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Original Research Article

Critical Review of the Legal Framework on Abortion in Ghana

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Introduction: **Ghana law defines abortion or miscarriage "as the premature expulsion of or removal of conception from the uterus or womb before the period of gestation is completed". *Objectives:* The authors investigated whether the law is too liberal and overly broad to safeguard the needs of the unborn while at the same time, ensuring the autonomy of the woman. The authors also reviewed what the definition means in relation to partial-birth abortions. *Method:* The review was conducted in several phases. The first phase was on broad literature review, covering several jurisdictions starting with the seminal common-law case of the United States of America, *Roe v. Wade* of 1973. The second phase was a narrow consideration of the state of public law on abortions in Ghana vis-à-vis term limits. The final phase was the crystallization of understanding, analysis and appraisal of the topic from the previous phases of the state of the law on abortion. *Result:* Abortion in Ghana is available on demand by the pregnant woman. Abortion can be had if there was a contraceptive failure. Inability to support or care for the child is another ground for abortion. If the pregnancy was not wanted, or needs to be terminated to prevent the birth of a child with defects, that is also acceptable. If the pregnancy resulted 'from rape or defilement of a female idiot or incest' abortion can be had. It is an abuse of the legal protection of the woman if a physician interferes with the choice to have an abortion. *Discussion:* The law does not set term limits as to when abortion could be obtained. There could be many instances where the fetus's interests are disregarded, especially in late term abortions where viability is implicated. The law on abortion is overly broad and supersedes even the most liberal reading of the most exemplary legal precedent on the rights of the woman to abortion: *Roe v. Wade*. It needs to be hauled back to a more rational and systematically manageable position consistent with recent development on post-natal care of viable fetus/child vis-à-vis the health of the woman. *Conclusion:* There is an urgent need for a re-statement of the law on abortion to prevent needless destruction of viable fetuses in Ghana in a systematic and organized way as it currently is. *Recommendations:* These are made to inform policy.**

Keywords: Legalization of Abortion; Expulsion of viable fetuses; Partial-birth abortions; Dilation and Extraction, (D&E); Maternal Mortality; Criminality.

INTRODUCTION

"Liberty is not guaranteed absolutely against deprivation, only against deprivation without due process of law," (Roe vs. Wade, dissent, Justice Rehnquist, 1973)

It is difficult to understand the motivation or the agitation and the inspiration for the enactment of Ghana's Abortion Law, the Consolidated Criminal Code, 1960 (Act 29) as amended, 1985. Although the law appears to implicitly sanction abortion on demand, there is confusion among experts and researchers that the law sets out modalities and term limits to abortion. Morhee and Morhee's (2006) overview of the law and the availability of abortion in Ghana seem to have suggested that the law criminalizes abortion. In fact, what the law does is that it provides the rubric for when abortion is totally legal and when it is totally illegal (Morhee and Morhee 2006:82). In line with this analysis, the Minnesota Citizens Concerned for Life Global Outreach, writing about abortions in Ghana, argued that "a focus on abortion does nothing for maternal health" in Ghana. That "the legalization of abortion has not bettered the health of the people", and that "… 26 years after abortion was legalized, improving maternal health and reducing maternal and neonatal

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mortality is the Ministry of Health's first priority" (MCCFGO, 2011; Shane 1997; Rogo 1993; Benson et al. 1993).

In this rubric, however, the law does not set term limits. It has no built-in controls or safeguards for the ethical practitioner or otherwise, but provides a subjective quality assessment as to what is proper, clean, safe or acceptable with respect to space/equipment/capacity to conduct an abortion (Aniteye and Mayhew 2013; Harries et al., 2009). What appears even more unattractive about the law is the permissiveness with which it allows the practitioner or otherwise the unfettered right to cause abortion of a fetus at any stage of the pregnancy.

