DR. A. P. Khade
ADHS

Recommendations for the control of unauthorized MTPs in the State of Maharashtra

Committee Report

Committee Members

1) Dr. Sanjay Oak, Director (Medical Education & Major Hospitals) KEM Hospital– Chairman
2) Dr. Piyush S. Goyal, Nowrosjee Wadia Maternity Hospital
3) Dr. A.L.Sharada, Director, Population first
4) Dr. D.K.Mangal/AnujaGulati, State Program Officer, United National Population Fund
5) Smt. PadmaDeosthali, CEHAT
6) Smt. Sneha Khandekar, Savitribai Phule Gender Resource Center
7) Dr. ShashankParulekar, Head of Department, Obst.&Gyn, KEM Hospital
8) Dr. HimangiWarke, Associate Professor, Obst.&Gyn, KEM
9) Dr. Kamakshi Bhate, Associate Professor, PSM, KEM

MUNICIPAL CORPORATION OF GREATER MUMBAI
SETH G.S.MEDICAL COLLEGE & KEM HOSPITAL
No. Director/ME&MH/ 917 of 17 October 2011

To,
Shri Suresh Shetty,
Hon. Health Minister,
Public Health Department,
Government of Maharashtra,
Mantralaya, Mumbai.

Sub: Meeting held on 8.9.2011 at 'Sahyadri' Guest House, with Hon.Health Minister Shri Suresh Shetty
- Committee recommendations for the control of unauthorized MTPs in the State of Maharashtra.

Respected Sir,

As directed by Hon.Health Minister Shri Suresh Shetty in the meeting held on 8th September, 2011 at Sahyadri Guest House, Mumbai, a committee was formed by Govt. of Maharashtra under the Chairmanship of Dr. Sanjay Oak, Director (Medical Education and major hospitals) regarding recommendations for the control of unauthorized MTPs in the State of Maharashtra. Recommendations of the Committee are enclosed herewith for perusal.

Submitted please.

Yours sincerely,

Sanjay Oak.

(Dr.Sanjay Oak)
Director
(Medical Education & Major Hospitals)

Encl: As above

Recommendations for the control of unauthorized MTPs in the State of Maharashtra - Committee Report

Committee Members

Dr. Sanjay Oak, Director (Medical Education & Major Hospitals) KEM Hospital **Chairman**	
Dr. Shashank Parulekar, Head of Department, Obst.&Gyn, KEM	Dr. Himangi Warke, Associate Professor, Obst.&Gyn, KEM
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MUNICIPAL CORPORATION OF GREATER MUMBAI
SETH G.S.MEDICAL COLLEGE & KEM HOSPITAL
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1. Preamble:

The objective of the committee formed by the Govt. of Maharashtra was to look into medical termination of pregnancy at various MTP centres. The committee has taken a note that there are legitimate licensed centres where the MTP activities are conducted and there are illegal, non licensed, non regulated centres at work. Therefore the committee would like to put on records that while carrying out objections, the committee strongly recommends the further propagation of availability of safe abortion services for women and therefore all the procedures to simplify the registration of legitimate centres. Maintenance of records of the initial and follow up visits for monitoring these centres must be strongly promoted. At the same time a diligent search of illegitimate centres which are non licensed and unregulated should be carried out. Non qualified quacks and personnel dealing with unsafe abortions need to be punished as per the provisions of law.

Therefore while the committee appreciated the golden objective to restore the male to female ratio, overzealous measures to curb the sex selection should not prove to be a tool for unsafe and illegal abortions.

1.1 Magnitude and problems of unsafe abortions

The demands of procreation and childbirth take a heavy toll on women's life. One of the most preventable tragedies for womankind is the problem of unwanted pregnancy and unsafe abortion.

Each year about 42 million induced abortions are estimated to be performed worldwide[1]. Of these an estimated 20 million abortions are unsafe with developing nations burdened with 97%. Even in societies and areas where effective contraception methods are available the abortion rate has not declined to zero although it sharply declines.

In India the annual estimates of abortion vary from 3.9 to 6 million with some projections claiming upwards of 12 million. Even a conservative 3.9 million annual abortions resulted in 70 million abortions in the initial 18 years since 1971 compared to official reported figures of 6.3 million abortions[2] – a gross underestimate, suggesting that a majority of abortions are either not reported or take place illegally. If one takes the reported rate of pregnancy related deaths due to abortions as 13%[3] (WHO 1998) as a standard for calculating maternal deaths from unsafe abortion this would mean 9.1 million maternal deaths for a 18 year period.

The Indian government has also repeatedly emphasized that MTP should not be viewed as a method of family planning or of reducing the national birth rate. In India

the incidence of abortion is always under reported. Some studies estimate the extent of under-reporting to be about 50 percent[4]. A study conducted by Chhabra and Nuna (1994), reveals that because of illegal abortions, 15000-20000 abortion-related deaths occur in India every year[5]. According to the Consortium on National Consensus for Medical Abortion in India (2008), every year an average of about 11 million abortions take place annually and around 20,000 women die every year due to abortion related complications[6]. Most abortion-related maternal deaths are attributable to unsafe abortions.

Abortions performed by uncertified providers are estimated to be two to ten times higher than those performed legally by physicians and hold potentially serious consequences for women's health[7]. Indeed, complications arising from abortion contribute to 8 percent of maternal deaths each year[8] (Office of the Registrar General of India, 2006)

At the level of the health system, abortion services are rarely available at the Primary Health centre (PHC) level. Most PHCs and even Community Health Centres (CHCs) lack trained staff and the required equipment and supplies for providing safe abortions or do not have the necessary certification.

Significant numbers of women were reported to have used a home remedy or obtained services from an informal provider in an attempt to terminate their pregnancy; most of which were unsuccessful, leading women to seek services eventually often in second trimester from the formal sector[9].

In Maharashtra, 45% of all abortions were carried out by providers were either not legally recognized as MTP service providers or performed in a place not legally approved for abortion. Most were conducted by allopathic physicians not certified to provide abortion, and just 2% and 12% were conducted by traditional practitioners and those trained in non allopathic systems of medicine respectively[10].

46% girls from rural Maharashtra are married below the age of 18 years who do not have access to information and health services and an uninterrupted supply of effective contraceptives. Also it is difficult for them to negotiate contraceptive use[10,11].

Post-abortion morbidity was reported by large proportions of women: 68% in the Maharashtra study, 54% in the Madhya Pradesh study and 26% in the Rajasthan study[10].

In India abortion is associated with guilt or moral stigma. Most women if they had to go for abortion, they would prefer sources which are not public and go to private clinics where privacy and confidentiality are better maintained[12].

Almost all the deaths and complications from unsafe abortions are preventable. In countries where women have access to safe abortion services their likelihood of dying

as a result of an abortion is no more than one per 200,000 procedures. In developing countries the risk of death following complications of unsafe abortions is several hundred times higher. It is not surprising that most interventions for safe abortions tend to be those which make safe abortion services easily accessible. Therefore the need to promote training and increase the pool of trained personnel. It is essential to promote the services for safe abortion in India that are accessible and affordable[13].

1.2 Legal Status of Abortion

The Medical Termination of Pregnancy Act, approved in India in 1971[14] and enacted in 1972, permits abortion (or MTP) by a registered medical practitioner for a broad range of social and medical reasons, including: to save the life of the woman; to preserve physical health; to preserve mental health; to terminate a pregnancy resulting from rape or incest and in cases of fetal impairment. Contraceptive failure also is sufficient ground for legal abortion[15]. Women must grant consent prior to the performance of the abortion. In the case of minors (defined as under age 18) and mentally retarded women, written consent of guardian is necessary (Annexure 1, Form C)). Legal abortions must be performed within the first 20 weeks of pregnancy and must be performed by a registered physician in a hospital established or maintained by the government or in a facility approved for the purpose by the government[16]. For abortions taking place between twelve and twenty weeks of pregnancy, a second opinion is required (Annexure 2). The MTP Act also offers protection to a practitioner if he/she adheres to and fulfils all requirements under the MTP Act.

Recognizing the failure of the MTP Act of 1972 to make legal abortions widely available, the government amended the Act in 2002. With the amendment, the authority for approval of registration of MTP centres has been decentralized from the state to the district level[17,18]. In the year 2003, the government introduced a further amendment to MTP Rules which has rationalized the criteria for physical standards of abortion facilities -- fixing different criteria as appropriate for conducting first-trimester and second-trimester abortions. While facilities such as an operation table and instruments for performing abdominal or gynaecological surgery, and equipments for anaesthesia, resuscitation and sterilization continue to be the minimum requirements for centres offering second-trimester abortion, the MTP Rules 2003 require a gynaecological or labour table rather than an operation table and resuscitation and sterilization equipment but not anaesthetic equipments for centres offering first-trimester abortion[19,20].

1.3 Medical Methods of Abortion

Medical abortion or abortion by orally administered regimens of mifepristone and misoprostol has recently been accepted worldwide as an effective and safe option for early abortions. The Drug Controller of India approved the use of medical abortion in April 2002[21]. Given the current situation in India, where abortion-related mortality and morbidity are high, medical abortion offers great potential for improving the access to abortion and safety, as it does not require extensive infrastructure and is non-invasive. Further, as the client does not need to be hospitalized, medical abortion

offers women greater independence, control and privacy. However, the potential for misuse is a matter of concern. In fact, although abortion tablets are required to be sold by medical prescription and consumed under medical supervision, these pills are reportedly widely available over-the-counter and unsupervised consumption is rising[22,23].

