



GUIDANCE:

**ENSURING ACCESS
TO SAFE ABORTION
AND ADDRESSING
GENDER BIASED
SEX SELECTION**

**Ministry of Health & Family Welfare
Government of India**

February 2015



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February 2015



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GOVERNMENT OF INDIA
MINISTRY OF HEALTH & FAMILY WELFARE
NIRMAN BHAVAN, NEW DELHI-110011

Foreword


An area of national concern is the dismal child sex ratio of 918 females per 1000 males as revealed by the Census 2011 data. This has gone down from 927 in 2001, and 945 in 1991, although the sex ratio at birth has shown slight improvement from 892 in 2000-02 to 909 in 2011-13. India is globally being acknowledged for its success in improving its health indicators. However, the sex ratio continues to be an area of concern. Efforts need to be strengthened at the national and state level to reverse this in favour of the girl child. It is indeed reassuring that various stakeholders have aligned their efforts with the Government in this direction.

Another priority area of intervention for the Government is to reduce deaths and disabilities faced by women as a result of unsafe abortions. Unsafe abortion is the third largest cause of maternal deaths in India and contributes to eight percent of all maternal deaths despite being preventable. Each day close to 10 women die on account of unsafe abortions.

The Government of India is concerned about both these issues. The interlinkages between the two issues often translate into conflation in implementing the two Acts. Our efforts are focused on addressing both the issues and implementing strategies for positive outcomes within the Reproductive Maternal Newborn Child and Adolescent Health (RMNCH+A) strategic framework.

I congratulate the Maternal Health Division, Ministry of Health and Family Welfare for taking the lead in identifying key areas of conflation and addressing them. I am confident that this guidance booklet shall provide the required information to the concerned stakeholders, namely the implementing authorities, the service providers at both government and private facilities as well as for communication initiatives of government and civil society to ensure proper implementation without negatively impacting either issue.

I hope that this handbook will be disseminated and used widely by all concerned.


(C.K. Mishra)



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Nirman Bhavan, New Delhi - 110011

Preface

India has seen a significant decline in the maternal mortality indicators and is on track to achieve the targets set under the Millennium Development Goals. While there is encouraging progress on the overall numbers, sex ratio at birth and child sex ratio as well as the contribution of unsafe abortions to maternal deaths continues to be a matter of concern.

Abortion, though legal in India for over four decades, is still the cause of death for close to 3500 women each year and many more women face morbidity as a result of unsafe abortion. This is a priority area for the Government and efforts need to be strengthened to ensure that comprehensive abortion care services are implemented across the country within the framework and provisions of the Medical Termination of Pregnancy Act (the MTP Act), 1971.

The Government enacted the Pre-Natal Diagnostic Techniques (Regulation and Prevention of Misuse) Act in 1994 to address sex determination. The Act was amended in 2003 to broad base the coverage and was renamed Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act. While this Act can contribute to hindering any further worsening of the gender imbalance, at the same time we need to make greater efforts to strengthen the status of girls and women in society. The recently launched national campaign of the Government for the girl child is designed with the purpose of challenging patriarchal norms and ensuring respect and safety for women.

We are all aware that while the two Acts are designed to address different issues, there are unavoidable interlinkages between these across the health system: at policy, planning as well as implementation levels. We acknowledge the challenges in simultaneously addressing gender biased sex selection while protecting women's access to safe, legal abortion services. This guidance is expected to provide information for making sustained efforts towards addressing both issues. As public health professionals and activists, we need to actively ensure that over-zealous implementation of the law for one issue does not negatively impact the other.

With this in view, the Ministry of Health and Family Welfare constituted an expert group that reviewed the situation from both perspectives; identified potential areas of conflation; mapped the target audiences and key stakeholders and documented guidance notes for ensuring access to safe abortion while addressing gender biased sex selection. I am confident that this guidance shall strengthen effective implementation of the two Acts as well as ensure balanced communication about both the issues.

This guidance booklet is designed to reach out to implementing authorities at the state and district level (for both the Acts) and also to providers and owners of facilities offering services in the public and private sector as well as those involved in developing communication material on the issues. I hope that all concerned stakeholders shall take time to review each section of this guidance booklet in the effort to strengthen women's access to safe abortion services and addressing gender biased sex selection.

(Dr. Rakesh Kumar)



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Acknowledgement

The Ministry of Health and Family Welfare is committed to strengthening efforts for the welfare and improved health outcomes for men and women in the country. The Reproductive Maternal Newborn Child and Adolescent Health (RMNCH+A) strategic approach has provided a comprehensive framework for integrated interventions at all levels of service delivery. While the policy framework is clear in its mandate, there are some technical areas which require detailed information for effective implementation. One such area is the issue of women's access to safe abortion and gender biased sex selection in favour of boys in India.

I am grateful to Shri Lov Verma, former Secretary (H&FW), Shri B.P. Sharma, Secretary (H&FW) and Shri C.K. Mishra, Additional Secretary and Mission Director for providing the guidance to address these issues. I am extremely indebted to Dr Rakesh Kumar, Joint Secretary (RMNCH+A) for his able and extraordinary leadership in taking the process forward.

The Maternal Health Division, MoHFW took the lead to demystify the complexities in the implementation of the two concerned Acts – The MTP and the PC&PNDT Act by bringing together a group of experts working on advancing women's access to safe abortion and addressing gender biased sex selection, in September 2014. The group members worked diligently to understand the on-ground realities for both the issues and carefully drafted the contents of this guidance booklet to provide the required guidance for implementers and stakeholders.

I would like to thank our experts Dr. Nozer Sheriar, FOGSI; Dr. Kalpana Apte, FPAI; Ms. Ena Singh, UNFPA; Dr. M.K. Sharma, Legal expert; Mr. Rizwan Parwez, Girls Count Campaign; Dr. A.P. Khade, Government of Maharashtra and Dr. Sharad Iyengar, ARTH for their commitment to the issue and active contribution in the development of this guidance. I acknowledge the efforts by Mr. Vinoj Manning, Ipas India for facilitating this process and working relentlessly to develop this comprehensive guidance. I would also like to thank Ms. Medha Gandhi and Ms. Anisha Aggarwal, Ipas India; Dr. Ravinder Kaur, Senior Consultant, MoHFW; Ms. Madhavi Misra, Technical Consultant, MoHFW and Ms. Ifat Hamid, Consultant (Gender), MoHFW for their contributions.

I am hopeful that the efforts put in by the experts in drafting this guidance shall be useful for all stakeholders while working towards strengthening women's access to safe abortion services and addressing the issues of gender biased sex selection.

(Dr. Manisha Malhotra)



Members of the Expert Group

- Dr. Rakesh Kumar, Joint Secretary (RMNCH+A), MoHFW
- Dr. Manisha Malhotra, Deputy Commissioner, Maternal Health, MoHFW
- Mr. Vinoj Manning, Executive Director, Ipas Development Foundation
- Ms. Ena Singh, Assistant Representative, UNFPA and member CSB
- Dr. Nozer Sheriar, Secretary General, FOGSI and member CSB
- Dr. A.P. Khade, PC&PNDT Consultant, Government of Maharashtra
- Dr. Neelam Singh, Chief Functionary Vatsalya, Uttar Pradesh
- Dr. Kalpana Apte, Senior Assistant Secretary General (Programme Implementation) FPAI
- Mr. Rizwan Parwez, Coordinator Girls Count, Delhi
- Dr. Sharad Iyengar, Chief Executive, Action Research & Training for Health (ARTH), Rajasthan
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- Dr. Ravinder Kaur, Senior Consultant Maternal Health, MoHFW
- Ms. Madhavi Misra, Technical Consultant Maternal Health, MoHFW
- Ms. Ifat Hamid, Consultant (Gender), MoHFW
- Ms. Anisha Aggarwal, Director, Development and Communication, Ipas Development Foundation
- Ms. Medha Gandhi, Director, Policy, Ipas Development Foundation

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Introduction

The census (2011) data revealed a dismal child sex ratio of 918 females per 1000 males. This was down from 927 in 2001 and 945 in 1991; and is still far from the normal sex ratio at birth.

