

OGUN STATE GUIDELINES FOR

SAFE TERMINATION OF PREGNANCY FOR LEGAL INDICATIONS

August 2025



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(ABRIDGED VERSION)

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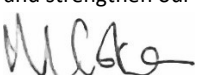
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Forward

Every woman's life matters. In Ogun State, no woman should die or suffer needlessly from a pregnancy that threatens her health or survival. Unsafe abortion remains a preventable cause of maternal deaths, yet many women who qualify for life-saving care do not receive it often because of uncertainty among health providers about what the law allows.

This Abridged Guidelines for Safe Termination of Pregnancy (STOP) for Legal indications is a call to action. It equips our healthcare workforce with the legal clarity, medical standards, when pregnancy poses a danger to a woman's life.

We urge every health provider, facility, and policy maker in Ogun State to use this policy document not as an option, but as a professional and moral obligation to save lives, uphold women's rights, and strengthen our health system.



Dr. Tomi Coker (MBBS.FRCOG)
Honourable Commissioner for Health Ogun State

Acknowledgement

The Ogun State Primary Health Care Development Board (OGPHECADEB), in collaboration with The Trust and Support foundation (TSF), is proud to announce the development of abridged guidelines for the safe termination of pregnancy for legal indications. This document is a testament to the power of collaboration and commitment to improving women's health outcomes.

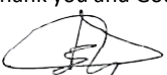
I extend my deepest gratitude to Dr Oladeinde Kayode, Permanent Secretary, Ministry of Health, for his visionary leadership and unwavering support, which were instrumental in the development and production of these abridged guidelines.

I wish to openly and profoundly appreciate all State ministries, civil society organisations, development partners for their commitment and invaluable technical input throughout this process. I particularly value the dedication of all professional associations and front line health workers who continue to champion safe, timely, and rights-based care for women whose pregnancies meet the legal indications for termination.

Special thanks go to the **The Trust and Support Foundation (TSF)** for their exceptional support and for expertly leading the technical adaptation process that made this document possible.

Finally, I wish to express my profound appreciation to the entire staff of the department of Community and Family Health Services, most especially Reproductive Health unit staff for their steadfast commitment and hard work. Their diligence throughout the development process was crucial to the successful completion of this document.

Thank you and God Bless.



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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 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 (STOP).

The law in Nigeria clearly stipulates that abortion can be performed to save a woman's life. Unfortunately, data indicates that health providers are unaware that there are medical indications that allow therapeutic abortions to be performed to save a woman's life as well as promote her health and wellbeing. The Violence Against Persons (Prohibition) (VAPP) act also make provisions for the cases of gender-based violence

The National Guidelines for Safe Termination of Pregnancy (STOP) developed in 2018 has been adapted in Ogun State. This guideline is for doctors practicing at facility level, taking into cognizance the task as well as the knowledge and skill of all cadres of health care workers. In addition, health program managers, program coordinators as well as instructors and reproductive health trainers may find it useful.

Goal and Objectives of the Guidelines

The goal of this document is to serve as a tool for the provision of STOP within the legal framework.

The objectives of this guideline are to:

1. Provide information and state the medical and legal indications for STOP in Ogun State.
2. Guide policy makers, health managers and health workers by outlining the standard and norms for providing STOP.

CHAPTER 2: LAWS RELATED TO SAFE TERMINATION OF PREGNANCY IN OGUN STATE, NIGERIA

Existing Ogun State Laws related to Abortion are cited in sections – 228, 229, 230 & 297 of the Criminal Code Law, Volume 1, Laws of Ogun State 2006 and sections 31 (1) and (2) of the Violence Against Persons (Prohibition) (VAPP) Law of Ogun State, 2017.

Abortion is limited to indications that continuation of the pregnancy poses a risk to the life of the person.

Whilst the VAPP Law which prohibits violence against persons also provides for necessary medical assistance and supports to victims.

