# THE IMPACT OF CONSCIENTIOUS OBJECTION ON ACCESS TO REPRODUCTIVE HEALTHCARE: LESSONS FROM NIGERIA, SOUTH AFRICA AND THE UNITED KINGDOM

**Chibuzo Noble OBASI***

**Abstract**

*This article examines the regulation of conscientious objection in reproductive healthcare through a comparative analysis of Nigeria, South Africa, and the United Kingdom. Conscientious objection refers to the refusal of healthcare providers to perform certain medical procedures based on moral, ethical, or religious beliefs. While freedom of conscience is protected under international human rights law, its exercise in reproductive healthcare often conflicts with women's rights to access essential medical services, including abortion, contraception, and post-abortion care. Using a doctrinal research methodology, the study analyses legislation, case law, and scholarly literature to explore how different jurisdictions balance healthcare providers' conscience rights with patients' reproductive rights. The article reveals that Nigeria operates within a regulatory vacuum where restrictive abortion laws and strong religious and cultural influences significantly limit access to reproductive healthcare. South Africa adopts a model of statutory accommodation through the Choice on Termination of Pregnancy Act, which recognizes conscientious objection while imposing referral obligations on objecting providers, though implementation challenges persist. The United Kingdom presents a more developed framework characterized by statutory regulation, judicial interpretation, and professional guidance that narrowly construe conscientious objection to safeguard patient access. The study argues that conscientious objection should not operate as an unregulated barrier to healthcare and emphasizes the need for legal accountability, referral obligations, and institutional regulation. It concludes by recommending comprehensive abortion law reform in Nigeria, the enactment of a statutory framework governing conscientious objection, and stronger professional standards to ensure that reproductive healthcare rights are effectively protected in line with international human rights obligations.*

**Keywords***:* Conscientious Objection; Reproductive Healthcare; Abortion; Nigeria; South Africa; United Kingdom; Human Rights; Medical Ethics.

## 1. Introduction

In the healthcare sector, the concept of conscientious objection is defined as a healthcare provider's refusal to perform a legally mandated medical or other procedure because of personal moral, ethical, or religious beliefs. The right to freedom of conscience is well affirmed in international human rights laws and in national constitutions but in practice it raises complex legal and ethical questions in the context of healthcare provision, especially in relation to reproductive health, such as abortion, contraception and post abortion care.[1]

Reproductive rights are recognized as a human rights. The Programme of Action of the 1994 International Conference on Population and Development (ICPD) made a clear and unambiguous statement that these rights are based on the fundamental right of all individuals and couples to choose, freely and responsibly, the number, spacing and timing of their children. Conscientious objection by

* **Chibuzo Noble Obasi** is a lecturer at the Faculty of Law, Abia State University, Umuahia Campus

[1]Wicclair, M.R; *Conscientious Objection in Health Care: An Ethical Analysis*, Cambridge University Press, 2011, 1.

healthcare providers to refuse to provide reproductive health services, in turn, may directly impact on the realization of these internationally recognized women's rights.[2]

This inherent tension grows significantly in settings where access to abortion and reproductive health care is further restricted by strict legal regulations, deep-rooted socio-cultural stigma, or gaps in health care facilities and services. The implications are well-documented – unsafe abortions, avoidable maternal mortalities, and the real-world denial of healthcare to women and others who are vulnerable.[3] As Chavkin et al. have noted, conscientious objection in reproductive healthcare has become a global issue, one that poses a risk to women's lives when services may be legally available but virtually inaccessible.[4]

The article uses a doctrinal research method that involves a systematic examination of legal rules, legislation, case law and authoritative secondary sources to explore the regulation of Conscientious Objection in the context of reproductive healthcare in Nigeria, South Africa and the United Kingdom. These three jurisdictions offer instructive differences: Nigeria has no legislation explicitly addressing conscientious objection, but maintains very restrictive abortion laws; South Africa has developed a comprehensive statute on abortion that specifically addresses the issue of conscientious objection; and the United Kingdom has had an established statute on conscience for a long time, along with a growing body of case law. The comparative analysis that follows has as its purpose the extraction of lessons which are relevant to the legal reform process in Nigeria and other similar jurisdictions.[5]

