RE-CHARACTERIZING ABORTION IN NIGERIA: AN APPRAISAL OF THE NECESSITY TEST

Victor Nnamdi Opara[*]

ABSTRACT

The Nigerian criminal jurisprudence prohibits abortion in all instances except when necessary to save the life of a woman. This has driven many women and girls seeking abortions to non-physician providers. These non-physician procedures turn out to be unhygienic and unsafe. Nigerian abortion statistics reveal an unacceptable high rate of maternal mortality and morbidity. This analysis undertakes a close contextual examination of the exceptions to outright prohibition, pointing out that the couching of some of the words make the attainment of the legislative aim a mirage or at least illusory. The analysis equally points out the heuristic discretionary potentials of some of the clauses, which the Nigerian medical community could creatively utilize to a woman's advantage. This paper calls for fundamental rethinking of the abortion life-saving provisions. Fortunately, towards the completion of writing of this paper, a bill was introduced in the Nigerian National Assembly which has the concomitant potential of amending the present abortion laws. The balance of

* Victor Nnamdi Opara LL.M. (Toronto); LL.B. (Hons) (Benin, Nigeria); Barrister and Solicitor of the Supreme Court of Nigeria. E-mail: victor. opara@utoronto.ca. This paper is dedicated to Mrs. Traphina Chitumogu Oparaojiaku (my ever-loving and caring Mother).

this interplay is reflected in a postscript. The general thrust of this paper is to generate the momentum that will lead to a liberalizing amendment to the present over-restrictive abortion regime in Nigeria.

I. INTRODUCTION

Nigerian criminal jurisprudence prohibits abortion in all instances except when necessary to save the life of a woman. Although there is no specific body of laws known as "the Abortion Act" in Nigeria, the prohibitions and their accompanying strict exceptions are embodied in the provisions of both the Criminal and Penal Codes of Nigeria. This restrictive statutory formula has driven many pregnant women and girls to non-physician providers in a bid to avoid reluctant parenthood by accessing secretly illegal and septic abortions. These procedures turn out to be unhygienic and unsafe. Moreover, abortions by some physician providers equally result in risks to users. This medical negligence is underpinned by the restrictive laws as well because the inefficiency of physician providers appears to be strengthened by the ignorance or general apathy of women seeking abortion. The effect is that most of these women and girls pay the price either through their lives or complications to their health. Abortion statistics in Nigeria reveal an unacceptable high rate of maternal mortality and morbidity, with unsafe abortion constituting the highest percentage within the myriad of contributory factors.

This analysis undertakes a close contextual examination of the exceptions, pointing out that the couching of some of the words and clauses in the exceptions make the attainment of the legislative aim a mirage or at least illusory. Some of the exceptions end up confounding and complicating the problems of pregnant women and girls rather than providing a veritable haven for them. Those confounding parts of the exceptions are so sweepingly drawn that they appear to empower non-physician providers to procure abortion. Moreover, the framing of the exceptions makes it difficult for medical practitioners to figure out when to legally render abortion services in line with the legislative aim. The analysis recognizing this quagmire points out the heuristic discretionary potentials of some of the clauses, which the Nigerian medical community could creatively utilize to the advantage of women.

On the whole, this paper calls for a fundamental rethinking of the abortion life-saving provisions and concludes by calling for an amendment of some of the exception clauses in order to incorporate the requisite life-saving devices in line with the proper legislative aim of the drafters. The effects of these restrictions on the reproductive and sexual health of Nigerian women once led the Nigerian Society of Gynecology and Obstetrics to sponsor a Bill in the Nigerian National Assembly called the Termination of Pregnancy Bill of 1981. This Bill sought to legalize abortion where two registered doctors were

convinced that the life of the pregnant woman was endangered, and where there was a substantial risk that the child would be born with a physical or mental handicap.[1] Although public opinion was in favor of the Bill, not surprisingly, two small but powerful pressure groups, one of which was composed of conservative women, vehemently opposed it. Ironically, that Bill was sponsored by the Nigerian medical community due to "the increasing number of illegal abortions carried out under inadequate health conditions which lead to high death rates among [women and girls]."[2] The reaction of the women can easily be explained. Nigerian women have always been subservient to their male counterparts as a result of the paternalistic and androcentric bias that pervades the entire sub-Saharan African society.

Fortunately, another opportunity has come in 2004. Towards the completion of the writing of this paper, Senator Stella Omu sponsored a bill in the Nigerian National Assembly. The bill entitled "Maternal and Child Welfare, Health Services (Procedure, etc) Bill [of] 2004" seeks a holistic reform of Nigerian reproductive health care system. The provisions of the nine-section bill are so embracing that it is not within the scope of this analysis to engage all the sections. Of particular relevance to this paper are sections 5 and 6 which impact abortion. The proposed bill, if passed, will provide the legal framework for overhauling the present Nigerian abortion regime; it will concomitantly repeal the present abortion laws as contained in the Criminal and Penal Codes.[3] In response to this recent development, this analysis includes a postscript, which charts the potentials of the proposed bill against the backdrop of a changing legal climate. The balance of the complex interplay of the present abortion laws and the proposed bill is dealt with accordingly.

The general thrust of this paper is to generate momentum that will lead to a liberalizing amendment to the present over-restrictive abortion regime in Nigeria. Structurally, the paper is divided into four parts. Part I introduces the topic, lays down a compendium of abortion statistics in Nigeria, delineates the statutory framework and gives an overview of the origin of dual criminal jurisdiction in Nigeria. Part II undertakes a close contextual analysis of the necessity test and carefully engages all the threshold matters that make up the test. In this regard, the paper compares the present Nigerian abortion regime with those of other advanced commonwealth jurisdictions, namely Britain and Canada. Part III seeks to appraise the extent to which the proposed bill is a

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1. For a detailed review of the Bill, *see* I.E. Adi, *The Question of Abortion*, July 1982 NIG. CURRENT L. REV. 191.

2. *See* REBECCA J. COOK & BERNARD M. DICKENS, EMERGING ISSUES IN COMMONWEALTH ABORTION LAWS (1983).

3. CODE CRIMINAL [C. CRIM.] ch. 21, § 228-30, 297 (1990) (Federation of Nig.); PENAL CODE [PENAL C.] § 232-35 (1983) (N. Nig.).

departure from its hopeful predecessor – the present abortion laws in Nigeria. Finally, Part IV embodies recommendations and conclusion.

A. Abortion Statistics in Nigeria

Unsafe abortion is one of the most serious problems facing thousands of Nigerian women and girls. As it turns out, non-physician abortion procedures lead to greater percentage of complications and death for women. The first survey of physician abortion providers[4] in Nigeria in 1998 reveals that each year, Nigerian women and girls obtain approximately 610,000 abortions, which is at the rate of twenty-five abortions in every one-thousand women and girls between the reproductive ages of fifteen to forty-four; it also reveals that only an estimate of 40 percent of these abortions are performed by physicians in established health facilities while the remaining 60 percent are performed by non-physician providers. In other words, 366,000 abortions are performed by non-physician providers annually.[5] Moreover, abortions by physician providers equally result in complications.[6] The survey equally estimates that annually 183,000 women and girls experience complications from abortions by non-physician providers, and do not receive treatment.[7] The 1998 survey was not significantly different from an earlier study carried out in 1996, which happens to be "the first comprehensive population-based study of unwanted pregnancy and induced abortion ever undertaken in any part of Nigeria."[8] This 1996 study categorically reveals that as a result of the restrictive stance of the law, "women frequently resort to clandestine abortion performed by unskilled practitioners, leading to high rates of maternal mortality and morbidity. Of the 50,000 maternal deaths that are estimated to occur in Nigeria annually, nearly 20,000

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4. *See* Stanley K. Henshaw et al., *The Incidence of Induced Abortion in Nigeria*, 24 INT'L FAM. PLAN. PERSP. 156, 162 (1998).

5. *See Id.* (observing that "this is the first time a national survey of physician abortion providers has been conducted in a developing country where abortion is largely illegal").

6. *Id.* at 161-62. The survey points out the percentage of complications emanating from different classes of non-physician providers and physician providers:

Respondents considered pharmacists or chemists as one of the two most common providers of abortions resulting in complications (mentioned by 50% of respondents), followed by paramedics (40%), nurses or midwives (35%) and other doctors (22%).... "Quacks"—individuals with no formal training who nonetheless provide medical treatment—were mentioned by 23% of respondents.

Id. The survey also noted that, "[a]ccording to a recent household survey of more than 3,700 women in Edo and Lagos, 8.8% of women who had had an abortion performed by a doctor had experienced complications that were treated in a private or government clinic." *Id.* at 159-60.

7. *Id.* at 159. The survey asserted that, "half of all women who have nonphysician abortions [that is 183,000] experience complications requiring treatment by a physician." *See* Henshaw, *supra* note 4, at 160.

