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Choice Determinants and Legal Framework of Medical and Surgical Abortions in Nigeria

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Abstract: *Induced abortion, that is, the wilful termination of pregnancy, is prohibited in Nigeria in all instances except when necessary to preserve the life of a woman. However, this singular exemption has driven many women seeking abortions to obtaining same clandestinely via medically unsafe means. Nevertheless, globally, the recognised and safe methods are Medical and Surgical Abortions. These methods, especially in the first trimester, offer a woman an option of either choosing the former or latter based on some determinants or factors peculiar to them. Thus, this article shall discuss abortion, the two major abortion procedures and their acceptable time frames. It will also examine the choice of Medical and Surgical Abortion Determinants, analyse the Nigerian legal framework on both abortion procedures, and then conclude and make some recommendations.*
Keywords: *Choice Determinants, Medical Abortion, Surgical Abortion, Legal Framework.*

I. Introduction

Abortion is the removal or expulsion of an embryo or fetus from the uterus which can be spontaneous, without any external manipulation, or induced either by medical, surgical, or other unorthodox means at any point during human pregnancy for therapeutic or elective reasons[1]. This implies that abortion can occur naturally, that is, spontaneously without human interference (this is also k1nown as miscarriage,) or can be intentionally induced or prompted by humans.

Induced abortion on the other hand is 'the act of causing a pregnancy to end early in order to prevent the baby from developing and being born alive[2]. Similarly, according to Worldometers, an abortion is the termination of a pregnancy by the removal or expulsion of an embryo or foetus from the uterus, resulting in or caused by its death[3]. Therefore, induced abortion is an intentional act of ending a pregnancy abruptly before its due date. In 2012, about one-fourth of Nigeria's 9.2 million pregnancies were unintended —a rate of 59 unintended pregnancies per 1,000 women aged 15–49. More than half (56%) of these unintended pregnancies ended in an induced abortion; 32% ended in an unplanned birth and 12% in a miscarriage[4]. Subsequently, it was reported by World Health Organisation in 2017 that every year in the world there is an estimated 40-50 million abortions. This corresponds to approximately 125,000 abortions per day[5].

Furthermore, induced abortion is achievable through two recognised procedures in medicine. It can be done either medically or surgically, especially, in the early stage of pregnancy. The advent of medical termination of pregnancy using Mifepristone and Misoprostol has enabled to undergo termination of pregnancy without a surgical procedure when the gestation is less than nine weeks[6] It may also be via a combination of Mifepristone and Gemeprost, or Misoprostol alone; while surgical abortion may occur by making use of Electric or Manual Vacuum Aspiration. Very importantly, this work will focus on medical and surgical abortion procedures during the first trimester, particularly, within the first nine to twelve weeks.

It should be noted that abortion is not legally permissible in all jurisdictions, such as, Nigeria. This is due to the legal framework that prohibits the termination of pregnancy in all its form, but, with the singular exception of saving the life of a woman. Unfortunately, the exemption clause has led to clandestine and unsafe medical abortion practices by unskilled providers, thus, affecting maternal morbidity and mortality. Examples of unsafe methods used in performing abortion in Nigeria are dilatation and curettage, a range of often harmful and ineffective drugs and insertion of solid or sharp objects into the cervix to perform abortions[7]. Therefore, Nigeria has one of the highest maternal mortality ratios in the world, and little improvement has occurred in recent years[8]. Also, as reported by Guttmacher Institute, complications of unsafe abortion range from pain and bleeding to more serious conditions, including sepsis (systemic infection), pelvic infections and injury from instruments—and even death. About 40% of women undergoing abortion experience complications serious enough to require medical treatment. Among women treated in Nigerian secondary and tertiary hospitals in 2012 for complications of pregnancy or delivery, almost 10% of 'near-miss events'—cases in which women would have died had the health system not intervened— were estimated to be due to unsafe abortion. Accordingly, in 2012, 212,000 women were treated in health facilities for complications of induced abortion. In

addition, an estimated 285,000 women had complications from unsafe abortion serious enough to require treatment in health facilities, but, did not obtain the care they needed[9]. However, in most parts of the western world however, both medical and surgical abortions are performed in safe and efficacious settings associated with low risks of complications[10].
Consequently, this article will examine the two recognised methods of pregnancy termination, and their effectiveness. It will proceed further to study the reasons, that is, determinants for opting for a particular procedure over the other; and then analyse the legal position of law on abortion in Nigeria, particularly, its effect on the two procedures. It will conclude and finally make some recommendations.