This pressure is especially stark in settings where there are existing constraints on access, such as due to strict laws, cultural stigmatization or inadequate health systems. As Chavkin et al. note, the phenomenon of conscience-based objections in reproductive health services has become an international issue, and can be life-threatening when women are able to access legally available health care services but are unlikely to have access to them in practice.[6]

## 2. Conceptualising Conscientious Objection in Reproductive Healthcare

### 2.1 The Nature and Scope of Conscientious Objection

Conscientious objection is not a singular concept. Traditionally, it denotes a refusal, based on personal conscience, to adhere to a legal requirement—a refusal historically most often associated with military service. The healthcare context, however, presents unique complexities. Here, such a refusal occurs within the professional provider-patient relationship, and its repercussions are primarily borne by a third party-the patient-who typically lacks a comparable right of refusal.[7]

Dickens and Cook delineate the scope of conscientious objection within healthcare to include both individual practitioners' refusal to participate in procedures and institutional refusals by faith-based

[2] Bunch, C. and Fried, S; 'Beijing '95: Moving Women's Human Rights from Margin to Center'; *Signs: Journal of Women in Culture and Society*, Vol 1, 2005.
[3]Kassebaum, N.J. *et al*; 'Global, Regional, and National Levels and Causes of Maternal Mortality'; *The Lancet*, Vol 384(9947), 2014.
[4]Chavkin, W., Leitman, L., Polin, K. and Global Doctors for Choice; 'Conscientious Objection and Refusal to Provide Reproductive Healthcare'; *International Journal of Gynaecology and Obstetrics*, Vol 123(Suppl 3), 2013.
[5]Ibid.
[6] Ibid.
[7] Dickens, B.M. and Cook, R.J; 'The Scope and Limits of Conscientious Objection'; *International Journal of Gynaecology and Obstetrics*, Vol 71(1), 2000, 71.

healthcare facilities.[8] This distinction carries considerable weight, given that institutional objections possess the potential to substantially curtail or even eliminate access to essential services across significant geographical regions. [9]Wicclair further differentiates between negative conscientious objection, characterized as a simple refusal to perform an action, and positive conscientious objection, which involves providers actively obstructing patients from accessing services elsewhere, potentially through harassment.[10]

There is a growing scholarly consensus that conscientious objection, irrespective of its underlying sincerity, does not constitute an absolute right. Savulescucontends that the medical profession's inherent duty of care necessitates boundaries on the extent to which personal convictions can legitimately justify the non-provision of treatment.[11] He further posits that practitioners unable to offer specific services ought not to occupy positions where those services are deemed essential. Cook and Dickens similarly assert that the escalating misuse of conscientious objection has surpassed ethically defensible boundaries.[12]

**2.2 Conscientious Objection and International Human Rights Law**

The principles of ICJ must be evaluated within the general framework of international human rights law. Freedom of conscience and religion, which forms a basis of Objection claims, is guaranteed by Article 18 of the International Covenant on Civil and Political Rights (ICCPR) and Article 9 of the European Convention on Human Rights (ECHR). These rights are not without restrictions however, and may be curtailed when necessary to ensure the rights and freedoms of others.[13]

At the other end of the equation, women's reproductive rights are based on various international documents. The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) requires state parties to provide access to health care services, including family planning services, equally for women and men. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Maputo Protocol) extends this, explicitly stating that women have the right to an abortion for pregnancy resulting from rape, incest or where the pregnancy would compromise the physical or mental health of the mother.[14]

The Committee on the Elimination of Discrimination against Women has also stated that access to reproductive healthcare must not be denied because of Objection, as state parties must ensure that people have access to services to which they are entitled, regardless of their Conscientious Objection.[15]

