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Demystifying the legal restrictions on abortion in Nigeria: Time to change the narrative

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Summary: *Approximately one in seven pregnancies in Nigeria end in an induced abortion, with about 4,6 per cent of women of reproductive age in Nigeria undergoing an abortion each year. Abortion itself is not a death sentence. However, death occurs in most cases, as a result of complications arising from unsafe abortion practices. Abortion remains a leading cause of maternal mortality in Nigeria. Approximately 63 per cent of abortions are unsafe and have been reported to contribute to 10 per cent of maternal deaths, with approximately 6 000 women dying each year in Nigeria. Owing to sociological and religious considerations and the provisions of the laws on abortion in Nigeria, abortion is mostly carried out by unqualified health service providers under clandestine circumstances. The likelihood of either a repeal or liberalisation of the laws in the near future is rather slim. Pending the repeal or modification of the laws, however, and in order to reduce the high incidence of unsafe abortion, this article adopts a purposeful outlook in discussing the laws and guidelines. It highlights the legal defences and positive indications for abortion within the current legal framework. It also considers the vulnerability theory and rights-based approach to improve access to abortion services in Nigeria notwithstanding the existing legal restrictions.*

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Key words: *access; health laws and policies; reproductive health rights; safe abortion; universal health coverage*

1 Introduction

Abortion is often understood as the intentional termination of pregnancy before 22 weeks or, in low-resource settings, before 28 weeks.[1] Abortion is classified as induced or spontaneous depending on the circumstances leading to the termination of the pregnancy.[2] Although the legal terminology employed in the criminal laws of Nigeria is miscarriage,[3] the use of the word 'abortion' has been employed mostly in discussing the legality or illegality of termination of pregnancies in Nigeria. Nigerian society is a largely conservative and religious one in which abortion is largely frowned upon. Discussing abortion is not a comfortable experience as it is often perceived to be an end result or driver of promiscuity in women and young girls.[4] Despite these dispositions, the incidence of abortion in Nigeria has remained high.[5]

Religious and cultural beliefs, as well as the low socio-economic status of the majority of the people, contribute to the increased practice of unsafe abortion in Nigeria. The partial perception of the existing laws has also resulted in increased patronage of unsafe abortion service providers.[6] Unsafe abortion exposes women and girls to numerous risks, and sometimes death.[7] The World Health Organisation (WHO) defines unsafe abortion as the termination of

1 Federal Ministry of Health 'National guidelines on safe termination of pregnancy for legal indications' (2018), https://abortion-policies.srhr.org/documents/countries/04-Nigeria-National-Guidelines-on-Safe-Termination-of-Pregnancy-for-Legal-Indications-2018.pdf#page=15 (accessed 12 December 2023).

2 World Health Organisation *Reproductive health indicators: Guidelines for their generation, interpretation and analysis for global monitoring* (2006), https://apps.who.int/iris/bitstream/handle/10665/43185/924156315X_eng.pdf (accessed 12 December 2023).

3 Criminal Code Act Cap C38 Laws of the Federation of Nigeria 2004, https://www.refworld.org/docid/49997ade1a.html. (accessed 12 September 2023); Penal Code (Northern States) Federal Provisions Act Cap P3, Laws of the Federation of Nigeria 2004, https://www.africanchildforum.org/clr/Legislation%20%20Country/Nigeria/nigeria_penal-north_1960_en.pdf (accessed 12 September 2023).

4 EO Orji, AB Adeyemi & OA Esimai 'Liberalisation of abortion laws in Nigeria: The undergraduates' perspective' (2003) 23 *Journal of Obstetrics and Gynaecology* 63.

5 A Bankole and others 'The incidence of abortion in Nigeria' (2015) 41 *International Perspectives on Sexual and Reproductive Health* 81; SK Henshaw and others 'The incidence of induced abortion in Nigeria' (1998) 1 *International Family Planning Perspectives* 156.

6 SO Bell and others 'Inequities in the incidence and safety of abortion in Nigeria' (2020) 5 *British Medical Journal Global Health* e001814.

7 E Adinma 'Unsafe abortion and its ethical, sexual and reproductive rights implications' (2011) 30 *West African Journal of Medicine* 245-249.

an unwanted pregnancy 'either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both'.[8]

In Nigeria, the estimated number of abortions carried out every year is approximately 760 000 abortions with about 60 per cent of these abortions being carried out by non-physicians.[9] Abortion itself is not a death sentence for the seeker. Causing death in most cases are the complications that arise from unsafe abortion practices by unqualified health service providers. Victims of unsafe abortion often present to hospitals too late. Unsafe abortion led to hospitalisation and mortality in about a quarter of the cases reported by Akande and others.[10]

A detailed understanding of the extant abortion laws and policies by all stakeholders is crucial in changing the narrative in Nigeria. This is even more so since calls for more liberal abortion laws have been met with strong opposition from religious and anti-abortion organisations. Okonofua and others reported that majority (approximately 80 per cent) of politicians and policy makers agree that unsafe abortion is a major cause of maternal mortality, but only about one-fifth were disposed to an amendment of the restrictive abortion laws in Nigeria.[11] Repeated calls for review of the laws by critical stakeholders have not yielded much to guarantee unhindered access to abortion services for women in Nigeria.[12] The move by these stakeholders has nevertheless resulted in the adoption of the National Guidelines on Safe Termination of Pregnancies for Legal Indication (NGSTPLI) in 2018.[13]

