A CONFLICT OF INTEREST: A SOCIO-LEGAL ANALYSIS OF THE BARRIERS TO ACCESSING COMPREHENSIVE ABORTION CARE IN GHANA.

A Research Paper presented by:

Sherifa Awudu

Ghana.

in partial fulfilment of the requirements for obtaining the degree of
MASTER OF ARTS IN DEVELOPMENT STUDIES

Major:

Human Rights, Gender and Conflict: Social Justice Perspectives
(SJP)

Specialization

Human Rights

Members of the Examining Committee:

Azubike Onuora-Oguno
Rosalba Icaza Garza

The Hague, The Netherlands
December 2021

Disclaimer:

This document represents part of the author's study programme while at the International Institute of Social Studies. The views stated therein are those of the author and not necessarily those of the Institute.

Inquiries:

International Institute of Social Studies
P.O. Box 29776
2502 LT The Hague
The Netherlands

t: +31 70 426 0460
e: info@iss.nl
w: www.iss.nl
fb: http://www.facebook.com/iss.nl
twitter: @issnl

Location:

Kortenaerkade 12
2518 AX The Hague
The Netherlands

Contents

List of Figures.

List of Tables.

List of Appendices.

List of Acronyms

CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
ICESCR.	International Covenant on Economic Social and Cultural Rights
UNFPA.	United Nations Population Fund
MSI	Marie Stopes International,
PPAG	Plan Parenthood Association of Ghana
CSE	Comprehensive Sexuality Education
SRHR	Sexual and reproductive health and rights
CAC	Comprehensive Abortion Care
NHIA	National Health Insurance Authority
NHIS	National Health Insurance Scheme
MHS	The Ghana Maternal Health Survey
HRAC	Human Rights Advocacy Centre
GHS	Ghana Health Service
MoH	Ministry of Health
WHO	World Health Organization.
MVA	Manual Vacuum Aspiration

Acknowledgement.

I would like to convey my absolute and sincere appreciation first of all to my supervisor, Dr Azubike Onuora-Oguno for his guidance, academic, professional and moral support though out the process of writing this paper. This paper would have been lacking without him. I am also very thankful to my second reader, Dr. Rosalba Icarza-Garza whose comments, feedback and criticisms were very instrumental in helping me identify and understand my mistakes to arriving at this final paper.

I highly appreciate all my research participants for allowing me to engage with them and for giving the opportunity to tell their stories; Samuel Lamptey of Act for Change and Akbar Y.R. Khomeini who assisted me in diverse ways during my fieldwork. A big thank you to Dr. Micheal Addaney for the timely and instrumental inputs during the writing of this paper.

I also thank my discussants Robert Okello, Esther Wanja Kamaara and Marilyn Ecklu for contributing immensely to my academic and personal growth and most importantly your invaluable inputs into this thesis.

This master's program has been a challenging experience especially because of COVID-19; thus, I would like to express gratitude to my family and friends for their support, prayers and encouragement from the beginning of this academic journey to this end. To the ISS family of the 4th floor in Dorus, thank you for an amazing ISS experience and for keeping me sane throughout this period.

Finally, I dedicate this paper to my late parents, Abdul Rahman Awudu and Mohammed Barikisu. Forever in our hearts.

Abstract

This study is a socio-legal analysis of the impact of abortion laws on reproductive health policies (National Health Insurance Scheme), and how these translate into the violations of the reproductive health rights of women and girls in Ghana. The study does this by investigating how the knowledge of the law affects choices and experiences of young women in seeking abortion services and the legal implications on implementation strategies geared towards reducing unsafe abortions in Ghana. This study uses the concepts of legal consciousness and mobilization as its theoretical frameworks and, methodologically uses a qualitative approach to analyse the data collected. The study argues that legal barriers indeed present itself through the limitations created by the law and its translations. However, legal barriers alone are unable to explain why the reproductive health rights of women are violated and why unsafe abortions still persists among young people. Thus, non-legal barriers such as religion, stigma, individual and institutional culture are also discussed in the study as enhancers of barriers to the reproductive health rights of young women. This study argues that the selective isolation of what is now identified as 'elective' abortion from the National Health Insurance Scheme is a violation of the reproductive health rights of young women in Ghana founded on the fact that the abortion laws provide a flexible opportunity for young women, but national policies like the National Health Insurance Scheme only accommodates medical emergencies leaving young women who do not have medically proven emergencies to resort to unsafe methods.

Relevance to Development Studies

Evidence over the years has established a connection between sexuality education to unplanned pregnancies and ultimately, unsafe abortions. It also showcases the impact unsafe abortions have on health, education and even broader on socio-economic factors of families, communities and nations. There has also been extensive research on socio-cultural practices and norms that influencing unsafe abortions among young women. Restriction to an already inefficient system of information and services to safe abortion is a human right violation that needs to be addressed critically in a way that involves all stakeholders from the point of Planning, Implementing, monitoring, evaluation and most importantly learning stages of intervention strategies. This research offers an alternative way of analysing the barriers to safe

abortion services in Ghana. I engage the frameworks of legal consciousness and mobilization to understand how the problem of study manifests itself away from the traditional socio-cultural lens. This contributes to the existing knowledge on unsafe abortions and can be useful when designing intervention programs.

Key Words

Abortion, reproductive health rights, legal consciousness, socio-legal, health insurance.

Chapter 1: Understanding the Route to Unsafe Abortions

1.0. Introduction

Ghana is a signatory to many international human rights treaties such as the Convention on the Elimination of all forms of Discrimination against women (CEDAW), the International Covenant on Economic Social and Cultural Rights (ICESCR) and the African Charter on Human and Peoples rights on the Rights of Women in Africa (Maputo Protocol). These treaties, even though they guarantee and make provisions for reproductive health rights, access to reproductive health care and services in the Ghanaian context remains a challenge.

The socio-cultural system of Ghana taboos conversations on sex (especially premarital), open sexuality dialogues, contraceptives and abortions based on religious, cultural, and moral grounds. This has created an unfavourable environment for sexually active young women and girls to seek information about reproductive health services and commodities. Service providers are challenged with concerns of confidentiality, stigma and judgement and such reasons are why health facilities are not often patronized for services such as abortions. The implication is that many unplanned pregnancies especially for young unmarried women and girls go unreported largely because of the perceived shame that accompanies sexual intercourse (both consensual and non- consensual), pregnancies out of wedlock and subsequently unsafe abortions. Young women and girls remain vulnerable and are not able to make safe and healthy choices about their reproductive health based on the inadequacy of knowledge on and how to exercise their reproductive health rights. Moreover, healthcare, and legal systems are seemingly not transparent enough to provide friendly and gender sensitive services and information for young women and girls, knowledge of the constitutional rights and other legal provisions are limited including knowledge on basic human rights enshrined both in local and national laws as well as international treaties ratified by Ghana.

Over the past decades, Non-governmental Organizations (NGO's), United Nations Population Fund (UNFPA), Marie Stopes International, Plan Parenthood Association of Ghana (PPAG) and others have raised concerns of unmet family planning needs which is one of the key attributes to unplanned pregnancy in Ghana and globally. Comprehensive Sexuality Education (CSE) initiatives constantly receive harsh criticisms and resistance based on religious, moral, and cultural grounds. This chapter introduces our research problem, as

well as concepts relevant to understanding the problem as well as the research questions posed by this research.

This research is divided in to 6 parts: chapter one will present a general introduction, to the research topic, contextual background research questions and objectives as well as literature review for the topic. Chapter two and three will discuss the theoretical and normative frameworks which will applied to the topic and methodological strategies respectively; chapter four and five will present the findings and results and the analysis of the data gathered and finally, chapter 6 will present conclusions to the paper. All other additional information will be shared in the attached appendixes. For purpose of this study, the term 'abortion seekers will represent young women and girls who have sought, are eligible to seek and or know others who have sought abortion services. It will also be used to represent respondents (right holders) in this research. The term 'women and girls' are also used to represent respondents of different demographics in this study.

1.1 Background of The Study

Reproductive health education remains inadequate for both in and out of school young people despite the strides made by governments and civil society organizations through reproductive health programming and interventions at local, regional, and national levels (Shaw 2009:4). Sexual and reproductive health and rights (SRHR) topics such as sex, contraceptives, and abortions are shrouded in cultural taboos and are often difficult conversations to hold. Young women find ways to information through their peers, social media and digital spaces which provide the opportunity and freedom to explore their sexualities and seek answers to their reproductive health concerns (Awudu 2021:2)[1]. This is supported by Waldman and Amazon-Brown as they argue that "the internet and digital technology have resulted in an explosion of opportunities for sexual reproductive health and rights information which are usually outside former government health and education domains" (2017:24). For some of these channels of information, questions have been raised on their credibility in providing correct and reliable information for safe and healthy sexual choices especially for young girls. The need for comprehensive sexuality education remains crucial in providing timely, factual, and reliable information and referral to sexual and reproductive health services for all specifically women. For instance, the knowledge of family planning, contraceptives, safe sexual

[1] This section of the paper is influenced by my argument made in my final assignment for 4218.

practices, and abortion services, can be very instrumental in the fight against unplanned pregnancies, unsafe abortions and sexually transmitted infections including HIV/AIDS.

The criminalization of abortion under Section 58 of the Criminal Offense Code does not permit a healthy mother to abort a healthy pregnancy even if mistakenly conceived and unwanted (1960:46). Thus, a person who intentionally prepares anything for abortion, administers anything for abortion, or aids a woman in aborting or attempting to abort, other than by a legally designated professional, in a registered facility and in the exceptional circumstances of rape, incest, or danger to child or mother, commits a second-degree felony (ibid: 46). The debate of including Comprehensive Abortion Care (CAC) into the National Health Insurance Scheme to expand health coverage and reduce mortality rate in Ghana will not be fully achieved if the law on abortion remains unchanged. Young women of reproductive ages resort to quacks and 'local medicines' in efforts to abort unintended pregnancies, contributing to the high rates of maternal mortality and morbidity (Morhee and Morhee 2006 :80). Even though Ghana is making strides to increase access to contraceptives and family planning commodities (which are still not covered under insurance), the unmet need for family planning is still very high in the country resulting in thousands of unplanned pregnancies, sexually transmitted infections unsafe abortions amongst others. (UNFPA Ghana, 2018) (Machiyama and Cleland 2014:203). Consequently, even if the CAC is captured into the National Health Insurance Scheme (NHIS) while self-autonomy vis-à-vis abortion is not encouraged through selective amendments of section 58 of Act 29, women will continue to demand the services of quack abortion doctors.

1.2. Research Problem Statement

Reproductive health care related topics are regarded as taboo conversations, choices and lifestyles that presents obstacles for interventions aimed at addressing these topics. Topics such as Rape, Defilement, family planning, contraceptive use, HIV/ AIDS, abortions, and Comprehensive Sexuality Education (CSE) has over the past years received strong opposition from Ghanaians. The public opinion coupled with Ghana national health policies and provisions have left huge impact on the sexual and reproductive health especially of young women who are consequently unable to make safe and healthy reproductive health decisions. Unplanned pregnancies result primarily from unprotected sex (consensual and non-consensual) and contraceptive failure; however, for a section of Ghanaian women, who find themselves with unplanned and unwanted pregnancies, the opportunity to abort the pregnancy

are faced with legal (abortion laws), structural (information, healthcare access and provision) and socio-cultural (including religious influences) barriers.

Ghana's National Health Insurance Scheme (NHIS) aims to advance universal health coverage and to reduce financial barriers to health care but does not cover 'elective' abortion services mainly due to legal status of abortions in Ghana. This has compelled abortion seekers including a section who qualify into the exemptions of the abortion laws, to pay for expensive abortion services, patronize over-the-counter medications, quack doctors, and resorting to other dangerous means to terminate pregnancies, often resulting into fatal outcomes. For instance, in 2013, a 16-year-old childhood friend was defiled by a 'respected' man in the community resulting in an unintended pregnancy. This girl who lives with an aunt was lured into ingesting pills with the intention of terminating the pregnancy, resulting in excessive bleeding and a surgical emergency for complete expulsion of the fetus. In this instance, the power relations in what might be considered sexual harassment (defilement), remains undiscussed mainly due to lack of knowledge and the various levels of a socio-cultural system of abuse and shame associated with such sexual and reproductive health concerns. Additionally, limited information on safe abortions, the culture of silence, as well as the shame associated with abortions can be associated to the decisions made which almost cost her life. Moreover, the inexistence of a standardized price for abortion care and services influences the choices of abortion seekers in Ghana which may be fatal to their health and ultimately, their lives.

1.3. Research Objectives

Based on the problem statement, this research sets out to investigate how the reproductive health rights of women and girls in Ghana are violated through a selective system of abortion service and health care delivery by examining the abortion laws and legal frameworks of the state, the National Health Insurance Policy. In order to do this, the research will ask the gaps, in law and policies, and how these gaps impact implementation strategies, choices of women and girls both in seeking services and in taking part in rights mobilization.

1.4 Research Question

The main research question for the study is:

How does the lack of recognition of abortion in NHIS constitute a violation of reproductive health rights in Ghana?

***The sub-questions are*:**

a. What are the gaps in the law in relation to abortions in Ghana, including the NHIS?
b. How does the gap in the law and implementation challenges impact on the reproductive rights of young women?
c. What is necessary to narrow some of these legal gaps and implementation challenges, through legal mobilization.

1.5 Literature Review: The Root of Unsafe Abortions in Ghana

The literature review covers the span of comprehensive sexuality education (CSE), comprehensive Abortion care (CAC) and the national health insurance scheme (NHIS). This section draws the link between CSE and CAC. The examined literatures provide insights into the research propositions on how the already identified problems would be resolved or ameliorated.