This implies that provided there is a willing physician or otherwise, abortion can be had in Ghana a day before a pregnant woman goes into labor to deliver a child. The law explicitly allows the expulsion of a fetus at any time during the pregnancy until "gestation is completed". The law defines abortion or miscarriage to mean thus:

(3) …. the premature expulsion or removal of conception from the uterus or womb before the period of gestation is completed.

DEFINITION OF VIABILITY IN THE GHANA LAW AND OTHER JURISDICTIONS

On the issue of viability, Morhee and Morhee, (2006) appeared to, perhaps, imply that the Ghana law set a term limit after which period there could be no abortion except to save the life of the pregnant woman. In this effort, they imported what perhaps doctors may have been implementing on their own thus: *"In the West African sub-region viability has been pegged at gestational age of 28 weeks, from the last menstrual period"*. This clearly is not found in the law and could not be used as a substitute for legislative basis for setting term limits for abortion in Ghana. The law is mute about balancing the 'viability' of the fetus with the interests of the pregnant woman. The word is not even mentioned or incorporated into the law as an implied concept.

The law was very unequivocal that abortion is permissible in Ghana so long as gestation was not completed. The law seems to suggest that the State has no interests whatsoever in how many abortions that are done each year and where along the gestational cycle the expulsion is executed; no matter how late into the pregnancy it is done (Baiden et al., 2006; Cook et al. 1999; Adanu and Tweneboah 2004). There is no protective provision for the life of the viable fetus in the Ghana law, safe what is afforded them in clinical practices according to the whims and caprices of the attending physician. Under the Ghana law, protection for the fetus begins only when labor sets in as articulated in Sections 60 and 61.

HOW OTHER LAWS OR COURTS DEFINE VIABILITY

Viability was defined by the *Roe* Court in 1973 to mean the gestational age at which a fetus is capable of surviving as an independent entity outside the womb, albeit assisted technologically. In the *Roe vs. Wade* matter, Justice Blackmun opined that 'the life and safety of the physician, his or her staff and the facility in which the abortion occurs, should matter to the law, so long as abortion could be had (Blackmun, 1973). The Ghana law has taken the position that the life of the pregnant woman supersedes all other considerations, period. This and other positions emanating from the abortion law are not in consonance with the Constitution of Ghana. It is also not internally consistent with itself. In Section 60 of the same Code and titled "Causing Harm to Child at Birth", it states:

Whoever intentionally and unlawfully causes harm to a living child during the time of its birth shall be guilty of second degree felony.

In Section 61, the law explains what it meant by causing harm to a child at birth. In that attempt, the law defines with sanctimony; who a child is in subsection 2 of Section 61 in a sentence full of circumlocutions and weak jurisprudence bothering on utter confusion thus:

*The time of birth includes the whole period from the commencement of labor until the time when the **child** so becomes a **person** that it may be murder or manslaughter to cause its death,* (Emphasis, ours).

According to Section 61 Subsection 2 of the Consolidated Criminal Code of 1960 as amended, the fetus is a child all throughout the pregnancy. However, just before labor starts and until actual delivery is completed, the fetus remains a child and then finally, miraculously when the delivery is completed, the child morphs, evolves, or somehow transfigures from being a child all along and materializes into a whole person! Therefore, now that the law agrees that the fetus is a child and a person, *whoever intentionally and unlawfully causes harm to a living child during the time of its birth shall be guilty of second degree felony.*

The legal brinksmanship demonstrated here points to one glaring fact that law making in Ghana can be very reckless, even careless. Sections 60 and 61 go to support the theory advanced by this paper that the provisions contained in Section 58 of the Consolidated Criminal Code sanctions the murder of the child with full faith and credit of legislative authority behind it. Section 61, therefore, renders activities under Section 58 felonious, since Sections 60 and 61 go after Section 58 and seems to be cancelling the provisions for abortion. In actuality, it doesn't. The mandate under Sections 60 and 61 where the vulnerable 'fetus/child' is deemed by law as 'a person', stands in stark contrast against Clause 28 (1) (a) and 28 (3) and (4) of the 1992 Constitution, which states that:

Parliament shall enact such laws as are necessary to ensure that:-

(a) Every child has the right to the same measure of special care, assistance and maintenance as is necessary for its development from its natural parents, except where those parents have effectively surrendered their rights and responsibilities in respect of the child in accordance with law;
(3) A child shall not be subjected to torture or other cruel, inhuman or degrading treatment or punishment.
(4) No child shall be deprived by any other person of medical treatment, education or any other social or economic benefit by reason of religious or other beliefs.