CHAPTER 3: LEGAL INDICATIONS FOR THE SAFE TERMINATION OF PREGNANCY IN OGUN STATE, NIGERIA

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

S/N	INDICATION	EXAMPLES
1	**Obstetric & Gynaecological Conditions**	● Hyperemesis gravidarum refractory to treatment with severe hepatic or renal impairment ● Genital tract cancers (see oncology below)
2	**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), Trilogy of Fallot,
  - Severe Pulmonary Stenosis, Transposition of great arteries without correction
- Severe Ebstein 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 ● Rheumatic Heart Disease ● Endomyocardial fibrosis with arrhythmias-AF (atrial fibrillation) ● Hypertrophic Cardiomyopathy (HCM) with arrhythmias) ● Any heart condition where the mother is in stage 3 or 4
3	**Kidney Diseases**	● Severe connective tissue disease like Systemic Lupus Erythematosus (SLE) with severe kidney damage refractory to treatment ● Worsening renal failure
4	**Cancers**	● Cancer of the Cervix, Uterus, Ovary, Breast & Leukaemia ● Other oncological cases that require treatment ● Malignant neoplasia that requires surgery, chemotherapy and/or radiotherapy that is incompatible with the life of the fetus

5	**Blood Diseases**	● Haemoglobinopathies with complications such as acute sequestration, acute chest/brain syndrome and pseudo-toxaemia of pregnancy
6	**Psychiatric and Other Mental Disorders**	● Psychiatric disorders with suicidal ideation like incest and rape ● Severe depression with suicidal attempt ● Major psychiatric disorder of grave consequence to the woman and the pregnancy such as severe suicidal ideation or attempts, severe substance use, alcohol dependence, and psychosis.
7	**Other Conditions**	● Advanced Diabetes Mellitus refractory to treatment and /or with organ failure ● Thyroid diseases requiring radio-iodine e.g. Graves' disease ● 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 syndrom
8	**Severe fetal conditions / malformation not compatible with extra uterine life**	● CNS abnormalities such as anencephaly, hydrocephalus with no demonstrable brain tissue ● CVS abnormalities such as transposition of great arteries without shunts, Atrio-ventricular discordance ● Multiple organ dysgenesis

CHAPTER 4: CARE PRECEDING THE SAFE LEGAL TERMINATION OF PREGNANCY

A. Confirmation of Pregnancy:

These steps confirm the pregnancy, gestational age, location and overall health for safe termination. It involves

1. History taking,
2. Physical examination,
3. Laboratory investigations including
   a. Reliable pregnancy test (urine or blood)
   b. Pelvic ultrasound scan if needed.

B. Steps in reaching decision for termination of pregnancy.

1. Clinician adjudges that continuation of pregnancy constitutes “danger to a woman's life” as enumerated in Chapter 3
2. **C**linician seeks second opinion for confirmation of indication (this might involve referring the patient in circumstances where a second opinion is not feasible in the facility)

C. Informing and counselling the patient:

The patient should be clearly informed of the risk to pregnancy continuation while observing the following:

a. Right to complete, correct, impartial and useful information.
b. Respect to dignity, privacy, and confidentiality
c. Freedom of conscience and of expressing their ideas
d. Respect for their willing and free choice
e· Right to equality and no discrimination

D) Content of Information and Counseling to the woman should also cover:

Give detailed information about the pregnancy and her medical condition, various appropriate options for termination of pregnancy, safety and potential side effect and complications, as well as her right to decline termination of pregnancy.

E) Informed Consent:

After adequate counselling about the procedure, possible risk and complication, the women or her relatives must sign the consent form authorizing the procedure which must be kept in the patient clinical record. If the woman is illiterate her digital impression will be sufficient. She reserves the

right to change her decision at any point in time before the procedure by signing a revocation form which should added to her clinical record and commencement of prenatal care should be ensured.

F) Patient evaluation.

Confirm pregnancy, gestational age, and patient general wellbeing to select the appropriate termination method.

Ensure pain management and appropriate prophylactic antibiotics pre or peri-operatively.

CHAPTER 5: METHODS OF SAFE TERMINATION OF PREGNANCY

A. Medical Methods

Medications used are mainly Mifepristone and Misoprostol. Their side-effects include nausea, vomiting, rigors, 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 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.

Guidelines:

- Whenever possible, women should be offered a choice of taking the medications at home or in the healthcare facility, since different women have different needs and desires. For some women, home may be a more private place but for others, the healthcare facility may afford a greater degree of privacy.
- Pain medication, such as ibuprofen and/or mild narcotics with instructions about how to take it.
- Information on whom to contact, including a telephone number where possible, in case of questions, problems or complications, or the possibility of an unsuccessful evacuation, and where to go to in the case of an emergency.

