, and those variables found to have a significant association in bivariate analysis were entered into a multivariate model. Marginal effects were assessed after the final logistic regression was conducted.
Results: A total of 853 out of 929 eligible students enrolled in the 15 public midwifery schools took the survey, for a response rate of 91.8%. In multivariate regression analysis, the factors significantly associated with reported likeliness to provide CAC services were having had an unplanned pregnancy, currently using contraception, feeling adequately prepared, agreeing it is a good thing women can get a legal abortion and having been exposed to multiple forms of education around surgical abortion.
Discussion: Midwifery students at Ghana's public midwifery training colleges report that they are likely to provide CAC. Ensuring that midwives-in-training are well trained in abortion services, as well as encouraging empathy in these students, may increase the number of providers of safe abortion care in Ghana.

Keywords: Abortion; Ghana; Family planning; Africa

1. Introduction

Lack of access to safe abortion is one reason for the 68,000 maternal deaths each year attributable to unsafe abortions worldwide [1,2]. Sub-Saharan Africa contributes the largest proportion of these deaths [3]. Recent data suggest that while the overall number of abortions is decreasing worldwide, the number of unsafe procedures is increasing [4,5]. Despite steps taken by several countries in recent years to ease legal and health system restrictions on safe abortion services, increasing rates of unsafe procedures persist [3].

Even in countries where the law is liberal, such as in South Africa, India and Zambia, which allow abortion either on demand or for a wide range of reasons, the full application of the law has been hindered [6,7]. These hindrances are due to multiple factors, including health system lack of preparedness to provide the service, women and providers not knowing the extent to which the service can be provided and resistance on the part of providers to offer services [8–11]. These countries have shown that provider willingness to perform abortions is a critical prerequisite to effectively implementing less restrictive laws. In some places, there may be a sufficient number of trained providers but few providers willing to perform abortion services [12].

Ghana, a country in West Africa with approximately 25 million inhabitants, has taken action to reduce unsafe abortions. In 1985, the law governing abortion was liberalized,

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allowing abortions for a wide range of indications, including to protect a woman's mental health [13]. Access to safe abortion care has been part of the national reproductive health strategy in Ghana since 2003.

Further, implementing international evidence [14], midwives are allowed to perform both medication and surgical abortions in pregnancies less than 12 weeks' gestation. Midwives provide the majority of the reproductive health care in Ghana [15], similar to many other countries. Strengthening the midwifery workforce is one strategy to improve the quality of reproductive health care for women [16], and allowing midwives to provide abortion care is one strategy to increase the number of trained providers closer to where women live [17]. In 2007, training in medical and surgical comprehensive abortion care (CAC) was added to the midwifery curriculum in the country. Such preservice training includes a focus on technical skills, interpersonal skills, value clarification and communication, and counseling in family planning and abortion [18] and has been identified as an important initiative to improve access to safe abortion services [12].

A paucity of trained, willing and committed service providers to offer high-quality and timely abortion services directly and indirectly contributes to maternal mortality due to unsafe abortions [19]. While previous work in Ghana has explored health care providers' willingness to provide abortion services [20], the attitudes of students have not been studied. Investigating how these students, the future health care workers, feel about providing abortion services is an important line of inquiry to ensure that Ghanaian women have access to service providers willing to perform the procedures for which they have been trained. The current study sought to investigate factors associated with final-year midwifery students' reported willingness to provide CAC once they have graduated.

2. Materials and methods

Final-year students at 15 public midwifery training colleges in all 10 regions of Ghana participated in a computer-based survey between September 2013 and May 2014. During the study period, there were 15 public midwifery training colleges which offered a diploma program (3 years; post secondary school) which had students in their final year (one school did not have a third-year class at the time of data collection). All 15 of these schools participated in this study. All final-year diploma students (those in their third year) and final-year postbasic students (those in their second year) were invited to take the survey by members of the study team in their school's computer laboratory. The survey was downloaded to the computers in the schools' computer labs, and participants were brought to the labs in groups to complete the survey. Some midwifery schools in Ghana offer both a diploma track (3 years of study with direct entry from post secondary school) as well as postbasic track (2 years of study but with a certificate in midwifery). Recruitment was open to both cadres of students at schools where both tracks were offered.

The main objective of the survey was to assess, using a discrete choice experiment, factors which would motivate these students to locate to rural areas postgraduation. Those results are being presented elsewhere and are similar to previous work by this study team [21]. A subset of the questionnaire was designed to assess students' reported training in surgical abortion techniques as well as their likeliness to provide abortion services once they graduated and were employed as midwives. These questions were guided by the literature as well as previous work by this study team [22].

Data were collected using Sawtooth Software (Orem, UT) and exported to Microsoft Excel (Redmond, WA). Data were uploaded from Excel to Stata version 13.0 (College Station, TX) for analysis.

Ethical review was provided by the Ghana Health Service Ethical Review Committee, the Kwame Nkrumah University of Science and Technology Committee on Publication and Human Ethics, and the University of Michigan Institutional Review Board.

The survey asked participants a series of demographic questions which included questions about their experience with unplanned pregnancies, as well as their own contraception use.

The survey further asked participants, "How likely are you to provide CAC after graduation? By CAC, we are referring to providing abortion care services, as permitted by law, in a safe, affordable and accessible manner. CAC also refers to post-abortion contraception counseling and empowering women to control their fertility." Response options were very likely, somewhat likely, neither likely nor unlikely, somewhat unlikely and very unlikely. Since the distribution of responses to this question was highly skewed (with 49.2% of respondents stating that they were very likely and 21% stating that they were somewhat likely), we continued analysis using a binary outcome, with all respondents who reported being very likely or somewhat likely being coded as "likely" and with all the rest being coded as "unlikely." We grouped the responses in this manner because participants who reported being "somewhat likely" to provide CAC services as well as those who responded that they were "very likely" to provide CAC services represent the group most likely to be providing these services. While we could have split the groups into those who answered "very likely" against all other responses due to half the sample noting that they are "very likely" to provide CAC after graduation, conceptually we believed that the likely group should include both the "very likely" as well as the "somewhat likely."

Following the question about how likely they were to provide CAC services, the survey asked all participants to clarify their response with an additional question. For those students who reported being unlikely to provide CAC services, response options included it is against the law, stigma, personal preference and religious beliefs. For those