This article seeks to analyse the existing laws and guidelines, while encouraging a purposeful perception towards the reduction of unsafe abortion practices in Nigeria. Existing literature has not given much consideration to the available legal defences and positive indications for legal abortion in Nigeria, especially in view of the NGSTPLI. The aim of this article, therefore, is to adopt a purposive approach to

8 World Health Organisation 'The prevention and management of unsafe abortion: Report of a WHO Technical Working Group' meeting held in Geneva, Switerland, from 12 to 15 April 1992 WHO/MSM/92.5, https://apps.who.int/iris/bitstream/handle/10665/59705/WHO_MSM_92.5.pdf?sequence=1 (accessed 11 October 2023).
9 Adinma (n 7).
10 OW Akande and others 'Unsafe abortion practices and the law in Nigeria: Time for change' (2020) 28 *Sexual and Reproductive Health Matters* 1758445.
11 FE Okonofua and others 'Perceptions of policymakers in Nigeria toward unsafe abortion and maternal mortality' (2009) 1 *International Perspectives on Sexual and Reproductive Health* 194-202.
12 Akande and others (n 10).
13 Federal Ministry of Health (n 1).

discuss the laws and guidelines relating to abortion in Nigeria. The article adopts a focused outlook in discussing the laws and guidelines by highlighting the legal defences, limitations of the laws and the positive indications for abortion within the current legal framework. The article also adopts the vulnerability theory and rights-based approaches to advocate improved access to safe abortion services in Nigeria notwithstanding the existing legal restrictions.

This study was conducted using both peer-reviewed and grey literature focusing on research evidence derived from the fields of law and medicine, especially in Nigeria. An electronic literature search was conducted in the following databases: Google, Google Scholar, PubMed and Jstor stable. Key words that correspond to the thematic objectives of the review were used in the search, including incidence of abortion; access to abortion services; safe abortion; maternal morbidity and mortality; reproductive health rights; and health laws and policy. Eligible articles were included for review only when abstracts contained explicit information about the issues of interest. The full text of the relevant articles and literature was then accessed and read. Also, relevant laws within the Nigerian legal system were reviewed and provisions relevant to the review were highlighted. The review included an analysis of existing case law relating to the issues of interest.

2 Abortion as a major contributor to maternal morbidity and mortality

According to the WHO, 'the high number of maternal deaths in some areas of the world reflects inequities in access to health services' with approximately 99 per cent of all maternal deaths occurring in developing countries.[14] Statistics reveal that a woman's chance of dying from pregnancy and child birth complications in Nigeria is one in 13.[15] Data from the WHO in 2019 revealed that the situation in Nigeria had further worsened, making the country the largest contributor to global maternal deaths in 2017.[16] The maternal mortality ratio in Nigeria was 917 per 100 000 live births in 2017. This was one of the worst in the world, leaving Nigeria ahead of South Sudan, Chad and Sierra Leone out of 185 countries included

14 WHO 'Maternal Mortality Fact Sheet' (2018), https://www.who.int/en/news-room/fact-sheets/detail/maternal-mortality (accessed 31 March 2023).

15 UNICEF *Maternal and child health*, http://www.unicef.org/nigeria/children_1926.html (accessed 13 October 2023).

16 WHO *Trends in maternal mortality 2000 to 2017: Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division* (2019), https://www.who.int/publications/i/item/9789241516488 (accessed 14 June 2023).

in the report.[17] By 2020 there was no improvement whatsoever with Nigeria retaining its status as the largest contributor to global maternal deaths. The country recorded 82 000 maternal deaths and a maternal mortality ratio of 1 047 per 100 000 live births in 2020.[18]

According to a study conducted between 2015 and 2019 in Nigeria, approximately 48 per cent of unintended pregnancies recorded ended in abortion.[19] Abortion significantly contributes to the very high maternal mortality ratio in Nigeria. According to a recent study by Performance Monitoring for Action (PMA), 4,6 per cent of reproductive-aged women in Nigeria undergo an abortion every year. This translates to approximately two million abortions annually.[20] About 63 per cent of these abortions are unsafe[21] and have been reported to contribute to 10 per cent of maternal deaths with approximately 6 000 women dying each year in Nigeria.[22] A study conducted by Abiodun also reported unsafe abortion as being responsible for up to 30 per cent of the overall maternal mortality in their study.[23] Similarly, Bankole and others revealed that approximately 212 000 women presented for treatment arising from complications of unsafe abortion. An additional 285 000 women were reported to have experienced serious health consequences but did not present for the necessary treatment.[24]

Poor access to accurate, reliable medical information on recommended abortion methods and to safe abortion care was identified as a key factor that aids in resorting to unsafe abortion practices.[25] Mitsunaga and others identified risk factors for induced abortion in Nigeria to include level of education, marital status, age at pregnancy, age at sexual debut, evidence of circumcision, ethnic group, religion, occupation, and abortion provider or facility.[26]

