Akwa Ibom State Guidelines

on Safe Termination of Pregnancy for Legal Indications

Ipas Partners for Reproductive Justice
NIGERIA HEALTH FOUNDATION

Table of contents

Foreword

Maternal Mortality refers to death due to complications from pregnancy or childbirth. From the year 2000 to 2020, the Global Maternal Mortality ratio (MMR) declined by 34 percent from 339 deaths to 223 deaths per 100,000 live births, according to UN inter-agency estimates. Nigeria's MMR has also declined from 814 to 556 per 100,000 live births although this is still far from the goal of less than 140 per 100,000 live births (WHO).

This is widely attributed to the implementation of several innovative interventions by national governments and partners over the last 2 decades. This rate of reduction, however, is not uniformly distributed throughout the world. In Nigeria, about 45,000 maternal deaths still occur and the annual rate of reduction for maternal mortality was less than 4 percent that is necessary to attain the Sustainable Development Goal (SDG) 3 target 3.1 reducing global maternal mortality to less than 70 per 100,000 live births by 2030. Unsafe abortion alone accounts for about 10 to 14 percent of maternal morbidity and mortality in Nigeria.

In Akwa Ibom State, the current Nigeria National Demographic Health Survey (2018) showed the Maternal Mortality ratio of 420 deaths per 100,000 live births.
It is reported that an estimated 1.25 million induced abortions occurred in Nigeria in 2012, equivalent to 33 abortions per 1000 women aged 15-49 years. The estimated unintended pregnancy rate was 59 per 100 women aged 15-49 years. Fifty-six percent of these unintended pregnancies ended in abortion. About 212,000 women were treated for complications of unsafe abortion, representing a treatment rate of 5.6 per 1000 women of reproductive age and an additional 285,000 experienced serious health consequences but did not receive the treatment they needed. Although there is no data available to show the abortion rate for Akwa Ibom State, the 2018 NDHS data shows that the state has the highest prevalence rate for unwanted pregnancy (28.5%). This could suggest by inference a high abortion rate as reports have shown that as many as 60% of unwanted and unintended pregnancies end in abortion (Awolude et al 2012). In a study among female senior secondary school students in Akwa Ibom State by Abah, Bassey et al (2020), the prevalence rate of abortion was 57.1%.

The high numbers of unintended pregnancies in the country have been attributed to the low contraceptive prevalence rate as well as the restrictive abortion law which permit abortion only on the legal grounds to protect the life and wellbeing of a woman. Even on these narrow legal grounds, information about legal services are unavailable to women and health care providers. Consequently, it is falsely presumed that no legal provisions exist for abortion although this is not the case.

In addition, health providers may have lacked training in safe abortion procedures and had insufficient information to be able to act within the law or be reluctant to

interpret existing legal provision. The lack of clear guidelines, effective procedures to guide providers' decisions to ensure the law is correctly interpreted has led to dire consequences for women and has contributed to increased risk of unsafe abortion and this may have contributed to the high maternal morbidity and mortality rates in Nigeria, and by inference, Akwa Ibom State.

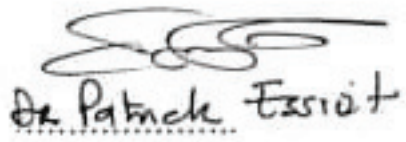
Therefore, having a guideline on Safe Termination of Pregnancy (SToP) for Legal Indications is of extreme importance to control unnecessary deaths of women who lose their lives as a result of conditions that are aggravated by continuation of pregnancy. I call on all stakeholders to support the Akwa Ibom state Government in the dissemination and implementation of this guideline to ensure that every woman gets the right care she deserves at the right time and place.

Prof. Augustine Vincent Umoh
Honourable Commissioner for Health,
Akwa Ibom state, June, 2024

Acknowledgment

The Akwa Ibom State Guideline on Safe Termination of Pregnancies for Legal Indications was adapted from the National guidelines under the leadership of the Akwa Ibom State Ministry of Health (SMoH) in collaboration with Ipas Nigeria Health Foundation, Society of Gynaecology and Obstetrics of Nigeria (SOGON), the Akwa Ibom State Ministry of Justice, Akwa Ibom State Ministry of Women Affairs, National Human rights Commission, development partners, representatives of law enforcement agencies, CBOs, and other key stakeholders. This process was facilitated by Mr. Samsu Gombwer, of Ipas, Professor Raphael Avidime Attah , and Professor Patrick Haruna Daru, of the Aminu Kano Teaching Hospital, and Jos University Teaching Hospital respectively.

To these individuals and organizations, the Akwa Ibom SMoH would like to extend our sincere appreciation. The SMoH highly appreciates the considerable resources, time and efforts dedicated to the development of this guideline. Ipas is especially commended for the support provided for this project.



Dr Patrick Essiet
The Permanent Secretary,
Akwa Ibom State Ministry of Health,
June 2024

Executive Summary

Nigeria is now ranked as having the second largest burden of maternal mortality in the world, after India. In Akwa Ibom State, the current Nigeria National Health Demographic Survey (2018) reported a Maternal Mortality ratio of 420 deaths per 100,000 live births.