8. FRIDAY E. OKONOFUA ET AL., CRITICAL ISSUES IN REPRODUCTIVE HEALTH: WOMEN'S EXPERIENCES OF UNWANTED PREGNANCY AND INDUCED ABORTION IN NIGERIA 20 (1996).

are attributable to complications of unsafe abortion."[9] The study also reveals that most abortions carried out by private doctors operating in private medical clinics had attendant high rates of complications.[10] It is estimated that in Nigeria, 1000 maternal deaths occur in every 100,000 live births, while in West Africa, the World Health Organization estimates that 12,000 deaths occur annually due to unsafe abortion.[11]

There is growing concern over teenage pregnancies in Nigeria and other African countries. Nearly two-thirds of cases of septic abortions come from girls between the ages of fifteen to nineteen.[12] Notwithstanding this shocking discovery, domestic African governments and their legal systems are still reluctant to squarely address the abortion quandary. It has been observed that, "the risk of maternal death for African women is 1 in 20 compared to 1 in 10,000 in developed countries."[13] What a shocking vacuum between two seemingly intertwined worlds. It is evident that the wide vacuum in maternal death rate between the developed and the developing world demonstrates that a large proportion of these unexpected and premature deaths arising from unsafe abortion are preventable.[14]

The above analysis reveals that the high rate of maternal mortality and morbidity in Nigeria is mainly as a result of women's recourse to non-physician providers, which in turn is due to the unduly restrictive abortion regime in Nigeria. Moreover, notwithstanding that non-physician providers perform more abortions in Nigeria than physicians, which leads to a high rate of complications, abortions by some private physician providers are equally shrouded with complications. Invariably, no matter the angle from which one views maternal mortality and morbidity in Nigeria, the law is always implicated. Complications resulting from physician providers translate to some degree of inefficiency on the part of medical practitioners in Nigeria. This inefficiency is underpinned by the restrictive stance of abortion laws. It is submitted that a liberalized abortion climate will make medical practitioners more responsible in the delivery of abortion services for four main reasons:

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9. *Id.* at 1.

10. *Id.* at 25.

11. *See* UN DEVELOPMENT PROGRAMME (UNDP), HUMAN DEVELOPMENT REPORT 154-155 (1996); *See also* WORLD HEALTH ORG., UNSAFE ABORTION: GLOBAL AND REGIONAL ESTIMATES OF INCIDENCE OF A MORTALITY DUE TO UNSAFE ABORTION WITH A LISTING OF AVAILABLE COUNTRY DATA (3d ed. 1998), www.who.int/reproductive-health/publications/MSM_97_16/MSM_97_16_abstract.en.html.

12. *See* W.M. Kabira, et al., *The Effect of Women's Role on Health: The Paradox*, 58 INT'L. J. GYNECOLOGY & OBSTETRICS 23, 26 (1997).

13. *Id.*

14. *See* WORLD HEALTH ORG., COMPLICATIONS OF ABORTION 13 (1995).

1) Reporting of the number of abortions performed will be improved and the government would have better records for statistical purposes. However, it should be cautioned that the names and personal details of users need not be included in the reports since the record is only needed for statistical purposes. This will help preserve the confidential information of abortion-seekers;[15]
2) Victims of medical negligence will be more willing to pursue their tort claims against erring practitioners;
3) The regulatory body of medical practice in Nigeria will be alert to discipline its members for breach of expected standard of practice;
4) The Nigerian Medical Council may be more willing to organize continuous medical education aimed at retraining its members on the use of current and safer procedures for the management of abortion and post-abortion complications.[16]

From an economic perspective, the reasons for the preference of non-physician providers might not be far fetched. The basic truth is that most of the women and girls seeking and accessing abortion are poor and lack the professional fees that physician providers require.[17] Besides, even when the financial constraint is removed, societal moral and religious predilections to abortion create substantial hindrance to the achievement of a safe reproductive community for women and girls. Almost all women and girls seeking and accessing abortion in Nigeria prefer having abortion in secret because of the

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15. *See* OKONOFUA, *supra* note 8, at 17. (stating that the 1996 study observes: "that a high proportion of the women [interviewed] mentioned the lack of confidentiality attendant with the use of doctors as an additional deterrent to the use of qualified doctors for the procurement of abortion."); *See also* M.K. Jinadu, et al., *Traditional Fertility Regulation Among the Yoruba of Southwestern Nigeria* 1 AFR. J. REPROD. HEALTH 56, 61 (1997) (describing a study conducted in 1990 among Nigerian Yoruba women and traditional healers, which aimed at identifying and describing the practice, preparation, and administration of traditional contraceptives, that observed the following: "When [the women were] asked why they preferred the use of traditional contraceptive methods to orthodox methods, approximately 85 percent of respondents mentioned the easy accessibility of the TMPs [traditional medical practitioners] and the assurance of privacy during consultation") (alteration not in original).

16. The 1996 study indicates that the most frequently used abortion procedure in Nigeria was dilation and curettage (D & C) whereas the most current, safest and effective method of pregnancy termination worldwide—manual vacuum aspiration (MVA)—was never mentioned. OKONOFUA, *supra* note 8, at 18. Moreover, RU was also not used. *Id.*

17. The 1996 study indicates that although most abortion costs are paid by the partners of the women (husbands or boyfriends), some women pay for the abortions themselves. *Id.* at 14. The study went on to observe that women "most frequently mentioned the high fees charged by doctors as the major deterrent to the use of doctors." *Id.* at 17. It is submitted that abortion dilemmas are mainly suffered by poor women in Nigeria because most rich women are financially capable of circumventing the restrictive domestic regime by traveling to foreign countries to access safe legal abortion. *See id.*

religious, cultural, and moral prejudices associated with it.[18] Additional health consequences that result from unsafe abortion are infertility, chronic disability, transfusion-related infections, and lack of emergency care for complications.[19]

B. Exemption Clauses

The full-prohibitive sections are sections 228, 229, and 230 of the Criminal Code,[20] and sections 233 and 234 of the Penal Code.[21] Abortion is totally prohibited under these sections, except when it is necessary to save the life of the mother. The relevant sections embodying the necessity test are section 297 of the Criminal Code and sections 232 and 235 of the Penal Code:

Section 297 of the Criminal Code:

> 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.[22]

Section 232 of the Penal Code:

> WHOEVER VOLUNTARILY CAUSES A WOMAN WITH CHILD TO MISCARRY shall, if such miscarriage be not caused IN GOOD FAITH FOR THE PURPOSE OF SAVING THE LIFE OF THE WOMAN, be punished with imprisonment for a term which may extend to fourteen years or with fine or with both (emphasis added).[23]

Section 235 of the Penal Code:

> WHOEVER before the birth of any child DOES ANY ACT WITH THE INTENTION of thereby preventing that child from being born alive or causing it to die after its birth and DOES BY SUCH ACT prevent that child from being born alive or causes it to die after its birth, shall, IF

18. According to a 1990 study conducted in Nigeria, women preferred traditional contraceptive methods to orthodox methods because of the easy accessibility of the traditional medical practitioners and the assurance of privacy during consultation. Jinadu, *supra* note 15.

19. See COMPLICATIONS OF ABORTION, *supra* note 14, at 15; *See also* Henshaw, *supra* note 4, at 14-15.

20. CODE CRIMINAL [C. CRIM.] ch. 21, § 228–30 (1990) (Federation of Nig.).

21. PENAL CODE [PENAL C.] § 233–34 (1963) (N. Nig.)

22. C. CRIM. ch. 21, § 297.

23. PENAL C. § 232.

> SUCH ACT BE NOT CAUSED IN GOOD FAITH FOR THE PURPOSE OF SAVING THE LIFE OF THE MOTHER, be punished with imprisonment for a term which may extend to fourteen years or with fine or with both (emphasis added).[24]

These exceptions constituting the necessity test cover voluntary abortion and not involuntary abortion that may occur as a consequence of prescriptions or administration of medical procedures. Of course, if abortion occurs through involuntary conduct, the mental element of the crime, intent, which is core to most offenses, will be lacking. As such no offense will arise. The only exception to this intent requirement is in rare instances of strict liability offenses, which do not require proof of mental elements.[25]

C. Origin of Dual Criminal Jurisdiction in Nigeria

All the sections of the Nigerian Criminal Code impacting abortion, in line with the abortion laws of most African commonwealth jurisdictions, are substantially adopted from the Offences Against the Person Act (Britain) of 1861,[26] and the Infant Life (Preservation) Act (Britain) of 1929,[27] but do not include the changes achieved in *R v. Bourne*[28] and the subsequent Abortion Act (Britain) of 1967, as amended, which reformed the 1861 Act.[29] These sections form part of the 'received' English law.[30] On the other hand, the Penal Code, which operates in the Northern states of Nigeria only, is drawn from both the

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24. § 235.

25. It is beyond the scope of this paper to attempt an exhaustive exploration of strict responsibility. For a comprehensive analysis of strict responsibility regime in the Nigerian criminal jurisprudence, *see* Victor N. Opara, *An Appraisal of the Doctrine of Strict Responsibility under the Criminal Code*, 5 JURIST 33 (1996).