1.5.1. Comprehensive Sexuality Education in Ghana

For purposes of this research paper, Comprehensive Sexuality Education (CSE) is a "rights-based and gender-focused approach to sexuality education whether in school or out of school. CSE includes scientifically accurate information about human development and reproductive health as well as information about contraceptive childbirth and sexually transmitted infections including HIV" (UNFPA 2016). Decades of debate over abstinence-based advocacy and comprehensive sexuality education for young women and girls have been based on various religious morals and cultural values of different populations and have received significant attention from policy makers locally and internationally. The abstinence movement for over a decade has proposed and implemented an abstinence-only sex education, "bringing abstinence programs to public schools and spawning single-issues organizations dedicated to promoting abstinence and reforming sexuality in the USA" (Calterone 2011: 417). In Ghana, abstinence-focused programs have thrived in both formal and informal educational systems, family units and religious systems. For example, government institutions, such as the Ghana Health Service (GHS) and the Ghana Education Service (GES)

execute government-led education initiatives such as the creation of 'Life Skills' formerly a compulsory subject of study in Junior High Schools (Awudu:2021:1).

Similarly, periodic health visits held by nurses and other health workers to public schools on menstrual hygiene and other reproductive health topics led by the GHS. These engagements were and have been abstinence-focused and employs fear-based approaches disproving young people's perception of sexuality as supported by Awusabo-Asare et al (2017:4). They are also based on claims that the delay of sexual debut can be an effective way to address reproductive health challenges that young girls face such as unplanned pregnancies and unsafe abortions, there remain a gap and argument that accessing correct and timely information is relevant to make safe and healthy reproductive health choices. Awusabo-Asare et al have argue that abstinence-only education programs have proven "little evidence of improving sexual and reproductive health outcomes" (2017:4) while Calterone suggests that to "appeal directly to parents and even adolescents themselves about the degenerate nature of sexual mores in the culture and the necessity to teach and proselytize about the importance of abstinence in their communities and to the peers" (2011:421).

On the other hand, researchers, and organizations like the United Nations Population Fund (UNFPA), have also argued the relevance of sexuality education in preventing unplanned pregnancies, unsafe abortions sexual harassment among all other socially unacceptable vices. The United Nations Population Fund (UNFPA) in their definition of CSE includes "scientifically accurate information about human development, anatomy, and reproductive health as well as information about contraceptives, childbirth and STI's including HIV". (2016: n.p). They further argue that CSE in theory and practice goes beyond the provision of information, but it enables the exploration and nurturing of positive values, related to their sexual and reproductive health. Moreover, sexuality education programs recognize that sexual activities can occur during adolescence so there is also the need to equip young women with knowledge and the ability to make informed decisions about their lives as supported by Awusabo-Asare et al (2017:4). It is also debated that sexuality education's focus on human rights, gender equality, and empowerment have demonstrated impact in areas including knowledge improvement self-confidence and self-esteem (ibid 2017:4).

The Alan Guttmacher Institute in 2014 presented that 4 in 10 females and 2 in 10 males in Ghana between the ages of 15-19 years already have sexual and or sexual experience and that by age 20, 83% of girls and 56% of boys would have had sex; with the median age of first intercourse being 17.4 and 19.5 for both girls and boys respectively. (Alan Guttmacher Institute 2004:1). UNFPA citing data from the 2014 Ghana Demographic and Health Survey

also indicates that approximately 16.9 % of girls under the age of 18 have given birth before (UNFPA 2020: n.p).Additionally, many adolescents between the ages of 15-19, married or not have had sex or engaged in sexual intercourse with rates of 43% and 27% for girls and boys respectively; "the median age of first sexual intercourse for both boys and girls is at 20 and 18 respectively, and among adolescents, 12% of girls 9% of boys had initiated sex before the age of 15" (Awusabo-Asare et al 2017:4). Given the above debates and submissions I argue that unplanned pregnancies result from unprotected sex and in some rare instances, contraceptives failure and increases the risk of sexual infection for sexually active people. The rejection of CSE by Ghanaians may also imply that a women and girls who experience unplanned pregnancies may also have limited information on their reproductive health and rights as well as safe abortion options and fairly represents the implications of weak reproductive care systems for women in Ghana.

1.5.2. The Law and Comprehensive Abortion Care in Ghana

Closely related to CSE is Comprehensive Abortion Care (CAC) and services which is relevant for this research topic questioning the reproductive health right of women and girls who experience unplanned pregnancies. Ghana has significantly shown progress in advancing quality health service by improving upon access to pre and post maternal health care services especially in rural and hard to reach communities, actively creating adolescent youth corners to provide youth-friendly and gender-sensitive services, an increasing number of health care providers and most importantly introducing progressive policies such as the reproductive and Health Policy, Adolescent Reproductive Health Policy and the National Health Insurance Policy within the Health care system. Unfortunately, Comprehensive Abortion Care (CAC) and services remain highly inaccessible, especially for young girls and women.

Guttmacher Institute reported that in 2017, "(53%) of all pregnancies nationally were unintended, ranging from 23% in the Northern zone to 51% in the Coastal zone and 66% in the Middle zone; An estimated 23% of all pregnancies in Ghana in 2017 ended in abortions" (Guttmacher 2020:1).The Ghana Maternal Health Survey (MHS) also pointed out the induced abortions reduce with age as it discovered that 19% of pregnancies among women under the age of 20 ends in induced abortion compared to the 6% of pregnancy among women aged 35-49" (MHS 2017:9). Regardless of the confounding figures as displayed above, abortions are still criminalized in Ghana and are not available for every woman upon request. For this research paper, abortion will be defined as the "premature expulsion or

removal of conception from the uterus or womb before the period of gestation is completed" (Criminal Offence Code 1960:47).

Abortions in Ghana remains illegal, according to the Criminal Offence Code. Subsection (2) of section 58 defines exemptions for this law and identifies these conditions as when "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 cannot make such request; 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 cannot give such consent it is given on her behalf by her next of kin or the person in loco parentis; or where there is a substantial risk that if the child were born, it may suffer from, or later develop, a serious physical abnormality or disease". (Criminal Offence Code 1960:47).

However, section 58 (1) remains subject to subsection (2) conditioning that anyone who consents to or administers to herself, or another a drug, poison, uses any instruments or any substance to cause an abortion; aids and abets a woman to cause abortion or miscarriage or supplies any poison, drugs, or instrument to cause abortion or a miscarriage shall be found guilty of an offense and liable on conviction to imprisonment for a term not exceeding five years. (Criminal Offence Code 1960:46). This restriction of who is granted permission to access abortions will subsequently lead to the employment of unsafe methods in hopes of terminating unintended pregnancies considering that "equitable access to and utilization of health care has been articulated as a basic human right" (Shaw 2009:134). Obaid claims that "inequality in accessing services between the rich and the poor, urban and rural, general population and ethnic minorities and other marginalized groups are greater in sexually productive health than almost any other health indicator" (2009:103). Knowledge on the abortion laws as well as the correct procedure to accessing the services are limited, and this ignorance of the law propagate perceptions to abortions and hinders women from accessing it rightly, consequently risking their lives (HRAC n.d :3).

In addition to the inadequacy of knowledge, fear-based education which highlights only stern social and legal punishment for abortion seekers who attempt to abort pregnancies, encourage women and girls to patronize the quack industry due to the anonymity and the 'cheap' rates offered. Ipas Ghana reports that financially disadvantaged women and girls are unable to afford abortion services in Ghana due to exorbitant rates being charged by both public and even worse private facilities. (2016: 2). Citing the special rapporteur on the Right

to Health, "poor marginalized women cannot afford safe abortion and often undertake procedures in an unsafe and unregulated environment which leaves them vulnerable to avoidable incidences of maternal mortality and morbidity". (Ibid:2). Medical personnel resort to it as a money-making venture with an excuse that it is a professional risk that can result in the evoking of licenses (ibid:3). IPAS further highlight that abortion fees range from "$22-$300 depending on the gestation of the pregnancy" (Ibid.:3) which is quite high as many people live under a dollar a day. For rural young women and girls from poor backgrounds, affording these rates is nearly impossible.

The introduction of the National Health Insurance Scheme in 2004, is one of the major government initiatives to reduce barriers to healthcare especially on maternal health to advance commitments towards universal health coverage (Dalinjong et al. 2018: 1). Unfortunately, comprehensive abortion care and services, (specifically elective abortion services) are not covered and information related to is very limited to the public. Sundaram et al argue that women and girls from the lower socioeconomic strata are more likely to seek and have unsafe abortions while wealthier woman due to their financial capabilities are likely to get better access to health care in the event of an unintended pregnancy and abortions (2012: 283).

Furthermore, legal ages to consent to sex and marriages in Ghana stand at 16 and 18 respectively, further creating gaps in service access for abortion seekers who fall within this age group. For minors, a guardian's consent is a requirement for (legal and safe) abortions procedures. However, IPAS global claims that "laws and policies guiding the ability of minors' to fully consent to abortion should take into consideration the "best interest of the child, account for minor's evolving capacities and protect confidentiality"(Skuster 2013:3), parental consents and involvements do not uphold these principles, thus the barrier to access. For fear of parents finding out, most young girls' resort to other unsafe methods which require no formalities. Consequently, it is evident that the socio-legal environment and politics around abortions have and continue to create barriers to information and service access to abortion seekers in Ghana. Most importantly, financial barriers created because of this socio-legal environment (this includes health initiatives borne out of legal structures) are enforced by selective service delivery and adds directions to this research. The next chapter will discuss the theoretical frameworks the national health insurance scheme and its contribution to the research problem.

Chapter 2 : Theoretical and Normative Frameworks; A Socio-Legal Perspective to Unsafe Abortions

2.0. Introduction

In this chapter the theoretical frameworks for the study are discussed by exploring the relevance of the adopted approaches to understand what violation means to abortion seekers, civil society and government stakeholders, in relation to abortions and abortion laws and how knowledge of the law can influence reproductive health choices of young women and girls in Ghana. The section also discusses the National Health Insurance Scheme (NHIS) as a normative framework and highlights how these frameworks when applied to the research questions, provides explanations and possible answers relevant to the study.

This research employs the frameworks of legal consciousness and legal mobilization to analyse and answer the questions of this research. Legal consciousness stems from the conceptualization of the research problem statements as well as the sub questions in our bid to understand knowledge levels and how they influence behaviours in standing with or against the law. Since this research is concerned both with the law and the people it governs, it is important to understand how the knowledge of people influences their actions in engaging, avoiding, or resisting the law and legal meanings. Legal Mobilization on the other hand examines to what extent legal structures and laws can be resisted by individuals, non-governmental and civil society organizations and how these actors can and are using existing human rights laws to abolish or amend abortion laws. In addition to this, legal mobilization and consciousness will assist in unpacking and answering the main research question. While the above-mentioned concepts are the primary analytical tools, legal translation and body politics are briefly discussed.

2.1. Legal Consciousness

Originally, the concept of consciousness can be attributed to different scholarly foundations within existing literature such as Ehrlich (1922) and Pound (1959). A particular social legal study of legal consciousness historically is that of Engle 1998. There have been some arguments that extensive studies on legal consciousness began mainly based on the realization

that society and law scholars neglected how the law affected the everyday practices of people. (Cowan 2004: 930).

Following this, there has been an interest by scholars to understand how law influences society and vice versa. This can also be argued to be attributed to the development of scholarships of legal consciousness. Conversely, Silbey (2005), state that the development legal consciousness within the period of 1980s to 1990s has experienced a lot of transformations. This is explained by the fact that scholars of legal consciousness focus on legal hegemonic analysis which depicts how institutions of state power within the Weberian sense strengthen the law. This is useful in my study in Ghana as it illuminates how government and nongovernmental institutions apply reproductive health rights into practice.

Ideally knowledge of the law can be argued to be an influencing factor for society to stand with and defend their law, but this is not always the reality. Scholars (e.g. Cowan 2004; Harding 2006; Silbey 2008) have established that the study of legal consciousness as an arm of socio-legal scholarships should then focus on the intersection and interrelations of law and society. After all, legal consciousness studies have transformed to investigate issues to do with the gaps on what law means in practice (reality) versus what it says in the book (living law and law in action) (Hertogh 2017; Sarat 1985). The need to understand and examine the extent to which ordinary citizens are aware (conscious) of their laws (both local and international) legal rules and institutions have been argued to be an essential and continues to gain popularity. Thus, this lens aids my research to appreciate the understandings of abortion seekers (right holders), vis-a-vis the duty bearers (government) and civil society on the socio-legal environment of abortion and reproductive health frameworks within the discursive power structures in Ghana. Hertogh approaches legal consciousness through a critical and secular lens to focus on why people resist law based on their strong criticisms (2018:6) and argues that the combination of 'law in action' and 'living law' (American and European approaches respectively) allows for a broader discussion on law both as an independent and dependent variable. Consistent with this lens, this research also examines such inconsistencies between domestic frameworks and global frameworks as well as analysis of the gaps identified and the reality of exercising reproductive health rights in Ghana.

Legal consciousness like any other framework has received some critics on the state of literature (Cowan2004). For instance, Cowan criticizes the 'law-first' approach arguing that the primary concerns of legal consciousness should be destiny of the society rather than that of the law (2004:929). Hertogh also argue that while laws in books (official law) are more of rules and norms, it can be distinguished from the 'law in action' through:

the implementation of the said rules and norms as well as patterns of decisions by legislative and judicial bodies. Equally "living law is not identical to law in action because it refers essentially to obligatory norms rather than actions" (Hertogh 2004: 474).

Based on the distinct nature of the approaches discussed above, this research proceeds to draw its analysis by applying the complementary argument of Hertogh (law in action plus living law). This allows me to appreciate the position of the abortion laws of Ghana, the existing nuances, who interprets the law and how the law is interpreted; what do abortions seekers understand (or not), among other key questions relevant to this approach and study. It's also useful to elucidate why abortion seekers continue to patronize and engage in unsafe abortion practices despite the so-called liberality of the laws.

2.2. Legal Mobilization

Legal mobilization is a process where "desire is translated into the claim as an assertion of rights" (Zemans 1982:700). While my approach to legal consciousness is understanding law, legal processes and how society interacts with the law, legal mobilization is concerned with how the demands and grievances of vulnerable groups such as abortion seekers (specifically rape and defilement survivors) are articulated and how such demands can further be championed into the legal system. This is usually pursued similarly to the roles of civil societies, local and international non-governmental organizations, and human rights activists' involving advocacy and programming of intervention focused on the interest of identified vulnerable groups in society.