Most of these deaths are, however, preventable as Akwa Ibom State aligns with the global Sustainable Development Goals (SDGs) efforts at eliminating all preventable maternal deaths by 2030. Every effort must henceforth be made to identify and prevent every prevalent, preventable cause of maternal death.

One neglected major area of preventable maternal death is that related to the provisions of "The Nigerian Abortion Law". The law permits the termination of pregnancy in circumstances where the continuation of such pregnancy threatens the life of the mother. Unfortunately, no formal efforts have been made, through the development of policy instruments, guidelines or tools, to implement these provisions to preserve the lives of Akwa Ibom women whose existence is threatened by the continuation of their pregnancies.

This State Guideline is intended to build the capacity of medical professionals to identify pregnancies for which the law is intended so that ethical and safe management can be instituted. The guideline provides information on the subsisting Nigerian law on the termination of pregnancy, a compendium of medical conditions and circumstances where the continuation of pregnancy endangers the woman's life and a description of the step-by-step options for an ethical and safe medical management.
It is envisaged that the enunciation, deployment, and use of this guideline will preserve the lives of pregnant women who would have died from the continuation of their pregnancies.

Editorial Team

Members of Akwa Ibom State Standards and Guidelines Adaptation Committee		
S/N	**Names**	**Ministry**
1.	Prof. Augustine Umoh	SMoH
2	Dr. Patrick Esiet	SMoH
3	Dr. Mrs. Eno Attah	AKSPHCDA
4	Dr. Iboro Udo	SMoH
5	Dr. Etop Antia	SMoH
6	Mrs. Ekaete Okono	SMoH, AKSPHCDA
7	Mrs. Ini Bassey	Hospitals Management Board
8	Patricia Etim	SMoH
9	Mrs. Comfort Thompson	SMoH
10	Mrs. Ekaete Afangide	AKSPHCDA
11	Mrs. Ekemini Udofia	PHC Ibesikpo Asutan
12	Dr. Ini Adiakpan	Ministry of Women Affairs & Social Welfare
13	Mrs. Eno Jerome	Ministry of Women Affairs & Social Welfare
14	Dr. Ime Sylvester Udoh	AKSPHCDA
15	Etido Bassey Edem	Ministry of Women Affairs & Social Welfare
16	Uko Essien Udom SAN	Min. of Justice
17	Bar. Joseph Umoren	Min. of Justice
18	Bar. Uloma I. Umozurike	Nat. Human Right Comm.
19	Prof. Emem Bassey	SOGON AKS
20	Dr. Uduak Usanga	Medical Women's Association of Nigeria AKS
21	Imaobong S. Raphael	SARC, Ikot Ekpene
22	Anietie Jackson	Joint National Assoc. of Persons with Disabilities, AKS Chapter
23	Dr. Ikanke Mathias	Cottage Hosp. Ikot Ekpaw
24	Lucy Anthony Dickson	Leprosy Hosp. Ekpene Obom

25	Mr. Nehemiah Monday Okon	Joint National Assoc. of Persons with Disabilities, AKS Chapter
26	Mrs. Uduak Umoh	WOCLIF
27	Dorothy Edet	Doro-Voice Initiative, AKS
28	Elizabeth Adebanjo	ARRDEC
29	Emediong Akpaso	UNFPA Nig., Akwa Ibom Youth Cohort
30	Cmdt. Eluyemi Eluwade	Nig. Sec. Civil Defence Corps
31	CSP Shulammite Otokpa	Nigerian Police Force
32	Mr. Godwin Archibong	Medical & Health Workers Union, AKS
33	Dr. Eneh Nchiek Edet	SMoH
34	Dr. Esin Nkoyo	Gen. Hospital Etinan
35	ASP Udeme Isikong	Nigeria Police Force
36	Emem Ette, Esq	Min. of Justice
37	Supt. Michael Asibor	Nigeria Security & Civil Defence Corps.
38	Edo Edem Okon	SMoH
39	Joshua Okon Inim	ARRDEC
40	Abasiodiong Udoakpan, Esq	Min. of Justice
41	Helen Effiong Etuk	SMoH
42	Pharm. Elisha Udoh	AKSPHCDA
43	Maria Sunday Evans	School of Midwifery Anua-Uyo
44	Florence Anietie Umoh	SMoH
45	Dr. George Ekanem	SMoH
46	Engr. Dr. Idorenyin Etiese Marksson	Uniuyo
47	Udeme I. Akah	SMoH
48	Idorenyin Akpan, Esq	Min. of Justice
49	Professor Raphael Avidime Attah	Aminu Kano Teaching Hospital, Kano
50	Professor Patrick Haruna Daru	Jos University Teaching Hospital
51	Mr. Samsu Gombwer	Ipas Nigeria Health Foundation
52	Mr Leonard Adiogu	Ipas Nigeria Health Foundation

