



**FEDERAL MINISTRY OF HEALTH, NIGERIA**

**National Guidelines  
on Safe  
Termination of Pregnancy  
for Legal Indications**

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## FOREWORD

Global Maternal Mortality ratio declined by 44 percent by 2015 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 annual rate of reduction necessary to attain the 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 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 provider's decisions to ensure the law is correctly interpreted has led to divesting consequence 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.

Therefore, having a guideline on Safe Termination of Pregnancy for Legal Indications is of extreme importance to control unnecessary death 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 Federal 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.

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Honourable Minister of Health  
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## ABBREVIATIONS AND ACRONYMS

AF	Atrial Fibrillation
ASD	Atrial Septal Defect
BV	Bacterial Vaginosis
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
SRH	Sexual and Reproductive Health
TOF	Tetra logy of Fallot
VAPP	Violence Against Persons Prohibition
VSD	Ventricular Septal Defect
WHO	World Health Organization

## **EXECUTIVE SUMMARY**

Nigeria is now ranked as having the second largest burden of maternal mortality in the world, after India. Most of these deaths are of known causes and are preventable. As Nigeria 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 deaths.

One neglected major area of preventable maternal deaths 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 Nigerian women whose existence are threatened by the continuation of their pregnancies.

This National 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 women's life and a description of the step-by-step options for 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.

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## **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 or 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 of 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. The rest 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.

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. However, there are no national standard guidelines to direct this practice. It is against this backdrop that the Federal Ministry of Health, with the support of stakeholders and partners developed this guideline on safe termination of pregnancies for legal indications to facilitate the reduction of maternal morbidity and mortality from the medical conditions that threaten women's lives when compounded by pregnancy and from abortion procedures themselves in Nigeria.

This guideline is for Doctors practicing at facility level, taking into cognisance the task as well as the knowledge and skill of all cadre 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 Guideline**

### **Goal**

The goal of this document is to serve as a tool for the provision of the safe termination of pregnancy within the legal framework, in circumstances where the continuation of such pregnancies threaten the lives of the women, thereby contributing to the reduction of maternal morbidity and mortality in Nigeria.

### **Objectives**

The objectives of this guideline are to:

1. Provide information and guidance on the legal indications for the safe termination of pregnancy in Nigeria.
2. State the medical indications for the safe termination of pregnancy for legal indications in Nigeria.
3. Outline the standards and norms for providing safe termination of pregnancy services for legal indications in Nigeria.
4. Guide policy makers 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 NIGERIA**

Existing Nigerian Laws related to abortion are cited in sections – 228, 229, 230 & 297 of the Criminal Code, sections 232, 233 and 234 of the Penal Code of the Nigerian Constitution and Violence Against Persons Prohibition (VAPP) Act, 2015.

### **CRIMINAL CODE 1916 revised 1990**

**Criminal Code Section 228: Attempts 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, is guilty of a felony and is liable to imprisonment for fourteen years.

**Criminal Code Section 229: 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 is guilty of a felony and is liable to imprisonment for seven years.

**Criminal Code Section 230: 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; is guilty of a felony and is liable to imprisonment for three years.

**Criminal Code Section 297: 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.

### **PENAL CODE 1959 revised 1990**

**Penal Code Section 232:** 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.

**Penal Code Section 233:** 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.

## **VIOLENCE AGAINST PERSONS' PROHIBITION (VAPP) ACT 2015**

This Act prohibits all forms of violence against persons in private and public life, and provides maximum protection and effective remedies for victims and punishment of offenders.

**VAPP Act, Section 38:** Every victim is entitled to receive the necessary materials, comprehensive medical, psychological, social and legal assistance through governmental agencies and/or non-governmental organisation 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 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 & 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 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

### **Maternal Heart and Vascular Diseases**

- Severe Aortic Stenosis (Aortic valve area  $\leq 1.0\text{cm}^2$ )-might be due to Rheumatic Heart Disease (RHD) or congenital heart disease (Bicuspid aortic valve)
- Severe Mitral Stenosis (Mitral valve area  $\leq 1.5\text{cm}^2$ )-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)  $\leq 30\%$
- Peripartum Cardiomyopathy – Cardiac failure with depressed ejection fraction (EF)  $\leq 30\%$
- 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 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 & Leukaemia
- Other oncological cases that require treatment
- Malignant neoplasia that require surgery, chemotherapy and/or radiotherapy that is incompatible with the life of the fetus