II. The Different Methods Of Procuring Abortion

Induced Abortion involves two major methods of procuring abortion. These are Medical and Surgical Abortion Procedures. Their details are discussed below.

2.1. Medical Abortion

Medical methods of abortion have been proved to be safe and effective[11]. The most effective regimens rely on the antiprogestogen, mifepristone, which binds to progesterone receptors, inhibiting the action of progesterone and hence interfering with the continuation of pregnancy. Treatment regimens entail an initial dose of mifepristone followed by administration of a synthetic prostaglandin analogue, generally misoprostol, which enhances uterine contractions and aids in expelling the products of conception[12]. Gemeprost is a prostaglandin analogue similar to misoprostol, but it is more expensive, requires refrigeration, and may only be administered vaginally[13]. Thus, although gemeprost demonstrates similar efficacy as misoprostol, misoprostol is the prostaglandin analogue of choice for abortion-related care[14]. A number of other prostaglandins that were used in the past, such as sulprostone and prostaglandin F2α, are no longer used because of their adverse side-effects or relative lack of efficacy[15].

2.1.1. Medical Abortion using Misoprostol Alone
This regimen is less effective and has more side-effects than the combination regimens with mifepristone or methotrexate pre-treatment, but where these drugs are not accessible, medical abortion can be induced if misoprostol is the only drug available. Effectiveness is lower than for surgical methods (84 per cent compared with 95 per cent). However, the safety level is much higher than resorting to unsafe, clandestine, illegal abortion[16].

2.1.2. Medical Abortion using Mifepristone (RU486) followed by Misoprostol or Gemeprost
Mifepristone with misoprostol has been proven highly effective, safe and acceptable for abortions occurring up to 9 weeks since the LMP. Efficacy rates up to 98% are reported[17]. Approximately 2–5% of women treated with the combination of mifepristone and misoprostol will require surgical intervention to resolve an incomplete abortion, terminate a continuing pregnancy, or control bleeding[18]. It should be noted that Misoprostol is an effective prostaglandin analogue that is considerably less expensive than Gemeprost and does not require refrigeration. It is therefore the prostaglandin analogue of choice[19].
The most effective medical regimen is mifepristone 200 mg orally followed 36–48 hours later by misoprostol 800 µg vaginally, administered in a health-care facility. A maximum of four further doses of misoprostol 400 µg may be administered at three-hourly intervals, vaginally or sublingually[20].
Following administration of the misoprostol, up to 90% of women will expel the products of conception over the following 4–6 hours. Most women are likely to require medication for cramping pain during this period of time[21]. In the case of a failed abortion where pregnancy is ongoing, re-administration of misoprostol or surgical abortion should be offered to the woman[22]. Women with incomplete abortions can generally be observed unless vaginal bleeding is heavy, or they may be offered re-administration of misoprostol or surgical completion of their abortion[23].

2.1.3. Medical Abortion using Methotrexate and Misoprostol
Methotrexate, which is a cytotoxic drug used to treat certain types of cancer, rheumatoid arthritis, psoriasis and some other conditions, has been used in combination with misoprostol as a medical method for early abortion (pregnancies of gestational age up to 7 weeks) in some countries where mifepristone has not been available. When combined with misoprostol, it is effective: a number of studies report an overall success rate of greater than 90% with 50 mg of methotrexate orally or intramuscularly, followed by 800 µg vaginal misoprostol 3–7 days later[24]. Once methotrexate is administered, the abortion must be completed, because both drugs are teratogenic. Therefore, women must be strongly advised to complete the abortion, either medically or surgically, once the medication has been administered[25].

