Abortion Laws and the Nigerian Woman: A Case for the Liberalization of Abortion Laws in Nigeria

OKOGBO, Awoloye Blessing Ph.D

Department of Sociology, Faculty of Social Sciences, Ambrose Alli University, Ekpoma, Edo State. Nigeria.

Corresponding Email: blessingokogbo@aauekpoma.edu.ng

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ABSTRACT

Nigeria's restrictive abortion laws that is embedded within the *Criminal Code* (applicable in southern states) and the *Penal Code* (applicable in northern states) only permit termination of pregnancy only to save the life of the mother. This restrictive legal framework has contributed significantly to the prevalence of unsafe abortion practices, maternal morbidity, and mortality among Nigerian women. This paper argues for the liberalization of abortion laws in Nigeria based on ethical, human rights, public health, and socio-economic grounds. Using a mixed-method approach. Empirical data from Ekpoma and Irrua (n = 584; in-depth interviews, FGDs, key informants) show a high prevalence of clandestine abortion (32.9% reported ever having an abortion) with most procedures performed outside formal health facilities by patent medicine vendors, traditional practitioners, or via self-induction, resulting in high rates of bleeding, infection, and long-term reproductive harm, while qualitative findings highlight stigma, ignorance of legal provisions, and systemic inequities as key barriers to safe reproductive healthcare. The findings reveal that restrictive abortion laws do not reduce abortion incidence but instead drive the practice underground, resulting in severe complications, psychological trauma, and preventable deaths. The study concludes that liberalization of abortion law accompanied by clear clinical guidelines, improved contraceptive access, and public education would reduce maternal deaths, align Nigeria with regional and global human-rights commitments, and promote the reproductive autonomy of women.

Keywords: Abortion law; Unsafe abortion; Maternal mortality; Women's rights; Nigeria; Reproductive health; Legal reform.

INTRODUCTION

Abortion remains one of the most controversial and emotionally charged issues in public health, ethics, law, and religion across the world. While in many developed countries abortion has been liberalized and incorporated into reproductive healthcare, the situation in Nigeria and in much of sub-Saharan Africa remains highly restrictive. The Nigerian legal framework governing abortion stems from the *Criminal Code Act* of 1916 (applicable to southern states) and the *Penal Code Act* of 1960 (applicable to northern states). Under these laws, abortion is only legally permissible when it is carried out to save the life of the pregnant woman. Any other form of termination is regarded as a criminal offence, punishable by imprisonment both for the woman and the person performing the procedure.

Despite these restrictive laws, abortion is widespread in Nigeria. The Guttmacher Institute (2015) estimates that over 1.25 million induced abortions occur annually, with a large proportion performed under unsafe conditions. This reflects a significant disconnect between the law and social reality. The restrictive nature of Nigerian abortion laws has not reduced abortion incidence but rather pushed it into unsafe and clandestine spaces, resulting in substantial health complications, infertility, psychological trauma, and maternal deaths (WHO, 2017; The Guardian Nigeria reporting; Akande, Adenuga, Ejidike, & Olufosoye, (2020). Unsafe abortion has become a major public-health issue in Nigeria. The World Health Organization, (2023) consistently identifies unsafe abortion as one of the top causes of maternal mortality in developing countries. Nigeria, which accounts for

about 20% of global maternal deaths, records thousands of preventable deaths annually due to complications from unsafe abortion. These deaths are particularly common among adolescents and young unmarried women, many of whom lack access to contraceptives and are afraid of societal stigma (Akande, et al, 2020; PMA research; 2017)

The contradiction between Nigeria's restrictive abortion law and its international obligations also underscores the urgency for reform. Nigeria is a signatory to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Maputo Protocol), which calls for the authorization of medical abortion in cases of sexual assault, rape, incest, or where the continuation of pregnancy endangers the health or life of the woman. However, domestic laws have not been harmonized to reflect these commitments.

Thus, the discourse on abortion in Nigeria goes beyond legal permissibility; it encompasses women's rights, health, morality, social justice, and development. Liberalizing abortion laws has become not only a health necessity but a human-rights imperative.

Historical Background of Abortion Laws in Nigeria

The legal framework regulating abortion in Nigeria is a product of the colonial era. The *Criminal Code Act of 1916* (derived from English common law) was enacted to govern the Southern Protectorate, while the *Penal Code Act of 1960*—influenced by Islamic legal principles—was adopted for the Northern Region. Both legal codes criminalized abortion in almost all circumstances, reflecting the moral and religious conservatism of the colonial authorities and the prevailing patriarchal norms.

Under the **Criminal Code (Sections 228–230)**, any person who unlawfully administers drugs or uses any instrument to procure a miscarriage is guilty of a felony and liable to imprisonment for up to **fourteen years**. The woman herself is also liable to imprisonment for up to **seven years** if she procures her own miscarriage. Only when a physician performs the procedure "in good faith and with reasonable care for the purpose of saving the life of the mother" can abortion be deemed lawful.