Abbrevations and Acronyms

AF	Atrial Fibrillation
AKS	Akwa Ibom State
ASD	Atrial Septal Defect
BV	Bacterial Vaginosis
CBOs	Community Based Organisations
CNS	Central Nervous System
CVS	Cardiovascular System
DCM	Dilated Cardiomyopathy
D&C	Dilatation and Curettage
D&E	Dilatation and Evacuation
EF	Ejection Fraction
EVA	Electric Vacuum Aspiration
FMOH	Federal Ministry of Health
GA	Gestational Age
Hb	Haemoglobin
HCM	Hypertrophic Cardiomyopathy
IUFD	Intrauterine Fetal Death
LNMP	Last Normal Menstrual Period
MVA	Manual Vacuum Aspiration
PAC	Post - Abortion Care
PCV	Packed Cell Volume
PDA	Patent Ductus Arteriosus
PSI	Population Services International
RHD	Rheumatic Heart Disease
SDG	Sustainable Development Goals
SMOH	State Ministry of Health
SRH	Sexual and Reproductive Health
SToP	Safe Termination of Pregnancy
TOF	Tetralogy of Fallot
VAPP	Violence Against Persons Prohibition
VSD	Ventricular Septal Defect
WHO	World Health Organization

Definition of Terms

Abortion is the termination of a pregnancy before 22 completed weeks (this gestational age refers to the age of attainment of viability for successful extra-uterine survival, and 28 weeks is widely used in low-resource settings). In the medical context, abortion can either be spontaneous (also called miscarriage) or induced.

Unsafe abortion is defined by the World Health Organization (WHO) as a procedure for terminating an unintended pregnancy, carried out either by persons lacking the necessary skills in an environment that does not conform to minimal medical standards or both.

Therapeutic Abortion is the termination of pregnancy performed when the pregnancy endangers the mother's health or when the fetus has a condition incompatible with normal life.

Chapter 1:
Introduction

In Nigeria, an estimated 20-40% of maternal deaths result from abortion complications, with a procedure-related death rate of 680 per 100,000 abortions. In 2012, there were 1,250,000 induced abortions in Nigeria (representing double the 1996 figure of 610,000), equivalent to a rate of 33 abortions per 1000 women aged 15 – 49. Over 80% of induced abortions are done by doctors in private settings, while others are either self-induced or performed by other health personnel and quacks.

These terminations are done for social reasons. Data on legal terminations in Nigeria are lacking, but the worsening trend and the complications that follow induced abortions indicate a lack of skill and appropriate technology for the safe termination of pregnancy. There is, however, no data available to show the abortion rate for Akwa Ibom State, although according to the 2018 NDHS data, the state has the highest prevalence rate for unwanted pregnancy (28.5%). In a study carried out among female senior secondary school students in Akwa Ibom State by Abah, Bassey et al. (2020), the prevalence rate of abortion was 57.1%. This suggests a high abortion rate in the state by inference, as previous reports have shown that 60% of unwanted and unintended pregnancies end in abortion (Awolude et al. 2012).

The law in Nigeria stipulates that abortion can be performed to save a woman's life. Unfortunately, data indicates that health providers are unaware of the medical reasons that allow therapeutic abortions to be performed to save a woman's life as well as promote her health and well-being. Against this background, the Akwa Ibom State Ministry of Health, with the support of stakeholders and partners, has adopted the National guidelines on the safe termination of pregnancies for legal indications. This is aimed at reducing maternal morbidity and mortality from medical conditions that threaten women's lives during pregnancy and from abortion procedures in Akwa Ibom State.

This guideline is for doctors practising at the facility level. It considers the tasks, knowledge and skills of all cadres of healthcare workers. Additionally, it may be used by health program managers, program coordinators, instructors, and reproductive health trainers.

Goal and Objectives of the Guideline

Goal

The goal of this document is to provide guidelines for the safe termination of pregnancy within the legal framework in Akwa Ibom State, particularly in cases where the continuation of the pregnancy poses a threat to the life of the woman. The aim is to reduce maternal morbidity and mortality in the state.

Objectives

The objectives of this guideline are:

- Provide information and guidance on the legal indications for the safe termination of pregnancy in Akwa Ibom State.
- Specify the medical indications for the safe termination of pregnancy in accordance with the law in Akwa Ibom State.
- Establish the standards and norms for providing safe termination of pregnancy services for legal indications in Akwa Ibom State.
- Guide policymakers and health managers in implementing safe termination of pregnancy for legal Indications And Related Interventions.

Chapter 2:

Laws Related to The Termination of Pregnancy in Akwa Ibom State

The existing laws related to abortion in Akwa Ibom State are cited in sections 182, 183, 184, and 253 of the Criminal Code Law, Cap39, Vol.2, Laws of Akwa Ibom State, 2022, and Violence against Persons (Prohibition) Law, 2020 (VAPP).

Criminal Code Law Of Akwa Ibom State as Revised in 2022

Criminal Code Law: Section 182 - Attempt to procure abortion - Any person who, with intent to procure the 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 commits a felony, and is liable to confinement for fourteen years.

Criminal Code Law: Section 183 - Attempt to procure own miscarriage - Any woman who, with intent to procure her own miscarriage, whether she is or is not with child, unlawfully administers to herself any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, or permits any such thing or means to be administered or used to her commits a felony and is liable to confinement for a term of seven years.

Criminal Code Law: Section 184 - Supplying drugs or instruments to procure abortion - Any person who unlawfully supplies to or procures for any person anything whatsoever, knowing that it is intended to be unlawfully used to procure the miscarriage of a woman, whether she is or is not with child, commits a felony and is liable to confinement for a term of three years.

Criminal Code Law: Section 253 - Surgical operations- 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.

