



राज्य कुटुंब कल्याण कार्यालय, पुणे

अतिरिक्त संचालक दुरध्वनी क्रमांक (वैयक्तिक) 020-26058996	अतिरिक्त संचालक, आरोग्य सेवा, कुटुंब कल्याण, माताबाल संगोपन व शालेय आरोग्य, कुटुंब कल्याण भवन, राजा बहादूर मिल रोड, पुणे रेल्वे स्टेशन मागे, पुणे - ४११००१, दुरध्वनी- ०२० - 26058739, 26058139, 26058476 Email - pndt07@gmail.com
आरोग्य सेवा	जा.क्र. राकुक्का/ पीसीपीएनडीटी / कक्ष-८ ड/मार्गदर्शन / /१७ दिनांक : ११/०७/२०१७. ४३७८८-८८३

प्रति,

- १) जिल्हा शल्य चिकित्सक,
जिल्हा सामान्य रुग्णालय,.....(सर्व)
- २) जिल्हा आरोग्य अधिकारी,
जिल्हा परिषद.....(सर्व)
- ३) वैद्यकीय आरोग्य अधिकारी,
महानगरपालिका,(सर्व)

विषय :- वैद्यकीय गर्भपात केंद्रांमध्ये आवश्यक ते रेकॉर्ड, रजिस्टर्स ठेवण्याबाबतच्या मार्गदर्शक सूचना

प्रस्तावना

- वैद्यकीय गर्भपात कायदा १९७१ यातील तरतूदी अन्वये लाभार्थींना गर्भपाता विषयक दिलेल्या सेवांच्या नोंदी निश्चित केलेल्या प्रपत्रांमध्ये ठेवणे आवश्यक आहे.
- या अचूक नोंदींचा उपयोग भविष्यामध्ये सेवांचा दर्जा उंचावण्यासाठी, ध्येयधोरणे ठरविण्यासाठी, विविध स्तरावर कार्यक्रमाचा आढावा घेण्यासाठी, मूल्यमापन करण्यासाठी सुद्धा होऊ शकतो या दृष्टीकोनातून नोंदणीकृत गर्भपात केंद्रांमध्ये नोंदी कोणत्या प्रपत्रांमध्ये, नोंदवहीमध्ये ठेवावयाच्या व याबाबतचा अहवाल सादरीकरण कसा करावयाच्या याबाबतच्या मार्गदर्शक सूचना खालील प्रमाणे

रेकॉर्डिंग व रिपोर्टिंगसाठी MTP Act अन्वये आवश्यक नोंदवह्या, फॉर्मस्

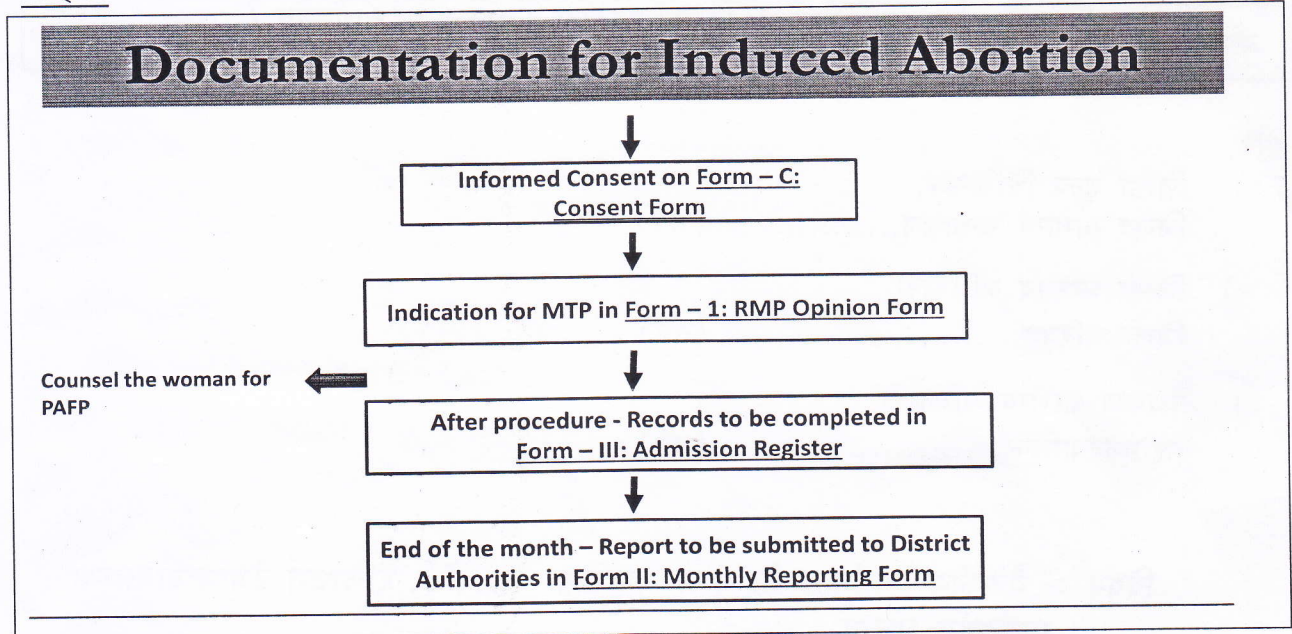
- Form C- Consent Form -(Annexure I)
- Form I- RMP Opinion Form. (Annexure II)