Legal mobilization is also applied to analyse the concerns of accountability of the activities of activists; and a tool for activists to hold state actors accountable (Gloppen 2008). For example, the activities of Marie Stopes International and Ipas have engaged government through their relevant agencies and ministries on the inclusion of family planning and contraceptives into the National Health Insurance Scheme. This study unpacks to what extent legal mobilization can effectively make progress and how actors are relevantly using international human rights laws and treaties towards holding the government of Ghana accountable on the legal victimization and violations of the rights of abortion seekers. Thus, legal mobilization can be argued to represent a means to an end; in this case a possible end to structural and legal barriers to accessing basic reproductive health rights. Handmaker also explains that while legal mobilization is an under-studied research area, it tends to present itself into two strands. The first strand draws "largely on social movements theory to account for law-based

advocacy which focuses more on the aims and objectives and of a particular law-based campaign" (2019:6); the second strand of legal mobilization research focuses on how strategies or public litigation is justified and managed" (ibid).

This research ties its analysis mainly to the fist strand stated above through the data collected from civil society, local and international and how these actors operate especially using recognized human rights laws and provisions. The translation of human rights concerns such as restrictive abortion laws into legal rights through the application of legal mobilization can be a challenging process. Specifically using the translation process of civil society, NGO's and human rights activists who usually advocate for their individual causes. This is very crucial on every law-based advocacy as translation can largely influence any legal mobilization and or advocacy process.

Civic actors in their position to challenge the state will require their capacity and ability to promote and to certain extent impose "national and international legal obligations through legal mobilization that have been shaped by structural changes and international normative frameworks and by associated political development" (Handmaker 2019:13). For these to be successful, it is appropriate to also consider capacity as well as other resources to enable the ability to lay claim against "a set of legal-normative expectations owed to individuals and groups, especially in relation to human rights law" (ibid: 13). Citing Ignatieff (2009) and in further unpacking the concept of role of civic actors in challenging the state as part of legal mobilization as a research area and analytical tool, also describe the legal capacity of these actors to have evolved "with juridical, advocacy and enforcement dimensions through a distinctly liberal nature" (ibid: 13). According to Onuora-Oguno et al (2018) a sustained deliberation of issues like has potentials of driving a desired change subtly.

Socio-legal scholar Sally Merry argue and provides in-depth explanation on the roles of translators/ intermediaries and how these processes influence transnational ideas and rights through Vernacularization and hybridity (Merry 2006:3). In this instance, organizations and activists such as Ipas, Planned Parenthood Association of Ghana and Marie stopes who frame discourses of local content and concurrently present local stories for international community play a huge role in the directions of any law-based advocacy and legal mobilization process. Citing Merry (2006) and Goodale and Merry (2007), Handmaker (2019:13) suggests that there is an existing challenge for the translation of norms and values within every setting. In settings of international law, translators such as civil actors must possess and exhibit what Merry describes as a double consciousness of the content of international law and the circumstances in which these narratives are framed and enforced both at the international

levels and relevant local/national contexts (2019:14). However, the position of the above arguments does not reflect or indicate that actors and stakeholders who are not familiar with international law cannot lay claims against government but such cases as stated by Handmaker are "less likely to be reflected in international and comparative legal discourses" (ibid:14).

One of the major critiques of Legal Mobilization as mentioned before is the limited research carried out in the area. There is limited literature especially in Sexual and reproductive health rights and most importantly, literature that stretches beyond litigation to include law-based advocacy and legal mobilization as a counter power (Handmaker 2019:7). In reference to this study, the absence of legal mobilization studies in the field of reproductive health posed both a challenge and opportunity. My inability to access enough literature to understand the thoughts and arguments of scholars on the topic within the Ghanaian, African and global context provided me an opportunity and challenged me to present my thoughts and analysis with little to no influences from external writers. Though a critic, this ultimately impacted on this research positively to present my work as a reference source for future researches in the area.

As an analytical tool, a legal mobilization lens to this research explains what is being done to solve the research question (specifically the research sub questions) and how efforts of civil society can be intensified. Complementing this approach to other like legal consciousness and translation allows a better framing of how the law can be expressed and viewed both as a means and an end. Harcout defines body politics as "the political struggles of people to claim control over their felt and lived biological social; and cultural embodied experiences" (2009:247).

Additionally, the definitions of a woman remain tied to the biological difference between who is considered a woman and who is considered a man but arguably, the female body is more complex than what we assume it to be. Thus, acknowledging how bodies are gendered creates a platform to appreciate the experiences of women and girls and constructs such as language, parenting, childbirth health (in every sense) and how these constructs shape discourses to challenge and resist norms and practices, legally, politically, socially and economically (Harcout 2009:17). The nexus between legal consciousness mobilization and body politics is important to show the non-legal driving forces for certain desires of the female body. For instance, the norm of pregnancy, for every female to want a child and must have a child to prove their self and to fit into society (ibid:17).

2.3. Ghana's National Health Insurance Scheme (NHIS)

In the early 1980s, Ghana instituted a 'cash and carry system of health care delivery due to budgetary constraints as a recovery strategy after providing citizens with free health care from the immediate post-independence era (Braimah and Mensah 2013:1378). This system presented many barriers to health care access to many Ghanaians especially for those in low-income households. Maternal and infant mortality is one of the many challenges presented by the 'cash and carry' system as many rural and poor women continue to seek the services of traditional birth attendants, during pregnancy and delivery instead of visiting health facilities. The government of Ghana budget, internally generated funds (IGF) and donor support remains the primary source of income for the health sector administrated through the Ministry of Health (MoH) and Ghana Health Service (GHS). The 19%, donor funding in 2017 is expected to reduce to 1% by 2022 to be replaced by a 14% increase in IGF's share and 4 % of government funding (UNICEF n.d :1)

The system of operationalization from registration, renewals, and payment of premiums, presents inequalities and discrimination between the rich and the poor. NHIS premiums in Ghana Range between GHC 7.2- 48 implying the different levels of accessibility based on how much a premium a beneficiary pays. If indeed the NHIS seeks to ensure equitable and universal access and remove financial barriers as argued by Garcia-Mandićo et al. (2020:2), then this challenge defeats its purpose. The Ghanaian National Health Insurance Scheme (NHIS), implemented by the Government of Ghana and spearheaded by the Ministry of Health has been in operations since 2004 intending to provide Ghanaians (subscribers), increased access to quality and timely health care services and commodities, with special emphasis on reaching those left behind and vulnerable (poor populations). This scheme according to Barimah and Mensah (2013: 1378) was also established as a poverty reduction strategy to make healthcare more accessible by reducing financial barriers which the previous 'Cash and Carry' system battled with. With this system in place, it is expected that Ghana will be making significant strides in achieving universal health coverage as well as meeting other obligations set by international Human Rights treaties to which Ghana has ratified; treaties such as the International Covenant on Civil and Political Rights (ICCPR article 6), Sustainable Development Goal's (SDG's), Convention on the Elimination of all forms of Discrimination Against Women,(CEDAW: articles 2,3 and 12) and the Maputo Protocol (article 14) which have obligations set towards the right to life, dignity, and right to health.

The inclusion of Comprehensive Abortion Care (CAC) and complete reproductive healthcare into the NHIS will no doubt reduce maternal morbidity and mortality rate in Ghana. While maternal mortality rate in Ghana declines each year, the less than 2 per cent decline is too insignificant. In India, for example, where CAC has been adopted into their healthcare system, their maternal mortality rate has been declining drastically each year. Recently, India has even published their guidelines for training of health professionals on CAC. According to the World Health Organization, unsafe abortions which is among the leading causes of maternal morbidity and mortality, is one easily preventable using reproductive healthcare (including contraceptives). Becker (1999) and (Adima 2011) cited by Latt et al. (2019) amongst others argue that there is significant evidence linking unsafe abortions with increased maternal mortality and mobility. According to (WHO 2018) most abortions related maternal deaths are due to unsafe and illegal abortions (2019 :1). Despite this Latt et al. (2019 :1) argue that even to the above claim suggest a reduction of maternal mortality if abortion reform laws are improved there is still no rigorous evidence, based on which these arguments can be upheld.

Research has exposed major barriers hindering fresh registration and renewal of NHIS policy among the rural communities. According to Kwarteng et. al. (2020:8), on the state of enrollment on NHIS in rural Ghana, there exist major reasons accounting for our inability to attain full coverage. While a vast majority of the rural people (78% for renewal and 92.6% for fresh registration) cannot afford the premium, other reasons are lengthy delays in the process (4.4%) coupled with poor attitude of NHIS staff (1.6%). There were still a percentage of the rural households who were not registered on the scheme because they had no knowledge of its existence. Kwarteng et. al. (2012) further observed that out of 1.2% of total exemptions for vulnerable groups, only 0.5% of NHIS membership was based on exemptions for the poor. Thus, a more targeted mechanism is required to ensure equity among all Ghanaians. Kwarteng et al. (2020) doubted the use of the Department of Social Welfare to identify the poor in communities. What the foregoing means is that if the inclusion of CAC and comprehensive reproductive health coverage will lead to increase in the premiums charged for NHIS while the mechanism for targeting and exempting the poorest in rural Ghana remain unencouraging, the purpose of universal healthcare coverage will not be achieved.

Additionally, politicization of the health care systems coupled with the government's inability to pay providers of services and distributors of commodities on time has enabled extortion as a result and manipulation of services and commodities by service providers

(doctors, pharmacists, nurses, and midwives) who run private institutions have been reported (and based on my experiences) to making referrals to their private health facilities and charging exorbitant prices for services. Other challenges also include the 'morality of policies, distrust in the system by beneficiaries, and most importantly, issues of confidentiality. With the institution of the NHIS, Maternal Mortality is one of the key areas covered by this scheme. According to the NHIS, the insurance covers obstetric and gynecological emergencies, antenatal care, deliveries (both normal and assisted), Caesarean sections, and postnatal care (NHIS 2021:np). While many beneficiaries are said to enjoy this system, some life-threatening health conditions are exempted from the scheme.

According to NHIS, HIV antiretroviral drugs and comprehensive abortion care and services do not fall under the insurance scheme which within my perspective is one of the major challenges. Incidence of abortion-related emergencies are continuously reported to the hospitals, unsafe abortions are still high in Ghana and impede the progress of the country's goals of zero maternal mortality and morbidity; persons living with HIV who cannot afford their drugs either deteriorate and eventually pass on or spread the infections among others. These financial barriers deepened the discrimination towards financially incapable young women who have access to this scheme for other ailments but are unable to use it in accessing abortion services thus, enabling only the rich and powerful who can afford can access these services. Societal rejection of CSE and the inadequacy of information from our educational, health and civic agencies on reproductive health coupled with an ineffective health system expose women and girls to uninformed and risky sexual behaviours such as unprotected sex which leads to unplanned pregnancies and possibly sexually transmitted infections. Specifically, for abortion seekers, the inadequacy of information on the abortion laws and access to the right services coupled with the financial barriers raised may influence them to seeking unsafe and illegal means of terminating their pregnancies. For seekers who fall within the exempted populations who can freely access the service (especially for rape and defilement cases), the current environment revictimizes them through these selective service delivery and financial barriers to abortion services.

An evident gap in all the thematic literatures reviewed shows that knowledge of the laws (abortion laws) and reproductive health and rights are either limited and or inaccurate and depict a consequential relationship that adversely affects the reproductive health rights of women and girls. But the extent to which the knowledge of the law as a catalyst affects these experiences remains relatively under researched.

2.4. Summary

In the preceding sections, I discussed the theoretical frameworks of legal consciousness and legal mobilization and how these frameworks relate to my study; specifically, how they can be applied to my analysis of the research findings. I discussed also some inadequacies of the above-mentioned frameworks based on existing critiques of literature. The chapter also presents a brief normative framework of the national health insurance scheme in Ghana, how it operates and some of the short falls relevant to the study topic to facilitate a better understanding of the context on which this study is based.

Chapter 3 : Methods and Research Design.

3.0. Introduction

This section presents the methodology and techniques applied for the data collection and analysis. The collection and analysis of data for this study remains in line with the research questions objectives as well as the analytical framework discussed earlier in this chapter which are prerequisites for a successful study.

3.1. Sources of Data and Participants

Primary data was the main source of data for this study, through conducting in-depth interviews, non- participant observation and the review of secondary data from government agencies and websites, reports, policy documents etc. In conducting this research, I engaged multiple qualitative methods such as interviewing officials of identified NGO and the National Health Insurance Authority and women and girls between the ages of 13 and 28. I also studied literature (including grey literature) available on print and electronic media on abortions and reproductive health in general that were relevant to the topic and analytical frameworks use in this study. This study also made efficient use of existing national and international legal frameworks including the Criminal Offense Act of Ghana, the CAC protocol among others. Reports, publications and other literatures from reproductive and public health NGOs like IPAS, Curious Minds Marie Stopes amongst others also provided rich sources of data for this study. Furthermore, a critical and intensive review of the existing regional and international human rights law instruments conventions and treaties of the United Nations and African Union treaties monitoring bodies were conducted. These include the Maputo protocol the convention on the elimination of discrimination against women amongst others.

3.2. Interviews

For this data collection process 25 face to face interviews with young women and girls between the ages of 13 to 28 were conducted to examine their knowledge on abortions, reproductive health abortion laws and the NHIS. I applied a semi structured interview guide which allowed me to probe deeper based on some of the responses I received from their respondents. As argued by Marshall and Rossman "a conversation with a purpose is a useful way of

getting large amounts of data quickly" (1999:109). Participants were identified and selected through snowball sampling, a process which allows identifying individuals using networks and referral-based systems. This approach was done through sending out volunteer calls and referrals from organizations that worked on abortion related issues and sexual and reproductive health and rights. Secondly, I conducted two additional sets of in-depth interviews with six officials from the National Health insurance authority and six interviews with four sexual reproductive health organizations namely Marie Stopes International (MSI), Planned Parenthood Association of Ghana (PPAG), Ipas and Curious Minds Ghana collectively. The non-random purposive sampling reach allowed me to intentionally select these participants who have experiences in working on the research area and or are knowledgeable about the legal environment of abortions and reproductive health care access in Ghana. O'Leary also explains that's in purposive sampling a researcher can select their respondents based on their expertise variance and particular criteria (2013:110).