Although the reasons for the skewed sex ratio stem from multiple deep-rooted social and cultural issues, the most common reason given to explain it is the supposed easy availability of ultrasound technologies and abortions in the country. In many places, an instant reaction based on this misunderstanding has led to restrictions on access to abortion services – especially second trimester abortions – seen as an easy solution to fix the problem of sex selection.

Such reactions have increased the challenges faced by women in accessing safe abortion services. This is important to note especially when data shows that abortion services are not available to lakhs of women who need them. It is estimated that even today almost half of all abortions in the country are unsafe – performed in unhygienic conditions by untrained providers.

Reducing mortality and morbidity due to pregnancy-related causes is an important priority for the Government of India. Unsafe abortion continues to be the third largest cause of maternal mortality in India and there is an urgent need to prevent death and disabilities suffered by women as a result of this. Abortion is legal in India for a broad range of conditions under the provisions of the Medical Termination of Pregnancy (MTP) Act, 1971 and efforts need to be strengthened to ensure its availability.

Taking note of both these issues, the Ministry of Health and Family Welfare, Government of India, constituted an expert group to draft a guidance booklet for effective implementation of the two Acts – the Medical Termination of Pregnancy Act, 1971 and the Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) (PC&PNDT) Act, 1994. Based on the range of stakeholders involved, the expert group decided to develop specific guidance documents for each group to ensure that these Acts are not wrongly combined by providers, government officials or monitoring bodies.

This booklet consists of the following three guidance documents, which can also be used as standalone reference guides:

- **Guidance for State and District Authorities:** This highlights areas of possible conflation and **provides clarity for implementing authorities regarding proper implementation as well as monitoring of both the Acts.**
- **Guidance for Service Providers:** This document is for owners of centres and/or providers of preconception and prenatal diagnostic services and/or MTP services. **It explains the relevant provisions of the two Acts that they should follow to ensure that their facilities, services and records are in compliance with the respective Acts.**
- **Guidance for Communication** on abortion and sex selection: This identifies the challenges in communicating about sex selection and contains **key pointers for the government and other stakeholders** to ensure that their IEC and mass media messages do not jeopardise access to legal abortion.

The background features a gradient of pink and red tones. Several large, overlapping circles in various shades of pink and red are scattered across the page. A large, stylized number '1' is positioned in the upper right quadrant, rendered in a light pink color. The word 'SECTION' is centered horizontally and partially overlaps the number '1'.

SECTION 1



Guidance for implementation
of the MTP Act and the PC&PNDT Act

FOR STATE AND
DISTRICT AUTHORITIES

Understanding the Context

Unsafe abortions contribute to eight percent of maternal deaths in India. In absolute numbers, close to 10 women die due to unsafe abortions each day.¹ While abortion has been legal in India since 1971, available research shows that 56% of the 6.4 million abortions that take place in the country are unsafe.² It is unfortunate that women continue to face severe complications which are totally preventable through just ensuring easy access to safe abortion services.

At the same time, declining sex ratio in India is an important area for intervention requiring national attention. Recent census data (2011) reveals a dismal child sex ratio of 918 girls per 1000 boys. This is down from 927 in 2001; and 945 in 1991. The sex ratio at birth at national level did increase from 892 in 2000-2002 to 909 in 2011-13. However, this is still not close to the normal sex ratio at birth (natural estimated range is 950-975 girls per 1000 boys³).

The Medical Termination of Pregnancy Act, 1971 (the MTP Act) which was amended in 2002 legalises abortion in India under certain conditions. The Central Government made the MTP Rules (amended in 2003) and the MTP Regulations, 2003 (applicable to all Union Territories). The Regulations under the MTP Act prescribe forms for recording opinion of the Registered Medical Practitioner (RMP), reporting to Chief Medical Officer (CMO) and for maintaining records etc. The State Legislatures are required to make similar or appropriate Regulations for the State and make them readily available to all concerned. In addition, the Central Government released the Comprehensive Abortion Care (CAC) Training and Service Delivery Guidelines (hereafter referred to as the National CAC Guidelines) in 2010 (updated in 2014) to strengthen access to CAC and prevent mortality and morbidity resulting from unsafe abortions. The Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994 (the PC&PNDT Act) as amended in 2003 along with the PC&PNDT Rules, 1996 as amended in 2011, 2012 and 2014 have been enacted to prevent misuse of pre-conception and pre-natal diagnostic techniques for determining the sex of the foetus and to prevent disclosure of the sex to the pregnant woman or her relatives.

¹Calculated estimates from RGI SRS 2001-03.

²Duggal R, Ramachandran V: The abortion assessment project – India: key findings and recommendations. *Reprod Health Matters* 2004; 12:122-129.

³Jha P, et.al: Trends in selective abortions of girls in India: analysis of nationally representative birth histories from 1990 to 2005 and census data from 1991 to 2011. *The Lancet*; 2011.

Interlinkages Between Access to Safe Abortion and Gender Biased Sex Selection

Gender biased sex selection (GBSS) in favour of boys is a symptom of pervasive social, cultural, political and economic injustices against women and girls, and a manifest action of gender discrimination. It has been perpetuated by illegal use of diagnostic technologies coupled with unethical medical practices. Efforts are being made by Government agencies in partnership with civil society to address this issue.

The most common reason given to explain GBSS is the purported easy availability of the combination of ultrasound technologies and facilities for abortion in the country. What lies behind the use of these technologies, however, is the fact that sex selection is first about the desire for determination and selection of the sex of the foetus in favour of boys. At times, an instant reaction based on a flawed understanding leads to imposing restrictions on access to abortion services and most significantly, second trimester abortions, seen as an easy solution to fix the problem of sex selection. Anecdotal evidence from various States highlight the challenges faced by women seeking safe abortion services on legal grounds due to restrictions imposed in efforts to address sex selection. It is, therefore, important to ensure that the implementation of each Act is done judiciously without impinging on the objectives of the other.

Purpose

This guidance is a ready reference for all implementing and monitoring authorities of the MTP and PC&PNDT Acts for effective implementation.

Ensuring Access to Comprehensive Abortion Care while Addressing Gender Biased Sex Selection

The Government of India is committed to ensuring access to CAC for women as part of the Reproductive Maternal Newborn Child and Adolescent Health (RMNCH+A) initiative under the National Health Mission (NHM). Various steps are being taken at the policy, programme and information communication levels to ensure the same. These however need to be translated into action at the state and district levels to ensure that women have access to CAC services and do not face morbidities and mortalities due to non-availability of information and services.

Understanding the MTP Act and its Implementation

The table below lists out the key provisions of the MTP Act and the National CAC Guidelines that must be kept in mind to ensure availability and monitoring of abortion services.

Issue	Key Provisions	Additional Information for Proper Implementation
<p>Conditions under which a pregnancy may be terminated</p>	<p>The MTP Act allows for termination of pregnancy on a broad range of conditions:</p> <ul style="list-style-type: none"> • Continuation of the pregnancy would involve a risk to the life of the pregnant woman or it may 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; • Pregnancy is caused by rape (presumed to constitute grave injury to mental health); • Pregnancy is caused due to failure of contraceptive in married woman or her husband (presumed to constitute grave injury to mental health). 	<p>Sex selection is not a legal ground for terminating a pregnancy.</p> <p>The provider/s must ensure that the ground for termination is clearly stated in the opinion form.</p> <p>The opinion of the provider is adequate to certify ground/s for providing abortion service.</p>
<p>Place where a pregnancy may be terminated</p>	<p>Hospital established or maintained by the Government or a place approved by the Government or the District Level Committee (DLC) headed by the Chief Medical Officer (CMO) or District Health Officer (DHO).</p> <p>As per the National CAC Guidelines, pregnancy may be terminated at Government facilities up to:</p> <ul style="list-style-type: none"> • Eight weeks of gestation at Primary Health Centre (PHC); • 12 weeks of gestation at Community Health Centre (CHC) or 24x7 PHC; • 20 weeks of gestation at District Hospital and above facilities. <p>The DLC may approve a (private) place to conduct:</p> <ul style="list-style-type: none"> • Terminations up to 12 weeks; or • Terminations up to 20 weeks. 	<p>The CMO shall properly examine the application for approval before making a recommendation to the DLC for approving the place.</p>

