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Abortion law and policy reforms in Ghana

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Abstract

In this chapter, our aim is to examine the trajectory of abortion law, policy and practice reforms in Ghana. We focus on legal and policy reforms precisely because there is a strong correlation between restrictive abortion laws, high levels of unsafe abortions and high but preventable maternal mortality and morbidity. We describe the possible scenario of abortion in the pre-colonisation era and the imposition of the English abortion law from the time of colonisation. Importantly, we chronicle the outcomes of a favourable change in the law during an opportune political moment against the impact on women and issues of access and demonstrate that a favourable abortion law is of no import unless and until it is translated into services for women. We outline the evolution of the process from review of the abortion law to the present and postulate that the national health service is best placed, working with partners, to reach women with services. We observe the importance of international and regional enabling treaties and agreements in creating an enabling environment for law reform as well as serving as an impetus for equitable and affordable access to services. We discuss the significance of interpretation of existing laws using accepted global norms in the interest of women and suggest how the stigma that surrounds abortion could be minimised by allowing abortion as a women's healthcare need as well as institutionalising abortion in the training of relevant cadres of health professionals. We argue that while progress in reforming Ghana's abortion law and policies has been slow, Ghana nevertheless provides an example of how restrictive abortion laws, if presented in a pro-active context, can be a powerful vehicle to promote provision of safe comprehensive abortion care services to redress harms from unsafe abortion.

1 Introduction

Since the 1994 International Conference on Population and Development (ICPD) in Cairo, there have been increased efforts to improve the sexual and reproductive health and rights of women and girls across the world.[1] These efforts have propelled both policy and legal reforms to increase access to safe induced abortion services in countries where it is legal.[2] For example, following the ICPD, restrictive laws on induced abortion in many countries across the world have either been repealed or relaxed to make safe abortion services available to women especially on health grounds.[3] This progress notwithstanding, an estimated 205 million women become pregnant each year, with nearly one in five pregnancies (40-50 million) ending in an induced abortion.[4] Half of all abortions globally are estimated to be unsafe and more than 80 per cent of these unsafe abortions occur in low-income countries.[5] Unsafe abortion is defined as a procedure for terminating a pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both.[6] Although the overall global abortion rate has declined, probably as a result of increased access to effective contraceptives, the proportion of unsafe abortion is on the rise, especially in low-income countries.[7]

As has been documented in literature, unsafe abortions may result in outcomes with enormous cost to individuals, families, communities and to national health services.[8] Globally, 13 per cent of all maternal deaths are attributed to unsafe abortion and almost all abortion-related deaths

1 See JK Ganle et al 'Disparities in abortion experience and access to safe abortion services in Ghana: Evidence from a retrospective survey' (2016) 20 *African Journal of Reproductive Health* 43.

2 See for example E Brookman-Amissah 'Woman-centred safe abortion care in Africa' (2004) 8 *African Journal of Reproductive Health* 37. See also E Brookman-Amissah & BJ Moyo 'Abortion law reform in sub-Saharan Africa: No turning back' (2004) 12 *Reproductive Health Matters* 227.

3 See P Aniteye & SH Mayhew 'Globalisation and transitions in abortion care in Ghana' (2019) 19 *BMC Health Services Research* 185.

4 CB Polis et al 'Estimating the incidence of abortion: Using the abortion incidence complications methodology in Ghana, 2017' (2020) 5 *BMJ Global Health* e002130.

5 As above.

6 World Health Organization *Safe abortion: Technical and policy guidance for health systems* 2nd ed (2012).

7 As above.

8 See for example Aniteye & Mayhew (n 3); Ganle et al (n 1); and Polis et al (n 4).

occur in low-middle income countries with the highest numbers in sub-Saharan Africa.[9] Beyond mortality, annually some seven million more women who survive unsafe abortion experience morbidity and disability that diminish their quality of life and may render them infertile.[10] Also, access to safe abortion remains a globally contested policy and social justice issue – contested because of its religious and moral dimensions regarding the right to life and personhood of a foetus versus the rights of women to make decisions about their own bodies.[11] While many countries have agreed to address the health consequences of unsafe abortion, they have often stopped short of committing to providing comprehensive abortion care (CAC) services.[12] In fact, close to 90 per cent of women in sub-Saharan Africa still live in countries where abortion laws are restrictive.[13]

In this chapter, our aim is to examine the trajectory of abortion law, policy and practice reforms in Ghana. We focus on legal and policy reforms precisely because there is a strong correlation between restrictive abortion laws, high levels of unsafe abortions and high but preventable maternal mortality and morbidity.[14] We argue that while progress in reforming Ghana's abortion law and policies has been slow, Ghana nevertheless provides an example of how restrictive abortion laws, if presented in a more pro-active context, can be a powerful vehicle to promote provision of safe comprehensive abortion care services to redress harms from unsafe abortion.

9 See Aniteye & Mayhew (n 3); and Polis et al (n 4).

10 See for example JK Ganle, TN Busia & E Maya 'Availability and prescription of misoprostol for medical abortion in community pharmacies and associated factors in Accra, Ghana' (2019) 144 *International Journal of Gynecology and Obstetrics* 167. Also see KJ Ganle, TN Tiwaa Busia & B Baatiema 'Stocking and over-the-counter sale of misoprostol for medical abortion in Ghana's community pharmacies: Comparison of questionnaire and mystery client survey' (2020) 28 *International Journal of Pharmacy Practice* 267.

11 See Aniteye and Mayhew (n 3).

12 As above.

13 For a discussion on abortions law in sub-Saharan Africa, see M Berer 'Abortion law and policy around the world: In search of decriminalization' (2017) 19 *Health and Human Rights* 13. For a similar discussion, also see DA Aladago et al'The consequences of abortion restrictions for adolescents' healthcare in Ghana: The influence of Ghana's abortion law on access to safe abortion Services' (2019) 6 *UDS International Journal of Development* 1.

14 As above.

The rest of the chapter proceeds as follows. The next section provides a brief overview of the prevalence of abortion and unsafe abortion in Ghana, and associated consequences. The second section takes a historical look at abortion and abortion legislation and reforms in Ghana. In line with Charles Ngwena's suggestion that the evolution, development and reform of abortion law in Africa can be understood to have occurred in three main phases, namely the indigenous or precolonial phase, the colonial phase and the post-colonial phase, we focus on pre-colonial, colonial and post-colonial abortion legislation and reforms in Ghana.[15] The aim is not only to present a historiographical account of the antecedence, evolution and trajectory of abortion law and policy reforms in Ghana, but also to highlight innovative approaches/strategies that have been deployed as part of the abortion law and policy reform agenda. This is followed by a reflection on outstanding gaps in Ghana's abortion law and policy reform agenda. The final section concludes with some recommendations.