3.3. Reliability and Validity

O'Leary refers to reliability as they "extent to which a measure procedure or instrument provides the same results on repeated trials" (2017:134). Bhattacharjee also defines reliability as "the degree to which the measure negative of a construct is consistent and dependable" (2012:56). On the other hand, O'Leary also argues that validity present the ability to access truth of a study (2017:129). Additionally, Grove and Burns (2005) also define validity as the extent to which research instruments can measure its intended purpose. Throughout this study, I consistently used the same interview guide among the different respondents. Also, I combined all data sources and methods (primary and secondary). The varying demographic of the sample size and backgrounds also allowed for proper triangulation of the data received. Having explained above concepts I will now move ahead to explain the process of my data analysis in the next section.

3.4. Data Analysis

The analysis of this data is done using a thematic analysis to group recurring themes which are thought to be crucial and relevant and have emerged from their field work. The analysis process includes transcription of data gotten from interviews categorization of data inserting data into thematic units. The transcription process was done personally as I understood the local languages used in the data collection process. The thematic units used for the analysis

took into consideration the position and backgrounds of the respondents (governments civil society or abortion seeker) as well as the age demographics of the abortion seekers interviewed.

3.5. Positionality

The nature of this study reflects the significance of considering positionality during the research process. Positionality involves the worldview of individuals and or the background of the researcher summoned by the varying on to logical epistemological and methodological assumptions (Sikes 2004). Furthermore, it entails power relations visibly or invisibly presents between researcher and respondents/participants and the relevance of an established relationship of trust throughout their research process (Brooks et al. 2015:2). The sensitive nature of the research topic required my awareness of how I present myself as a researcher (non-judgmental researcher). Positionality also creates room for neutrality which is an essential component of any research of this nature. As a pro-choice advocate my affiliation to this research topic puts me in a position central to the knowledge that emerged from my participants (O'Leary 2014). Thus, the need to query my power as a researcher and how it can influence data collection and the production of knowledge was crucial during the data collection and analysis phases of this study respectively.

My personal experience with the topic dates to the age of 13 when I witnessed first-hand unsafe abortion process carried out by my childhood friend. This was a time where most knowledge we had on sexual reproductive health revolved around menstrual hygiene, fear-based accidents program as well as HIV and AIDS prevention programs. At this point it is important to mention that the said childhood friend got pregnant after being defiled by an elderly man who acquired over the counter medications in hopes of aborting the pregnancy. Over the years my conscious effort to understand human rights especially on issues of reproductive health has resulted in many engagements with local and international organizations such as Ipas, Marie Stopes international, the Planned Parenthood association of Ghana (PPAG), The United Nations population fund (UNFPA) amongst others who are reproductive health champions. But despite all these engagements and interventions from these organizations I continue to question how far knowledge is disseminated and if we have made progress from when I was 13 years old.

The concepts of legal consciousness, legal translation and legal mobilization gave me an eye-opening experience on how the law can re-victimizes vulnerable people whom it should

protect or otherwise. Secondly the role of activists and organizations in translating human rights agendas both locally and internationally and finally how we can solve problems (in this case unsafe abortions) through the socio-legal lens.

3.6 Reflexibility and Ethical Considerations

In conducting this study, I was aware of and considered the sensitivity of research topic by upholding key ethics which are important for a good social science research. As a set of moral principles and obligations, ethics provide guidance to proper behavioural conduct in a research study (De Vos 2002). Thus, voluntary, and informed consent were requested and received (to collect and use data and possible reach out later for follow ups) from respondents prior to every engagement (Interviews). The official letter provided by the university outlining my research and in traducing me as a student was also very useful to negotiate for engagement opportunities which were successful especially with government agencies and non-governmental organizations.

Confidentiality is a major ethical concern and this study upheld this not exposing the identities and individual views of all participants specifically young women and girls interviewed during the data collection process. Additionally, the interview process was conducted individually in a conducive space to allow efficient conversations. Babbie and Mouton (2001) emphasis that guaranteeing confidentiality in each study is very useful in every social science research. For some of the respondents who wanted their stories to be shared, their real names and identities are also not disclosed in this study to ensure anonymity.

This study also applied the 'No-Harm' principle which ensures that social research does not inflict harm to any studied population. Due to the COVID-19 situation during the data collection period, 1.5 meters were maintained during each engagement. Nose masks, sanitizers, soap water and tissues were also provided to adhere to the safety protocols of government of Ghana. Finally, there were some respondents who engaged in the local dialects, thus efforts to honestly transcribe their views of the respondents were also highly considered. O'Leary elucidates that a researcher must be neutral in the research process during the process to avoid imputing the unintended into the narrative data (2014).

During my field work, it was a bit of a challenge to get comfortable spaces to carry out these interviews because respondents couldn't settle on suitable grounds for my engagements with them. This is because I had offered them the option to choose a suitable location which would make them most comfortable. Thus, for some of my respondents, it required that I

ride (on my motorcycle) to places of their choosing and for the others, especially those in the urban centres, I made use of a radio room in one of the community centres of a local organization.

3.7 Limitation and Practical Challenges

The main limitation of this research is that I had to undertake the field work under strict COVID restrictions. Equally, another challenge is that access to government documents are difficult to come by and not readily accessible. The COVID-19 restrictions also posted significant implications on the data collection processes, modes or methods of data collection and the total number of respondents to be engaged. Due to the sensitive nature of the topic, not all participants opened up fully after conscious efforts like switching to local languages they were comfortable speaking in and patiently waiting for them to talk. Finally, one major challenge was that accessing government officials at the national Health insurance authority was difficult. After three weeks or continuous efforts, I was left with little choice which was to reach out to a friend to help facilitate my engagements with them.

Chapter 4 . Presentation of Data; Uncovering the Positions of Right Holders, Duty Bearers and Civil Society.

4.0. Introduction

This chapter covers a collection of identified themes based on which the findings of this research has been grouped on. These themes show an overview of how the identified and engaged stakeholders understand the relevance of sexuality education, the perceptions of what abortions are and represent and the legal environments both locally and internationally. This chapter also examines the varied understandings of the operations and positions of the National Health Insurance Scheme and civil society in respect to abortions, the choices and influencing factors of the abortion decision making dynamics as well as factors that influence their sexual and reproductive health choices. The chapter also presents some of the challenges and barriers faced by abortion seekers in terms of accessing reproductive health care, specifically safe abortions (realizing their reproductive rights) and how these challenges influence their reproductive health choices. Further examined are the multiple views of young women and girls in relation to the inclusion of abortions into the National Health Insurance scheme as well as alternatives to curbing unsafe abortions in Ghana. My investigation will also discuss the progress that has been made (or not) in making reproductive health care accessible for young women (abortion seekers) from the viewpoint of civil society and government actors (in this case, NHIS). The findings are presented in three sections, from the perspective of the duty bearer, (Government of Ghana), the right holder (abortion seekers) and Civil society (NGO's and Human Rights advocates).

4.1 The Rights Holders

Generally, young abortion seekers (rights holders) knowledge on reproductive health and rights revolved around menstrual health, sexually transmitted infections, abortions and general body hygiene. However, many cited inadequate information on sexual and reproductive health rights relating to reporting mechanisms for rape and defilement cases especially when it results in unplanned pregnancy. Young women also understood the concepts of unplanned pregnancies, the consequences as well how some of the decisions are influenced by

virtue of the fact that the pregnancies are unplanned. All respondents agree on the relevance of reproductive health education with some respondents tracing examples of their sources of reproductive health information to the interventions of local and international NGO's.

Through my fieldwork, opinions differed on contributory influences on unsafe abortions, the definitions of safe and unsafe abortion as well as respondents' opinions on the perceptions of what abortions represent. Some of the respondents gave educational, religious and cultural-based reasons on why they stood against abortions while others were torn between standing for or against abortions. For some like *Respondents A and H* quoted below, it was situational.

> *'To me abortion is not something we should encourage but depending on the situation, it can be good. I have a friend who has no place to live, but somehow ended up pregnant. If she had kept the pregnancy, the unborn child would've suffered both in her belly and when it is bor. In her situation, it was good she aborted the pregnancy (Respondent A)'.*

> *'Abortion is good, but it is not good. If you get pregnant whiles in school, you have to abort it before you can proceed so it that case abortion is good (Respondents I and H)'.*

Respondents of the study had either carried out an unsafe abortion before, acquainted to another person who has or both. Respondents collectively matched that abortion is risky, painful and a not pleasant experience. I probed to understand where and how they and or their friends carried out their abortions and what influenced these choices. Some of them shared their experiences quoted below:

> *'My abortion was very painful, and my survival was God's mercy. I took in 'Cytotec' because the guy was not ready and pursuing the pregnancy meant he would leave me. I swallowed two pills and inserted two pills, but the pregnancy did not get terminated so I consumed alcohol to facilitate the process. My friend on the other hand attempted to abort during when she was about 6 months in. it was scary, so we sought help from a neighbour who claimed it was complicated. He created a hole in a club bottle, inserted it into her vagina and kept blowing air into the bottle. He said the harder he blew air the quicker the baby will come out and luckily, it did. We all thought we may get arrested by the police if our friend had died (Respondent L)'.*

> *'In my community akpeteshie[2] (spirit/Hard alcohol) is one of the most effective ways to abort pregnancies. But I was scared so I went to the pharmacy. They prescribed and sold Cytotec to me which I took. The first time it didn't work so I went back, and I was given another dose after which the pregnancy terminated but not without excruciating pain (Respondent A)'.*

[2] Akpeteshie is a local and home brewed alcoholic spirit.

Respondents also claimed that getting medication from the pharmacy meant it was legal and safe otherwise, the pharmacy will not be in a position to sell it. As I probed deeper into where, how and by whom they had their procedures, over the counter medications both from drug stores and pharmacies[3] were very popular. It is important to note at this point that the drug Cytotec was mentioned by at least 12 of my respondents as a drug used for their abortions. A few mentioned going to the health facilities which after I probed further turned out to be quite interesting. I share two instances below:

> *'I went to a 'doctor' who carried out my abortion. He and his colleague, both 'doctors' operate in their house behind the Tamale teaching hospital. I knew he was a doctor because any people go to him to abort their pregnancies and I haven't heard of anyone complain of complications before. He operated on me while I was awake, and it was painful. In the room was a container with lots of blood from all the procedures he had done that day. He prescribed medications for me saying that they will help me heal faster and better (Respondent T).'*

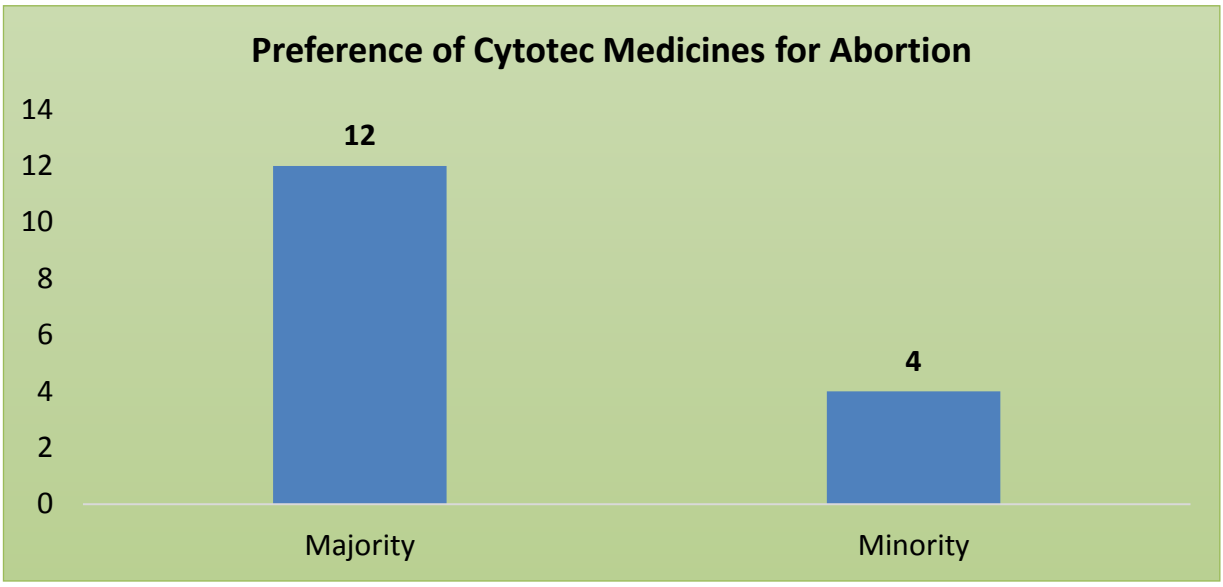
Another responds with a similar story shared:

> *'I got pregnant at a time when I wasn't ready. So, my partner and went to a hospital (name withheld). Though a dental hospital, they had a doctor who performs abortions. Since my pregnancy was only a month old, it was pretty quick. He performed the procedure and pulled out lots of blood with a bottle like machine after which prescribed some medications for me (Respondent M).'*

Table 4.1: Preference of medication by participants.

Preference of Cytotec Medicines	**Majority**	**Minority**
Number of Participants	12	4

[3] Drugstores in Ghana are all not licensed and are popular places where one can get medications but without a trained and licensed pharmacist and mostly without prescriptions.