[8] Dickens, B.M. and Cook, R.J; 'The Scope and Limits of Conscientious Objection'; *International Journal of Gynaecology and Obstetrics*, Vol 71(1), 2000, 71.
[9] Ibid.
[10]Wicclair, M.R; *Conscientious Objection in Health Care: An Ethical Analysis*, Cambridge University Press, 2011, 1.
[11]Savulescu, J; 'Conscientious Objection in Medicine'; *BMJ*, Vol 332(7536), 2006, 294.
[12] Cook, R.J. and Dickens, B.M; 'The Growing Abuse of Conscientious Objection'; *Virtual Mentor*, Vol 8(5), 2006.
[13] Article 9 of the European Convention on Human Rights (ECHR).
[14]Ngwena, C.G; 'Inscribing Abortion as a Human Right: Significance of the Protocol on the Rights of Women in Africa'; *Human Rights Quarterly*, Vol 32(4), 2010.
[15] Ibid.

## 3. Conscientious Objection and Reproductive Healthcare in Nigeria

### 3.1 The Legal Framework Governing Abortion in Nigeria

Nigeria is, quite possibly, the most difficult place in which to analyze CONSCIENTIOUS OBJECTION because it is the law itself, and not provider refusal, that is the main obstacle to reproductive health care. Under the Criminal Code Act (enacted in the southern states), abortion is illegal unless done to save the life of the mother, while in the northern states, it is regulated by the Penal Code which also does not explicitly mention conscientious objection. No law expressly recognizes a right to conscientious objection nor provides any mechanism to control provider refusals in reproductive health settings.[16]

Prosecuting abortion is also a criminal offence under the Criminal Code, with provider facing up to fourteen years' imprisonment and the woman up to seven years.[17] The Penal Code also provides for criminalization of abortion, except in the case of saving the mother's life. In the circumstances, it is almost paradoxical that the issue of conscientious objection arises at all: when abortion is mostly illegal, it is providers who refuse to do the procedure who are indeed practicing conscience, not those who do. However, conscientious objection is still relevant in Nigeria regarding the few legally recognized exceptions, and regarding post abortion care, contraception and emergency reproductive health interventions.

The effects of this limiting environment are dire. Nigeria is one of the countries with the highest unsafe abortion rates in sub-Saharan Africa, with estimates of approximately 1.25 million unsafe abortions annually and significant morbidity and mortality due to unsafe abortion, as documented by Bankoleand Kassebaum.

### 3.2 Conscientious Objection in Practice: The Nigerian Healthcare Setting

There is no statutory provisions for conscientious objection in Nigeria, and healthcare providers in the country are thus in a situation of regulatory vacuum. Nigeria's health professionals hold a generally negative attitude towards abortion, and religious and moral beliefs are important determinants of attitudes and, more significantly, socio-cultural and institutional pressures can be described as informal conscientious objection regimes.[16]

Religion plays a vital role in influencing the attitudes in Nigeria towards reproductive healthcare and its significance cannot be overemphasized. In Nigeria, there is almost a 50:50 split between Christians and Muslims with a strong doctrinal stance against abortion on both sides. In this medical culture, a notion of human rights is generally shaped in an African context, as a communitarian and religiously coloured worldview that gives priority to the life of the unborn, which results in the existence of conscientious refusals that are "medically" treated as legally unregulated, but are widely accepted and socially normal.[17]

Conscientious objection also hinders access to contraception, post-abortion care, and emergency obstetric services, aside from abortion. Arowolo and Aluko also record that the politics of conscience

[16]Bankole, A; *Unwanted Pregnancy and Induced Abortion in Nigeria: Causes and Consequences*, New York, Guttmacher Institute Press, 2006; Ogbu, O.N; *Modern Nigerian Legal System*, 3rd ed, Enugu, Snaap Press Ltd, 2013.