Although implicit in the clauses is the view that the child should have been born to enjoy this constitutional provision, Article 28, clauses (3) and (4) seem to provide protective cover to also the fetus. If this reading is reasonable, then Section 58 of the Criminal Code goes against the ethical values of autonomy, capacity, benevolence and non-malfeasance. It is a direct opposite of the goals and aspirations of the Children Rights Act, 1998 (Act 560) Part 1 Section 13 (1) which says that:

No person shall subject a child to torture or other cruel, inhuman or degrading treatment or punishment including any cultural practice which dehumanizes or is injurious to the physical and mental well-being of a child.

The expulsion of a fetus at any time during the course of a pregnancy is one of those acts that ought to fall under the prohibition of this law, it is surmised.

THE ABORTION LAW AND THE FEMINIST AGENDA

Ghana's history does not denote any orchestrated feminist struggle or agitation or demands on any specific issues. Issues of gender equity, abortion rights, privacy issues, affirmative action, and women's rights progression have occurred without the organized effort of a significant number of women or men. Such developments have emerged on the socio-political landscape over the years through the instigation of donors, a handful of civil society organizations and other supra-national institutions.

The developments can largely be attributable to, rather curiously, 'the benevolence or goodwill of men of politics,' who oversee an otherwise male-centric socio-political system. These men may have been motivated by genuine concerns for the plight of women to eliminate unsafe abortions and improve maternal health care in Ghana. It is also possible that they were simply seeking to please a segment of their constituencies or donors. So far the key drivers in the abortion industry in Ghana are those captured in the figure below (Oye Lithur, 2004). This figure was drawn from the work and advocacy of the entities mentioned in the figure.

In 1973 the U. S. Supreme Court decided a case which legalized abortion. This was not through legislation, but at common law or judge made law and by so doing, gave the world its most celebrated abortion case; *Roe vs. Wade*, 410 U.S. 113:150 (1973). The facts of the case are:

Jane Roe, a single woman who was residing in Dallas County, Texas, instituted this federal action in March 1970 against the District Attorney of the county. She sought a declaratory judgment that the Texas criminal abortion statutes were unconstitutional on their face, and an injunction restraining the defendant from enforcing the statutes.

Roe alleged that she was unmarried and pregnant; that she wished to terminate her pregnancy by an abortion performed by a competent, licensed physician, under safe, clinical conditions. She claimed that the Texas statutes were unconstitutionally vague and that they abridged her right of personal privacy, protected by the First, Fourth, Fifth, Ninth, and Fourteen Amendments. The *Roe* Court ruled 7-2 that the right to privacy under the due process clause of the 14th Amendment of the U.S Constitution extended to include the woman's right to have an abortion, but that this right must be balanced against the state's legitimate interests.

These interests were two in regulating abortions: protecting prenatal life and protecting women's health. The Court opined that the state's interest became stronger over the course of a pregnancy. It resolved this balancing test by tying the state regulation of abortion to the third trimester of pregnancy. The Court rejected *Roe's* trimester framework, but affirmed *Roe's* central holding that a woman has a right to abortion until viability. Roe decision defined 'viable' as being 'potentially able to live outside the mother's womb, albeit with artificial aid', adding viability 'is usually placed at about seven months (28 weeks) but may occur earlier, even at 24 weeks' (*Roe vs. Wade*, 410 U.S. 113 (1973).