26. Offences Against the Person Act, 1861, 24–25 Vict., c. 100, § 1 (Eng).

27. Infant Life (Preservation) Act, 1929, 19 & 20 Geo. 5, c. 34, §1(1) (Eng.).

28. The King v. Bourne, 1 K.B. 687 (Eng. C.C.A. 1939).

29. *See* Abortion Act, 1967, c. 87, § 1 (1967) (Eng.). The Act does not apply to Northern Ireland. On a more general note, the Nigerian Criminal Code was substantially based on the Queensland Criminal Code of Australia which itself was based on a code drafted by Sir James Fitzpatrick in 1879 and aimed at replacing the common law of crime in England, although the code was rejected by the British Parliament for whom it was initially drafted. *See generally* James S. Read, *Criminal Law in the Africa of Today and Tomorrow*, 7 J. AFR. L. 5 (1963).

30. The introduction of the main body of English law in Nigeria dates back to 1863 when the British colonial authorities enacted Ordinance No. 3 of 1863 following the creation of the Colony of Lagos in 1862. *See generally* A.E.W. PARK, THE SOURCES OF NIGERIAN LAW 1-12 (1963). More than a century and four decades after, the sources of law which the British colonial authorities established for the Colony of Lagos has remained a standard for the whole of Nigeria without many substantial changes. *Id.* Historically Nigerian law is derived from three sources, which are: (a) English Law—this comprises the general law of England which was introduced into or received by Nigeria; (b) Nigerian domestic legislation and case law; and (c) Nigerian customary law. *Id.* For a detailed historical analysis of the Nigerian legal system *see id.*

Indian Penal Code and the Scottish laws which are based upon the customary or common law of Scotland.[31] The enforcement of two codes with criminal liability content under one jurisdiction might appear strange to some legal systems since criminal laws are to a greater extent regulated by federal or central legislatures.

In 1954 there was a major regulatory shift in the Nigerian legal system. Prior to 1954 Nigeria had a unified system of law, and there was only one legislature for the entire country. Steps to decentralize the unified legislative body started in 1952 with the establishment of regional legislatures. In 1954 a full-fledged federal system of government with tripartite legislative jurisdictional lists was born in Nigeria. As a result, Nigeria was divided initially into three regions and a federal territory. The Northern region appointed a panel of jurists in 1958 to act as an advisory body to its government. The main task of the panel was to advise the Regional government on the application of both Moslem and non-Moslem laws.[32] The panel came up with the recommendation that a Penal Code Law and a Criminal Procedure Code Law be enacted and made applicable throughout the Region and that these laws should replace the Nigerian Criminal Code Ordinance[33] and the Nigerian Criminal Procedure Ordinance[34] both of which were, prior to the panel's recommendations, applicable throughout Nigeria. The adoption of the recommendations by the Regional government led to the enactment of the Penal Code in 1963.[35]

II. CONTEXTUAL ANALYSIS OF THE NECESSITY TEST

The issues raised by the exception clauses will be discussed in the course of this analysis. Some recurrent thresholds are that performance of the abortion be done "in good faith" through "surgical operation" with "reasonable care and skill" by "a person/whoever" and for the purpose of "preserving the mother's

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31. The Penal Code is substantially a replication of the Penal Code of Sudan, which in turn was drawn from the Indian Penal Code drafted by Lord Macaulay in 1834. *See generally* ALAN GLEDHILL, THE PENAL CODES OF NORTHERN NIGERIA AND THE SUDAN (London: Sweet & Maxwell 1963). Lord Macaulay had used the common law of England and Scotland as the corner stones of his draft.

32. In the defunct Northern Region and the present Northern states of Nigeria, the major substantive law that the courts administer is the Moslem Law of the Maliki School. *See* ASAF A. A. FYZEE, OUTLINES OF MUHAMMADAN LAW 18-20 (3 ed., 1964).

33. Nigerian Laws, 1948, c. 42 (In 1958 this Ordinance became known as the Criminal Code); CODE CRIMINAL ch. 42, § 228-30 (Federation of Nig.).

34. Nigerian Laws, 1948, c. 43. In the same vein in 1958, this Ordinance became known as the Criminal Procedure Act. *See* Laws of the Federation of Nigeria and Lagos, 1990, c. 43 (Criminal Procedure Act).

35. *See* PENAL CODE [PENAL C.] (1963) (N. Nig.).

life" or "saving the life of the woman."[36] These thresholds constitute core parts of the necessity test.

A. Reasonable Care and Skill

One of the thresholds in section 297 of the Criminal Code is that the abortion provider must exercise "reasonable care and skill." Moreover, the performance of the abortion is required to be "reasonable" when viewed from "the patient's state at the time and to all the circumstances of the case." These thresholds indicate that the context under which an abortion is performed invariably matters a lot, and that there are many areas of uncertainty that appear to be left to the discretion of the abortion provider. Section 297 is substantially adopted from subsection 1(1) of the Infant Life (Preservation) Act (Britain) of 1929.[37] However, that subsection does not contain the "reasonable care and skill," "reasonable performance," and "circumstantial" evidence requirements of section 297, all of which appear to have been imported from the decision of *R. v. Bourne*.[38] With respect to the reasonable performance requirement, every performance does not necessarily render abortion unreasonable. Where the performance is illegal,[39] then even objectively reasonable good faith cannot transform such an illegal abortion into a reasonable one. Such abortion-without-consent will amount to criminal battery. In that case, if the woman dies, the physician will be liable, since death will be as a result of intended abortion. The man equally may be punished as a criminal conspirator[40] or principal offender.[41]

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36. *See* CODE CRIMINAL [C. CRIM.] ch. 21, § 228-30 (1990) (Federation of Nig.).

37. *See* Infant Life (Preservation) Act, 1929, 19 & 20 Geo. 5, c. 34, §1(1) (Eng.).

38. *See Bourne*, 1 K.B. at 690 & 694. ("A MAN OF THE HIGHEST SKILL, ... performs the operation ... ON REASONABLE GROUNDS AND WITH ADEQUATE KNOWLEDGE, ... the jury are quite entitled to take the view that the doctor who, UNDER THOSE CIRCUMSTANCES AND IN THAT HONEST BELIEF, operates, is operating for the purpose of preserving the life of the mother") (emphasis added).

39. For example, this may occur where an abortion is intentionally performed on a woman without her consent for the convenience of her husband or boyfriend and the physician. The man could instruct the physician to cause his girlfriend to miscarry, probably because he is already married and does not want to obstruct the harmony in his home or does not desire a polygamous marriage. This scenario was played out in State v. Ade-Ojo, 12 CC.H.C.J. 27 (1972), where a man hired two medical practitioners to perform an abortion on his girlfriend. The man was charged and convicted, but the practitioners were not charged since they acted as prosecution witnesses. *Id.* However, the fact that the practitioners were neither charged nor convicted does not mean that their conduct was legally permissible. *Id.* Their escape route was simply a question of legal technicality: the State needed independent evidence to prove its case which largely depended on the evidence of the man or the practitioners. *Id.* The Court frowned at the conduct of the practitioners and the presiding Judge expressed his disgust in Page 31 of his judgment by promising to send a copy of the judgment to the Attorney General and the Nigerian Medical Council for appropriate disciplinary actions against the practitioners. *Id.* Although the statutory reasonable-performance threshold was not under review in this case, it appears the facts of the case fit nicely to the circumstances contemplated by this threshold.

40. *See* PENAL C. §§ 96 & 97, section 96 of which provides the following: "(1) When two or more

Moreover, as the Criminal Code does not define "skill," one is to conjecture whether nurses, midwives and, paramedics are repositories of contemplated abortion skill.

B. Surgical Operation

Abortion by purely medical procedures such as the administration of drugs will appear not to be accommodated within the Criminal Code exemption. This is because in medical parlance, surgery and medicine are considered to be somewhat different notwithstanding that they may appear inextricably intertwined in some material particular. The words "surgeon," "surgery," and "medicine" have been defined respectively as:

> [surgeon is] one who applies the principles of the healing art to external diseases or injuries, or to internal injuries or malformations, requiring manual or instrumental intervention. [In other words, he is] [o]ne who practices surgery.... The term *surgery*, comes from two Greek words signifying *the hand* and *work*, meaning a manual procedure by means of instruments.... The practice of *medicine*, in contradistinction to the practice of *surgery*, denotes the treatment of disease by the administration of drugs or other sanative substances.[42]

In *R. v. Edgal*,[43] the now defunct West African Court of Appeal was of the opinion that section 297 of the Criminal Code applied to surgical operations only. This surgical operation requirement indicates that this threshold adds to the risk of abortion users in Nigeria by unnecessarily exposing them to greater danger. Surgery is a complicated procedure and Nigerian health facilities may not boast of modern sophisticated surgical instruments and equipment which would guarantee safety to a higher degree, unlike their counterparts in

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persons agree to do or cause to be done—(a) an illegal act; or (b) an act which is not illegal by illegal means, such an agreement is called a criminal conspiracy." Section 97 outlines the punishment for criminal conspiracy. § 97.

