Received: 6 February 2024 | Revised: 24 May 2024 | Accepted: 1 June 2024 | Published online: 16 June 2024

DOI: 10.1002/ijgo.15733

REVIEW ARTICLE

Gynecology

The importance of abortion training for obstetrician-gynecologists: A comparison of the United States, Sweden, and Ghana

Cerisa Obern[1] | Emmanuel Morhe[2] | Kristina Gemzell-Danielsson[3] | Jody Steinauer[4]

[1]Department of Women's and Children's Health, Uppsala University, Uppsala, Sweden

[2]Department of Obstetrics and Gynecology, University of Health and Allied Sciences, Ho, Ghana

[3]Department of Women's and Children's Health, Karolinska Institute and Karolinska University, Stockholm, Sweden

[4]Department of Obstetrics, Gynecology and Reproductive Sciences, University of California San Francisco, San Francisco, California, USA

Correspondence
Cerisa Obern, Dag Hammarskjölds väg 14B, 752 37 Uppsala, Sweden.
Email: cerisa.obern@uu.se

Abstract

Since 2020, World Health Organization guidelines state that universal access to abortion care is critical for individual and community health, and for the realization of human rights. Yet the right to access safe abortion care is severely restricted in many countries. This article outlines institutional and educational systems in the USA, Sweden, and Ghana, which all require obstetrics and gynecology (ob-gyn) training to include abortion care but vary in implementation. It argues that regardless of the political environment, the specialty should protect abortion training worldwide. In Sweden and Ghana, ob-gyn residents are required to participate in abortion training, while in the USA they are permitted to opt out. In Sweden, practicing ob-gyn specialists are required to provide abortion care, whereas in Ghana and the USA, this care is optional, leading to geographic disparities in abortion care access in these two countries. In the USA, the Supreme Court's *Dobbs* ruling jeopardizes programs' abilities to meet the training mandate, a requirement that was insufficiently implemented even before the ruling. It is critical that all clinicians are well-equipped to provide accurate information to their patients and provide pre- and post-abortion care. For this reason, we recommend that abortion is included in all undergraduate medical education programs in accordance with the recommendations of FIGO (the International Federation of Gynecology & Obstetrics). To meet WHO guidelines that require ob-gyn specialists to provide abortion care in an emergency, we urge FIGO to create a guideline about expectations for abortion training integration in obstetrics and gynecology.

KEYWORDS
abortion, abortion care, family planning, medical education, sexual and reproductive health

1 | INTRODUCTION

Since 2020, World Health Organization (WHO) guidelines state that universal access to abortion care is critical for individual and community health, and for the realization of human rights. Yet the right to access safe abortion care is severely restricted in many countries. This right is of great importance for the 73 million people who annually undergo induced abortions worldwide. Access to abortion

is inversely linked with the number of unsafe abortions, which can lead to permanent injury or death.[1]

FIGO (the International Federation of Gynecology & Obstetrics) clearly states that an individual obstetrics and gynecology (ob-gyn) physician's right to their own beliefs about abortion must not negatively affect patient care and that they must provide abortion care in the setting of an emergency when no one else can provide the care.[2] WHO says that all who have the skills to provide abortion care must provide the services in urgent and emergent situations, even if they otherwise would object to providing care based on their conscience.[3] Therefore, all ob-gyn physicians must learn abortion skills so that they can provide life-saving care if necessary. In 2023, FIGO, in collaboration with the International Federation of Medical Students Associations and the World Association of Trainees in Obstetrics and Gynecology, published guidelines for undergraduate medical education. They stated that all medical students should learn about abortion as part of their comprehensive sexual and reproductive health training so that they can counsel and refer patients, and provide pre- and post-abortion care, in accordance with their countries' laws and the scope of their clinical practice.[4] Three countries, the USA, Sweden, and Ghana, all currently offer abortion care training to their ob-gyn residents, varying from compulsory to optional. This article seeks to outline three distinct institutional and educational systems that exist in these countries and argues that regardless of the political environment, the ob-gyn specialty should continue to protect and support the institutions and educational systems worldwide that offer abortion care training.

