Implications of the Restrictive Abortion Laws and Challenges to The Implementation of Women's Reproductive Rights in Nigeria

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Abstract

This paper examines the legal framework governing abortion and women's reproductive rights in Nigeria, highlighting its provisions, ethical debates and profound implications. Through a critical analysis of domestic legislation, judicial interpretations, and international human rights instruments, it reveals that Nigeria's highly restrictive abortion laws contribute significantly to a public health crisis marked by high rates of unsafe abortions, maternal mortality, and morbidity. The study exposes a critical disconnection between Nigeria's domestic laws and its international obligations, compounded by deeply entrenched economic barriers that undermine women's autonomy and access to essential healthcare. By contrasting Nigeria's situation with more progressive jurisdictions like South Africa and the United Kingdom, this paper argues for urgent legal and policy reforms that prioritise women's health, dignity, and human rights. It aims to bridge the gap between legal theory and lived realities, ensuring women's access to safe reproductive healthcare, upholding their fundamental human rights, and fostering a more equitable and just society.

Keywords: Abortion, Reproductive Rights, Maternal Mortality, Human Rights, Public Health

1. Introduction

Women's reproductive rights, including the right to access safe and legal abortion, have become a focal point in global discussions on human rights, public health, and gender equality. In many parts of the world, including Nigeria, these rights evoke passionate legal, moral, religious, and cultural debates. In spite of the global recognition of the right to health as a human right, Nigeria is yet to either domesticate international treaties or enact specific laws on reproductive health rights. However, certain legislative provisions, such as the Constitution of the Federal Republic of Nigeria, the Penal Code, the Criminal Code, the Administration of Criminal Justice Act (ACJA), the Labour Act, expressly guarantee certain aspects of these rights but are silent on the other parts. Some pieces of legislation even outright dismissed certain parts which constitute a major aspect of the reproductive right. Consequently, women in Nigeria are yet to fully enjoy their rights with respect to reproductive health.

The major flaw of Nigeria's legal framework on abortion lies in its rigidity and failure to reflect evolving human rights norms and public health realities. *The Criminal Code* and *Penal Code*, which apply in Southern and Northern Nigeria respectively, criminalise abortion except where it is carried out to preserve the life of the mother. This provision does not adequately consider other critical circumstances such as rape, incest, mental health risks, or severe foetal abnormality situations where international human rights instruments would otherwise justify the legal provision of abortion services. The restrictive legal frameworks are not preventing abortions

from happening but instead driving many women to resort to hazardous means to terminate pregnancies, contributing to a public health crisis of unsafe abortion, maternal mortality and morbidity, while simultaneously infringing upon the fundamental reproductive rights and bodily autonomy of Nigerian women.

The contradiction between Nigeria's restrictive abortion laws and its international legal obligations, including commitments under the Maputo Protocol and CEDAW, underscores a significant legal and ethical gap. Although Nigeria has ratified these treaties, there has been no domestication or legislative reform on Nigeria's abortion law. This disconnect raises questions about the country's commitment to upholding women's rights and dignity as enshrined in both international law and the Nigerian Constitution, which guarantees the right to life, dignity, health, and personal liberty.

1.1. Ethical Debates on Abortion

Abortion, in its most common usage, refers to the discontinuation of a pregnancy before the attainment of viability.[1] In other words, the termination of pregnancy before the foetus is capable of living outside the womb. In the medical and health studies, there exist two types of abortion, namely, medically induced abortion and spontaneous abortion, often regarded as miscarriage. The former is deliberate or intentional, while the latter is accidental. In this study, the former is the focus. The debate on abortion is between the pro-choice and pro-life advocates. The questions that have been addressed by both parties to the controversy include: when does life begin? Is a foetus a human being? Are the life and health of the mother of greater value than that of the foetus? What is the effect of the quality of foetal life and its viability on its right to life?

Pro-choice (pro-abortion) advocates variously aver that life begins at viability, at birth, or until there is capacity for social interaction.[2] Thus, to them, a foetus is not a person. A variant of the argument is that the "human being does not begin to exist until the embryo is fully implanted in the uterus…"[3] In *Paton v. British Pregnancy Advisory Service Trustees*,[4] the court affirmed that "the foetus cannot, in English Law, have a right of its own, at least until it is born and has separate existence from its mother." This personhood criterion has been invoked by pro-abortion groups to justify legal abortion laws. They argued that rights are attached to a person and that a foetus is not a person. If the foetus is not a person, all that it can have is a privilege accorded to it by the community and/or law.

On the other hand, pro-lifers (anti-abortionists) argue that embryos and foetuses are pre-born children. The anti-abortionists hold that after conception, the embryo is alive and can now replace its own dying cells and needs nothing more but food and time to grow into a mature

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[1] Black's Law Dictionary (Bryan A. Garner Ed. 2004); The New International Webster's Comprehensive Dictionary of the English Language in Encyclopaedic Edition (Typhoon Media Corp. 2004).
[2] Scientists for Life, 'The Positions of Modern Science on the Beginning of Human Life and Why a Human Embryo is Not a Parasite Virginia' (Sunlife Greystone Pub., 2004) 5.
[3] McSweeny, '*Sex and Conception*' (African University Press 2019) 15.
[4] *Paton v. British Pregnancy Advisory Service Trustees* [1979] QB 276; [1978] 2 ALLER 987 (QBD)

adulthood. They hold on to the scientific claim that by twenty-five days, the heart is already beating and that by thirty days, the brain is fully formed and all the organs are set for action.[5] Anti-abortionists like Karl Barth have the view that the foetus has its own autonomy. Seeing that it has its own brain, nervous system and even blood circulation, it can have its own illness without the mother being sick, and it may be healthy when the mother is critically ill. Therefore, while a pro-choice advocate will not see any moral problem in the act of abortion and will support that a pregnant woman should have the freedom to choose an abortion if she does not want to have a baby, a pro-lifer considers abortion ethically wrong and as murder.