### **Blood Diseases**

- Haemoglobinopathies with complications as acute sequestration, acute chest/brain syndrome and pseudo-toxaemia 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

### **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 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, its gestational age, site, and patient's general wellbeing towards the safe termination of the pregnancy. This should be done by using patient's history, detailed examination, a reliable urine pregnancy test and 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 physical 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 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:
- d) Right to complete, correct, impartial and useful information
  - e) Right to dignity, privacy and confidentiality
  - f) Freedom of expression of their ideas
  - g) Right to choice
  - h) Right to equality without discrimination

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

- 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 testing

e) **Informed Consent**

After due information and counseling, 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 and 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 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 (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. 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.

**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.

**Table 1: Summary of Recommended Medical Abortion Regimen**

Trimester	Duration of pregnancy	Drug	Dosage	Route of Administration
First Trimester	0-9 weeks (63 days)	Mifepristone + 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: 1 <sup>st</sup> 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: 1 <sup>st</sup> 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	over 12 weeks (>84 days)	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 200µg 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 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 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.

#### **Uterine evacuation procedure:**

The steps for performing MVA are:

1. Prepare instruments
2. Assist the woman and have her void urine, especially if general anaesthesia use is not intended
3. Perform cervical antiseptic preparation
4. Perform paracervical block if necessary
5. Dilate cervix if necessary using cannulae in 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 processing

#### **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 subsection 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 complication that occurs before, during or immediately after medical 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).
- 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.
- Provide psychological and emotional support.

### ***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 counseling and referral for other reproductive-health needs, including contraceptive counseling and services.

### ***Family Planning and Contraceptive Services***

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

### ***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.
- Advise clients to return to the clinic, as soon as possible, if they have any complaint.

## **CHAPTER 7: MONITORING AND EVALUATION FOR THE SAFE TERMINATION OF PREGNANCY FOR LEGAL INDICATIONS**

Monitoring and Evaluation is very important to help health workers, program managers, and policy makers monitor services to assess whether they are being provided to standard so that appropriate measures can be instituted to achieve set goals. In keeping track of 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, 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: Safe Termination of Pregnancy for Legal Indications Logical Frame Matrix**

<b>Project Description</b>	<b>Performance Indicator (PI)</b>	<b>Means of Verification (MOV)</b>	<b>Assumptions</b>
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.	Annual Reports	Appropriate provision of funds by policy makers
	% decrease in maternal morbidities from unsafe abortions.	Population Surveys	Strong stakeholders support
	% decrease in maternal mortality from unsafe abortions	NDHS	
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 health 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.	Annual Program Reports	Funds available for training health care providers
	% of providers providing safe termination of pregnancy services.	Health Facility Surveys	
	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.	Supportive Supervisory Reports	
	% 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.	Supportive Supervisory Reports, Health Facility Surveys, Exit interviews	

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# APPENDIX

## Form 7a. National Termination of Pregnancy for Legal Indication: Patient's Form

### Form 7a.

Name of Facility: .....

Type of Facility: .....

Date: .....

Age of the client in years .....

Marital status .....

Highest level of education completed .....

Religion: .....

Tribe: .....

State of origin .....

LGA of origin .....

Parity .....

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 .....

Comments .....

Side effects/Complications .....

Post Abortion Treatment .....

Family planning counselling provided: Yes ..... No: .....

Type of contraceptive services accepted .....

If declined, indicate reasons for declining: .....

.....

Date of Discharge: .....

Date of Return Visit: .....

**Form 7b. National Termination of Pregnancy for Legal Indication: 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

<b>Name of Facility:</b> <b>State:</b> <b>LGA:</b> <b>Month and year of report:</b>	<b>Termination of pregnancy for legal indications</b>	<b>Post-Abortion Care</b>	<b>Total</b>
Number of women who received abortion care			
Completed gestation (weeks)			
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			