41. C. CRIM. ch. 2, § 7. The man may equally be punished under the Criminal Code as a principal offender. *Id.* Section 7 of the Criminal Code provides the following:

> When an offence is committed, each of the following persons is deemed to have taken part in committing the offence and to be guilty of the offence, and may be charged with actually committing it, that is to say:—(a) every person who actually does the act or makes the omission which constitutes the offence; (c) every person who aids another person in committing the offence; (d) any person who counsels or procures any other person to commit the offence.

Id.

42. Bouviers's Law Dictionary 3209 (8th ed. 1984).

43. R. v. Edgal, 3 W.A.C.A. 133 (W. Afr. Ct. App. 1938).

developed countries that are technologically current. If the same result could be achieved through a purely medical procedure, like administration of drugs, why limit the woman's choice to surgery?

The health implications of this limitation would be highly appreciated when viewed from the alarming increase in the spread of HIV infection especially, in sub-Saharan Africa and Nigeria in particular.[44] There are cases where patients have contracted HIV infections through their surgeons.[45] Surgeons equally stand the risk of infecting or being infected with HIV from their patients. They are constantly exposed to patients' blood, and when their equipment or surgical instruments are not adequately sterilized, their facilities may be a disguised infection-transmitting channel. Improperly sterilized surgical instruments are basic means of spreading HIV infections to women and girls receiving abortions. Moreover, as a result of the possibility of hemorrhage during surgical operations, women and girls accessing abortion stand the risk of contracting HIV through transfusion of contaminated blood.[46] While it is acknowledged that surgeons owe a professional duty of care and skill to patients, abortion users may not have the moral support to bring up claims due to societal predilections towards abortion.[47] Moreover, even where such claims are sought, prosecutions on grounds of failure to provide such duties are rare in Nigeria.[48] Although the risk of patients' exposure to surgeons' HIV-infected

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44. According to the Federal Ministry of Health, reproductive health in Nigeria is highly deteriorating. Draft of the National Reproductive Health Policy and Strategy 9-10 (Federal Ministry of Health 2000). One major national indicator of this is "the continual increase of HIV sero-positivity rate among antenatal clinic clients from 1.4% in 1991/92 to 4.5% in 1995/96 and 5.4% in 1999." *Id.* The Ministry further observed that "there are at least 2.7 million sexually active Nigerians infected with the AIDS virus. Eighty per cent of HIV infections in Nigeria are contracted through sexual intercourse. *Other causes of [HIV] infection are through unsterile injections and the inadvertent transfusion of unsafe blood* and body piercing, scarification or cutting." *Id.* (emphasis added).

45. On risks associated with surgery, *see* Van Mol et al v. Ashmore, [1999] 168 D.L.R. (4th) 637 (Can.). On the implications of HIV infection for women, *see generally* Karen.H. Rothenberg & Stephen J. Paskey, *The Risk of Domestic Violence and Women with HIV Infection: Implications for Partner Notification, Public Policy, and the Law*, 85 AM. J. PUB. HEALTH 1569–74 (1995).

46. *See* Draft of the National Reproduction Health Policy, *supra* note 44.

47. Stigmatization can foster a climate of abandonment of one's rights. It may also mean that a woman who has a claim may not pursue it for fear of being labeled. A great deal of discrimination faced by abortion users is underpinned by social construct of morality and "normality."

48. To my knowledge, among the scant abortion cases in Nigeria, only two reported cases involved the prosecution of medical practitioners. Comm'r of Police v. Modebe, 1980 (1) NCR 367; State v. Johnson Oke, 9 C.C.H.C.J. 1305 (1975). Not surprisingly, the defendants were acquitted in both cases. *See* Isabella Okagbue, *Pregnancy Termination and the Law in Nigeria*, Vol. 21 No.4 STUD. FAM. PLAN. 197, 199 (1990) (observing that "[b]oth public prosecutors and the courts have traditionally been reluctant to prosecute and convict members of the medical profession for acts performed as part of their professional functions. With regard to abortions, in particular, the issue is compounded....").

body is so low that some commentators regard it as non-existent,[49] it has been correctly observed that:

> Surgeons or dentists may cut themselves through their protective gloves particularly in undertaking procedures in which they do not have sight of their hands, and they may then bleed into patients' bodies before it is surgically or otherwise appropriate for them to remove their hands.[50]

This observation is in line with current realities. Therefore, the exemption clause in the Criminal Code is a flagrant exposure of abortion users in Nigeria to greater risks of HIV infection to the extent that it permits abortion to save the woman's life only when it is performed through surgical operation. Comparatively, the Penal Code exemption, which is silent in section 232 as to the manner of achieving the life-saving objective and in section 235, which permits the life-saving objective to be achieved by "any act" appears preferable.

C. Performance of the Act by a Person or Whoever

The Criminal Code and the Penal Code permit "a person" and "whoever" respectively to carry out the necessary life-saving abortion. In other words, provided abortion is carried out in good faith to save the life of the mother, it appears the qualification of the person providing abortion is immaterial. These words are so sweeping that non-physician providers appear empowered. To that extent, the couching of the laws may be responsible for the high rate of maternal mortality and morbidity in Nigeria resulting from non-physician abortions. It must, however, be pointed out that in this regard, the Criminal Code exemption seems better than that of the Penal Code in that it requires the exercise of "reasonable care and skill" as seen above. But this comparison cannot be stretched too far because although the Penal Code does not specifically use the "reasonable care and skill" supplement, its definition of "good faith"[51] accords with the Criminal Code requirement of "reasonable care and skill." Deference should be made for some non-physician providers such as nurses, midwives and paramedics who may provide abortion services with reasonable care and skill since they are professionally qualified health personnel and may have observed

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49. *See* Susan L. DiMaggio, *State Regulations and the HIV-Positive Health Care Professional: A Response to a Problem that Does Not Exist,* 19 AM. J.L. & MED. 497, 497–99 (1993).

50. *See* Bernard M. Dickens, *Health Care Practitioners and HIV: Rights, Duties and Liabilities in* HIV, LAW, ETHICS, AND HUMAN RIGHTS—TEXTS AND MATERIALS 66, 92 (D.C. Jayasuriya ed., 199H).

51. See the analysis on "good faith" *infra* section II(E).

physicians carry out such procedures.[52] However, the inability to manage complications that may result occasionally is the more crucial point to note.

Due to the shortage of medical practitioners in most rural communities in Nigeria and the high cost associated with accessing medical practitioners, which most poor women and girls in Nigeria cannot afford, it is advisable that nurses, midwives, and paramedics be permitted to perform abortion at early stages of pregnancy. The international and African medical communities have endorsed nurses, midwives, and paramedics in the providing of abortion in the early stages of pregnancy, although with a requirement that they act under the supervision of a medical doctor who would intervene in case of potential emergencies.[53] The necessity test raises a paradox in that while the "any person/ whoever" threshold permits any person to perform an abortion, another threshold requires the use of reasonable care and skill, which has professional underpinnings. While it could be argued that physicians, as well as nurses, midwives, and paramedics, owe duty of care and skill to their patients, such duty cannot be expected of laypersons. An herbalist who does not know the medical composition of the herbs he administers to procure abortion cannot be expected to owe duty of care and skill, nor will a hospital clerk. Such professional duties are beyond laypersons. While such duties can be enforced against professionals through license-withdrawal, it is difficult to enforce these duties against people who have no license to protect.[54] Accordingly, the law

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52. It has been acknowledged that, "since some non-physician providers such as midwives, nurses and paramedics have obtained medical training ...[they] should be able to perform abortions that do not result in medical complications." *See* Henshaw, *supra* note 4, at 160.

53. On views of Africans *see* Fre' Le Poole-Griffiths, *The Law of Abortion in Ghana*, 9 U. GHANA L.J. 103, 123 (1972); Charles Ngwena, *The History and Transformation of Abortion Law in South Africa*, 30(3) ACTA ACAD. 32, 44–48 (1998) (observing that "[p]ermitting midwives to perform abortions in the first trimester is a realistic way of meeting a dire need. Abortions during this trimester are safer and can be performed medically without putting the patient unduly at risk."); On views of the international community *see* Rebecca. J. Cook & Bernard M. Dickens, *Abortion Laws in African Commonwealth Countries*, 25 J. AFR. L. 60, 73 (1981) (citing JOHN M. PAXMAN, ET AL., THE USE OF PARAMEDIDALS FOR PRIMARY HEALTH CARE IN THE COMMONWEALTH: A SURVEY OF MEDICAL-LEGAL ISSUES AND ALTERNATIVES (1979)); John Guillebaud, *Medical Termination of Pregnancy: Combined with Prostaglandin RU 486 is Effective*, 30 BRIT. MED. L.J. 352 (1990); Mary W. Rodger & David T. Baird, *Introduction of Therapeutic Abortion in Early Pregnancy with Mifeppristone in Combination with Prostaglandin*, LANCET, Dec. 19, 1987.