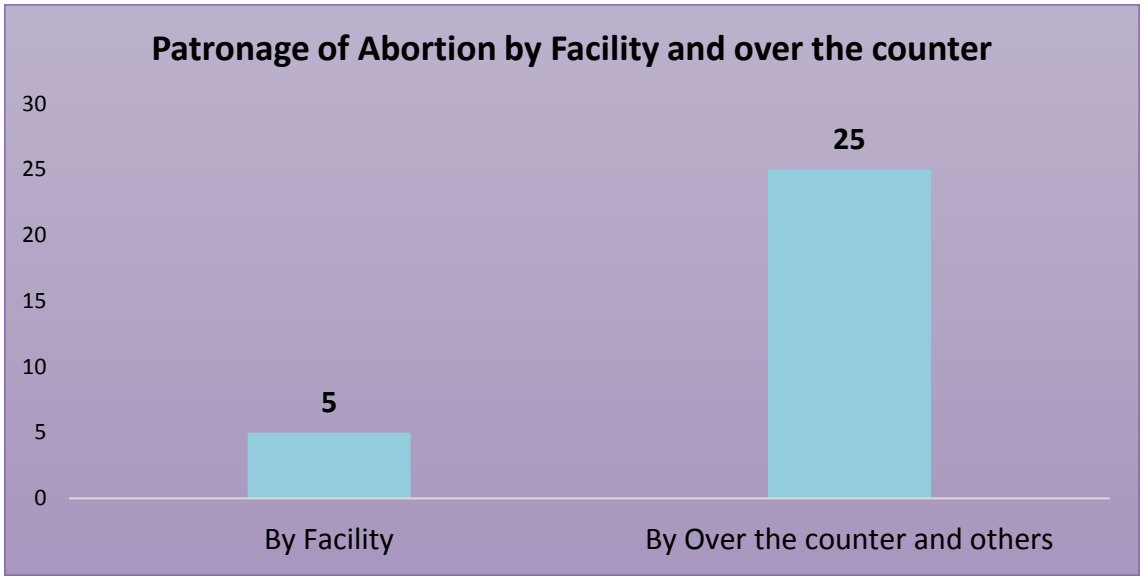


For most of my respondents, the decision to go to a particular facility or to seek a service were based on financial capabilities. There was a collective understanding that abortions at the hospital or health facilities were expensive, thus, the patronage of over the counter medications and other means. For Respondent L, she expressed:

'If I had enough money, I would've gone to the hospital so I can get professional health care.'

Table 4.2: Patronage of Abortion by Facility and Over the Counter

Abortion Patronage	**By Facility**	**By Over the counter and others**
Number of Participants	5	25

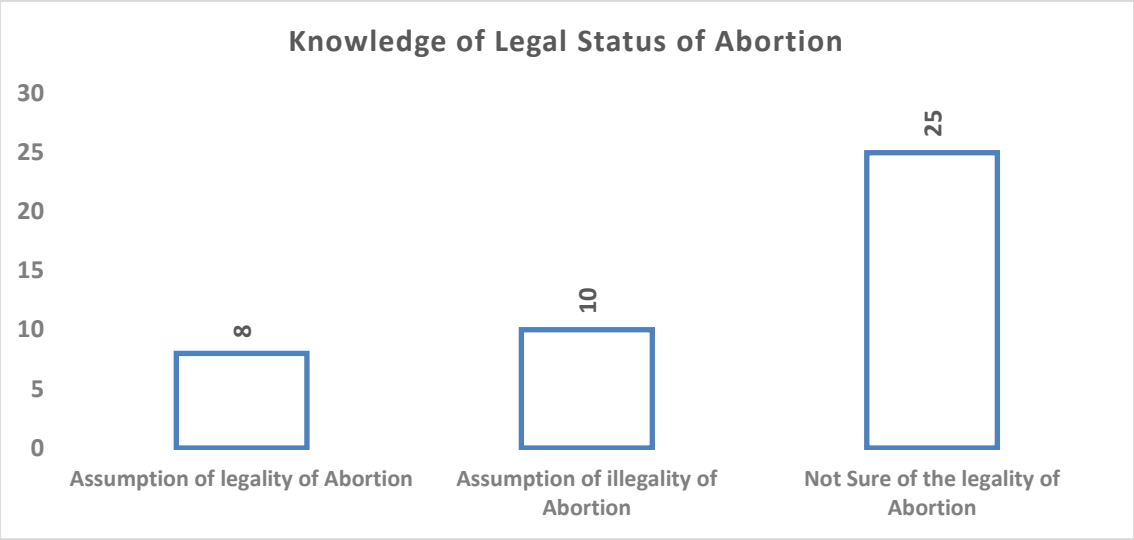


None of the total number of respondents were sure of the legal status of abortions in Ghana. 8 out of the 25 respondents assumed abortions were legal in Ghana based on the following assumptions such as:

a. That if they can buy abortion drugs from the drug stores and pharmacy.
b. That health providers and hospital staff are able to bring medications home to sell.
c. That payment for the service at the hospital or any other facility; and
d. Government has done anything about abortions even though it is public knowledge that most girls and women engage in them.

Table 4.3: Knowledge of Legal Status of Abortion

Knowledge of legal status of Abortion	**Assumption of legality of Abortion**	**Assumption of illegality of Abortion**	**Not Sure of the legality of Abortion**
Number of Participants	8	10	25



10 out of the 25 respondents assumed abortions were illegal based on the following reasons:

a. To commit abortions is to commit murder and murder is illegal in Ghana.
b. The secretive ways of selling abortion drugs in Ghana by pharmacies and drug stores,
c. That doctors who perform abortions when caught are arrested by the police
d. Religion is against abortions so government can't allow it.
e. Medical Staff and people in the pharmacy take brines and or increase cost of medicines before selling it to abortion seekers.

3 respondents speculated that abortions 'can be' legal only if the procedure is done by a doctor, and only if you are raped or defiled and if the pregnancy was a threat to the life of mother while the remaining 4 respondents did not have any answer to the question.

Out of the total number of respondents, 17 had carried out abortions before, out of which only 2 consulted 'doctors'; one from a dental facility and the other operating in their house. According to the 17 respondents who have experienced abortions, their decisions on where to seek abortion services were not influenced by the legality and or laws regarding abortions, but mainly due to the urgency to abort their pregnancies. It is also crucial to highlights that for all respondents, the legal exemptions of the law in terms of abortions access didn't exist because anyone can access abortions once they make the decisions. Additionally, 23 respondents shared the view that decisions on abortions should be made by both the parties (male and female) because the pregnancy is a product of the actions of both parties. 2 respondents however shared an opposite view stating:

'I think women should make a decision for abortions. For instance, if the man has multiple children with other partners and you know he won't take responsibility, then you have to make the decision so you don't give birth to a child who will suffer at the end (Respondent Ma)'.

'When you have a child less than a year old and realize you are pregnant, then the decision to abort should fall on the woman because pregnancy and breastfeeding is not easy and can affect the health of the mother (Respondent Me').

Table 4.4: Decisions on Abortion

Decisions on Abortion	Not Influenced by legality	Influenced by legality
Number of Participants	17	0

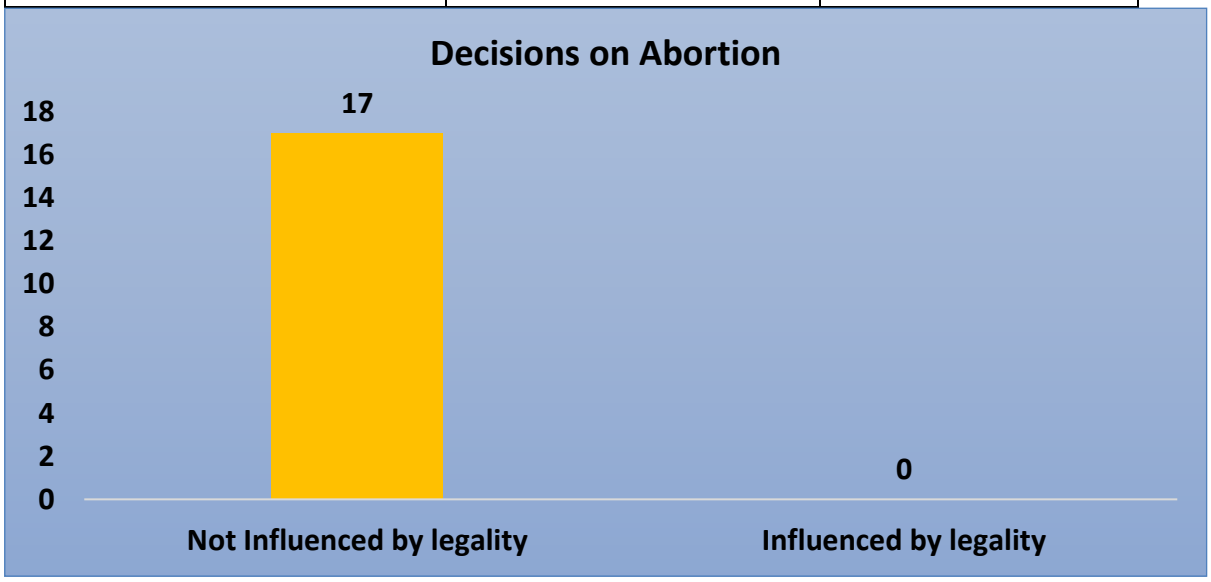
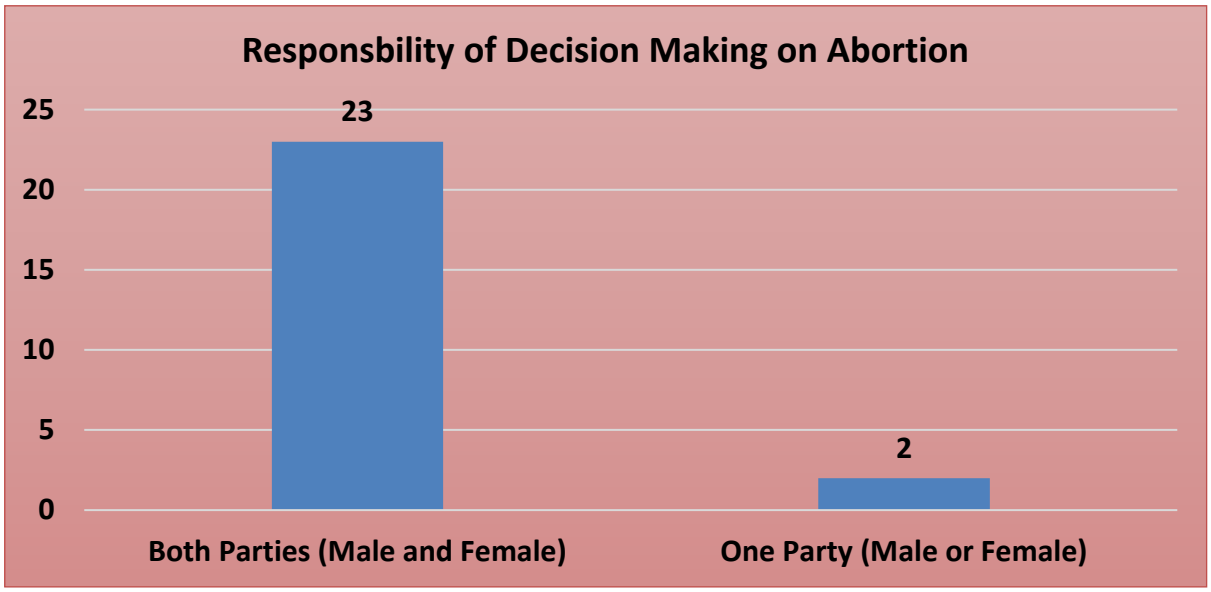


Table 4.5: Responsibility of Decision making on Abortion

Responsibility of Decision making on Abortion	Both Parties (Male and Female)	One Party (Male or Female)
Number of Participants	23	2



On the existence of laws and policies, both nationally and internationally, 17 out of the total number of participants shared and maintained that they are not aware of the any existing policy and laws on abortions in Ghana and internationally, 3 speculated their existence and the remaining 5 respondents were unsure. All respondents are members and subscribers to the National Health Insurance Scheme (NHIS) who primarily use the 'regular' health services such as malaria, fever, among others. All respondents shared the view that the NHIS does not pay for abortions and that they never sought abortions with their NHIS cards. Furthermore, all respondents had no knowledge on the NHIS policies and how it worked.

I probed more into the exemptions of the NHIS and respondents shared common views on the questions in respect to services especially towards abortions and family planning commodities. Some of the responses include:

'When I had my miscarriage, NHIS didn't pay for my medical bills. I paid for it myself. Also, NHIS doesn't pay for abortions, I paid 250 cedis for mine (Respondent A).

NHIS does not pay for abortions because they are expensive. Even when you go to the hospital with malaria, the only medication they give for free is 2 cedis paracetamol, the rest they will prescribe for you to go and buy (Respondent Ma)'.

'There was a robbery at the place we stay. Area boys came around, took our moneys and raped some of us and left me and one other girl pregnant. I was able to buy a drug called u-pill to terminate mine because I didn't want to give birth to the child. My friend decided to take chorkor bomb but when she was told about the implication, she changed her mind. I thought she had let go of the idea, but she mixed Akpeteshie with a lot of

sugar and paracetamol and drank it to abort. She lost a lot of blood, so she died, on the other hand, I had my womb removed because not everything came out. The rest decomposed and it nearly killed me too. Throughout my stay at the hospital, NHIS didn't cover much and we had to pay for most of the expenses (Respondent Z)'.

Centred on the responses, I investigated further to find out their views on the possibility of including abortion services to the NHIS. There were varying responses based on varying reasons. 20 respondents rejected the idea of including abortions into the national health scheme giving reasons such as:

'The high cost of abortions can act as a deterrent for young people to engage in safe sex and to prevent unwanted pregnancy. It is cheaper to buy condoms and other contraceptives than to pay for abortions (Respondent V)'.

'When abortions are allowed into the NHIS, more people will engage in irresponsible sexual behaviours and abuse the service which can be harmful to the health of women and girls (Respondents S and T)'.

'Per my religion, abortion is murder and that is a sin so I don't think it should be covered under the NHIS (Respondent Z)'.