2 | ABORTION RIGHTS ARE UNDER THREAT IN THE USA. EDUCATIONAL INSTITUTIONS SHOULD CONTINUE TO SAFEGUARD ABORTION CARE TRAINING

In June 2022, the Supreme Court of the United States ruled in favor of *Dobbs* in the case of *Dobbs v. Jackson Women's Health Organization* and overturned *Roe v. Wade*, the 1973 court decision that previously underpinned access to abortion.[5] This ruling allows individual states to further restrict and even ban abortion access. As of May 1, 2024, the Guttmacher Institute estimates that only 19 states, including Washington D.C., protect abortion care either somewhat or entirely, another four have some restrictions and protections, while 27 states have very restrictive policies.[6] This ruling jeopardizes the ability for residency programs to meet the requirement to routinely train ob-gyn residents in abortion care. It could leave residents involuntarily incompetent to provide the care needed by future patients. It will also make it challenging to teach all medical students the core obstetrical and gynecologic content needed to be physicians.[7]

Abortion is common in the USA. In 2020, there were 930000 abortions, with an abortion rate of 14.4 per 1000 women aged 15–44 years.[8] An estimated one in four women have an abortion in their lifetime.[9] Approximately 39% of all abortions in 2017 were medical abortions (mifepristone and misoprostol), and 93% of all abortions in 2021 happened before 13 weeks of gestation.[10,11] Only 1% of abortions were performed after 21 weeks of gestation.[11] In the USA, it is up to each state to establish legal parameters around abortion care.[8]

The Association of Professors of Gynecology and Obstetrics, an organization that makes recommendations about undergraduate medical education in obstetrics and gynecology, urges that all student graduates are able to do nondirective pregnancy counseling, with knowledge about all methods of abortion including their rare complications, as well as the public health implications of legal abortion.[12] Unfortunately, these are not enforced and undergraduate medical education about abortion varies. Similarly, abortion is not an expectation for nursing education—although 19 states do allow advanced practice clinicians to provide abortion care based on strong evidence of safety—and education is only included in a minority of programs.[13–16] In the medical specialty of Family Medicine, training is not a requirement but early abortion is considered within the scope of practice. Yet, training in abortion care is only integrated in 40 of over 693 accredited family medicine programs.[17]

In contrast to medical and nursing education and residency training in Family Medicine, the Accreditation Council for Graduate Medical Education (ACGME), the US organization that monitors professional educational standards within graduate medical education, requires abortion training to be offered in ob-gyn residency programs.[18] It permits residents to opt out of performing abortions, but generally recommends that residents spend time in clinical settings where abortion care is provided to learn about pre- and post-abortion care, as studies have documented the benefits of partially participating.[18,19]

Although the requirement that abortion training is integrated in ob-gyn training is enforced, training varies by programs. As of 2020, approximately 60% of residents reported that their training program had routine, scheduled training, 29% optional training, and 8% no training. Many residents graduate without satisfactory training in all methods of uterine evacuation for both abortion and management of pregnancy loss.[20] For many programs, the ability to offer routine abortion training is affected by state- and hospital-level restrictions. Even before the recent Supreme Court decision, many hospital and state restrictions limited abortion care and training, often with the hospitals instituting more restrictions than their states' legislative policies.[21]

Despite abortion restrictions in the USA, abortion is considered an important component of comprehensive reproductive health care in the medical profession. The American College of Obstetricians and Gynecologists (ACOG), the national professional organization of obstetrics and gynecology, states that “safe, legal abortion is a necessary component of comprehensive health care” and is committed to maintaining access to abortion. ACOG recommends routine, opt-out training. Although it respects individuals' personal opposition to abortion, it states that healthcare professionals must avoid imposing their personal biases upon their patients or allowing their beliefs to compromise their patient's access to care or information and that all ob-gyn physicians must provide abortion care in the setting of an emergency if no one else is able to provide the care.[22]

After completing their residency, ob-gyn physicians can go on to do a 2-year Complex Family Planning (CFP) Fellowship, approved through the ACGME in 2020. As of 2022, there are 29 CFP fellowships. Previously, there were two CFP sites dedicated to family medicine training and other CFP sites trained both ob-gyn and family physicians; however, as of 2022 the ACGME approval is only for ob-gyn-based fellowship sites.[23] There is a 1-year fellowship program for family physicians called the Reproductive Health Care and Advocacy Fellowship. Another subspecialty, Maternal-Fetal Medicine (MFM), frequently includes abortion training because MFM specialists care for those with health complications and fetal anomalies.[24]