17 As above.
18 WHO *Trends in maternal mortality 2000 to 2020: Estimates by WHO, UNICEF, UNFPA, World Bank Group and the UNDESA/Population Division* (2023).
19 Guttmacher Institute 'Nigeria country profile: Unintended pregnancy and abortion', https://www.guttmacher.org/regions/africa/nigeria (accessed 15 August 2024).
20 Performance Monitoring for Action (PMA) 'Results from 2018-2020 PMA abortion surveys in Nigeria', https://www.pmadata.org/sites/default/files/data_product_results/Nigeria%20Unsafe%20Abortion%20Disparities.pdf. (accessed 20 April 2023).
21 As above.
22 National Population Commission (NPC) (Nigeria) and ICF 'Nigeria demographic and health survey 2018' Abuja, Nigeria and Rockville, Maryland, USA, NPC and ICP.
23 OM Abiodun 'Complications of unsafe abortion in South West Nigeria: A review of 96 cases' (2013) 42 *African Journal of Medicine and Medical Sciences* 111-115.
24 Bankole and others (n 5).
25 Performance Monitoring for Action (n 19).
26 TM Mitsunaga, UM Larsen & FE Okonofua 'Risk factors for complications of induced abortions in Nigeria' (2005) 14 *Journal of Women's Health* 515.

Complications reported in their study include infection and bleeding, which may lead to death. Abbas also identified bleeding, sepsis or perforation of the uterus, chronic pelvic pains and secondary infertility as health consequences of unsafe abortion.[27] Risk factors for complications arising from unsafe abortion were identified to include facilities and skill of the abortion provider; method of abortion and antibiotics used; general health of the woman; presence of sexually-transmitted diseases; female circumcision; age; parity; and gestational age.[28]

2.1 Vulnerability of women and reduction of maternal mortality

The principle of universal health coverage (UHC) was advanced in 2015 by the international community as one of the Sustainable Development Goals (SDGs).[29] The SDGs were a follow-up to the 2015 Millennium Development Goals (MDGs) formulated in 2000 by the United Nations (UN).[30] SDG 3.7 aims to achieve UHC. SDG 3.1, however, specifically targets the reduction of the global maternal mortality ratio to less than 70 per 100 000 live births by 2030.[31] As noted in the preceding part, abortion significantly contributes to the high maternal mortality ratio in Nigeria and, thus, access to safe abortion is highly likely to reduce the number of maternal deaths in Nigeria.

Consistent with the SDGs, the vulnerability theory justifies the need for interventions to address the risk of unsafe abortion resulting in morbidity and mortality of women in Nigeria.

The theory posits that vulnerability is an inherent quality of all humans.[32] Vulnerability, therefore, is associated with the potential to be affected by something and is a condition that limits one. Vulnerability may be limiting, but Gilson believes that it is a condition that can enable one if handled appropriately and with commensurate attention.[33] The fact that all human beings are prone to dependency

27 YG Abbas 'Causes and impacts of unsafe abortion in Nigeria' Master's dissertation, Vrije Universiteit, https://bibalex.org/baifa/Attachment/Documents/AnnX9ogxFq_2016102609545587.pdf (accessed 15 April 2023).
28 As above.
29 United Nations 'Sustainable Development Goals Knowledge Platform', https://sustainabledevelopment.un.org/ (accessed 21 May 2023).
30 United Nations 'Millennium Development Goals and beyond 2015', http://www.un.org/millenniumgoals (accessed 29 May 2023).
31 United Nations 'Sustainable Development Goals Targets and Indicators', https://sdgs.un.org/goals/goal3#targets_and_indicators (accessed 15 August 2024).
32 MA Fineman 'The vulnerable subject: Anchoring equality in the human condition' (2008) 20 *Yale Journal of Law and Feminism* 9-15.
33 E Gilson 'Vulnerability, oppression and ignorance' (2011) 26 *Hypatia* 308-332.

emphasises the responsibility of government to compensate persons for their vulnerability by addressing issues of vulnerability in its varying aspects. In the current context, while vulnerability may be considered a general fact of life, Okin holds the view that vulnerability is not a general fact of life but an injustice to women as a group, which is a creation of social institutions and arrangements.[34]

The vulnerability theory has been used as the basis for studies relating to exposure of women and adolescents to HIV and early pregnancies in separate studies by Fathalla and Rashad[35] and Roberto de Vogli and Birbeck.[36] Okin holds the view that vulnerability is an injustice to women as a group and is a creation of social institutions and arrangements.[37] In the context of abortion, the restrictive laws on abortion are only applicable to women. Only women require abortion and are therefore vulnerable to unsafe abortion practices. The vulnerability theory makes the need to change the legal and institutional arrangements to enhance access to institutions, resources and services for disadvantaged social groups (in this case, women) more apparent. Kohn is of the view that the vulnerability theory is effective and more appropriate to prompt special intervention for vulnerable groups in relation to the specific threat being faced by such groups.[38] Bluhm, in agreement with Kohn, also believes that the vulnerability theory can help solve some problems inherent in health, disease and illness in the philosophy of medicine.[39] The restrictive laws of Nigeria only apply to women and make them vulnerable to death when compelled to seek abortion under unsafe circumstances. The vulnerability theory, therefore, justifies the need for laws that allow women to access safe abortion services and which enables them to exercise their reproductive autonomy without the risk of losing their lives in the process.