[17]Olubusola, A.A; 'Abortion Laws in Nigeria: A Case for Reform'; *Annual Survey of International and Comparative Law*, Vol 23(1), 2019.

in Nigeria's health care institutions has been against women, and in particular the poor rural women who have less ability and access to alternative care.[18]

### 3.3 Nigeria's Obligations under International and Regional Human Rights Law

Nigeria is a state party to CEDAW, ICCPR, the African Charter on Human and Peoples' Rights and Maputo protocol, which have positive obligations for access to reproductive healthcare. In 2004, Nigeria ratified the Maputo Protocol which explicitly calls on state parties to allow medical abortion of rape victims, sexual assault, incest, and where it "threatens the mental or physical health of the mother".[19]

Furthermore, the lack of any regulatory mechanism for conscientious objection, such as ensuring referrals or the availability of willing providers of abortions to women in states that have ratified the Maputo Protocol but have restrictive laws at home, makes the situation worse.[20]

## 4. The South African Framework: A Comparative Model

### 4.1 The Choice on Termination of Pregnancy Act

The legal framework to regulate conscientious objection in reproductive health services is best illustrated in South Africa in Africa. Importantly, the CTOPA does include a specific clause on conscientious objection in section 15 which allows for no person to be compelled to perform or assist in a termination of pregnancy if they have a conscientious objection to the act, but they must refer the pregnant woman to another healthcare provider.[21]

The South African framework is therefore based on two principles: the right of the individual providers to conscientiously object, and a duty to ensure that patients are not thereby denied access to services. The key to balancing competing rights in the law is the referral obligation. Strebel and Colvin note that it is a "conscious legislative choice" that the right to conscience extends to no right to impede access to lawful healthcare.[22]

### 4.2 Challenges in Implementation

Although South Africa has progressive legislation, there have been a number of challenges with its implementation. The study demonstrates a lack of compliance with the referral obligation, with many providers who invoke conscientious objection not referring to a willing provider or even communicating to the patient his/her rights. They discovered that conscientious objection has become a structural obstacle to abortion access in South Africa, with those who are objecting to abortion being clustered in certain facilities thus creating "service deserts" in certain provinces.[23]

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[18] Arowolo, D. and Aluko, F; 'Women's Reproductive Rights and the Politics of Conscience in Nigeria'; *Journal of Law and Religion in Africa*, Vol 3, 2012.

[19] African Union; *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol)*, 2003, art 14(2)(c).

[20] Ibid.

[21] *Choice on Termination of Pregnancy Act* 92 of 1996 (South Africa), ss 2–4.

[22] Ibid.

[23] Strebel, A. and Colvin, C.J; 'Conscientious Objection and its Impact on Abortion Service Provision in South Africa'; *Reproductive Health*, Vol 11(1), 2014.

Moreover, the phenomenon of institutional conscientious objection (where the healthcare provider, based on their faith or moral convictions, refuses to provide particular service without also refusing to provide that service at the facility level) has become a major problem that is not solved by the CTOPA, as the latter specifically refers to individual providers, not institutions. This has resulted in the condition that in many instances entire facilities are virtually unavailable for termination services as required by law.[24]

In the South African context, a step forward in the legislation is insufficient to ensure meaningful access if it is not adequately enforced and subjected to accountability mechanisms, as Heino et al. note, in the context of the European healthcare landscape, but with parallels that can be drawn to the South African case.[25]

### 4.3 The Constitutional Dimension

The Constitution of the Republic of South Africa (1996) provides a uniquely rich rights framework for addressing the tension between conscientious objectionand reproductive healthcare access. Section 27 guarantees the right to have access to healthcare services, including reproductive healthcare,[26] while section 15 protects freedom of conscience, religion, thought, belief, and opinion. The Constitutional Court has affirmed that socioeconomic rights, including the right to health, impose positive obligations on the state to take reasonable measures to progressively realise these rights.[27]

This constitutional architecture creates a framework in which conscientious objection claims must be evaluated not simply as exercises of individual conscience but as state-regulated activities with public health implications. The state's obligation to ensure access to reproductive healthcare services — including through the regulation of conscientious objection — is a direct constitutional imperative that cannot be displaced merely by invoking the conscience of individual providers.