Regarding the life and health of the mother being of greater value than that of the foetus, the anti-abortionists are of the view that maternal indications are unacceptable. This refers to any condition or circumstance related to the mother that suggests a need for a specific medical intervention, like induction of labour or termination of pregnancy, to ensure her well-being and the safety of the pregnancy. Anti-abortionists frown at any kind of abortion, especially those performed for maternal indications, because it treats humanity as a means to a selfish end. To them such a choice can never contribute to the chooser's authentic human fulfilment.[6] Hence, they are of the view that, in all cases, whenever a woman has become pregnant, she has to allow the pregnancy to come to term despite all contrary indications because the protection of the child's right to life is not legalism but the correct use of law.[7]

To the pro-choice advocates, the protection and/or preservation of the mother's life or health is a major argument for a legal abortion. They argue that maternal indications can be purely medical, physical, emotional and/or psychological. It may even relate to the mother's age. Thus, to them, the health of the mother, including her psychosocial convenience, is a sufficient reason for a legal abortion. The major assumption behind this position is that the foetus is a part of the maternal body, and so abortion should be available to any woman without "insolent inquisitions or ruinous financial charges…"[8]. Hence, the psychological inconvenience of a mother should be a ground for abortion, as preserving the life of the mother 'extends beyond acts to save her physical existence to ensuring her psychological balance.[9] What this requires is that whenever the mother feels that the child is not prepared for life, like in cases of rape or incest, she may wish to assume responsibility for it or may not wish to.

Furthermore, on the quality of a foetal life as a ground to determine its viability, the pro-choice insists that a defective foetus should not be allowed to come to term. To them, aborting such a foetus will save a future child from gross pain and suffering. It will also save a certain family from the physical, mental and financial stress of caring for a defective child.

[5] McSweeny, '*Sex and Conception*' (African University Press 2019) 16.
[6] D O'Brien, '*More Questions on Anencephaly*' (Russell E S Pub 2009) 1–2.
[7] A. Fagothey, *'Right and Reason: Ethics in Theory and Practice*' (Mosby 1999) 255.
[8] D. Callaham, 'Abortion Law Choice and Morality' in World Book Encyclopaedia (Child-Craft International Inc. 1979) 160.
[9] A Ogwuche, *'Compendium of Medical Law*' (Espee Printing & Advertising 2006) 99.

The anti-abortionists on the other end maintain that a foetus's life should be valued not on the quality of life but on its sacredness. It is the sacredness of life that makes it integral[10]. They worry that the availability of abortion on grounds of foetal abnormality encourages prejudice towards any person with a handicap and insidiously creates the impression that the only valuable people are those who conform to some ill-defined stereotype of "normality."

1.2. Women's Reproductive Rights

Reproductive rights in women is a broad concept, encompassing not just abortion but also the right to sexual and reproductive health, access to information, contraception, safe childbirth, and freedom from violence and discrimination in reproductive matters. It guarantees reproductive health. The definition of reproductive rights from the International Conference on Population and Development (ICPD)[11] emphasises a state of complete physical, mental, and social well-being related to the reproductive system. It is not merely the absence of disease but a state of complete physical, mental and social well-being in all matters related to the reproductive system and to its functions and processes. This broad definition encompasses the entire human life cycle, recognising that reproductive health is integral to overall human well-being and development.

The key aspects of reproductive health include maternal health (prenatal, childbirth, postnatal care), adolescent reproductive health (sexuality education, prevention of early pregnancies), protection from HIV/AIDS and other sexually transmitted infections, and protection against rape and other assaults. Harmful practices such as Female Genital Mutilation and early forced marriage also significantly undermine reproductive health rights in Nigeria. Reproductive rights are not isolated but are deeply connected to broader human rights like the right to life, dignity, privacy, and freedom from cruel and degrading treatment. They emphasise that women should have the power to make decisions about their bodies and personal choices concerning reproduction, without discrimination, coercion, or violence.

1.3. Legal Framework Governing Women's Reproductive Rights Beyond Abortion

Although there is no law in Nigeria that is labelled Abortion Law, there are two major statutes regulating abortion practice in Nigeria. They are the *Criminal Codes*[12] of the southern states and the *Penal Codes*[13] of the northern states of the country. The provisions of both Acts are quite similar with slight variations influenced particularly by the dictates of Sharia law, which is largely practised in some parts of the north. The provisions of these codes are largely similar and make abortion a criminal felony punishable with imprisonment.

[10] P Singer, 'Value of Life' in Warren T Reich (ed.), *Encyclopaedia of Bioethics* (Macmillan 1998) 825.
[11] United Nations Population Fund (UNFPA), Programme of Action of the International Conference on Population and Development (1994), Cairo.
[12] Criminal Code Act, Cap. C38 Laws of the Federation of Nigeria (LFN) 2010.
[13] Penal Code Act (Northern States) Federal Provisions Act, Cap. P3 Laws of the Federation of Nigeria (LFN) 2010.