34 SM Okin 'Gender inequality and cultural differences' (1994) 22 *Political Theory* 1.
35 M Fathalla & H Rashad 'Sexual and reproductive health of women' (2006) 333 *British Medical Journal* 816-817.
36 R de Vogli & GL Birbeck 'Potential impact of adjustment policies on vulnerability of women and children to HIV/AIDS in sub-Saharan Africa' (2005) 23 *Journal of Health, Population and Nutrition* 105.
37 Okin (n 34) 22.
38 NA Kohn 'Vulnerability theory and role of government' (2004) 26 *Yale Journal of Law and Feminism* 1.
39 R Bluhm 'Vulnerability, health, and illness' (2012) 5 *International Journal of Feminist Approaches to Bio-ethics* 156.

3 A rights-based approach to addressing the issue of access to abortion

The neglect of women's reproductive health has been identified as part of a larger and methodical discrimination against women.[40] The principle of non-discrimination and equal enjoyment of fundamental human rights without any form of distinction is at the core of human rights provisions right from the Preamble to the 1945 United Nations Charter.[41] The issue of reproductive health of women and their reproductive rights was addressed in the provisions of the International Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).[42] According to the provision of article 24, CEDAW specifically recognises the need to protect the reproductive rights and health of women by imposing obligations on states to adopt all necessary measures to repeal or modify existing laws, penal provisions, social and cultural patterns, customs and prejudicial practices that constitute discrimination against women. Other provisions include the rights of women to the protection of their health and function of reproduction under articles 11 and 12. These provisions impose clear obligations on states to eliminate discrimination in health care by providing access to women-centred services. Article 16 further requires states to ensure that women have freedom to determine freely and responsibly the number and spacing of their children.

Again, at the UN Conference in 1994, reproductive rights were declared an integral part of fundamental human rights. This is in recognition of the fact that the protection of women is fundamental in the attainment of development in any society.[43] Principle 8 of the Programme of Action (POA) adopted at the end of the Conference[44] emphasises women's ability to control their fertility and the right to access sexual and reproductive health (SRH) services. Paragraph 8.25 specifically recognises the health impact of unsafe abortion as a major public health concern and urges states to address this issue which negatively affects women's health.

40 RJ Cook 'International human rights and women's reproductive health' (1993) 24 *Studies in Family Planning* 80.

41 United Nations Charter of the United Nations 24 October 1945 1 UNTS XVI, https://www.refworld.org/docid/3ae6b3930.html (accessed 5 October 2023).

42 Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm (accessed 5 October 2023).

43 NI Aniekwu *Reproductive health law: A jurisprudential analysis of gender specific human rights for the African region* (2011) 54.

44 United Nations 'International Conference on Population and Development (ICPD) Programme of Action (POA)' (1994), http://www.unfpa.org/webdav/site/global/shared/documents/publications/2004/icpd_eng.pdf. (accessed 5 October 2023).

The 1994 Conference was closely followed by the Fourth World Conference on Women that took place in September 1995. The Conference reiterated many of the rights in the POA and also ended with significant progress in the development of women's reproductive rights. Declarations made at the Conference (Beijing Declaration)[45] addresses specific reproductive health and rights issues pertaining to women, including the recognition and reaffirmation of the right of all women to control all aspects of their health, including their fertility under article 17, and the state's obligations to ensure access to services for women to enhance their SRH under article 30.

At the regional level, the right to health is guaranteed in the African Charter on Human and Peoples' Rights (African Charter).[46] The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women's Protocol)[47] contains more detailed provisions relating to reproductive health and rights of women and is a direct response to African women's needs.[48] In the current context, the provision of article 14 of the Women's Protocol protects the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest and in circumstances where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the fetus.

The provision of article 14(2)(c) has been interpreted by the African Commission in 2014[49] to mean that women are not to be subjected to criminal proceedings or be punished for having benefited from health services that provide them abortion and post-abortion care. The provision also entails that health personnel should not fear prosecution or disciplinary action for providing abortion and post-abortion care services, in the cases provided for in the Protocol.[50] The provision was also interpreted to impose an obligation on state parties to provide a legal and social environment

45 United Nations 'Beijing Declaration Platform for Action', https://www.ohchr.org/sites/default/files/Documents/Issues/Women/WG/BeijingDeclarationPlatformAction1995.pdf (accessed 5 October 2023).

46 African Union African Charter on Human and Peoples' Rights CAB/LEG/67/3 rev 5, 21 ILM 58 1982 art 16, https://www.refworld.org/docid/3ae6b3630.html (accessed 5 October 2023).

47 African Union Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa' 11 July 2003, https://www.refworld.org/docid/3f4b139d4.html (accessed 5 October 2023).

48 NI Aniekwu 'The Additional Protocol to the African Charter on Human and Peoples' Rights: Indications of capacity for African municipal systems', http://www.saflii.org/za/journals/LDD/2009/12.pdf (accessed 5 July 2023).

49 African Union Commission General Comment 2 on arts 14(1)(a), (b), (c) and (f) and art 14(2)(a) and (c) of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa' 55th ordinary session held from 28 April-2 May 2014 in Luanda, Angola, https://achpr.au.int/en/node/854/ (accessed 15 August 2024).