1.4 Factors Underlying Persistence of Unsafe Abortions

Despite the liberalization of abortion services and the introduction of safer abortion techniques, abortion continues to be unsafe for the vast majority of women seeking such services. Several factors operating at the individual, family, and community level contributing to this situation are[24]:

- Lack of awareness of the legal status of abortion and the facilities where abortion services are legally provided
- Limited access to services
- Poor quality of services
- Cost of services
- Gender roles and norms

1.5 Magnitude and problem of declining sex ratio

The biologically normal sex ratio at birth ranges from 102 to 106 males per 100 females. However, ratios higher than normal – sometimes as high as 130 – have been observed. This is now causing increasing concern in some South Asian, East Asian and Central Asian countries[25]. States have an obligation under human rights laws to respect, protect and fulfil the human rights of girls and women. In addition, more than 180 States are signatories to the 1994 Programme of Action of the International Conference on Population and Development (ICPD). As part of this undertaking States agreed to[26]:

> *. . . eliminate all forms of discrimination against the girl child and the root causes of son preference, which result in harmful and unethical practices regarding female infanticide and prenatal sex selection.*
>
> United Nations (1994); paragraph 4.16

At the same time, States have an obligation to ensure that these injustices are addressed without exposing women to the risk of death or serious injury by denying them access to needed services such as safe abortion to the full extent of the law. The government has thus already taken action in a number of ways, with varying degrees of success.

The phenomenon of skewed sex ratios at birth or in early childhood is not a recent development. In India, the sex ratio is expressed as the number of females per 1000 males. In India, the census data show skewed child sex ratios dating back to the early 20th century[27]. Such disparities almost always reflect a preference for boys as a result of deeply embedded social, cultural, political and economic factors. The rise in sex-ratio imbalances and normalization of the use of sex selection is caused by deeply embedded discrimination against women within institutions such as marriage systems,

family formation and property inheritance laws. In India there are also substantial regional variations.

Since the early 1980s, the availability of ultrasound and other diagnostic technologies which can detect the sex of a fetus has in some parts of the world led to an accelerated increase in sex-ratio imbalances at birth. It is against the backdrop of this intense pressure from family members and broader social norms that women seek to discover the sex of a fetus. Currently, this is usually done around the 14th to 16th week of pregnancy when the most widely used detection technique ultrasonography) becomes effective for determining sex. In some circumstances, they may be forced by their family or community to have an abortion because they are carrying a female fetus[28].

Even where abortion is legal, as in India, some health-care providers have reacted to sex selection by denying access to abortion resulting in women seeking clandestine abortions with elevated risks to their health[29].

Legal restrictions on the use of technology for sex selection purposes (either for sex determination or abortion) have been put in place over the past three decades. These restrictions have included laws that prohibit determination and disclosure of the sex of the fetus (except on medical grounds) and those that prohibit any advertising relating to prenatal sex determination. Such laws are associated with punishments such as fines and/ or imprisonment for anyone contravening them. Laws are also implemented through a range of additional control approaches, such as stipulating the precise conditions under which women are eligible for prenatal procedures, or regulating the sale of ultrasound machines[30]. Following an ultrasound examination, women can go to a different clinic to have an abortion while providing a reason that is acceptable within the legal framework[31].

Recent evidence, both direct and indirect, highlights that the number of sex selective abortions has increased vastly. This is indirectly reflected in the latest Census figures that indicate that the child (0-6 years) sex ratio declined from 945 females per 1000 males in 1991 to 927 females per 1000 males in 2001. The decline in child sex ratios (lower than normal female sex ratio) is not always the result of sex selective abortions of the female foetus. There are other reasons for this which includes female infanticide, neglect and high female child morality. It is also now known that sex ratio may change without deliberate human interventions and a country going through a demographic transition may have higher number of males to females.

In the case of abortion, the proportion of sex-selective abortions to abortions for other non-medical reasons has been estimated at between 2.5% and 17% among married women in community based studies in West India [9,32,33]. A very large percentage of women seek abortions for other reasons, and any restrictions in place may put their health and lives in jeopardy and may also violate their human and reproductive health rights[31].

Amendments have also been introduced in the Prenatal Diagnostic Techniques (Regulation and Prevention of Misuse) (PNDT) Act of 1994. This was necessitated as the PNDT Act had failed to curb the practice of testing for sex determination and consequent sex-selective abortion in the country. With the recent amendment to the PNDT Act, preconception and pre-implantation procedures for sex selection are banned in the country. The Amendment stipulates compulsory maintenance of written records by diagnostic centres/ doctors offering sonography service[34]. With these measures, the government expects to prevent women from resorting to sex-selective abortions, which are conducted during the second-trimester and carry a high risk of complications for women.

2. Objectives:

To provide recommendations for the control of unauthorized MTPs in the State of Maharashtra

3. Committee composition:

A committee was formed by Govt. of Maharashtra under the Chairmanship of Dr. Sanjay Oak, Director (Medical Education and major hospitals) regarding recommendations for the control of unauthorized MTPs in the State of Maharashtra. Committee comprising of following members:

1) Dr. Sanjay Oak,
   Director (Medical Education & Major Hospitals) – Chairman

2)) Dr. ShashankParulekar, Head of Department, Obst.&Gyn, KEM
3) Dr. HimangiWarke, Associate Professor, Obst.&Gyn, KEM
4) Dr. Kamakshi Bhate, Associate Professor, PSM, KEM
5) Dr. PiyushS.Goyal, Nowrosjee Wadia Maternity Hospital
6) Dr. A.L.Sharada, Director, Population first
7) Dr. D.K.Mangal/AnujaGulati, State Program Officer, United National Population Fund
8) Smt. PadmaDeosthali, CEHAT
9) Smt. Sneha Khandekar, Savitribai Phule Gender Resource

4. No.of meetings held at the office of Director(ME&MH):

The meetings held on 19.9.2011, 24.9.2011, 7.10.2011 and 15.10.2011 to finalize the recommendations. Minutes of the meetings are enclosed

5 Recommendations for control of unauthorized MTPs :

Specific recommendations have been based upon a review of data on sex selection, medical termination of pregnancy, its human rights implications and upon experiences gathered till date.

5.1 Expansion of safe abortion care services

There is a wide scope for expansion of abortion care services both in public and private health care service sectors as only about less than a quarter and less than one third of sectors are engaged in abortion care service provision, respectively.

The skewed distribution of the available abortion care facilities in favour of urban areas leaves a large number of rural population to be served by a much smaller proportion of rural based abortion care facilities. This might have implications for the quality of abortion care that rural women receive.

Women particularly in rural areas have hardly any option of accessing safe abortion services at a primary health centre (PHC) - the first contact point between the rural population and a qualified medical doctor. The PHCs should be upgraded so that safe abortion care services can be provided at these centres without coercion. These services would be easily accessible without having to incur huge costs.

5.2 Implementation of the MTP Act

The Medical Termination of Pregnancy Act was approved in India in 1971 and enacted in 1972. The MTP rules were amended in 2003. The Act does not provide the right to abortion but liberalizes the conditions under which women may have access to abortion services provided by approved medical practitioners. The MTP Act offers protection to a practitioner if he/she adheres to or fulfils all the recommended requirements under the Act. However the MTP Act is being poorly implemented.

Adherence to the MTP Act should be ensured. Those violating the MTP Act should be punished. The punishment for offences under the MTP Act should be made stringent.

5.3 Certification and licensing of facilities (MTP centres):

Where certification of abortion providers is required, its sole purpose should be to ensure that providers meet essential criteria for the safe provision of care. The licensing requirements must meet the nationally agreed criteria as per the MTP Rules, 2003[35]. The District Level Committee is appointed by the Government and is responsible for approval or suspension of place for performing MTPs and is chaired by the Chief Medical Officer or District Health Officer. There should be a higher authority for monitoring the District Health Officer.

Facility licensing is to ensure client safety and comprehensiveness of care. In order to do this, the amendments to the MTP act 2003 for decentralization of registration and monitoring of MTP services should be operationalised. However, such licensing requirements should not impose excessive requirements for sophisticated equipment,

infrastructure or staff that are not essential to provision of safe services and would unnecessarily restrict access (Annexure1, Form A and Form B).

The registration process should be simple and should come through in a short time span without delay. There should be an online registration facility.

The registration should be renewed every three years and adequacy of facilities should be assessed during renewal. This will be helpful in ensuring safe provision of abortion care services.

The recent amendment regarding decentralization of the authority for the approval of MTP centres to district level serves to encourage registration of abortion facilities by minimizing administrative delays and thus improving the availability of abortion facilities.

5.4 Monitoring and evaluation of services:

As with all health services, abortion services should be subject to quality monitoring and evaluation every six months after approval of registration. Evolution of standards for inspection and monitoring of these centres is essential. The district level committee should depute a chief medical health officer (CMHO)/ representative for the six monthly monitoring visits.

Every third month a personal interview with the owner regarding abortion services, adequacy of facilities, data maintenance and record keeping should be mandatory. The records of monitoring visits should be maintained. They can also help in assessing whether abortion services are actually available to those women eligible by law.

Individuals should be recruited for monitoring and evaluation of abortion care services if required. An independent office responsible for registration and monitoring of these services is welcome.

The regular and accurate collection of service statistics and regular monitoring and evaluation at the facility level are a key to assess adequacy of facilities for maintaining and improving the quality of services delivered.

5.5 Maintenance and analysis of records

As per the MTP Regulations 2003 it is mandatory for each MTP centre to maintain an admission register from which significant information can be obtained (Annexure 4).

The MTP centre should send their monthly report to concerned appropriate authority.

There was a difference of opinion over the issue of documentation and monitoring of second trimester abortions. Dr. Oak, Dr. Parulekar and Dr. Goyal were of the opinion that the evidence regarding sex of the abortus should be documented by a digital image taken prior to disposal with date. The responsibility of maintaining this evidence should rest with the registered medical practitioner performing the MTP. This practice would be

helpful in monitoring the second trimester terminations performed and will defer service providers from performing sex selective abortions.

However all the other committee members (Dr. A.L.Sharada, Dr. D.K.Mangal, AnujaGulati, Smt.PadmaDeosthali, Dr.HimangiWarke, Dr.Kamakshi Bhate) did not agree to this suggestion and strongly objected to it due to the following reasons:

- Evidence indicates that it is women especially poor women, survivors of sexual assault, other marginalized women who may need 2nd trimester abortion due to lack of resources and other barriers and may be denied the service if more stringent monitoring and questioning of 2nd trimester abortion is carried out. Limitations on offering second trimester abortions and/or increasing reporting requirements for abortions would discourage providers from offering these services. A situational analysis in Maharashtra in 2007 highlighted an alarming fact that most civil and district hospitals refrain from providing 2nd trimester abortion out of fear of any investigations.
- In places where they will be offered, the already prevalent practice of under-reporting of abortion cases will ensue.
- India recognizes the magnitude of the menace of unsafe abortions and has only recently started taking steps to curb the same. Efforts so far have shown positive results – the contribution of unsafe abortions to maternal mortality has reduced from 12 percent in 1998-99 to eight percent in 2001[8].Any attempts to restrict access to safe abortions will greatly hamper this progress and will limit the health system in addressing one of the most easily preventable causes of maternal deaths.