Similarly, under the **Penal Code (Section 232)**, applicable in Northern Nigeria, a woman who causes her own miscarriage faces imprisonment of up to **fourteen years** or a fine, or both. The person performing the act faces the same penalty. The law allows abortion only if performed to save the woman's life, and only when conducted by a registered medical practitioner. This provision reflects a strong moral and religious influence, particularly from Islamic jurisprudence, which generally prohibits abortion except to preserve maternal life.

These colonial-era laws have remained virtually unchanged since Nigeria's independence in 1960. Although medical advancements, social realities, and global human-rights standards have evolved, Nigeria's abortion legislation has not kept pace. Consequently, the country operates one of the most restrictive abortion regimes in Africa.

At present, there are no federal laws explicitly permitting abortion in Nigeria beyond the life-saving exception. Regulation falls under both the **Criminal Code Act (Southern States)** and the **Penal Code Act (Northern States)**, creating slight variations across regions but maintaining the same restrictive intent.

- **Criminal Code Act (Sections 228–230)**: prohibits unlawful abortion and penalizes both the provider and the woman, with limited exception for saving maternal life.
- **Penal Code Act (Sections 232–236)**: similar prohibition, though allows slightly broader interpretation where the procedure is performed "in good faith for the purpose of saving the life of the woman."
- **Child Rights Act (2003)**: indirectly impacts abortion debates by protecting minors from sexual abuse but does not address pregnancy termination.
- **National Health Act (2014)**: guarantees access to healthcare but is silent on abortion, creating policy inconsistency.

- **Medical and Dental Practitioners Act**: mandates doctors to uphold ethical standards but provides no guidance on abortion practice beyond the life-saving clause.

As a result, Nigerian health practitioners often face legal ambiguity. Many doctors are reluctant to perform even life-saving abortions for fear of prosecution, disciplinary action, or social backlash. This climate of fear and uncertainty pushes abortion practices underground, often into unsafe hands.

Objectives of the Study

The main objective of this paper is to make a case for the liberalization of abortion laws in Nigeria. Specifically, the study seeks to:

1. Examine the current legal framework governing abortion in Nigeria and its implications for women's health and rights.
2. Assess the social, psychological, and economic factors contributing to abortion practices among Nigerian women.
3. Evaluate the effects of restrictive abortion laws on maternal mortality and women's overall well-being.
4. Compare Nigeria's abortion laws with more liberal frameworks in selected African countries.

LITERATURE REVIEW

Conceptual Clarifications

Abortion

Abortion refers to the intentional termination of a pregnancy before the fetus attains viability, often defined clinically as before 20–24 weeks of gestation or before the fetus can survive independently outside the uterus (World Health Organization, 2021). Medically, abortion is broadly classified into **spontaneous abortion** commonly known as miscarriage which occurs without deliberate human intervention, and **induced abortion** also known as therapeutic, which is purposefully initiated by either medical or non-medical means (Sedgh, Bearak, Singh, Bankole, Popinchalk, Ganatra, Rossier, Gerdts, Tunçalp, Johnson, Johnston, & Alkema, 2016). Induced abortion may further be categorized into **safe abortion**, when it is performed by trained health professionals using evidence-based methods in hygienic conditions, and **unsafe abortion**, when the procedure is conducted by unskilled persons or in environments that do not meet minimal medical standards (WHO, 2021).

Globally, induced abortion is a common reproductive health event, with an estimated 73 million procedures carried out annually (Guttmacher Institute, 2020). However, the safety and legality of abortion vary substantially across contexts, shaped by legal frameworks, cultural norms, and access to healthcare systems. In high-income countries with liberal abortion laws, the vast majority of procedures are safe, whereas in low- and middle-income countries with restrictive policies, unsafe abortions remain a major contributor to maternal mortality (Singh, Remez, Sedgh, Kwok, & Onda,2018; WHO, 2021).

In Nigeria, the concept of abortion is heavily burdened with moral, religious, and legal stigma**.** Public discourse often treats abortion as synonymous with sin, crime, or social deviance. This perception is historically rooted in colonial-era criminal codes that criminalized abortion except to save the life of the mother, coupled with strong Christian and Islamic moral doctrines that condemn the intentional termination of pregnancy (Bankole, Adewole, Hussain, Awolude, Singh, & Akinyemi, 2015; Bamidele, & Fasuyi, 2022). As a result, abortion is culturally constructed not merely as a medical event but as a moral transgression, reinforcing secrecy and shame.

The social discomfort is reflected linguistically in the widespread use of euphemisms such as "D & C" (dilatation and curettage), "evacuation," or "cleaning up," instead of explicitly stating abortion. These lexical substitutions serve as a cultural mechanism to "sanitize" the act and avoid direct moral confrontation in interpersonal and clinical communication. The silence and euphemism surrounding abortion further hinder open discussion,

impede reproductive health education, and push many women toward clandestine and unsafe procedures**,** especially in contexts where social judgment outweighs medical reasoning.