2 Unsafe abortion in Ghana

Over the last three decades, Ghana has achieved significant gains in population health. Life expectancy has improved, together with a significant reduction in under-five mortality from 155 in 1988 to 40 per 1 000 live births in 2022; reduction in infant mortality rate from 77 in 1988 to 28 per 1 000 live births in 2022; reduction in neonatal mortality rate from 43 in 1988 to 17 per 1000 in 2022; reduction in financial barriers to healthcare access due to the introduction of a national health insurance scheme (NHIS) and a free maternal care policy; increased skilled birth attendance during delivery from 41 per cent in 1988 to 88 per cent in 2022; reduction in HIV prevalence from 3.6 per cent in 2007 to 1.7 per cent in 2020; and introduction of the Mental Health Act.[16] These improvements notwithstanding, several critical challenges remain. One such challenge relates to unsafe abortion and access to safe abortion services.

15 CG Ngwena 'Access to abortion: Legal developments in Africa? From a reproductive and sexuality rights perspective' (2004) 19 *SA Public Law* 328.

16 See Ghana Statistical Service (GSS) and ICF. 2023. *Ghana Demographic and Health Survey 2022: Key Indicators Report*. Accra, Ghana, and Rockville, Maryland, USA: GSS and ICF.

Recent estimates from the 2022 Ghana Demographic and Health Survey suggest a national abortion rate of 7 per cent.[16] Estimates from the 2017 Ghana Maternal Health Survey data provide absolute numbers: approximately 200 000 (95 per cent CI 161 495 to 237 622) induced abortions occurred in Ghana in 2017, translating into a rate of 26.8 (95 per cent CI 21.7 to 31.9) abortions per 1 000 women aged 15-49.[17] The rate however varies between geographical regions. For example, the abortion rate was lowest in the Northern Zone (18.6, 95 per cent CI 14.7 to 22.5), followed by the Coastal Zone (25.2, 95 per cent CI 18.9 to 31.6) and the Middle Zone (30.4, 95 per cent CI 21.0 to 39.9).[18] Crucially, 70.8 per cent of the approximately 200 000 abortions in 2017 were deemed illegal, corresponding to a count of 141 316 (95 per cent CI 107 719 to 174 913) illegal abortions, and estimated as 60.1 per cent in the Coastal Zone, 72.2 per cent in the Northern zone, and 78.3 per cent in the Middle Zone.[19] Other previous estimates suggested that about 90 per cent of women in Ghana have heard about abortion and nearly two in ten have had an abortion.[20] In addition to the unacceptably high unsafe abortion rate in Ghana, 11-30 per cent of maternal deaths in Ghana are due to unsafe abortions and adolescents contribute about 35 per cent of these deaths.[21] Furthermore, Ghana spends about GH¢37.8 million (US$8.5 million) out of pocket on unsafe abortions, which suggests an increased risk of catastrophic expenditure and poverty for many.[22]

In Ghana, safe abortions are principally performed using manual vacuum aspiration (MVA), medication abortion, dilation and curettage (D&C) and dilation and evacuation (D&E), albeit only medical practitioners and obstetricians practice D&C and D&E.[23] In the 2017 Ghana Maternal Health Survey, a little over a third of women who

17 Polis et al (n 4).
18 As above.
19 As above.
20 Ghana Statistical Service (GSS), Ghana Health Service (GHS) & ICF International 'Ghana Demographic and Health Survey 2008' (2009).
21 See Aniteye & Mayhew (n 3).
22 For a detailed discussion on this issue, see G Schieber et al *Health financing in Ghana* (2012).
23 Ghana Health Service *Prevention and management of unsafe abortion: Comprehensive abortion care services standards and protocols* (2012). See also W Chavkin, P Baffoe & JK Awoonor-Williams 'Implementing safe abortion in Ghana: "We must tell our story and tell it well"' (2018) 143 *International Journal of Gynecology and Obstetrics* 25.

had an abortion used pills, either Misoprostol alone (18 per cent) or a combination of Mifepristone and Misoprostol (20 per cent), while about a quarter used dilation and curettage (D&C) or dilation and evacuation (D&E) (24 per cent).[24] These methods are similar to what had been documented ten years earlier. For instance, the 2007 Ghana Maternal Health Survey found that the most common action taken to end a pregnancy is D&C (40 per cent), with a combined 21 per cent of women reporting taking tablets including Cytotec (Misoprostol), and 12 per cent having MVA to terminate the pregnancy.[25] As regards unsafe abortion however, a variety of other methods are used. For instance, slightly more than a quarter of women (27 per cent) used a non-medical method such as drinking milk, coffee, alcohol, or other liquid with sugar, drinking a herbal concoction, or other home remedy, using a herbal enema, inserting a substance into the vagina, heavy abdominal massage, excessive physical activity, and other tablets (exact kinds unknown) to terminate their pregnancy.[26] But it is not only the use of non-medical and potentially unsafe methods that is of concern. In the 2017 survey, only 41 per cent of the women who had an abortion sought help from healthcare personnel; 33 per cent consulted a pharmacist or chemical seller; 16 per cent sought help from someone else, and 10 per cent did not seek help from anyone.[27] In addition, 37 per cent of the women in the 2017 survey had abortions at home, which could have potential adverse outcomes. Many women in Ghana also make out-of-pocket payment for abortion services. For instance, 93 per cent of women aged 15-49 years who had an induced abortion in the five years preceding the 2017 Ghana Maternal Health Survey made a payment for their most recent induced abortion.[28]

Finally, women in Ghana report several reasons for choosing abortion. Over one-fifth of women recently cited 'not being ready', 'too young', or 'wanting to delay childbearing' (21 per cent) as their main reason for choosing abortion.[29] Other reasons include not having money to care for a baby, wanting to space their births, wanting to continue going to school

24 See GSS et al (n 16).
25 See GSS et al (n 20).
26 See GSS et al (n 16).
27 As above.
28 As above.
29 As above.

or other life circumstances (including nobody to help look after a baby, wanting to continue working, and not wanting more children).[30] These reasons are similar to reasons documented ten years earlier, where not having enough money to take care of the baby was the reason most often given for having an abortion.[31] Ten years before the 2017 Ghana Maternal Health Survey, wanting to continue schooling was reported as the most commonly mentioned reason for having an abortion among women under age 20 (at the time of the abortion), women with first or second order pregnancies, and women who have attended secondary school or higher.[32] While a discussion on Ghana's abortion law is offered later, it is important to highlight that many of the reasons why Ghanaian women choose induced abortion appear not to be grounds for termination of pregnancy as currently provided for under Ghana's abortion law. As we argue later, this seeming disconnect is one more reason why some have called for further liberalisation of Ghana's abortion law.