It is important that abortion providers are not isolated and targeted as this would directly reduce access to safe abortion for women. In view of the difference of opinion this issue warrants further debate.

A system of online reporting should be formulated.

There should be an independent body consisting of a statistician, data entry operator and data analyst for analyzing the data accurately. The USG, PCPNDT data and MTP data should be analyzed by the same body by trained personnel.

Expertise of software engineers will be helpful for tracking the performance of the MTP centres.

Over the time, if baseline information has been collected, including data on mortality and morbidity from unsafe abortion, and if basic service statistics are routinely and accurately kept, programmes will be able to evaluate the extent to which full access to legal services reduces maternal mortality and morbidity.

These statistics and other information gathered through monitoring and evaluation should be shared and discussed with stakeholders and used to make decisions about improvements to services.

Good monitoring includes listening to providers who can have important recommendations to improve quality of care. Basic service statistics include, at a minimum, a record of abortions provided, women seen but not provided with services, women referred to higher levels of care, treatment of complications of abortion and contraceptive methods accepted.

Selected facility-level data should be sent routinely to higher levels to enable monitoring across facilities and geographic areas, and should be used at the national level for informing policy and planning. It can also be very useful to monitor the costs to the health facility of providing legal abortion and of treating complications of unsafe abortion.

Routine monitoring should include[36]:

- Analysis of patterns or problems in services using service statistics (e.g. numbers of women seen but not provided with services, numbers of complications, numbers of contraceptive methods provided by type)
- Proportion of women seeking repeat abortions
- Family trends
- Observation of counseling and clinical services to assess quality of interaction with the woman throughout the process, to correct any shortfalls in adherence to technical standards, or other practices that jeopardize quality of care (e.g. judgmental attitudes, imposition of "informal charges")
- Functioning of logistics system to ensure regular supply of equipment and consumables
- Regular aggregation of data from facility level upwards
- Assessment of progress to remedy problems identified in routine monitoring.

5.6 Tools for Operationalizing District Level Committees (DLCs)[37]

The DLC is empowered by the government to approve the sites for providing MTP services and also monitor them to ensure that the services are being provided under safe and hygienic conditions. The following tools will facilitate the DLC in discharging its duties and ensuring improved reporting of MTP services in the district:

a. Reference sheet: Activities for Operationalizing DLCs (P. No. 34,35)

b. MTP Site Verification Form (P. No. 36-38)

c. MTP Site Monitoring Form (P. No. 39-41)

d. Quarterly reporting Form (P. No. 42 – 44)

5.7 Identification of non licensed, unregulated centres

A diligent search of illegitimate centres which are non licensed and unregulated should be carried out. Non qualified quacks and personnel dealing with unsafe abortions need to be punished as per the provisions of law.

People can report such centres anonymously. All anonymous complaints should be analyzed.

5.8 The health impact of unsafe abortion should be considered as a major public-health concern and reduce the recourse to abortion through expanded and improved family planning services

5.9 Legal and policy measures supportive of girls and women

A number of supportive measures have also been undertaken. In India, the Hindu Succession (Amendment) Act passed in 2004 makes it possible for daughters to inherit family property almost on a par with sons, and the Maintenance and Welfare of Parents and Senior Citizens Act passed in 2007 requires both sons and daughters to be responsible for the care of parents in proportion to the share of property to be inherited. Although these legal changes do not by themselves modify behavior, they constitute a major shift in the legal basis of inheritance and care in old age. They also send out a clear message that the legal rights of men and women are to be recognized as equal.

Addressing the root causes of gender discrimination and inequalities requires taking supportive measures for girls and women. Such measures must focus on securing the foundations for the self determination of girls and women by improving:

- access to information, health care services and nutrition;
- access to education; and
- personal security – including protection from coercion.

Additional measures may also need to be taken in the form of policies that are implemented and monitored to ensure that high birth order girls (i.e. those born second, third or fourth in a family) have equal access to education and health services. For example, short-term measures such as providing incentives for families with daughters only may help to increase the perceived value of girls, while longer-term efforts to change deep-rooted thinking and attitudes take effect. The incentives should be regulated. Other measures to support girls or families that only have girls can take many forms, including direct subsidies at the time of birth, scholarship programmes, gender-based school quotas and financial incentives aimed at improving their economic situation.

5.10 Awareness activities

An essential element in efforts to reduce sex-ratio imbalances are sensitization and awareness raising programmes conducted by both governments and nongovernmental organizations. By addressing and involving relevant social and other networks (such as health personnel and young women and men) these activities aim to change mindsets and attitudes towards girls, and to increase recognition of the value of girls and women in society. Approaches include showcasing women's successes and the contributions they have made to their family. These are particularly successful when they provide correct information from trusted sources, stimulate debate at local and national level, and lead to an explicit endorsement of attitudes that are supportive of greater equality.

Imbalanced sex ratios are an unacceptable manifestation of gender discrimination against girls and women and a violation of their human rights.

5.11 Policies need to clearly demarcate the purposes and domains of the PNDT Act and the MTP Act

The PNDT Act and the MTP Act do not conflict or contradict but coexist. The PCPNDT Act needs to be implemented strictly which will be an adequate statutory mechanism to address sex selection. Dialogue between various groups that work to implement the PCPNDT Act and the MTP Act should be encouraged and undertaken to reach consensus on addressing both issues without hindering either. Policies need to ensure that measures for preventing sex selective abortion do not affect access to safe abortion care.

5.12 Ongoing communication campaigns against sex selective abortions should be used to emphasize that sex determination is illegal; while abortion is legal (for certain conditions) in the country.

Communication campaigns should also emphasize the importance of early and safe abortion seeking behavior to avoid abortions in the second trimester

5.13 A strong message regarding prosecution against service providers and clinics convicted under PCPNDT Act should be disseminated widely in the media.

5.14 Medical Associations such as Indian Medical Association (IMA), The Federation of Obstetric and Gynaecological Societies of India (FOGSI) and Radiological Associations should take strict action against members violating PCPNDT Act. The Maharashtra Medical Council should also act as per provisions of PCPNDT Act.

5.15 All MTP Centres should abide by the directives as per Biomedical waste (Management and Handling) Rules, 1998 regarding biomedical waste management and reporting.

5.16 Regulation of the private sector

It is dangerous to only implement the MTP act and begin registration followed by monitoring and inspection of MTP facilities. This is likely to isolate abortion providers. All MTP centres have to be registered under the BNHRA (Bombay Nursing Home Regulation Act) 2005 amongst other laws. The registration under all these Acts, compliance to minimum requirements and monitoring should be carried out together. These should be under one umbrella and the district heath officers should be trained on all these laws. This should be done for all and not only MTP centres. Non-governmental organisation (NGO) participation should be welcomed as a whistle blower.

6. Recommendations for Medical Abortion

As per the MTP Rules, 2003 medical abortion can be advocated in case of termination of early pregnancy upto seven weeks using Mifepristone and Misoprostol. The Central Drugs Standard Organization, Director General of Health Services for medical termination of pregnancy has approved a combipack of one 200mg tablet of mifepristone and four 200mcg tablets of misoprostol for medical termination of pregnancy for gestation between 49-63 days in December 2008[35]. The Ministry of Health and Family Welfare, Government of India is taking action on modifying the MTP Rules in accordance with this approval. In developing countries, the combination of mifepristone and misoprostol has proved highly successful at terminating pregnancies, with an average success rate of 95%.

It is still illegal in India to acquire medical abortion drugs without a prescription, although studies suggest that over-the-counter sales of the drugs are common practice[22,23]. Under the MTP (Amendment) Act, pharmacists are only supposed to sell mifepristone and misoprostol by prescription. Although it is not legal for pharmacists to provide medical abortion pills without a prescription, the reality is that this is a fairly common occurrence in India.

Only a doctor who is duly qualified under the MTP Act 1971 can prescribe drugs for medical abortion. Prescription for medical abortion can never be given by a non allopathic doctor.

Inorder to stop over-the-counter and unsupervised consumption of these drugs is recommended that the pharmacists should not be allowed to dispense drugs and the drugs should be distributed through a government agency. The registered medical practitioner at the MTP centre should dispense these drugs. The registered medical practitioner will also be responsible for maintaining the records. The role of dispensing drugs for medical abortion should be withdrawn from the chemist completely. The cost and distribution of the drugs should be regulated at the government level so as not to reduce the access due to unreasonable costs. The registered medical practitioner at the MTP centre should dispense these drugs and maintain records.

The registered medical practitioner, as defined by MTP Act, can prescribe the drugs for medical abortion at his/her clinic provided he/she has access to a place provided for terminating pregnancy under the MTP act. The clinic should display a certificate to this effect from the owner of the approved place. The clinic where medical abortion drugs are prescribed by an approved medical practitioner, does not need approval as long as it has referral access to an MTP approved site.

The consent form (Annexure 5) should be maintained for every case and a monthly report sent to the owner of the centre affiliated for further reporting.

All the obligations, liabilities and punishments are equally applicable to the medical termination of pregnancies with drugs, as they would be for any other first trimester MTP.

6.1 Clinical protocol

The woman will require visit to hospital/clinic on three occasions:

First Visit (day 1): to take Tab Mifepristone 200 mg orally, in the presence of a health functionary

Second Visit (day 3): to take tablet Misoprostol, 400mcg (two 200 mcg tablets) oral/vaginal if within seven weeks (49 days)

to take tablet Misoprostol, 800mcg (four 200 mcg tablets) oral/vaginal for gestational age 49-63 days

Third Visit (day 15): to ensure that abortion is complete

It is recommended that the drugs are given under supervision by a registered medical practitioner after proper counseling. Medical method of abortion client card and chart are given to the woman. Client card (Annexure 6) includes the date of first, second and third visit and the directives in case of an emergency. The chart (Annexure 7) helps to assess the womans health during 15 days of the medical abortion.