Induced Abortion and Its Determinants

Induced abortion does not occur in a social vacuum; it is shaped by a constellation of demographic, socio-economic, cultural, relational, and health-system factors that intersect to influence whether a woman decides to terminate a pregnancy. Scholars emphasize that decisions surrounding induced abortion are often rational responses to structural constraints, rather than arbitrary moral failures (Bankole et al., 2015; Sedgh et al., 2016).

One major determinant is unintended pregnancy, often arising from non-use, inconsistent use, or failure of contraceptive methods. In many African contexts, low contraceptive uptake results from myths, partner objection, fear of side effects, and limited service availability, (Ajayi, Adeniyi, & Akpan, 2018; Idowu, Ukandu, Mattu, Olawuyi, Abiodun, Adegboye, Chibu-Jonah, Siakpere, Ishola, Adeyeye, & Alabi, 2020). When pregnancy is not planned particularly in economically strained households abortion becomes a considered option.

Economic constraints remain another driver of abortion decisions. Married women may seek abortion when they perceive additional childbearing as financially unsustainable, especially in settings where childcare costs, schooling responsibilities, and household expectations fall disproportionately on women, (Bankole, Singh, & Haas, 1998; Lamina, 2015; Ojo, Ojo, & Orji, 2021). Economic pressure intersects with **marital instability**, such as separation, infidelity, or uncertainty about spousal paternity, further encouraging termination.

Cultural and relational determinants also matter. For some married women, abortion serves as a means of preserving social reputation, especially where pregnancies outside socially "appropriate" contexts — such as within polygynous tensions, postpartum periods, or after extramarital relations attract stigma. Moreover, male partners exert significant influence: spousal disapproval or coercion has been cited both as a prompt for abortion and a barrier to seeking safe services, (Izugbara, Otsola, & Ezeh, 2009). Health-related determinants include pregnancies that threaten maternal health or those involving fetal anomalies incompatible with life. In countries with restrictive abortion laws like Nigeria, even medically indicated abortions are often delayed or performed clandestinely due to legal fear or moral judgement (WHO, 2021). Where health systems are weak or fragmented, women resort to non-medical practitioners or self-induction using pharmaceuticals and unsafe techniques.

At the structural level, restrictive legal frameworks, poor access to formal abortion care, and entrenched religious doctrine collectively push abortion-seeking underground. The interaction of punitive laws and moral condemnation creates a paradox: abortion does not become less frequent, only more clandestine and more dangerous.

In sum, induced abortion is typically a structured decision conditioned by material realities, gendered power relations, and health-system constraints, rather than a purely personal or impulsive act. Understanding these determinants is essential for designing policies that reduce unsafe abortion without reducing women's agency or dignity.

Liberalization of Abortion Laws

Liberalization refers to the process of loosening legal restrictions governing abortion to permit it under broader circumstances. In practice, liberalization may take several legal forms, including:

(a) **decriminalization** — the removal of criminal penalties for those who obtain or provide abortion;

(b) **legalization under defined grounds** — such as to preserve a woman's physical or mental health, fetal anomaly, rape or incest, or socio-economic indications; and

(c) **integration into health systems** — recognizing abortion as part of essential reproductive healthcare and providing it within regulated health facilities and insurance schemes.

It is important to emphasize that liberalization does **not** entail the promotion of abortion as a first-line reproductive choice. Rather, it seeks to ensure that when abortion is medically, socially, or psychologically

indicated, women are able to access it safely, legally, and affordably without resorting to clandestine or unsafe methods that threaten life and wellbeing.

Empirical evidence supports the public-health rationale for liberalization. According to the World Health Organization (2012), countries that have liberalized abortion laws — including South Africa, Ethiopia, Ghana and Tunisia recorded significant reductions in unsafe abortion practices and in maternal morbidity and mortality associated with abortion complications. These findings suggest that restrictive laws do not eliminate abortion; they merely increase its danger. In contrast, liberal regulatory and service environments reduce preventable deaths and shift abortion care from informal and unsafe spaces into accountable medical systems.

Beyond public-health justification, liberalization is increasingly framed as a rights-based reform, grounded in international human rights instruments that affirm bodily autonomy, non-discrimination, and the right to the highest attainable standard of health. In contexts such as sub-Saharan Africa, liberalization aligns with regional commitments such as the Maputo Protocol, which urges States to authorize medical abortion in defined circumstances to safeguard women's lives and dignity.

In sum, liberalizing abortion law is not a permissive moral agenda but an evidence-based legal and public-health intervention anchored in harm reduction, human dignity, and reproductive justice.