1.3.1. The Criminal Code

The Criminal Code is modelled on the *English Offences Against the Person Act of 1861* and is applicable in Southern Nigeria. The relevant provisions of the Criminal Code are *Section 228* which criminalises anyone who unlawfully administers anything or uses force with intent to procure a miscarriage, imposing a fourteen-year imprisonment. *Section 229* also criminalises a woman who attempts to procure her own miscarriage, liable to seven years imprisonment. *Section 230* criminalises supplying or procuring anything intended for an unlawful miscarriage, with a three-year imprisonment, and *Section 297* provides the only legal exception, stating that a person is not criminally responsible for terminating a pregnancy for the preservation of the mother's life if done in good faith and with reasonable care and skill and if the operation is reasonable, having regard to the patient's state at the time and to all the circumstances of the case. This section's ambiguity often leads to narrow interpretations, largely excluding broader health considerations like mental well-being, unlike the more expansive interpretation in the English case of *R v Bourne*,[14] which suggests that preserving the life of the mother should include not only the protection of her physical but also of her mental well-being. In this regard, the acquittal case of Dr Aleck Bourne, a recognised gynaecologist who, contrary to the law, invited the police to prosecute him for having conducted an abortion on a 14-year-old girl who had been raped. He was afterwards indicted under the provisions of *Section 58 of the Offences Against the Person Act 1861* for unlawfully procuring the abortion. However, he was acquitted by the court that found he had acted bona fide to preserve the life of the young woman who was bound to suffer serious physical and psychological trauma.

1.3.2. The Penal Code

The *Penal Code* provisions are substantially the same as those in the *Criminal Code* and are applicable in Northern Nigeria. *Section 232* criminalises causing a woman to miscarry unless done in good faith for the purpose of saving the life of the woman, punishable by fourteen years imprisonment. This combines the offence of causing a woman to miscarry with the defence of good faith for the purpose of saving the life of the woman contained in *Section 297* of the *Criminal Code*. This provision was the subject of the decision in *Pam-Tok v State.*[15] There, the appellant was convicted of causing a miscarriage contrary to *Section 232 of the Penal Code*. The case for the prosecution was that he performed an operation and thereby caused a secondary school female student to miscarry a three-month-old child. The appellant put up a defence that he performed the operation when the student had a partial miscarriage and was bleeding and the operation was necessary to save the student's life. The trial court convicted the appellant. On appeal, he argued that the trial court did not consider his defence adequately. The court in dismissing the appeal and conviction and reaffirming the sentence, held that the onus was on the appellant to show that he acted in good faith for the purpose of saving the life of the student. *Section 233* addresses causing the death of a woman with intent to cause her miscarriage, imposing up to fourteen years

[14] *Rex v Bourne* [1938] 2 All ER 615.
[15] *Pam-Tok v State* [1979] 78,84 (CA).

imprisonment and a fine, or life imprisonment if done without the woman's consent. *Section 234* creates a strict liability offence punishable with imprisonment for a term which may extend to five years or with a fine or with both, where a person unintentionally causes a woman to miscarry by using force on her. The miscarriage need not be intended, the force need not be unlawful, and the offender need not know that the woman was with child. From all the provisions discussed, it can be concluded that both codes make abortion a criminal offence at any stage of pregnancy, unless for the sole purpose of saving the mother's life. Consent is immaterial and does not serve as a defence, though it may be a mitigating factor under the Penal Code.

1.3.3. The Constitution of the Federal Republic of Nigeria 1999

Section 17, though non-justiciable, obliges the state to ensure adequate medical and health facilities. Chapter 4 provides for general human rights like personal liberty[16], private and family life[17], freedom of thought, conscience, and religion,[18] and freedom of expression and assembly[19], all of which can be argued to protect various aspects of reproductive health and autonomy for example, right to information, decision-making on family size, privacy regarding HIV status, choices like IVF.

1.3.4. The Administration of Criminal Justice Act 2015

This Act aims to unify criminal justice administration. It includes gender-sensitive provisions like requiring female officers to search women,[20] and protecting the privacy of women[21]. Critically, Section 404 suspends the death sentence for pregnant women until after childbirth and weaning, protecting maternal and child health.

1.3.5. Violence Against Persons Prohibition Act 2015

This Act criminalises all forms of violence, including spousal battery, forceful ejection, confinement, and economic/psychological abuse. Section 20(1) prohibits harmful traditional practices like female genital mutilation and forced marriage. However, its effectiveness is limited by the fact that many states are yet to adopt it, and it still does not explicitly criminalise spousal rape.

1.3.6. Labour Act 1971

Section 54 provides maternity protection for women, including twelve weeks of maternity leave (six pre-delivery and six post-delivery) and 50% of wages for a minimum service period. It also allows nursing mothers half an hour twice daily for breastfeeding. This provision is non-

[16] Constitution of the Federal republic of Nigeria (CFRN) 1999, s.35.
[17] CFRN s.37.
[18] CFRN s.38.
[19] CFRN ss. 39- 40.
[20] Administration of Criminal Justice Act (ACJA) 2015, s. 9(3).
[21] ACJA s.12

discriminatory regarding marital status, as affirmed by the *Omolola Olajide v IGP*[22] case that voided discriminatory police regulations. According to Regulation 127 of *the Police Act*[23], an unmarried woman who gets pregnant in the force shall be discharged never to be re-enlisted without the approval of the Inspector General of Police. However, in *Omolola's case*, this Regulation was voided by the National Industrial Court as discriminatory.