50 As above.

that is conducive to the exercise by women of their sexual and reproductive rights by revisiting, where necessary, restrictive laws, policies and administrative procedures relating to safe abortion in the cases provided for in the Protocol.

To further enhance the realisation of women's reproductive rights in the African region, the African Union (AU) adopted the revised Maputo Plan of Action (MPoA) 2016-2030[51] as a Continental Policy Framework on Sexual and Reproductive Health and Rights (SRHR) to ensure universal access to comprehensive sexual and reproductive health services in Africa.

The revised MPoA is not a treaty and, thus, it lacks the binding force of law. However, it is a long-term plan that focuses on nine specific areas where actions are needed to fully enhance access to reproductive health rights and consistent with the POA adopted at the 1994 UN Conference. The identified areas under paragraph 6 of the MPOA include political commitment, leadership and governance; health legislations, financing and investments; and health information and education. Paragraph 7 of the MPoA expressly identifies the elements of SRH to include maternal health and new-born care and safe abortion care. Also, paragraph 18 requires the removal of legal, regulatory and policy barriers limiting access to sexual and reproductive health commodities, programmes and services.

However, there currently is no evidence that this comprehensive policy document has been holistically adopted for implementation within the extant policy framework in Nigeria. Also, while the African Charter has been domesticated as part of the laws of Nigeria in compliance with section 12 of the Constitution, the African Women's Protocol has not been so domesticated and therefore is not part of Nigerian laws.

A rights-based approach to access to abortion services in Nigeria holds significant promise and will address the limitations inherent in the criminal laws. The domestication of the African Women's Protocol by the Nigerian government is a much-needed positive step in this direction.

51 African Union Commission 'Maputo Plan of Action 2016-2030 for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health Rights', https://au.int/sites/default/files/documents/24099-poa_5-_revised_clean.pdf (accessed 5 October 2023).

4 Legal restrictions on abortion in Nigeria

The applicable criminal law provisions in Nigeria in the context of abortion is the Criminal Code Act (CCA) and the Penal Code Act (PCA). The CCA is applicable in the southern part of Nigeria while the PCA applies in Northern Nigeria. The provisions of both Acts are quite similar with slight variations influenced particularly by the dictates of Shari'a law which is largely practised in some parts of the north.

In the current context, the provisions relating to abortion are not so different with both Acts containing similar provisions that seek to restrict instances when abortion can be lawfully carried out. Based on the similarities, this article will focus on the CCA for the sake of brevity, whilst highlighting the slight differences as may be necessary in the course of discussions.

Section 228 of the CCA punishes anyone who intentionally procures a miscarriage of a woman by any means irrespective of whether the woman is or is not with child. Under section 229 of the same Act, any woman who intentionally procures her own miscarriage is guilty of an offence punishable with seven years' imprisonment. It thus is immaterial that the woman was not in fact pregnant, and the intent to abort suffices for conviction. Also, by the provision of section 309 of the CCA, any act done or omitted to be done that kills a child whether before or during the birth of a child is criminal and the person who does or omits to do the act is deemed to have killed the child. Such a person will be guilty of murder or manslaughter under the CCA, and the punishment is death or life imprisonment under sections 319 and 320 of the CCA. Acts or omissions preventing a child from being born alive is also an offence punishable with life imprisonment under section 328 of the CCA. Still within the context of abortion, the law punishes anyone who unlawfully supplies anything intended to be used to procure the miscarriage of a woman. Such a person is liable to three years' imprisonment under section 230 of the CCA.

The provisions of the Nigerian Criminal Code negate the international rights standards relating to reproductive health care. One of ways of promoting the realisation of reproductive rights is ensuring access to reproductive healthcare services by addressing issues constituting barriers to access. Eliminating barriers to access is consistent with the SDGs under Goal 3 with targets of achieving universal health coverage. The criminal law provisions that impose punishments on those who procure, seek to procure or supply

anything needed to procure a miscarriage constitute a legal barrier to accessing reproductive health services and, therefore, is a violation of the reproductive rights of women. The provisions are discriminatory against women as only women need to seek abortion and related services. The provisions are at variance with states' obligations under CEDAW to eliminate discrimination in health care by providing access to women-centred services and to protect the reproductive rights and health of women by adopting all necessary measures to repeal or modify existing laws, penal provisions, social and cultural patterns, customs and prejudicial practices that constitute discrimination against women. Also, the provisions violate the clear obligations to protect the reproductive rights of women imposed on states under the African Women's Protocol.

5 Demystifying the legal restrictions

5.1 Raising a legal defence to justify abortion

The positive angle, however, is that there is a legal defence available to anyone who commits the above offences under section 297 of the CCA to the extent that the acts were carried out in the course of surgical operations. Section 297 thus is a general defence for acts committed during surgical operations. It provides as follows:

> A person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon any person for his benefit, or upon an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable, having regard to the patient's state at the time and to all the circumstances of the case.

