Benue State Guidelines on Safe Termination of Pregnancy for Legal Indications

BENUE STATE GOVERNMENT

Ipas Partners for Reproductive Justice
NIGERIA HEALTH FOUNDATION

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Foreword

Globally, the Maternal Mortality ratio declined by 44 per cent between 1990 and 2015. The total number of maternal deaths around the World dropped from about 532,000 in 1990 to an estimated 303,000 in 2015. This equates to an estimated global maternal death ratio of 216 maternal deaths per 100,000 live births, down from 385 in 1990 (estimates by WHO, UNICEF, UNFPA, World Bank Group & United Nations Population Division). In 2020, the maternal mortality ratio in the African region was estimated at 531 deaths per 100,000 live births. Countries with extremely high maternal mortality rates are South Sudan, with 1223 deaths, followed by Chad, with 1063 deaths and Nigeria, with 1047 deaths per 100,000 live births (WHO Statistics). Despite the implementation of several innovative interventions by the Federal Ministry of Health, Social Welfare, and Development Partners over the last two decades, maternal mortality remains high. 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 is less than 4 per cent; annual rate of reduction is necessary to attain Millennium Development Goal 5. Unsafe abortion alone accounts for about 10 to 14 percent of maternal morbidity and mortality in Nigeria.

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.

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 permits abortion only on the legal grounds to protect the life and well-being of a woman. Even on these narrow legal grounds, information about legal services is unavailable to women and healthcare 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 and skills in safe abortion procedures and had insufficient information to be able to act within the law or be reluctant to interpret existing legal

provisions. The lack of clear guidelines and effective procedures to guide providers'

decisions to ensure the law is correctly interpreted has led to divesting consequences for women and has contributed to the increased risk of unsafe abortion, and this may have contributed to the high maternal morbidity and mortality rates in Nigeria.

Therefore, reducing unsafe abortions led to the development of Guidelines for Safe Termination of Pregnancy (STOP) for Legal Indications is of extreme importance to control unnecessary death of women who lose their lives because of conditions that are aggravated by continuation of pregnancy.

In this light, all stakeholders are encouraged to support the Benue State Government in the dissemination and implementation of these guidelines to ensure that every woman gets the right care at the right time and place.

Signed
Dr. Yanmar Ortese
Honourable Commissioner for Health and Human Services,
Benue State

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Signed
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Abbreviations and Acronyms

AF	Atrial Fibrillation
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

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 (WHO 2013). Over 80% of induced abortions are done by doctors in private settings. The rest are either self-induced or performed by other health personnel and quacks.

In Benue State, a 10 Year review of unsafe abortion in a tertiary hospital revealed a prevalence of 17.3% of all gynaecological admissions to be due to induced unsafe abortion, which also contributed to 25.1% of all maternal mortality recorded during the review period (Agulebe et al. 2024). Data on safe termination of pregnancy due to legal indications are lacking for Benue State, 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.

The law in Nigeria clearly stipulates that abortion may be legally indicated in situations where the woman's life is medically threatened. Unfortunately, in Benue State, most health providers are unaware of the medical indications for performing therapeutic abortions to save a woman's life as well as promote her health and well-being. It is against this backdrop that the Benue State Ministry of Health, with the support of stakeholders and partners, developed these guidelines on the safe termination of pregnancies for legal indications.

These guidelines are for doctors practising at the facility level, taking into consideration the task and the knowledge and skill of all cadres of health care providers. In addition, health program managers, program coordinators, instructors, and reproductive health trainers may also find them useful.

Goal and Objectives of the Guidelines

Goal

The goal of this document is to serve as a tool for providing safe termination of pregnancy within the legal framework in circumstances where the continuation of such pregnancies threatens the lives of the women. Thus, it will contribute to reducing maternal morbidity and mortality and promoting the health and well-being of women in Benue State.