The National Guidelines on Safe Termination of Pregnancy for Legal Indications 2018 also emphasises the legality of therapeutic abortion when carried out to save the life of a woman, or to promote her health and well-being. 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.[24]

1.4. Regional and International Conventions and the Nigerian Stance

Nigeria's position as a signatory to several key international and regional human rights instruments underscores a significant commitment to women's rights on paper. However, a critical examination reveals a stark disconnect between these international obligations and the reality of domestic law and practice.

1.4.1. The African Charter on Human and Peoples' Rights

The African Charter on Human and Peoples' Rights, adopted in 1981 and ratified by Nigeria in 1983, forms a foundational human rights framework. It broadly promotes and protects human rights in Africa. While not explicitly detailing reproductive rights, its provisions on the right to life,[25] human dignity,[26] health,[27] and family protection[28] provide a basis for arguing for women's reproductive rights as fundamental human rights. Despite its domestication, the non-justiciability of socio-economic rights in Chapter II of the Nigerian Constitution often takes precedence, limiting the enforcement of African Charter on Human and Peoples' Rights provisions related to healthcare access and facilities.

[22] *Omolola Olajide v IGP* [2021] (NICN).
[23] Police Act 2020 Cap. P19, Laws of the Federation, 2004
[24] O Adejumo, 'Demystifying The Legal Restrictions On Abortion In Nigeria: Time To Change The Narrative'. (2024) 24 *African Human Rights Law Journal* 559.
[25] African Charter on Human and Peoples' Rights (ACHPR), a. 4.
[26] ACHPR, a.5
[27] ACHPR, a.16
[28] ACHPR, a.18

1.4.2. The Additional Protocol to the African Charter on Women's Rights 2003

The Additional Protocol to the African Charter on Women's Rights 2003, also known as the Maputo Protocol, adopted in 2003 and entered into force in 2005, is the most significant regional instrument for women's rights in Africa. It directly responds to women's specific needs, setting out clear standards for their recognition and protection. Crucially, the Maputo Protocol is pioneering as the first treaty to recognise abortion as a woman's human right under certain conditions. Article 14 of the Protocol explicitly addresses women's health and reproductive rights, guaranteeing women the right to control their fertility, the right to decide whether to have children, their number and spacing, the right to choose any method of contraception and the right to family planning education.

Similarly, Article 14(2)(c) calls upon State Parties to take all appropriate measures to protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus. It also mandates protection from sexual harassment and violence[29]and defends widows' rights.[30]

Despite Nigeria being a signatory to the Maputo Protocol, the government has not yet domesticated and fully implemented all its requirements. This failure has profound and negative impacts on the human and reproductive rights of women and girls in the country. The case of *Dorothy Njemanze & Ors v. Federal Republic of Nigeria*[31], which applied the Maputo Protocol in a gender-based violence case, serves as a landmark regional pronouncement, yet its domestic application remains limited without full domestication.

1.4.3. The Convention on the Elimination of All Forms of Discrimination against Women

Adopted by the United Nations General Assembly in 1979 and effective in 1981, the Convention on the Elimination of All Forms of Discrimination against Women also known as CEDAW is often called the International Bill of Rights for Women. It is a gender-specific instrument designed to identify and address human rights issues unique to women. CEDAW mandates measures to eliminate discrimination against women and promote gender equality, justice, respect, and protection of women's rights. CEDAW pays significant attention to women's reproductive rights, including the right to maternity protection and childcare, access to adequate healthcare facilities, including information, counselling, and family planning services and the right to decide freely and responsibly on the number and spacing of their children, and access to the information, education, and means to exercise these rights.

Although Nigeria is a signatory to CEDAW, it remains undomesticated and, by virtue of Section 12 of the 1999 Nigerian Constitution, largely unenforceable within the country's legal

[29] ACHPR, a.12(1)(c).
[30] ACHPR, a.20 and 21.
[31] *Dorothy Chioma Njemanze & 3 Ors v Federal Republic of Nigeria* [2017] ECW/CCJ/APP/17/14, 8(ECOWASCJ)

system. This non-domestication creates a significant legal and ethical void, hindering Nigeria's ability to fully uphold its commitments to women's reproductive rights on the ground.

It can be observed from the foregoing that a glaring inconsistency exists between Nigeria's international human rights obligations and its domestic legal framework. Whereas internationally committed to protecting broader reproductive rights, including conditional access to safe abortion, Nigeria's internal laws remain largely restrictive and unyielding. This disconnect is a challenge, leaving women vulnerable and undermining efforts to improve public health and gender equality.

1.5. The Public Health Effects of Abortion Law in Nigeria

Throughout history, the criminalisation of abortion had forced women in all jurisdictions to embrace unreliable and dangerous means of eliminating unwanted pregnancies. The restrictive abortion law in Nigeria has not achieved its aim of discouraging abortion; rather, it has pushed most women into clandestine and unsafe abortions often performed by unskilled providers under unsafe and unsanitary conditions. These unsafe abortions have profound and far-reaching implications on public health. The consequences are maternal mortality and morbidity, haemorrhage, infection and infertility.