Issue	Key Provisions	Additional Information for Proper Implementation
<p>Who can terminate a pregnancy</p>	<p>Medical termination of pregnancy can be legally provided only by a 'registered medical practitioner' (RMP) – a medical practitioner who possesses any recognised medical qualification as defined in clause (h) of section 2 of the Indian Medical Council Act, 1956, whose name has been entered in a State Medical Register and who has one or more of the following experience or training in gynaecology and obstetrics:</p> <ol style="list-style-type: none"> 1. In the case of a medical practitioner, who was registered in a State Medical Register immediately before the commencement of the Act, with experience in the practice of gynaecology and obstetrics for a period not less than three years. 2. In the case of a medical practitioner, who was registered in a State Medical Register after the commencement of the Act and: <ol style="list-style-type: none"> a. Has completed six months of house surgency in gynaecology and obstetrics; or b. Has experience in any hospital for a period of not less than one year in the practice of obstetrics and gynaecology; or c. Holds a post-graduate degree or diploma in gynaecology and obstetrics; or d. Has assisted an RMP in the performance of 25 cases of MTP 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. 	<p>Training as detailed in 2d will enable the RMP to do only first trimester terminations (up to 12 weeks of gestation).</p>

Issue	Key Provisions	Additional Information for Proper Implementation
<p>Certificate of Approval</p>	<p>Form B – The certificate of approval for a ‘private’ place issued by the DLC chaired by the CMO shall be conspicuously displayed such that it is easily visible to visitors.</p> <p>All Government facilities are by default approved to provide CAC services and therefore do not need a certificate of approval.</p>	<p>The certificate of approval issued by the DLC chaired by the CMO is not for a fixed/limited period and does not require renewal. Doctors conducting MTP at the facility are not certified by the DLC. However, only an RMP as defined in the Act can perform MTP at an approved facility.</p> <p><i>Each district must have a functional DLC to ensure approval for private facilities and subsequent inspection of approved places.</i></p> <p>It is recommended for both public and private facilities to have site signages indicating availability of safe abortion services.</p>
<p>Documentation</p>	<p>Form I – Opinion form for each MTP done must be duly filled with reason for termination and signature with date within three hours of termination of the pregnancy.</p> <p><i>Opinion of the second RMP</i> in case of second trimester abortions must also be recorded either at the time of admission or within three hours of termination of pregnancy.</p> <p>Form II – Reporting Format – A monthly statement of all MTPs done must be sent to CMO on this format. This should include both surgical and medical methods of abortions (MMA).</p> <p>Form III – Admission Register – All MTPs conducted at the facility must be recorded in the (confidential) admission register maintained at the facility for each calendar year.</p>	<p>The column for indicating the reason for termination of the pregnancy must never be left blank. It must be filled as per the conditions prescribed in the MTP Act as relevant for the pregnant woman.</p> <p>Incomplete abortion, inevitable abortion, missed abortion, blighted ovum are obstetric complications and do not come under the purview of the MTP Act and thus need not be recorded as per the MTP Act.</p> <p>The Admission Register is a confidential document and is not open to inspection by any person except under the authority of law. The same has to be kept in safe custody.</p> <p>No entry of an MTP done shall be made in any case-sheet, operation-theatre register, follow-up card or any document or register other than the Admission Register maintained at the facility.</p> <p>Admission Register needs to be preserved for a period of five years from the date of last entry.</p> <p>There is no requirement for recording sex of the abortus in the Admission Register or any other records.</p>

Issue	Key Provisions	Additional Information for Proper Implementation
Documentation	<p>Form C – Consent Form – Consent of only the woman is required if she is of and above the age of 18 years. Only in case of a minor and/or a mentally ill woman of any age, her guardian's consent is required.</p> <p>Information about termination of pregnancy under the provisions of Section (5) of the MTP Act must be sent in a sealed envelope to the CMO the same day or the next working day.</p>	<p>Consent from husband/parent/guardian is not required for seeking an abortion from a woman who is of or above 18 years of age and who is not mentally ill.</p> <p>Guardian under the MTP Act means a person having the care of a minor or a mentally ill person. This person does not necessarily have to be the legal guardian.</p> <p>Additional documentation of age proof is not required in addition to Form C.</p>
Medical Methods of Abortion (MMA) from Unapproved Facilities	<p>In case of termination of early pregnancy up to seven weeks using a combination of mifepristone with misoprostol, the RMP can prescribe the drugs at his/her clinic provided he/ she has access to a place approved for terminating pregnancy under the MTP Act.</p>	<p>An RMP can prescribe MMA at a clinic that does not have the approval from the DLC only when s/he has displayed a certificate reflecting access to a certified place, issued by the owner of such place.</p> <p>MMA must be available in public health facilities as prescribed in the RMNCH+A framework.</p>
Inspection of Admission Register	<p>The Admission Register is open to inspection only to a person under the authority of law.</p>	<p>The confidentiality of the woman must always be ensured during inspection and should not be disclosed to anyone including media etc.</p>
Termination of Pregnancy by an RMP at an Unapproved Place	<p>In case of an emergency; any pregnancy may be terminated by an RMP to save the life of the woman at an unapproved place.</p>	<p>Information about the same must be sent to the CMO the same day or latest the next working day.</p>
Inspection of the Approved Place – Taking Suitable Action	<p>The CMO is authorised to inspect the places approved for conducting MTP to verify whether MTP is conducted under safe and hygienic conditions.</p> <p>The DLC, in appropriate cases, after affording opportunity to the owner, may suspend or cancel the certificate of approval. The owner may file a review application (within 60 days) to the Government against such suspension or cancellation.</p> <p>The Government, after giving the owner an opportunity of being heard may confirm, modify or reverse the order.</p>	<p>The routine and periodic inspection by the CMO will ensure that safe and hygienic conditions are maintained for MTP service delivery.</p> <p>DLC members are not authorised to conduct inspections unless formally deputed by the CMO for the same.</p>

PC&PNDT Act and its Implementation

The table below lists out the key provisions of the PC&PNDT Act for addressing pre-birth (pre-conception and pre-natal) gender biased sex selection.

Issue	Key Provisions	Additional Information for Proper Implementation
Purpose	<p>The PC&PNDT Act prohibits use of technology such as ultrasound for the purposes of sex determination and finally, it prohibits asking for or disclosure of sex of the foetus or advertising for such a service.</p> <p>It is designed for the prohibition of sex determination or sex selection before and/or after conception.</p>	<p>Does not restrict access to safe abortion or require monitoring of abortion services.</p> <p>At times, it is assumed that most abortions are for sex selection. This perception is untrue and not supported by any study or facts.</p>
What it regulates	<p>The use of pre-natal diagnostic techniques like ultrasound and amniocentesis by allowing their use only to detect:</p> <ul style="list-style-type: none"> • Genetic abnormalities • Metabolic disorders • Chromosomal abnormalities • Certain congenital malformations • Hemoglobinopathies • Sex linked disorders 	<p>This Act does not regulate abortion service delivery, documentation or its reporting.</p> <p>Abortion service delivery is to be monitored under the MTP Act.</p>
Setting-up of a genetic counselling centre, genetic laboratory, genetic clinic, ultrasound clinic and imaging centre	<p>The qualifications for a medical practitioner at any of these facilities includes:</p> <ol style="list-style-type: none"> 1. A gynaecologist or paediatrician having six months of experience or four weeks training in genetic counselling; or 2. A medical geneticist. <p>The facility should have adequate space and display educational charts/models/equipment for carrying out genetic counselling prior to getting it registered.</p> <p>For a genetic laboratory: The facility should have adequate space and practitioner with qualifications as below:</p> <ol style="list-style-type: none"> 1. A medical geneticist; 2. A laboratory technician, having a B.Sc. degree in Biological Sciences or a degree or diploma in medical laboratory course with at least one year experience in conducting appropriate pre-natal diagnostic techniques, tests or procedures. 	<p>A medical practitioner qualified under the Act to conduct ultrasonography in a genetic clinic/ultrasound clinic/imaging centre is permitted to register with a maximum of two such clinics/centres in a district.</p>