3 Abortion in pre-colonial Ghana

Like much of sub-Saharan Africa, literature on the topic of abortion in pre-colonial Ghana is very scanty. This scarcity, as Charles Ngwena argues in the larger context of abortion in pre-colonial Africa, is partly because the pre-colonial phase has been the least documented of phases in the development of abortion in Africa.[33] The scarcity is also partly because of the tradition of oral history in much of Africa that has not always allowed contemporaneous documentation of abortion traditions and practices.[34] But the scarcity is also partly related to the fact that abortion was not generally considered to be a matter in the public domain for public debate.[35]

30 As above.
31 See GSS et al (n 20).
32 As above.
33 CG Ngwena 'Inscribing abortion as a human right: Significance of the Protocol on the Rights of Women in Africa' (2010) 32 *Human Rights Quarterly* 783.
34 See Ngwena (n 15).
35 As above.

These limitations notwithstanding, a few anthropological and historical studies suggest that abortion was widely practiced.[36] For instance, among the Akan in pre-colonial Ghana, Rattray observed that abortion was often induced to save the life of a pregnant adulteress, and that the abortifacient was a drink decocted from the leaves of the plant called *abini duru* in Twi, mixed with salt.[37] Fortes and colleagues, who conducted anthropological research among the Akan (Asante) in 1945, also mentioned abortion briefly.[38] Fortes and colleagues argued that the idea of an unwanted pregnancy in marriage was unheard of among the Akan, and that an Akan country-woman would be horrified at the suggestion of an induced miscarriage.[39] They however noted that induced abortion was used by married women impregnated through adultery, which was considered a very serious private wrong against the husband.[40] In a later survey on abortion in 400 pre-industrial societies including Ghana, Devereux argued that there is every indication that abortion was an absolutely universal phenomenon, and that it is impossible to even construct an imaginary social system in which no woman would ever feel at least impelled to abort.[41]

Thus, while aggregated or disaggregated data on pre-colonial abortion are very hard to find, both pre-colonial anthropological research and contemporary historical narratives all suggest that in pre-colonial Ghanaian society, abortion was widely practiced under several circumstances, including in the event of pre-initiation or adulterous

36 For a detailed discussion, see DA Ampofo 'Abortion in Accra: The social, demographic perspectives' in NO Addo et al (eds) *Symposium on implications of population trends for policy measures in West Africa* (1970) 79. See also DK Patterson *Health in colonial Ghana: Disease, medicine and socio-economic change, 1900-1955* (1981).

37 RS Rattray *Religion and art in Ashanti* (1927). Also see G Devereux *A study of abortion in primitive societies* (1955).

38 M Fortes, RW Steel & P Ady 'Ashanti Survey, 1945-46: An experiment in social research' (1947) 110 *The Geographical Journal* 149-177. https://doi.org/10.2307/1789946.

39 As above.

40 See also W Bleek *Sexual relationships and birth control in Ghana: A case study of a rural town* (1976); W Bleek 'Avoiding shame: The ethical context of abortion in Ghana' (1981) 54 *Anthropological Quarterly* 203; W Bleek & NK Asante-Darko 'Illegal abortion in Ghana: Methods, motives and consequences' (1986) 45 *Human Organization* 333; and W Bleek 'Did the Akan resort to abortion in pre-colonial Ghana? Some conjectures' (1990) 60 *Journal of the International African Institute* 121 for a detailed discussion on this topic.

41 See Devereux (n 37).

pregnancies.[42] This is more probable given that the knowledge of necessary techniques was available. Indeed, Bleek counted as many as 53 methods for inducing abortion among the Kwahu in the Eastern region of Ghana; a total which rose to 79 once supplementary data from other Akan researchers were included.[43] Bleek therefore argued that knowledge of abortifacients can be taken as a further indication of the historical origin of the practice, and that such a high frequency is unlikely unless abortion was common in earlier generations.[44]

An important point to underscore in relation to abortion in pre-colonial Ghana is that no legislation or policy existed that proscribed abortion in the public domain. Consequently, abortion was often not criminal except in few cases where local customary sanctions and rituals of purification were imposed.[45] This position is indeed consistent with what has been documented in many pre-colonial African countries. For instance, Charles Ngwena argues that the issue of punishment for abortion was generally not for the public realm partly because abortion was often regarded as a private matter for resolution by the family rather than indigenous courts, with women playing a pre-eminent role.[46] This position is also echoed by Armstrong and Nhlapo, who contend that although abortion in pre-colonial Africa was socially frowned upon and was often a cause for shame for women who practiced it, sanctions meted out by an indigenous court appeared to be the exception rather than the norm.[47] Thus, there was both private moral censure and a measure of public tolerance of abortion. Apart from the fact that abortion was often seen as a private family affair, it could also be argued that pre-colonial Ghana, just as in many pre-colonial African societies, lacked a public health system capable of both maintaining and policing population health including induced abortion. As Charles Ngwena argues, healthcare (in pre-colonial Africa) was essentially a private matter for the individual

42 Devereux (n 37). See also Bleek (1990) (n 40).
43 See Bleek (1976) (n 40) 212-214. See also Bleek & Asante-Darko (n 40).
44 As above.
45 Both Rattray (n 37) and Fortes (n 38) underscore this point in their research in pre-colonial Ghana.
46 Ngwenya (n 15).
47 AK Armstrong & RT Nhlapo *Law and the other sex: The legal position of women in Swaziland* (1985).

and the family and so was abortion. 'It was only as a result of colonialism that abortion entered into the public domain.'[48]

4 Criminalising and policing abortion in Ghana – the colonial experience

Colonialism remains one of the most important historical epochs in Africa's history and its deeply rooted imprints are still visible today. As scholars have previously written, colonialism not only led to the subjugation of colonial peoples; colonial powers also imposed their own legal systems, including abortion laws, on many of their colonies in Africa.[49] Ghana was colonised by Britain, and like most British colonies, English common laws were used for everyday political, economic and social administration.[50] In colonial Ghana, laws on abortion were shaped by Britain's Offences Against the Person Act of 1861 and the judicial interpretation of English common law. Specifically, under section 58 of the 1861 Act, it was a criminal offence for a woman to unlawfully procure an abortion. This law was often interpreted in British colonies including Ghana to mean that abortion was illegal. Even in later years when this colonial law was modified or interpreted to accommodate the immediate necessity to save the life of the mother, no efforts were made to disseminate such information to the public nor were service providers willing to openly offer abortion services. This effectively rendered public provision of safe abortion services illegal in colonial Ghana. Sadly, this continued long after the end of British colonial rule in Ghana, and long after Britain reformed and liberalized its own abortion laws.[51]

5 Reforming colonial abortion legislations in Ghana – the post-colonial experience

Following Ghana's independence in 1957, efforts were made to develop independent structures and legislation commensurate with its new status as a sovereign nation. Among other things was the codification of various laws, which culminated in the promulgation of the 1960 Criminal Code