Objectives

The objectives of these guidelines are:

- Provide information and guidance on the legal indications for the safe termination of pregnancy in Benue State.
- State the medical indications for the safe termination of pregnancy for legal indications in Benue State.
- Outline the standards and norms for providing safe termination of pregnancy services for legal indications in Benue State.
- Guide Benue State policymakers and health managers on the implementation of safe termination of pregnancy for legal indications and related interventions.

Chapter 2:

Laws Related to the Termination of Pregnancy in Benue State Nigeria

Existing Benue State and Nigerian Laws related to abortion are cited in sections – 228, 229, 230 & 297 of the Criminal Code, sections 233, 234 and 235 of the Penal Code Law Cap 124 Laws of Benue State, 2004 and Violence Against Persons Prohibition (VAPP) Law, 2019.

Penal Code Law CAP :124, Laws of Benue State, 2004

Section 233 of the Penal Code Law Cap: 124, Laws of Benue State, 2004: States that "whoever voluntarily causes a woman with child to miscarry shall, if such 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".

Section 234: States that "whoever with intent to cause the miscarriage of a woman whether with child or not does any act which causes the death of such woman, shall be punished –

a.) with imprisonment for a term which may extend to fourteen years and shall also be liable to fine; and

b.) if the act is done without the consent of the woman, with imprisonment for life or for any less term and shall also be liable to fine

Benue State Violence Against Persons (Prohibition) Law 2019

Section 40 of the Law is of the effect that every victim is entitled to receive the necessary materials and comprehensive medical, psychological, social and legal assistance through governmental agencies and/or non-governmental organisations and victims are entitled to be informed of the availability of legal, health, social services and other assistance.

Chapter 3:

Legal Indications for the Safe Termination of Pregnancy in Benue State, Nigeria

The conditions that may constitute a threat to the life of a woman who is pregnant who could benefit from safe legal termination of pregnancy are listed below:

Obstetric and Gynaecological Conditions

I. Hyperemesis gravidarum refractory to treatment with severe hepatic or renal impairment

II. Genital tract cancers (see oncology below)

III. Severe fetal conditions/ malformation not compatible with extrauterine life

IV. CNS abnormalities such as anencephaly hydrocephalus with no demonstrable brain tissue

V. CVS abnormalities such as transposition of great arteries without shunts, Atrioventricular discordance

VI. Multiple organ dysgenesis

Maternal Heart and Vascular Diseases

I. Severe Aortic Stenosis (Aortic valve area ⩽1.0cm2)-might be due to Rheumatic Heart Disease (RHD) or congenital heart disease (Bicuspid aortic valve)

II. Severe Mitral Stenosis (Mitral valve area ⩽1.5cm2)- might be due to Rheumatic Heart Disease (RHD)

III. Eisenmenger Syndrome – Reversal of shunt – left to right to right to left

IV. Hypertension in the first or second trimester that cannot be controlled, including pre-eclampsia and eclampsia

V. Pulmonary embolism

VI. Atrial Septal Defect (ASD), Ventricular Septal Defect (VSD) and Patent Ductus Arteriosus (PDA) with either atrial fibrillation and or severe pulmonary hypertension

VII. Congenital Cyanotic Heart Disease

- Tetralogy of Fallot (TOF), Trilogy of Fallot
- Severe Pulmonary Stenosis, Transposition of great arteries without correction

VIII. Severe Eustein Anomaly

IX. Dilated cardiomyopathy (DCM) with depressed ejection fraction(EF) ⩽30%

X. Peripartum Cardiomyopathy – Cardiac failure with depressed ejection fraction (EF) ⩽30%

XI. Coarctation of the aorta with left ventricular dysfunction

XII. Mechanical Valves – in situation of Rheumatic Heart Disease

XIII. Mitral valve or Aortic Valve replacement on warfarin as anticoagulant

XIV. Endomyocardial fibrosis with arrhythmias- Atrial Fibrillation (AF)

XV. Hypertrophic Cardiomyopathy (HCM) with arrhythmia

XVI. Any heart condition where the mother is in stage 3 or 4

Kidney Diseases

i. Severe connective tissue disease like Systemic Lupus Erythematosis (SLE) with severe kidney damage refractory to treatment
ii. Worsening renal failure