While the above respondents rejected the idea, other respondents welcomed the idea expressing the following concerns:

'Hospital staff encourage us to do family planning. They take us through all the contraceptives so that even if you engage in sexual activities you are protected. But they forget that sometimes contraceptives fail. Adding abortions to the NHIS will save lives and prevent some big problems (complications). Over the counter drug sellers don't examine you, they just sell the drugs. What if I am allergic or have a condition that puts me at risk such as high sugar levels and high blood pressure, but they don't care they only want the money (Respondent H)'.

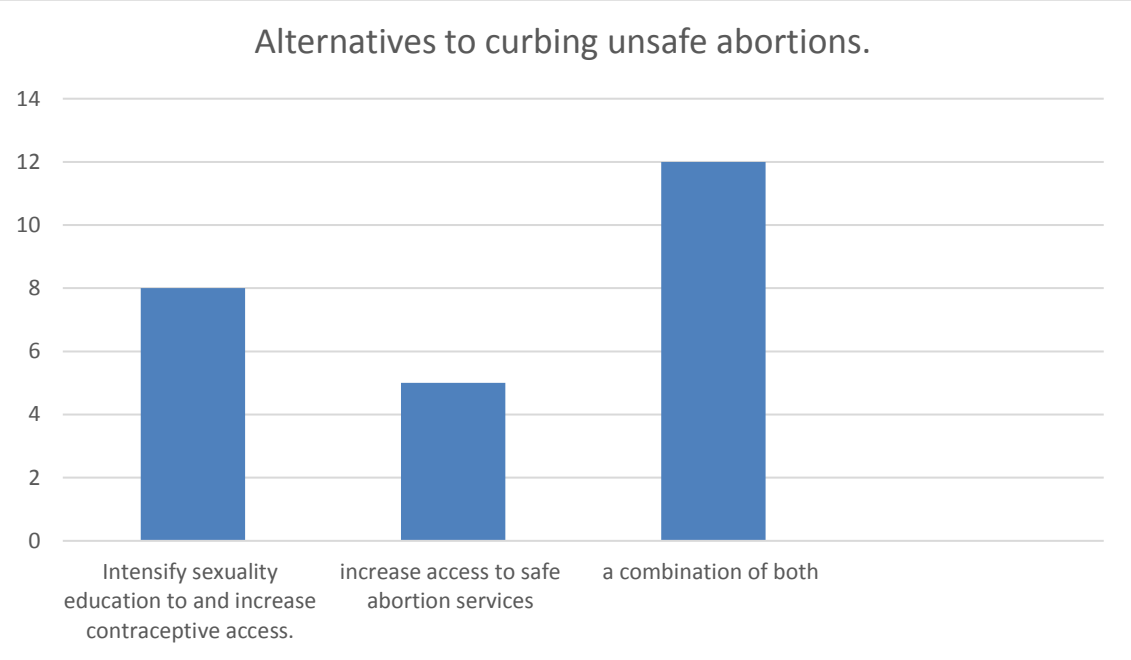
'People drink akpeteshie and 'chorkor[4]' bomb because the hospitals and even the pharmacies are expensive. If NHIS covers abortions, then it will solve the problem of 'I don't have money' (Respondent D)'.

Finally, 8 respondents shared the view that unsafe abortions can be curbed if governments and stakeholders intensified sex education, increase contraceptive access to prevent unplanned pregnancies instead of making abortions accessible to all. 5 respondents indicated that an increase access to safe abortions is key to curbing unsafe abortions and the remaining 12 respondents opted for a combination of both.

[4] Chorkor Bomb is an abortion pill made up of local ingredients. It is described to give excruciating pain. if endured mostly results in the termination of the pregnancy but can lead to death when a pain killer is consumed to manage the pain.

Table 4.6: Alternatives to curbing unsafe abortions

Alternatives to curbing unsafe abortions.	**Intensify sexuality education to and increase contraceptive access.**	**Intensify sexuality education ot and increase contraceptive access.**	**Intensify sexuality education ot and increase contraceptive access.**
Number of Participants	8	2	12



The data presented above, depicts a clear picture that respondents have some form of information on the ways of aborting pregnancies, safe or not and where to get these services. There is also some level of misinformation on and some assumptions which can be argued to have influenced the choices of my respondents. For example, to seek an abortion from a dental hospital or from the home of a supposed doctor goes against the law and can be considered and unsafe abortion as the certification of these doctors can be questionable. This can be attributed to many factors such as the assumption that everyone ion a doctor's coat is a doctor, ignorance of the law, and eagerness to terminate pregnancies. Ultimately, the lack of knowledge on the law, their reproductive health rights as well as other reproductive health information, remains key influences on their choices of services, and commodities.

4.2. The Duty Bearer

By definition, the duty bearers in this context are represented by 4 staff of the National Health Insurance Authority who were engaged as already highlighted in the previous chapter. During the field work for this study, it was discovered that the scheme through the collection of premiums, government and donor support operates primarily as a curative support system. That is to remove financial barriers at the point of health delivery and confirming that the presence of monetary barriers to accessing health care usually results to preventable deaths and morbidity. Based on the above, I probed more into the exemption list which included the exemption of family planning and what they termed as 'elective' or 'luxury' abortion services. All respondents revealed that the legal status of abortion remains a key reason why they do not insure over the service. However, all respondents also shared the view that the bureaucratic system of decision making and the fact that abortions remain a sensitive topic will also make the conversion of including elective services to the scheme.

All respondents made reference to the inclusions of 'obstetric emergencies' which include services such as caesarean section and the Manual Vacuum Aspiration (MVA). In other words, only when the woman's life is medically in danger and on the advice of a qualified medical personal will the insurance cover such a service. Continuous reference was also made to the enabling environment created for pregnancy and childbirth such as free cards and services for pregnant women and newly born infants. This according to respondents are very good indicators for achieving universal health coverage through improved reproductive health rights. An enquiry on the abuse of obstetric emergencies revealed that there is not enough data at the authority to ascertain the impact. Respondents also share the view that for medical staff who treat home induced abortions under the Scheme are condoning illegalities are re liable to be punished by the law. After all, NHIS pays only for medically required procedures and not self-induced procedures.

A further investigation on the exemptions of the law revealed a possibility to align the operations of the scheme to cover all categories of abortion seekers as indicated in the criminal offence code. There is an acknowledge that the exclusion of the elective abortion service especially to vulnerable seekers such victims of rape and defilement can be tricky. Respondent expressed:

> *'We need to take into account the forces and politics that come to play such as religion and other forms of propaganda. As an authority, we abide by the law and if we encounter challenges, we present and push an agenda (Respondent B)'.*

'We can only have this conversation when the legal status of abortion changes. Until then, we can only assume and speculate. We need numbers to make a case. For example, if we only record 10 rape cases that results in pregnancy then making that exemption in the NHIS may not be necessary (Respondent A)'.

A revealing comment regarding achieving Universal Health Coverage (UHC) made by one of the respondents implied that for a category of people, the status of the law implies an exclusion to access of services which might also represent inequalities ultimately affecting the universal health coverage goal of the scheme. Additionally, the key objective of the scheme is to eliminate financial barriers, thus marginalizing certain groups defeats the purpose of the scheme. Respondents shared varied views on the inclusion of 'elective abortions' into the coverage of scheme. For some it was based on morality and religion.

'I don't think we need to open the gates to elective abortions in Ghana. Rather intensive work should be done in preventing unwanted pregnancies (Respondent E)'.

'There is the need to prove that the pregnancy is as a result of rape or defilement for instance, OR that you are medically incapable of carrying the pregnancy to term. If these are not justified and proven, then the NHIS has nothing to with abortion (Respondent P)'.

Some respondents also overruled the idea of young people engaging in sexual activity and in cases of cases such as rape, defilement and incest, NHIS expects that the legal process is filled irrespective of how cumbersome it maybe. A key finding is that the NHIS also relies on the interventions of Civil society and NGO's to fund, research and test new findings. The exclusion of family planning in practice even though it is highlighted under the National Health Insurance policy framework (2004:23) and national health insurance act 852 (2012:19) to be a part of the insurance package, is in the process in review after the involvement of the civil society and a pilot in 7 districts in Ghana. This position that family planning is the closest inclusion the authority can make within this context was shared by al respondents. Little to no reference were made to international human rights laws and treaties such as the CEDAW even though I made specific enquiries.

In summary, the NHIA as a government agency, is interested in curative support and not prevent care and operates in accordance to the provisions of the laws of Ghana. While changes can be made to the insurance coverages, it largely depends on a review of the abortion laws. There is also a disconnect between the exemptions and provisions of the abortions laws and the data collected in the field and the insurance policy frameworks n which will be dived inadeptly ion the next chapter of this study. Finally, there has been a growing advocacy-based consultation and pressure from civil society organizations such as IPAS, Marie stopes

international among others on the inclusion of family planning and ultimately abortion services and commodities.

4 3. The Civil Society and Human Rights Advocates

In this section of the chapter, I present findings collated from 4 reproductive health organizations namely; Planned Parenthood Association of Ghana, (IPPF Affiliate), Ipas[5], Marie Stopes International and Curious Minds Ghana. Through my findings, all respondents shared the opinion that abortion seekers are very knowledgeable on how to terminate pregnancies but are mostly unaware of the legalities. Respondent from Ipas revealed that there has been significant progress in creating awareness on the legality of the law especially with the involvement of traditional leaders (specifically queen mothers), key opinion leaders at the grassroots however, there is still a lot more to be done. Before the close down of the Ipas Ghana country office, they worked with the Ghana health service, police service and the lawyers to educate and raise awareness to these key service providers on the laws of abortions in Ghana after discovering that they were also not aware just like abortion seekers. Thus, the engagement with these key stakeholders coupled with policymakers such as the Parliamentary select committee on health allowed for a platform to be provided for such discourses in discussions to happen and to advocate for abortion services to accessible and available to every girl and woman.

> *'So far, we have started the conversation we have also broken the taboo string around abortions in Ghana and have provided platforms on various levels of advocacy so yes, we have made a lot of progress. However unsafe abortions still exist and there seem to be a lot of work to do in this field and a very good place to start is cost of abortions (Cynthia)'.*

Organizations such as Marie Stopes International (MSI) are prominent and known for their grassroot and national level advocacy as well as providers of abortion services in their facilities across the country. On the issue of the cost of abortions, this study revealed that facilities of Marie Stopes charge between 250 to 350 cedis depending on the gestation period and the procedure needed for the service. However, MSI also has in place a waiver system where services are still provided for women and girls at much lesser cost or free of charge for clients who cannot afford. Similarly, PPAG revealed that for their facilities that provide abortion service, they also run a waiver system, where the cost is reduced and in some rare

[5] Ipas closed down the Ghana country office mid 2020 but are a reliable authority and relevant source of information for this topic. The engagement involved former staff of the Ghana country office.

cases removed for financially disadvantaged clients. Even though the law does not fully allow it, Ghana Health Service (GHS) through consultation meeting with stakeholders like PPAG and MSI have set up their own system of operations to incorporate CAC into their programs and are currently making strides towards reducing the stigma surrounding abortion and to improve access to women especially young girls.

Further investigation also disclosed that through the interventions of IPAS, a protocol on the provisions of safe abortion care in Ghana was drafted but for almost a decade, the protocol has not been utilized largely because the legal status of abortion remains unchanged. This protocol has been revised by various stakeholder meetings involving PPAG, MSI and the Ministry of Health and at the point of this study has not been made public. It is crucial to note that that a key addition made to the revised protocol according to PPAG is the self-care abortion method where abortion seekers can self-administer abortion medications. this is intended to improve confidentiality and to break the stigma around visiting well known abortion facilities. But this also presents the challenge of drug stores and pharmacies and their history of exploitation as well as their negligence towards protocols and guidelines.

All respondents have worked intensively on training medical and police personnel including those in training, young people at the grassroots, community leaders and traditional rulers on the abortion laws with the focus on the liberality, to ensure that abortion seekers are aware that abortion is not completely illegal. A respondent shared:

> *'Once a pregnancy is not wanted, we can claim that the mental state of the mother can be affected so we should provide the service. The law doesn't not specify when it refers to risked health if the mother as an exemption. Per our interpretation, mental health is still part of health so we will use that translation to save lives. It doesn't look like the laws will be amended anytime soon and there have been little changes, but we will continue to provide the service. If they want to terminate their pregnancies, they will so why not give them the service and guide them to prevent it from happening again? (Respondent AF)'.*

In reference to international human rights laws, respondents reveal that treaties and conventions like the CEDAW, the Maputo protocol and the ICCPR have been instrumental for their interventions locally and internationally. These are applied in their grassroot programs that engaged directly with young people especially in hard to reach communities, in their engagement with policy makers, key service personnel and most importantly at the international level where some reports have been submitted to the Human Rights Committee (HRC) at the United Nations for educational, trainings and advocacy purposes. I also found out that PPAG and MSI are largely involved in the progress made with regards to the inclusion of family planning into the NHIS. MSI made reference to Ghana's commitment towards

FP2020 as a key catalyst to this progress especially and that a good step will be the inclusion of CAC under the NHIS.

4.4. Summary

Significant progress has been made through grassroot to national and international level interventions programs to ensure that access to safe abortions are available to abortion seekers in order to prevent unsafe abortion related mortality and morbidity. However, knowledge of the abortion laws remains limited to both abortion seekers, key service providers such as the nurses, midwives and doctors and policy makers regardless of the amount of advocacy carried out on abortions in Ghana. Civil society and NGO's interpret the law and takes advantage of the grey areas and nuances to provide services to abortion seekers and are in consultations to include family planning under the NHIS which has seen significant progress even with the institutional barriers they face from government stake holders. Additionally, the legal status of abortions also remains one of the key barriers to interventions intended to provide and increase access to reproductive health rights for women and girls in Ghana. In the next chapter we will apply a socio-legal lens using the chosen frameworks to analyse and make meanings to these findings.