48 See Ngwena (n 15) 335.
49 As above.
50 Brookman-Amissah & Moyo (n 2).
51 Ngwena (n 15).

of Ghana (Act 29).[52] Sections 58, 59 and 67 of Ghana's 1960 Criminal Code dealt with the issue of induced abortion. Section 58 says:

> (1) Subject to the provisions of subsection (2) of this section –
> (a) any woman who with intent to cause abortion or miscarriage administers to herself or consents to be administered to her any poison, drug or other noxious thing or uses any instrument or other means whatsoever; or
> (b) any person who –
> (i) administers to a woman any poison, drug or other noxious thing or uses any instrument or any other means whatsoever with the intent to cause abortion or miscarriage, whether or not that the woman is pregnant or has given her consent;
> (ii) induces a woman to cause or consent to causing abortion or miscarriage;
> (iii) aids and abets a woman to cause abortion or miscarriage;
> (iv) attempts to cause abortion or miscarriage; or
> (v) supplies or procures any poison, drug, instrument or other thing knowing that it is intended to be used or employed to cause abortion or miscarriage, shall be guilty of an offence and liable on conviction to imprisonment for a term not exceeding five years.

Unfortunately, the restrictive colonial abortion legislation inherited from the British Government was indigenised and adopted in the 1960 Criminal Code. Like its colonial antecedent, sections 58, 59, and 67 of Ghana's 1960 Criminal Code permitted abortion, only if the abortion was part of any medical treatment of the woman.[53] However, the fact that abortion was included under the penal code immediately foreclosed any serious public policy engagement with the topic of abortion. Abortion was simply a criminal offence punishable by law. This understanding continued until the repeal of the 1960 Criminal Code (Act 29, sections 58, 59 & 67) in 1985. The Provisional National Defense Council Law 102 (PNDCL 102) amended sections 58, 59 and 67 by introducing several circumstances under which legal abortion could be provided. The amended section 58 of PNDCL 102 states:

> (a) any woman who with intent to cause abortion or miscarriage administers to herself or consents to be administered to her any poison, drug or other noxious thing or uses any instrument or other means whatsoever; or
> (b) any person who –
> (i) administers to a woman any poison, drug or other noxious thing or uses any instrument or any other means whatsoever with the

52 RAS Morhee & ESK Morhee 'Overview of the law and availability of abortion services in Ghana' (2006) 40 *Ghana Medical Journal* 80.
53 As above.

intent to cause abortion or miscarriage whether or not that the woman is pregnant or has given her consent;

(ii) induces a woman to cause or consent to causing abortion or miscarriage;

(iii) aids and abets a woman to cause abortion or miscarriage;

(iv) attempts to cause abortion or miscarriage; or

(v) supplies or procures any poison, drug, instrument, or other thing knowing that it is intended to be used or employed to cause abortion or miscarriage, shall be guilty of an offence and liable on conviction to imprisonment for a term not exceeding five years.

(2) It is not an offence under subsection (1) of this section if an abortion or a miscarriage is caused in any of the following circumstances by a registered medical practitioner specialising in gynaecology or any other registered medical practitioner in a Government hospital or in a private hospital or clinic registered under the Private Hospitals and Maternity Homes Act, 1958 (No. 9) or in a place approved for the purpose by legislative instrument made by the Secretary (for Health):

(a) where the pregnancy is the result of rape, defilement of a female idiot or incest and the abortion or miscarriage is requested for by the victim or her next of kin or the person in loco parentis, if she lacks the capacity to make such a request;

(b) where the continuance of the pregnancy would involve risk to the life of the pregnant woman or injury to her physical or mental health and such woman consents to it or if she lacks the capacity to give such consent it is given on her behalf by her next of kin or the person in loco parentis; or

(c) where there is substantial risk that if the child were born, it may suffer from, or later develop, a serious physical abnormality or disease.

Thus, while abortion under PNDC Law 102 is generally seen as an offence, the law recognised and introduced the above mentioned grounds on which legal abortion could be procured. It has been argued that the legal provisions for abortion in PNDC Law 102 make Ghana's abortion law open to a liberal interpretation, due to the broad application of 'health' (physical, mental and social – as per the World Health Organization (WHO) definition of health) as an indication for procuring induced abortion.[54] Although the relatively vague nature of many of the provisions in PNDC Law 102 could have negative consequences whereby legitimate providers are not aware of the wide circumstances within which they can legally provide abortion services, the law is liberal enough to allow practitioners to work within it without

54 As above.

attracting too much negative public attention.[55] In this way, PNDC Law 102 serves an important defining moment in Ghana's abortion law and policy reform journey. What remains unclear to date is why and how such a relatively positively dramatic reform came about. Our engagement and involvement with key players in the abortion debate in Ghana however revealed potential explanations. First, the 1980s presented difficult political and economic circumstances. In particular, economic recovery programmes such as structural adjustment programmes required the rolling back of the state's role in the provision of social and economic goods, including health. Cost recovery measures implemented in the health sector particularly led to catastrophic out-of-pocket payment for basic health services. As a result, several health indicators including infant and maternal mortality deteriorated. Overwhelmed with maternal deaths from and as a result of unsafe abortion, a group of Obstetricians and Gyneacologists – supported by the late Prof Fred Sai – advocated for a change in Ghana's abortion law. They accordingly approached the then Head of State – President Jerry John Rawlings – to request a change in the abortion law. President Rawlings, not well versed in these issues, simply asked them to proceed. This led to the drafting of PNDC Law 102. As there was no parliament at the time, no debate was had on it, and the law was promulgated as part of the criminal code. Thus, a combination of strategic framing and opportunity and tacit support of the Head of State at the time facilitated the liberalisation process. But that is not the only reason. During the years of military dictatorship in the 1980s, the influence of institutionalised religion was lessened, which meant less opposition to liberalisation of the abortion law.[56] Additionally, liberalisation of the abortion law was part of broad social and economic transformations including structural adjustment programmes as well as several preparatory efforts by Ghana to ratify a number of international treaties that demanded respect for women's rights and/or required state parties to take steps to reduce maternal mortality through tackling the problem of unsafe abortions.

55 SD Rominski & JR Lori 'Abortion care in Ghana: A critical review of the literature' (2014) 18 *African Journal of Reproductive Health* 17.

56 P Aniteye & SH Mayhew 'Shaping legal abortion provision in Ghana: Using policy theory to understand provider-related obstacles to policy implementation' (2013) 11 *Health Research Policy and Systems* 23.