- Form III- Admission Register. (Annexure III)
- Form II- Monthly reporting format (Annexure IV)
- Form B - Certificate of Approval (only for private MTP canter) (Annexure V)

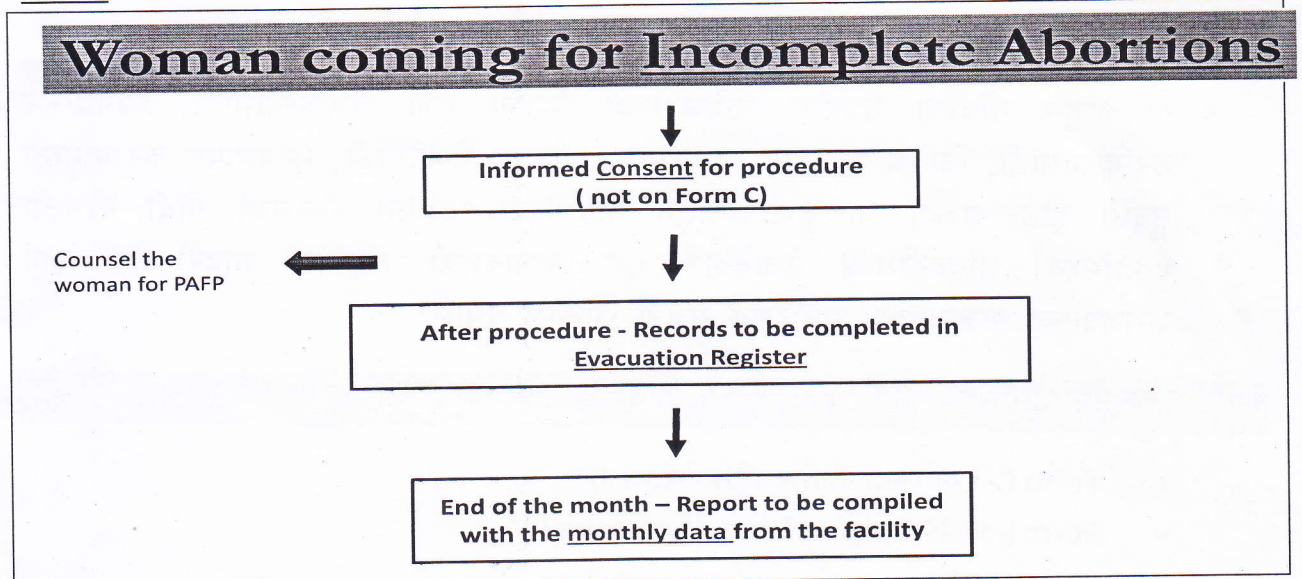
वरील सर्व प्रपत्रांची माहिती जोडपत्र १ ते ५ मध्ये सोबत जोडण्यात आले आहे.

वैद्यकीय गर्भपातासाठी करावयाच्या नोंदीचा क्रम

१. Induced गर्भपाताच्या केसेस च्या नोंदी ठेवण्यासाठी खालील रजिस्टर ठेवणे बंधनकारक आहेत.



2. Incomplete गर्भपाताच्या केसेस च्या नोंदी ठेवण्यासाठी खालील रजिस्टर ठेवणे बंधनकारक आहेत.



अहवाल सादरीकरण

१) राज्यातील प्रत्येक गर्भपात केंद्रातून खालीलप्रमाणे गर्भपाताची माहिती दरमहा DHIS-2 मध्ये भरण्यात यावी