Chapter 5 : Discussion of Results - Situating the Legal and Non-Legal Barriers of Abortions in Ghana

5.0. Introduction

The primary focus of this chapter is to provide a deeper analysis of the fieldwork data through the lens of the analytical frameworks discussed in chapter two towards answering our research question and sub-questions. I also analyse the extent of compliance and violations in relation to the obligations of the state based on my findings and the existing non-legal factors which contributes to violations on accessing reproductive health care and abortion services in Ghana.

5.1. The law vs. Policy: a Violation or Confusion?

A textual review of the abortion law reveals opportunities for women and girls to access abortion services in Ghana. Despite the definitive indications such as the provisions on rape, defilement and incest, the law remains vague on the definition of what is considered 'danger to the health of the mother'. The criminal offence codes' reference to the 'mental and physical health of the mother' does not state or require professional certification as proof of mental health instability to ascertain whether the need of an abortion. Additionally, the definition of mental health also covers a vast field of feelings and experiences which based on the fieldwork is being used by organizations such as PPAG and MSI as basis to provide safe abortion services to young girls and women. For these organization, these circumstances allow for girls and women seeking abortion to access these services freely and safely. Consistent with the data derived from the civil society organizations engaged in this study, the provisions do indeed reflect a non-discriminatory opportunity for women and girls to access safe abortion services provided that such requests meet the provisions indicated in subsection (2)[6] of the same abortion law.

[6]It is not an offence under subsection (1) of section 58 if an abortion is carried out 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 (Criminal offense Act 1960).

On the other hand, the national health insurance policy framework (2004) and the national health insurance Act (2012), maintain that the abortion services outside the premise of a medical emergency is not and will not be covered under the scheme. This is also supported by and in line with the data collected as any circumstance outside the definitions of a medical emergency is referred to as 'elective' or 'luxury' and thus, cannot be covered by the scheme. Additionally, the insurance Act makes provisions and gives the scheme through the governing authority NHIA, the power to freely decide what additional benefits can be added to the respective packages, which is indicative of the findings on the current pilot to include family planning into the package prescriptions. Based on the this position, the selective provision of services to only women and girls who are in medical emergency (the gap in law) as against the varying demographic of women and girls exempted by the law can be contended to be an obstruction to the reproductive health rights of women and girls who seek abortions services and commodities. This also corresponds to the responses gathered on the varied opinions on the legalities on abortions both from the right holder, duty bearer and most importantly the civil society organizations.

As a government body, legal and policy compliance to the laws of the state seems disregarded based on the findings. While this can be challenged using the independence of the scheme in deciding the coverage of the packages, I argue that the independence of choice of the scheme must remain in accordance of the laws of the state in a non-discriminatory sense of inclusion. It is also important to include that there is a deeper intersectional relation of religion, culture and patriarchal values of policy makers and staff of the authority, and their reluctance to expanding the benefit packages of the scheme which can also be attributed to the freedom of choice granted by the state. This also applies to the girls and young women engaged in this study as already highlighted in my findings. In line with the religious and cultural oriented nature of the Ghanaian people, I argue that in addition to imposing barriers to the operations of initiatives such as the NHIS structurally, the current legal status of abortion also preserves itself from 'change or amendment' by through the provisions of freedom of choice of insurance benefits.

The ratification of international human rights laws such as the CEDAW and the ICESCR and regional treaties such as the Maputo Protocol by the government of Ghana which is supposed to have made available provisions for the realizations of basic human rights do not indicate specific provisions that speak to the woman's right to seek abortions but make provisions for general health rights. Articles 12 and 16 also speaks to accessibility to pregnancy (maternal) services including family planning and the right to decide at free will

the number and spacing of children respectively. These provisions though available also remains inaccessible to young girls and women.

5.2 Non-Legal Barriers

Data from the study also depicts a structural inadequacy of knowledge dissemination on reproductive health rights, abortion services and laws among women and girls, health service personnel, relevant government agencies and other stakeholders is influenced and shrouded in assumptions, religion, and personal and cultural beliefs and norms. There is also limited knowledge and misinformation not only on the part of the respondents (girls) but also on the part of some of the respondents from the National Health Insurance Authority as some respondent were not very conversant with the reproductive health rights and the laws on abortion. Additionally, a difference in levels of consciousness and how decisions and choices are influenced for each group of respondents engaged in this study. For example, the right holder has little to no knowledge of the law and their reproductive health rights, nonetheless, there seem to be considerable support to stand with the law based on non-legal factors such as religion. Clearly, this has immense impact on the existing disconnect between what the law prescribes vis a vis the reality at the grassroots exhibited by all group of respondents engaged in this study. The above speaks to support the theoretical argument of the relevance of a comprehensive sexuality education framework for women and girls as against other methods that re currently employed by the Ghanaian government (fear and abstinence-based sexuality education). In terms of implementation, the bureaucratic process of getting an abortion in a public health facilitates, the high rates of abortion services (which are not covered by the NHIS), the fear of stigmatization and arrest, as well as limited knowledge on the availability of services from organizations such as MSI and PPAG can be attributed to the shrouded legal knowledge on reproductive health rights in Ghana.

5.2.1 Unseen Discourses, Stigma and Decisions of Abortion

Out of all my findings, the rejection of the inclusion of abortion by majority of my respondents remains an interesting dynamic I had not anticipated. My assumption as a researcher is that women and girls who have experienced the pain and anguish of having to perform or seek an (un) safe abortion, would readily embrace the idea of an increased access and availability of the service through the NHIS. However, this was not the case as majority of my

respondents (right holders) were again this idea. This position has been contested by respondents (right holders and duty bearers) who supported the idea of a more inclusive and comprehensive sexuality education system as a means of avoiding unplanned pregnancies and subsequently, unsafe abortions. Thus, I questioned whether or not this position should be attributed to their level of consciousness on their reproductive health rights such as the right to seek and access safe abortion service or the fact that they have no and incorrect knowledge on the laws of abortions or purely social influences such as religion and culture or perhaps a mixture of both.

An increase in knowledge on reproductive health rights may or may not change the position of my respondents but decisions made can be argued to come from a 'seemingly' informed situation. This buttresses the reason that knowledge of the law doesn't always reflect in people choices in standing with or resisting the law as many other factors come into play. It is also important to include in my analysis that whiles knowledge may be instrumental in changing the narratives, there is also a deeper power play that remains undiscussed and cannot be dealt with using my frameworks. For my respondents, the major influence on their choices of seeking a service are all related to financial capabilities. Even though the NHIS is said to cover miscarriages as an obstetric emergency, the data from my respondents show that this may not always be the case. For instance, the respondent who reported to have paid for her own bills after a miscarriage ideally should have been covered by the scheme. Assuming she was aware of her reproductive rights, to what extend could she have gone in claiming these rights? Similarly, the financial burden in this study presents itself beyond the premise of the NHIS but also in terms of who between the man and the woman has the financial power to decide whether or not a pregnancy is wanted or not. To understand this, I realized that the limitations of the frameworks of legal consciousness and mobilization as this would require in-depth analysis with other concepts and frameworks.

5.3. How far have we progressed? Struggles towards mitigating unsafe abortion/ increasing access to Abortion services in Ghana

The current legal status and the gaps as established indicates that for a significant change to happen, there's the need for an amendment or change in the law in order for safe abortions to be accessible and available for everyone who seeks the service. While this can be ambitious, my deduction is that a change in law is only half of the work needed and that for the

current challenge to be mitigated, we need to have an efficient system in disseminating available and accessible reproductive health rights information for all in order to change the narrative of unplanned pregnancies and unsafe abortions. Organizations such as PPAG and MSI have employed different strategies such as community and stakeholder (including policy makers) engagements, and the provision of services despite the antagonistic situation created by both the legal and socio-cultural environment. Evidently, these approaches are effectively playing a role in curbing unsafe abortions and introducing young girls to contraceptives, preventing future occurrences of unplanned pregnancies. These organizations are assumed and expected to be aware of the law and most importantly in this context, translate these local and international laws into simple language.

Based on the data, reproductive health rights information is disseminated through these organizations but there is an indication of a misinterpretation to an extent which can be attributed to the gap on consciousness. I presume here again that perhaps the language used in translation during their engagements at grassroots may be inadequate due to the issue of age appropriateness and basically the opportunity to engage comprehensively. In addition to the gaps in the translation processes, the organization's and the donors' objectives also plays important roles in this narrative. The expected outcomes for both the donor and the organization and how these influence the translation process for different groups can present both legal and non-legal barriers to reproductive health rights. It is important to also analyse to what extent these organizations are willing to go in the raising awareness and provision of reproductive health services.

It is central to emphasize that the activities of civil society have to be complimented by activities of government in order to achieve a far-reaching impact. Two good examples from the data collected is the piloting of the inclusion of family planning into the NHIS and the review and amendment of the provision of safe abortion protocol are good steps towards reproductive health justice for women and girls. The adaptation of 'Reproductive Health Education' formerly CSE by some local NGOS's like PPAG and Curious Minds is also an effective strategy towards increasing awareness on reproductive health rights. Such domesticated complimentary efforts coupled with the employment of international human rights law as a means legal mobilization bring s to practice the double consciousness argument of Merry (2006) on the need for relevant framings of international to fit into the local narrative.

5.4. Summary

This chapter begins with an analysis of the gaps present between the National (abortion) laws and the NHIS policies in Ghana as well the gaps in domesticating international human rights treaties and laws in relation to the provision of abortion services in Ghana. The chapter further examines the non-legal barriers that aggravates the legal barriers that inhibits access to information and services to abortions in Ghana. Thereafter the chapter exposes the progress made so far in mitigating unsafe abortions through the activities of stakeholders such as organizations and possibly a direction in which the discourses on reproductive health in being shaped. As observed and highlighted both in this chapter and the previous chapter both legal and non-legal barriers are complimentary catalysts inhibiting access the realization of rights with access to information and services being one of the main challenges. This is exhibited in how the legal consciousness of participants (right holders) were and how it influences or have influenced their decisions in seeking reproductive health care services and information. The next chapter will synthesis the whole study into a concluding chapter.

Chapter 6 : Summary of Key Findings, Conclusions and Recommendations

This study attempted to answer how and why exemptions of what we can now refer to as elective abortion from the National Health Insurance scheme (NHIS) constitutes a violation of reproductive health rights of women and girls in Ghana. In chapter 1, I introduce the background to the problem by explaining the context and critically engaging the relevant reproductive health and rights debates and existing literature (CSE AND CAC) on access to information and services. I then present my research questions, objectives that have guided the study progress. My questions examined the present gaps in law relating to abortions and the NHIS, how the law creates implementation barriers that influence the choices of women and girls when accessing abortion services contributes to the violations of rights. Furthermore, the study discussed the contributions of non-legal structures in inhibiting access to SRHR knowledge and services and how the gaps in the law and implementation impact on it with active health rates. Finally, I dive into possibilities of change and progress through mobilization assessing where we are and what we are doing assisted in managing incidents of unsafe abortions.

In chapter 2, I introduce and employ the frameworks of legal consciousness and mobilization in my attempt to make meanings of the data taken from the field. Represents my methodological strategies discussing how I got that data, and this enabled me to provide a three-layer diagnosis of my problem of study. The approaches allowed for a comprehensive data collection and in-depth analysis of both primary and data from existing literature.

Chapter 3 presented and themed my findings into right holders (female respondents), duty bearers (NHIA) and Civil society organizations (Reproductive health organizations). The findings speak to different levels of legal and non-legal knowledge and consciousness on the problem of study and how these levels shapes interventions, health care delivery and government obligatory strategies related to achieving and realizing the reproductive health rights of women and girls.

Chapter 4 provides in-depth analysis of laws, policies that proves that the exemption of CAC from the NHIS does indeed constituent a violation of the reproductive health rights of women and girls in Ghana. The application of legal consciousness as an analytical concept was useful in clarifying the extent to which respondents were aware of the legal structures,

their sources of knowledge and also allowed for an understanding of translation processes as part of consciousness and how they the varying levels of consciousness impacted the choices of young women. The concepts of legal mobilization allowed a better understanding of strategies being used in mitigating the barriers and concurrently, exhibit how the legal environment also impacts on implementations strategies used in the mobilization process. The chapter makes an analysis of both legal and non-legal barriers and how both trajectories present themselves in the problem of study.

Generally, young women who have experienced unsafe abortions are not in support of increasing abortion services to all based on issue of religion and possible irresponsibility and abuse of service. However, they believe that unintended pregnancies which results in unsafe abortions can be curbed with an effective and include sexuality education strategies and programs. Nonetheless, civil society organizations are working hard to eliminate barriers and improve on access to information and services through strategies such as 'no return policies and waiver systems of abortion service delivery.

The law also remains a key barrier to improving accessing to abortions service specifically with the exclusions of abortion from the NHIS in Ghana. Non-legal barriers such as religion, and cultural values influences the legal factors and strengthen the barriers faced by women and girls. Also, while the presence pf the legal factors persists, issues of translation also determines how knowledge is shared, consumed and reproduced through choices and structures of abortion care and services.

6.1. Areas for Further Scholarly Research

A useful area for further study could be a comparative study of the extent to which legal consciousness can warrant a effective mobilization process such as the identification and acknowledgement of rights violations, the decision to fight for rights, and or change in attitudes and perceptions and behaviours in seeking safe abortion services. This may display whether or not knowledge of the law has the possibility of challenging and altering non-legal elements such as religious stance and cultural norm and behaviour towards seeking safe abortion services and engaging in reproductive health knowledge sharing. It can also provide relevant data to feed into the formulation and implementation of both governmental and non-governmental interventions as well as a possible policy reform to curb the problem.

References.

Awusabo-Asare, K., Stillman, M., Keogh, S., Doku, D.T., Kumi-Kyereme, A., Esia-Donkoh, K. and Bankole, A (2017) 'From paper to practice: Sexuality education policies and their implementation in Ghana', *New York: Guttmacher Institute* 3-38.

Babbie, E & Mouton, J (2001) 'The practice of social research: South African edition', *Cape Town: Oxford University Press Southern Africa*.