Since then, *Roe vs. Wade* has become the yardstick for international best practice on abortion law. This case has split the American nation into "pro-choice" and "pro-life" constituencies that help to define the broader political groupings of the two predominant parties, the Democrats and the Republicans. *Roe's* apparent legislative and policy influences on societies like Ghana are yet to be assessed. What can be said so far on this is that Ghana's abortion law appears to be more liberal in many respects than that of the United States of America's due to the lack of controls and term limits (Aniteye and Mayhew 2013; Morhee and Morhee 2006; Baiden et al., 2006).

In this paper, the authors investigated whether the Ghana law is too liberal and overly broad to safeguard the needs of the unborn while at the same time, ensuring the autonomy of the woman. The authors also reviewed what the definition of abortion means to the health care provider or practitioner from the medico-legal lenses of autonomy, capacity and benevolence. The authors conclude that the right to privacy formed the backbone for the decision in *Roe vs. Wade*. In the case of Ghana, the right to privacy has not been part of the variables considered for the Ghana law. Secondly, the right to privacy is not guaranteed by the 1992 Constitution of Ghana but may be found in the penumbras of the substantive rights guaranteed by the constitution. Considering the developments leading to the abortion law, it is difficult to know how Ghana moved away from its wholly criminal abortion law to an entirely liberal and overly broad law on abortion.

The law does not appear to have been on epidemiological or annual statistical data on abortion. There was no empirical basis for the law, no real serious research as to the prevalence and incidence of both legal and illegal abortions at the end of the first, second, third trimester, except the legislative fiat that somehow, abortion needed to be legalized in Ghana. There does not, therefore, appear to be a legitimate basis for the law to decriminalize abortion in such an overly broad manner as to have no care for the viable fetus. The State has a responsibility and interest in ensuring that the lives of all persons are guaranteed and protected against harm (Arembepola et al. 2014; Baiden et al. 2006; Benson et al. 1996; WHO 1998).

> *"The State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient. This interest obviously extends at least to the performing physician and his staff, to the facilities involved, to the availability of after-care, and to adequate provision for any complication or emergency that might arise. The prevalence of high mortality rates at illegal 'abortion mills' strengthens, rather than weakens, the State's interest in regulating the conditions under which abortions are performed. Moreover, the risk to the woman as her pregnancy continues. Thus, the State retains a definite interest in protecting the woman's own health and safety when an abortion is proposed at a late stage of pregnancy, (Justice Harry Blackmun, Roe v. Wade, 410 U.S. 113:150 (1973).*

As at 2004, the actors interested in the abortion debate were less than 10 persons consisting of medical doctors, lawyers and a handful of other interested parties. This shows the entire national mindset on families, children, marriage, and how the life of the viable fetus is considered by even the religious members of the national population (Alvare 2013; Martin 2010; Akerlof et al., 1996). Oye Lithur (2004) proffered that "our liberalized law was neither publicized nor debated in the public domain and this has resulted in low knowledge of the law on abortion, where as much as 58% of the abortions performed in Ghana take place outside the legally designated health institutions (Oye Lithur, 2004).

Fig 1. Key drivers in the national abortion industry

METHOD

We searched databases for reports, editorials and published papers in the English Language. A search on Goggle Scholar on 'review of the Consolidated Criminal Code of 1960, Act 29, section 58' yielded less than 40 entries and 'abortion practices in Ghana' or 'national statistics on abortions in Ghana' yielded equally fewer entries. With the exception of several publications in the Ghana Medical Journal, many of what was found was not helpful to the topic. Hand searching of selected printed journals and grey literature such as technical reports, conference proceedings and workshops as well as reported Court cases were also assessed.