Cancers

i. Cancer of the Cervix, Uterus, Ovary, Breast & Leukaemia
ii. Other oncological cases that require treatment
iii. Malignant neoplasia that require surgery, chemotherapy and/or radiotherapy that is incompatible with the life of the fetus

Blood Diseases

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

Psychiatric and other Mental Disorders

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

Other Conditions

i. Advanced Diabetes Mellitus refractory to treatment and /or with organ failure
ii. Thyroid diseases requiring radio-iodine e.g. Graves' disease
iii. Thyro-cardiac disease with atrial fibrillation

Note: Any other maternal pathology that puts the life of a pregnant woman at risk 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:

This step confirms the pregnancy, its gestational age, site, and the patient's general well-being to ensure a safe termination. It should be done using the patient's history, detailed examination, a reliable urine pregnancy test, and a pelvic ultrasound scan when necessary.

The Medical History

Ask and document the following:

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

Physical Examination

Undertake the following:

- General and systemic physical examination to establish the general health and confirm the life-threatening condition(s) of the woman.
- Bimanual pelvic examination to establish:

  a. Uterine size and position
  b. The presence of other uterine or pelvic pathology, such as fibroids

Laboratory Investigation

Do the following laboratory tests, where necessary:

i. Blood group and Rh factors
ii. Urine analysis
iii. Pregnancy test
iv. VDRL
v. Smear and Gram's stain of vaginal discharge as appropriate
vi. Cervical cancer screening (Pap smear)
vii. Ultrasound and genetic tests as appropriate
viii. HIV, Hepatis B & C screening
ix. Indirect coombs test for Rhesus Negative women

B) Steps in reaching a 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 Counselling 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

1. Detailed information about the pregnancy and her medical condition(s).
2. Different methods of pregnancy termination that are appropriate for her gestation.
3. Efficacy and safety methods of termination of pregnancy in her circumstance
4. Potential adverse effects and complications, and their clinical implications
5. Her right to decline the pregnancy termination and assurances of care if opting out
6. Counselling on HIV testing

E) Informed Consent

After due information and counselling, ensure that the woman or her representative signs the informed consent form to express their acceptance or decline of the offered termination of pregnancy.

If the woman is illiterate, her digital impression will be sufficient. Keep the informed consent form and the authorization for the procedure 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 dedicated to that purpose.

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

duly documented.

F) Patient Evaluation

This step is applicable when the woman consents to the termination of the pregnancy, and its purpose is to re-confirm the gestational age, uterine size, and the state of the patient's health for the purposes of selecting the appropriate method of termination of the pregnancy.

Pain management options should include appropriate analgesia and conscious sedation when necessary. All women having a termination of pregnancy should receive appropriate prophylactic antibiotics pre- or peri-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 normal life.

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

A. Medical Methods

Medical methods of abortion entail the use of pharmacological drugs to terminate pregnancy. Medical methods of abortion have proved acceptable in many settings, including low-resource settings. Medications used are mainly Mifepristone and Misoprostol. The 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. 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 (63days)

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. Women are more likely to be satisfied with the procedure

if they have realistic expectations about the abortion process. Hence, they should be availed of complete information about what to expect and the possible side-effects of both medical and surgical methods of abortion.

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, administered in a 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. This should also be administered in a healthcare facility.

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 is a greater sensitivity of the uterus to prostaglandins, so the dose of misoprostol should be reduced to 200 µg 4 hourly vaginally, or sublingually for up to 4 doses. This should also be administered in a healthcare facility.