Issue	Key Provisions	Additional Information for Proper Implementation
	<p>The genetic laboratory should have the equipment for chromosomal studies, bio-chemical studies and molecular studies:</p> <p>For setting-up a genetic counselling centre/ultrasound clinic/imaging centre:</p> <ol style="list-style-type: none"> 1. The facility must have adequate space; 2. The qualification for a practitioner in these facilities is as below: <ol style="list-style-type: none"> a. A gynaecologist with experience of performing at least 20 chronic villi aspirations per vagina or per abdomen, chronic villi biopsy, amniocentesis, cordocentesis, foetoscopy, foetal skin or organ biopsy or foetal blood sampling etc. under the supervision of an experienced gynaecologist in these fields; or b. A sonologist, imaging specialist, radiologist or RMP with post graduate degree or diploma or six months training in sonography or image scanning; or c. A medical geneticist. <p>All genetic clinics/ultrasound clinics/imaging centres should have the following equipment for carrying out the tests or procedures:</p> <ol style="list-style-type: none"> a. Equipment and accessories necessary for carrying out clinical examination by an obstetrician or gynaecologist. b. An ultra-sonography machine including mobile ultrasound machine, imaging machine or any other equipment capable of conducting foetal ultrasonography. c. Appropriate catheters and equipment for carrying out chorionic villi aspirations per vagina or per abdomen. d. Appropriate sterile needles for amniocentesis or cordocentesis. e. A suitable foetoscope with appropriate accessories for foetoscopy, foetal skin or organ biopsy or foetal blood sampling shall be optional. f. Equipment for dry and wet sterilisation. g. Equipment for carrying out emergency procedures such as evacuation of uterus or resuscitation in case of need. h. Genetic works station. 	<p>The consulting hours for each medical practitioner need to be clearly specified by each clinic where the medical practitioner is registered.</p>

Issue	Key Provisions	Additional Information for Proper Implementation
Pre-Conception and Pre-Natal Diagnostic Techniques and Service Provision	<p>As mandated by the PC&PNDT Act, all laboratories, centres, clinics and RMPs must ensure that:</p> <ul style="list-style-type: none"> • No laboratory or centre or clinic will conduct any test including ultrasonography (USG) for the purpose of determining the sex of the foetus. • No person, including the one who is conducting the procedure as per the law, will communicate the sex of the foetus to the pregnant woman or her relatives by words, signs or any other method. • No advertisement shall be posted for prenatal and/or preconception sex determination facilities in the form of a notice, circular, label, wrapper or any document, or advertisements through internet or other media in electronic or print. This is a punishable offence. 	<p>It must be understood that not all USGs are for the purpose of sex selection.</p>
Documentation	<p>All records, charts, forms, reports, consent letters and all documentation as mentioned below need to be preserved for a period of two years. In case of any legal or other proceedings against the genetic counselling centre, genetic laboratory or clinic, the records shall be preserved till the final disposal of such proceedings.</p> <p>Form D – records by Genetic Counselling Centres; Form E – records by Genetic Laboratory and Form F – records by Genetic Clinic/Ultrasound Clinic/Imaging Centre (including a mobile Genetic Clinic)</p>	<p>All such records shall, at all reasonable times, be made available for inspection to the Appropriate Authority (AA) or to any other person authorised by the AA in this behalf.</p> <p>The AA is not entitled to inspect MTP records.</p>
Profiling of Women	<p>As per the PC&PNDT Act, it shall be presumed, unless proved otherwise, that the woman was compelled to undergo pre-natal diagnostic technique for the purpose other than permitted under the Act.</p>	<p>It is therefore important that the confidentiality of women is not breached during inspection visits by the concerned officials or by the media.</p> <p>It must be ensured that the written consent of the woman is obtained in the prescribed Form G following counselling about the side effects of the procedures (as permitted under the Act under prescribed conditions) and that a copy of the consent form is given to the pregnant woman.</p>

Issue	Key Provisions	Additional Information for Proper Implementation
Role of the Appropriate Authority (AA)	<p>The AA's role includes:</p> <ul style="list-style-type: none"> • Grant, suspend/cancel and renew certificate of registration of a Genetic Counselling Centre or Genetic Laboratory or Genetic Clinic; • Enforce standards prescribed for these centres and clinics; • Investigate complaints of breach of the provisions of the Act or rules made under this Act and take immediate action; • AA may seek and consider advice of the Advisory Committee on application for registration, complaints for suspension or cancellation. However, the AA must ensure that the recommendation is in line with the provisions of PC&PNDT Act; • Take appropriate legal action against the use of any sex selection technique by any person at any place, suo moto or brought to its notice and also initiate independent investigation in this matter; • Create public awareness against the practice of sex selection or pre-natal determination of sex; • Supervise the implementation of the Act and rules; • Recommend to the Central Supervisory Board and state Supervisory boards, modifications required in the rules in accordance with changes in technology or social conditions; • Take action on the recommendations of the Advisory Committee made after investigation of complaint for suspension or cancellation of registration. 	
Certificate of Registration	<p>Every Genetic Counselling Centre, Genetic Laboratory or Genetic Clinic is required to be registered by the AA.</p> <p>After completing all the required formalities as prescribed, the AA may grant a certificate of registration in the prescribed format.</p> <p>This certificate shall be displayed by the centre in a conspicuous place.</p> <p>The registration is valid for a period of five years.</p>	<p>No centre is permitted to advertise availability of services for sex determination.</p> <p>A notice in English and in local language clearly stating that 'disclosure of the sex of the foetus is prohibited under law' must be prominently visible on display at every centre or clinic in its premises.</p> <p>At least one copy of the PC&PNDT Act and the Rules must be available at each registered centre or clinic for perusal by the clientele.</p>

Issue	Key Provisions	Additional Information for Proper Implementation
Renewal of Registration	<p>The application for renewal has to be submitted on the prescribed Form A in duplicate to the AA 30 days before the date of expiry of registration.</p> <p>After the necessary enquiry and inspection, renewal certificate is issued as per the prescribed Form B.</p> <p>In case the certificate is not renewed, rejection of application is issued in Form C.</p> <p>On receipt of the renewed certificate, both copies of the earlier certificate shall be surrendered to the AA immediately.</p>	
Inspection	<p>Every Genetic Counselling Centre, Genetic Laboratory, Genetic Clinic, Ultrasound Clinic, Imaging Centre, nursing home, hospital, institute or any other place where any of the machines or equipment capable of performing any procedure, technique or test capable of pre-natal determination of sex or selection of sex before or after conception is used come under the purview of inspection for the facility, equipment and records by the AA or any person authorised by the AA. The AA or authorised person may seal, seize any ultrasound machine, scanner or any other equipment, capable of detecting sex of the foetus if it is not registered. These machines shall be confiscated and action taken against the owners.</p> <p>They may also examine, seal and seize any of the following documents:</p> <ul style="list-style-type: none"> • Registers • Records maintained including forms • Books • Pamphlets • Advertisements • Material objects including records, machines and equipment. 	<p>The Act does not govern inspection of abortion service delivery.</p> <p>Inspection extends to any machine that is capable of determining the sex before or after conception.</p> <p>A list of any document(s)/ object(s) found and seized should be prepared in duplicate at the place of effecting the seizure. Both copies of such list need to be signed on every page by the AA or the officer authorised in this behalf and by the witnesses to the seizure.</p> <p>If it is not practicable to make the list at the place of effecting the seizure, these reasons need to be recorded in writing, and the list can be prepared at another place in presence of the witnesses.</p>