Violence Against Persons (Prohibition) Law 2020 (VAPP)

This Law prohibits all forms of violence against persons in private and public life and provides maximum protection and effective remedies and rights for victims and

punishment of offenders.

VAPP Law, Section 38(1): Every victim of violence as defined in section 46 of this Law, is entitled to the following rights to - a) receive the necessary materials, comprehensive medical, psychological, social and legal assistance through governmental agencies and/or non-governmental agencies providing such assistance and victims are entitled to be informed of the availability of legal, health, social services and other assistance; b) be informed of the availability of legal, health and social services and other relevant assistance and be readily afforded access to them; and c) rehabilitation and re-integration programme of the State to enable victims to acquire, where applicable and necessary, pre-requisite skills in any vocation of the victim's choice and also in necessary formal education or access to micro-credit facilities.

Chapter 3:
Legal Indications for the Safe Termination of Pregnancy in Nigeria

The conditions that may constitute a threat to the life of a pregnant woman and severe congenital abnormalities incompatible with life, warranting safe, legal termination of pregnancy, are listed below:

Obstetric & Gynaecological conditions

- Hyperemesis gravidarum refractory to treatment with severe hepatic or renal impairment
- Genital tract cancers (see oncology below)
- Severe fetal conditions/ malformation not compatible with extrauterine life
- CNS abnormalities such as anencephaly and hydrocephalus with no demonstrable brain tissue
- CVS abnormalities such as transposition of great arteries without shunts, atrio-ventricular discordance
- Multiple organ dysgenesis

Maternal Heart and Vascular diseases

- Severe Aortic Stenosis (Aortic valve area ≤1.0cm2)-might be due to Rheumatic Heart Disease (RHD) or congenital heart disease (Bicuspid aortic valve)
- Severe Mitral Stenosis (Mitral valve area ≤1.5cm2)-might be due to Rheumatic Heart Disease (RHD)
- Eisenmenger Syndrome – Reversal of shunt – left to right, to right to left
- Hypertension in the first or second trimester that cannot be controlled, including pre-eclampsia and eclampsia
- Pulmonary embolism
- Atrial Septal Defect (ASD), Ventricular Septal Defect (VSD) and Patent Ductus Arteriosus (PDA) with either atrial fibrillation and or severe pulmonary hypertension
- Congenital Cyanotic Heart Disease
  - Tetralogy of Fallot (TOF), Tetralogy of Fallot,
  - Severe Pulmonary Stenosis, Transposition of great arteries without correction
- Severe Ebstein's Anomaly
- Dilated cardiomyopathy (DCM) with depressed ejection fraction (EF) ≤30%
- Peripartum Cardiomyopathy – Cardiac failure with depressed ejection fraction (EF) ≤30%
- Coarctation of the aorta with left ventricular dysfunction

- Mechanical Valves – in situation of
- Rheumatic Heart Disease
- Mitral valve or Aortic Valve replacement on warfarin as an anticoagulant
- Endomyocardial fibrosis with arrhythmias- Atrial Fibrillation (AF)
- Hypertrophic Cardiomyopathy (HCM) with arrhythmias
- Any heart condition where the mother is in stage 3 or 4

Kidney Diseases

- Severe connective tissue disease like Systemic Lupus Erythematosus (SLE) with severe kidney damage refractory to treatment
- Worsening renal failure

Cancers

- Cancer of the cervix, uterus, ovary, breast, and leukemia
- Other oncological cases that require treatment
- Malignant neoplasia that requires surgery, chemotherapy and/or radiotherapy that is incompatible with the life of the fetus.

Blood Diseases

- Haemoglobinopathies with complications such as acute sequestration, acute chest/ brain syndrome and pseudo-toxemia of pregnancy.

Psychiatric and other Mental Disorders

- Psychiatric disorders with suicidal ideation
- Severe depression with suicidal tendencies such as may occur in rape and incest

Note: Any other maternal pathology that puts the life of a pregnant woman at risk and severe congenital abnormalities incompatible with life, as determined by a qualified medical practitioner, e.g.

- Autoimmune diseases (SLE, Scleroderma),
- Drugs: Immunosuppressive drugs,
- Infections: Overwhelming sepsis, Pott's disease, Rubella syndrome

Chapter 4:
Care Preceding the Safe Legal Termination of Pregnancy

A) Confirmation of Pregnancy:

The purpose of this step is to confirm the pregnancy, determine its gestational age and location, and assess the patient's general well-being in preparation for a safe termination of the pregnancy. This involves reviewing the patient's history, conducting a detailed examination, using a reliable urine pregnancy test and performing a pelvic ultrasound scan when necessary.