6.2 Records pertaining to medical abortions should be maintained

6.3 Record of complications and failures

A record of complications pertaining especially to heavy bleeding necessitating the use of IV fluids, blood transfusion or curettage, sepsis, incomplete abortion, continuation of pregnancy, adverse drug reactions, etc. should be maintained.

A record should me maintained of women referred with complications after having taken the pills over the counter or prescribed by another registered medical practitioner. The treatment given and outcome should be recorded.

6.4 Reporting to authorities

- Every head of the hospital or practitioner must send a monthly record of medical abortions to the Chief Medical Officer of the State as per MTP Act.
- Confidentiality should be maintained.

A concerted and sustained advocacy effort to make abortions safe directed towards national and state policy-makers as well as programme managers, coupled with a sustained campaign to increase the overall awareness about abortion laws and policies amongst women and dispel myths about abortion amongst policymakers and programme managers, are needed to ensure the political and administrative commitment to provide safe abortion care to a woman seeking termination of an unwanted pregnancy within an enabling legal and policy framework.

A significant policy message emerging is that access to affordable, high quality, legal abortion services must be improved, particularly in rural areas. Until this is done, informal providers and uncertified facilities will remain the best option for poor and rural women despite the fact that abortion has been legal in India for over 30 years. Increasing knowledge of the legality of abortion among such providers is important, as it is likely to encourage their referral when complications arise.

Immediate policy measures needed to bring about a change in the current abortion scenario in India are[38]-

- Increasing availability of safe abortion services
- Creating qualified providers and facilities
- Simplifying the registration process,
- Linking policy with technology and research and
- Good clinical practice
- Providing comprehensive and quality abortion care

7. Salient action points:

i) Expansion of safe abortion care services both in public and private health care service sectors will improve the access to these services. The PHCs should be upgraded so that safe abortion care services can be provided at these centres without coercion. These services would be easily accessible without having to incur huge costs. A significant policy message emerging is that access to affordable, high quality, legal abortion services must be improved, particularly in rural areas. Access to safe abortion services without any barriers or coercion for use of contraception, must be provided by the state.

ii) Strict implementation of the MTP Act is essential. Those violating the MTP Act should be punished. The punishment for offences under the MTP Act should be made stringent.

iii) Certification and licensing of facilities should be through a simple registration process which should come through in a short time span without delay. There should be an online registration facility. The licensing authority should ensure client safety and comprehensiveness of care. Access to safe abortion services without any barriers or coercion for use of contraception, must be provided by the state. In order to do this, the amendments to the MTP act 2003 for decentralization of registration and monitoring of MTP services should be operationalised.

iv) The District Level Committee is appointed by the Government and is responsible for approval or suspension of place for performing MTPs. There should be a higher authority for monitoring this committee.

v) The registration of a centre should be renewed every three years.

vi) The abortion services should be subject to quality monitoring and evaluation every six months after approval of registration. An independent office responsible for registration and monitoring of these services is welcome.

vii) The MTP centre should send their monthly report to concerned appropriate authority. A system of online reporting should be formulated.

viii) There was a difference of opinion among the committee members over the issue of documentation and monitoring of second trimester abortions. Some committee members were of the opinion that the evidence regarding sex of the abortus should be documented by a digital image taken prior to disposal with date. The responsibility of maintaining this evidence should rest with the registered medical practitioner performing the MTP. This practice would be helpful in monitoring the second trimester terminations performed and defer service providers from sex-selective abortions.

However all the other committee members did not agree to this suggestion and strongly objected to it. Limitations on offering second trimester abortions and/or increasing reporting requirements for abortions would discourage providers from offering these services. In places where they will be offered, the already prevalent practice of under-reporting of abortion cases will ensue. It is important that abortion providers are not isolated and targeted as this would directly reduce access to safe abortion for women. In view of the difference of opinion this issue warrants further debate.

ix) All anonymous complaints regarding medical termination of pregnancies and unlicensed MTP centres should be analyzed.

x) The health impact of unsafe abortion should be considered as a major public-health concern and reduce the recourse to abortion through expanded and improved family planning services.

xi) In the context of medical abortion the registered medical practitioner, as defined by MTP Act, can prescribe the drugs at his/her clinic provided he/she has access to a place provided for terminating pregnancy under the MTP act. The clinic should display a certificate to this effect from the owner of the approved place.

xii) Inorder to stop over-the-counter and unsupervised consumption of these drugs is recommended that the pharmacists should not be allowed to dispense drugs and the drugs should be distributed through a government agency. The cost and distribution of the pill should be regulated at the government level so as not to reduce access due to unreasonable costs. The registered medical practitioner at the MTP centre should dispense these drugs and maintain records.

xiii) Records pertaining to medical abortion should be maintained. Every head of the hospital or practitioner must send a monthly record of medical abortions to the Chief Medical Officer of the State as per MTP Act.

xiv) A record should be maintained of women referred with complications after having taken the pills over the counter or prescribed by another registered medical practitioner.

xv) It is essential to increase the overall awareness about abortion laws and policies amongst women and dispel myths about abortion amongst policymakers.

xvi) Legal and policy measures supportive of girls and women must be adopted. Addressing the root causes of gender discrimination and inequalities requires taking supportive measures for girls and women. Such measures must focus on securing the foundations for the self determination of girls and women by improving:

a. access to information, health care services and nutrition;
b. access to education; and
c. personal security – including protection from coercion.

xvii) Providing incentives for families with daughters only may help to increase the perceived value of girls. Other measures to support girls or families that only have girls can take many forms, including direct subsidies at the time of birth, scholarship programmes, gender-based school quotas and financial incentives aimed at improving their economic situation.

xviii) An essential element in efforts to reduce sex-ratio imbalances is sensitization and awareness raising programmes conducted by both governments and nongovernmental organizations.

xix) Policies need to clearly demarcate the purposes and domains of the PNDT Act and the MTP Act. The PCPNDT Act needs to be implemented strictly which will be an adequate statutory mechanism to address sex selection.

xx) The USG, PCPNDT data and MTP data should be analyzed by the same body by trained personnel.

xxi) These statistics and other information gathered through monitoring and evaluation should be shared and discussed with stakeholders and used to make decisions about improvements to services.

xxii) Ongoing communication campaigns against sex selective abortions should be used to emphasize that sex determination is illegal; while abortion is legal (for certain conditions) in the country

xxiii) A strong message regarding prosecution against service providers and clinics convicted under PCPNDT Act should be disseminated widely in the media.

xxiv) Medical Associations such as Indian Medical Association (IMA), The Federation of Obstetric and Gynaecological Societies of India (FOGSI) and the Radiological Associations should take strict action against members violating PCPNDT Act. The Maharashtra Medical Council should also act as per provisions of PCPNDT Act.

xxv) All MTP Centres should abide by the directives as per Biomedical waste (Management and Handling) Rules, 1998 regarding biomedical waste management and reporting.

xxvi) Regulation of the private sector is mandatory. All MTP centres have to be registered under the BNHRA (Bombay Nursing Home Regulation Act) 2005 amongst other laws. The registration under all these Acts, compliance to minimum requirements and monitoring should be carried out together. These should be under one umbrella and the district heath officers should be

trained on all these laws. NGO participation should be welcomed as a whistle blower.

xxvii) Overzealous measures to curb the sex selection should not prove to be a tool for unsafe and illegal abortions. Services for safe abortion in India that are accessible and affordable should be promoted

xxviii) Additions in the Annexure 3 of the MTP Act

xxix) Additional Annexures 5, 6 and 7 for medical method of abortion to be incorporated.

(References attached at P.45)

(Dr.Sanjay Oak)
Director
(Medical Education & Major Hospitals)

Salient Features of the MTP Act, Rules and Regulations

MTP Act

The Medical Termination of Pregnancy (MTP) Act of 1971, governs the provision of MTPs in the country. This legislation was enacted from the public health perspective, given the very high mortality and morbidity due to consequences of unsafe abortions.

The MTP Act specifies the indications for which a pregnancy can be legally terminated, who could terminate the pregnancy and the place where the pregnancy could be terminated. It also covers the consent requirement for the MTP procedure. The MTP Act offers protection to a practitioner if she/he adheres to or fulfils all the recommended requirements under the Act.

Salient features of the MTP Act

A) Who can terminate a pregnancy?

Only a Registered Medical Practitioner can terminate the pregnancy. He/she should:

- Possess a recognized medical qualification as defined in the Indian Medical Council Act, 1956
- Have her/his name entered in a state medical register
- Have such experience or training in gynecology and obstetrics as prescribed by the MTP Rules made under this Act

B) When can pregnancy be terminated?

A pregnancy can be legally terminated only when the Registered Medical Practitioner is of the opinion formed in good faith that:

- Continuation of pregnancy is a risk to the life of the pregnant women or it can cause grave injury to her physical or mental health
- Substantial risk that the child, if born, would be seriously handicapped due to physical or mental abnormalities
- The pregnancy was caused by rape (presumed to constitute grave injury to mental health)
- Pregnancy caused due to failure of contraceptive in married women or her husband (presumed to constitute grave injury to mental health)
- However, for termination between 12-20 weeks, the opinion of two Registered Medical Practitioners is required (Form I, Annexure-2)

C) Places where pregnancy can be terminated

- MTP can be performed only in a hospital established or maintained by the Government
- A place approved by the Government or a District Level Committee constituted by the Government

D) Consent

- Only the consent of woman is required to terminate the pregnancy. (Form C, Annexure-1)
- In case of minor (less than 18 years) or a mentally ill person, consent of a guardian is required (Form C, Annexure-1)

If termination is performed by a Registered Medical Practitioner in good faith to save a woman's life, it will not be treated as an offence even if it is done at a non-approved site or by a Registered Medical Practitioner who does not have the legal requirements to perform MTP.

