PROVIDING MID-TRIMESTER ABORTION IN A SETTING WITH RESTRICTIVE LAWS: THE NIGERIAN EXPERIENCE

Oladapo Shittu
Department of Ob-Gyn
Ahmadu Bello University Teaching Hospital
Zaria, Nigeria

GOAL

A characterization of the mid-trimester abortion services available in Nigeria, with a view to advancing strategies for reduced morbidity & mortality

OBJECTIVES

Seek to Present:

- Country RH Profile and Legal Atmosphere
- Two Illustrative Case Reports
- Discussion of Issues Arising
- Strategies to Address Issues

THE COUNTRY: Nigeria

NIGERIAN ABORTION LAWS 1

"Any person who with intent to procure miscarriage of a woman whether she is or not with child, unlawfully administers to her or causes her to take any poison or other noxious thing, or uses any force or means, whatever, is guilty of a felony, and is liable to imprisonment for 14 years"

- British Colonial government (1861)

NIGERIAN ABORTION LAWS II

Section 297 of the criminal code provides:

"Any person is not criminally responsible for performing in good faith 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 of the circumstances of the case"

REPRODUCTIVE HEALTH PROFILE: Nigeria

- Population: 144million (2005 Census)
- Population Growth Rate: 2.8%
- Population Doubling time: 25 years
- Annual Pregnancy Rate: 6.8million
- Current Contraceptive Use: 12% (8% for modern)
- Women with Unwanted Pregnancy: 28%
- Abortion Rate: 25 per 1,000 women *
- Annual Number of Abortions: 760,000*
- Mid-Trimester Abortion Rate: 13%*
- Maternal Mortality Ratio: 800 #
- Abortion Mortality: 11% of Maternal Mortality#

*Guttmacher & CAUP
Federal Ministry of Health

MID-TRIMESTER ABORTIONS IN A TEACHING HOSPITAL (ABUTH) OVER 5 YEARS (2001-2005)

Characteristics	5-Year Total	Annual Average
Number of Deliveries	6,025	1,205
Total Abortions	870	178
1st Trimester Abortions	733(82%)	147
2nd Trimester Abortions	137(18%)	27
2nd T-Abortion: Severe Complications	•Hemorrhage & Transfusion =29 •Sepsis =14 •Genital Trauma =8 •Death =3	

1st CASE REPORT

- Miss T.D.
- 24-Year old university student & daughter of a University Don.
- Sought abortion at 5-months from Doctor (friend to her boyfriend)
- ARM was done in Doctor's apartment and patient instructed to return after expelling conceptus
- Severe Pains, Fever & Bleeding ensued by 5th Day, no expulsion
- Two D&Cs were performed on Days 5 & 8 in Doctor's apartment
- Patient Collapsed after 2nd Procedure and was rushed to local Teaching Hospital
- Admitted with Severe Anemia, Septicaemia, and Peritonitis
- Initial Treatment:
  - Rehydration
  - Electrolytes Correction
  - Broad-spectrum Antibiotics
  - Anti-Tetanus prophylaxis
  - 3 Units Blood Transfusion
- Laparatomy:
  - Extensive pelvic Abscess
  - Agglutination of all pelvic Organs
  - Bilateral Pyosalpinges
  - Left Ovary popped out during dissection
- Wound disruption & repair
- Was discharged after 38 days
- Currently (2007):
  - She has Infertility
  - Chronic Pain

2nd CASE REPORT

Mrs. F.M. was a 29-year old housewife to a businessman. She was Para 0+3:

- 1996 - TOP at 6 months (premarital)
- 1998 - spontaneous abortion at 6 months
- 2000 - spontaneous abortion at 6 months despite Cerclage at Private clinic

Presented in 2001, with 3-month pregnancy. The following were found:

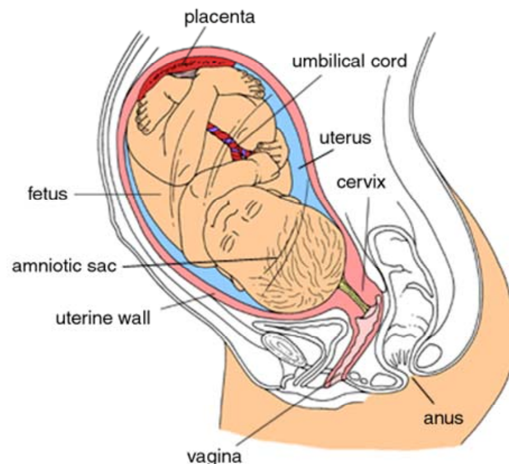
- The TOP she had in 1996 was done by a doctor who performed an unusual operation (details)
- She had a "hole into the uterus, behind the cervix"

- A cerclage was performed but she miscarried again in the 6th month.