The medical history: Ask and document the following:

- Age
- Reproductive history (number of pregnancies, deliveries, abortions)
- First day of Last Normal Menstrual Period (LNMP)
- Gestational age based on LNMP
- History of drug allergy
- Any medical or surgical illnesses that are life-threatening
- Contraceptive history

Physical examination: Undertake the following:

- General and systemic examination to establish the general health and confirm the life threatening condition(s) of the woman
- Bimanual pelvic examination to establish:
    - Uterine size and position
    - The presence of other uterine or pelvic pathology, such as fibroids

Laboratory investigation: Do the following laboratory tests, where necessary

- Blood group and Rh factors
- Urine analysis
- Pregnancy test
- VDRL
- Smear and Gram's stain of vaginal discharge as appropriate
- Cervical cancer screening (Pap smear)
- Ultrasound and genetic tests as appropriate
- HIV, Hepatis B & C screening
- Indirect coombs test for Rhesus Negative women

B) Steps in reaching Decision for Termination of Pregnancy

i. Clinician adjudges that the continuation of the pregnancy constitutes a "danger to a woman's life" as enumerated in Chapter 3
ii. Clinician seeks second opinion for the confirmation of indication (this might involve referring the patient in circumstances where a second opinion is not locally feasible)

C) Informing and Counseling the Patient:

In general, pregnancies may be planned or unplanned, wanted or unwanted. In any of these circumstances, the patient should be clearly informed of the risks to pregnancy continuation while observing the following rights due to her:

a) Right to complete, correct, impartial and useful information
b) Right to dignity, privacy and confidentiality
c) Freedom of expression of their ideas
d) Right to choice
e) Right to equality without discrimination

This process may involve more than one session of contact or other persons who are critical to the woman's decision-making (but only if the woman requests additional sessions).

D) Content of information and Counseling to the Woman should also cover

- Detailed information about the pregnancy and her medical condition(s)
- Different methods of pregnancy termination appropriate for her gestation
- Efficacy and safety of methods of termination of pregnancy in her circumstance
- Potential adverse effects and complications and their clinical implications
- Her right to decline the pregnancy termination and assurances of care if opting out
- Counselling on HIV testin

E) Informed Consent

After providing the necessary information and counselling, ensure that the woman or her representative signs the informed consent form to indicate their acceptance or decline the offer to terminate the pregnancy.

If the woman is illiterate, her digital impression will be sufficient. Keep the informed consent form and the procedure authorisation in the clinical record.

She reserves the right to change her decision at any time before the procedure, in which case, she should revoke her informed consent by completing and signing a form

specifically for that purpose.

If the woman decides against the termination of the pregnancy, she should be given all the special antenatal care required for her medical condition. All these details should be duly documented.

F) Patient Evaluation

This step is applicable when the woman consents to the termination of the pregnancy. Its purpose is to re-confirm the gestational age, uterine size, and the state of the patient's health to determine the most suitable method of termination of the pregnancy.

Pain management options should include appropriate analgesia and conscious sedation when necessary. Additionally, all women undergoing termination of pregnancy should receive appropriate prophylactic antibiotics pre- operatively

Chapter 5:

Methods of Safe Termination of Pregnancy

Therapeutic abortion is the termination of a pregnancy performed when the pregnancy endangers the mother's health or when the fetus has a condition that is incompatible with everyday life.

The following are contemporary methods used for the termination of a pregnancy:

A. Medical Methods

Medical methods of abortion involve the use of pharmacological drugs to terminate pregnancy. They have been proved acceptable in many settings, including low-resource settings. The medications mainly used are mainly Mifepristone and Misoprostol. These medications are increasingly available globally, and the combination of mifepristone and misoprostol for medical abortion is now included on the WHO model list of essential medicines. However, their side effects include nausea, vomiting and diarrhoea.

Contraindications to their use include chronic or acute adrenal or hepatic failure, inherited porphyria, and allergy to any of the drugs used. Caution and clinical judgment are required before using them for women receiving long-term corticosteroids and for those who have bleeding disorders, severe anaemia, pre-existing heart disease or cardiovascular risk factors.

i. Mifepristone and Misoprostol:

Pregnancies of gestational age up to 9 weeks (63 days)

Administer an oral dose of mifepristone, 200 mg, followed 24 – 48 hours later by misoprostol, 800 µg, vaginally, sublingually or buccally. Following the administration of the misoprostol, up to 90% of women will expel the products of conception within 4–6 hours. Most women are likely to require pain relief medication for cramping pain during this period.

In the case where pregnancy fails to expel after the first dose of misoprostol, re-administration of misoprostol or surgical abortion (see below) should be offered to the woman after 3-4 hours. Women with incomplete abortion can generally be observed unless vaginal bleeding is heavy, whereupon they may be offered a repeated dose of

misoprostol or a surgical completion of the abortion. Facilities offering medical methods of abortion must also have the capacity to provide vacuum aspiration services or by linkage to a nearby facility if needed. Providing complete information about what to expect and the possible side effects of both medical and surgical methods of abortion can help ensure that women are more likely to be satisfied with the procedure.

Pregnancies of gestational age from 9 to 12 weeks (63–84 days)
Administer mifepristone, 200 mg, orally, followed 36–48 hours later by misoprostol, 800 µg, vaginally, in the healthcare facility. A maximum of four further doses of misoprostol, 400 µg, may be administered at 3-hourly intervals, vaginally or sublingually.

Pregnancies of gestational age over 12 weeks (>84 days)
Administer an oral dose of mifepristone, 200 mg, followed 36–48 hours later by an initial dose of misoprostol, either 400 µg orally or 800 µg vaginally, with further doses of 400 µg of vaginal or sublingual misoprostol every 3 hours, up to four further doses. For pregnancies beyond 24 weeks of gestation, the dose of misoprostol should be reduced to 200 µg due to the greater sensitivity of the uterus to prostaglandins.

ii. Misoprostol alone:

Pregnancies of gestational age up to 12 weeks (84 days)
Administer misoprostol, 800 µg, sublingually every 3 hours or vaginally/ buccally every 3 – 12 hours, for up to 3 doses.