For the research question we used search combinations of *"Abortion on Demand, Ghana"; or "Interpretation of the Abortion law, Ghana only"; "public health legislation on abortion, Ghana, only"; "traditional rules on abortion"; "Ghana medical ethics on abortion", "privacy issues in Ghana law," and "Supreme Court of Ghana ruling on Abortion law".*

The volume of material on Ghana law were so few that almost all the literature identified were read, even if they did not relate to the topic per se. Therefore, there was no need to establish inclusion criteria for any of the reports (scholarly paper, opinion, editorial, book chapter, internal post-operations reports, and annual reports) on the matter. Published papers such as Arambepola et al., 2014; Aniteye and Mayhew 2013; Harries et al., 2009; Morhee and Morhee 2006; Baiden et al., 2006; Adanu and Tweneboa 2004; Cook et al., 1999; Benson et al., 1996 on abortion in Sri Lanka, Sub-Sahara, Ghana, and elsewhere were assessed and cited in this work. Common law cases from other jurisdictions, namely, the United States of America and others were also used in this paper.

RESULT AND DISCUSSION

(a) Abortion Statistics in Ghana

Due to the lack of national data on either legal or illegal abortions, we are compelled to start our analysis of the year during which data became available. It is reported that the national abortion statistics doubled in 2011 from the total reported abortions in 2009 to 16,182 (GSS 1998). Of the total incremental figure reported, 216 were girls between ages 10 and 14, while 7,800 were also girls between ages 15 and 19. The figure for 2010 alone was 10,875 recorded abortions, whiles 2009 were 8,717.

The reasons for the uptick in the abortion statistics were attributed to the fact that more wealthy and educated urban women were choosing to have abortions so as not to disrupt their professional progression (GSS 1998, Guttmacher Institute, 2004, Ghana Health Service and Aboagye, 2012). With respect to Induced abortion, Geelhoed et al. (2002) also Lassey and Wilson (1998) found that in rural Ghana, 22.6% of reported abortion cases were induced abortions. However, hospital based data from the Korle Bu Teaching Hospital, Accra and Komfo Anokye Teaching Hospital; Kumasi also reported that 22% (KBTH) and 30% (KATH) of maternal deaths were attributable, respectively, to unsafe abortions.

Additional published data suggested that about 7% of all pregnancies in Ghana ended in abortions. It has been reported that as much as 15% of women aged 15-49 have ever had an abortion with about 17 out of every 1,000 women of reproductive age having abortions in the southern part of Ghana in the 1990s (Guttmacher, 2010). In terms of induced abortions, there are severe distortions in the data, partly due to attempts to hide the real situation under the erroneous assumption that abortion is illegal in Ghana, even though abortion has been legal in Ghana since 1985.

(b) Data on Unintended Pregnancies in Ghana

There appears to be a more reliable data when it comes to unintended pregnancies, where about 300,000 infants are born each year as a result. It is estimated that 37% of births in the country are unplanned, 23% are mistimed, and 14% are unwanted. Although not all the unintended pregnancies are unwanted, 14% are clearly unwanted. Abortion is "highest (25 per 1,000 women) among 20-24 year old women and lower in each successive age group. Among the educated class and/or wealthy women abortion is higher than those with less education or less wealthy (Guttmacher, 2010).

Similarly, there is evidence that abortion is higher among the urban professional women registering about 21 abortions per 1,000 pregnancies compared to the rural areas with 10 abortions per 1,000 pregnancies. Among those aged 20 to 24, the rate of abortion is 34% (Guttmacher, 2010). This data may only refer to abortions done in authorized public clinics and hospitals, but may not include figures from private clinics or quacks. In fact no systematic data on abortions are maintained by the various stakeholders in the healthcare delivery system.

(c) Abortions among women in Ghana compared with abortions among Black women in U.S.A

Comparing the Ghana situation with statistics on Black women in the United States of America provides an interesting juxtaposition. The Centers for Disease Control, CDC in the United States of America reported that "non-Hispanic Black women had the highest abortion rates (31.8 abortions per 1,000) of women aged 15 to 44 years with ratios of (483 abortions per 1,000 live births). This is based on data culled in 2010 from 46 reporting states. At the same time there was a 5% decrease of abortions among the same ethnic group from 34.8 abortions per 1,000 women in 2007 to 33.2 in 2010. Among all the races, Black women obtained the highest

abortions after 13 weeks of gestation compared to other women in the surveillance (CDC, MMWR, 2013).