1.5.1. Maternal Mortality and Morbidity from Unsafe Abortion

Maternal mortality, also known as maternal death, is defined as the death of a woman while pregnant or within forty-two (42) days of the termination of pregnancy from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.[32] It refers to deaths due to complications from pregnancy or childbirth. Several factors have been noted to be responsible for the high prevalence of this preventable menace, ranging from direct medical factors and causes, which include unsafe abortion and its complications, obstructed labour, hypertensive disorders of pregnancy, haemorrhage and sepsis, to indirect causes, that is, conditions that existed before pregnancy but were aggravated by pregnancy, for example, sickle cell disease, anaemia, and HIV/AIDS; socio-economic determinants such as ignorance and illiteracy, poverty, and place of residence; cultural factors, for example, harmful traditional practices, to knowledge and attitudes towards seeking healthcare. 70% of maternal deaths in Nigeria are caused by one of five complications: haemorrhage, infection, unsafe abortion, hypertensive diseases of pregnancy, and obstructed labour.[33]

Despite numerous attempts at mitigating its unenviable contribution, unsafe abortion remains a common cause of maternal morbidity and mortality, especially in low and medium-income countries.[34] Nigeria has one of the highest maternal mortality and morbidity rates in the world, mostly due to unsafe abortions, as these unsafe abortions are often associated with complications

[32] World Health Organisation Trends in Maternal Mortality: 2000-2017 <https://www.who.int/news-room/fact-sheets/detail/maternal-mortality#:~:text=Key%20facts,most%20could%20have%20been%20prevented> accessed 5 July 2025.
[33] GM Piane, 'Maternal Mortality in Nigeria: A Literature Review' (2019) 11 *World Medical and Health Policy* 83.
[34] E Enabudoso and others, 'Harm Elimination Project for Unsafe Abortion in Nigeria: An Operations Research' (2019) *Tropical Journal of Obstetrics and Gynaecology* 126.

ranging from sepsis, haemorrhage requiring blood transfusion, uterine and bowel perforation, pelvic abscess, endotoxic shock, renal failure, and death to long-term sequelae like ectopic pregnancy, cervical incompetence, cervical dystocia, chronic pelvic pain, and infertility, with grave implications for the future reproductive health of the woman. According to the World Health Organisation, 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.[35] 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.[36]

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 in the report.[37] 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 1,065 per 100,000 live births in 2020, 1,046 in 2021 with a 1.78% decline from 2020, 1,016 in 2022 with a 2.87% decline from 2021 and 993.00, with a 2.26% decline from 2022.[38]

Additionally, a study conducted between 2015 and 2020 shows abortion significantly contributes to the very high maternal mortality ratio in Nigeria.[39] Subsequently, a study by Performance Monitoring for Action found that 4.6 per cent of reproductive-aged women in Nigeria undergo an abortion every year. This translates to approximately two million abortions annually,[40] and about 63 per cent of these 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.[41] 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.[42] Poor access to accurate, reliable medical information on recommended abortion methods and safe abortion care, level of education and abortion provider or facility were identified by Performance Monitoring for Action as a key factor that aids in resorting to unsafe abortion practices.

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[35] World Health Organisation (WHO, 2011), 'Unsafe abortion: global and regional estimates of the incidence of unsafe abortion and associated mortality' <https://www.who.int/news-room/fact-sheets/detail/maternal-mortality#:~:text=Key%20facts,most%20could%20have%20been%20prevented> accessed 5 July 2025.
[36] World Health Organisation (2019), 'Trends in maternal mortality 2000 to 2017' <https://www.who.int/publications/i/item/9789241516488> accessed 5 July 2025.
[37] ibid.
[38] World Health Organisation 2023, 'Trends in maternal mortality 2000 to 2023' <https://www.macrotrends.net/global-metrics/countries/nga/nigeria/maternal-mortality-rate> accessed 5 July 2025.
[39] Guttmacher Institute, 'Nigeria country profile: Unintended pregnancy and abortion', <https://www.guttmacher.org/pubs/2006/08/08/Nigeria-UP-IA.pdf.> accessed 5 July 2025.
[40] 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 5 July2025.
[41] National Population Commission (Nigeria) and ICF Report: 'Nigeria Demographic and Health Survey 2018 <https://www.scirp.org/reference/referencespapers?referenceid=3241515>accessed 5 July 2025.
[42] M Abiodun, 'Complications of Unsafe Abortion in South West Nigeria: A Review of 96 Cases' (2013) *African Journal of Medicine and Medical Sciences* 111.

1.5.2. Haemorrhage, Infection and Infertility

A study conducted by the Guttmacher Institute in Nigeria reveals that one out of every four women that underwent abortion has developed one form of complication or another. With 25% of them developing a serious life-threatening complication ranging from severe bleeding, injury to the visceral organs and infertility. The complications are more severe with increasing gestational age of the pregnancy. 58% of the women develop complications if the procedure is performed after weeks, while only 20% will experience complications if the pregnancy is less than 12 weeks.[43] The level and severity of the complications also depend on the methods and the skills of the providers. The complications are more severe among women that use traditional remedies and less among those that use injections or tablets. Also, the complications are more in the northern part of the country than in the southern part. This may not be unconnected with the higher prosperity among women in the south than in the north.[44] Therefore, it is more likely for women in the north to use the service of a cheap, unskilled provider. While on the other hand, her southern counterpart can more often afford to pay for safe abortion services in the hospital.