Socio-Cultural Determinants of Abortion Practices

Abortion decisions in Nigeria are deeply embedded in socio-cultural and religious contexts. Oye-Adeniran, Adewole, Umoh, Iwere, & Gbadegesin, 2005; Oginni, Ahmadu, Okwesa, Adejo, & Shekarau, (2018) observed that cultural norms emphasize chastity before marriage and condemn pregnancy outside wedlock. Consequently, young unmarried women who become pregnant often face social ostracism and may resort to abortion to avoid shame. Religious opposition further complicates the issue. Christianity and Islam, which dominate Nigerian society, both prohibit abortion as sinful. Churches and mosques strongly influence public opinion, framing abortion as murder and encouraging women to carry pregnancies to term irrespective of circumstances. As a result, even policy makers are reluctant to support abortion law reform for fear of backlash from religious constituencies (Okonofua, Hammed, Nzeribe, ajudeen, Abass, Adeboye, Adegun, & Okolocha, 2009). Gender inequality and patriarchal control also play crucial roles. The male-dominated structure of Nigerian society limits women's reproductive decision-making. According to Afolabi, (2019); Eniola, (2018) the absence of female representation in legislative processes contributes to the persistence of gender-biased laws that ignore women's lived realities. With the recent incident that happened on the 22nd October, 2025 at the National Assembly between Senator Adams Oshiomhole and Senator Natasha Akpoti Uduaghan on the issue of abortion bill indicates that women are not allowed to speak even with matters that affect them and their reproductive right.

Economic and Health Implications of Restrictive Laws

The restrictive legal environment has enormous economic and health consequences. Women who undergo unsafe abortions often suffer severe complications requiring prolonged hospital stays, blood transfusions, and surgical interventions—all of which strain Nigeria's already limited healthcare resources (Izugbara, Egesa, & Kabiru, 2020).

At the household level, unsafe abortion perpetuates poverty. Women who die or become infertile due to unsafe procedures deprive families of caregivers and breadwinners. Henshaw, Adewole, Singh, Bankole, Oye-Adeniran, & Hussain,2008; Prada, Bankole, Oladapo, Awolude, Adewole, & Onda, (2015) argue that unsafe abortion is both a health and a development issue, as it undermines women's productivity and the achievement of Sustainable Development Goals (SDGs) 3 and 5.

Comparative Perspectives: Lessons from Other African Countries

Examining other African countries provides valuable insights into the impact of liberalized abortion laws.

South Africa is one of the most progressive African nations regarding reproductive rights. The *Choice on Termination of Pregnancy Act* (1996) allows abortion on request up to 12 weeks of gestation and under specific

conditions up to 20 weeks, (Jewkes, Rees, & Dickson, 2005).) Following legalization, studies showed a significant decline in abortion-related mortality. Their model demonstrates that liberalization, coupled with access to safe healthcare, can dramatically improve maternal outcomes.

Similarly, Ethiopia liberalized its abortion laws in 2005 to allow termination in cases of rape, incest, fetal impairment, or danger to the woman's health. Berhane, Tesfaye, & Gebremedhin, (2017) reported a sharp reduction in unsafe abortion and a corresponding improvement in maternal health outcomes. Since then, maternal deaths from unsafe abortion have dropped remarkably, and public-health facilities now provide safe abortion and post-abortion care. The Ethiopian experience shows that reforming abortion laws need not conflict with religious values if framed around health and compassion.

Ghana's *Criminal Code Amendment (1985)* expanded grounds for abortion to include rape, incest, and risk to mental or physical health. Despite cultural conservatism, Ghana's gradual reform—supported by public-health education and expanded contraception—has reduced unsafe abortion complications.

Kenya's 2010 Constitution recognizes a woman's right to abortion when the life or health of the mother is at risk, or in emergencies. Though implementation remains uneven, it reflects a significant shift toward recognizing reproductive rights.

Tunisia legalized abortion in 1973, and access has since been integrated into public healthcare. As a result, the country records one of the lowest abortion-related mortality rates in Africa.

These examples demonstrate that liberalization does not increase abortion rates but instead reduces unsafe procedures, improves reproductive health, and promotes gender equality. Nigeria's continued adherence to colonial-era provisions reflects a failure to evolve. Evidence from South Africa, Ethiopia, Ghana, and Kenya demonstrates that moderate liberalization can coexist with cultural values while saving lives. Nigeria's failure to reform its laws perpetuates a cycle of unsafe practices, preventable deaths, and violation of women's rights.

Psychological and Social Consequences of Unsafe Abortion

Beyond physical health, unsafe abortion has profound psychological and social consequences. Many women experience depression, anxiety, guilt, and post-traumatic stress disorder (PTSD) following unsafe or coerced abortions (Obi & Alabi, 2020). These effects are compounded by stigma and lack of emotional support. According to Otoide, konofua, & Oronsaye, (2018), women who survive unsafe abortion often suffer lifelong psychological trauma, especially those who underwent procedures in secrecy or under coercion. Social stigma also affects reintegration, with some women losing educational or employment opportunities.

Several studies have examined the incidence, determinants, and consequences of abortion in Nigeria. Bankole et al. (2015) estimated that 1.25 million induced abortions occur annually in Nigeria, corresponding to a rate of 33 abortions per 1,000 women aged 15–49 years. The study also found that the majority of these procedures are unsafe, as 60% are performed by untrained providers in unregulated settings.