This regimen is 75–90% effective in completing abortion. Sublingual administration is less effective than vaginal administration unless it is given every 3 hours, but this regimen has higher rates of gastrointestinal side- effects. Oral and rectal administrations are not recommended due to their low efficacy.

Pregnancies of gestational age over 12 weeks (84 days)
The recommended regimen is to administer misoprostol, 400 µg, vaginally or sublingually every 3 hours for up to 5 doses. In nulliparous women, the vaginal administration of misoprostol is more effective than a sublingual dosing. For pregnancies beyond 24 weeks of gestation, there isa greater sensitivity of the uterus to prostaglandins, so the dose of misoprostol should be reduced to 200 µg4 hourly vaginally, or sublingually for up to 4 doses.

Table 1:
Summary of Recommended Medical Abortion Regimen

Trimester	Duration of Pregnancy	Drug	Dosage	Route of Administration
First Trimester	0-9 weeks (63 days)	Mifeprestone + Misoprostol	200mg 800 µg*	Mifepristone: Orally Miso-prostol: Vaginal, buccal, or sub-lingual
First Trimester	9 – 12 weeks (63- 84 days	Mifepristone + Misoprostol	200mg 800 µg#	Mifepristone: Orally, Misoprostol: 1st dose vaginally, additional doses after 3 hours, 400µg vaginally or sublingually, up to 5 doses
First Trimester	9-12 weeks (63-84 days)	Misoprostol alone	800 µg	Sublingually every 3 hours or vaginally/ buccally every 3 – 12 hours, for up to 3 doses.
Second Trimester	over 12 weeks (>84 days)	Mifepristone + Misoprostol	200mg 400 µg# orally, 800 µg vaginally	Mifepristone: orally Misoprostol: 1st dose 400 µg orally, or 800 µg vaginally. Additional doses, 400 µg vaginally or sublingually every 3 hours up to 4 doses total
Second Trimester	20-24 weeks pregnancy	Misoprostol alone	400 µg	vaginally, sublingually every 3 hours for up to 5 doses
Second Trimester	pregnancy more than 24 weeks	Misoprostol alone	less than 400 µg	vaginally, sublingually 100µg over 4 hours for up to 4 doses

*Misoprostol is administered 1-2 days (24-48 hours) after initial Mifepristone dose.

Misoprostol is administered 36-48 hours after initial Mifepristone dose.

Note: After 7 weeks of gestation, oral administration of misoprostol should not be used

B. Surgical Methods

Surgical methods of abortion entail the use of trans-cervical procedures for terminating pregnancy, and they include:

a. Manual vacuum aspiration
b. Dilatation and evacuation
c. Electric vacuum aspiration

Manual Vacuum Aspiration

The recommended surgical technique for abortion up to gestational age of 12weeks is **Manual Vacuum Aspiration (MVA).**

When MVA is performed on normal women for a first-trimester abortion, the use of local anaesthesia is usually sufficient, and they feel well enough to leave the healthcare facility after observation for about 30 minutes in a recovery room. Longer recovery periods may be needed for patients targeted by this guideline and for abortions performed at a higher gestational age when sedation or general anaesthesia should be used.

Manual Vacuum Aspiration is a very safe procedure. Though rare, complications with vacuum aspiration can include pelvic infection, excessive bleeding, cervical injury, incomplete evacuation, uterine perforation, anaesthetic complications and ongoing pregnancy (failed evacuation). Abdominal cramping and menstrual-like bleeding may occur with any abortion procedure, and patients should be given appropriate counselling and support.

Before the MVA procedure:

- Provide counselling to the woman and obtain informed consent
- Perform a clinical assessment, including a physical examination
- Perform essential laboratory investigations
- Decide if cervical preparation is necessary. The following group of women may need cervical preparation:
    - — Nulliparous women and those aged 18 or below with gestational duration of more than 9 weeks
    - — All pregnant women at a gestational age of more than 12 weeks. Depending on their availability, administer either of the following drugs in the recommended dosages:
- Misoprostol 400 µg vaginally or orally, 3 to 4 hours before the procedure; or
- Mifepristone 200 mg orally, 36 hours before the procedure; and
- Discuss her contraceptive needs/pain management options.

Uterine evacuation procedure:

The steps for performing MVA are:

1. Prepare instruments
2. Assist the woman and have her void urine, mainly if general anaesthesia use is not intended
3. Perform cervical antiseptic preparation
4. Perform paracervical block if necessary
5. Dilate cervix if necessary using cannula in an incremental size or plastic dilators
6. Insert cannula appropriate for the gestational age
7. Suction uterine contents until cavity is confirmed empty
8. Inspect tissue (and perform histology where possible)
9. Perform any concurrent procedures
10. Take immediate post-procedure steps, including instrument processin

Dilatation and Evacuation (D&E)

This is used after 12–14 weeks of pregnancy. It is the safest and most effective surgical technique for later abortion, where skilled, experienced providers are available.