Haemorrhage is the excessive and uncontrolled bleeding. It is one of the most immediate and life-threatening complications of unsafe abortion. Unsafe abortion is one of the main factors of haemorrhage-related complications. A study in a Nigerian hospital revealed that 71.9 per cent of abortion-related complications involved haemorrhage.[45] In the hands of unskilled providers or through self-induced methods involving sharp objects or unverified medications, the uterus may be perforated or lacerated, leading to internal bleeding. In many cases, women experiencing such haemorrhage do not reach hospitals on time due to fear of prosecution, lack of finance, or social stigma. By the time they arrive, their bodies are often in hypovolemic shock, a condition that can quickly become fatal without urgent blood transfusions and surgical intervention. Consequently, hospitals, especially in rural areas, frequently lack the necessary resources to respond effectively. There are not enough beds, not enough blood, and not enough trained professionals. Thus, what could have been a manageable medical complication in a safe clinical setting becomes a death sentence in a system burdened by preventable emergencies.

Also following unsafe abortions, infections are tragically common. Sepsis is the commonest early complication of infection from unsafe abortion and one of the leading causes of abortion-related deaths in Nigeria.[46] It is a severe, body-wide infection resulting from bacteria entering the bloodstream. It normally manifests itself with high-grade fever and purulent, offensive vaginal discharge. It mostly arises due to the use of unsterilised instruments or hands, introducing bacteria into the uterus by quacks or by the women themselves in non-sterile environments. It

[43] Guttmacher Institute, 'Nigeria country profile: Unintended pregnancy and abortion', <https://www.guttmacher.org/pubs/2006/08/08/Nigeria-UP-IA.pdf.> accessed 5 July 2025.
[44] National Population Commission and Nigeria Demographic and Health Survey 2008 (NPC/ICF Macro 2009) <https://www.dhsprogram.com/pubs/pdf/fr222/fr222.pdf> accessed 5 July 2025.
[45] T Fetters and Others, 'High Severity of Abortion Complications in Fragile and Conflict-affected Settings: A Cross-sectional Study' <https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-023-05427-6?utm>accessed 5 July 2025.
[46] A Ibrahim and others, 'Pattern of Complicated Unsafe Abortions in Niger Delta University Teaching Hospital' (2013) 11 *Nigerian Health Journal* 112.

accounts for 50-80% of all complications from illegal abortion in the country. The finding is in line with a study conducted in the Niger Delta in 2011, which shows that genital sepsis caused 88.9% of all the complications of unsafe abortions, followed by retained products of conception at 82.5%.[47] Sepsis is considered the main cause of maternal mortality,[48] and if the woman survives, she might end up with long-term health consequences. Even when the infection does not prove immediately fatal, it can lead to long-term complications such as chronic pelvic inflammatory disease. This condition causes persistent pelvic pain and recurrent infections and contributes significantly to another major consequence of unsafe abortion which isinfertility.

For many women, the most haunting consequence of unsafe abortion is the loss of the ability to have children in the future (infertility). If a womb infection is left untreated, there's a small chance that it could cause pelvic inflammatory disease. This can increase the risk of infertility or an ectopic pregnancy, where an egg implants itself outside of the womb. There are two types of infertility: primary and secondary infertility. In the case of primary infertility, there has not been any pregnancy, but in secondary infertility there is a history of pregnancy in the past, either delivered or aborted. The growing rate of secondary infertility due to abortion has been attributed to the various methods used by both trained and untrained illegal abortionists, such as inserting different instruments in the uterus. The trauma to the reproductive system, whether through surgical injury, infection, or scarring, can result in irreversible infertility. Sometimes infertility results because of the complete removal of the uterus to treat complications of unsafe abortions. This is particularly tragic in a society where a woman's value is often culturally tied to her ability to bear children.

Apart from these medical consequences of unsafe abortion, women and their families also suffer social and psychological consequences. If a girl becomes pregnant or has an abortion that is known, the family has to contend with social stigma attached to the condition. And if she drops out of school or cannot work, the family has to bear the economic burden of supporting her. For the young girl that had an unwanted pregnancy and abortion, the psychological trauma is huge, and sometimes the psychological and social implications become indelible for life.

1.6. The Effects of the Abortion Laws in Other Jurisdictions

The United Kingdom liberalised abortion by allowing termination up to 24 weeks.[49] This is permitted where continuing the pregnancy would pose a greater risk to the woman's life, or to her physical or mental health, than ending it.[50] It is also allowed where continuing the pregnancy would pose greater risks to the health of her existing children, or where there is substantial risk that the child would be born with serious physical or mental abnormalities.[51] These reforms have saved women's lives. They have promoted reproductive justice. They have also made abortion safer and given women greater control over their fertility. It has saved women's lives, encouraged

[47] ibid.
[48] ibid.
[49] Abortion Act 1967, s. 1(1)(a)
[50] Abortion Act 1967, s. 1(1)(b)
[51] Abortion Act 1967, s. 1(1)(c)(d)

reproductive justice and increased the safety and ease with which women in the UK can now control their fertility. The crucial importance of abortion legality in the UK has been to reduce maternal mortality and morbidity. In the 1st decade of legal abortion, the proportion of all maternal deaths that were due to abortion dropped from 25% to 7%. The number of recorded deaths due to abortion declined from 160 during 1961-63 to 9 during 1982-1984.[52] Currently, the United Kingdom's abortion-related mortality is among the lowest globally, attributed to the accessibility of safe, regulated procedures and the healthcare system's support for women's reproductive decisions while prioritising their safety and dignity.[53]