The above provision exonerates a person carrying out an abortion in cases where the act was done in good faith, and with reasonable care and skill for the patient's benefit. It also extends to cases where the abortion was carried out for the preservation of the mother's life and if it was reasonable having regard to the patient's state, and to all the circumstances of the case. The PCA does not have an equivalent provision that considers the patient's state or all circumstances of the case. However, the defence of acting in good faith for the purpose of saving the life of the woman is included in the provision of section 232 of the PCA together with the defined offence.

A purposive interpretation of the provision of section 297 appears to undoubtedly justify abortion in situations where the life of the mother is at risk, but it should not end there. The latter part of the

provision envisages a holistic consideration of the circumstances of the case, reasonableness, and having regard to the patient's state. Deflem is of the view – and we agree – that abortion laws 'can never simultaneously satisfy conflicting, pro-life and pro-choice, claims. In a society characterised by an increasing diversity of values and beliefs, law becomes more necessary and more impossible.'[52] Therefore, whatever position the law holds, whether liberal or restrictive, laws must be interpreted positively and in a holistic manner that takes into cognisance the facts of each case. The provision of section 297, therefore, may suffice to hinge an argument to justify abortion in some peculiar circumstances that not only place the woman in a poor physical state, but also in a poor emotional, mental or any state at all that is considered detrimental to her health, progress and development. This may, for instance, be considered in cases of pregnancies resulting from rape or incest or of a young adolescent who may be subjected to stigma, emotional abuse or torture for falling pregnant at a young age.

Although this view remains yet to be tested in the courts, it holds promise as a tenable defence if the laws are not reviewed to conform with modern trends on the right to self-determination in matters of reproduction and protection of the right to reproductive autonomy. In the case of *R v Edgal*[53] the position of the Court reflects a purposive interpretation of the laws. The facts were that persons charged with conspiracy to commit abortion under the Nigerian Criminal Code contended that the attempted abortion was undertaken to preserve the life of the mother. The Court relied on the English court's decision in the earlier case of *R v Bourne*[54] to whittle down the provisions of section 228 of the Criminal Code. The Court held that it was permissible to carry out abortion for the preservation of the life or health of the mother. This decision is a precedent, albeit a persuasive one, to support a purposive and positive interpretation of section 297 to argue for abortion in exceptional cases and based on peculiar facts, for instance, in cases of incest, rape, adolescent or teenage pregnancies that are likely to negatively affect their future as well as their emotional or mental well-being.

Mental health is an area that holds a promise in handling cases of women and girls seeking abortion. In cases where a patient is not psychologically, emotionally or mentally positioned to carry a pregnancy to term, especially considering the circumstances relating

52 M Deflem 'The boundaries of abortion law: Systems theory from Parsons to Luhmann and Habermas' (1998) 76 *Social Forces* 778.
53 (1938) 4 WACA 133.
54 (1938) 3 All ER 615.

to conception (for instance, in cases of rape and incest), a medical practitioner may proceed to abort the patient's pregnancy within the umbrella of section 297, particularly where such finding or diagnosis of mental incapacity can be corroborated by another practitioner. It perhaps is in consideration of this factor that the 2018 NGSTPLI[55] includes mental and psychiatric disorders as the conditions under which a medical practitioner can lawfully terminate pregnancies in Nigeria. The provisions of the NGSTPLI are discussed in detail in part 5.4 below.

Laws that make abortion legally restrictive are long overdue for review. This is to the end that the law, at the very minimum, makes an exception for the termination of a pregnancy arising from unpleasant circumstances such as rape or incest. This will be consistent with modern trends. In the interim, however, and pending the review or repeal of existing laws, the provision of section 297 appears to hold some promise in raising a defence for abortion in the above circumstances.

5.2 Discharging the evidential burden of proof

Apart from the legal defence under section 297, the likelihood of securing a prosecution under the provision of sections 228 and 229 is rather slim. In the case of section 229, which punishes the woman who aborts, proof of the offence will most likely result in self-indictment. The possibility of securing prosecution is made more apparent if one considers the fact that the law imposes no obligation on medical practitioners treating post-abortion cases to report cases of women who may have illegally procured abortion. In any event, and even if we are to assume that such obligation exists, a medical practitioner providing post-abortion care may not be able to conclusively ascertain the legality or illegality of the abortion. This is because the abortion could very well have been carried out under lawful circumstances – that is, to save the life of the mother, or it could have been a spontaneous abortion. Consistent with the above, Chigbu and others note that most women who present for post-abortion care arising from complications often deny the fact that they attempted to or did abort the pregnancy. They rather claim, even against clinical evidence, that the abortion was spontaneous.[56]

55 Federal Ministry of Health (n 1).
56 CC Chigbu and others 'Impact of abortion laws on women's choice of abortion service providers and facilities in South-Eastern Nigeria' (2018) 21 *Nigeria Journal of Clinical Practice* 1119.

On the flip side, assuming the medical practitioner was the one who initially provided the abortion services, it would also have been illogical for the same person to proceed to indict themselves by reporting the woman for conviction under section 229. This is because the medical practitioner would also be indicted and may be found liable under section 228. Schur thus states that 'women who submit to abortions are virtually never prosecuted. And the physician who departs from his legitimate practice to perform an occasional abortion rarely gets in trouble with the law.'[57] He concludes that 'satisfying evidentiary requirements is a major difficulty'.