Barimah K. B, and Mensah J (2013) 'Ghana's National Health Insurance Scheme: Insights from Members, Administrators and Health Care Providers', *Journal of health care for the poor and underserved*, 24(3): 1378–90. doi: 10.1353/hpu.2013.0144.

Bhattacherjee, A (2012) 'Social science research: principles, methods, and practices', *University of South Florida: Florida.*

Brooks, R., Riele, K. & Maguire, M (2015) 'Identity, power and positionality'. In *Ethics and educa-tion research* pp. 100-116. 55 City Road, London: SAGE Publications. Inc. doi: 10.4135/9781473909762.n6

Calterone Williams, J (2011) 'Battling a 'sex-saturated society': The abstinence movement and the politics of sex education' *Sexualities* 14(4): 416-443.

Cowan, D (2004) 'Legal consciousness: some observations', *The Modern Law Review* 67(6):928-958.

Criminal Offense Code, (1960) 'The Criminal Code (Amendment)ACT 2003 (ACT 646)' Acts of Ghana. Available at: <https://www.ilo.org/dyn/natlex/docs/ELECTRONIC/88530/101255/F575989920/GHA88530.pdf >.

Dalinjong, P. A., Wang, A. Y., and Homer, C. S. (2018) 'The implementation of the free maternal health policy in rural Northern Ghana: Synthesized results and lessons learnt', *BMC research notes* 11(1): 1-6.

De Vos, A. S. (2002) (*ed.*) *Research at grass roots: For the social sciences and human services professions.* Pretoria: J.L. Van Schaik.

Garcia-Mandicó, S., Reichert, A., and Strupat, C. (2019) *The social value of health insurance results from Ghana*. Washington, D.C.: World Bank (World Bank e-Library). Available at: < http://elibrary.worldbank.org/doi/book/10.1596/1813-9450-9004 >.

Ghana Statistical Service, Ministry of Health (2018) *Ghana Maternal Health Survey 2017*. Available at: < https://dhsprogram.com/pubs/pdf/FR340/FR340.pdf >.

Gloppen, S. (2008) 'Litigation as a Strategy to Hold Governments Accountable for Implementing the Right to Health', *Health and Human Rights* 10(2): 21-36.

Goodale, M. and Merry, S. (2007) *The Practice of Human Rights: Tracking Law Between the Global and the Local.* Cambridge: Cambridge University Press.

Grove, S. K. and Burns N. (2005) *The practice of nursing research: Conduct, critique, & utilization, (5th Ed.).* Philadelphia: Saunders.

GuttMacher Institute. (2020) 'Incidence of Abortion and Provision of Abortion-Related Services in Ghana'. *Factsheet.* Available at: <https://www.guttmacher.org/sites/default/files/factsheet/incidence-abortion-and-provision-abortion-related-services-ghana.pdf >.

Handmaker, J. (2019) 'Researching legal mobilization and lawfare', *ISS Working Paper Series / General Series* 641: 1-19. Available at < http://hdl.handle.net/1765/115129 >

Harcourt, W. (2009) *Body politics in development: Critical debates in gender and development*. Zed Books Ltd.

Harding, R. (2006) 'Dogs Are "Registered", People Shouldn't Be': Legal Consciousness and Lesbian and Gay Rights', *Social & Legal Studies 15*(4): 511-533.

Hertogh, M. (2004) 'A 'European' conception of legal consciousness: rediscovering Eugen Ehrlich', *Journal of Law and Society 31*(4): 457-481.

Hertogh, M. (2018) *Nobody's law: Legal consciousness and legal alienation in everyday life*. Springer.

Human Rights Advocacy Centre. (n.d) 'Sexual and Reproductive Health in Ghana; Submission to the UN Human Rights Council', *United Nations Universal Periodic Review of Ghana.* Available at : <https://uprdoc.ohchr.org/uprweb/downloadfile.aspx?filename=4479&file=EnglishTranslation > .

Ipas Ghana. (2016) Supplementary information for List of Issues for Ghana, scheduled for adoption by the Human Rights Committee during its 115th session, October-November 2015. Available at: < https://tbinternet.ohchr.org/Treaties/CCPR/Shared%20Documents/GHA/INT_CCPR_CSS_GHA_24188_E.pdf >.

Kwarteng, A., Akazili, J., Welaga, P., Dalinjong, P.A., Asante, K. P., Sarpong, D., Arthur, S., Bangha, M., Goudge, J., and Sankoh, O. (2020) 'The state of enrolment on the National Health Insurance Scheme in rural Ghana after eight years of implementation', *Int J Equity Health* 19, (4) < https://doi.org/10.1186/s12939-019-1113-0 >.

Latt, S. M., Milner, A., and Kavanagh, A. (2019) 'Abortion laws reform may reduce maternal mortality: an ecological study in 162 countries', *BMC women's health 19*(1): 1-9.

Machiyama, K., and Cleland, J. (2014) 'Unmet need for family planning in Ghana: the shifting contributions of lack of access and attitudinal resistance', *Studies in Family Planning 45*(2): 203-226.

Marshall, C. and G.B. Rossman (1999) *Designing qualitative research, 3rd Edition*. New Delhi: SAGE Publications.

Merry, S. E. (2006) 'Localizing human rights and rights consciousness', *Human rights and gender violence: Translating international law into local justice* 108(1): 179-217.

Merry, S. E. (2006) 'Transnational human rights and local activism', Mapping the middle. *American anthropologist 108*(1): 38-51.

Merry, S. E. (2006) *Human rights and gender violence: translating international law into local justice*. Chicago: University of Chicago Press (Chicago series in law and society).

Ministry of Health, Ghana Health Service, UNICEF (n.d). 'Health Budget Brief', *Republic of Ghana*. Available at: <https://www.unicef.org/ghana/media/2296/file/Budget%20Brief%20-%20Health%20and%20Nutrition.pdf >.

Ministry of Health. (2004) *National Health Insurance Policy Framework for Ghana.* Revised Version. Available at < https://www.moh.gov.gh/wp-content/uploads/2016/02/National-Health-Insurance-Policy-framework.pdf >.

Ministry of Health. (2012) 'Prevention & Management of Unsafe Abortion', *Comprehensive Abortion Care and Services Standards and Protocols, Third Edition.* Available at <https://abortion-policies.srhr.org/documents/countries/02-Ghana-Comprehensive-Abortion-Care-Services-Standards-and-Protocols-Ghana-Health-Service-2012.pdf >.

Morhee, R. A. S. and Morhee, E. S. K. (2006) Overview of the law and availability of abortion services in Ghana. *Ghana medical journal 40*(3). Available at: <:https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1790853/ >.

National Health Insurance Scheme (2021) Available at: < http://www.nhis.gov.gh/Default.aspx >.

O'Leary, Z. (2013) The Essential Guide to Doing Your Research Project. Sage.

O'leary, Z. (2017). *The essential guide to doing your research project*. Sage.

O'Leary, Z. (2014) 'T*he Essential Guide to Doing Your Research Project',* pp. 1-17 & 18-30. London: Sage.

Obaid, T. A. (2009) 'Fifteen years after the International Conference on Population and Development: What have we achieved and how do we move forward?', *International Journal of Gynecology & Obstetrics 106*(2) : 102-105.

Onuora-Oguno, A. C., Ike, C., and Barau, C. (2018) 'Deliberative and struggle theories of rights realization: examining the protection of women in Nigeria', *Journal of Law, Society and Development 5*(1): 1-16. Available at: < https://journals.co.za/doi/abs/10.25159/2520-9515/7068 >.

Republic of Ghana. (2012) *National Health Insurance Act (ACT 852).* Available at : <https://www.nhis.gov.gh/files/ACT852.pdf >.

Sarat, A. (1985) 'Legal effectiveness and social studies of law', *Legal Studies Forum (*9):23

Shaw, D. (2009) 'Access to sexual and reproductive health for young people: bridging the disconnect between rights and reality', *International Journal of Gynecology & Obstetrics 106*(2): 132-136.

Sikes, P. (2004) *Methodology, procedures and ethical concerns: Doing Educational research guide for first time researchers.* London : Sage.

Silbey, S.S. (2005) 'After Legal Consciousness'*, Annual Review of Law and Social Science* (1): 323-368.

Skuster, P. (2013) 'Young Women and Abortion: Avoiding Legal and Policy Barriers', *Chapel Hill, NC, Ipas.* Available at: < https://www.ipas.org/wp-content/uploads/2020/06/YWALPBE13-YoungWomenandAbortionAvoidingLegalPolicyBarriers.pdf >.

Sundaram, A., Juarez, F., Bankole, A., and Singh, S. (2012) 'Factors associated with abortion-seeking and obtaining a safe abortion in Ghana', *Studies in family planning 43*(4): 273-286.

The Alan Guttmacher Institute (2004) 'Adolescents in Ghana: Sexual and Reproductive Health', *Research in Brief, 2004 Series* (1). Available at: <https://www.guttmacher.org/sites/default/files/report_pdf/rib1-04.pdf >.

United Nations Population Fund (2016) 'Comprehensive Sexuality Education' Available at: <https://www.unfpa.org/comprehensive-sexuality- education#:~:text=Com-

prehensive%20sexuality%20education%20is%20a,school%20or%20out%20of%20school.&text=But%20it%20also%20goes%20beyond,their%20sexual%20and%20reproductive%20health >.

United Nations Population Fund (2020) *Adolescent and Youth Dashboard – Ghana.* Accessed Available at: < https://www.unfpa.org/data/adolescent-youth/GH.>

Waldman, L. and Amazon-Brown, I. (2017) 'New digital ways of delivering sex education: A practice perspective', *Sex Education in the Digital Era IDS Bulletin*, 23-41.

Zemans, F. K. (1982) 'Framework for analysis of legal mobilization: A decision-making model', *American Bar Foundation Research Journal 7*(4):989-1071.

Appendix 1: Interview Guide for Young Women and Girls.

1. Are you sexually active? Have you been sexually active?
2. What do you know about reproductive health? Or Sex education?
3. Do you think sex or reproductive health education is essential?
4. What do you think about abortions? What have you heard about abortions?
5. Have you sought abortion services before? What was your reason for an abortion? How was the experience?
6. How and where was your abortion carried out?
7. What informed your decision of the type of service provider you chose for procedure? (If yes to question 5).
8. Do you know anyone who has sought abortion services before? What was their experience??
9. In your view, are abortions legal in Ghana? explain your answer'
10. Did your answer in (9) influence your decisions in assessing abortion services? If yes, how? And if No, why?
11. In your view, does the law exempt certain groups of people to access abortions? Or are abortions (legal or illegal) for everyone?
12. Should the decision of abortion solely be from the woman?
13. Should a woman always have the right to have an abortion in case of an unwanted pregnancy?
14. Are you aware of the existence or any international treaty that promotes abortion rights?
15. How do you think they can be applied to advancing the reproductive health rights of women in Ghana?

NHIS.

1. Are you registered under the National Health Insurance Scheme?
2. What services do you seek with it?
3. Do you know that some services are not covered by NHIS? If yes, why do you think so?
4. Do you think abortions should be included in NHIS? Why?
5. Have you ever sought abortions with your NHIS card? If YES, Why and if No Why?

6. What do you know about the laws and policies around abortions and the National Health Insurance Scheme?
7. Do you think a pregnancy prevention initiative such as intensifying sex education and contraceptive access would be a better option to prevent unplanned pregnancies and subsequently unsafe abortions?

Appendix 2: Interview Guide for Non-Governmental Organizations.

a. What work have you done around abortions in Ghana?
b. Are Unsafe abortion a serious health problem in Ghana? Why?
c. What is the status of abortions in Ghana and how did you or your organization leverage on that for your advocacies and interventions?
d. What does the legal environment on abortions looks likes currently?
e. Are abortion seekers (girls and women) aware of the abortion laws? To what extent?
f. Where do abortion seekers usually seek services?
g. How are abortion clients treated in terms of privacy?
h. What have been done so far in advocating and realizing the reproductive rights of women in Ghana?
i. What are the gaps created by the status of abortion in terms of access for abortion seekers?
j. Which of the international laws and treaties have you applied in your advocacy towards abortion rights of women and girls and why?
k. How have you utilized those international laws and treaties, ratified by Ghana to advocate for the abortion rights for women in Ghana and subsequently reproductive health rights?
l. What do you think about the exclusion of CAC under the NHIS?
m. When it comes to cost, privacy, and safety of procedure, do you believe the inclusion of CAC into NHIS will advance the reproductive health of women in Ghana? If yes, how? If no, why?
n. Have you had any consultations and work around advocating for NHIS and CAC? What progress has been made and where do you stand now?
o. Do you have any other comments that may be relevant for my research?

Appendix 3: Interview Guide for National Health Insurance Authority.

a. What were the influencing factors and guiding principles for the NHIS and its policies?
b. How have we advanced?
c. Ghana has ratified many international conventions when it comes to human rights, how dies the NHIS contributes towards the achievement of these outcomes and or violations of some of the provisions.
d. Are you aware of any gaps either presented by the NHIS or the health environment/ structures that obstructs the achievements of universal health coverage?
e. Are you concerned with the revictimization of abortion seekers in Ghana?
f. To what extent does the NHIS cover family planning commodities and services, as well as screening and treatment for STI's in Ghana?
g. What are the guiding principles that exempt CAC and ART/D from the scheme?
h. Are there special instances such as the specified exceptions for abortions made by the criminal code where the NHIS can cover for CAC?
i. Is there a possibility for an alignment of needs of abortion seekers based on the provisions of criminal code (abortion exemptions) to the NHIS? If yes, how? And if No, why?
j. Against the popular believe that CAC should be included into the NHIS, do you believe that the inclusion will advance the country's goal of universal health coverage?
k. Ghana has ratified many international conventions when it comes to human rights, how does the NHIS contributes towards the achievement of these outcomes and or violations of some of the provisions.
l. Did the policy consider international laws and treaties such as the ICCPR, CEDAW, MAPUTO PROTOCOL and the UDHR and how the policy violates their provisions?
m. Has there been consultations from local and international organizations towards the inclusion of abortion services under NHIS?