54. It has been observed that

> [t]raditional healers and, for instance, birth attendants significantly practice health care in many areas. ... A legal distinction remains, however, between academically qualified, professionally licensed health care practitioners such as physicians and nurses, and practitioners who have received no training that complied with widely recognized standards, who accept allegiance to no enforceable code of ethical practice, and whom the law would not hold to higher standards of knowledge, proficiency and care than are expected of a layperson. The legal rights, duties and liabilities of those who deliver health care services differ, depending on their status and the expectations

should specifically mention the category of persons contemplated within the necessity test as is the case with abortion laws of most commonwealth jurisdictions.[55]

D. Preserving/Saving the Woman's Life

This phrase appears to be central to the necessity test. An important issue that arises from an analysis of this threshold is the contextual meaning of "preservation of the mother's life" and "saving the life of the woman." These sections do not provide any specific criteria that would serve as a barometer for determining when abortion becomes necessary to save the life of the mother. The inability of the law to lay down any tangible criteria for determining when a pregnant woman's life deserves to be saved appears to be a welcome discretionary tool. It gives wide discretion to a medical practitioner to address a pregnant woman's circumstances based on his or her personal interpretation of the situation. Moreover, the use of phrases such as "reasonable," "ground of performance," "patient's state," and "all the circumstances of the case" reveal that the determination of the life-saving/life-preserving context is essentially a question of fact, and there is no absolute formula or bright line test. By permitting the medical practitioner to act within his discretion, the fear of inadequate evidence to prove reasonable grounds in the event of alleged illegal inducement or criminal participation is removed, thereby making it possible for medical practitioners to act when saving the life of the woman becomes apparently necessary.

This appears to heighten the object and purpose of the legislature, which is to create an exception to outright prohibition when saving the woman's life becomes paramount. The English abortion precedent-setting case, *R v. Bourne,*[56] construed section 58 of the British Offenses Against the Person Act of 1861, which is similar to the sections of the Nigerian Codes under review, as impacting on a physician abortion provider. While considering the meaning of the phrase "for the purpose of saving the life of the mother" the court opined:

> In cases where the doctor anticipates, basing his opinion upon the existence of the profession, that the child cannot be delivered without the death of the mother, it is obvious that the sooner the operation is

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they reasonably create of the availability and calibre of the services they offer. Dickens, *supra* note 50, at 67-68.

55. *See e.g.*, Abortion Act 1967, ch. 87, s. 1 (Eng.) (specifically using the words "registered medical practitioner(s)" to refer to the class of persons permitted to "terminate pregnancy"); CODE CRIMINAL ch. 46, § 287(1) (Can.) (Specifically using the words "a qualified medical practitioner ... in an accredited or approved hospital" to label the persons eligible to "procure miscarriage").

56. *Bourne*, 1 K.B. 687.

> performed the better. The law does not require the doctor to wait until the unfortunate woman is in peril of immediate death. In such a case he is not only entitled, but it is his duty to perform the operation with a view to saving her life ... I think those words ought to be construed in a reasonable sense, and, if the doctor is of opinion, on reasonable grounds and with adequate knowledge, that the probable consequence of the continuance of the pregnancy will be to make the woman a physical or mental wreck, the jury are quite entitled to take the view that the doctor who, under those circumstances and in that honest belief, operates, is operating for the purpose of preserving the life of the mother.[57]

In other words, the threshold is not limited to danger to life, but covers danger to therapeutic health as well.[58] A physician, who is of the opinion that a woman's life or health is likely to be endangered by the continuation of pregnancy, is protected by this phrase if he or she performs the abortion. The opinion need not be based on full conviction, but rather any reasonable belief, since the gathering of complete evidence might lead to the woman's death or irreversible danger to her health. In other words, only *prima facie* evidence is required if the object and purpose of the necessity test is to be achieved. According to the Supreme Court of Canada in *R v. Morgentaler,* it is a basic tenet of the criminal justice system that when a legislature creates a defense to a criminal charge, the defense should not be illusory or so difficult to attain that it is practically impossible.[59] Accordingly, the discretion given to the Nigerian medical community in this life-preserving threshold is a welcome development that aims to achieve the desired legislative aim of the drafters. The West African Court of Appeal in the Nigerian case of *R. v. Edgal,*[60] where four people were charged with unlawfully supplying drugs to procure an unlawful abortion, applied the thrust of the *Bourne* decision. The Court, in adopting the *Bourne* analysis, held that no abortion is unlawful when performed to save the life of the woman.[61]

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57. *Id.* at 693-94.

58. Unfortunately, it appears Nigerian courts are keeping sealed lips on this creative aspect of the *Bourne* decision. Even in *Edgal,* where the reasoning in *Bourne* was applied, the West African Court of Appeal steered away from engaging in this issue. 1 W.A.C.A. 133. However, at least one legal scholar is optimistic that although this aspect of *Bourne* remains to be judicially explored in Nigeria, it is likely that the courts will adopt the entire reasoning in *Bourne* because English decisions are persuasive authorities in Nigeria. *See* Okagbue, *supra,* note 48, at 198.

59. R. v. Morgentaler, 44 [1988] D.L.R. (14th) 385, 386 (Can.).

60. *See Edgal,* 4 W.A.C.A. 133.

61. *Id.*

Another issue that arises under this life-preserving theme is the legitimacy of the invocation of conscientious objection by medical personnel under the circumstances of a life-threatening pregnancy. Although Nigerian criminal jurisprudence does not make provisions for right of conscientious objection in abortion matters, the Nigerian Constitution does provide for such right.[62] Moreover, it has become part of the criminal justice system of most commonwealth jurisdictions to include such rights in abortion laws.[63] The exercise of right of conscientious objection is limited, however; it is not available to a medical practitioner when a treatment is necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman.[64] Accordingly, the Nigerian medical community cannot validly invoke this right as a mechanism for refusing to perform abortion when the life of a pregnant woman is jeopardized. Apart from the fact that such a refusal will constitute an element of criminal negligence under the Nigerian criminal jurisprudence, it would also go against medical ethics, which is founded on the saving of life.[65] Besides, such a refusal to render life-saving abortion will serve no public interest.

In addition, the life-preserving threshold plays an important role in determining the duties of medical practitioners when confronted with women experiencing complications as a result of unsafe or incomplete abortion. It is not uncommon to see instances where women who are experiencing complications are denied emergency care in hospitals as a result of either misinterpretation of the legal restrictions of abortion or the moral/religious inclination of the medical practitioner. The bleak atmosphere is even more complicated when a girl or unmarried woman is involved; most hospitals find it unreasonable to provide such services. It has been argued that:

> [C]omplications require emergency assessment and management. These women need emergency care which must be provided even

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62. *See* NIG. CONST. (Constitution of the Federal Republic of Nigeria, 1999) ch. 1V (Fundamental Rights), § 38(1) ("Every person shall be entitled to freedom of thought, conscience and religion...").

63. *See e.g.*, Termination of Pregnancy Act (Zambia) 1972 § 4; *See also* the Abortion Act, 1967, § 4 (Eng.).

64. This limitation of right to conscientious objection is embodied in abortion laws of most commonwealth countries as follows: "Nothing shall affect any duty to participate in any treatment which is necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman." Termination of Pregnancy Act, 1972, § 4(2) (Zambia); *see also* The Adoption Act, 1967, §4(2) (Eng.).

65. This argument is supported by the observation that "if a case arose where the life of the woman could be saved by performing the operation and the doctor refused to perform it because of his religious opinions and the woman died, he would be in grave peril of being brought before this Court on a charge of manslaughter by negligence." *Bourne*, 1 K.B. 687.

> where there are legal restrictions on induced abortion. Assessment of the woman's condition and provision of services must be available on a 24-hours-a-day basis from the point at which the woman first contacts the health care system to the point at which she receives the care she requires.[66]

It is against health doctrines for women presenting with complications emanating from unsafe or incomplete abortion to be denied emergency assessment and treatment. As the medical profession is founded on the saving of lives, and as the overarching legislative aim of creating the exceptions to outright prohibitive abortion in Nigeria is to save the life of pregnant women who are prejudiced by the continuation of pregnancy, the Nigerian medical community must live up to its expected professional standards, and must, as a matter of necessity, provide adequate medical treatment to victims of unsafe or incomplete abortion.

E. Good Faith

While the Criminal Code is silent on the meaning of "good faith," the Penal Code in section 37 defines "good faith" as "nothing is said to be done or believed in good faith which is done or believed without due care and attention."[67] In 1979, the Federal Court of Appeal in *Dr. D.I. Pam Tok v. The State* had the opportunity of construing the Penal Code "good faith" threshold as it applies to abortion providers in Nigeria.[68] Dr. Tok, a medical practitioner, was charged with causing the death of a woman in the process of procuring abortion contrary to section 232 of the Penal Code. The prosecution argued that Dr. Tok performed an operation and thereby caused a secondary school student to miscarry a "three month" old child.[69] Dr. Tok's defense was that he performed the operation when the student had a partial miscarriage, was bleeding, and the operation was necessary to save the life of the student.[70] There was evidence that the deceased had unsuccessfully attempted to procure her own abortion before consulting the practitioner.[71] Although the surgical operation was performed in a hospital, several irregularities surrounded Dr. Tok's conduct including non-registration of the patient in the hospital roster.[72] Dr. Tok's defense of treating for an incomplete abortion was rejected by both

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66. *See* Complications of Abortion, *supra* note 14.