Violation of the Act

Consequences of violating provisions of the Act can be quite severe:

- Any person terminating a pregnancy, who is not a Registered Medical Practitioner, can be punished with rigorous imprisonment for a minimum of two years and a maximum of seven years
- Anyone terminating a pregnancy at a place, which is not approved, can be punished with rigorous imprisonment for a minimum of two years and a maximum of seven years.
- The owner of a non-approved place, performing termination of pregnancy can also be punished with rigorous imprisonment for a minimum of two years and a maximum of seven years.

MTP Rules

The MTP Rules cover the composition of the DLC, site approval process and experience and training requirement of MTP provider.

Salient features of the MTP Rules, 2003

A) Composition and tenure of District Level Committee (DLC)

The District Level Committee is appointed by the Government and is responsible for approval/suspension of place for performing MTPs, and is chaired by the Chief Medical Officer or District Health Officer and consists of the following:

- 3 to 5 members including Chairperson
- One member shall be a Gynecologist/Surgeon/Anesthetist
- Other members should be from the local medical profession, non-governmental organization and Panchayati Raj Institution of the district
- At least one member of the Committee should be a woman

The tenure of the Committee shall be for two calendar years and the tenure of the NGO member shall not be for more than two terms.

B) Requirements for approval of a place

Rules now segregate sites that offer only first trimester (up to 12 weeks) MTPs and sites that offer MTPs up to 20 weeks.

- A place can be approved for terminating pregnancies up to 12 weeks if it has the following facilities:
  - Gynecology examination/labor table
  - Resuscitation and sterilization equipment
  - Drugs and parenteral fluids
  - Back-up facilities for treatment of shock
  - Facilities for transportation
- **For terminating pregnancies up to 20 weeks the place should have the following facilities:**
  - An operation table and instruments for performing abdominal or gynecological surgery
  - Anesthetic equipment, resuscitation and sterilization equipments.
  - Drugs and parenteral fluids for emergency use, notified by Government of India from time to time
- **Medication Abortion (MA)**

  In case of termination of early pregnancy up to seven weeks using Mifepristone and Misoprostol, the Registered Medical Practitioner, as defined by the MTP Act, can prescribe the drugs at his/her clinic provided he/she has access to a place approved for terminating pregnancy under the MTP Act. The place where MA is prescribed does not need approval. The clinic should display a certificate to this effect from the owner of an approved place.

C) Approval process

- The approval for the place should be applied in Form A (Annexure-1) and addressed to the Chief Medical Officer of the district
- The CMO shall verify information provided in the application or inspect the place to satisfy himself that the termination of pregnancy may be made under safe and hygienic conditions. If the CMO is satisfied after verification, enquiry or inspection, he/she recommends the approval of such place to the District Committee (DLC)
- The Committee after considering the application and the recommendations of the CMO may approve the place and issue a certificate of approval in Form B (Annexure-1)
- The place shall be inspected within 2 months of the receipt of application and certificate of approval may be issued within next 2 months or if there is any deficiency noted, within 2 months of the deficiency being rectified by the applicant
- Other Rules
  - The CMO may inspect the approved place as often as may be necessary to verify that MTPs are being performed under safe and hygienic conditions
  - If the CMO has reason to believe that there has been death or injury to pregnant women at the place or that the termination is not being done under safe and hygienic conditions, he/she can seek any information or seize any article, medicine, admission register or other documents
  - If the CMO, after inspection, is satisfied that the facility is not being maintained properly and termination cannot be made in safe and hygienic conditions, he/she shall report this fact to the Committee and the District Committee may suspend or cancel the approval after giving the owner an opportunity of making representation
  - The owner of the place whose approval has been suspended or cancelled, can apply again for approval after making additions or improvements to the place
  - The owner whose approval has been suspended or cancelled can apply for a review within 60 days of the order
  - The Government may confirm, modify or reverse the order

D) Experience and training required by a Registered Medical Practitioner

- Up to 20 weeks gestation
  - A practitioner who holds a post-graduate degree or diploma in Obstetrics and Gynecology
  - A practitioner who has completed six months as House Surgeon in Obstetrics and Gynecology
  - A practitioner who has at least one year experience in the practice of Obstetrics and Gynecology at any hospital that has all facilities
- Up to 12 weeks gestation only

  A practitioner, who has assisted a Registered Medical Practitioner in 25 cases of medical termination of pregnancy of which at least five have been performed independently in a hospital established or maintained by the government or a training institute approved for this purpose by the government

Essentials of safe and legal abortions

Abortion is legal only when it fulfils the following conditions:

- A Registered Medical Practitioner who is allowed to terminate pregnancy as defined by the MTP Act performs it

- It is performed at an approved place under the Act
- Other requirements of the Act like consent, opinion of Registered Medical Practitioner etc. are fulfilled.

MTP Regulations 2003

The MTP Act empowers the State Governments to form regulations, maintain records and report the MTP services to the state. The salient features of the MTP Regulations 2003 are:

1. Form of certifying opinion or opinions

- When one RMP forms or two RMPs form an opinion to terminate the pregnancy he/she shall certify such opinion in Form I (Annexure-2).
- Every RMP who terminates any pregnancy shall certify such termination in Form I (Annexure-2).

2. Custody of Forms

- Form C with the consent of the woman and Form I for intimation of the termination shall be sealed in an envelope by the RMP(s) performing the termination and shall be kept in their safe custody until it is sent to the head of the hospital/owner of the approved place or CMO.
- The serial number assigned to the pregnant woman in the admission register and the name(s) of the RMP(s) shall be noted on each envelope and shall be marked "SECRET".
- Every envelope shall be sent immediately after termination of pregnancy to the head of the hospital/owner of the hospital where pregnancy was terminated and will be kept in safe custody.
- Every head of the hospital/owner of the approved place shall send a monthly statement of MTP cases to the Chief Medical Officer of the state on Form II (Annexure-3).

3. Maintenance of Admission Register

- Every Head of the hospital/owner of the approved place shall maintain a register as per Form III (Annexure-4) for recording the details of the women and keep in secret custody for five years from the end of the calendar year it relates to. It is a secret document not to be disclosed to any person except under authority of Law.
- Entries in the Admission Register shall be made serially and a fresh serial started at the beginning of each calendar year. The serial no. will be distinguished by the year, e.g. SN 5/2006; 5/2007.
- No entry shall be made in any case-sheet, operation theatre register, follow-up card or any other document other than the Admission Register. Reference to the woman in other records will be made by the S.No. assigned to her in the Admission Register.

Annexures

Annexure 1- MTP Act, Rules and Regulations
Application form for site approval – Form A
Certificate of approval – Form B
Consent Form – Form C
*** No change**

Annexure 2
RMP opinion form – Form I
*** No change**

Annexure 3
MTP reporting form – Form II
***Addition in Point 3 in MTP regulations 2003: data regarding No.of MTPs performed upto 12 weeks. The No.of surgical and medical abortions should be reported.**
***Addition in Point 5: Other methods of contraception should also be documented**

Annexure 4
Admission register – Form III
***No change**

Annexure 5
Consent form for MTP by medical method of abortion

- **Additional Annexure to be incorporated.**

Annexure 6
Medical method of abortion Client Card

- **Additional Annexure to be incorporated.**

Annexure 7
Health assessment during 15 days of the medical method of abortion

- **Additional Annexure to be incorporated.**

Annexure 1

APPLICATION FORM FOR SITE APPROVAL

FORM A
(See sub-rule (2) of rule 5)

Category of approved place:
A Pregnancy can be terminated upto 12 weeks
B Pregnancy can be terminated upto 20 weeks

1. Name of the place (in capital letters)

2. Address in full

3. Non-Government/Private/Nursing Home/Other Institutions

4. State, if the following facilities are available at the place

Category A

Gynecological examination / labour table.
Resuscitation equipment.
Sterilization equipment.
Facilities for treatment of shock, including emergency drugs.
Facilities for transportation, if required.

Category B

(ii) An operation table and Instruments for performing abdominal or gynaecological surgery.

(iii) Drugs and parental fluid in sufficient supply for emergency cases.

(iv) Anaesthetic equipment, resuscitation equipment and sterilization equipment.

Place :
Date :

Signature of the owner of the place

CERTIFICATE OF APPROVAL

FORM B
(See sub-rule (6) of rule 5)

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

AS READ WITHIN UPTO----------WEEKS

Name of the Place

Address and other descriptions

Name of the owner

Place :

Date :

To the Government of the _____

CONSENT FORM

FORM C
(See rule 9)

I _____ daughter/wife
of _____
aged about _____ years of _____
_____
(here state the permanent address)
at present residing at
_____
do hereby give my consent to the termination of my pregnancy at
_____
_____
(State the name of place where the pregnancy is to be terminated)

Place :
Date :

Signature

(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 :
Date :

Signature

Annexure 2

RMP OPINION FORM
FORM I
(See Regulation 3)

I.....
(Name and qualifications of the Registered Medical Practitioner in block letters)
.....
(Full address of the Registered Medical Practitioner in block letters)
I.....
(Name and qualifications of the Registered Medical Practitioner in block letter)
.....
(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 ..... (Full address of woman in block letters) for the reasons given below**.

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 Registered Medical Practitioner
Signatures of Registered Medical Practitioners

*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 or 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 a 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 a pregnancy would involve a grave injury to her physical or mental health.

Place :
Date :

Signature of the Registered Medical Practitioner
Signatures of the Registered Medical Practitioners

Annexure 3
MTP REPORTING FORM
FORM II
[See Regulation 4 (5)]

1. Name of the State .....
2. Name of Hospital/approved place .....
3. Duration of pregnancy (give total No. only)
   (a) Upto 12 weeks .....
   Surgical method .....
   Medical method .....

   (b) Between 12-20 weeks .....

