Editorial

The Public Health Impact of the Nigerian Abortion Policy and the Case for the Reform of the Nation's Abortion Laws

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The policy on abortion in Nigeria is restrictive except to save the life of the woman or preserve the mental health[1]. This policy derives from the Nigerian national abortion laws which were introduced by the British colonial masters in 1916. The criminal code was then adopted throughout the country and 43 years later, the penal code was introduced to replace the criminal code in northern Nigeria to reflect the norms of the British law in colonial India being an Islamic country, as this is the predominant religion in northern region of Nigeria. The criminal code is retained in southern Nigeria and the relevant sections are: section 228, 229 and 230 respectively[2]. Section 228 stipulates guilt of felony for the persons that perform the abortion and liable to 14 years jail term. Section 229 prescribes guilt of felony on a woman who induces abortion on herself or submits herself for abortion and liable to 7 years imprisonment. Section 230 prescribes guilt of felony on the supplier of the materials used for the abortion and liable to 3 years imprisonment.

The relevant sections of the penal code that operates in northern Nigeria are sections 232, 233 and 234 respectively[3] (the Penal Code, Law No. 18 of 1959). Section 232 prescribes 14 years imprisonment or option of fine or both on the person who performs the abortion. In section 233, it stipulated that if the procedure resulted in the death of the woman, the person is liable to imprisonment which may extend to 14 years and also liable to fine. If it was done without the consent of the woman, the person who undertook the procedure is liable to jail term for life or less and also liable to fine. Section 234 prescribes punishment for some who caused miscarriage unintentionally by force, if it was unknown that the woman was pregnant the person is liable to 3 years imprisonment or fine or both. Knowing that the woman was pregnant may cause the jail term to be extended to 5 years.

A critical question that must be raised is that despite the robust and elegant nature of the Nigeria abortion laws, how many people have been arraigned, prosecuted and convicted for performing the act of abortion in Nigeria? Practically none from available records and yet Nigeria has one of the highest rates of abortion in the world. Worst still it has been and still is a very viable means for the law enforcement agencies to extort money from abortion service providers, and this drives the practice underground with quacks and backstreet professional taking the center stage. Interestingly, the colonial masters who imposed restrictive abortions laws on most of the countries that still hold tenaciously to these laws, have all since liberalized their laws with drop in abortion rates, morbidity and mortality from abortions. Opposition to liberalization of the Nigeria abortion laws have been largely on ethical, cultural and religious grounds. But of significant

note inspite of these perceived opposition is that, when individuals on both sides of the divide have an unwanted pregnancy, they do seek abortion because of the odium and stigma associated with an unwanted pregnancy particularly when it is of doubtful paternity.

The impact of anti-abortion laws on maternal mortality is best illustrated by data showing the prevalence of unsafe abortion and abortion mortality in countries with restrictive laws compared with those with liberal abortion laws. The prevalence of unsafe abortion is highest in countries with the most restrictive laws, up to 25 unsafe abortions per 1000 women of reproductive age[4,5] while countries that allow abortion on request have a median unsafe abortion rate of two or less per 1000 women. Case-fatality rates from unsafe abortion are also highest in countries where abortion is legally restricted. In such countries, the median ratio for unsafe abortion mortality is 34 deaths per 100,000 live births, compared to one or less per 100,000 live births in countries that allow abortion on request. The reader should be aware that abortion statistics are often hard to obtain, and those statistics that are available are frequently inaccurate. Official abortion statistics are often low due to incomplete reporting particularly in countries with restrictive laws. In contrast, other organizations that provide estimates of abortion statistics may be motivated to inflate the numbers, for example, high numbers of illegal abortions are an element of their rationalization for legalized abortion. Romania and South Africa are two countries that best demonstrate the effects of liberal abortion laws on maternal mortality. Maternal mortality due to abortion increased in Romania after a restrictive abortion policy was introduced in 1966. By 1989, mortality ratios had risen seven-fold to peak at 148 deaths per 100,000 live births, with abortion accounting for 87% of the deaths[4,6]. When the policy was reversed in 1989, mortality ratio fell by more than half to 68 within one year, and by 2002 the ratio had fallen to as low as nine per 100,000 live births, with abortion accounting for less than 50% of the deaths. Similarly, abortion became legal and available on request in South Africa in 1997[7]. After the law was passed, abortion-related deaths dropped by 91% in South Africa from 1994 to 1998-2001[8].

Without doubt, liberalization of abortion laws is an important strategy to reduce mortality due to unsafe abortion. In the last 12 years, 12 developing countries have liberalized their abortion laws. These include Albania, Benin, Burkina Faso, Cambodia, Chad, Ethiopia, Ghana, Guinea, Guyana, Mali, Nepal and South Africa[4]. Although the effects of these laws on mortality have not been systematically quantified in all these countries, for countries where accurate data is available, abortion liberalization has been shown to result in substantial decline in maternal mortality[4]. With the known positive effect of abortion liberalization in reducing maternal mortality, it is surprising that many developing countries are still holding on to restrictive anti-abortion laws.

Two types of arguments are often put forward by those opposed to abortion liberalization in developing countries. The first is that liberalization will increase the rate of abortion and overburden the health-care infrastructure. However, experiences in countries that liberalized abortion laws such as Barbados, Canada, South Africa, Tunisia and Turkey indicate that abortion liberalization has not been associated with increase in abortion[9]. By, contrast the Netherlands, which has unrestricted access to free

abortion and contraception, has one of the lowest abortion rates in the world[9]. The second argument, especially for low resource countries, is that women will still not seek safe abortion services even when abortion is liberalized. The examples of India, Zambia and Ghana where women continue to experience poor access to safe abortion care despite liberal abortion laws are often cited to support this viewpoint[10,11]. Factors associated with poor access in such circumstances include women's and providers' inadequate knowledge of the revised law, continued stigmatization of abortion and sexuality due to socio-cultural and religious reasons, and weak health systems in some of the developing countries[11,13]. Addressing these problems as part of abortion law reform, in addition to advocacy and public health education would increase the benefits of liberalization in reducing mortality associated with unsafe abortion[4].

Clearly unsafe abortion remains a major challenge and significant contributor to maternal morbidity and mortality. If the set millennium development goal of maternal mortality reduction is to be achieved and the ICPD programme of action realizable in Nigeria, then concerted efforts must be made and geared towards addressing the key reasons and all intermediating factors why women undertake unsafe abortion. Key amongst these is that it is necessary to advocate for a review of the existing restrictive laws in Nigeria and other developing countries in order to reduce the high morbidity and mortality from unsafe abortion. Advocacy and public health education that would increase the women's and provider's knowledge of the revised law, help deal with the issue of religious and socio-cultural stigmatization of abortion, would certainly increase the benefits of liberalization in reducing mortality associated with unsafe abortion and this is advocated for priority attention.

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