Similarly, Sedgh et al. (2016) found that restrictive laws have failed to curb abortion prevalence. Instead, they have increased the risk of complications such as hemorrhage, sepsis, infertility, and death. Many Nigerian women resort to unsafe methods such as ingestion of harmful substances, insertion of sharp objects, or use of unregulated drugs purchased from local chemists. Akinlusi, Rabiu, Adewunmi, Imosemi, Ottun, & Badmus, (2018), observed that unsafe abortion remains a leading cause of maternal morbidity and mortality in Nigerian hospitals, especially among young unmarried women and adolescents. They found that stigma, fear of arrest, and lack of access to modern contraceptives were the main factors pushing women toward unsafe abortion. Okonofua, Ogu, Agholor, Adeyemi, & Abebe, (2019) also reported that post-abortion complications account for a large share of emergency gynecological admissions in tertiary hospitals. The study concluded that legal reform and improved access to reproductive health services are necessary to protect women's lives.

Thus, unsafe abortion creates a cycle of silence, shame, and psychological distress that could be prevented through legal and medical safeguards.

International and Regional Human Rights Perspectives

The international human-rights community increasingly recognizes access to safe abortion as a component of reproductive rights. The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) obliges state parties to eliminate discrimination in health services, including those related to family planning. The Maputo Protocol (Article 14) explicitly requires African states to authorize abortion in cases of sexual assault, rape, incest, and health risks to the mother or fetus.

Center for Reproductive Rights (2019) noted that Nigeria's current laws contradict these obligations, effectively criminalizing women for exercising their reproductive rights. The persistence of such laws also violates the African Charter's guarantees of dignity, life, and equality.

Human-rights jurisprudence from regional bodies, such as the African Commission on Human and Peoples' Rights, further reinforces that denying access to safe abortion constitutes cruel, inhuman, and degrading treatment (African Commission on Human and Peoples' Rights. ACHPR, 2016).

Therefore, the liberalization of abortion laws in Nigeria is not merely a domestic issue but part of a broader struggle for compliance with international human-rights standards.

The reviewed literature consistently shows that restrictive abortion laws do not reduce abortion incidence; instead, they drive it underground, increasing maternal mortality and morbidity. Empirical studies across Nigeria highlight unsafe abortion as a leading cause of preventable deaths, particularly among adolescents and poor women. Socio-cultural, religious, and economic factors further exacerbate the problem, while fear of legal prosecution discourages post-abortion care.

However, there remains a research gap in integrating sociological perspectives especially how culture, law, and gender intersect to shape women's experiences of reproductive health. Most studies focus on medical or legal dimensions without adequately exploring the psychological and social consequences of restrictive laws.

This study addresses these gaps by combining quantitative data on women's abortion experiences in Ekpoma and irrua, Edo State, with qualitative insights into their perceptions, and interactions with the healthcare and legal systems.

Theoretical Framework

This study is anchored on two interrelated theories: **Feminist Legal Theory** and **Reproductive Rights Theory**. Together, they provide a normative and analytical lens for understanding the gendered and rights-based implications of restrictive abortion laws in Nigeria.

Feminist Legal Theory contends that law is neither neutral nor objective; rather, it has been historically shaped through a patriarchal lens that privileges male-defined morality, religious norms, and socio-cultural expectations over women's lived realities. Within this framework, restrictive abortion statutes are not accidental legal artifacts but instruments of structural gender control. By criminalizing abortion, the State assumes guardianship over women's reproductive capacity, effectively subordinating women's autonomy to male-constructed notions of morality, family, and nationhood. Feminist legal scholars argue that such laws reinforce unequal power relations, silence women's reproductive agency, and perpetuate institutionalized gender inequality. Consequently, the feminist legal approach calls for legal reforms that explicitly center women's bodily autonomy, reproductive dignity, and decision-making power.

Reproductive Rights Theory, in contrast but in complement, situates the abortion question within a universal human-rights paradigm. It conceptualizes reproductive decision-making — including the choice to terminate a pregnancy — as integral to the rights to health, life, privacy, dignity, and non-discrimination. From this perspective, denying access to safe and legal abortion constitutes not merely a public-health failure but a violation of fundamental human rights. International legal instruments such as the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the African Union's Maputo Protocol explicitly recognize the obligation of States to ensure safe abortion under specified conditions. Restrictive abortion laws

therefore represent a breach of these obligations and perpetuate systemic gender-based exclusion from guaranteed rights.

Taken together, Feminist Legal Theory and Reproductive Rights Theory provide a coherent analytical foundation for this study. They illuminate how Nigerian abortion laws simultaneously function as mechanisms of gender oppression and as sites of human-rights violation, thereby justifying liberalization not only as a public-health imperative but as a matter of social justice and legal reform.

MATERIAL AND METHODS

Research Design: This study adopted a mixed-methods design, combining both quantitative and qualitative approaches to provide a comprehensive understanding of abortion laws and their impact on Nigerian women. The mixed-methods design was deemed appropriate because abortion is not only a legal and health issue but also a socio-cultural and psychological phenomenon that requires both numerical and narrative insights.. Structured questionnaires were used to generate numerical data that were statistically analyzed. The qualitative component involved in-depth interviews (IDIs) and focus group discussions (FGDs) with selected participants, healthcare providers, and community leaders. These sessions' explored participants' perceptions of the abortion law, its effects on women's health, and their attitudes toward legal reform.