4. Religion of women :
(a) Hindu
(b) Muslim
(c) Christian
(d) Others
(e) Total

5. Termination with acceptance of contraception:
(a) Sterilisation
(b) I.U.D.
(c) Other methods

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 4

ADMISSION REGISTER
FORM III
(See Regulation 5)

(To be destroyed on the expiry of five years from the dated of the last entry in the register)

S.No.	Date of Admission	Name of Patient	Wife/ Daughter	Age	Religion	Address	Duration of Pregnancy
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)

Reasons on which pregnancy is terminated	Date of termination of pregnancy	Date of discharge of patient	Result & Remarks	Name of Registered Medical Practitioner(s) by whom opinion is formed	Name of Registered Medical Practitioner(s) by whom pregnancy is terminated
(9)	(10)	(11)	(12)	(13)	(14)

Annexure 5

CONSENT FORM FOR MTP BY MEDICAL METHOD OF ABORTION

I have been explained about the process of medical method of abortion, which is a method to terminate a pregnancy using a combination of two medicines. I understand that I will be required to take the prescribed doses of mifepristone on Day 1, followed by misoprostol on Day 3. I also understand that I will be required to come to the clinic for a follow-up visit on Day 15 to confirm the completion of the procedure.

I understand that many women experience some side effects with medical methods of abortion such as nausea, vomiting, diarrhoea, abdominal pain, cramping and bleeding. The bleeding may be heavier than I usually experience during my menstruation.

My doctor/ counsellor has also explained that there are chances that the method may fail to terminate the pregnancy. In such a situation, it will be necessary for me to undergo a surgical abortion to complete the process. If I experience any symptoms identified by my doctor as danger signs, or if I have any concerns about the procedure during the course of the 15 days, I may call my doctor.

I, _____ daughter/wife of _____ aged about _____ years, residing at _____

do hereby give my consent for the termination of my pregnancy at _____

_____

Place: _____

Date: _____

Signature

I, _____ son/daughter/wife of _____ aged about _____ years, residing at _____

do hereby give my consent for the termination of the pregnancy of my ward _____ who is a minor/mentally ill person at _____

Place: _____

Date: _____

Signature

Annexure 6
MEDICAL METHOD OF ABORTION CLIENT CARD

Details of the patient:

Name: _____

Phone number: _____

Residential address: _____

_____

_____

_____

Date of first visit: _____

Date of second visit: _____

Date of third visit: _____

In case of emergency, please contact:

Doctor: _____

Phone number: _____

Hospital address: _____

_____

_____

_____

This chart will help you to assess your health during the 15 days of the medical method of abortion procedure. Put a (x) against any symptom that you experience each day during those 15 days.

During the procedure →	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
 Spotting															
 Routine menstrual bleeding															
 Excessive bleeding															
 Nausea/ vomiting															
 Pain/ cramps															
 Fever/ chills/ rigors															

Annexure 7

TOOLS FOR OPERATIONALIZING DLCS

Reference Sheet: Activities for Operationalizing District Level Committees (DLCs) under the MTP Act, 1971

Step 1: Formation of DLC

SN	Activity	Sub-activity
1.	Form DLC	1. CMHO to identify 5-8 responsible persons from the categories specified under the MTP Rules 2003
		2. CMHO to select 3-4 persons (excluding CMHO) representing the categories specified under the MTP Rules 2003 to be DLC members and get their written consent.
		3. CMHO to inform the list of the DLC members to Director, Public Health and Family Welfare, Directorate Health Services, Maharashtra

Step 2: Site Certification by DLC

SN	Activity	Sub-activity
1.	Preparation for site verification and approval	1. CMHOs to chair a meeting of the DLC members to plan and agree on the activities and their process during the term of two years
		2. Inform private doctors & nursing homes regarding DLC and invite applications for approval of their sites to provide MTP services through: a. representatives of the DLC b. communication to FOGSI and IMA chapters c. press release in local media d. notice at CMHO's office notice board
		3. CMHO to ensure availability of adequate forms A, B, C, I, II and III (MTP Regulations 2003) at his office.
		4. CMHO to depute a nodal staff at his office responsible for the following: a. providing application form for approval of sites to doctors requesting them b. maintain record of the applications received c. maintain a register of sites inspected and approved.
		5. CMHO to plan or depute a representative from the DLC to conduct site verification visits

SN	Activity	Sub-activity
2.	Site verification visit	1. CMHO/Representative to conduct site verification to assess adequacy of facilities for providing quality MTP services on the site verification form and recommend to the DLC for approval if satisfied.
		2. If CMHO/Representative not satisfied during the visit, CMHO to provide written information regarding the result of the verification visit to the DLC. The record of the visit to be maintained.
3.	Site approval	1. DLC to meet to review CMHO/Representative's recommendations of site verification and decide on the site approvals to be made or if not satisfied the owner to be notified for hearing. 2. CMHO to communicate to the owner of the sites the DLC approval (refer suggested covering letter) with the Certificate of Approval (Form B, MTP Rules)
4.	Site re-verification visit	1. CMHO/Representative to revisit the site on receiving an application from the owner after his/her hearing in #3 above and site verification to be conducted, if satisfied recommend the site for approval to the DLC.
5.	Approved site monitoring visits	1. CMHO/Representative to conduct monitoring visit to the approved sites to assess adequacy of facilities for providing quality MTP services are maintained, using the site monitoring form.
		2. Maintain records of the monitoring visits.

1.	Meetings of DLC	1. Hold at least one meeting every quarter to review recommendations for site approval, progress of the DLC activities, and reporting of MTPs from the service providers.
2.	Compiling MTP data received from private sites	1. CHMO to maintain a register capturing the MTP data received from the approved sites in Form II.
3.	Reporting to Directorate of Health Services	1. CMHO to send quarterly activity report to the Nodal Officer MTP, Family Welfare, Directorate of Public Health Services on the quarterly reporting form for information.

_____ District Level Committee under MTP Act 1971

(Name of District)

MTP Site Verification Form

Name of the owner_____

Name of the site_____

Address of the site_____

_____

Type of clinic (Tick '✓' the appropriate box)	NGO	Private Clinic	Nursing Home	Other institutions

Applied for provision of MTP services (Tick '✓' the appropriate box):	upto 12 weeks	upto 20 weeks

Date of verification visit (d/m/y)_____

Note: '✓' the appropriate response for each item assessed. Enter any special observation in the column of Remarks.

SN	Item	Yes	No	Remarks
1.	Essential equipment present and functional as required for the duration of pregnancy to be terminated **Upto 12 weeks:** a. Gynecological examination table/labour table b. Resuscitation equipment c. Sterilization equipment d. Drugs and parenteral fluids (Refer annexure 'A') e. Backup facilities for treatment of shock (IV fluids & referral linkage) f. Facilities for transportation **Upto 20 weeks:** a. Operation table b. Instruments for performing abdominal or gynecological surgery c. Anaesthetic equipment d. Resuscitation equipment e. Sterilization equipment f. Drugs and parenteral fluids for emergency use as notified by GoI (Refer annexure 'A')			

S.N.	Item	Yes	No	Remarks
2.	Instruments for performing per-speculum and pelvic examination in the OPD			
3.	Instruments for performing MTP upto 12 weeks present and functional			
4.	Instruments and drugs for performing MTP from 12-20 weeks present and functional			

Recommendation to DLC:

A. The site is suitable to perform MTP services upto _____weeks. The Distri
Level Committee may approve the site to perform MTP services upto _____week

B. The site is assessed and found not suitable to perform quality MTP services due to:
(List specific details of deficits identified):

Signature of CMHO/Representative
District
Seal of CMHO

Date

_____ District Level Committee

Considering the recommendations of the CMHO/Representative, the District Level Committe
_____(Name of District), is of the opinion to approve the si

(Name and address of the site) _____ _____
_____of (name of owner) _____
to perform MTPs upto _____weeks.

Signature Chairman (DLC)

Date of DLC Meeting

Annexure - A[1]

Ministry of Health and Family Welfare
(Department of Family Welfare)

NOTIFICATION
New Delhi, the 30th December, 2004

S.O. 50(E).- In exercise of the powers conferred under (c) of Rule 5 of the Medical Termination of Pregnancy Rules, 2003, to notify the drugs and parenteral fluids for emergency use, Central Government hereby notifies that places approved for conducting termination of pregnancy, under Section 4 of the Medical Termination of Pregnancy (Amendment) Act, 2002 (64 of 2002), shall provide for the following drugs and parenteral fluids for emergency use:

(i) Drugs and parenteral fluids

a. Antibiotics-Ampicillin, amoxicillin trihydrate, cephalexin or a suitable alternative.

b. Analgesic-paracetamol, pentazocine, dicylomine or a suitable alternative.

c. Local anaesthetic-Injection Lignocaine 1 per cent.

d. Injection Diazepam.

e. Uterotonics-Injection Oxytocin and Injection Methylergometrine maleate. Injection Prostaglandins are optional.

f. Injection Atropine sulphate.

g. 5 per cent dextrose and Ringer lactate solution with IV sets and cannulae or scalp vein sets.

(ii) Facilities for treatment of emergencies

a. Injection Adrenaline

b. Injection Aminophylline

c. Injection Sodium bicarbonate 7.5 per cent

d. Injection Calcium gluconate 10 per cent.

e. Antiemetics-Injection Metaclopramide or a suitable alternative.

f. Antihistaminics-Injection Promethazine hydrochloride or a suitable alternative.

g. Steroid-Injection Hydrocortisone succinate.

h. Injection Frusemide.

i. Injection Dopamine.

Additional drugs and parenteral fluids:

(i) Ethacridine lactate solution with Foley's catheter for instillation

(ii) General Anaesthetic drugs

[F. No. M-12015/59/2003-MCH]
S. S. BRAR, Jt. Secy.

[1]Attach with MTP site verification form.

_____ District Level Committee under MTP Act 1971

(Name of District)

MTP Site Monitoring Form

Name of the owner _____

Name of the site _____

Address _____

_____

Type of clinic (Tick '✓' the appropriate box)	NGO	Private Clinic	Nursing Home	Other institutions

Approved for conducting MTP services (Tick '✓' the appropriate box):	upto 12 weeks	upto 20 weeks

Date of monitoring visit (d/m/y) _____

Note: '✓' the appropriate response for each item assessed. Enter any special observation in the column of Remarks.