Also, in cases where a woman may have considered the option of reporting the person who carried out the abortion on her in the case of an unsuccessful abortion attempt or a successful one with negative consequences, the fear of being charged as an accomplice under section 228 and being found guilty under section 229 is enough to deter any thoughts of making such report to seek redress. This situation played out in the case of *State v Njoku,* where the Court made a finding to the effect that the woman was an accomplice in the conspiracy to procure her own abortion.[58] Recent developments, including the acceptability of medical abortion, may make the successful conviction of a woman under section 229 even more challenging as a woman who successfully aborts her fetus is unlikely to incriminate herself.[59]

For the above reasons, most potential abortion cases present as murder or manslaughter cases, arising from abortion[60] and not strictly from a charge hinged on abortion.[61] Perhaps, it is for this reason that the PCA, unlike the CCA, specifically punishes any act intended to cause miscarriage but which results in the death of a woman. The provision of sections 228 and 229 thus are bedevilled with an inherent challenge of proof of the offences therein. The burden of proof in criminal cases is proof beyond reasonable doubt.[62] To successfully convict, it is not enough to merely suspect that the person in question has possibly unlawfully procured a miscarriage. The fact of the illegality of the procurement of the abortion must be proved beyond all reasonable doubt. It is only then that the burden

57 EM Schur 'Abortion and the social system' (1955) 3 *Social Problems* 97.
58 (1973) ECSLR 638.
59 Medical abortion is recognised as the acceptable form of abortion under the African Women's Protocol and the NGSTPLI discussed in part 6 below.
60 *State v Akpaete* (1976) 2 FNR 101.
61 PC Okorie & OA Abayomi 'Abortion laws in Nigeria: A case for reform' (2019) 23 *Annual Survey of International and Comparative Law* 169.
62 Evidence Act 2011 sec 135, https://www.refworld.org/docid/54f86b844.html. (accessed 5 October 2022).

of proof would have been discharged to ground a conviction under sections 228 and 229 of the CCA.

5.3 Socio-legal considerations

Social realities continue to influence people's decisions to resort to abortion under hidden and unsafe circumstances in utter disregard of the laws. Incidences of unwanted pregnancies and unsafe abortion in Nigeria remain high and disturbing. As far back as 1955, Devereux states – and this still holds true – that from all indications, abortion is 'an absolutely universal phenomenon, and that it is impossible even to construct an imaginary social system in which no woman would ever feel at least impelled to abort'.[63]

One of the major reasons why people continue to seek unsafe abortion in Nigeria is because the laws restricting abortion are at variance with sociological realities. Laws that do not reckon with societal needs and realities are likely to become obsolete and ineffective. In most cases, such laws lack the legitimacy that ought to drive its enforcement. Apart from legitimacy needed to influence compliance with laws, the significance of rational calculation; self-interest and sanctions in determining obedience to laws was emphasised by Hyde.[64] In context, the self-interest of the woman and the need to protect same appear to trump the legal restrictions imposed by the criminal laws. Self-interest will, therefore, influence the decision of an adolescent whose pregnancy was occasioned by rape, or a young unmarried lady who is afraid of society's reaction to the news of having a child outside wedlock. The need to self-protect would propel them to make rational decisions that will save them from perceived fears and negative societal reactions.

The punishment for offences relating to abortion also appears to have no deterrent effect sufficient to keep people from seeking abortion. The law is an instrument of social change, and a law that is unable to achieve needed change is a bad law. In this case, a law that is unable to reduce the incidence of unsafe abortion cannot be said to be a good and effective law. Therefore, there is a the need for Nigeria to take positive steps to reform its criminal law provisions consistent with its obligations under ratified international treaties and trends in other jurisdictions in Africa. As far back as 2012, Rwanda amended its penal laws to approve induced abortion where pregnancy was as

63 G Devereux 'A study of abortion in primitive societies' (1955) 122 *Journal of Nervous and Mental Disease* 498.

64 A Hyde 'The concept of legitimation in the sociology of law' (1983) *Wisconsin Law Review* 396.

a result of rape, incest or forced marriage, or where the pregnancy seriously jeopardises the health of the pregnant woman. The amendment also substantially reduced the prescribed penalties for violations of the provisions criminalising abortion.[65] Women who had previously been convicted for abortion-related offences have also been pardoned, with more than 500 women pardoned and released between 2016 and 2023.[66]

In Kenya, the High Court in Malindi in *PAK and Salim Mohammed* recognised the constitutional right to abortion and further held that the arbitrary arrest and prosecution of persons seeking abortion and healthcare workers providing abortion care are illegal and a violation of the reproductive rights of women. The provisions of the Penal Code that criminalise abortion was held to be a violation of the reproductive rights of women.[67] The High Court in Malawi in 2021 equally adopted a broad and purposive interpretation of the law within existing legal restrictions on abortion in the country. In *CM v The Hospital Director of Queen Elizabeth Central Hospital*[68] the Court held that the indication for abortion is legal where the life of a pregnant woman is in danger, but further held that the statutory indication for preservation of life necessarily includes preservation of the physical and mental health of the pregnant woman.