In the USA, medical institutions consider abortion care to be critical for patient safety and patient-centered care and consider it a core part of the ob-gyn identity. However, they allow individuals to opt out of providing abortion care if their beliefs do not compromise patient access to care, except in the setting of an abortion needing to be done to save the life or health of the woman. Additionally, integration of abortion training is not fully enforced, and states further restrict abortion care in the post-Roe era. Forty-five percent of all residency programs are in states anticipated to ban abortion, and more than 2600 residents train in these programs.[25] After the *Dobbs* decision, the ACGME slightly modified their expectation that all residents have access to abortion training. They continued to require that all programs must include abortion training and stated that if abortion provision was banned in their state, they must provide didactic education and support the residents to travel out of state for training.

One unique part of the US medical education history is that after the ACGME initially required abortion training in 1995, Dr. Uta Landy founded an organization called the Kenneth J. Ryan Residency Training Program in Abortion and Family Planning to support departments to integrate abortion care and training. The Ryan Program has supported 115 programs to integrate training, and their role has expanded after the *Dobbs* decision. As of the 2023/24 academic year, the Ryan Program is working with ACOG and Innovating Education in Reproductive Health, an online source with free content about public health and clinical aspects of abortion care, to create a virtual curriculum that can be accessed by all residents.[26] In addition, the Ryan Program is supporting programs in states with restrictive policies to partner with programs in less restrictive states so that their residents can travel for training. The impacts of the restrictions on training are not yet fully understood.

3 | SWEDEN'S INSTITUTIONAL SYSTEM OBLIGES THOSE INVOLVED IN WOMEN'S HEALTH TO PROVIDE ABORTION CARE

In contrast to the US approach to training, in Sweden it is obligatory that ob-gyn residents and midwives learn to provide abortion care. This aspect of professional identity is supported by a system that requires all healthcare professionals involved in women's health to ensure swift and safe access to abortion.

Sweden legalized abortion in 1974 and allows abortions until week 18, without exceptions, and until viability—at present considered as 21^{+6} weeks—with special permission from the Swedish Board of Health and Welfare, for fetal anomalies, social problems, physical diseases, or psychiatric diseases.[27,28] Most abortions performed in Sweden today (85%) are performed before week 9, with 35 550 abortions occurring in 2023 or 18 per 1000 women of reproductive age (15–44 years).[27] Only 1% of all abortions occur after week 18, when special permission is required. Procedural abortions, performed with suction aspiration, are offered from week 7 to week 12 (outside this window only by trained providers) and most abortions (96%) performed are medical.[28]

Abortion is deemed "care that cannot be postponed", and all ob-gyn clinical departments must provide abortion care as part of mainstream ob-gyn care.[29] As abortion is an important part of the job description, no one is permitted to opt out of learning about abortion or providing abortion care for any reasons (including religious or personal objections).[29] In these cases, another job must be chosen. A Swedish study that assessed attitudes of ob-gyn physicians and midwives towards legal abortion found strong support for Swedish abortion policies.[30] However, there have been attempts to challenge this law, for example in 2014 a midwife challenged her employer's requirement, which adhered to Swedish law, that she perform abortions.[31] These challenges have never been successful and the requirement to provide abortion care has been upheld.

The healthcare system is slowly evolving to solely depend on midwives in providing first-trimester medical abortions for healthy women, similar to what has happened with contraceptive counseling since 1976. Currently, both ob-gyn physicians and midwives are involved in providing contraception and abortion care. The exact pattern of a patient's visit may differ between clinics but at many clinics, the ob-gyn physician's role consists of consulting the patient in case of any health problems or in pregnancies of more than 10 weeks. Both midwives and ob-gyn physicians can perform the ultrasound to confirm an intrauterine pregnancy and determine the gestation. Either the midwife or the ob-gyn physician then administers the initial tablet, mifepristone, and distributes misoprostol and pain medication to be taken at home or, if preferred by the patient, in the clinic. In the event of a procedural abortion, an ob-gyn physician carries out a suction aspiration evacuation.[28]

In Sweden, all medical students receive thorough theoretical knowledge about abortion care. Each student is required to be able to apply the laws and national guidelines about abortion, and to define induced abortion and the process involved. Additionally, each student must reflect on the treatment of those seeking abortions from one's own and others' values and opinions.[32] Although a clinical rotation at an abortion clinic is not required per se, it is recommended within the limits of clinical availability. Seminars and theoretical knowledge about abortion are required for all medical students.