67. *See* Penal Code [Penal C.] § 233-34 (1963) (Northern Nig.)

68. Pam Tok v. The State FCA/K/84/78 (unreported decision) (Federal Court of Appeal 1979) (Nasir, Uwais & Ademola JJ.F.C.A).

69. *Id.*

70. *Id.*

71. *Id.*

72. *Id.*

the trial and appellate Courts because his general conduct did not portray "good faith."[73] Moreover, The Federal Court of Appeal held that the onus was on the appellant practitioner to show that he acted in good faith for the purpose of saving the life of the patient.[74] He was accordingly convicted under section 232 of the Penal Code.

The combined effect of a purposive statutory interpretation and judicial construction of good faith appears to be very clear; it restricts the procurement of a life-saving abortion to any person who can prove that they exercised due care and attention during delivery of the medical services. This is a question of fact to be proved by the amount of evidence gathered by the abortion provider and their general conduct during delivery of the services. While the legislative aim of the drafters may have been well intended, the omnibus word "whoever," as analyzed in section C of this paper, renders the legislative intention a mere formality. In other words, the diligence requirement is not restricted to qualified medical personnel, but transcend all categories of people who can prove they acted with "due care and attention" while providing abortion. To that extent, "good faith" in its present form, irrespective of its statutory interpretation in the Penal Code, appears devoid of procedural content. Of course, non-physician providers can equally claim to have acted diligently in their services to women and girls accessing abortion. The rest will be left for evidence to determine whether due diligence was actually exhibited, which determination may not require the exhibition of medical professionalism. However, this unfortunate situation could be avoided if "whoever" and "a person" are replaced with the proper professional class contemplated by the drafters. In that case, "good faith" would have more effective procedural underpinning since the observance of "due care and attention" will be restricted to only the permitted class of medical personnel. As such, the due diligence requirement will transform to a creative discretionary tool that most trained medical personnel sympathetic to the course of women can effectively rely upon in making their services available to women seeking abortion.

On the other hand, a broader construction of "good faith" might reveal some hidden legislative intentions. The traditional notion of good faith is to require a physician abortion provider to obtain an independent medical opinion of his colleagues before undertaking any abortion procedure. This traditional meaning is given content and expression in the British Abortion Act of 1967[75] which exempts a physician abortion provider from criminal responsibility if two other registered medical practitioners concur that the continuation of pregnancy

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73. Pam Tok v. The State FCA/K/84/78 (unreported decision) (Federal Court of Appeal 1979) (Nasir, Uwais & Ademola JJ.F.C.A).

74. *Id.*

75. *See* Abortion Act, 1967, c. 87, § 1 (Eng.).

would endanger the life of the pregnant woman, or cause injury to the physical or mental health of the pregnant woman, or cause substantial physical or mental handicap to the unborn child.[76] However, this peer-concurrence requirement does not apply where the physician abortion provider is unilaterally of the opinion that abortion is immediately necessary to save the life or to prevent grave permanent injury to the physical or mental health of the pregnant woman.[77] Another commonwealth jurisdiction that *de jure* requires peer concurrence is Canada. Section 287 of the Criminal Code of Canada[78] is the abortion law in Canada *de jure*. This section exempts a physician abortion provider from criminal responsibility only where he, among other requirements, obtains the approval of a three-person therapeutic abortion committee. The procedural technicalities required in obtaining this committee approval was vehemently disapproved by the Supreme Court of Canada in the celebrated abortion-liberalizing case of *R. v. Morgentaler*.[79] The Court was of the opinion that the interest in the life or health of a pregnant woman, which Parliament held out to take precedence over the interest in prohibiting abortions when the continuation of the pregnancy of the woman would be likely to endanger her

life or health, was entrenched at least as a minimum when the right to life, liberty and security of the person was enshrined in section 7 of the Canadian Charter of Rights and Freedom.[80] It noted that

> [a]n aspect of the respect for human dignity on which the Charter is founded is the right to make fundamental personal decisions without interference from the state ... The decision of a woman to terminate her pregnancy falls within this class of protected decisions. It is a decision which has profound psychological, economic and social consequences for the pregnant woman. Section 251 clearly violates this right to liberty since it takes the decision away from the woman and gives it to a committee.[81]

Discussing the impact of this committee-approval requirement the Court argued that the present legislative scheme in Canada not only subjects a pregnant woman to considerable emotional stress as well as unnecessary physical risk but that it leads to an even deeper flaw in asserting that a woman's capacity to

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76. § 1(1).

77. § 1(4).

78. *See* CODE CRIMINAL ch. 46, § 287(1) (Can.).

79. *See Morgentaler*, 44 D.L.R. (14th) at 385-86.

80. CAN. CONST. (Constitution Act, 1982) pt. I (Canadian Charter of Rights and Freedoms), § 7.

81. *See Morgentaler*, 44 D.L.R. (14th) at 388.

reproduce is not to be subject to her own control.[82] The *Morgentaler* Case is the *de facto* abortion law in Canada, having overruled the abortion provision of the Criminal Code of Canada.

This extended construction of good faith operates as an access-limiting factor. Apart from the delay associated with it, there is also the danger of financial impediment on women accessing abortion. Accessing professional medical opinion of the would-be committee may involve some cost to the woman. In Nigeria, the overall cost of procuring abortion in most cases is borne by the partners of the women accessing abortion. However, in some cases, the women pay for the abortions themselves.[83] This is unlike what occurs in some advanced commonwealth jurisdictions where such costs are paid through government health insurance plans. As such, the requirement of committee approval will likely increase the overhead expenses of women and girls seeking and accessing abortion. Therefore to require that a medical committee be consulted before a pregnant woman or girl could access abortion indirectly means denying the 'pregnancy victim' an opportunity of accessing abortion. This creates a dichotomy between appearance and reality, between availability and accessibility of abortion. In other words, a systemic inequality is triggered by this extension in as much as poor women and girls will be unwittingly excluded from accessing abortion. This obviously will run counter to internationally endorsed instruments of equal rights jurisprudence.[84] As such, it is thought that Nigerian society is not ripe for the extended traditional committee-approval model of good faith.

The maintenance of the present statutory meaning appears to be a better viable option. The failure of the traditional committee-approval model in Canada, for instance, illustrates that the model only adds to the vulnerability of women and girls. Hence this model will serve no public purpose in Nigeria. Besides, it has the potential to defeat the overarching legislative aim of the drafters in creating exception to outright prohibition of abortion when saving the life of the woman becomes necessary. In addition, one of the reasons why Nigerian women and girls patronize backstreet abortionists is because of the secrecy associated with such clandestine services.[85]

Invariably, an imposition of committee-approval requirement will amount to more publicity which Nigerian women and girls are likely to shy away from. This will have the negative effect of forcing them back to backstreet providers at the detriment of their lives and health. Already abortion statistics have

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82. *Id.*

83. *See* OKONOFUA, *supra* note 8, at 14.

84. *See e.g.*, Convention on the Elimination of All Forms of Discrimination Against Woman, *opened for signature* Dec. 18, 1979, pt. I, art. 1, 1249 U.N.T.S. 13, 16.

85. *See* Jinadu, *supra* note 15; *see also* OKONOFUA, *supra* note 8, at 17.

revealed an enormous increase in the death as well as complications in the health of women accessing abortion through backstreet abortionists; there is therefore no public purpose served by a further complication of the bleak atmosphere. Accordingly, the extended traditional committee-approval meaning of good faith should be resisted in Nigeria since our present medical history does not give room to that. Such extensions will only muffle and gag the legislative intention. As the present statutory definition in section 37 of the Penal Code is clear, no attempt should be made to undertake any further voyage of discovery; at best that would only amount to a fishing expedition which may not properly address present realities in Nigerian society.

III. POSTSCRIPT ON PROPOSED LEGISLATION: THE MATERNAL AND CHILD WELFARE, HEALTH SERVICES BILL OF 2004

Nigeria has always been less poised than other Commonwealth jurisdictions to pursue a holistic reform of abortion law. This reluctance may be due to the fact that in a secular and constitutional democracy like Nigeria, the sensitive issue of abortion generates pluralistic and dichotomous views, which are played out in the moral, religious, ethical, cultural, political, and legal perceptions of society. Our experience under the present abortion laws thus far has not been entirely satisfactory and Nigerian case law has had a checkered history with respect to the issue of abortion. In 1981, as a result of the toll of abortion on the life and health of Nigerian women and girls, the Nigerian Society for Gynecology and Obstetrics sponsored a Termination of Pregnancy Bill[86] Unfortunately, the National Assembly did not approve that benign gesture. Fortunately another attempt has been made in 2004 to stamp an era of emancipation of Nigerian women and girls from untold abortion hardship. Senator Stella Omu, of the House of Senate recently introduced the Maternal and Child Welfare, Health Services (Procedure, etc) Bill of 2004 ("the Bill") to the National Assembly.[87] The Bill will concomitantly provide a legal framework for overhauling an abortion regime that has marginalized, oppressed and killed thousands of women and girls; it will revolutionize abortion law in Nigeria.[88] The Bill avoids most of the confounding technicalities of the present laws. Undoubtedly, it is resounding success for those scholars who have advocated for a liberal abortion climate in Nigeria.[89] This section does not aim at

86. *See* Adi, *supra* note 1.