The laws in Ghana are also somewhat liberal, and to an extent recognises the reproductive rights of women to seek abortion under circumstances similar to those stated under the African Women's Protocol. Under the extant law, abortion will not be an offence where it is carried out by a licensed medical professional and in cases where pregnancy was the result of rape or incest, or where the pregnancy constitutes a risk to the physical or mental health of the pregnant woman.[69]

Nigeria should take a cue from the developments in other jurisdictions where the right to safe abortion have been upheld by the courts and abortion laws reformed consistent with international human rights obligations. Some efforts so far made are discussed below. However, there is a need for more deliberate action to repeal or amend the extant criminal law provisions.

65 J Påfs and others 'Implementing the liberalised abortion law in Kigali, Rwanda: Ambiguities of rights and responsibilities among health care providers' (2020) 80 *Midwifery* 102568.
66 https://www.npr.org/sections/goatsandsoda/2023/09/02/1194431567/rwanda-women-abortion-laws-kagame-presidential-pardon-jail (accessed 15 August 2024).
67 *PAK and Salim Mohammed v AG* Malindi High Court Petition E009 of 2020.
68 (2021) MWHC 43.
69 Criminal Offences Act 29 of 1960 sec 58.

5.4 National Guidelines on Safe Termination of Pregnancy for Legal Indications 2018

A major development in the policy framework relating to abortion in Nigeria was the formulation of the NGSTPLI[70] by the Federal Ministry of Health in 2018. The NGSTPLI reiterates the fact that abortion alone accounts for up to 14 per cent of the maternal morbidity and mortality in Nigeria. It seeks to build capacity for medical practitioners by providing information on the laws relating to abortion and also assisting them to clearly identify circumstances that threaten the life and well-being of pregnant women and which suffices to justify abortion, within the boundaries of the law.

As a welcome development, the NGSTPLI emphasises the legality of therapeutic abortion when carried out to save the life of a woman, or to promote her health and well-being.[71] It lists an array of conditions, diseases and disorders that put the mother at risk and which allow a medical practitioner to lawfully terminate a pregnancy. These include obstetric and gynaecological conditions; maternal heart and vascular diseases; kidney diseases; cancer; blood diseases; psychiatric and mental disorders; auto-immune diseases; thyro-cardiac diseases; advanced diabetic mellitus with organ failure; and other maternal pathology situations that put the mother at risk.

In addition, a crucial step in reaching a decision to abort involves obtaining a second opinion for confirmation of the indication for abortion. This step appears to be a prerequisite that cannot be waived under any circumstances. The NGSTPLI thus specifically recommends a referral to obtain the needed second opinion where same cannot be obtained locally. It is worth noting that it also prescribed medical abortion as one of the recommended and acceptable methods for the safe termination of pregnancies.

5.5 Violence Against Persons Prohibition Act 2015

The enactment of the Violence Against Persons Prohibition Act in 2015 indeed was a welcome development, especially as it relates to the protection of the rights of women in Nigeria. In the context of access to safe abortion and reproductive health services, the Act reiterates the recognition of not only constitutionally-guaranteed

70 Federal Ministry of Health (n 1).
71 As above.

rights, but also provisions in international human rights treaties to which Nigeria is a party.[72]

The Act specifically highlights the right of victims of violence to receive and be readily given access to medical, psychological, social and legal assistance. Section 41 of the Act requires protection officers to ensure that victims of violence have easy access and transportation to medical facilities and hospitals for treatment, if required. This Act has been passed by the House of Assembly of some states with significant additions to improve on the provisions of the Act. The Ogun State and Oyo State laws, for instance, mandate free medical treatment and counselling for victims of violence in hospitals in the states.[73] The affirmation of the rights of victims of violence to access necessary medical services is suggestive of the fact that women who have been victims of sexual violence and who may require abortion services are not to be denied same under the Act.

The relevance of this Act to the abortion discourse is also apparent in the provision that gives recognition to the rights of victims of violence within the international human rights framework. As will be seen in the next part, the international human rights framework appears to provide a firm basis for improved access to safe abortion services for women.

6 Conclusion and recommendations

The legal restrictions in the criminal code laws of Nigeria give an illusionary satisfaction that is at variance with current realities on the incidence of abortion in Nigeria. Discussions on abortion are usually limited to these restrictions, which have been shown to be significantly ineffective. There usually is very little or no discussion at all on the limitations of the laws and the available defences to the offences under the criminal laws. Not much publicity has been given to the NGSTPLI, which partly resolves the uncertainties surrounding situations and circumstances in which pregnancies can be lawfully terminated.

Therefore, there is a need for sensitisation of all stakeholders on a holistic appraisal of the laws and guidelines on abortion in Nigeria. The adoption of a rights-based approach to access to abortion

72 Violence Against Persons (Prohibition) Act 2015 sec 38, https://www.refworld.org/docid/556d5eb14.html. (accessed 5 October 2023).
73 Ogun State Violence Against Persons Law 2017 secs 31 & 66; Oyo State Violence Against Women Law 2016 sec 38.

services in Nigeria will also significantly address the limitations in the criminal laws. A good starting point will be the domestication of the African Women's Protocol, which recognises the right to medical abortion under specified circumstances. Enhanced access to safe abortion services for women in Nigeria will ultimately result in a decline in the maternal morbidity and mortality rate in Nigeria.