Since 1974, ob-gyn residents have been obligated to work at an abortion clinic during their specialist training. Although there is no specific number of abortions they must perform to be certified as a

specialist, residents generally spend several weeks providing abortion care, including counseling and performing abortions in regular clinics and while on call. In addition to clinical work, residents must also participate in a 4-day course about abortion and contraception. During these 4 days, legal, medical, and surgical aspects of abortion care are discussed as well as contraception methods post-abortion and miscarriage management.[33] This training became mandatory in 2015 and the curriculum was created by the Swedish Society of Obstetrics and Gynecology and is overseen by the Swedish Board of Health and Welfare.[33] At the conclusion of an ob-gyn residency, an appointed supervisor certifies that the resident has obtained the required skills, including competence in abortion care measured by quality and performance.

4 | GHANA CREATED A FORMAL PROGRAM TO LEGITIMIZE THE SPECIALTY AND INCREASE ACCESS TO ABORTION

Despite Ghana having the second most liberal abortion law in sub-Saharan Africa, abortion care still faces a number of challenges. First, the apparent ambiguity of the law and its inclusion in the colonial era criminal code cause confusion when enforcing policy to provide abortion care to the full extent of the law.[34,35] Second, there is a scarcity of healthcare providers who will offer comprehensive abortion care. Third, there is sparse accurate information about the legality and availability of abortion care in the country. Fourth, men are often recognized as the primary decision makers regarding the fertility choices of couples. Lastly, stigma exists around both seeking and providing abortion care.[35] The interpretation of the law can offer flexibility and a more liberal inclusion, or hinder healthcare providers from understanding the breadth of circumstances under the law that allow for an abortion.[34,36] Over the years, abortion prosecutions have been very rare or non-existent in the country's law reports. Indeed, the country has made some progress in improving access to abortion care.

In Ghana, abortion has been liberalized since 1985 and is permitted in cases of rape, defilement, incest, fetal abnormalities incompatible with life, or where continuation of the pregnancy poses a risk to the woman's life, and physical or mental health.[37,38] Ghana signed the Cairo (1994) Consensus on definition and scope of reproductive health. In 2003, Ghana adopted a policy strategy to provide abortion care to the full extent of the law to reduce preventable maternal morbidity and mortality from unsafe abortion.[38] In 2006, comprehensive abortion care (CAC) standards and protocols were developed and implemented by the Ghana Health Service under the supervision and guidance of the Ministry of Health, non-governmental organizations, UN agencies, and healthcare professional societies and legal experts.[34,38] Additionally, Ghana ratified the Maputo protocol in 2007, and currently recognizes abortion care as essential health care.[39]

The Ghana Health Service highlighted safe abortion as one of five components of reducing maternal morbidity and mortality intervention.[38] Despite this distinction, research indicates that policy makers do not regularly disseminate updated CAC standards and protocols. Many practitioners and healthcare providers are not aware of current policy and practice guidelines,[37] with one study finding as many as half of all healthcare providers unaware of the legality of abortion.[35] Nonetheless, the CAC standards and protocols have been progressively revised to address many of the issues commonly raised by researchers; notably gestational age limit, the definition of "mental health" and legal service providers. Most of the revisions follow the WHO guidelines that were modified to suit the local situation. This created an enabling environment for training various cadres of healthcare professionals in support of task-sharing, a key strategy adopted to improve access to care.

As of 2022, there are seven medical schools in Ghana, five of which are public.[40] Each accredited medical school has its own curriculum that is regularly reviewed and approved by the Ghana Medical and Dental Council and the Ghana Tertiary Education Commission.[41,42] The curricula in medical schools cover abortion in relevant sections of basic sciences and clinical training, particularly pathology, pharmacology of related medications, community health, and ob-gyn. Medical students are expected to acquire knowledge on the prevention and management of abortion, including observation of procedures.

