

Ghana's R3M Program Is Associated with Greater Provision of Safe Abortions

Ghana's Reducing Maternal Mortality and Morbidity (R3M) program helps to increase provision of safe abortion services and postabortion care, according to a quasi-experimental study of provider survey data.¹ Compared with providers not exposed to R3M, those exposed to the program were more likely to provide safe abortions and postabortion care (odds ratios, 4.0 and 2.0, respectively). Neither provider attitudes about abortion nor knowledge of abortion law was associated with these outcomes, but provider confidence in performing the procedure was a strong positive predictor.

The R3M program was launched in 2006 in seven districts in the Greater Accra, Ashanti and Eastern regions of Ghana, and provides technical and financial support to improve access to and provision of comprehensive abortion care and family planning services. To investigate the program's effect, investigators compared providers from the districts exposed to R3M with two control groups of providers from nonexposed districts: one group in the same regions (who may have had some exposure because of geographic proximity) and one in the distant Brong Ahafo region. Data were collected in 2011–2012 through face-to-face interviews with providers who were legally eligible to provide abortions and worked in facilities having the capacity to offer gynecologic care. Providers were asked questions about their characteristics and those of their facility, as well as about their abortion training, experience and attitudes. The investigators used propensity score analysis and estimated associations of the R3M program exposure with two outcomes: provision of safe abortion services and provision of post-abortion care.

Analyses were based on data from 197 providers in the districts exposed to the R3M program, 148 providers in nearby nonexposed districts and 112 providers in remote nonexposed districts. Larger proportions of providers exposed to R3M than of those not exposed provided safe abortion services (54% vs. 13%) and postabortion care (66% vs. 33%), had been trained in at least one abortion technique (84% vs. 52%), correctly answered six or more questions probing

knowledge of abortion law (80% vs. 62%), had confidence in their ability to provide safe abortions (77% vs. 36%) and felt that their facility supported abortion provision (81% vs. 37%).

In multivariate analyses, exposed providers were more likely than all nonexposed providers to provide safe abortion services (odds ratio, 4.0); the difference was smaller when exposed providers were compared with only the nonexposed providers in the same regions (2.5) and much larger when they were compared with only the nonexposed providers in the distant Brong Ahafo region (15.7). Exposure to the program was associated with a similar increase in the odds of providing safe abortion services when analyses were restricted to providers who were trained in at least one method of abortion (3.8).

Compared with peers who had low confidence in their ability to perform abortions, more confident providers had greater odds of providing safe abortion services (odds ratio, 7.7). In contrast, providers' knowledge of abortion law, attitude toward abortion, perceived facility support for abortion and religion were not associated with this outcome in the study sample as a whole; however, among providers who were trained in at least one method of abortion, Catholics were less likely than peers of other religions to provide services (0.4).

Exposed providers were twice as likely as all those not exposed to provide postabortion care (odds ratio, 2.0). However, no difference was found when the exposed group was compared with either the nearby nonexposed group or the remote nonexposed group individually, or when analyses were restricted to providers who knew of at least one method of abortion. Here also, confident providers were much more likely to provide postabortion care than nonconfident peers (odds ratio, 4.9). And provider type played a role too, as midwives, nurses and medical assistants were less likely than doctors to provide this care (0.3). Knowledge, attitudes, perceived facility support and religion were not associated with this outcome in the study sample as a whole.

The authors comment that the study's results "show that any intervention to improve comprehensive abortion care in Ghana should focus on providing training in abortion techniques and on building provider confidence in service provision" and "hopefully encourage the expansion of the R3M programme to cover the entire country, especially the more

remote areas." They acknowledge that their analysis was limited by the lack of facility-level data, and suggest that future research could assess the program's impact on both women and facilities, and examine the interplay between provider and facility characteristics.
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REFERENCE

1. Sundaram A et al., The impact of Ghana's R3M programme on the provision of safe abortions and postabortion care, *Health Policy and Planning*, 2015, 30(8):1017–1031.