However, a WHO toxicology panel recommended against the use of methotrexate for inducing abortion, based on concerns of teratogenicity if the pregnancy was not successfully aborted[26]. Although the actual risks are as yet unknown, limb defects and skull and facial abnormalities in pregnancies that continued after failed attempts to induce abortion with methotrexate have been reported[27]. It is therefore recommended that services wishing to introduce medical methods of abortion use combination regimens of mifepristone and misoprostol. Other agents are used to stimulate uterine contractions and induce abortion after 12 weeks, but available data regarding their safety are limited. These agents include hypertonic saline, or hyperosmolar urea, injected intra-amniotically; ethacridine lactate administered intra- or extra-amniotically; prostaglandin analogues administered parenterally or intra- or extra-amniotically; and oxytocin injected intravenously or intramuscularly[28]. These methods and routes of administration, however, are invasive and likely to be less safe, and the time to complete abortion is longer when compared to the use of methods such as combined mifepristone and misoprostol[29].

2.2. Surgical Abortion

The recommended surgical technique for abortion up to gestational age less than 15 weeks is vacuum aspiration[30]. The high efficacy of vacuum aspiration has been well established in several randomized controlled trials. Complete abortion rates between 95% and 100% are reported[31]. Electric and manual vacuum technologies appear to be equally effective; however, the use of manual vacuum aspiration is associated with less pain in pregnancies under 9 weeks' gestation and with more procedural difficulty over 9 weeks' gestation[32]. Vacuum aspiration under 14 weeks' gestation is more effective and associated with fewer minor complications than medical abortion[33].

Vacuum aspiration involves evacuation of the contents of the uterus through a plastic or metal cannula, attached to a vacuum source. Electric vacuum aspiration (EVA) employs an electric vacuum pump. With manual vacuum aspiration (MVA), the vacuum is created using a hand-held, hand-activated, plastic 60 ml aspirator (also called a syringe). Available aspirators accommodate different sizes of plastic cannulae, ranging from 4 mm to 16 mm in diameter. For each procedure, the appropriately sized cannula should be chosen based on the gestational age and the amount of cervical dilatation present; generally, the diameter of the cannula corresponds to the gestational age in weeks. Depending on the duration of pregnancy, abortion with vacuum aspiration takes from 3 to 10 minutes to complete and can be performed on an outpatient basis, using analgesics and/or local anaesthesia. The completion of abortion is verified by examination of the aspirated tissue. In very early pregnancy, the cannula may be inserted without prior dilatation of the cervix. Usually, however, dilatation using mechanical or osmotic dilators, or pharmacological agents such as misoprostol or mifepristone, is required before insertion of the cannula. Generally, vacuum-aspiration procedures can be safely completed without intrauterine use of curettes or other instruments[34].

Most women who have a first-trimester abortion with local anaesthesia feel well enough to leave the health-care facility after observation for about 30 minutes in a recovery room. Longer recovery periods are generally needed for abortions performed later in pregnancy and when sedation or general anaesthesia has been used[35].

III. Choice Of Medical And Surgical Abortion Determinants

Both surgical and medical methods are available because some studies emphasise that women prefer to have a choice[36], and that women may prefer one method over the other based on clinical grounds or on their beliefs or experience with previous abortions[37]. After general counselling, in most of the clinics, all women with an early pregnancy are offered the choice between a medical or a surgical abortion. The characteristics of each method are explained and written information about the methods and the differences between them are distributed, so that women can make an informed choice about which they prefer[38]. Therefore, the choice of abortion procedure that a woman undergoes is subject to some determinants, which may, or may not prove some health risks or challenges to a woman's health. Such determinants include age of the pregnancy, accessibility, motivation, satisfaction, and the benefits or risks of such procedure.

3.1. Age of the Pregnancy

The 1997 Guidelines issued by the Royal College of Obstetrics and Gynaecology state that, 'Women presenting early in pregnancy (< nine weeks of gestation) should have access to a choice of surgical or medical methods of abortion'[39]. Subsequently, in 2008, the International Planned Parenthood Federation (IPPF) in its guidelines further provides that medical abortion is used from four up to seven or nine weeks, according to local protocols, and after 14 weeks, while surgical methods are preferred from 9–14 weeks, but the efficacy of medical abortion during weeks 9–14 is being studied[40]. Similarly, WHO's Handbook recommends medical abortion within the first 12 weeks or 84 days of pregnancy, and Vacuum aspiration (VA) up to 12–14 weeks[41]. Therefore, for women who make abortion decision early enough, they have the opportunity to choose a preferred method/procedure, whereas, the ones who decide late and their pregnancies have advanced beyond 9 weeks are

left with no other choice but to opt for surgical abortion, hence, time is of essence, and the age of a pregnancy will determine a woman's choice of pregnancy termination.