The Ghana College of Physicians and Surgeons (GCPS) oversees residency training programs and their development. The GCPS is responsible for certifying training centers and supervising resident training. Abortion care training and service provision are an integral part of internship and resident training in obstetrics and gynecology in Ghana, and residents are not allowed to opt out of training. All general practitioners and ob-gyn specialists are expected to be able to provide abortion care, yet this care is optional. This access also differs by region and proximity to urban areas as healthcare providers and patients in urban areas are more likely to terminate a pregnancy than those in rural areas.[43] Furthermore, many young medical practitioners and specialists choose to go abroad or remain in urban areas, leaving some rural areas of Ghana without licensed physicians.

Several national and international organizations, such as the Planned Parenthood Association of Ghana, Ipas, Marie Stopes International, American College of Nurse-Midwives, and WHO have played important roles in providing training both to doctors and midwives and spreading information from the global community about abortion rights.[38] There has been a gradual incorporation of abortion care into the pre-service curricula of reproductive-health-related courses in tertiary institutions to facilitate task-sharing of abortion care among non-physician healthcare professionals, including physician assistants.

One partnership that has played an integral role in abortion training exists between the University of Michigan and the two largest Ghanaian universities, the University of Ghana and Kwame Nkrumah University of Science and Technology. This collaboration has helped conceive and build the curriculum for the International Family

Planning Fellowship Program (IFPFP) in 2008. This 2-year fellowship aims to legitimize the specialty and address the stigmatization of abortion care by integrating it into the professional role through a formal pathway. Inspired by the Fellowship in Family Planning in the USA, the IFPFP is designed to suit Ghanaian health services and medical institutions and local norms.[38] Through seminars, mentorship, leadership, and clinical training, it teaches ob-gyn skills in advanced family planning and abortion care. It seeks to improve access to information, increase the number of specialists and introduce new clinical services. The fellowship also offers a subspecialty certification in family planning and abortion.[38] Fellowship-trained specialists now work in a number of institutions and in positions around the country. This leads to an increase in the availability of abortion services across Ghana, through direct care and by increasing training of other medical personnel and students.[38] As provider stigma still contributes to the high occurrence of conscientious objection, task sharing with midwives and physician assistants may be critical to expand abortion access.[43]

5 | SUMMARY

This reflection on abortion training aims to provide insights into the core principles of ob-gyn education within the official guidelines of three countries. It seeks to illuminate the foundation of the ob-gyn specialization and identity and to demand a contemplation of the ob-gyn specialization's education and the institutions that oversee and legitimize abortion care training, despite different and changing legal landscapes. Regardless of the legal framework that dictates abortion care, we strongly recommend that ob-gyn training institutions in all countries protect access to abortion training and safe abortion as essential health care. It is pertinent to the health of those seeking abortions and their larger communities that practitioners are well-equipped to provide accurate information and refer their patients to safe abortion care and to safely perform abortions, particularly in the case of an emergency. In addition, in accordance with FIGO's recommendation that abortion be included in all undergraduate medical education programs, we recommend that medical students are also required to learn about abortion care to ensure that they can, at a minimum, counsel and refer patients, and provide post-abortion care. Finally, we recommend that FIGO produce a guideline about expectations for abortion training integration in obstetrics and gynecology.

AUTHOR CONTRIBUTIONS

CO and JS planned and designed the manuscript. CO, JS, EM, and KG-D all contributed to the writing and revisions of the manuscript. All authors have read and approved the final manuscript.

ACKNOWLEDGMENTS

Aliza Adler and Michaela Garcia have been instrumental in providing support in editing and references, without their help this article would not have been possible.