Issue	Key Provisions	Additional Information for Proper Implementation
Sale of Ultrasound Machines/ Imaging Machines	No organisation including a commercial organisation or person, including manufacturer, importer, dealer or supplier of ultrasound machines or imaging machines, scanner or any other equipment, capable of detecting sex of the foetus, shall sell, distribute, supply, rent, allow or authorise the use of any such machine or equipment in any manner, whether on payment or otherwise, to any Genetic Counselling Centre, Genetic Laboratory, Genetic Clinic, Ultrasound Clinic, Imaging Centre or any other body or person unless such centre, laboratory, clinic, body or person is registered under the PC&PNDT Act.	<p>A report must be sent to the concerned AA with list of those to whom the machines/equipment has been provided every three months.</p> <p>An affidavit that such machines/equipment shall not be used for sex determination should be taken by the seller/supplier in writing.</p>
Regulation of Portable Machines	<p>The portable machines/equipment which have the potential for selection of sex before or detection of sex during pregnancy shall be permitted only:</p> <ol style="list-style-type: none"> a. when the portable machine is used within the premises of the registered facility for indoor patients b. as part of a mobile medical unit, offering a bouquet of other health and medical services. 	<p>Other health and medical services include:</p> <ol style="list-style-type: none"> 1. Curative 2. Reproductive and Child Health Services 3. Family Planning Services 4. Diagnostics 5. Specialised facilities and services including X-ray; ECG, ultrasound. <p>Emergency services and care in terms of disaster or epidemic or public health emergency or accident.</p>

Areas for Intervention on the next page...

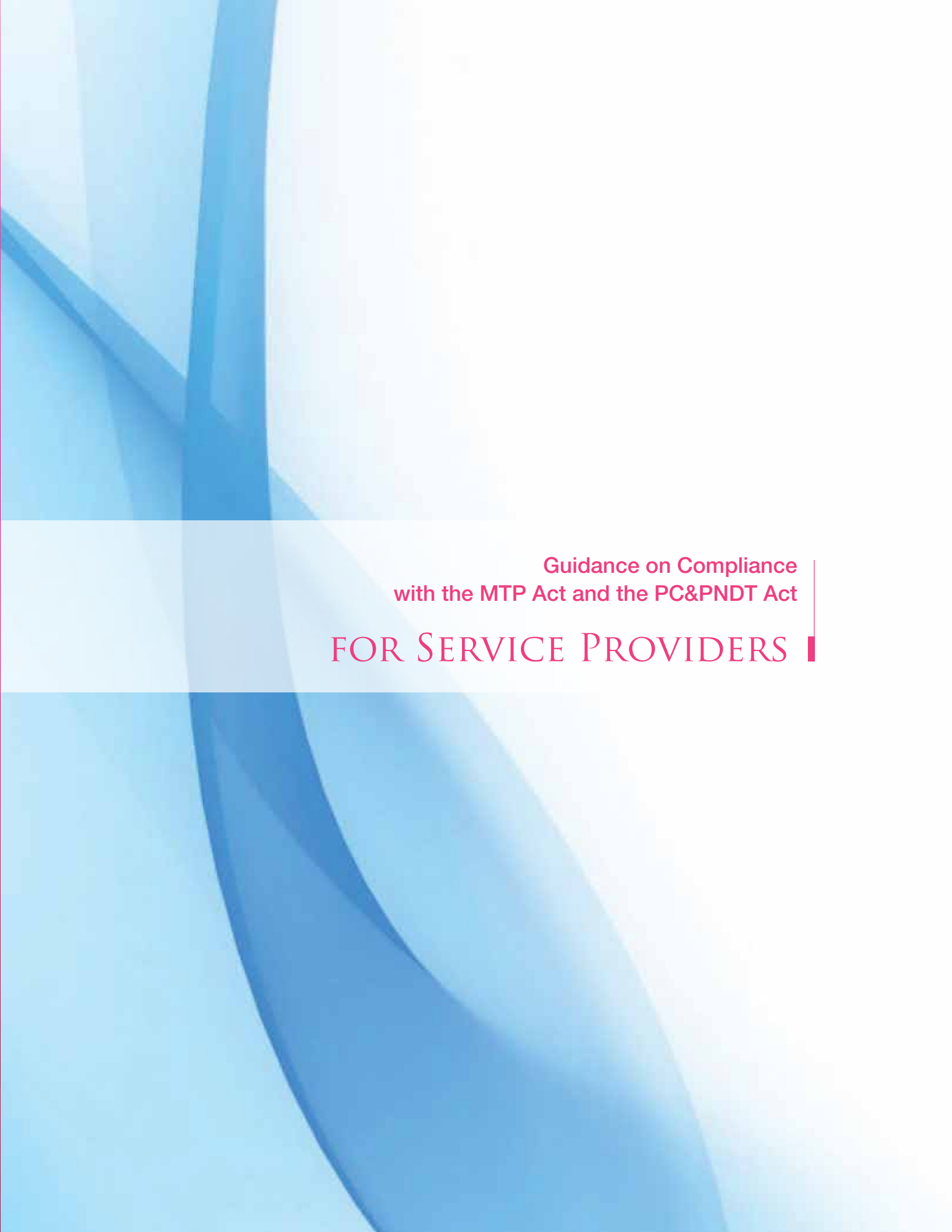
Areas for Intervention

In the context of declining sex ratio in the country, it is important to ensure proper implementation of the PC&PNDT Act. However, at the same time, it is important to ensure that women's access to safe abortion services is safeguarded and women are not forced to seek services from untrained providers posing a risk to their lives, facing lifelong morbidities and even mortality. It is therefore important to ensure that:

- Dedicated nodal officers may be appointed for planning and monitoring the implementation of the MTP Act and PC&PNDT Act exclusively.
- All concerned state and district officials are oriented on the key provisions of the MTP Act and PC&PNDT Act. This will enable them to effectively monitor the implementation of both the Acts.
- Periodic workshops for state and district officials are conducted on both the issues.
- All relevant documents at the State level should have equal focus on addressing sex selection and ensuring access to safe abortion services.
- Periodic workshops with concerned stakeholders including media, professional associations (Obstetrics-Gynaecology, Radiologists, Indian Medical Association etc.) are conducted.
- Proper implementation of the MTP Act and PC&PNDT Act at the State and District levels such that safe abortion services are available to women and gender-biased sex selection is also addressed.
- Systems are set up to periodically review the implementation of both the Acts.

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SECTION



Guidance on Compliance
with the MTP Act and the PC&PNDT Act

FOR SERVICE PROVIDERS

Background

The Medical Termination of Pregnancy Act, 1971 (MTP Act) was enacted in India to reduce the mortality and morbidity associated with unsafe abortions. It entitles women access to safe abortion services under certain specific conditions. The MTP Act lays down the criteria for which a pregnancy can be terminated, by whom, where and up to which gestational age. MTP is performed by qualified health providers using surgical methods or medical abortion drugs (mifepristone and misoprostol). Only induced abortions come under the purview of the MTP Act, which therefore does not cover spontaneous, missed, inevitable and incomplete abortions. The MTP Act offers protection to a practitioner if she/he adheres to the provisions of the MTP Act; and Rules and Regulations made under the MTP Act.

The Pre-Natal Diagnostic Techniques (PNDT) (Regulation and Prevention of Misuse) Act, 1994 was enacted to prevent misuse of pre-natal diagnostic techniques used to determine the sex of the foetus. This Act aims to regulate the use of pre-natal diagnostic techniques for the purpose of detecting genetic abnormalities, certain congenital malformations or sex linked disorders. The Act was amended in 2003 and renamed as the Pre-Conception and Pre-Natal Diagnostic Techniques (PC&PNDT) (Prohibition of Sex Selection) Act to additionally bring pre-conception sex selection techniques within its purview. The Rules framed under the Act were amended between 2011 and 2014.

Who is this Guidance for?

Owners and managers of (diagnostic) centres and clinics; and/or providers of preconception and prenatal diagnostic services and/or MTP are the primary audience for this document.

How to Use this Guidance?

This document is a guidance note on understanding both the MTP Act and the PC&PNDT Act and has to be read in conjunction with the provision of the two Acts and relevant Rules and Regulations. The note has been cross-referenced in bold with the corresponding sections in the respective Acts, Rules and Regulations.