"… 12 abortion-related deaths occurred in 1994, four deaths in 1995, and nine deaths in 1996. Because of this variability and the relatively small number of abortion-related deaths every year, national case-fatality rates were calculated for consecutive 5-year periods during 1973–2002 and a 7-year period during 2003–2009. The national legal induced abortion case-fatality rate for 2003–2009 was 0.67 legal induced abortion-related deaths per 100,000 reported legal abortions. This case fatality rate was similar to the rate for the preceding 5-year period (1998–2002) but lower than the case-fatality rate of 2.09 legal induced abortion-related deaths per 100,000 reported abortions for the first 5-year period (1973–1977) immediately following initial nationwide legalization of abortion in 1973. Possible abortion-related deaths that occurred during 2010–2013 are under investigation…" (MMWR, 2013)

(d) Is Abortion culpable for Maternal mortality?

Data for various diseases and from various sources in Ghana appears to be confusing and not properly rationalized to reduce inconsistencies. A recent report issued by, curiously, the Minnesota Citizens Concerned for Life Global Outreach about abortions in Ghana said:

"… Maternal mortality has recently been declared a national emergency and is currently a major priority for government and development partners. Health system weaknesses such as insufficient human resources, especially in rural areas with vulnerable populations, poor access to essential medicines and health technology, and insufficient financing all constrain our collective efforts to achieve MDGs 4, 5 and 6 (WHO Country Cooperation Strategy 2008-1011, Ghana).

Maternal mortality estimates in Ghana vary significantly. The 2007 Ghana Maternal Health Survey provides two estimates of Ghana's maternal mortality rate: 378 and 580 deaths per 100,000 live births. In 1993, the Ghana Demographic and Health Survey showed a rate of 214; in 2007, a WHO/UNICEF/UNFPA/World Bank study showed a rate of 560. Ghana is far short of meeting the United Nations goal of maternal death reduction (MCCL-GO, 2011:2).

While these figures are disturbing, it is doubtful if the lack of access to abortion clinics or legal abortions is the culprit for the current state of maternal healthcare in Ghana. The proximal cause for the current outcome could well be the refusal of health facilities to accept card-holders from the National Health Insurance Scheme as a means of entitlement or payment for medical services in lieu of actual cash payment. In fact the proximate cause of the maternal healthcare challenges and mortality could be due to a myriad of reasons beyond those probably posed by the abortion law.

(e) What constitutes a criminal abortion under the Code

The code is very explicit about what constitutes a criminal abortion. What constitutes criminal abortion under the Ghana law is more about the consolidation of abortion procedure in the hands of medical personnel rather than it is about criminality per se. The relevant part, Section 58 (1) (a) through (b) says about abortion and miscarriages that:

(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.

From 1960 since the provision on criminal abortion has been in place, only three cases were found to have been prosecuted at the Superior Court. In none of the cases was a woman punished for causing self-abortion or aiding and abetting another to cause abortion on her body (Oye Lithur, 2004).

All the prohibited acts under Section 58 Subsection (1) (a) and (b) through under Subsection (2) are excusable under specific circumstances. Section (2) says:

> 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 specializing in gynecology 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.

The following are conditions under which abortion is allowed under the Ghana law. Who determines what these conditions are or who ascertains the veracity of the person alleging any of these conditions was left mute. The presumption is that a pregnant woman is so transformed that her capacity to tell the truth about her circumstances cannot be called into question.

Conditions #1 under which abortion is allowed: Rape, Defilement or Incest

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

Conditions #2: Physical, Mental Risk to the life of the pregnant woman

(b) where the continuance of the pregnancy would involve risk to the life of the pregnant woman or injury or 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

Conditions #3: Child with physical abnormality or Disease

(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.