CONFLICT OF INTEREST STATEMENT

The authors have no conflicts of interest.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

ORCID

Cerisa Obern https://orcid.org/0000-0003-0731-7169
Emmanuel Morhe https://orcid.org/0000-0003-1696-1132
Kristina Gemzell-Danielsson https://orcid.org/0000-0001-6516-1444
Jody Steinauer https://orcid.org/0000-0001-7714-0106

REFERENCES

1. World Health Organization. WHO abortion fact sheet. Fact sheets. 2021. Accessed July 14, 2022. https://www.who.int/news-room/fact-sheets/detail/abortion
2. International Federation of Gynecology and Obstetrics. Conscientious objection: a barrier to care. 2021.
3. World Health Organization. Safe abortion: technical and policy guidance for health systems. 2003.
4. The International Federation of Medical Students Associations. IFMSA, FIGO and WATOG joint statement on abortion and contraception in medical education. 2023.
5. Oyez. *Dobbs v. Jackson Women's Health Organization*. Oyez; 2021.
6. Guttmacher Institute. Interactive map: US abortion policies and access after Roe. 2024. Accessed July 14, 2022. https://states.guttmacher.org/policies/
7. Vinekar K, Karlapudi A, Bauer CC, et al. Abortion training in U.S. obstetrics and gynecology residency programs in a post-Dobbs era. *Contraception*. 2024;130:110291. doi:10.1016/j.contraception.2023.110291
8. Jones RK, Kirstein M, Philbin J. Abortion incidence and service availability in the United States, 2020. *Perspect Sex Reprod Health*. 2022;54:128-141. doi:10.1363/psrh.12215
9. Guttmacher Institute. One in four US women expected to have an abortion in their lifetime. 2024.
10. Guttmacher Institute. Abortion incidence and service availability in the United States, 2017. 2017.
11. Diamant J, Mohamed B, Leppert R. *What the data says about abortion in the U.S.* Pew Research Center; 2024. Accessed May 7, 2024. https://www.pewresearch.org/short-reads/2024/03/25/what-the-data-says-about-abortion-in-the-us/
12. Association of Professors of Gynecology and Obstetrics. APGO Medical Student Educational Objectives. 11th ed. 2019.
13. ACOG Committee opinion no. 612: Abortion training and education. *Obstet Gynecol*. 2014;124:1055-1059. doi:10.1097/01.AOG.0000456327.96480.18
14. Weitz TA, Taylor D, Desai S, et al. Safety of aspiration abortion performed by nurse practitioners, certified nurse midwives, and physician assistants under a California legal waiver. *Am J Public Health*. 2013;103:454-461. doi:10.2105/AJPH.2012.301159
15. Foster AM, Polis C, Allee MK, Simmonds K, Zurek M, Brown A. Abortion education in nurse practitioner, physician assistant and certified nurse–midwifery programs: a national survey. *Contraception*. 2006;73:408-414. doi:10.1016/j.contraception.2005.10.011
16. Dube N. States Allowing Non-Physicians to Provide Abortion Services. Office of Legislative Research. 2022.
17. Wulf S, Vinekar K, Dehlendorf C, Srinivasulu S, Steinauer J, Carvajal DN. Implications of overturning Roe v Wade on abortion