3.2. Accessibility

The availability and accessibility of abortion services have long been a concern for reproductive health professionals, as women seeking an abortion have a fairly narrow time period during which they can obtain the procedure. Accessibility is harder to measure than availability, because of the variety of possible barriers, both tangible and intangible. Besides distance from a provider, cost is the most obvious tangible barrier. The provision of specific services, such as second-trimester pregnancy termination, can determine accessibility for individual women. Among the barriers that are less tangible, and therefore more difficult to quantify, are women's lack of accurate information about the legality of abortion and about where and how to obtain abortion care, misinformation about abortion, intimidation by protesters, state-required waiting periods and mandated counseling topics that may not be relevant to a woman's personal situation, and antiabortion attitudes among family or friends[42]. In lieu of these accessibility barriers, the American College of Obstetricians and Gynecologists makes some recommendations to ensure the availability of safe, legal, and accessible abortion services free from harmful legal or financial restrictions[43].

In addition, as with other types of health care, women are likely to be more satisfied with their abortion-related care if they have access to the types of services that best meet their physical and personal needs. Thus, for a woman who decides early in pregnancy that she wants an abortion, quality of care may be enhanced if she can choose between a medical and a surgical procedure, and if she is not required to wait for one or more weeks to meet minimum gestation limits[44].

3.3. Motivation

What motivates a woman's in choosing either a medical or surgical abortion method? Whenever choice is exercised, motivation comes into play. A woman's motivation may be to avoid having a general anaesthesia and the experience of the long drawn out physical process of the medical termination. Furthermore, motivation is drawn from the findings about future choices. Essentially those having a surgical termination would generally choose the same method as it offers more considerable services.

However, a large proportion of those who had experienced the medical procedure would choose a different option, primarily because of distress associated with the process and seeing the fetus and the expectation of less pain. Hence, after implementation of such services, evaluation would clearly be required to assess the validity of these proposed benefits[45].

3.4. Satisfaction

A woman's satisfaction with the method used may influence whether she would choose the same method again. Satisfaction is usually more positive for the surgical abortion group than the medical abortion group[46]. This is largely due to women experience with each procedure, especially, regarding the severity of pain, the intensity and duration of bleeding. Thus, because the frequency of severe side effects is higher in women having a medical than a surgical abortion; women experiencing severe side effects are less frequently satisfied with the medical procedure than women with less or no side effects[47]. Counselling and expectations, as well as differences in coping strategies are other aspects with impact on satisfaction. Another major factor that determines satisfaction is the success or failure rate after each procedure. Unfortunately, the failure rate after a medical procedure is worse than that after a surgical procedure, thus, avoidance of a surgical procedure subsequent to medical abortion is a major reason for choosing a medical procedure.

3.5. The Advantages and Disadvantages of Each Procedure

The benefits and risks of each procedure also determines its choice by women. For instance, medical abortion is advantageous in the sense that it is effective and safe for very early pregnancies. It avoids anaesthesia, instruments or vacuum aspiration, unless it fails. It also induces a miscarriage-like process. It is usually performed at home instead of a clinic during the actual abortion, hence, many women feel more comfortable and private[48]. However, it is risky as it takes days and sometimes weeks to end a pregnancy. It is not completely predictable because there is more uncertainty about when a woman will bleed and pass the pregnancy. Similarly, bleeding can be very heavy[49] while cramping can be very severe and last longer than with a surgical abortion[50]. Furthermore, at least two to three visits are required, sometimes more. Most importantly, it fails much more often than surgical abortion and takes longer to complete[51].

On the other hand, surgical abortion has its own benefits, such as, it is quick, predictable, and usually over in a few minutes. It is highly successful. It is very effective and safe for very early pregnancies as well as when done later in a pregnancy. It involves less bleeding and cramping for less time. it is mostly performed by a doctor

with support of medical and counselling staff on site. It is best if there is a need to conceal a pregnancy/abortion altogether. Likewise, it involves less medications than a medical abortion[52]. Nevertheless, the procedure is disadvantages because it involves a doctor inserting instruments inside the vagina and uterus. The anaesthetics and drugs used to manage pain during the procedure may cause side effects (but serious problems are rare). There may also be possible complications, although they occur in less than one percent of cases. It may not be done as early in the pregnancy as with a medical abortion, depending on the doctor or clinic[53].