## 5. The United Kingdom Model: Statutory Conscience and Judicial Oversight

### 5.1 The Abortion Act 1967 and the Conscience Clause

The United Kingdom - and specifically England, Scotland, and Wales - has regulated conscientious objection in the context of abortion since the enactment of the Abortion Act 1967. Section 4 of the Act provides that no person shall be under any duty to participate in any treatment authorized by the Act to which they have a conscientious objection, except where treatment is necessary to save the life or prevent grave permanent injury to the physical or mental health of a pregnant woman.[28]

The Abortion Act 1967 liberalized abortion law in England, Scotland, and Wales (Northern Ireland remained under a stricter regime until 2019), permitting abortion on specified grounds up to 24 weeks of gestation. The conscience clause in section 4 reflects the legislative recognition that the Act imposed

[24]Strebel, A. and Colvin, C.J; 'Conscientious Objection and its Impact on Abortion Service Provision in South Africa'; *Reproductive Health*, Vol 11(1), 2014.
[25]Heino, A. *et al*; 'Conscientious Objection and Induced Abortion in Europe'; *European Journal of Contraception & Reproductive Health Care*, Vol 18(4), 2013.
[26] Section 27 of Constitution of the Republic of South Africa (1996)
[27] Ibid.
[28]*Abortion Act* 1967 (UK), s 4.

obligations that some providers would find morally untenable, and sought to accommodate those objections while preserving access to services through the referral mechanism.[29]

### 5.2 Judicial Interpretation: Greater Glasgow Health Board v Doogan

The United Kingdom's most significant judicial contribution to the jurisprudence on conscientious objection in reproductive healthcare is the Supreme Court decision in *Greater Glasgow Health Board v Doogan.*[30] Two Roman Catholic midwives claimed a conscientious objection to participating in the supervision and delegation of tasks related to lawful abortions, arguing that section 4 of the Abortion Act extended to their supervisory and administrative roles.[31]

The Supreme Court unanimously rejected this expansive interpretation, holding that the right to conscientious objection extended only to direct participation in the treatment procedures that bring about the termination, and not to the management and supervision of staff who were themselves directly involved.[32] The decision is doctrinally significant in establishing that the conscience clause must be construed narrowly, and that operational demands of the healthcare system impose limits on how broadly conscientious objection can extend. This is consistent with the approach advocated by Dickens and Cook that the scope of conscientious objection must have defined limits.[33]

### 5.3 Regulatory Guidance and Professional Standards

In addition to the statutory framework, the UK's professional regulatory bodies have developed guidance that shapes the exercise of conscientious objection in practice. The General Medical Council (GMC) guidance on personal beliefs and medical practice affirms that doctors may withhold certain procedures on grounds of conscience but must always ensure that patients can access the services they need, including by referring patients promptly to another practitioner and providing adequate information about their options.[34]

The Nursing and Midwifery Council (NMC) has similarly emphasized that the duty of care to patients takes precedence over personal beliefs in clinical settings, and that nurses and midwives must not allow their personal views to compromise the care they provide. These professional standards complement the statutory conscience clause by establishing the parameters within which conscientious objection may legitimately be exercised, and by embedding referral obligations as professional duties rather than merely statutory requirements.[35]

Westeson's analysis of the European Court of Human Rights jurisprudence on reproductive health information and abortion services is instructive here. The ECtHR has consistently held that states must ensure that conscientious objection does not prevent effective access to reproductive healthcare services, and that systemic failure to regulate CONSCIENTIOUS OBJECTION constitutes a violation of the positive obligations under Article 8 of the ECHR (the right to private and family life).[36]

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[29] Ibid.
[30] *Greater Glasgow Health Board v Doogan* [2014] UKSC 68, [2015] AC 640.
[31] Supra
[32] Dickens and Cook (n 5).
[33] General Medical Council; *Personal Beliefs and Medical Practice*, London, GMC, 2013.
[34] Ibid.
[35] Westeson, J; 'Reproductive Health Information and Abortion Services: Standards Developed by the European Court of Human Rights'; *International Journal of Gynaecology and Obstetrics*, Vol 122(2), 2013.
[36] Ibid.