Remarks:

- The combination regimen is more effective than use of misoprostol alone.
- Evidence suggests that the vaginal route is the most effective. Consideration for patient and provider preference suggests the inclusion of all routes.
- Pregnancy tissue should be treated in the same way as other biological material unless the individual expresses a desire for it to be managed otherwise.
- Misoprostol can be repeated at the noted interval as needed to achieve success of the abortion process.
- The use of misoprostol in patients with prior uterine scar should only be considered in a facility that can undertake the emergency management of uterine rupture which although is a rare complication.

Table 1Summary of Recommended Medical Abortion Regimen

Indication	Drug	Dosage	Route of Administration
For medically indicated abortion at < 12 weeks	Mifepristone + Misoprostol OR Misoprostol alone	200 mg 800 µg 800 µg	200mg Mifepristone administered orally, followed 1-2 days later by 800 µg Misoprostol administered vaginally, sublingually, buccally. 800 µg Misoprostol Vaginally, sublingually or buccally. Repeat doses of Misoprostol can be given every 3 hours until expulsion.
For medically indicated abortion at ≥ 12 weeks	Mifepristone + Misoprostol OR Misoprostol alone	200 mg 400 µg	200 mg Mifepristone administered orally, followed 1 repeat doses of 400 µg Misoprostol administered vaginally, sublingually or buccally every 3 hours 400 µg Misoprostol administered Vaginally, sublingually or buccally every 3 hours until expulsion

Indication	Drug	Dosage	Route of Administration
For incomplete abortion at < 14 weeks	Misoprostol	600 µg start OR 400 µg	Orally Sublingually
For incomplete abortion at ≥ 14 weeks	Misoprostol	400 µg	Misoprostol: Sublingually, vaginally, or buccally every 3 hours until expulsion
For missed abortion at < 14 weeks	Mifepristone + Misoprostol OR Alternative Regimen: Misoprostol	200 mg 800µg* 800 µg	200mg Mifepristone administered orally, followed by 800µg Misoprostol administered by any route (buccal, vaginal, or sublingual). The minimum recommended interval between use of Mifepristone and Misoprostol is 24 hours. Buccal, vaginal, or sublingual route. It should be noted that at gestational ages ≥ 9 weeks, evidence shows that repeat dosing of Misoprostol (every three hours until expulsion of products of conception) is more efficacious to achieve success of the abortion process.

Indication	Drug	Dosage	Route of Administration
For missed abortion at ≥ 14 weeks	Mifepristone Misoprostol OR Misoprostol alone	200 mg 400 µg	200 mg Mifepristone orally, followed 1-2 days later by 400 µg Misoprostol administered sublingually or vaginally every 4-6 hours until expulsion.

B. SURGICAL METHODS

Manual Vacuum Aspiration

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

Before the MVA procedure:

- Provide counseling to the woman and obtain informed consent
- Perform a clinical assessment, including 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 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.

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/surgical procedures are completed but before a woman is discharged from the facility. It is necessary to ensure that any complication that occurs before, during or immediately after medical/surgical care are identified and addressed.

Post procedure care:
Observe 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 breaths, severe abdominal pains). Administer intramuscular 250 iu of anti-D IgG after 12 weeks but before 20 weeks of gestation and 500 iu if gestational age is greater than 20 weeks to all non-sensitized RhD negative women. Provide counseling on other reproductive health services including contraception. Provide psychological and emotional support.

Refer when necessary.

Family Planning and Contraceptive Services

- 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.
- Check the Family Planning WHO Medical Eligibility Criteria for the patient's clinical conditions against the contraceptive method chosen.

Referral

- Refer any woman who may require additional emotional or mental health support.
- Provide counseling and referral for other reproductive-health needs, including contraceptive counseling and services.

Follow-up

- Provide information about what to expect and what to do following discharge from the facility.
- Advice clients to return to the clinic, as soon as possible, if they have any complaint.
- Give two weeks clinic appointment if necessary.
- Telephone follow-up calls should be conducted within 2 weeks of the procedure when clinic appointment is not possible.

CHAPTER 7: DOCUMENTATION

- Accurate and thorough documentation is vital. Record the patient's condition, the procedure performed, and any follow-up care. All legal and medical documentation should be complete and securely stored.
- Complete Form 7a (Patient's Form) and generate a monthly summary on Form 7b (Monthly Summary) for routine reporting to the National Health Management Information System (NHMIS)


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