Study area: The study was conducted in Ekpoma and Irrua. They are both administrative headquarters of Esan West and Esan Central Local Government Areas of Edo State, Nigeria. They are semi-urban town and home to the Ambrose Alli University and the Irrua Specialist Teaching Hospital respectively, both of which serve as major centers for education and healthcare in Edo State. The population of Ekpoma and Irrua are ethnically homogeneous, predominantly consisting of the Esan people, with Christianity being the dominant religion, followed by Islam and traditional beliefs.

The target population consisted of women of reproductive age (15–49 years) residing in both communities at the time of the study. This population was chosen because women within this age range are most likely to experience pregnancy and therefore confront issues related to abortion laws and access to reproductive healthcare. In addition to women, the study included key informants such as medical doctors, nurses, midwives, and traditional birth attendants (TBAs), who provided professional insights into abortion-related cases, complications, and the healthcare system's response to restrictive laws.

Sample size: A total of 600 participants were selected using multistage sampling. Out of which 584 respondents becoming our focus for analysis representing 98% of our study population. Ekpoma and Irrua were divided into several political wards; three political wards each were randomly selected using simple random sampling. Within each ward, systematic sampling was used to select households from an updated voter register. Every 5th household was selected until the desired number was reached. In each household, one eligible woman aged 15–49 was selected using simple random sampling.

For the qualitative component, 10 participants were purposively selected for in-depth interviews (5 women who had experienced abortion and 5 healthcare providers) from each community and two focus group discussions (FGDs) of 8 participants each — one for women and one for community leaders with Ekpoma and Irrua communities. This combination ensured diversity of perspectives while maintaining focus on the subject of abortion law and its implications.

Participation was voluntary, and informed consent was obtained from each participant. IDIs and FGDs were collected through recordings and conducted in English and Esan languages where necessary.

Data analysis: The data analysis process involved both quantitative and qualitative techniques. Descriptive statistics such as frequencies, percentages, and means were computed to describe respondents' characteristics and responses. Transcripts from IDIs and FGDs were analyzed thematically.

Scope: This study was limited to Ekpoma and Irrua communities in Edo State, and the findings may not be entirely generalizable to all Nigerian contexts due to regional variations in culture and religion.

PRESENTATION OF FINDINGS AND DISCUSSION

Socio-Demographic Characteristics of Respondents

Table 1 presents the distribution of respondents by age, marital status, education, and occupation. A total of 584 valid responses were analyzed.

Table 1: Socio-Demographic Characteristics of Respondents

Demographic Characteristic	Variable	Frequency	Percentage (%)
Age	15–19	78	13.4
	20–24	188	32.2
	25–29	138	23.6
	30–34	58	9.9
	35–39	46	7.9
	40-44	40	6.8
	45-49	36	6.2
Marital Status	Single	312	53.4
	Married	245	42.0
	Divorced/Widowed	27	4.6
Educational Level	Primary	20	3.4
	Secondary	168	28.8
	Tertiary	396	67.8
Occupation	Student	263	45.0
	Trader	133	22.8
	Civil Servant	123	21.1
	Artisan	65	11.1

Source: Field Survey, 2025

The distribution table above show that the largest age group among respondents was 20–24 years (32.2%), followed by 25–29 years (23.6%). This reflects a predominantly youthful population, which is consistent with the demographic profile of the two communities Ekpoma and Irrua.

Over half of the respondents (53.4%) were single, indicating that many abortion cases in these two areas may involve unmarried women who face social stigma regarding premarital pregnancy.

The high proportion of respondents with tertiary education (45%) suggests that the participants were relatively enlightened and could provide informed opinions about abortion laws. Students formed the majority occupational group (44%), further confirming that abortion-related issues are common among young, educated, and unmarried women. This findings aligned with Akinlusi et al. (2018), who found that unsafe abortion in Nigeria is most prevalent among young, unmarried women seeking to avoid shame and social rejection.

Awareness and Knowledge of Abortion Laws in Nigeria

Table 2: Respondents' Awareness of the Legal Status of Abortion

Awareness Level	Frequency	Percentage (%)
Aware that abortion is illegal except to save the woman's life	345	59.1
Unaware of specific law but know abortion is "wrong"	174	29.8
Believe abortion is fully illegal under all circumstances	49	8.4
Believe abortion is legal in Nigeria	16	2.7

Source: Field Survey, 2025

The findings indicate that 59.1% of respondents were aware that abortion is legally restricted except to save a woman's life, while 29.8% lacked detailed legal knowledge but associated abortion with moral wrongness. Only 2.7% believed abortion is fully legal, reflecting widespread confusion about the exact legal provisions.

This limited awareness underscores the information gap in Nigeria's reproductive-health education. The multiple interpretation given to abortion laws, coupled with socio-religious taboos, contributes to misinformation. These results corroborate Bankole et al. (2015), who observed that most Nigerian women have limited legal literacy concerning reproductive rights. Similarly, Okonofua et al. (2019) reported that uncertainty about the law prevents many women from seeking timely post-abortion care, thereby increasing health risks.