Indicator No.	Indicator
M7	Medical Termination of Pregnancy (MTP)
22	Total MTPs done in Government institutes (22.1+22.2) *
22.1	Up to 12 weeks of pregnancy
22.1.1	Total MTPs done by Medical Method of Abortion (MMA) method*
22.1.2	Total MTPs done by Manual Vacuum Aspiration (MVA) method*
22.2	More than 12 weeks
22.2.1	Total MTPs done by Medical Method of Abortion (MMA) method*
22.2.2	Total MTPs done by other method*
23	Total MTPs done in Private Institutes directly reported to PHC (23.1+23.2)
23.1	Up to 12 weeks of pregnancy
23.1.1	Total MTPs done by Medical Method of Abortion (MMA) method*
23.1.2	Total MTPs done by Manual Vacuum Aspiration (MVA) method*
23.2	More than 12 weeks
23.2.1	Total MTPs done by Manual Vacuum Aspiration (MVA) method*
23.2.2	Total MTPs done by other method*
	Total MTP's Done (22+23)
23.3	MTP performed : Cause wise break up (sum of 23.3.1 to 23.3.7)
23.3.1	Danger to life of pregnant women
23.3.2	Grave injury to physical / mental health of pregnant women
23.3.3	Pregnancy caused by rape
23.3.4	Substantial risk to child born like physical or mental abnormalities
23.3.5	Failure of contraceptive use
23.3.6	Minor/below age of 18
23.3.7	Mentally retarded

- २) राज्यातील प्रत्येक गर्भपात केंद्रातून खालीलप्रमाणे वैद्यकीय गर्भपात कायदयान्वये **Form II** प्रमाणे संबधित जिल्हा शल्य चिकित्सक व वैद्यकीय आरोग्य अधिकारी यांना अहवाल सादर करण्यात यावा.

Monthly Reporting Form – Form II

FORM II
[See Regulation 4(5)]

1. Name of the State
2. Name of the Hospital/approved place
3. Duration of pregnancy (give total No. only)
 - (a) Up to 12 weeks.
 - (b) Between 12 - 20 weeks
4. Religion of woman
 - (a) Hindu
 - (b) Muslim
 - (c) Christian
 - (d) Others
 - (e) Total
5. Termination with acceptance of contraception.
 - (a) Sterilisation
 - (b) I.U.D.
6. Reasons for termination:
(give total number under each sub-head)
 - (a) Danger to life of the pregnant woman.
 - (b) Grave injury to the physical health of the pregnant woman.
 - (c) Grave injury to the mental health of the pregnant woman.
 - (d) Pregnancy caused by rape.
 - (e) Substantial risk that if the child was born, it would suffer from such physical or mental abnormalities as to be seriously handicapped.
 - (f) Failure of any contraceptive device or method.

Signature of the Officer Incharge
with Date

त्याअनुषंगाने आपणास सुचित करण्यात येते की, आपल्या अधिनस्त येणाऱ्या सर्व गर्भपात केंद्रांना उपरोक्त मागदर्शक सूचनांप्रमाणे सर्व आवश्यक ते एमटीपी रेकॉर्ड, रजिस्टर्स ठेवण्याबाबतच्या सूचना निर्गमित कराव्यात तसेच आपल्या भेटी दरम्यान गर्भपात केंद्रामध्ये उपरोक्त सूचनांप्रमाणे आवश्यक ते एमटीपी रेकॉर्ड, रजिस्टर्स न ठेवल्याचे आढळल्यास त्या केंद्राविरुद्ध आपल्या स्तरावरून योग्य ती कारवाई करण्यात यावी.

अतिरिक्त संचालक, आरोग्य सेवा,
कुटुंब कल्याण, माताबाल संगोपन व शालेय आरोग्य पुणे

प्रत सविनय सादर :-

- १) मा. अप्पर मुख्य सचिव, सार्वजनिक आरोग्य व कुटुंब कल्याण विभाग, मंत्रालय, मुंबई-३२
- २) मा. आयुक्त (आरोग्य सेवा) तथा अभियान संचालक, एन.एच.एम- महाराष्ट्र राज्य, मुंबई -४०० ००१
- ३) मा. संचालक, आरोग्य सेवा, महाराष्ट्र राज्य, मुंबई -४०० ००१

Annexure I

Consent Form – Form C

FORM C

(See rule 9)

I.....daughter/wife of.....aged about
.....years.....

(here state the permanent address)

at present residing at.....

do hereby give my consent to termination of my pregnancy at.....