(f) Prostaglandin Abortion or Partial-birth Abortions

The U.S. Supreme Court affirmed the *Roe v. Wade* ruling in the *Stenberg v. Carhart*, 530 U.S. 914 (2000). It struck down the State of Nebraska's late term abortion statute as unconstitutional, and reiterated *Roe's* three points, establishing the woman's right to privacy and therefore to abortion. The three points were that:

First, a woman has the right to choose to have an abortion before fetal viability and to obtain it without undue interference from the state;

Secondly, the state has obligation to restrict abortion after viability, if the law contains exceptions for pregnancies endangering the woman's life or health;

And *third*, the state has legitimate interests from the pregnancies outset in protecting the life of the woman and the life of the fetus that may become a child.

It is interesting to note that the United States Congress passed the *Partial-Birth Abortion Ban Act of 2003* to proscribe a particular method of ending fetal life in the later stages of pregnancy, after the Supreme Court's ruling in *Stenberg v. Carhart*, (2000) that the Nebraska's "partial birth abortion statute violated the Federal Constitution as interpreted in *Planned Parenthood of Southeastern Pa v. Casey, 505 U.S. 833* and *Roe v. Wade*, 410 U.S. 113, (1973).

The issue of late term abortions concerns pre-viability and post-viability tests as enunciated by the *Roe vs. Wade* ruling. As already reported here, the Ghana Consolidated Criminal Code does not bother itself with such niceties as pre-viability and post-viability or partial-birth abortions. It simply lumps the entire cycle of abortion into a word, 'gestation' and states that abortion or miscarriage (inclusive of late term abortion) may happen any time before "gestation is completed". In protecting the life and health of the pregnant woman, the law decided to also allow women to play God and decide when viable life would be retained or systematically destroyed through late term procedures as seen in *Stenberg vs. Carhart*. The facts of the *Carhart* case provided a gruesome medical exposition about late term abortion procedures as it pertained in Nebraska, U.S.A at that time.

It can be said that this is an event that probably happens in Ghana rather frequently for many reasons, although there were no reliable figures to establish incidence and or prevalence. Due to financial and other considerations, the number of abortions in Ghana after 13 weeks or more is quite significant (Guttmacher, 2010). Morhee and Morhee (2006:83) also reported that "… legal abortion is only available to wealthy and educated women". While these two statements may describe the reality on the ground, they may not describe it in its entirety. There is no evidence that only wealthy women do have access to legal abortion neither is it the preserve of the economically vulnerable to have illegal abortions.

What these two statements reveal, namely, that of Guttmacher (2010), Morhee and Morhee (2006), and like the situation reported by the CDC (2013) about Black women in America, is that due to financial constrains, late term abortions may be common in Ghana among women of all economic classes. Other researchers have reported, however, that it is not only financial ability that determines when a woman would elect to have a abortion. They found that the values of abortion services providers are also important factors in when the woman may elect to terminate a pregnancy (Arambepola et al., 2014; Aniteye and Mayhew 2013; Alvare 2013; Harries et al., 2009; Benson et al., 1996).

The facts of the *Carhart* case are that:

> A Nebraska physician who specialized in late term abortions, LeRoy Carhart, brought suit against the Attorney General of Nebraska, Don Stenberg, seeking declaratory judgment that the state law banning certain forms of abortions was unconstitutional. The thrust of his case was based on the undue burden test articulated by a dissenting opinion in *Akron v. Akron Center for Reproductive Health* and by the Court in *Planned Parenthood of Pa. v. Casey*. The federal district court and the U.S Court of Appeals ruled in favor of Carhart before the case was appealed to the Supreme Court. The offensive part of the Nebraska statute to Carhart was that it *prohibited "partial birth abortion", which it defined as any abortion in which the physician "partially delivers vaginally a living unborn child before killing the unborn child and completing the delivery.*

In this case, evidence was given to describe the procedure used normally in the second trimester, late term abortions thus:

> "In the second-trimester procedure, "dilation and evacuation" (D&E), the doctor dilates the cervix and then inserts surgical instruments into the uterus and maneuvers them to grab the fetus and pull it back through the cervix and vagina. The fetus is usually ripped apart as it is removed, and the doctor may take 10 to 15 passes to remove it in its entirety."