D&E requires the preparation of the cervix using osmotic dilators or pharmacological agents and evacuating the uterus using Electric Vacuum Aspiration with 12–16 mm diameter cannulae and long forceps.

Depending on the duration of the pregnancy, the preparation to achieve adequate cervical dilatation can require from 2 hours to 2 days. Many providers find the use of ultrasound helpful during D&E procedures, but its use is not essential.

> **Note: Use of dilatation and curettage (D&C)** is now obsolete and the World Health Organization (WHO) has since recommended the replacement of D&C with MVA in all units.

Tissue examination following surgical abortion

After surgical methods of abortion, an immediate examination of the products of conception is important. With vacuum aspiration, beginning around 6 weeks of pregnancy, trained providers can visually identify the products of conception, specifically chorionic villi and the gestational sac. If the aspirate does not contain products of conception, ectopic pregnancy should be suspected, and the woman should undergo further evaluation. If the contents of the aspirate contain less tissue than expected, the possibility of incomplete abortion and further treatment with re-aspiration should be considered. The subjection of tissues retrieved to histologic evaluation could be considered where facilities exist.

Chapter 6:

Post-procedure Care

Post-procedure care includes all services provided after the medical procedures are completed but before a woman is discharged from the facility. It is necessary to identify and address any complications that occur before, during, or immediately after medical care.

Post procedure care:

- Observe the client for at least one hour, paying attention to the woman's underlying medical condition.
- Ensure adequate recovery from the procedure as well as from perioperative medications.
- Detect and manage symptoms of post-procedure complications (Check vital signs every 15 minutes, watch out for excessive bleeding, dizziness, shortness of breath, and severe abdominal pains).
- If available, administer intramuscular 250 iu of anti-D IgG before 20 weeks of gestation and 500 iu after 72 hours into the deltoid muscle to all non-sensitized Rh-D negative women.
- Provide psychological and emotional support.

1. Referral

- Continue with the treatment of the woman for her underlying medical condition.
- Refer any woman who may require additional emotional or mental health support.
- Provide counselling and referral for other reproductive health needs, including contraceptive counselling and services.

2. Family Planning and Contraceptive Services

- Providers should ensure that clients do not have a similar high-risk pregnancy and consequently should be availed of an effective contraceptive option before discharge.
- Check the WHO Medical Eligibility Criteria for the patient's clinical conditions against the contraceptive method chosen.

3. Follow-up

- Provide information about what to expect and what to do following discharge from the facility.
- Telephone follow-up calls should be conducted within 2 weeks of the procedure.
- Advice clients to return to the clinic, as soon as possible, if they have any complaint.

Chapter 7:

Monitoring and Evalution for the Safe Termination of Pregnancy for Legal Indications

Monitoring and Evaluation are very important to help health workers, program managers, and policymakers monitor services and assess whether they are being provided to standard so that appropriate measures can be instituted to achieve set goals. In tracking the implementation of the safe termination of pregnancy policy and services, data needs to be collected and analysed routinely across the three tiers of the health system.

Each health facility offering services for the safe termination of pregnancy for legal indications should keep a record of each client/patient who receives such services in their facility. The healthcare provider should complete Form 7a in the Appendix below for each patient/client and file appropriately. Monthly summaries should be generated on Form 7b, in the Appendix below, for routine reporting to the National Health Management Information System (NHMIS). For program managers at the National and State levels, the Logical Frame Matrix highlights the extent of policy implementation using the key indicators to be monitored.

See Table 2, below:

Table 2:

Safe Termination of Pregnancy for Legal Indications Logical Frame Matrix

Project Description	Performance Indicator (PI)	Means of Verification (MOV)	Assumptions
Provision of Safe Termination of Pregnancy Services within the legal framework in circumstances where the continuation of such pregnancies threaten the life of the women thereby contributing to the reduction of maternal morbidity and mortality	• Number of maternal deaths averted due to increased access to safe termination of pregnancy for legal indications • % decrease in maternal morbidities from unsafe abortions • % decrease in maternal mortality from unsafe abortions	• Annual Reports • Population Surveys • NDHS	• Appropriate provision of funds by policy makers • Strong stakeholders support

To provide information and guidance on the legal indications for the safe termination of pregnancy in Nigeria	• Number of dissemination meetings for the guidelines held • Number of guidelines distributed to heath facilities	• Program Records • Health Facility Surveys	• Funds available for printing, dissemination and distribution of the policy guideline
To set the standards and norms for providing safe termination of pregnancies services for legal indications in Nigeria	• % of women seeking safe termination of pregnancy services for legal indications • % of providers providing safe termination of pregnancy services • Number of health facilities with safe termination of pregnancy commodities and equipment • Number and percentage of clients receiving counseling on safe pregnancy termination • Number and type of contraceptives dispensed on site • % of women who received contraceptive counseling • % of women desiring contraception who received a method	• Annual Program Reports • Health Facility Surveys	• Funds available for training health care providers • Funds available for procuring commodities and equipment
	• % of cases in which infection preven-tion practices were adhered to fully • % of women who agree that service fee is reasonable. Average amount of time spent from counseling to intervention (waiting time) • Hours during which services are available • % of women who received respectful care	• Supportive Supervisory Reports • Supportive Su-pervisory Re-ports, Health Facility Sur-veys, Exit in-terviews	

References

1. National Population Commission (NPC) [Nigeria] and ICF International. 2014. Nigeria Demographic and Health Survey 2013. Abuja, Nigeria, and Rockville, Maryland, USA: NPC and ICF International.