Also, the enactment of the *Choice on Termination of Pregnancy Act,1996 (Choice Act)*[54] has portrayed South Africa as the leading country in Africa in terms of the safeguard of reproductive rights. It has to a very large extent lowered the incidence of maternal deaths and morbidity linked to abortion, in that, it does not prohibit abortion but makes it legal and accessible.[55] During the first twelve weeks, abortion is available on the request of the mother.[56] From 12 to 20 weeks, abortion is legal for reasons such as adverse effects on the woman's health (mental and physical), socio-economic status, rape, incest, or severe foetal abnormality. After 20 weeks, abortion is available only under very limited circumstances.[57] It is provided for free at government hospitals and clinics for the first three months. Following the implementation of South Africa's *Choice Act*,[58] abortion-related deaths dropped by over 90%, reflecting a profound improvement in maternal safety once abortion became legal and accessible through the public health system. Specifically in the west of Pretoria, a study comparing post-enactment periods showed a decline in the abortion-related maternal mortality ratio from 63.6 per 100,000 live births in 1997–1998 to just 5.54 per 100,000 in 2003–2005, a reduction of almost 91%.[59] These manifest in the reduction in the number of women reporting for medical treatment over complications arising from abortion, even shortly after the commencement of the *Choice Act*.[60]

Thus, the UK and South Africa have built systems where early, legal, and safe abortions reduce the incidence of complications and long-term health costs. Also, the clarity and accessibility of abortion laws in the UK and South Africa foster trust in the healthcare system. Women can seek services without fear of prosecution or societal condemnation, reducing delays and increasing the

[52] National Library of Medicine, 'Twenty-one Years of Legal Abortion: A British Perspective' (1989) <https://pubmed.ncbi.nlm.nih.gov/2502225/> accessed on 5 July 2025.
[53] United Kingdom Department of Health, 'Abortion Statistics, England and Wales in 2021' <https://www.gov.uk/government/statistics/abortion-statistics-for-england-and-wales-2021> accessed on 5 July 2025.
[54] Choice on Termination of Pregnancy Act 1996 (Choice Act) Act 92.
[55] JMS Greenberg & M Steven, 'Safe abortion in South Africa: 'We have Wonderful laws, but we don't have People to Implement those Laws.' (2018) 143 *International Journal of Gynaecology and Obstetrics* 39.
[56] ibid.
[57] ibid.
[58] Choice on Termination of Pregnancy Act,1996.
[59] A Mbele and C. Pattinson, 'Impact of the Choice on Termination of Pregnancy Act on Maternal Morbidity and Mortality in the West of Pretoria' (2006) <http://hdl.handle.net/2263/4889> accessed 5 July 2025.
[60] R Jewkes & H Rees, 'Dramatic decline in abortion-related mortality due to the Choice on Termination of Pregnancy Act' (2005) 95 *South African Medical Journal* 250.

likelihood of safe outcomes. In South Africa, the law does not only permit abortion but also ensures access in public hospitals, without parental or spousal consent, reinforcing women's autonomy.

1.7. Challenges to the Realisation of Women's Reproductive Health Rights in Nigeria

A number of factors inhibit the provision and availability of maternal health and reproductive health care in Nigeria. As such, the right to reproductive health in Nigeria seems to be a mirage. The inadequacy or lack of implementation of laws and policies, the prevalence of systemic corruption, weak infrastructure, ineffective health services, and the lack of access to skilled healthcare providers worsened by the separation of responsibilities for the provision of health care among the country's three tiers of government are among the factors militating against the enjoyment of the rights.[61] The vast scale of maternal death in Nigeria and the lack of necessary government commitment to effectively address the problem have more than just public health implications; they also constitute serious violations of human rights that are protected under national, regional, and international law. Although the *ACHPR* has been domesticated, *Chapter II of the Constitution* has overriding effect on the Act; thus, no right of action can lie against the state for breach of the provisions of social economic rights. Section 6 of the Criminal Code and Section 282 of the Penal Code[62] have by implication expressly legalised spousal rape. The section provides that "unlawful carnal knowledge means carnal connection which takes place otherwise than between husband and wife". It follows therefore, that in Nigeria, a man can never be found culpable of raping his wife. It is glaring, therefore, that this section is a gross violation of women's health and reproductive rights, the Nigerian law as it is, is obsolete and highly oppressive to women and not in consonance with contemporary international instruments on health and reproductive rights which laws have conceded to women the right to the highest standard of health and spacing out of their children. It is submitted that on no account should a woman be forced by her husband to submit to sexual relations with him when it is apparent she is not emotionally or medically fit. In fact, the 1993 *United Nations Declaration on the Elimination of Violence against Women* established marital rape as a human rights violation.[63]

Cultural and religious norms are a major challenge to the achievement of women's reproductive rights. Religious teachings deeply influence personal conduct, especially in the areas of sexuality, marriage, gender, childbearing, and parent-child relationships. Not only does religion shape the values of individuals and the cultures of societies, it has the power to influence government policy. It affects public policies through the involvement of religion in political processes and also through the religious beliefs of political leaders, policy makers, and civil servants. Several practices that infringe on women's reproductive health rights are culturally acceptable. For instance, female genital mutilation is a practice that has defied attempts by government to eradicate because it is

[61] C Obinna, 'OTNPC, Ogun Obas Worry Over Infant and maternal health' Vanguard (2009) <https://www.vanguardngr.com/2009/09/otnpc-ogun-obas-worry-over-infant-and-maternal-health/> accessed 5 July 2025.

[62] Criminal Code Act Cap. C38 and Penal Code Act (Northern States) Federal Provisions Act, Cap. P3 Laws of the Federation of Nigeria (LFN) 2010.