Subsequently, she had:

- Investigations
- Operative repair of Uterus and cervix
- In 2004, conceived, booked, had elective caesarean delivery at term, delivered of 3.6Kg male child
- Since lost to follow-up

2nd CASE REPORT



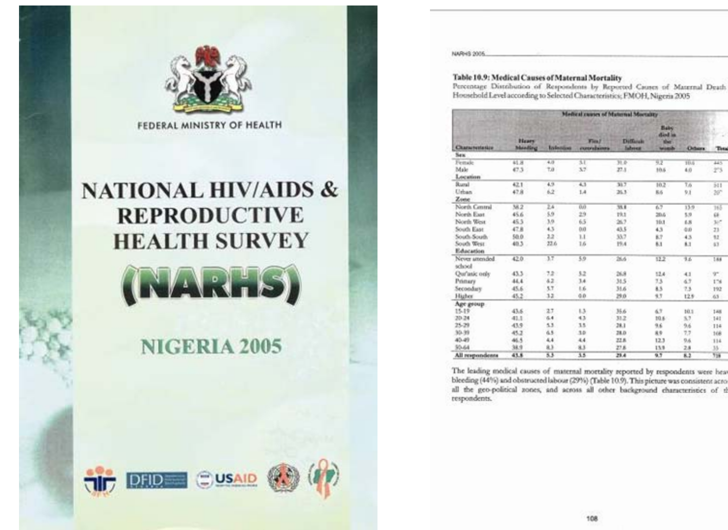
ANALYSIS OF REPORTS

- Evidences of reliance on surgical techniques
- Illustrative of use of unorthodox and dangerous techniques, probably designed by the doctors
- No recourse to litigation by patients, relatives or care providers
- Patronage of the better staffed and equipped Public Hospital as last resort

DISCUSSION

- Induced abortion is still in demand and only the resource-constrained formal private & informal health sectors provide it
- Prevailing laws obstruct women's access to safe abortion care and:
  - Predispose to more morbidities & mortalities
  - Little or no clinical materials in the public hospital for the training of safe In- and Pre- service abortion providers
  - It stifles research on abortion care
  - Condones official silence and gaps in data on health…..

…..GAPS IN DATA



NARHS 2005

Table 10.9: Medical Causes of Maternal Mortality
Percentage Distribution of Respondents by Reported Causes of Maternal Death at Household Level according to Selected Characteristics; FMOH, Nigeria 2005

Characteristics	Medical causes of Maternal Mortality						
	Heavy bleeding	Infection	Fits/ convulsions	Difficult labour	Baby died in the womb	Others	Total
Sex							
Female	41.8	4.0	5.1	31.0	9.2	10.6	445
Male	47.3	7.0	3.7	27.1	10.6	4.0	[illegible]
Location							
Rural	42.1	4.9	4.3	30.7	10.2	7.6	511
Urban	47.8	6.2	1.4	26.3	8.6	9.1	[illegible]
Zone							
North Central	38.2	2.4	0.0	38.8	6.7	13.9	165
North East	45.6	5.9	2.9	19.1	20.6	5.9	68
North West	45.3	3.9	6.5	26.7	10.1	6.8	[illegible]
South East	47.8	4.3	0.0	43.5	4.3	0.0	23
South South	50.0	2.2	1.1	33.7	8.7	4.3	92
South West	40.3	22.6	1.6	19.4	8.1	8.1	63
Education							
Never attended school	42.0	3.7	5.9	26.6	12.2	9.6	188
Qur'anic only	43.3	7.2	5.2	26.8	12.4	4.1	[illegible]
Primary	44.4	6.2	3.4	31.5	7.3	6.7	178
Secondary	45.6	5.7	1.6	31.6	8.5	7.3	192
Higher	45.2	3.2	0.0	29.0	9.7	12.9	63
Age group							
15-19	43.6	2.7	1.3	35.6	6.7	10.1	148
20-24	41.1	6.4	4.3	31.2	10.6	5.7	141
25-29	43.9	5.3	3.5	28.1	9.6	9.6	114
30-39	45.2	6.5	3.0	28.0	8.9	7.7	168
40-49	46.5	4.4	4.4	22.8	12.3	9.6	114
50-64	38.9	8.3	8.3	27.8	13.9	2.8	36
All respondents	**43.8**	**5.3**	**3.5**	**29.4**	**9.7**	**8.2**	**718**

The leading medical causes of maternal mortality reported by respondents were heavy bleeding (44%) and obstructed labour (29%) (Table 10.9). This picture was consistent across all the geo-political zones, and across all other background characteristics of the respondents.

108

RECOMMENDATIONS

1. Intensification of advocacy for law reforms is necessary if MDG-5 is to be achieved
2. Expansion of Capacity for Abortion care is necessary without awaiting law reforms:
   1. Abortion care details be integrated into ongoing postabortion care trainings (In- & Pre-service)
   2. Use of likes of HIV-infection, gross fetal anomalies etc to secure IRB approvals for introduction of medical abortion
3. Scale-up of symposia, lectures & presentations at annual scientific meetings of medical professionals will keep them updated on safer methods & keep subject topical
4. Medical abortion methods be introduced to training curricula of relevant health workers, for its proven safety, accessibility & inexpensiveness

CONCLUSION

Restrictive abortion laws are major obstacles to reducing maternal morbidity and mortality, and will impede attainment of MGD-5. As advocacy efforts are intensified for law reforms, capacity for safe abortion care should be expanded without further delay.