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 Misoprostol: 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

Surgical Methods

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

- Manual Vacuum Aspiration
- Electric Vacuum Aspiration
- Dilatation and Evacuation

Manual Vacuum Aspiration

The recommended surgical technique for abortion up to gestational age of 12weeks is

A. Manual Vacuum Aspiration (MVA)

The recommended surgical technique for abortion up to gestational age less than 12 weeks 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 occur with any abortion procedure and patients should be given appropriate counselling and support.

Before the MVA Procedure:

- Provide counseling 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 the 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:

a. Prepare instruments.
b. Assist the woman and have her void urine, especially if general anaesthesia use is not intended.
c. Perform cervical antiseptic preparation.

d. Perform paracervical block if necessary
e. Dilate cervix if necessary using cannulae in incremental size or plastic dilators
f. Insert cannula appropriate for the gestational age
g. Suction uterine contents until cavity is confirmed empty
h. Inspect tissue (and perform histology where possible)
i. Perform any concurrent procedures
j. Take immediate post-procedure steps, including instrument processing

B. Electric Vacuum Aspiration (EVA)

The procedure is the same as that of Manual Vacuum Aspiration, except that in Electric Vacuum Aspiration, suction pressure is created using an electric suction pump.

C. 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 ensure that any complications that occur before, during, or immediately after medical care are identified and addressed.

1. 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, and watch out for excessive bleeding, dizziness, shortness of breath, and severe abdominal pain.)
- If available, administer intramuscular 250 iu of anti-D IgG before 20 weeks of gestation and 500 iu thereafter within 72 hours into the deltoid muscle to all non-sensitized RhD-negative women.
- Give or provide psychological and emotional support.

2. Referral

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

3. Family Planning and Contraceptive Services

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

4. Follow-up

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

Chapter 7:

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

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

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, also in the Appendix below, for routine reporting to the National Health Management Information System (NHMIS). For program managers at 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:

Termination of Pregnancy for Legal Indications: Logical Framework 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 threatens 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

Project Description	Performance Indicator (PI)	Means of Verification (MOV)	Assumptions
To provide information and guidance on the legal indications for the safe termination of pregnancy in Benue State	• 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 pregnancy services for legal indications in Benue State	• % 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 counselling on safe pregnancy termination. • Number and type of contraceptives dispensed on site • % of women who received contraceptive counselling. • % of women desiring contraception who received a method • % of cases in which infection prevention practices were adhered to fully • % of women who agree that service fee is reasonable. Average amount of time spent from counselling to intervention (waiting time) • Hours during which services are available. • Percentage of women who received respectful care	• Annual Program Reports • Health Facility Surveys • Supportive Supervisory Reports • Supportive Supervisory Reports, Health Facility Surveys and Extender views	• Funds available for training health care providers • Funds available for procuring commodities and equipment
	• % 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 Su-pervisory Re-ports, Health Facility Sur-veys, Exit in-terviews	

References

1. National Population Commission (NPC) [Nigeria] and ICFInternational. 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. ww.who.int/reproductivehealth/publications/monitoring/ maternal-mortality-2013/en/.

3. Oladapo OT, Adetoro OO, Ekele BA, ChamaC, Etuk SJ, Aboyeji AP, OnahHE, 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, ImaraluJO, KutiO, Nwachukwu D, Omo-Aghoja L, TunauK, TukurJ, Umeora OUJ, Umezulike AC, Dada OA, Tuncalp Ö, VogelJP, 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 1451near-misses in public tertiary hospitals in a low-income country. BJOG 2015; DOI: 10.1111/1471-0528.13450.

4. Akinrinola Bankole, Isaac F. Adewole, RubinaHussain, 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. IntPerspectSex ReprodHealth.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://www.figo.org/sites/default/files/uploads/projectpublications/Miso/FIGO_Dosage_Chart%20EN_0.pdf. Accessed on February 15, 2018.

11. The Laws of Benue State of Nigeria: In Force on the First Day of January, 2004

Appendix

Form 7a.

Benue 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 7b.

Benue 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:**	**Post Abortion Care**	**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		


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