training in US family medicine residency programs. *Ann Fam Med*. 2023;21:545-548. doi:10.1370/afm.3042
18. The Accreditation Council for Graduate Medical Education. Clarification on requirements regarding family planning and contraception. 2017.
19. Steinauer JE, Hawkins M, Turk JK, Darney P, Preskill F, Landy U. Opting out of abortion training: benefits of partial participation in a dedicated family planning rotation for ob-gyn residents. *Contraception*. 2013;87:88-92. doi:10.1016/j.contraception.2012.09.002
20. Horvath S, Turk J, Steinauer J, Ogburn T, Zite N. Increase in obstetrics and gynecology resident self-assessed competence in early pregnancy loss management with routine abortion care training. *Obstet Gynecol*. 2022;139:116-119. doi:10.1097/AOG.0000000000004628
21. Turk JK, Landy U, Chien J, Steinauer JE. Sources of support for and resistance to abortion training in obstetrics and gynecology residency programs. *Am J Obstet Gynecol*. 2019;221:156.e1-156.e6. doi:10.1016/j.ajog.2019.04.026
22. Increasing access to abortion. *Obstet Gynecol*. 2020;136:e107-e115. doi:10.1097/AOG.0000000000004176
23. Society of Family Planning. Complex Family Planning Fellowship. 2024. Accessed May 7, 2024. https://societyfp.org/fellowship/
24. *The Accreditation Council for Graduate Medical Education*. Maternal-Fetal Medicine Milestones; 2022.
25. Vinekar K, Karlapudi A, Nathan L, Turk JK, Rible R, Steinauer J. Projected implications of overturning Roe v Wade on abortion training in U.S. obstetrics and gynecology residency programs. *Obstet Gynecol*. 2022;140:146-149. doi:10.1097/AOG.0000000000004832
26. Bixby Center for Global Reproductive Health. Innovating education in reproductive health. n.d. Accessed May 21, 2024. https://www.innovating-education.org/
27. National Board of Health and Welfare. Statistik om aborter, statistics on abortion. 2023. Accessed May 21, 2024 . https://www.socialstyrelsen.se/statistik-och-data/statistik/alla-statistikamnen/aborter/
28. Swedish Society of Obstetrics And Gynecology. Induced abortion, report number 78 (inducerad abort). 2018.
29. Gemzell Danielsson K, Cleeve A. Case study of abortion training integration in training model in Sweden. In: Landy U, Darney PD, Steinauer J, eds. *Advancing Women's Health through Medical Education*. Cambridge University Press; 2021:331-335. doi:10.1017/9781108884709
30. Hammarstedt M, Lalos A, Wulff M. A population-based study of Swedish gynecologists' experiences of working in abortion care. *Acta Obstet Gynecol Scand*. 2006;85:229-235. doi:10.1080/00016340500409976
31. Selberg R. The midwife case and conscientious objection: new ways of framing abortion in Sweden. *Int Fem J Polit*. 2020;22:312-334. doi:10.1080/14616742.2019.1608841
32. Obstetrics and Gynecology Course. Course guide for obstetrics and gynecology. Gothenburg University. 2021.
33. Swedish Society of Obstetrics and Gynecology. Residency course on abortion, contraception and miscarriage (ST Kurs-Abort, antikonception och missfall). 2022.
34. Chavkin W, Baffoe P, Awoonor-Williams K. Implementing safe abortion in Ghana: "We must tell our story and tell it well". *Int J Gynecol Obstet*. 2018;143:25-30. doi:10.1002/ijgo.12674
35. Schwandt HM, Creanga AA, Adanu RMK, Danso KA, Agbenyega T, Hindin MJ. Pathways to unsafe abortion in Ghana: the role of male partners, women and health care providers. *Contraception*. 2013;88:509-517. doi:10.1016/j.contraception.2013.03.010
36. Ghana Health Service, Ministry of Health. Comprehensive abortion care services. Standards and protocols. 2021.
37. Ganle JK, Obeng B, Yeboah JY, Tagoe-Darko ET-D, Mensah CM. Disparities in abortion experience and access to safe abortion services in Ghana: evidence from a retrospective survey. *Afr J Reprod Health*. 2016;20:43-52. doi:10.29063/ajrh2016/v20i2.5
38. Morhe SK, Dalton VK. Case study of abortion training and integration in Ghana. In: Landy U, Darney PD, Steinauer J, eds. *Advancing Women's Health through Medical Education*. Cambridge University Press; 2021:282-289. doi:10.1017/9781108884709
39. Solidarity for African Women's Rights Coalition (SOAWR). Equality now, make every woman count (MEWC). Twenty years of the Maputo Protocol: where are we now? 2023.
40. Medical and Dental Council. List of accredited medical and dental training institutions in Ghana and corresponding programs. 2022. Accessed May 8, 2024. https://www.mdcghana.org/medical-and-dental-training-institutions-in-ghana/
41. Medical and Dental Council. Medical and Dental Council- about us. 2024. Accessed May 8, 2024. https://www.mdcghana.org/about-us/
42. Ghana Tertiary Education Commission. Establishment of the Ghana Tertiary Education Commission. 2019. Accessed July 8, 2022. https://www.gtec.edu.gh/general-overview
43. Aborigo RA, Moyer CA, Sekwo E, et al. Optimizing task-sharing in abortion care in Ghana: stakeholder perspectives. *Int J Gynecol Obstet*. 2020;150:17-24. doi:10.1002/ijgo.13000

SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

How to cite this article: Obern C, Morhe E, Gemzell-Danielsson K, Steinauer J. The importance of abortion training for obstetrician-gynecologists: A comparison of the United States, Sweden, and Ghana. *Int J Gynecol Obstet*. 2024;167:598-603. doi:10.1002/ijgo.15733