87. Maternal & Child Welfare, Health Services Bill (2004).

88. *Id.*

89. J.B. Akingba & S.A. Gbajumo, *Procured Abortion: Counting the Cost*, 7(2) J. NIG. MED. ASS'N 17 (1970). For a sequential ordering of compendious scholarly papers on Nigerian abortion medico-legal regime, *see* J.B. AKINGBA, THE PROBLEM OF UNWANTED PREGNANCIES IN NIGERIA TODAY (1972); J.B. Akingba, *Abortion, Maternity, and Other Health Problems in Nigeria*, 7(4) NIG. MED. L.J. 465 (1977); Adi,

considering the Bill in its entirety, but rather closely engages only the provisions that either expressly, implicitly or potentially impact on abortion. These provisions are charted in line with their concomitant effect of amending or reforming the abortion provisions of the Nigerian Criminal Code and Penal Code.

Section 5(1)(c) of the Bill makes it an offence for

> any person who through any act of negligence or omission or dereliction of his lawful duties causes or influences, however remotely, the miscarriage or termination of the pregnancy of any woman; provided [that] no medical doctor or nurse/midwife shall be criminally liable for termination of a pregnancy to save the life of a woman.[90]

The punishment for this offence is "a fine of 350,000 naira or imprisonment for a period not exceeding five years or both such fine and imprisonment" (section 6(2)).[91] These two sections are the only sections that impact on abortion apart from the interpretative section 9, which defines the terms as used in the Bill. These sections will potentially repeal sections 228, 229, 230, and 297 of the Criminal Code and sections 232, 233, 234, and 235 of the Penal Code all of which presently govern abortion in Nigeria. Of more particular interest to this paper are the balances of the complex interplay of the abortion sections of the Bill and sections 297of the Criminal Code and 232 and 235 of the Penal Code. These provisions in the present laws make up the necessity test.

At first blush, it is clear that the Bill has succeeded in eliminating most of the confounding clauses of the necessity test such as "performance of abortion by any person (or whoever)."[92] The Bill expressly permits "medical doctor or nurse/midwife" to perform abortion.[93] This categorization will assist in containing backstreet abortion providers. One shortcoming of this welcome categorization formula is the elimination of paramedic personnel. Common sense knowledge will reveal that paramedics are as competent as nurses or midwives, and in some cases may be more qualified. This observation is due to the fact that some paramedics are qualified doctors from foreign jurisdictions who have not yet been licensed by their jurisdiction of residence. Accordingly, shutting them out from the list of permitted abortion providers may not be the

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supra note 1; T.B.E. Ogiamien, *A Legal Framework to Liberalize Abortion in Nigeria*, 1988-91 NIG. CURRENT L. REV. 107; Okagbue, *supra* note 48, at 197; OKONOFUA, *supra* note 8; Henshaw, *supra* note 4, at 159; WOMEN'S HEALTH AND ACTION RESEARCH CENTRE, ABORTION LAW IN NIGERIA: THE WAY FORWARD (2000).

90. Maternal & Child Welfare, Health Services Bill (2004).

91. *Id.*

92. *See* C. CRIM. ch. 21, § 297; PENAL C. §§ 232, 235.

93. *Supra*, note 87, at § 5(1)(c).

best option. In view of the somewhat high rate of maternal mortality and morbidity resulting comparatively from Nigerian physician abortion providers, nurses, midwives and paramedics,[94] it is recommended that all classes of legal abortion providers--medical practitioners, nurses, midwives, and hopefully paramedics, be required to undergo some prescribed retraining. This goal can easily be achieved through section 8 of the Bill, which grants the Federal Minister of Health the "power and responsibility to oversee performance of the instructions of this Act."[95]

The Bill has also succeeded in getting rid of "reasonable care and skill."[96] This riddance is a welcome development in that the categorization of permitted abortion providers invariably accomplishes this task. All registered medical personnel are under statutory regulatory bodies. These bodies have rules of professional responsibility that include duties of professional skill and competence in service delivery to patients. The clause "surgical operation"[97] is not part of the Bill. This riddance is a good development because it leaves open the suitable abortion procedure to the permitted abortion providers. A cursory review of Nigerian abortion cases reveals that most abortions are achieved through administration of drugs.[98] The Bill does not make any reference to "good faith" which is one of the thresholds in the present law.[99] This silence is good because it avoids the potential danger of interpreting "good faith" broadly to encompass medical peer-approval and consent, which will obviously pose a lot of delays in abortion matters.[100] The existing interpretation of this nebulous concept has too much uncertainty and ambiguity for effective application within the Nigerian criminal justice system.

More importantly the Bill reinforces the need to provide abortion "to save the *health* and life of a woman" (emphasis added).[101] This is an extension of the "preserving/saving the woman's life"[102] threshold in the present laws and appears to be the only footprint of the necessity test thresholds that is retained by the Bill. The Bill, while recognizing the need to provide abortion to save the

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94. *See* Henshaw, *supra* note 4, at 162.

95. *See* C. CRIM. ch. 21, § 297.

96. *Id.*

97. *Id.*

98. *See* State v. Njoku, E.C.S.L.R. 638 (1973); State v. Johnson Oke, 9 CC.H.C.J. 1305 (1975); Commissioner of Police of Midwestern Region of Nigeria v Oruware, 1 All N.L.R. Par II, 85 (1974); *Modebe*, 1 N.C.R. 367; R. v. Ejikeme, 10 W.A.C.A.. 252 (1944); *Edgal*, 4 W.A.C.A.133 (1938); *Ade-Ojo*, 12 CC.H.C.J. 27; R. v. Idiong and Umo, 13 W.A.C.A. 30 (1950); and *Tok*, FCA/K/84/78.

99. *See* C. CRIM. ch. 21, § 297. .

100. Abortion Act, 1967, ch. 87, § 1 (Eng.); *see also* C. CRIM. ch. 46, § 287(1).

101. *See* C. CRIM. ch. 21, § 297; PENAL C. §§ 232, 235.

102. *Id.*

life of the woman, goes beyond strictly saving the life of the woman, which is the only permitted ground under the present laws, to include saving the health of the woman,[103] which includes therapeutic health. This is a great achievement. It literally codifies the *Bourne* decision. Moreover "health" is defined in section 9(1) of the Bill to mean "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[104] This is in accord with World Health Organization's meaning of health. As a result of this subtle but fundamentally important shift in the life-saving analysis, it is possible for much to be achieved theoretically through this medium. The heuristic potentials of this provision, which advocates can harness, include demanding for abortion for any of the following grounds:

a) Where the continued pregnancy would endanger the life of the pregnant woman or constitute a serious risk to her physical health;
b) Where the continuation of the pregnancy would constitute a serious threat to the pregnant woman's mental health and create a danger of permanent damage to her mental health;
c) Where there was a serious risk that the child to be born would suffer a physical or mental defect of such a nature as to be irreparably handicapped;
d) Where the pregnancy was a result of unlawful sexual intercourse including rape, incest or intercourse with a minor or mentally defective female unable to appreciate the consequences of intercourse or bear parental responsibilities.

With respect to the last option, theoretically the expanded clause could be axiomatic to advocacy in abortion for victims of rape and incest, however some practical and technical difficulties may defeat this benign and rationally connected objective. There is the need to reduce the trauma and emotional distress of victims of rape and incest by broadening the grounds for legal abortion to expressly include rape or incest, contrary to observations canvassed elsewhere.[105] In the English case of *R. v. Bourne*[106] mentioned earlier, an obstetric surgeon performed an abortion on a 15-year old girl who was raped on the grounds that she would otherwise have become a mental wreck. This case

103. Maternal & Child Welfare, Health Services Bill (2004), § 5(1)(c).

104. *Id.*

105. *See* Okagbue, *supra* note 48, at 203 (observing that "[r]ape and incest sometimes serve as indications for abortion in various jurisdictions. As a separate indication, this ground may be somewhat superfluous because it may be more properly subsumed under the medical indication of risk of injury to the physical or mental health of the pregnant woman.").