In sum, in deciding the choice of abortion method to obtain, the determinant factors discussed above must be considered. For instance, the research conducted by Loeber[54] recaps the reasons why women choose one abortion method over the other. For the medical abortion users, the main reasons given were fear of aspiration, and the perception that medical abortion was more natural and more like a miscarriage. Some said specifically that they would terminate the pregnancy only if the medical method was available. Women choosing a surgical abortion expected the procedure to be faster and easier, they liked the idea that it would be over before they went home, and some wanted an IUD inserted at that stage as well[55]. Also, some women wished to avoid awareness and involvement in the process of the termination and were concerned about the pain or emotional impact of the medical termination[56]. In both groups, women with previous abortions let their experience influence their present choice[57], while some chose their method because of advice or reports from others such as doctors or friends[58].

IV. Legal Framework Of Abortion In Nigeria

There is uncertainty as to the legal framework of abortion is Nigeria. One of the reasons for this is due to the fact that there is no express definition of 'abortion,' neither is there any provision controlling its practice in both the Nigerian Constitution and laws prohibiting criminal acts in Nigeria namely, the Penal Code Act[59] and the Criminal Code Act[60].

4.1. Penal Code Act[61]

The relevant sections are sections 232 to 234. According to section 232:

> Whoever voluntarily causes a woman with child to miscarry shall, if the 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.

This section, especially the phrase 'for the purpose of saving the life of the woman' is the crux of the Nigerian legal framework on abortion. Impliedly, this means that abortion is illegal in Nigeria and only exempted for the singular purpose of saving the life of the mother. Thus, where anyone procures a woman's miscarriage/abortion while her life is not in danger, such a person will be liable to a maximum term of fourteen years imprisonment or with fine or with both.

Likewise, by section 233, whoever intentionally causes the miscarriage of a woman whether with child or not, which thereafter results in the death of that woman, shall be punished and liable to fourteen years imprisonment and fine; but if the act is performed without the woman's consent, he or she will be answerable to imprisonment for life or for a lesser term and also fine. In *Commissioner of Police v. Modebe[62],* a medical doctor was accused of occasioning the death of a pregnant woman through medical administration. The deceased, before visiting the doctor had administered drug to herself in a bid to terminate her pregnancy. Subsequently, when she visited the doctor, he discovered that the foetus had been septic and a miscarriage had commenced. He then began treatment manually by removing the septic remains of the foetus from the deceased's body and also administered analgesic to her in order to reduce her pains and prevent the spread of infection. After some days and due to complications, the deceased died in the accused hospital. The court held that the immediate cause of the miscarriage and her death were the drugs that she took before meeting the accused, however, the latter worsened it by failure to take her to the hospital for instant medical treatment.

Furthermore, under section 234, a person will be liable to a maximum term of three years or with fine or with both where he/she forcefully but unintentionally causes a woman to miscarry, but where the force was intentional, the guilty person shall be punished with imprisonment for a term which may extend to five years or with fine or with both.

4.2. Criminal Code Act[63]

Section 228 of the Act provides as follows:

> Any person who, with intent to procure miscarriage of a woman whether she is or is not with child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, is guilty of a felony and is liable to imprisonment for fourteen years.

This implies that where a third party, that is, any person administers a poisonous substance or uses force or anything on a woman, whether she is pregnant or not, in order to cause her miscarriage, such a person is guilty under the law and answerable to 14 years imprisonment. On the other hand, where a woman by herself procures her own miscarriage, whether or not she is pregnant, she will be guilty of felony and liable to imprisonment for seven years[64]. Furthermore, section 230 applies to the supplier of poisonous substance who has the knowledge that such is meant to be used unlawfully for miscarriage purpose by a woman. The guilty supplier will be liable to three years imprisonment. Lastly, section 297 provides:

> 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.

This section recognises and permits the performance of a surgical operation, in other words, surgical abortion, by a person possessing reasonable care and skill[65] on a pregnant woman whose life needs to be preserved. Thus, this is the sole ground on which the person performing the surgical operation is excluded from criminal liability.