The 'CAC Training & Service Delivery Guidelines (2010)' by the Ministry of Health & Family Welfare, Government of India offer recommendations for high quality abortion care services. (http://nrhm.gov.in/images/pdf/programmes/maternal-health/guidelines/abortion_care_training.pdf)

The Government of India (GoI) is currently developing standard operating procedures on the PC&PNDT Act, until then additional information can be found here:

- Handbook on Pre-Conception & Pre-Natal Diagnostic Techniques Act, 1994 and Rules with Amendments, Government of India ([http://www.rajswasthya.nic.in/PCPNDT%2005.12.08/Hand%20book%20with%20Act%20&%20Rules%20\(5\)%20%20\(1\).pdf](http://www.rajswasthya.nic.in/PCPNDT%2005.12.08/Hand%20book%20with%20Act%20&%20Rules%20(5)%20%20(1).pdf))

- A Code of Conduct to be Observed by Appropriate Authorities, Gazette Notification of India dated 24/2/2014 (<http://www.rajswasthya.nic.in/The%20Gazette%20of%20India%20Website%20.pdf>)
- FAQs for Medical Professionals (<http://india.unfpa.org/drive/FAQsforMedicalProfessionals.pdf>)
- Ministry of Health & Family Welfare, GoI. CEHAT and UNFPA. The Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994, Answers to Frequently Asked Questions: A Handbook for Implementing Bodies, March 2007 (<http://www.cehat.org/go/uploads/Publications/FAQ%20Implementing%20Bodies.pdf>)

Provisions Under the MTP Act, Rules, and Regulations for Compliance

The MTP Act enacted in 1971 and as amended in 2002; the MTP Rules, 2003; and the MTP Regulations, 2003 govern the provision of abortions or MTP in India. The MTP Act, and the Rules and Regulations framed thereunder provide an ambit under which legal abortion services can be provided up to 20 weeks of pregnancy.

The MTP Act provides details about the following aspects of abortion services:

- Conditions under which pregnancy may be terminated. [**MTP Act: Section 3 (2)**]
- Who can provide abortion services. [**MTP Act: Section 2 (d) and Rule 4**]
- Sites where abortion service can be provided. [**MTP Act: Section 4**]
- Documentation and records for abortion services. [**Rule 5, Rule 9, Regulation 3, Regulation 4 (5), and Regulation 5**]
- Punishments for violation of the MTP Act. [**MTP Act: Section 5 (2), Section 5 (3), and Section 5 (4)**]

Legal Provider

Currently, MTP can be legally provided only by a registered medical practitioner (RMP) – a medical practitioner who possesses any recognised medical qualification as defined in clause(h) of Section 2 of the Indian Medical Council Act, 1956, whose name has been entered in a State Medical Register and who has one or more of the following experience or training in gynaecology and obstetrics [**MTP Act: Section 2 (d); and Rule 4**]:

1. In the case of a medical practitioner, who was registered in a State Medical Register immediately before the commencement of the Act, experience in the practice of gynaecology and obstetrics for a period not less than three years.
2. In the case of a medical practitioner, who was registered in a State Medical Register after the commencement of the Act and:
 - a. Has completed six months of house surgency in gynaecology and obstetrics;

or

 - b. Has experience at any hospital for a period of not less than one year in the practice of obstetrics and gynaecology;

or

c. Holds a post-graduate degree or diploma in gynaecology and obstetrics;

or

d. Has assisted an RMP in the performance of 25 cases of MTP 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. *This training will enable the RMP to do only first trimester terminations (up to 12 weeks of gestation).*

Site Approval

- A private site has to be approved by the District Level Committee (DLC) for providing MTP services. There are separate requirements for approval for first and second trimester abortion services. [MTP Act: Section 4 (b) and Rule 5]
- The certificate of approval by the DLC needs to be conspicuously displayed at the site to be easily visible to persons visiting the place. [Rule 5 (7)]
- Public sector sites do not need separate approval for providing MTP services. [MTP Act: Section 4 (a)]
- MTP Act allows provision of medical methods of abortion (MMA) up to seven weeks of pregnancy at an unapproved site provided it has access/referral linkages to an MTP approved site. For the purpose of access the RMP should display a certificate to this effect from the owner of the approved site. (Rule 5 Explanation)
- MTP site approval does not need renewal unless the Chief Medical Officer (CMO), upon inspection, has a reason to believe that the facilities are not properly maintained and procedures are not conducted under safe and hygienic conditions, and the DLC suspends or cancels the site's approval. [Rule 7 (1)]

Record Keeping

Under the MTP Act, the records that are **mandatory** for all facilities (government and private) are:

1. **Form I** – Opinion formed by RMP(s) to provide services, is certified in this form. [Regulation 3]
For length of pregnancy which does not exceed 12 weeks, signature of one RMP is required whereas for length of pregnancy between 12 and 20 weeks, signatures of two RMPs are required.
2. **Form C** – Consent for the termination of pregnancy is taken in this form. [Rule 9]
Pregnancy of a woman who is above 18 years of age can be terminated with only her consent. If she is below 18 years of age or is mentally ill, written consent of guardian needs to be taken. [MTP Act: Section 3 (4)]
(‘Guardian’ under the MTP Act means a person having the care of a minor or a mentally ill person.)
3. **Form III** – This is the Admission Register and is used to record details of women whose pregnancy is terminated. This needs to be kept for a period of five years from the end of the calendar year it relates to. [Regulation 5]

Records pertaining to induced abortion/MTP services are confidential. They are not open for inspection by any person except under the authority of law. [Regulation 6]

Reporting

Form II – Monthly statement of MTP cases done at a hospital or approved place. The head of the hospital or owner of the approved place should send the monthly statement of MTP cases to the CMO of the district. [Regulation 4 (5)]

Provisions Under PC&PNDT Act and Rules to be Observed for Compliance

The PNDT Act, 1994, amended and renamed as the PC&PNDT Act in 2003 was enacted with the following objectives:

- to provide for the **prohibition** of sex selection, before or after conception;
- for **regulation** of pre-natal diagnostic techniques for the purposes of detecting genetic abnormalities or metabolic disorders or chromosomal abnormalities or certain congenital malformations or sex-linked disorders;
- for the **prevention** of their misuse for sex determination.

Legal Providers

Rules framed under the PC&PNDT Act prescribe the qualification of employees at a Genetic Counselling Centre, Genetic Laboratory, Genetic Clinic, Ultrasound Clinic and Imaging Centre.

A Genetic Counselling Centre can be set up by a person who is or employs:

- A gynaecologist or paediatrician having six months' experience or four weeks training in genetic counselling; or
- A medical geneticist

and has adequate space and educational charts/models/equipment for carrying out genetic counselling. [Rule 3 (1)]

A Genetic Laboratory can be set up by a person who is or employs:

- A medical geneticist; and
- A laboratory technician with a B.Sc. degree in Biological Sciences or a degree or diploma in medical laboratory course with at least one year experience in conducting appropriate prenatal diagnostic techniques, tests or procedures. [Rule 3 (2) (b)]

Such laboratory should have or acquire equipment, as prescribed in Rule 3 (2)(b), necessary for carrying out chromosomal studies, bio-chemical studies and molecular studies.

A Genetic Clinic/Ultrasound Clinic/Imaging Centre can be set up by a person having adequate space and who is or employs:

- A gynaecologist having performed at least 20 procedures in chorionic villi aspirations per vagina or per abdomen, chorionic villi biopsy, amniocentesis, cordocentesis, foetoscopy, foetal skin or organ biopsy or foetal blood sampling etc. under the supervision of an experienced gynaecologist in these fields; or
- A sonologist or imaging specialist or RMP with a post-graduate degree or diploma or six months training duly imparted as prescribed in the PC&PNDT (Prohibition of Sex Selection) (Six Months Training) Rules, 2014 (see below); or
- A medical geneticist. **[Rule 3 (3) (1)]**

The Genetic Clinic/Ultrasound Clinic/Imaging Centre should have or acquire equipment, as prescribed in Rule 3 (3) (2), necessary for carrying out the tests or procedures.