(State the name of place where the pregnancy is to be terminated)

Place.....

Signature

Date.....

(To be filled in by guardian where the woman is a mentally ill person or minor)

I.....son/daughter/wife of.....aged about
.....years of.....at present residing at

(permanent address).....do hereby
give my consent to the termination of the pregnancy of my ward.....who is a
minor/lunatic at.....

(place of termination of my pregnancy)

Place.....

Signature

Date.....

Annexure II

Opinion Form - Form I

14

The Medical Termination of Pregnancy Regulations, 2003

FORM I
[See Regulation 3]

I.....
(Name and qualifications of the Registered Medical Practitioner in block letters)

.....
(Full address of the Registered Medical Practitioner)
I.....
(Name and qualifications of the Registered Medical Practitioner in block letters)

.....
(Full address of the Registered Medical Practitioner) hereby certify that "I/we am/are of opinion, formed in good faith, that it is necessary to terminate the pregnancy of....."

.....
(Full name of pregnant woman in block letters) resident of..... for the reasons given below**
.....(Full address of pregnant woman in block letters) of the woman referred to
* I/We hereby give intimation that "I/We terminated the pregnancy of the woman referred to above who bears the serial No.in the Admission Register of the hospital/approved place.

Place.....
Date.....
Signature of the Registered Medical Practitioner

Strike out whichever is not applicable,
**of the reasons specified items (i) to (v) write the one which is appropriate:—

- (i) in order to save the life of the pregnant woman,
- (ii) in order to prevent grave injury to the physical and mental health of the pregnant woman,
- (iii) in view of the substantial risk that if the child was born it would suffer from such physical or mental abnormalities as to be seriously handicapped,
- (iv) as the pregnancy is alleged by pregnant woman to have been caused by rape,
- (v) as the pregnancy has occurred as result of failure of any contraceptive device or methods used by married woman or her husband for the purpose of limiting the number of children

Note.—Account may be taken of the pregnant woman's actual or reasonably foreseeable environment in determining whether the continuance of her pregnancy would involve a grave injury to her physical or mental health.

Place.....
Date.....
Signature of the Registered Medical Practitioner/Practitioners

Annexure III

Admission Register – Form III

Admission Register

Name of Facility _____ Month _____ Year _____

S. No.	Date of admission	Name of the patient	Wife/daughter of	Age (in years)	Religion	Address	Duration of pregnancy	Reasons for which pregnancy is terminated	Date of termination of pregnancy	Date of discharge of patient	Result & remarks	Name of Registered Medical Practitioners (s) by whom the opinion is formed	Name of Registered Medical Practitioners by whom pregnancy is terminated	Data for God reporting format 2012	
														Method of (MVA/ EVA/ MMA/ D&C/ Others)	Post Abortion Contraception (Tubal Ligation TL/IUCD/ Oral Pills OCP/ Condoms CC/ None)
1				5	6	7	8	9*	10	11	12	13	14	15	16

* Note : In Coloum 9 write:- 'A' for Risk to the life or grave injury to mother's physical / mental health, 'B' for Pregnancy caused by rape; 'C' for Risk of congenital abnormalities and 'D' for Failure of contraception

Monthly Reporting Form – Form II

FORM II

[See Regulation 4(5)]

1. Name of the State
2. Name of the Hospital/ approved place
3. Duration of pregnancy (give total No. only)
 - (a) Up to 12 weeks.
 - (b) Between 12 - 20 weeks
4. Religion of woman
 - (a) Hindu
 - (b) Muslim
 - (c) Christian
 - (d) Others
 - (e) Total
5. Termination with acceptance of contraception.
 - (a) Sterilisation
 - (b) I.U.D.
6. Reasons for termination:
(give total number under each sub-head)
 - (a) Danger to life of the pregnant woman.
 - (b) Grave injury to the physical health of the pregnant woman.
 - (c) Grave injury to the mental health of the pregnant woman.
 - (d) Pregnancy caused by rape.
 - (e) Substantial risk that if the child was born, it would suffer from such physical or mental abnormalities as to be seriously handicapped.
 - (f) Failure of any contraceptive device or method.

Signature of the Officer incharge
with Date _____

Annexure V

Form B

[Refer sub-rule(6) of rule 5]

Certificate of Approval

The place described below is hereby approved for the purpose of the Medical Termination of Pregnancy Act, 1971 (34 of 1971)

As read within uptoweeks

Name of the Place

Address and other descriptions

Name of the Owner

Place:-

Date:-

To the Government of the.....