The debate in that case was about two distinct procedures in use in "partial-birth abortions". In Nebraska prohibited "partial-birth abortion" which it defined as any abortion in which the physician "partially delivers vaginally a living unborn child before killing the unborn child and completing the deliver". This procedure was commonly known as "D&E" or dilation and evacuation. This procedure is normally used in second trimester abortion due to increased amount of fecal material (*Gonzales v. Carhart* 2006). Dr. Carhart wanted to use a variation of this procedure called "D&X" or (Dilation and Extraction) or "intact D&E".

In D&X procedure, rather than commencing curettage inside the uterus, the physician extracts parts of the fetus intact or largely intact or pulls out fetus' entire body instead of ripping it apart. In order to allow the head to pass through the cervix, the doctor typically pierces or crushes the skull (*Gonzales v. Carhart* 2006). The physician then after begins the process of dismembering. This process, it was argued was safer and involved fewer risks for the woman. It also lowered the risk of leaving harmful fetal tissue in the uterus. It minimized the number of instruments the physician needed to use (*Gonzales v. Carhart* 2006).

Although *Gonzales v. Carhart* dealt with federal statute, but *Stenberg v. Carhart* dealt with state statute, the facts of the two cases are similar. The U.S Supreme Court ruled that the Nebraska law banning partial birth abortion was unconstitutional if it did not take into account an exception for the health of the woman or if the law applied to several abortion procedures which had the potential to infringe upon the privacy of the woman and violate the "right to privacy" interpreted from the U.S Constitution as described in the *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U. S. 833 and *Roe v. Wade*, 410 U. S. 113, 1973 decisions.

Following the ruling in the Stenberg v. Carhart, 530 U. S. 914, 2006, the U. S. Congress passed the *Partial-birth Abortion Ban Act of 2003*. This Act proscribed a particular method of ending fetal life in the later stages of pregnancy. Although the Ghana law allows late term abortions, there is no limitation as to the period of gestation and the age of the fetus.

CONCLUSION

As it has been demonstrated in this paper, the national law on abortion appears too liberal or hastily put together without the care of the woman particularly in late term, partial-birth abortions and for the life of the fetus. The abortion law has had very little or no impact on the maternal healthcare in Ghana, it appears.

If the health of the woman was the motivating factor for the enactment of the law, the legalization of abortion has failed to address important issues on abortion, such as access of the woman to safe, secure abortion clinics, well resourced with competent medical and support staff. Pre- and Post-abortion counseling services are not part of the regular features of abortion services delivery in Ghana. In as much as there is stigma attached to abortion in Ghana, more public education, debate, and rationalization of the law are needed (Harrison 1997).

RECOMMENDATIONS

To the Ministry of Health and the Ghana Health Service

It is about high time the abortion law is critically reviewed by a team of knowledgeable researchers on the issues concerning abortion together with concerned citizens and civil society organizations working in the area of abortion services delivery. The views of those opposed to abortion should be sought and concerns addressed.

To the Legislature of Ghana

It is a dereliction of duty of care by the house to the citizens of Ghana, if the issue of partial-birth abortion legislation is not promulgated, debated and passed to protect the life of the viable fetus. Sections 60 and 61 of the Consolidated Criminal Code, as amply shown in this paper, do not provide the protections needed for the life of the viable fetus.

To the Ghana Health Service

Ghana needs better abortion data than what we have at this current time.

CONFLICT OF INTEREST

We declare that none of the authors has any conflict of interests. The cost of this research was borne by the authors. None is currently undertaking a project being financed by any entity with interests for or against the right to abortion.

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