Experience and Prevalence of Abortion

Table 3: Respondents Who Have Ever Had an Abortion

Response	Frequency	Percentage (%)
Yes	192	32.9
No	392	67.1

Source: Field Survey, 2025

About one-third (32.9%) of respondents admitted to having had an abortion at least once. Given the stigma associated with abortion in Nigeria, this figure likely underrepresents the true prevalence of abortion in Ekpoma and Irrua. A 20 years old student revealed that some persons used euphemisms like 'evacuation' or 'clean up' to avoid moral judgment. In her word '*I wouldn't call it abortion, l just went for a D & C because I couldn't face my parents with the pregnancy*.'

This finding reinforces Sedgh et al. (2016), who estimated that the abortion rate in Nigeria is 33 per 1,000 women aged 15–49 years. It also supports WHO, (2012) who highlighted that restrictive laws force women to seek clandestine abortions in fear of legal or social punishment.

Methods and Safety of Abortions

Table 4: Type of Abortion Procedure Used by Respondents

Type of Procedure	Frequency	Percentage (%)
Hospital/Clinic (Medical doctor)	143	24.5
Patent medicine dealer (Chemist)	255	43.7
Traditional/Herbal method	54	9.2
Self-induced using drugs/instruments	132	22.6

Source: Field Survey, 2025

The data above reveal that a majority of respondents (75.5%) underwent abortions outside hospital settings, either through chemists, traditional methods, or self-induction. Only 24.5% accessed medically supervised procedures.

This pattern mirrors the national situation, where restrictive laws push abortions underground, creating fertile ground for unsafe practices. According to Izugbara et al. (2020), over half of abortion cases in Nigeria are carried out by unqualified providers. The reliance on chemists and traditional practitioners in this study further demonstrates the health risk posed by criminalization.

One healthcare provider interviewed affirmed to the fact that it is a common occurrence. In his words *"We see many young girls coming with complications like heavy bleeding, infections, sometimes perforated wombs. Most of them went to untrained people because they were afraid of being reported."* This evidence underscores the urgent need for safe abortion services within formal healthcare settings as part of reproductive health reform.

Health Consequences and Post-Abortion Complications

Table 5: Common Complications Experienced After Abortion

Complication	Frequency	Percentage (%)
Severe bleeding	158	27.1
Infection (fever, sepsis)	96	16.4
Infertility/irregular menstruation	90	15.4
No complication reported	240	41.1

Source: Field Survey, 2025

Nearly half of respondents (43.5%) reported experiencing at least one medical complication following abortion. Severe bleeding (27.1%) and infections (16.4%) were the most frequent problems, aligning with hospital reports nationwide. These complications constitute a significant public-health concern. Okonofua et al. (2019) and Akinlusi et al. (2018) similarly identified unsafe abortion as a leading cause of maternal morbidity in Nigerian tertiary hospitals. A 25years old respondent recounted her experience thus: "*After the abortion, I bled for almost two weeks. I couldn't go to the hospital because I feared they would arrest me. I just prayed and used herbs*." Such testimonies emphasize the human cost of restrictive abortion laws and the psychological trauma experienced by women in secrecy and fear.

Attitudes toward Liberalization of Abortion Laws

Table 6: Respondents' Opinions on Liberalizing Abortion Laws

Opinion	Frequency	Percentage (%)
Strongly support	240	41.1
Support to some extent	189	32.3
Oppose	102	17.5
Strongly oppose	53	9.1

Source: Field Survey, 2025

The results above show that 73.4% of respondents either strongly support or support, to some extent, the liberalization of abortion laws. This indicates a growing awareness that criminalization endangers women's lives rather than protects them. 26.6% of the participants who opposed liberalization largely cited religious or moral reasons, with one respondent who vehemently oppose the legalization of abortion laws. In her words "*God forbids taking a life. Legalizing abortion will make our youth immoral.*" However, many participants supporting reform argued that legalization will save lives, ensure safety, and protect victims of rape or incest. This reflects shifting public opinion, particularly among educated women, consistent with findings from Aimakhu, Adepoju, Nwinee, Oghide, Shittu, & Oladunjoye, (2014) that urban and educated populations in Nigeria are more supportive of reproductive-rights reforms. Studies show that unsafe abortion contributes significantly to maternal mortality in Nigeria, with about 10–15% of all maternal deaths attributed to unsafe termination of pregnancy. Yet, the criminalization of abortion discourages women from seeking post-abortion care even when complications arise. The law, therefore, not only endangers the lives of women but also reinforces social inequality, as wealthier women can access safe procedures in private clinics, while poor women suffer the consequences of unsafe and illegal abortions.

Thematic Insights from Qualitative Data

The qualitative analysis produced five major themes:

- **Fear and Stigma:** Respondents repeatedly mentioned fear of social rejection, parental punishment, and religious condemnation as reasons for secrecy.
- **Economic Constraints:** Poverty and financial instability were major drivers of abortion decisions, with several women noting they could not afford to raise a child.