S.N.	Item	Yes	No	Remarks
1.	Admission register maintained as per standard format			
2.	Confidentiality and privacy of woman maintained in the OPD, OT and post-operative ward			
3.	Essential equipment present and functional as required for the duration of pregnancy to be terminated **Upto 12 weeks:** a. Gynecological examination table/labour table b. Resuscitation equipment c. Sterilization equipment d. Drugs and parenteral fluids (Refer annexure 'A') e. Backup facilities for treatment of shock f. Facilities for transportation **Upto 20 weeks:** a. Operation table b. Instruments for performing abdominal or gynecological surgery c. Anaesthetic equipment d. Resuscitation equipment e. Sterilization equipment f. Drugs and parenteral fluids for emergency use as notified by GoI (Refer annexure 'A')			

SN	Item	Yes	No	Remarks
4.	Instruments for performing per-speculum and pelvic examination in the OPD			
5.	Instruments for performing MTP upto 12 weeks present and functional			
6.	Instruments and drugs for performing MTP from 12-20 weeks present and functional			
7.	Consent form, C maintained			
8.	RMP opinion form (Form I) and MTP reporting form (Form II) available at the site and being used			
9.	Infection prevention practices practiced to prevent infection especially HIV/HBV/Ebola			
10.	Records being sent to CMO regularly			

Recommendation to DLC:

A. The site is performing and reporting quality MTP services as per standards and can continue providing services upto _____weeks.

B. The site is not able to perform quality MTP services due to lack of:
(List any specific details of deficits identified)

Signature of CMHO/Representative

District

Date

Seal of CMHO

Annexure - A[1]

Ministry of Health and Family Welfare
(Department of Family Welfare)

NOTIFICATION

New Delhi, the 30th December, 2004

S.O. 50(E).- In exercise of the powers conferred under (c) of Rule 5 of the Medical Termination of Pregnancy Rules, 2003, to notify the drugs and parenteral fluids for emergency use, Central Government hereby notifies that places approved for conducting termination of pregnancy, under Section 4 of the Medical Termination of Pregnancy (Amendment) Act, 2002 (64 of 2002), shall provide for the following drugs and parenteral fluids for emergency use:

(i) Drugs and parenteral fluids

a. Antibiotics-Ampicillin, amoxicillin trihydrate, cephalexin or a suitable alternative.

b. Analgesic- paracetamol, pentazocine, dicylomine or a suitable alternative.

c. Local anaesthetic-Injection Lignocaine 1 per cent.

d. Injection Diazepam.

e. Uterotonics-Injection Oxytocin and Injection Methylergometrine maleate. Injection Prostaglandins are optional.

f. Injection Atropine sulphate.

g. 5 per cent dextrose and Ringer lactate solution with IV sets and cannulae or scalp vein sets.

(ii) Facilities for treatment of emergencies

a. Injection Adrenaline

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c. Injection Sodium bicarbonate 7.5 per cent

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e. Antiemetics-Injection Metaclopramide or a suitable alternative.

f. Antihistaminics-Injection Promethazine hydrochloride or a suitable alternative.

g. Steroid-Injection Hydrocortisone succinate.

h. Injection Frusemide.

i. Injection Dopamine.

Additional drugs and parenteral fluids:

(i) Ethacridine lactate solution with Foley's catheter for instillation

(ii) General Anaesthetic drugs

[F. No. M-12015/59/2003-MCH]

S. S. BRAR, Jt. Secy.

[1]To be attached with MTP site monitoring form.

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District Level Committee
The Medical Termination of Pregnancy (Amendment) Act, 2002

QUARTERLY REPORTING FORMAT

From (Month/ Year): _____ to (Month/ Year): _____

District: _____ Date of reporting: _____

Submitted to: Nodal Officer (MTP), Department of Public Health & Family Welfare, Govt. of MP, Bhopal

Reporting indicators	Status for the quarter
Number of applications received for site approval on Form A	
Number of sites approved by DLC	Upto 12 weeks Upto 20 weeks
Number of approvals pending at the end of reporting period	
Total number of MTP sites registered in the district till date	Upto 12 weeks Upto 20 weeks

Remarks/Comments:

Name of CMHO: _____

Signature: _____

Seal

Enclose: 1. List of health facilities approved in this quarter 2. Summary of MTP cases.

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District Level Committee
The Medical Termination of Pregnancy (Amendment) Act, 2002

From (Month/ Year): _____ to (Month/ Year): _____

District: _____ Date of reporting: _____

Submitted to: Nodal Officer (MTP), Department of Public Health & Family Welfare, Govt. of M.P, Bh

List of health facilities approved during the reporting quarter

S.N.	Name of the Health Facility	Name of Owner	Approved for providing MTP u (Pl. ✓ one)	
			12 weeks	20 we
1.				
2.				
3.				
4.				
5.				
6.				

Signature of CMHO

Seal

Attachment to Quarterly DLC Activity Report

Summary of MTP cases

From (Month/ Year): _____ to (Month/ Year): _____

District: _____ Date of reporting: _____

Submitted to: Nodal Officer (MTP), Department of Public Health & Family Welfare, Govt. of MP, Bhopal

Summary of MTP Cases reported in FORM II by Approved MTP Sites

S.N.	Name of Approved Site	Total MTPs performed in the Quarter	
		Up to 12 weeks	Up to 20 weeks

Signature of CMHO

Seal

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बृहन्मुंबई महानगरपालिका
सेठ गो.सु.वै.महाविद्यालय आणि रा.ए.स्मारक रुग्णालय
क्रं. संचालक/वैशिवप्ररु/८३३ दि. १९.९.२०११

विषय – गर्भधारणापूर्व व प्रसवपूर्व निदानतंत्र (लिंग निवडीस प्रतिबंध) कायदा १९९४ सुधारीत २००३ ची (पीसीपीएनडीटी) अंमलबजावणी करणेबाबत.

माननीय महोदय,

गर्भधारणापूर्व व प्रसवपूर्व निदानतंत्र (लिंग निवडीस प्रतिबंध) कायदा १९९४ सुधारीत २००३ ची अंमलबजावणी करणेबाबत मा.मंत्री महोदय(आरोग्य) श्री.सुरेश शेट्टी यांच्या अध्यक्षतेखाली दि.८ सप्टेंबर, २०११ रोजी दुपारी ३ वाजता सहयाद्री अतिथीगृह, मलबार हिल,मुंबई येथे बैठक घेण्यात आली. बैठकीत मंत्रीमहोदयांनी डॉ.संजय ओक,संचालक(वैद्यकीय शिक्षण व प्रमुख रुग्णालये) केईएम रुग्णालय, बृहन्मुंबई महानगरपालिका यांच्या अध्यक्षतेखाली महाराष्ट्र राज्यामध्ये स्त्रीभृण हत्या प्रतिबंध करण्यासाठी एक समिती गठित करण्याचे आदेश दिले.त्यानुसार खालील अधिकारी व एनजीओचे प्रतिनिधींची नियुक्ती करण्यात येत आहे.

१. डॉ.संजय ओक, संचालक(वैद्यकीय शिक्षण व प्रमुख रुग्णालये) केईएम रुग्णालय –अध्यक्ष
२. डॉ.पियुश शशी गोयल, वाडिया रुग्णालय, सदस्य
३. डॉ.अे.एल.शारदा, संचालक, पॉप्युलेशन फर्स्ट
४. डॉ.डी.के.मंगल/अनुजा गुलाटी, स्टेट प्रोग्रम ऑफिसर, युनायटेड नेशन पॉप्युलेशन फंड
५. श्रीमती पद्मा देवस्थळी, सेहत प्रतिनिधी
६. श्रीमती स्नेहा खांडेकर, सावित्रिबाई फुले जेंडर रिसोर्स
७. डॉ.शशांक परुळेकर, प्राध्यापक व विभागप्रमुख, स्त्रीरोग व प्रसुतीशास्त्र विभाग,केईएम रुग्णालय
८. डॉ.हिमांगी वारके,सह.प्राध्यापक, स्त्रीरोग व प्रसुतीशास्त्र विभाग,केईएम रुग्णालय
९. डॉ.कामाक्षी भाटे, सह.प्राध्यापक,रोगप्रतिबंधक व सामाजिक औषधशास्त्र विभाग,केईएम

समितीची पहिली बैठक दि. १९.९.२०११ रोजी सकाळी १०.३० वाजता संचालक(वैशिव प्ररु) यांच्या दालनांत घेण्यात आली. गर्भधारणापूर्व व प्रसवपूर्व निदानतंत्र (लिंग निवडीस प्रतिबंध)कायदा १९९४ सुधारीत २००३ ची (पीसीपीएनडीटी) कायद्याची अंमलबजावणी अतिशय प्रभावशालीपणे होण्याच्या दृष्टीने मुंबई व महाराष्ट्र राज्यात नियंत्रण ठेवण्यासाठी मार्गदर्शक तत्वे तयार करणे गरजेचे असल्याचे संचालकांनी सांगितले. मार्गदर्शक तत्वे तयार करताना खालील गोष्टी विचारात घेण्याची आवश्यकता आहे:

अ) पीसीपीएनडीटी कायद्याची अंमलबजावणी प्रभावीपणे करण्यासाठी स्त्रीरोग व प्रसुतीशास्त्र तज्ञ, रेडिओलॉजी/सोनोग्राफी केंद्र चालविणारे तज्ञ तसेच जनुकिय क्रेंद्र/प्रयोगशाळा तज्ञ यांनी यांच्याकडे तपासणीसाठी येणा-या रुग्णांची माहिती अद्ययावत ठेवावी तसेच दर महिन्याला संकलित माहिती राज्य शासनाच्या कार्यालयात पाठविण्यात यावी.

ब)माहितीचे संकलन करण्याकरिता जिल्हास्तरीय विषेश कार्यालय स्थापन करण्यात यावे.

ब) एमटीपी केंद्राचे रजिस्ट्रेशन सक्तीचे करण्यात यावे व रजिस्ट्रेशनची पध्दत सोपी असावी.