The PC&PNDT (Prohibition of Sex Selection) (Six Months Training) Rules, 2014, state that in order for RMPs to be qualified to provide services, they must undergo six months training in ultrasonography titled 'the Fundamentals in Abdomino-Pelvic Ultrasonography (USG): Level One for M.B.B.S. Doctors', from an institution notified by the State Health Medical Education department. The period of training for obtaining a certificate of training is 300 hours. [G.S.R. 14 (E), dated 9-1-2014, published in the Gazette of India, Ext Pt.II, S.3 (i), dated 10-1-2014]

Gynaecologists with a post-graduate diploma/degree and radiologists with a post-graduate diploma/degree need not undergo this training. Medical practitioners already using ultrasonography (even before the amendment) are exempt from training but have to undergo a competency based assessment no later than January 2017.

Site Registration

- All applications for registration have to be made to the Appropriate Authority (AA) in whose jurisdiction the unit lies. Applications, in duplicate, have to be made in Form A with an accompanying affidavit as prescribed in **Rule 4**.
- With effect from 5 June, 2012, the applicable fees for different types of units are given below
 - Rs. 25,000 for Genetic Counselling Centre, Genetic Laboratory, Genetic Clinic, Ultrasound Clinic or Imaging Centre. **[Rule 5 (a)]**
 - Rs. 35,000 for institute, hospital, nursing home, or any place providing jointly the service of a Genetic Counselling Centre, Genetic Laboratory and Genetic Clinic, Ultrasound Clinic or Imaging Centre or any such combination. **[Rule 5 (b)]**
- A certificate of registration is valid for a period of five years. **[Rule 7]**
- An application for renewal of certificate of registration shall be made in duplicate in Form A, to the AA 30 days before the date of expiry of the certificate of registration. **[Rule 8 (1)]**

- Registration and renewal of registration is granted in duplicate in Form B. [**Rule 6 (2), Rule 6 (5), Rule 8 (2)**]
 - Rejection of registration is communicated in Form C. [**Rule 6 (3), Rule 6 (5), Rule 8 (3)**],
 - The registration certificate has to be displayed in a conspicuous place in the laboratory clinic/mobile medical unit. [**PC&PNDT Act: Section 19 (4); Rule 6 (2); and Rule 6 (2A)**]
 - In case of change in under-mentioned, intimation in writing should be made to the AA 30 days in advance of the expected date of such change, and seek re-issuance of certificate of registration from the AA, with the changes duly incorporated [**Rule 13**]:
 - In case of change in place and address
 - In case of change in employee
 - In case of change in equipment installed
 - In case of change in ownership or change in management. [**Rule 6 (7)**]
 - All reasonable facilities should be made available for inspection of the place, equipment and records to the AA or an authorised person in this behalf. [**Rule 11**]
 - Portable ultrasound machine or device can be used under two conditions. [**Rule 3B (1)**]
1. The portable machine is used within the premises it is registered, for providing services to indoor patients.
 2. As part of a mobile medical unit offering a bouquet of other health and medical services as described in [**Rule 3B (1) Explanation**].
- A Mobile Genetic Clinic shall operate and offer pre-natal diagnostic techniques only as part of a Mobile Medical Unit offering a bouquet of other health and medical services, in urban slums, or rural or remote or hilly or hard to reach areas for improved access to health care services by underserved populations. Standalone mobile ultrasound clinics offering only pre-natal diagnostic facilities are prohibited. There should be adequate space in the unit to provide facilities for patients. [**Rule 3B (2)**]
 - Each medical practitioner qualified under the Act to conduct USG in a Genetic Clinic/Ultrasound Clinic/Imaging Centre shall be permitted to be registered with a maximum of two such clinics/centres within a district. The consulting hours for such medical practitioner, shall be clearly specified by each clinic/centre. [**Rule 3 (3) (3)**]

Since registration is required of any site offering pre-natal diagnostic procedure as defined in **Section 2 (i) of the PC&PNDT Act** – “all gynaecological or obstetrical or medical procedures such as ultrasonography, foetoscopy, taking or removing samples of amniotic fluid, chorionic villi, embryo, blood or any other tissue or fluid of a man, or of a woman before or after conception, for being sent to a Genetic Laboratory or Genetic Clinic for conducting any type of analysis or pre-natal diagnostic tests for selection of sex before or after conception” – by this definition, Assisted Reproductive Technology clinics and IVF/infertility centres also come under the purview of the PC&PNDT Act and should be registered if using any procedure before or after conception on a man or a woman that carries the potential to determine sex of the foetus.

Record Keeping and Reporting

Under the PC&PNDT Act, the records that are **mandatory** to be kept are:

- Register – containing the names and addresses of the men/women given genetic counselling, subjected to pre-natal diagnostic procedures or pre-natal diagnostic tests, name of the their spouse/father, and the date on which they first reported for the counselling, procedure or test. **[Rule 9 (1)]**
- Mandatory records – different forms to be maintained by different categories of units
 - Genetic Counselling Centre – Form D **[Rule 9 (2)]**
 - Genetic Laboratory – Form E **[Rule 9 (3)]**
 - Genetic Clinic, including a mobile Genetic Clinic/Ultrasound Clinic/Imaging Centre – Form F **(Rule 9 (4))**
- All case-related records, forms of consent, laboratory results, microscopic pictures, sonographic plates/slides, recommendations and letters shall be preserved for a period of two years. In the event of any legal proceedings, the records should be kept until the final disposal of the proceedings. **[Rule 9 (6)]**
- In case records are maintained on computer or other electronic equipment, an authenticated printed copy should be preserved. **[Rule 9 (7)]**
- Complete report for each month should be sent to the AA by the fifth day of the following month. **[Rule 9 (8)]**

Inspection

If the AA has reason to believe that an offence under the PC&PNDT Act has been or is being committed, such Authority or any officer authorised on this behalf may enter and search at all reasonable times, with assistance if required; and examine, seize and seal any of the following **[PC&PNDT Act: Section 30 and Rule 12]:**

- Registers
- Records maintained including forms
- Books
- Pamphlets
- Advertisements
- Material objects including records, machines and equipment

A list of any document(s)/object(s) found and seized shall be prepared in duplicate at the place of effecting the seizure. Both copies of such list will be signed on every page by the AA or the officer authorised in this behalf and by the witnesses to the seizure.

If it is not practicable to make the list at the place of effecting the seizure, these reasons need to be recorded in writing, and the list can be prepared at another place in presence of the witnesses.

Overview of Legal Compliance

	MTP Act	PC&PNDT Act
Provider Eligibility/ Employee Qualifications	The provider has to be an RMP as defined in MTP Act: Section 2 (d); and Rule 4.	Qualifications of employees should be as per Rule 3 and the Six Months Training Rules, 2014.
Site Approval/ Registration	A private site needs to be approved by the DLC as specified in MTP Act: Section 4. The MTP site approval certificate (Form B) should be displayed at the site as detailed in Rule 5 (7).	All units have to be approved by the AA as detailed in the PC&PNDT Act: Section 18, Section 19. The registration certificate has to be displayed in a conspicuous place in the unit [PC&PNDT Act: Section 19 (4), Rule 6 (2)]. Mobile units are also supposed to display the certificate. [Rule 6 (2A)] Change in the details of the Unit provided in the registration should be intimated to the AA 30 days in advance of the expected date of change. [Rule 13]
Consent	The woman has to be counselled and her consent received in Form C prior to the procedure, as specified in MTP Act: Section 3 (4) and Rule 9.	Written consent has to be obtained in Form G for invasive procedures such as amniocentesis and the 'declaration of pregnant woman' contained in Form F (Section D) has to be signed for non-invasive procedures such as USG. [Rule 10 (1)]
Records	Form I (Regulation 3), Form III (Regulation 5) and Form C (Rule 9) have to be maintained.	Records have to be maintained in Form D/E/F according to the category of unit, as specified in PC&PNDT Act: Section 29 and Rule 9.
Reporting	Cases done have to be reported on a monthly basis in Form II to the CMO.	Complete reports for each month should be sent to the AA by the fifth day of the following month. [Rule 9 (8)]
Copy of the Act and Rules	It is recommended that a copy of the MTP Act, Rules and Regulations be available in the facility.	A copy of the Act and Rules has to be kept in the unit for public information. [Rule 17 (2)]