As shown in table 1, Ghana is a signatory to several important international human rights treaties, conventions, covenants, declarations, agreements and programmes of action that address the abortion issue and support a woman's right to exert control over her own body, and for a woman's right to autonomy.[57] Notably and in the context of our discourse, these include but are not limited to the following: the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW); the International Covenant on Civil and Political Rights (ICCP); the International Covenant on Economic, Social and Cultural Rights (CESCR); and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT). Ghana has also ratified the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, also known as the Maputo Protocol, the only international human rights agreement that explicitly makes reference to abortion as a human right.

Table 1: Ghana ratification status by Treaty

Treaty description	**Treaty name**	**Signature date**	**Ratification date, accession(a), succession(d) date**
Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment	CAT	7 Sep 2000	7 Sep 2000
Optional Protocol of the Convention against Torture	CAT-OP	6 Nov 2006	23 Sep 2016
International Covenant on Civil and Political Rights	CCPR	7 Sep 2000	7 Sep 2000
Second Optional Protocol to the International Covenant on Civil and Political Rights aiming to the abolition of the death penalty	CCPR-OP2-DP	Not signed	Not ratified

57 United Nations Human Rights Treaty Bodies 'UN Treaty Database' Consulted on 31 October 2022.

Convention for the Protection of All Persons from Enforced Disappearance	CED	6 Feb 2007	Not ratified
Convention on the Elimination of All Forms of Discrimination Against Women	CEDAW	17 Jul 1980	2 Jan 1986
International Convention on the Elimination of All Forms of Racial Discrimination	CERD	8 Sep 1966	8 Sep 1966
International Covenant on Economic, Social and Cultural Rights	CESCR	7 Sep 2000	7 Sep 2000
International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families	CMW	7 Sep 2000	7 Sep 2000
Convention on the Rights of the Child	CRC	29 Jan 1990	5 Feb 1990
Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflict	CRC-OP-AC	24 Sep 2003	9 Dec 2014
Optional Protocol to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography	CRC-OP-SC	24 Sep 2003	Not ratified
Convention on the Rights of Persons with Disabilities	CRPD	30 Mar 2007	31 Jul 2012
African [Banjul] Charter on Human and Peoples' Rights	N/A	Signed	Ratified

Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa	N/A	Signed	Ratified
Protocol to the African Charter on Human and Peoples' Rights on the Establishment of an African Court on Human and Peoples' Rights	N/A	9 Jun 1998	Not ratified
African Charter on the Rights and Welfare of the Child	N/A	18 Aug 1997	Feb 2004

Furthermore, the requirement by the Constitution of Ghana for Parliament to ratify and domesticate all international treaties adopted and which must be certified by the Attorney General to be compatible with the Constitution and relevant national laws have all been met.

The ratification of international human rights laws such as the CEDAW in 1986 and regional treaties such as the Maputo Protocol by the government of Ghana provided an enabling framework within which provisions for the realisation of basic human rights including general health rights and access to safe abortion services could be discussed. For instance, under the CCPR, the government of Ghana has a responsibility to protect every person's right to life (article 6), and according to this Human Rights Committee, that means the government must take all possible measures to increase the life expectancy of all people.[58] This Committee explicitly described illegal and unsafe abortion as a violation of article 6, noting the link between illegal and unsafe abortion and high rates of maternal mortality.

Additionally, post-abortion care was a critical part of the Safe Motherhood Initiative that was developed in the 1980s and implemented in the 1990s. While the relatively liberal nature of PNDC Law 102 portended several benefits, the lack of transparency in the process

58 Human Rights Committee, General Comment 6: Art 6 (16th Sess, 1982) in Compilation of General Comments and General Recommendations by Human Rights Treaty Bodies, Note by the Secretariat, 26 April 2001, UN Doc HRI/GEN/1/Rev.5 (2001) at 115 para 5.

of legal development and reform negatively impacted knowledge of Ghana's abortion law as it was not well disseminated. Consequently, neither the public nor clinicians appeared to clearly understand that abortion is legally permitted in these circumstances. Similarly, many women continued to turn to unqualified providers and received unsafe procedures, with associated high rates of death and morbidity.

6 Recent reforms and innovations

As indicated earlier, Ghana's revised abortion law was not widely disseminated and only few senior Obstetrician Gynaecologists knew about it. For two decades, Ghanaian women thus continued to die from unsafe abortions. In 1993 however, a fortuitous discovery of the law on the shelves of the Ministry of Health by the second author of this chapter led to its dissemination at the annual meeting of the Ghana Medical Association in 1994. This led to a communique by the Ghana Medical Association calling for the implementation of Post-Abortion Care (PAC), including for training and services.[59] Around this time also, Partners for Reproductive Justice (Ipas), a US-based non-profit organisation working globally to improve access to safe abortion services, introduced the low-tech MVA instrument into the two teaching hospitals in Ghana and trained consultants in its use.[60] They in turn trained Obstetrics and Gynaecology Residents to expand services.

Also, in 1994, USAID supported a study in Ghana to determine the capability and acceptability of trained midwives to provide PAC services using the MVA kit. The results of the study were an emphatic 'YES' for midwives' competency and acceptability by women. The 1996 dissemination of the study's results to an international and regional audience led the WHO to recommend trained midwives and nurses to provide PAC services. Meanwhile the ICPD conference had taken place in 1994 and there were also attempts by Ghana's MOH to train and equip doctors and mid-level providers (MLPs) to provide elective abortion as permitted by Ghana's abortion law.

59 See Brookman-Amissah & Moyo (n 2).

60 PK Aboagye et al *An assessment of the readiness to offer contraceptives and comprehensive abortion care in the Greater Accra Eastern and Ashanti regions of Ghana* (2007).

Between 2001 and 2004, the Ipas Africa Alliance was involved in widespread advocacy and sensitisation workshops and seminars and one-on-one meetings with various identified stakeholders and strategically identified groups like the women lawyers' associations, and other relevant groups in Ghana. Advocacy was aimed at development of the processes for full implementation of the law and provision of safe services including by trained MLPs in order for services to reach women where there were few or no doctors. This included invoking International and Regional Human Rights and Women's Rights agreements and standards, including the ICPD Programme of Action's paragraph 63(iii) mandate, the Maputo Protocol, Maputo Plan of Action, MDGs, and declarations by sub-regional institutions like the West African Health Organization (WAHO), all of which called for provision of safe abortion services as allowed by national laws and also the Abuja Declaration for African Union member states to allocate 15 per cent of national budgets to health.