2. WHO, UNICEF, UNFPA, The World Bank, United Nations Population Division. Trends in maternal mortality: 1990-2013. May 2014. www.who.int/ reproductivehealth/publications/monitoring/ maternal-mortality-2013/en/.

3. Oladapo OT, Adetoro OO, Ekele BA, Chama C, Etuk SJ, Aboyeji AP, Onah HE, Abasiattai AM, Adamu AN, Adegbola O, Adeniran AS, Aimakhu CO, Akinsanya O, Aliyu LD, Ande AB, Ashimi A, Bwala M, Fabamwo A, Geidam AD, Ikechebelu JI, Imaralu JO, Kuti O, Nwachukwu D, Omo-Aghoja L, Tunau K, Tukur J, Umeora OUJ, Umezulike AC, Dada OA, Tuncalp, Vogel JP, Gu¨lmezoglu AM, Nigeria Near- miss and Maternal Death Surveillance Network. When getting there is not enough: a nationwide cross- sectional study of 998 maternal deaths and 1451 near-misses in public tertiary hospitals in a low-income country. BJOG 2015; DOI: 10.1111/1471-0528.13450.

4. Akinrinola Bankole, Isaac F. Adewole, Rubina Hussain, Olutosin Awolude, Susheela Singh and Joshua O. Akinyemi The Incidence of Abortion in Nigeria International Perspectives on Sexual and Reproductive Health, 2015, 41(4):170–181, doi:10.1363/4117015

5. Henshaw, S. K.; Singh, S.; Oye-Adeniran, B. A.; Adewole, I. F.; Iwere, N.; Cuca, Y. P. The incidence of induced abortion in Nigeria. International Family Planning Perspectives. 1998;24(4):156-164

6. Okonofua FE, Hammed A, Nzeribe E, Saidu B, Abass T, Adeboye G, Adegun T, Okolocha C. Perceptions of policymakers in Nigeria toward unsafe abortion and maternal mortality. Int Perspect Sex Reprod Health. 2009 Dec;35(4):194-202.

7. Iyioha IO and Nwabueze RN, eds., Comparative Health Law and Policy: Critical Perspectives on Nigerian and Global Health Law, Surrey, UK: Ashgate Publishing, 2015.

8. WHO. Safe Abortion Guidelines: Updates and Recommendations. August 31, 2012. file:///C:/Users/Dell%20User/Downloads/WHOUPDE13.pdf . Accessed on February 15, 2018.

9. RCOG. Best Practice in Comprehensive Abortion Care. Best Practice Paper Nos. 2. June 2015. https://www.rcog.org.uk/globalassets/documents/guidelines/best-practice-papers/best-practice-paper- 2.pdf . Accessed on February 15, 2018.

10. FIGO. Misoprostol-only Recommended Regimens. 2017. https://wwwhttps://www.figo.org/sites/default/files/uploads/project- publications/Miso/FIGO_Dosage_Chart%20EN_0.pdf . Accessed on February 15, 2018.

Appendix

Form 1.

Akwa Ibom State Safe Termination of Pregnancy for Legal Indications: Patient's Form

Name of Facility: .....

Type of Facility: .....

Date form filled: .....

Age of the client in years: .....

Marital status: .....

Disability status: .....

Highest level of education completed: .....

Religion: .....

Tribe: ..... State of origin: .....

LGA of origin: .....

LMP: .....

EDD: .....

EGA: .....

USS estimated gestational age: .....

Clinical estimation of uterine size: .....

Indication for legal termination: .....

Method of legal termination: .....

Type of analgesia/anaesthesia: .....

Name of Provider .....

Designation of provider: .....

Date of procedure: .....

Side effects/Complications: .....

Post Abortion Treatment: .....

Family planning counseling provided: Yes: ..... No: .....

Type of contraceptive services accepted

.....

If contraception is declined, indicate reasons for declining:

.....

Comments

.....

.....

Date of Discharge: .....

Date of Return Visit: .....

Adapted from the National Termination of Pregnancy for Legal Indications : Form 7a

Form 2.

Akwa Ibom State Safe Termination of Pregnancy for Legal Indications: Monthly Summary Form

INSTRUCTION: This form should be completed every month to summarize the data on clients/patients who received termination of pregnancy for legal indications and clients who receive related abortion care services in each facility. This summary will be reported to the State Coordinators for onward delivery/reporting to the central HMIS

Name of Facility: **LGA:** **Month and year of report:**	**Number**
Women who received abortion care	
Less than 8 weeks	
8 to 12 weeks	
Greater than 12 weeks	
Type of procedure/method	
MVA	
D&E	
Medical abortion	
Other (specify.....)	
Women who expressed desire to delay further pregnancy	
Women who received a contraceptive method	
Women referred for a contraceptive method	
Women referred to another facility for abortion care (by reason)	
Women with major complications	
Women who died from complications of abortion	


UNITY AND FAITH, PEACE AND PROGRESS