If abortion is permitted in order to preserve the life of a woman, then, the questions to be answered are: Whether Surgical Abortion is the only recognised abortion procedure in Nigeria? Is Medical Abortion permitted? Do Nigerian women have a choice in deciding the preferred abortion procedure even in the face of danger or does the law impose a particular procedure on them?

Medical Abortion seems not to fall within the context of the Criminal Code exclusion because in medical practice, medicine and surgery are two different procedures. While the former denotes the treatment of disease by the administration of drugs or other sanative substances, the latter connotes a manual procedure by means of instruments[66]. Further, in *R. v. Edgal[67]* the 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 modem sophisticated surgical instruments and equipment which would guarantee safety to a higher degree, unlike their counterparts in 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[68]?

Also, the surgical operation clause is not without some health implications as it has resulted in alarming increase in the spread of HIV infection especially, in sub-Saharan Africa and Nigeria in particular[69]. There are cases where patients have contracted HIV infections through their surgeons[70]. 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 haemorrhage during surgical operations, women and girls accessing abortion stand the risk of contracting HIV through transfusion of contaminated blood[71].

The above analysis portrays that the Nigerian laws on abortion, particularly, the Criminal Code act which permits abortion where it is necessary to save the life of a woman leaves her with no choice of abortion procedure, except, surgical operation. Hence, it is advisable that section 232 of the Penal Code should be extended beyond the North and applied to the whole of Nigeria as it is quiet on the manner of achieving the life-saving objective on a woman, and which implies that the act of abortion can either be by medical or surgical process. This will give a woman an opportunity to make an autonomous choice after acquiring complete information about the two procedures.

V. Conclusion And Recommendations

Medical and Surgical Abortion Procedures are the two practically recognised methods of procuring induced abortion in the world, and generally in Medicine, a patient is given complete information about the benefits and risks of his or her ailment and treatment. Similarly, a woman has a right to be fully informed about available abortion procedures and their benefits and risks. This will enable her to make an autonomous decision by choosing a preferred procedure. Hence, determinants, such as, age of the pregnancy, accessibility, motivation, satisfaction, and the advantages and disadvantages of each procedure impact on a woman's decision. In a peculiar country like Nigeria, the legal framework bars abortion in all its forms, but, permits same except where it is necessary to safe the life of the woman. This exemption clause in the Criminal Code Act has a major defect as it only recognises surgical abortion. Therefore, based on the defects above, some recommendations are proffered.

Firstly, since Nigeria is a highly religious state which would possibly frown at the liberalization of abortion law, it is suggested that the government should embark on sexual education, the orientation on the use of modern contraceptive methods and the awareness of the dangers of illegally and unsafe induced abortion. Furthermore, the government should make available free access to reproductive health services, including contraceptives in order to reduce the maternal morbidity and mortality resulting from unsafe induced abortion.

Secondly, surgeons and other medical personnel that are involved in surgical operations should be very careful in performing abortions on their patients. They should ensure that they perform such in safe environments and make use of sterilised equipment in order to prevent the transmission of infection and diseases like HIV/AIDS to their patients. The government should also make adequate provision for sufficient surgical equipment like protective gloves, surgical blades. All these efforts will help in discouraging women from procuring unsafe abortions in Nigeria.

Furthermore, the exemption clause in the Criminal Code Act should be amended to adjust to changing societal realities. This is necessary as the clause only permits surgical abortion where a woman's life is in danger, unlike its Penal Code Act counterpart in the North which allows any act of abortion in order to prevent the life of a woman. Thus, as the World Health Organisation prescribes Medical and Surgical Abortions as safe procedures in early pregnancies, the Criminal Code Act should be expanded beyond surgical abortion and include medical abortion as an alternative for women requiring abortion in early pregnancy in order to preserve their lives.

Finally, subsequent to the amendment of the Criminal Code Act of Nigeria, women should be enlightened about their right of choice of abortion procedures. However, the right of choice can only be enjoyed when medical practitioners enlighten and give women full information about the methods available, the determining factors, including the benefits and risks of each procedure. These information will enable women to choose a preferred procedure between the two methods, rather than the law imposing one procedure on them while trying to safe their lives.

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[62] (1975) 5 U.I.L.R. 8.
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