In 2005 following intensive advocacy and sensitisation by Ipas, a Strategic Assessment was undertaken by the Ministry of Health (MoH) of Ghana with technical support from Ipas and WHO HRP and including other local partners as well as community representatives.[61] The purpose of the assessment was to enable key stakeholders to discuss issues of interest in reproductive health including abortion.[62] The assessment, commissioned by the MoH, was conducted by a 17-member team some of whom were obstetricians and midwives, as well as representatives from Ipas and other international NGOs.[63] Major findings from the study included poor knowledge of the abortion law among the public and many health providers and the dangerous methods used by women and girls to induce abortion.[64] Other findings were the strong 'culture of silence' surrounding abortion and the current willingness of communities to openly discuss abortion issues.[65] The high costs of abortion services and the clandestine nature in which services are provided were

61 PK Aboagye et al (n 60). Also, see Ipas Ghana 'IPAS Ghana: Our story so far (2006-2013)' (2014); and Ipas Ghana 'Celebrating 10 years of women's healthcare in Ghana' (2017).
62 PK Aboagye et al (n 60).
63 As above.
64 As above.
65 As above.

identified as well as the increase of medical abortion in urban areas.[66] Recommendations from the Strategic Assessment therefore included the dissemination of the law and development of standards and guidelines based on an agreed upon interpretation of the 1985 amended abortion law.[67] It also called for institutionalization of training for providers, including preservice training for doctors, midwives and nurses.

Following the strategic assessment in 2005, and with support from Ipas and WHO and in collaboration with other relevant NGOs, standards and guidelines were developed for comprehensive abortion care services.[68] About this same time in 2006, a global funder for women's reproductive health entered into partnership with five international organisations working in women's reproductive health in Ghana – Ipas, Population Council, Marie Stopes International, Engender Health and Willows International – to support the Ghana Health Service (GHS) to implement the 'Reducing Maternal Mortality and Morbidity' (R3M) programme. The overall goal of the R3M programme in Ghana was to contribute to the Government of Ghana's (GoG) commitment to attain Millennium Development Goals 5 (namely, reduce by three quarters the maternal mortality ratio by 2015 using the 1990 figure as baseline) and the Sustainable Development Goal (SDGs) goal 3 by improving access to family planning especially long-acting and permanent methods and to reduce maternal mortality and morbidity due to unsafe abortion.[69] The R3M programme was the first in Ghana to focus on providing CAC. Prior to the R3M programme, both GoG and donor supported interventions had been limited to providing PAC.[70] The R3M programme originally focused on three regions of Ghana: Ashanti, Eastern and Greater Accra. The programme subsequently expanded to include two additional regions (Central and Western regions) in 2017. The R3M programme was implemented by a consortium of the above named five independent international non-governmental organisations (INGOs).

66 As above.
67 As above.
68 As above.
69 See Ghana Health Service 'Strategic plan for the implementation of comprehensive abortion care services in Ghana' (2005).
70 See PK Aboagye et al (n 60) and Ipas Ghana (2014) (n 61). See also Population Council 'Contributing to MDG5: Reducing maternal morbidity and mortality in Ghana' (2012) for more details of the R3M programme in Ghana.

Also, about the same time, Medication Abortion became widely available and acceptable and training in provision of this service made it more possible to work with a wider range of providers and women.[71] It also necessitated a review of the Standards and Guidelines to incorporate requirements for, and access to, medication abortion. Training and services set-up improved access for women to receive comprehensive reproductive health services including safe abortion and contraception/family planning services. The consortium also worked in advocacy with a wide range of perceived partners and Champions including traditional Queen mothers who are opinion leaders and very influential at national and community levels.[72] They also included the Ghana Police Service in the advocacy campaign and actually worked to include international agreements and the Ghana abortion laws in the training curriculum of police officers.[73] The Obstetrics and Gynaecology department of the National Police Hospital became a centre for training in safe abortion services and service delivery.

The overall achievements of the R3M programme have been a reduction in unsafe abortion rates and increased awareness about safe abortion among women and especially youth. Indeed, while Ghana did not achieve the MDG 5 targets and has yet to achieve SDG 3 targets related to reduction in maternal mortality, overall, there is near unanimity that the R3M Ghana programme has been successful in making important contributions to reducing maternal mortality through the provision of safe and quality CAC and family planning services.[74] This success is the result of the collective efforts of a group of experienced and passionate organisations and individuals who clearly understood what the challenge was and what needed to be done to address it. The success of the R3M programme was also the result of a new model of cooperation to address maternal mortality, using a broad-based, bottom-up approach, driven by a committed donor and local experts or people who had sound understanding of the local context. In the final analysis, the story of the R3M Ghana programme reflects the collective history and efforts of a committed donor and a people whose passion to save the lives of women

71 As above.
72 See Ganle, Busia & Maya (n 10).
73 Population Council (n 70).
74 As above.

and girls were mostly born out of experiences in and outside of clinical encounters, where they have witnessed several women die painfully and needlessly from unsafe abortion. It is therefore important that individuals who seek to address a difficult issue like abortion not only have technical expertise but also understand the context of their work and are passionate enough about what they do or want to do.

7 Other factors that facilitated the roll out of safe abortions services in Ghana

International NGOs have been critical players in Ghana for communicating and advocating on the global rights perspectives and frameworks. For example, R3M, taking up global debates on abortion rights pushed for evidence, reviews and piloting of interventions as well as providing training and support to influence service provision in Ghana.[75] Ipas was particularly influential at a global level, and in working with in-country partners at all levels. In March 2003, Ipas organised a landmark regional conference in Addis Ababa, Ethiopia to take '[a]ction to reduce maternal mortality in Africa'. This meeting for African leaders including Ministers of Health was seminal in the subsequent roll out of access to safe abortion services in Ghana.[76] It was attended by a high-level Ghanaian delegation led by the Minister of Health. Other participants from 15 African countries included three Ministers of Health, high level policy makers, health and other professionals, women's health and rights' activists, media practitioners, religious groups and youth representatives. The WHO Safe Abortion Technical and Policy Guidance for Health Systems was first introduced and launched at this meeting as were other policy and advocacy documents and tools. The WHO Guidance described how countries could ensure access to safe abortion services to the full extent permitted by law. As part of their commitment to help reduce preventable deaths of women from unsafe abortions, a communiqué was signed by all the participating countries to act to reduce maternal mortality, using the WHO prescribed document.[77]

75 As above. See also A Sundaram et al 'The impact of Ghana's R3M Program on the provision of comprehensive abortion care services' (2015) 30 *Health Policy and Planning* 1017 for more details on the impact of the R3M programme in Ghana.
76 Ipas Ghana (2014) (n 61).
77 See Aniteye & Mayhew (n 3).

Taking inspiration from the deliberations of the meeting in Ethiopia, Ghana formed an interdisciplinary reproductive health group to implement the recommendations from the meeting.[78] A Ghana Health Service taskforce was tasked with developing a strategic plan to address the problem of unsafe abortion in Ghana.[79] The GHS, with significant technical support from Ipas and MSI, revised the National Reproductive Health Service Policy and Standards, incorporating an additional objective under: 'Prevention of Unsafe Abortion and Post Abortion Care' allowing for provision of safe abortion services to the full extent of the law.[80] The document provided, for the first time, clear descriptions of CAC and PAC provision at different service delivery levels.[81] The Ipas 2003 meeting and the WHO Guidelines served as the impetus for the 2003 Policy and Standards revision.