बृहन्मुंबई महानगरपालिका
सेठ गो.सु.वै.महाविद्यालय आणि रा.ए.स्मारक रुग्णालय
क्रं. संचालक/वैशिवप्ररु/ दि. २४.९.२०११

विषय – गर्भधारणापूर्व व प्रसवपूर्व निदानतंत्र (लिंग निवडीस प्रतिबंध) कायदा १९९४ सुधारीत २००३ ची (पीसीपीएनडीटी) अंमलबजावणी करणेबाबत.

माननीय महोदय,

गर्भधारणापूर्व व प्रसवपूर्व निदानतंत्र (लिंग निवडीस प्रतिबंध)कायदा १९९४ सुधारीत २००३ ची (पीसीपीएनडीटी) कायद्याची अंमलबजावणी अतिशय प्रभावशालीपणे होण्याच्या दृष्टीने मुंबई व महाराष्ट्र राज्यात नियंत्रण ठेवण्यासाठी मार्गदर्शक तत्वे तयार करण्यासाठी गठित करण्यात आलेल्या समितीची दुसरी बैठक दि. २४.९.२०११ रोजी सकाळी १०.३० वाजता संचालक(वैशिव प्ररु) यांच्या दालनांत घेण्यात आली. बैठकीस खालील अधिकारी उपस्थित होते.

१०. डॉ.संजय ओक, संचालक(वैद्यकीय शिक्षण व प्रमुख रुग्णालये) केईएम रुग्णालय –अध्यक्ष
११. डॉ.पियुश शशी गोयल, वाडिया रुग्णालय, सदस्य
१२. डॉ.डी.के.मंगल, स्टेट प्रोग्रम ऑफिसर, युनायटेड नेशन पॉप्युलेशन फंड
१३. श्रीमती पद्मा देवस्थळी, सेहत प्रतिनिधी
१४. डॉ.शशांक परुळेकर, प्राध्यापक व विभागप्रमुख, स्त्रीरोग व प्रसुतीशास्त्र विभाग,केईएम रुग्णालय
१५. डॉ.हिमांगी वारके,सह.प्राध्यापक, स्त्रीरोग व प्रसुतीशास्त्र विभाग,केईएम रुग्णालय
१६. डॉ.कामाक्षी भाटे, सह.प्राध्यापक,रोगप्रतिबंधक व सामाजिक औषधशास्त्र विभाग,केईएम

मार्गदर्शक तत्वे तयार करताना खालील गोष्टी विचारात घेण्याची आवश्यकता आहे असे समितीच्या सभासदांनी निदर्शनास आणून दिले:

१. एम.टी.पी. हे सुरक्षित,कायदेशीर, तज्ञ डॉक्टर्सकडून करण्यात येणे गरजेचे आहे. कॉन्ट्रसेप्टीव्हस वापरण्यामध्ये उदासिनता त्यासाठी जनजागृतीची गरज आहे. राज्यातील मुलींचे/महिलांचे सक्षमीकरण करण्याची गरज आहे. राज्यातील मुलींना मोफत शिक्षण, कपडे,सायकली यासारखे प्रोत्साहनपर देऊ केल्यास मुली सुशिक्षित होतील व त्यामुळे त्यांचे आरोग्य, निर्णयक्षमता व मानसिक बळकटीकरण होईल.
२. एमटीपी करणा-या सेंटर्सनी रुग्ण महिलेचे व्होटर्स कार्ड ज्यात महिलेचे वय व नाव असेल हे पाहणे बंधनकारक करावे.
३. मालमत्तेच्या/घराच्या ॲग्रीमेंट/कागदपत्रांवर पत्नी/मुलगी यांचे नाव घालणे बंधनकारक करण्यात यावे जेणेकरुन महिलांना आर्थिक स्थैर्य, हक्क, आणि समाजातील आर्थिक उलाढालींची जाणीव प्राप्त होईल.
४. माहितीचे संकलन करण्याकरिता जिल्हास्तरीय विषेश कार्यालयात सॉप-टवेअर अभियंताची नेमणूक करण्यात यावी.
५. ऑन लाईन रजिस्ट्रेशनची सोय असावी.
६. नर्सिंग होम्स, गर्भपात सेंटर्स यांच्याकडून दर महिन्यातून एकदा जिल्हास्तरीय कार्यालयात ऑनलाईन माहिती पाठविण्यात यावी. जिल्हास्तरीय वैद्यकीय अधिका-याने त्याचे संकलन करावे.

७. जिल्हास्तरीय वैद्यकीय अधिका-याने दर तीन महिन्यातून एकदा नर्सिंग होम्स, गर्भपात सेंटर्सना भेट देऊन सर्वेक्षण करण्यात यावे.

८. तसेच परवाना दिलेला कालावधी संपल्यानंतर मुदत वाढविण्याच्या अगोदर सेंटर्सची फेरतपासणी करणे.

९. नर्सिंग होम तसेच रुग्णालयांमध्ये एमटीपीसाठी भरण्यात येणारा फॉर्म पूर्ण भरलेला असावा.

१०. सेकंड ट्रायमेस्टर एमटीपी मध्ये गर्भलिंगाची नोंद करण्यात यावी व त्याचे डिजीटल फोटोग्राप-स घेऊन (तारखेसहित) नोंद करण्यात येणे बंधनकारक करावे.

१०.एमटीपी करणा-या नर्सिंग होम्स, गर्भपात केंद्रे तसेच रुग्णालयांना बायोमेडिकल वेस्टचे लायसन्स असणे कायद्याने बंधनकारक करण्यात यावे.

११.हुंडा घेणारा व देणारा यांना कठोर शिक्षा होणे गरजेचे आहे.

पुढील बैठक शनिवार दि.१.१०.२०११ रोजी घेण्यात येईल.

संचालक
(वैद्यकीय शिक्षण व प्रमुख रुग्णालये)

MUNICIPAL CORPORATION OF GREATER MUMBAI
SETH G.S.MEDICAL COLLEGE & KEM HOSPITAL
No. Director/ME&MH/874 of 17 October 2011

Sub: Recommendations for control of unauthorized medical termination of pregnancy in the State of Maharashtra.

3rd Meeting of the Committee was held in the chamber of Director(ME&MH) on 7.10.2011 at. 11.00 a.m. when following officers were present:

1) Dr.Sanjay Oak,Director(ME&MH)
2) Dr.Piyush S.Goyal, Wadia Hospital
3) Dr.A.L.Sharada, Director, Population first
4) Dr.D.K.Mangal, State Program Officer, United National Population First
5) Dr.Anuja Gulati, State Program Officer, United National Population First
6) Ms.Padma Devasthali, CEHAT
7) Ms.Sneha Khandekar, Savitribai Phule Gender Resource
8) Dr.Shashank Parulekar, HOD, Ob.& Gy.,KEM
9) Dr.Himangi Warke, A.P.Ob.& Gy.KEM
10) Dr.Kamakshi Bhate, AP, PSM KEM

The following issues were discussed by Dr.Oak with the Committee members:

1. The objective of the committee formed by the Govt. of Maharashtra was to look into medical termination of pregnancy at various MTP centres. The committee has taken a note that there are legitimate licensed centres where the MTP activities are conducted and there are illegal, non licensed, non regulated centres at work. Therefore the committee would like to put on records that while carrying out objections, the committee strongly recommends the further propagation of availability of safe abortion services for women and therefore all the procedures to simplify the registration of legitimate

centres. Maintenance of records of the initial and follow up visits for monitoring these centres must be strongly promoted. At the same time a diligent search of illegitimate centres which are non licensed and unregulated should be carried out. Non qualified quacks and personnel dealing with unsafe abortions need to be punished as per the provisions of law.

2. Therefore while the committee appreciated the golden objective to restore the male to female ratio, overzealous measures to curb the sex selection should not prove to be a tool for unsafe and illegal abortions.

3. All MTP Centres should abide by the directives as per Biomedical waste (Management and Handling) Rules, 1998 regarding biomedical waste management and reporting.

4. Cost and distribution of the Medical abortion pills should be controlled at Government level.

The next meeting will be held on 14.10.2011 at 11.00 a.m.

Director
(Medical Education & Major Hospitals)

MUNICIPAL CORPORATION OF GREATER MUMBAI
SETH G.S.MED.COLLEGE & KEM HOSPITAL
No.Director(ME&MH)/ dt.15th Oct. 2011

Fourth meeting to discuss the issue of Control of unauthorized medical termination of pregnancy in the Statement of Maharashtra was convened on Saturday, 15th Oct.2011 at 11.00 am when following members were present –

1.Dr.Sanjay Oak, Director(ME&MH) – In the chair
2.Dr.Himangi Warke, AP.,OB&Gy,KEM
3.Dr.Piyush Goyal,M.D.,Wadia Hospital
4.Dr.A.L.Sharda,Director,Population First
5.Dr.Anuja Gulati,absent
6.Dr.Padma Deosthali, Res.Centre of Anusandhan Trust
7.Ms.Sneha Khandekar,Savitribai Phule Gender Resource Centre
8.Dr.Shashank Parulekar, HOD,Ob & Gy.,KEM – Absent
9.Dr.Kamakshi Bhate, A.P.,PSM,KEM.

The committee made following suggestions –

1. Medical Abortion Pills are not to be dispensed over the counter and should be dispensed only on prescription. Thus cost and distribution of medical abortion pills should be monitored at Govt. level
2. There should be a proper documentation and reporting of MTPs to the district level.
3. Proper monitoring and registration mechanism of MTP centres should be undertaken. An independent office responsible for monitoring and control of these mechanisms is welcome. Monitoring should be done 6 monthly.
4. MTP Centre registration should be renewed 3 yearly.
5. Medical Associations such as IMA, FOGSI and Radiological Associations should take strict action against members violating PCPNDT Act.
6. The Maharashtra Medical Council should also act as per provisions of PCPNDT Act.
7. A strong message regarding prosecution against service providers and clinics convicted under PCPNDT Act should be disseminated widely in the media.
8. All MTP Centres should abide by the directives as per Biomedical waste management and reporting as per law.
9. Every effort should be made towards safe, accessible, affordable MTP services.

15.X.11

Director (M.E.& M.H.)