106. *See Bourne*, 1 K.B. 687.

is very popular in most commonwealth jurisdictions mainly because of its expansive defense of therapeutic abortion far beyond the necessity test to encompass the protection of the physical or mental health of the woman.[107] An express inclusion of rape or incest as permissible grounds for abortion will create a more practical climate for victims to have recourse to abortion facilities without much difficulty, and will also place the burden on the state to prove the contrary. Otherwise, using the health definition of the Bill may not easily achieve this objective for victims of rape or incest, as the burden of proving rape or incest may be placed on them. The high cost of accessing expert evidence, coupled with the general bureaucracy that surrounds most Nigerian facilities may severely inhibit this worthwhile legislative intention.[108] It is disheartening to prevent victims of rape from accessing abortion considering the general circumstances surrounding their dilemma. Arguably, government is to blame for the porous security in the country, which intensifies the vulnerability of women. Failure to treat rape as an indication for abortion translates into government insensitivity of national realities. This joining of the theoretical concerns of rape and incest with their practical impact on abortion should be a central concern of policy makers and advocates.

Overall, although the Bill may not achieve a veritable haven for those seeking abortion, since abortions by physician providers have had some consequences on women's reproductive health as well, the Bill's abandonment of the confounding thresholds characterizing the present laws appears to have

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107. *Id.*

108. From my experience in campus journalism as Senior Staff Writer, Editor, Associate Editor and Editor in Chief of a Nigerian campus magazine—KAMPUSWATCH, University of Benin—from 1993 through 1998, there was hardly any week during academic sessions that at least one girl was not raped on campus. Most of the victims chose not to report the violation because of a myriad number of factors, including humiliations from colleagues and peers; rejection by friends; potential effects on the victim's future chances of marriage; security concerns, and most, if not all, of the rape offenders were members of secret cults who could go to the extent of killing to defend their selfish interests and lopsided anti-social cult values. A rape victim who reported the incident would be subjecting herself to further risks, gang rape and possible death; and finally, the university communities do not have enough programs that could enhance detection of campus crimes or encourage victims to report their ordeals. Unfortunately, Nigerian campus magazines do not report all the anomalies occurring on campus because of inadequate security measures to protect their writers in the event of attacks from clandestine cults. These secret cult activities fly in the face of the clear wording of section 38(4) of the Nigerian Constitution: "Nothing in this section [right to freedom of thought, conscience and religion] shall entitle any person to form, take part in the activity or be a member of a secret society." NIG. CONST. (Constitution of the Federal Republic of Nigeria, 1999) ch. 1V (Fundamental Rights), § 38(4). *See* Lambert Oghenerobo Jr., *Cult War: Uniben Under Siege,* 1(8) KAMPUSWATCH 9 (1996); *Who Killed Williams Ubong?* 1(9) KAMPUSWATCH 8 (1997). On the national scene, rape incidence is also high especially during inter-ethnic riots or religious conflicts. Soldiers and police personnel deployed to quell those riots and conflicts seize the opportunity to rape innocent women and girls. *See, e.g.*, HUMAN RIGHTS WATCH, BACKGROUND REPORT: THE DESTRUCTION OF ODI AND RAPE IN CHOBA (1999), http://www.hrw.org/press/1999/dec/nibg1299.htm.

the potential of downplaying or reducing the consequences emanating from physician providers. Medical practitioners will be more willing to provide abortion services based on their subjective interpretation of "saving the health and life of a woman."[109] Abortion will be performed in a more secure atmosphere; secrecy is bound to dwindle as a result of the Bill's openness. The close supervision of the law will encourage users to pursue their claims in the event of medical negligence, and will also have the effect of improving the efficiency of physician providers. On the whole, the Bill will result in a win-win situation. Another important accomplishment of the Bill will be the creation of a uniform abortion law in Nigeria. By concomitantly repealing the abortion provisions of the Criminal and Penal Codes, the Bill would achieve an incremental harmonization of the somewhat divergent Codes.

IV. CONCLUSION & RECOMMENDATIONS

While the objective of the necessity test is to provide an escape route from a fully prohibitive abortion regime, some of the means chosen to advance that objective appear unsuitable. Some of the thresholds in their present state neither present a veritable haven nor viable refuge for women and girls whose lives are jeopardized by the continuation of pregnancy. The words "whoever" and "a person" should be expunged from the exception clauses; in their place, words capable of specifically identifying the contemplated class of persons permitted to perform abortion should be substituted. This categorization is in order to exclude backstreet abortionists. On the other hand, the present statutory meaning of "good faith" should be maintained since an extended meaning will trigger technicalities and procedural dangers.

It is advisable that qualified nurses, midwives, and paramedics be permitted to perform abortions at early stages of pregnancy. This is for practical accessibility purposes in view of the dearth of medical practitioners in most Nigerian rural communities, coupled with the high cost of accessing medical practitioners. This may bridge the gap between availability and accessibility. In Nigeria, maternities are recognized birthing centers that are owned and run by nurses and midwives. So far, the Nigerian public appears satisfied with their services. Permitting them to diversify into abortion at early pregnancy will presumably be acceptable too. However, they should be made to consult and work with a medical practitioner in case of potential emergencies. The statutory means of achieving life-saving abortion must be expanded to include purely medical procedures, like administration of drugs. Unfortunately, the present "surgical operation" channel is too restrictive and appears to permit only

109. Maternal & Child Welfare, Health Services Bill (2004).

medical practitioners to perform abortion. This narrow channel should be abandoned.

It is recommended that the National Assembly set up a law reform commission with the aim of carrying out a program of research into abortion. The commission should be given the task of conducting opinion polls aimed at getting the perceptions of society towards abortion. The public opinion that existed as at the time the laws were enacted might have shifted substantially. As the current opinion of members of society help to determine what the law should be, it is not jurisprudentially justifiable for laws enacted many decades ago to remain in force without revision. It does not help our legal system to have a jurisprudence that is static and rigid, undermining innovations, technology and modern realities. It does not improve our legal system to have a jurisprudence that holds tenaciously to old time tradition and belief even when it has dawned on us that the world is changing for the better. Accordingly, it has been argued that:

> It is revolting to have no better reason for a rule of law than that so it was laid down in the time of Henry IV. It is still more revolting if the grounds upon which it was laid down have vanished long since, and the rule simply persists from blind limitation of the past.[110]

The text of the British Offences against the Person Act of 1861, which substantially constitutes the abortion laws in Nigeria, is more than two centuries old.[111] It therefore makes no practical sense nor serves any public purpose that an antiquarian law should continue to exist without regard to social dynamics and prevailing realities. There is no justifiable reason for Nigeria to continue its tenacious loyalty to the outdated Act.

It is further recommended that the Nigerian Judiciary should bring creativity to bear in abortion matters. As this paper has revealed, it was the creative interpretation of Justice Macnaghten in *R. v. Bourne* that motivated the British Parliament to amend and clarify the Offences Against the Person Act of 1861.[112] This is embodied in the present Abortion Act of 1967. In a similar vein, the Canadian example is equally illustrative of judicial creativity. It is the creative judgment of the Supreme Court of Canada in *R. v. Morgentaler* that is presently the *de facto* abortion law in Canada. That case overruled the statutory abortion provisions in Canada. Moreover, a look at three U.S. Supreme Court

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110. Justice Holmes, *The Path of the Law*, 10 HARV. L. REV. 61 (1897).

111. *See Bourne* 1 K.B. at 690 (in which Macnaghten J. observed that: "The defendant is charged with an offence against s. 58 of the Offences Against the Person Act, 1861. That section is a re-enactment of earlier statutes, the first of which was passed at the beginning of the last century in the reign of George III.").

112. *Id.*

cases: *Griswold* (1965); *Eisenstadt* (1972) and *Roe v. Wade* (1973) reveals that although the U.S. Congress did not at anytime in between these cases change the law, the Court brought about a fundamental change which virtually heightened the jurisprudence of individual autonomy and to some reasonable extent equality rights jurisprudence in the American legal system. Nothing prevents Nigerian courts from flexing similar judicial creative muscles.

This analysis has shown that induced abortion is prevalent in Nigeria notwithstanding the restrictions of the law. It would therefore be necessary for Nigerian government to face present realities by developing policies that aim to address this critical issue in order to reduce the high rate of maternal mortality and morbidity arising from this practice. The present abortion laws, from all indications, appear to have failed in that the aim of unduly restricting abortion is to prevent women and girls from seeking and accessing abortion, notwithstanding, the rate of abortion still continues to escalate daily. Invariably, the end that the law was designed to achieve has been defeated. Justice Holmes noted, "[A] body of law is more rational and more civilized when every rule it contains is referred articulately and definitely to an end which it subserves...."[113]

Nigerian women and girls do not seem to be deterred by the legal consequences of the "crime" of abortion. The aftermath, however, is that most of the abortions are carried out in medically unsafe environments, thereby endangering the lives of users. The law is responsible for this loss of life. It therefore behooves the Nigerian National Assembly to amend the law in order to make it conform to modern reality. A viable alternative mechanism would be the adoption of a somewhat liberal approach. This anticipated liberal formula can easily be achieved through the enactment of the abortion provisions (section 5) of the Maternal and Child Welfare, Health Services Act of 2004, with thorough amendments to some other parts of the Bill. It is hoped that this second opportunity will not be wasted again.

113. Holmes, *supra* note 111.