In addition to the role of international NGOs, local civil society activism has played an important role in the opening up of CAC services in Ghana. For instance, local organisations such as the Planned Parenthood Association of Ghana, Curious Minds Ghana (a youth focused organisation), and Alliance for Reproductive Rights (a network of local Ghanaian NGOs promoting a rights-based approach to sexual and reproductive health), have all advocated for the provision of CAC services in public health facilities at no or reduced cost. Other major CSOs that have supported access to safe abortion have been the women lawyers' groups, and to some extent the Ghana Medical Association. During the period of the R3M programme, associations of Queen mothers for reproductive health (referred to earlier) who had been sensitised and trained as advocates also contributed hugely to work at a grassroots level by instructing and encouraging young girls and women in their communities to seek legal safe abortions.

Furthermore, personal commitments and influences of key persons in the MoH also played a big part in the adoption and implementation of the policies and guidelines for safe abortion services. A critical 'window of opportunity' had opened when the leadership of the MoH's Reproductive Health Unit changed, and the new head was much more

78 As above.
79 As above.
80 As above.
81 As above.

committed to the need for safe abortion services to tackle maternal mortality. Two other individual activists committed to safe abortion services, a renowned international public health practitioner (the late Prof Fred Sai) and a lawyer-parliamentarian (Hon Nana Oye Lithur), were actively involved in both the policy and guidelines development and amendments.

Other issues that contributed to advocacy for implementation of Ghana's abortion law included the Mexico City Policy. Over the years, the Mexico City Policy or Global Gag Rule imposed by respective Republican US administrations made the environment more difficult and constituted an impediment for officials in Ghana's MoH and its affiliates to fully embrace safe abortion and sometimes even PAC services.[82] The 'Gag Rule' prohibits funding to NGOs that provide information about or services for safe abortion.[83] Although the Policy did not directly apply to governments and ministries of health in low-income countries, it created a 'Chill Effect' that adversely discouraged ministries of health from working on abortion issues. In Ghana, the 'Gag Rule' re-imposed by President Bush Junior particularly resulted in the Planned Parenthood Association of Ghana (PPAG) – which received significant USAID funding – having to withdraw outreach services and lay off staff as a result of losing funding through not signing on to the 'Gag Rule'.[84] Such visible draconian backlash for a big organisation like PPAG proved a huge disincentive for work on abortion for the MoH and other NGOs.

8 Current status of legal services

Since 2019, the global funder for women's reproductive health that supported the establishment and implementation of the R3M programme in Ghana started to transition support away from the R3M programme to the Government of Ghana. Under this transition funding, the Ghana Health Service (GHS) will receive funding support from October 2020 through September 2023 to ensure the continuity of abortion services in the public sector. The objective of this transition

82 As above.
83 Aniteye & Mayhew (2013) (n 56). See also Aniteye & Mayhew (2019) (n 3).
84 As above.

funding is to institutionalise CAC services as permitted by Ghana's law at all levels of the healthcare system. This institutionalisation requires that GHS strengthens its health systems to deliver and monitor comprehensive abortion services. The expectation is that by 2023, CAC services would have been institutionalised, thereby allowing many more women easy access to safe, legal CAC services. Two sectors of physicians that have remained a challenge to integrate into the CAC programme are the private physicians, who do not work for the GHS, and physicians who work for the Christian Health Association of Ghana (CHAG), that contract with the GHS. Although these groups of physicians are supposed to be subject to GHS/MoH policies and guidelines, oversight and enforcement are sometimes very limited.[85] Therefore, the extent to which full institutionalisation of CAC services occurs at all levels of and across the healthcare system by 2023 will depend on how successfully both private and CHAG physicians are integrated into comprehensive abortion care.

9 Outstanding gaps in need of further reforms and lingering issues

While there is no organised anti-abortion presence in Ghana, many in the country are very religious and believe that their religious teachings oppose abortion.[86] Religious opposition has indeed led to high levels of stigma toward both women seeking the service and clinicians providing it.[87] This personal opposition is also expressed as conscientious objection by doctors and midwives who refuse to provide legal abortions.[88] Indeed, over the years relevant government bodies have made periodic reports to treaty monitoring bodies especially to the Human Rights Committee and to CEDAW. Shadow reports have also been submitted by CSOs and other concerned women lawyers' groups. In 2014 among other things, the CEDAW Committee was concerned that, despite the legal

85 As above.
86 As above.
87 As above.
88 See NO Lithur 'Destigmatising abortion: Expanding community awareness of abortion as a reproductive health issue in Ghana' (2004) 8 *African Journal of Reproductive Health* 70. See also P Aniteye, B O'Brien & SH Mayhew 'Stigmatized by association: Challenges for abortion service providers in Ghana' (2016) 16 *BMC Health Services* 486 for a further discussion on the topic.

provisions for abortion, safe abortion remained largely inaccessible due to the stigma associated with voluntary termination of pregnancy in the society, its relatively high cost and the fact that it is not covered by the national health insurance scheme.[89] The Committee was concerned by the percentage of unsafe abortion-related maternal deaths in Ghana (articles 3, 6, 7 and 17). The CEDAW Committee stated concerns about the 'stigma on abortion and general lack of awareness about the conditions under which abortion is legally available, resulting in numerous women resorting to unsafe abortion' and urged the government of Ghana to ensure safe, legal abortion is affordable to all women. In his 2012 report on his Mission to Ghana, the Special Rapporteur on the right to health similarly expressed concerns over high rates of maternal death from unsafe abortion and the exclusion of abortion from the National Health Insurance Scheme. According to the Special Rapporteur, poor and marginalised women cannot afford safe abortion and 'often undertake procedures in unsafe and unregulated environments, which leave them vulnerable to avoidable incidences of maternal morbidity and mortality'.[90]And in 2016, the Human Rights Committee comments included entreaties to Ghana to increase its efforts to reduce maternal mortality resulting from unsafe abortions by adapting its regulations on pregnancy and abortion to ensure that women do not have to undertake unsafe abortions. Ghana should also ensure that voluntary termination of pregnancy is available to individuals regardless of their means, for example by considering incorporation of abortion into the national health insurance scheme; and should further implement awareness-raising policies to combat stigmatisation of women and girls who seek abortion as well as ensure access to contraception and adequate and affordable reproductive health services for all women and adolescents. Both treaty body comments, it seemed, were concerned not about the law, but about implementation of a good law to reach more women.