## 6. Extracting Lessons for Nigeria

### 6.1 The Three Models in Comparative Perspective

The comparative analysis of the three jurisdictions reveals three distinct regulatory models for managing conscientious objection in reproductive healthcare. Nigeria represents a model of legal absence - where the primary barriers to reproductive healthcare are found in restrictive abortion laws rather than conscientious objection regulation, and where conscientious objection operates informally and without accountability mechanisms. South Africa represents a model of statutory accommodation - where conscientious objection is expressly recognized in legislation alongside a referral obligation, but where implementation failures undermine the effectiveness of the framework. The United Kingdom represents a model of statutory regulation with judicial oversight - where a longstanding conscience clause is shaped by judicial interpretation and professional regulatory standards.[37]

Each model carries specific implications for access to reproductive healthcare. In Nigeria, the absence of a conscientious objection framework means that provider refusals are ungoverned - neither expressly permitted nor constrained. This creates a context in which the most religiously and culturally conservative practices dominate, to the detriment of women who need care. As Harris et al. have observed, context is decisive in determining the impact of conscientious objection: where legal services are available in theory but inaccessible in practice due to provider refusals, the formal guarantee of rights is rendered hollow.[38]

South Africa demonstrates both the potential and the limits of legislative reform. The CTOPA's section 15 represents a principled legislative approach to conscientious objection, but the gap between statutory text and lived reality reveals the indispensability of implementation mechanisms, enforcement, and accountability. Law reform without systemic investment in training, monitoring, and enforcement risks creating what Simmons has described as 'parchment rights' - legally recognized but practically unenforceable.[32]

The United Kingdom model offers perhaps the most complete set of lessons. The Doogan decision establishes the principle that conscientious objection must be construed narrowly in healthcare settings, and that the operational demands of the healthcare system - particularly the imperative of ensuring patient access - limit the scope of individual conscience rights. The complementary role of professional regulatory guidance in shaping conscientious objection practices demonstrates that legal frameworks and professional standards must operate in tandem.[39]

### 6.2 The Human Rights Framework as a Unifying Standard

Across all three jurisdictions, international human rights law provides the normative framework for evaluating the adequacy of conscientious objection regulation. The right to health, the right to non-discrimination, and the right to privacy are implicated whenever conscientious objection operates to deny access to reproductive healthcare. The Maputo Protocol - which binds both Nigeria and South

[37]Heino, A. *et al*; 'Conscientious Objection and Induced Abortion in Europe'; *European Journal of Contraception & Reproductive Health Care*, Vol 18(4), 2013.
[38] Harris, L.F. *et al*; 'Conscientious Objection to Abortion Provision: Why Context Matters'; *Global Public Health*, Vol 13(5), 2018.
[39]Ibid.

Africa - imposes a particularly direct obligation to ensure that women can access abortion services in specified circumstances, an obligation that cannot be displaced by provider conscientious objection in the absence of adequate alternative access arrangements.[40]

Cook and Dickens have argued that the human rights framework requires the following minimum standards for the regulation of conscientious objection in reproductive healthcare: individual providers must be permitted to conscientiously object; they must not be permitted to obstruct access or harass patients; they must be required to refer to willing providers; institutions must not be permitted to impose facility-wide refusals that eliminate access in given areas; and states must ensure sufficient willing providers to guarantee meaningful access.[41]

Nigeria fails on virtually all these measures - not merely because it lacks a conscientious objection framework, but because its restrictive abortion laws effectively prevent the existence of willing providers for the most commonly sought services. South Africa satisfies some of these minimum standards at the statutory level but falls short in implementation. The United Kingdom most closely approximates the human rights standard, but even it faces challenges around institutional conscientious objection and geographic access disparities.[42]