- **Religious and Cultural Conflict:** While some participants personally believed abortion was wrong, they acknowledged that the law should make exceptions for rape, incest, or health risks.

- **Psychological Effects:** Many women described long-term emotional trauma. One respondent said: "Even after years, I still feel guilty whenever I hear about abortion in church."

- **Call for Reform:** Both healthcare providers and women emphasized that law reform could reduce deaths and allow doctors to operate without fear of prosecution.

These themes echo findings from Obi and Alabi (2020) and Otoide et al. (2018**)**, who emphasized the psychological burden of unsafe abortion and the need for compassion-driven policy.

DISCUSSIONS OF FINDINGS

Findings revealed a paradoxical situation where, despite stringent legal restrictions, abortion remains widespread. Women, especially the young and unmarried, continue to seek unsafe procedures due to stigma, lack of access to contraceptives, and the fear of social and legal punishment Nigeria's restrictive abortion regime has inadvertently fostered a thriving underground network of unsafe abortion providers. This has grave implications for the country's maternal health indicators. (WHO, 2017) estimates that unsafe abortion accounts for up to 13% of maternal deaths globally, and Nigeria contributes a disproportionate share of these fatalities. Liberalization of abortion laws, alongside proper medical supervision and post-abortion care, would drastically reduce morbidity and mortality, as demonstrated in South Africa, Ghana, Tunisia and Ethiopia following their reforms. It would also ease the burden on the healthcare system by minimizing emergency cases caused by botched procedures. The Nigerian woman faces a triple burden, legal restriction, social stigma, and patriarchal moral judgment. Denying women autonomy over their reproductive decisions violates fundamental human rights as enshrined in the Maputo Protocol (Article 14) and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). The law's silence on pregnancies resulting from rape or incest compounds the trauma of victims. Legal reform is thus essential to align domestic legislation with regional and international human-rights obligations. Cultural and religious opposition remains a major obstacle to liberalization. However, these moral perspectives can coexist with humane, evidence-based legal reform. As seen in other African societies, dialogue between religious leaders, health experts, and policymakers can help reconcile faith with compassion. Liberalization of abortion laws for the Nigerian women will ensure that abortions, when performed, are safe, medically supervised, and within regulated health facilities that will significantly reduce maternal deaths. The current laws are vague and inconsistently applied. Reform would clarify the scope of permissible abortions and protect both women and healthcare providers from criminal liability in legitimate cases. Treating complications from unsafe abortions drains healthcare resources. Legalizing safe abortion services will redirect these funds toward preventive and educational programs. Legal reform would reduce the shame and trauma associated with abortion, allowing women to make decisions in a supportive environment. Many African countries such as South Africa, Tunisia, Ghana and Ethiopia that have successfully reformed their abortion laws are saving lives today. Nigeria's continued resistance reflects outdated colonial-era statutes that no longer align with global reproductive-rights standards.

CONCLUSION AND RECOMMENDATIONS

The study explored the awareness, experiences, and attitudes of women in Ekpoma and Irrua, Edo State, concerning Nigeria's abortion laws and the need for their liberalization. Guided by sociological and public-health perspectives, it examined how restrictive abortion legislation shapes women's reproductive choices, health outcomes, and psychological well-being. The study concludes that restrictive abortion laws in Nigeria have failed to achieve their moral objectives instead driving the practice underground and endangering the lives of women. Criminalization does not eliminate abortion it only makes it unsafe. The overwhelming support for reform among educated Nigerian women reflects a shift in public consciousness and a growing recognition that women's health and autonomy must be prioritized over outdated moral prohibitions Liberalizing abortion laws, in line with public health evidence and human rights standards, is not only a legal necessity but also a moral imperative. It represents a step toward justice, equity, and compassion in Nigeria's reproductive health landscape.

As Nigeria aspires to meet the Sustainable Development Goals (SDGs), particularly Goal 3 on health and well-being and Goal 5 on gender equality, the nation must recognize that protecting women's reproductive rights is central to sustainable development goals.

Legislative Reform

- **Amend Sections 228–230 of the Criminal Code (South) and Sections 232–236 of the Penal Code (North):** These provisions should be updated to permit abortion in cases of rape, incest, severe fetal impairment, and threats to a woman's physical or mental health.
- **Domestication of the Maputo Protocol:** The Nigerian National Assembly should domesticate and implement Article 14 of the **Maputo Protocol**, guaranteeing women's reproductive autonomy.
- Establish **licensed reproductive-health centers** where abortion and post-abortion care can be safely provided by trained professionals.
- Train medical personnel in **safe abortion techniques** and emergency management to prevent avoidable deaths.
- Integrate **contraceptive education and distribution** into maternal health programs to reduce unwanted pregnancies.
- Conduct **mass media campaigns**, community workshops, and school-based programs to improve legal literacy on women's reproductive rights.
- Partner with civil-society organizations and women's groups to advocate for policy change at local and national levels.
- Promote dialogue with **religious and traditional leaders** to correct misconceptions and foster empathy.
- Emphasize that legal reform is aimed at saving lives, not encouraging immorality.

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