[63] UN General Assembly, Declaration on the Elimination of Violence Against Women: Report of the Secretary General (2006) UN Doc A/61/122/.

culturally etched in the society. Even the victims of female genital mutilation would rather suffer the pain than face societal disapproval and/or ostracism. The issue that has generated the most heated conflict between religion and reproductive health is the issue of abortion, as many religious groups view it as morally unacceptable, often prioritising doctrine over the health, dignity, and autonomy of the woman. Another major constraint to the attainment of reproductive health in Nigeria is the poverty level of women and unequal access to resources for women, including healthcare. About 70% of the population live below the poverty line, the majority of whom are women. Women's disproportionate poverty, low social status, and reproductive role expose them to high health risks, resulting in needless and largely preventable suffering and deaths. Many of the women and girls who die each year during pregnancy and childbirth could have been saved by relatively low-cost improvements in reproductive healthcare, yet the healthcare services in Nigeria are poor. Suffice it to say that the problem of poor or even non-existent healthcare services in the country contribute largely to the increased maternal mortality rate, which has remained one of the highest in the world.[64]

Additionally, the patriarchal nature of Nigerian society is the bane of discrimination, where women are believed to exist solely for the benefit of men. The women in Nigerian culture are not permitted to make an input as far as the spacing and number of children a couple may wish to have. It is the sole prerogative of the men to determine the size of the family, even when it is very obvious that further childbearing would endanger or jeopardise her life or job security. This violates the reproductive rights of women in the society. Subsequently, patriarchal medical consent practices, that is, the requirement for spousal consent before certain medical procedures such as caesarean sections can be performed on married women, is one significant and deeply troubling impediment to the realisation of women's reproductive rights in Nigeria. While medical ethics and human rights standards uphold the principle of informed consent, which requires that every competent adult must give voluntary and informed permission for medical treatment, the Nigerian healthcare context often deviates from this ideal. In many hospitals across Nigeria, doctors frequently demand the signature of a husband before proceeding with life-saving obstetric interventions like caesarean section. This practice not only undermines the woman's legal and moral right to bodily autonomy, but it has, in numerous cases, led to preventable maternal deaths. There are instances where women in urgent need of surgical delivery have died because their husbands outright refused to give permission or were unavailable or unreachable for the procedure. This practice is both ethically indefensible and legally questionable. It violates the woman's right to health, to life, and to make autonomous decisions about her medical care, all of which are guaranteed under international instruments to which Nigeria is a party.

1.8. Conclusion

The legal framework on abortion in Nigeria**,** being the *Criminal Code* in the southern states and the *Penal Code* in the northern states criminalise abortion except in circumstances where it is necessary to save the life of the pregnant woman. On the other hand, the legal framework

[64] N Aniekwu, 'Reproductive Health Law: A Jurisprudential Analysis of Gender-Specific Human Rights for the African Region (Ambik Press Nigeria, 2011), p. 84.

governing women's reproductive rights in Nigeria includes the *1999 Constitution of Nigeria*, *the National Health Act 2014*, the *Violence Against Persons (Prohibition) Act 2015*, the *Administration of Criminal Justice Act (ACJA) 2015* and the *Labour Act 1971*. In contrast to Nigeria, countries like South Africa and the United Kingdom have implemented liberal abortion laws that recognise the complex medical, social and psychological realities surrounding pregnancy, reproductive decision-making and uphold women's reproductive rights. Nigeria's restrictive legal frameworks expose women to significant harm, both physically and psychologically. While the law aims to deter abortion, it has in fact pushed countless women into unsafe and clandestine procedures, often performed by unskilled providers in unsanitary conditions. This contributes directly to Nigeria's alarmingly high maternal mortality and morbidity rates and places a burden on the already fragile healthcare system in terms of cost and availability of medical supplies.

Nigeria's abortion laws are inconsistent with its obligations under international and regional human rights instruments, such as the *Convention on the Elimination of All Forms of Discrimination Against Women and the Maputo Protocol*. Both instruments, which Nigeria has ratified, require state parties to ensure access to safe abortion at least in cases of rape, incest, and danger to the psychological health of the mother. However, the findings reveal that Nigeria has neither domesticated nor implemented these obligations through legislative reform. The result is a wide gap between Nigeria's international commitments and its domestic legal practices.

1.9. Recommendations

This paper recommends amendment of the existing abortion laws to allow for legal and safe abortion services under broader circumstances, such as cases of rape, incest, foetal anomalies, and risks to the woman's mental and physical health. This would align with international human rights standards and public health imperatives and improve women's health outcomes. This legal reform should be paired with public health initiatives and community education to reduce stigma and empower women. In addition, the government should take positive steps to domesticate international human rights treaties of which they are signatories, which explicitly recognise and promote women's reproductive rights. This domestication will ensure that their provisions on reproductive health, including access to comprehensive sexual and reproductive health services and freedom from gender-based violence in Nigeria, are legally binding and enforceable within the country. Also, abolition of patriarchal medical consent practices requiring spousal consent for critical medical procedures, particularly life-saving obstetric interventions like caesarean sections. This is a significant impediment to women's bodily autonomy and a direct cause of preventable maternal deaths. Lastly, women should be urgently sensitised on their health, reproductive rights and their role in family planning by women-led organisations. Evidence shows that when women receive education and support from trusted female counsellors and healthcare providers, they are more likely to embrace family planning methods.