**7. Conclusion and Recommendations**

Conscientious objection in reproductive healthcare is not simply an exercise of individual conscience: it is a regulatory and governance challenge with profound implications for women's health, dignity, and rights. When conscientious objection operates without legal regulation, as in Nigeria, it functions as an ungoverned barrier to care that disproportionately affects the most vulnerable women. When it is regulated but poorly enforced, as in South Africa, it creates a gap between statutory promise and practical reality. When it is regulated with judicial oversight and professional guidance, as in the United Kingdom, it can be accommodated without systematically compromising access - though challenges persist.[43]

The lessons from this comparative analysis point towards a model of regulated accommodation: one that takes conscience seriously as a fundamental human value while insisting that its exercise in clinical settings must be governed by clear rules, enforced referral obligations, and institutional accountability. For Nigeria, the path forward requires both fundamental law reform - including the alignment of abortion law with regional human rights obligations -and the development of a statutory framework for conscientious objection that genuinely reconciles the rights of providers with the rights of patients.[44]

The right of a woman to access reproductive healthcare is not contingent on the moral approval of her healthcare provider. The challenge of law and policy is to give effect to this principle in systems where conscience, culture, and resources all conspire against it. The comparative experience of South Africa and the United Kingdom demonstrates that this challenge is not insuperable - but it requires political

[40] Bunch, C. and Fried, S; 'Beijing '95: Moving Women's Human Rights from Margin to Center'; *Signs: Journal of Women in Culture and Society*, Vol 1, 2005.
[41]Ikeatu, E.G; 'Violations of Women's Reproductive Rights in Nigeria'; *NAUJILJ*, Vol 11, 2020.
[42]Ibid.
[43]Savulescu, J; 'Conscientious Objection in Medicine'; *BMJ*, Vol 332(7536), 2006, 294
[44]Ogbu O.N., Modern Nigerian Legal System, 3rd ed, Enugu, Snaap Press Ltd, 2013.

will, legal imagination, and a genuine commitment to the full realization of women's rights as human rights.[45]

The foregoing analysis supports the following recommendations for Nigeria. First and most foundationally, Nigeria should undertake a comprehensive review of its abortion law with a view to aligning domestic legislation with the Maputo Protocol's minimum requirements. Olubusola has argued persuasively that Nigeria's criminal prohibition of abortion is inconsistent with its regional human rights obligations and its constitutional guarantee of the right to health.[46]

Second, and consequentially, Nigeria should enact a statutory framework for conscientious objection in reproductive healthcare that: (a) expressly permits individual providers to conscientiously object to procedures that violate their sincerely held beliefs; (b) imposes a mandatory referral obligation upon objecting providers; (c) prohibits institutional conscientious objection where it would eliminate access in a given area; (d) requires healthcare facilities to maintain and disclose information about the availability of willing providers; and (e) prohibits the obstruction of patients seeking to access legally available services.[47]

Third, Nigeria should invest in healthcare provider training to address the cultural and religious dimensions of resistance to reproductive healthcare. As Arowolo and Aluko note, the intersection of religion and politics in Nigeria's public health landscape requires a nuanced approach that does not simply attempt to override conscience through legal compulsion, but rather engages with providers' concerns while establishing clear professional standards.[48]

Fourth, the regulatory and professional bodies governing healthcare practice in Nigeria - including the Medical and Dental Council of Nigeria and the Nursing and Midwifery Council of Nigeria - should develop and enforce professional standards on conscientious objection that complement any statutory framework. The UK model demonstrates the value of professional guidance in operationalizing statutory conscience clauses and embedding referral obligations as professional duties.[49]

[45] Ibid.
[46]Olubusola A.A., 'Abortion Laws in Nigeria: A Case for Reform', Annual Survey of International and Comparative Law, Vol 23 Issue 1, 2019.
[47]Kassebaum, N.J. *et al*; 'Global, Regional, and National Levels and Causes of Maternal Mortality'; *The Lancet*, Vol 384(9947), 2014.
[48]Nawrot, O; 'Conscientious Objection and African Vision of Human Rights'; *Prog Health Sci.*, Vol 6(1), 2016.
[49] Simmons B.A., Mobilizing for Human Rights: International Law in Domestic Politics, Cambridge University Press, 2019.