Additionally, Ghana's abortion law as it stands now has some perceived problems related to the definition of who a 'medical practitioner' is.

89 JK Awoonor-Williams et al 'Prevalence of conscientious objection to legal abortion among clinicians in northern Ghana' (2018) 140 *International Journal of Gynecology and Obstetrics* 31.

90 CEDAW, Concluding observations on the combined sixth and seventh periodic reports of Ghana, 14 November 2014, UN Doc CEDAW/C/GHA/CO/6-7 (2014) paras 36(d), 37(c).

The Ghana Health Service's operational protocols for management of abortion and PAC procedures clarified that medical practitioners (doctors), obstetricians, nurses, midwives, community health officers and medical assistants with midwifery training are allowed to provide either medication or surgical abortions, at different levels of the healthcare system. Similarly, nurses/midwives and community health officers are allowed to perform medication abortions with pregnancies less than nine weeks, and where pregnancies are over nine weeks, these providers are only allowed to conduct medical abortion at levels where doctors are available to supervise them (for example, district level). This operational protocol notwithstanding, some still contend that reference to a 'medical practitioner' in the law means only doctors. This has often created confusion, and sometimes fear, among nurses, midwives, and community health officers who are not medical doctors. Currently, a more pragmatic approach to interpretation of the law that allows task-shifting of abortion from the specialists to trained midwives and nurses is followed. This approach is supported by the Office of the Attorney General of Ghana. For instance, in 2006 when the second author of this chapter led a consultation meeting with the Attorney General as part of the development of Standards and guidelines, the Attorney General did indicate that it was entirely up to the MoH/Ghana Health Service to decide who a medical practitioner is, and also to consider issues of 'task shifting'

Another outstanding challenge relates to the grounds for obtaining legal abortion. As we indicated earlier in this chapter, the reasons many women, especially young girls, give for seeking abortion are not necessarily covered by Ghana's abortion law. For instance, the 2017 GMHS findings suggest that nearly all the reasons why adolescents seek abortion may not fall within the legal conditions of the current Ghana abortion law. These findings suggest a mismatch between the current law and the practical abortion needs of women and especially adolescents. Clearly, any abortion law reform that does not recognise in its provisions or implementation that the majority of abortions are sought on socio-economic grounds; that women will choose to have abortion, regardless of legal proscriptions; and that the state has a duty to provide services to render abortion safe, will always fall short of serving the needs of women, and will always create a need for unsafe, illegal abortion.

While the absence of gestational age limits for performing abortions is one of the most liberal aspects of Ghana's abortion law, the question of gestational age at which induced abortion should be permitted has become a thorny issue. PNDC Law 102 defines abortion as the premature expulsion of, or removal of conceptus from the uterus or womb before the period of gestation is completed. While some have suggested that the period before completion of gestation indicates a perceived period prior to foetal viability,[91] others have interpreted the period before completion of gestation to mean any time before delivery.[92] In response to this debate, the current GHS policy guidelines have sought to clarify that abortion refers to the termination of pregnancy prior to foetal viability, defined as any time before 28 weeks of gestation, which is in conformity with current WHO accepted policy.[93] It, however, still does not indicate any specific gestational age limits for safe abortion, which would have constituted a barrier for adolescents who usually seek abortions late or are unable to act within such time. Our view is that it is better not to specify gestational age limitations in the law as is currently the case. This is because gestational age limitations for abortion are likely to change as medical advances make it possible for increasingly lower gestation of foetuses to survive outside the uterus. Therefore, a more pragmatic and flexible approach may better serve the needs of both the present and future.

Another outstanding issue relates to conscientious objection. PNDCL 102 does not have provision for conscientious objection. Meanwhile, recent research in Ghana suggests that more than a third of trained providers and over half (57.6 per cent) of practitioners of the Christian Health Association of Ghana (CHAG) facilities in Northern Ghana are conscientious objectors.[94] Moreover, some health workers either discourage adolescents from having abortions or prevent abortions from being carried out in facilities that they oversee.[95] Women, especially

91 HRC, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover. Addendum: Mission to Ghana, 10 April 2012, UN Doc A/HRC/20/15/Add.1 (2012) para 40.
92 ID Norman, M Kweku & FD Binka 'Critical review of the legal framework on abortion in Ghana' (2015) 1 *Donnish Journal of Law and Conflict Resolution* 010.
93 GHS (2012).
94 As above.
95 Awoonor-Williams et al (n 89).

adolescents who seek services from conscientious objectors may be given inaccurate information or scolded for seeking safe abortion services.[96] There is thus a need for some policy guidelines in this regard.

10 Conclusion

Ghana, like most African countries that were colonised, inherited her abortion legislation from the colonial government. While the colonial era law remains largely unchanged, the key innovation in Ghana has been to relax the law, that is, to reframe the law so as to maximise access to safe abortion services. This has been accomplished through proactive interpretation of Ghana's abortion law so that many more women qualified for legal services. This has included reframing abortion and CAC in public health terms; rightly including abortion together with contraception and PAC in a comprehensive package of CAC services that women need; and training new cadres/categories of health workers to provide essential CAC services including manual vacuum aspiration and medical abortion. This reframing has been widely embraced.

While abortion-related morbidity and mortality burden can be reduced by liberalised abortion laws, the experiences from Ghana do suggest that legalisation of abortion, although necessary, does not guarantee women's and especially adolescents' access to safe abortion services. Therefore, interventions to remove financial costs/barriers and improve the availability of quality services must be considered as part of any policy reform. As the WHO has argued, refusing to remove financial barriers to safe abortion or not adding safe abortion services to national health insurance constitutes an inequity and a violation of women's rights.[97]

Again, legalisation of abortion is important; but Ghana's experience has shown that awareness creation among healthcare workers, women/girls, and the general population is also very important. Furthermore, normalisation of abortion as a health issue would be important and this could be achieved in great part by institutionalisation of abortion by making abortion care part of the routine preclinical training of all health staff. Thus, integration of abortion services with other reproductive

96 As above.
97 WHO (n 6).

health services and avoidance of stand-alone abortion clinics should be aimed at as this is more cost-effective and greatly reduces the stigma around abortion.

Finally, some have suggested a review of the current Ghana abortion law to take into consideration the issues discussed above. But others think that with so much that is changing continually in health and medicine and abortion, an abortion law should not be rigid and too prescriptive. Rather the interpretation by competent agencies, in this case, the GHS, should be relied upon to provide guidance in operationalising the law. We think that a move to change the law in the future could pose challenges in the current multiparty democracy and in a country awash with religious and evangelistic zeal! This is a real concern for us and many advocates for women's reproductive justice and safe abortion. Therefore, we believe the proactive reframing and interpretation of the law has so far worked well and we support such continuous proactive interpretation of the law.

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