Overview of Legal Compliance

	MTP Act	PC&PNDT Act
Provider Opinion	<p>Every RMP who terminates any pregnancy should, within three hours from the termination of the pregnancy, certify the termination in Form I as prescribed in Regulation 3 (2). In case pregnancy is terminated using MMA, Form I may be completed within three hours of prescribing the medical abortion drugs.</p> <p>For MTP in the second trimester, the opinion of two RMPs is required as specified in MTP Act: Section 3 (2) (b).</p>	
Code of Conduct		The Code of Conduct as prescribed by Rule 18 has to be observed by every person working in the unit.
Statutory Notices	<p>The MTP site approval certificate (Form B) should be displayed at the site as detailed in Rule 5 (7).</p> <p>In case an RMP prescribes medical abortion drugs from an unapproved place, a certificate showing access to an approved place should be displayed.</p>	
Declaration		<p>Any person conducting USG/image scanning should give a declaration on each report that he/she has neither detected nor disclosed the sex of the foetus of the pregnant woman to anybody; before undergoing the procedure, the pregnant woman should declare that she does not want to know the sex of her foetus. [Rule 10 (1A)]</p> <p>Declaration of the doctor and pregnant women are both contained in Section D of Form F. For invasive procedures, consent of the pregnant women needs to be taken in Form G.</p>

3

SECTION



GUIDANCE FOR COMMUNICATION

On Abortion and Sex Selection

Introduction

The issue of Gender Biased Sex Selection (GBSS) can be approached from various angles. What works depends on the target audience – their understanding and perception of the issue; and the language in which they articulate it.

However, communication on GBSS has often used ‘fear and guilt’ to communicate the heinous nature and consequences of the practice; and the urgency to address it. Often enough, this confuses sex selection with abortion and creates a misconception that abortion is illegal.

This guidance is aimed at identifying the challenges in communicating about sex selection; and emphasising the importance of protecting access to safe abortion. It then suggests ways by which communication about sex selection can be made effective without jeopardising access to legal abortion.

What do the Laws Say?

The Pre-Conception and Pre-Natal Diagnostics Techniques (Prohibition of Sex Selection) Act

The Pre-Natal Diagnostic Techniques (PNDT) (Regulation and Prevention of Misuse) Act came into force in 1994. Subsequently, the Act was amended in 2003 to strengthen it and include prevention of use of pre-conception diagnostic techniques as well. It is now called the Pre-Conception and Pre-Natal Diagnostics Techniques (Prohibition of Sex Selection) Act, 1994 (PC&PNDT Act). The Rules under the Act were further amended in 2014 to regularise training in ultrasonography for MBBS doctors.

The amended Act:

- prohibits determination and disclosure of the sex of the foetus;
- bans advertisements related to preconception and prenatal determination of sex;
- includes in its purview all technologies of sex determination, including the latest chromosome separation technique;
- makes it mandatory for all diagnostic clinics to prominently display a signboard clearly indicating that detection and revelation of the sex of the foetus is illegal;
- makes non-maintenance of records of pregnant women undergoing scanning an offence;
- requires all facilities having pre-conception and pre-natal diagnostic procedures, tests, facilities, with the potential of determining sex of the foetus to be registered;
- requires manufacturers to furnish information about the clinics and practitioners to whom the ultrasound machine has been sold.

The Medical Termination of Pregnancy Act

The Medical Termination of Pregnancy (MTP) Act was passed in 1971. It made abortion legal in India under certain conditions. These conditions include:

- grave risk to the life of the pregnant woman;
- risk of physical or mental injury to the pregnant woman; or
- risk of physical and mental abnormalities in the child (if born) so as to be seriously handicapped.

In addition, MTP is also permitted in cases of pregnancy due to rape and contraceptive failure (only for married women) as these are considered as causing grave injury to the mental health of the pregnant woman.

The Overlap Between Abortion and Sex Selection

From a gender equality perspective, sex selection is a reflection of discrimination against girls and subordination of women as a group. Not providing women access to safe abortion services despite legally valid reasons deepens this subordination.

It is important to note that many women seek abortion services for reasons that are legally valid. However, access to safe services is an area of big concern. It is estimated that of the 64 lakh abortions performed in India every year, 36 lakh (56%) are unsafe.⁴ In fact, about eight percent of maternal mortality in India still occurs due to unsafe abortions. Abortion complications are the third major cause of maternal death, after haemorrhage and sepsis.⁵

Calculated on basis of actual girls born as compared to the number that should have been born if the sex ratio at birth was normal (around 952), the estimated missing female births out of the total births is 5.7 lakhs or 4.6%.⁶ If this number of missing female births is juxtaposed against the estimated number of total abortions (64 lakhs), it can be estimated that of all the abortions in the country, only nine percent are likely to be sex selective.

This provides evidence that curbs on abortion will not be effective or efficient in preventing sex selection.

Very often the practice of sex selection is linked to access to legal abortion.

The use of terminologies such as foeticide, and bhrun hatya further adds to this confusion.

Sex selection can be prevented by ensuring that technology is used only for medical reasons; and by effective monitoring to stop unethical and illegal practices both in provision of abortion and use of technology.

⁴Duggal R. and Ramchandran V., The abortion assessment project – India; key findings and recommendations, Reproductive Health Matters, 2004, 12 (24, Suppl.): 122-129.

⁵2001-03 Special Survey of Death, Registrar General, India.

⁶Trends in sex ratio at birth and estimates of girls missing at birth in India (2001-2008), UNFPA 2011.

Communicating on Related Concepts

1. **The Gender Angle:** Very often, the term sex selection does not communicate the practice or the problem in its entirety. The term sex selection is better understood when it can be used along with information and data on reductions in proportion of girls, and along with concepts such as 'missing girls' to elaborate the point.

To emphasise the gender angle, the term gender-biased sex selection should be used.

2. **Technology Misuse:** It is important to focus on technology misuse as the basis that leads to identification of the sex of the foetus, and that is violation of the law.

Use terms such as *ling janch* (sex determination) and *ling chayan* (sex selection).

Terms like *bbrun batya* or female foeticide, *paap* or sin (of abortion as most refer to it), *maar dalna* or killing or murder should be avoided.

3. **Daughter Discrimination:** Discrimination against daughters forms the basis of the practice of sex selection. It is important to consistently focus on this issue and promote positive communication about the girl child.

It is useful to stress on messages such as: health is more important than sex of the child; some get girls, others get boys and this is nature.

Messages should promote love, care and attachment associated with a daughter and joy and celebration linked to her birth – *Mubarak ho! Beti hui hai.*

4. **Abortion:** Very often communication against sex selection can be perceived as that against legal abortion. It is advisable not to be silent on abortion to avoid misguided and misinterpreted communication. It should be emphasised that abortion is legal in India for certain reasons.

It is also important to state that banning second trimester abortion will not resolve the problem of sex selection, but will fuel unsafe provision of abortions, increasing deaths and injuries caused due to complications of unsafe abortions.

What is required is effective implementation of the laws governing the two distinct practices of sex selection and abortion. It is important to remember the distinct intents with which these laws were put in place – to ensure safe abortion (MTP Act) and to prevent misuse of technology (PC&PNDT Act).

Make sure that ‘all’ abortion is not understood as illegal.

Abortion for reasons of sex selection definitely needs to be prevented, and its illegality should be emphasised.

5. **Human Rights:** With reference to sex selection, the argument on right to life or right to be born can mean that one is ascribing rights of personhood and civil status to the foetus. This could imply that even the process of legal abortion will be seen as a violation of the rights of the foetus. This kind of positioning is incorrect and should be avoided.

The practice of sex selection violates the rights of women. The National Human Rights Commission (NHRC) has clarified the rights perspective on this issue –

“NHRC considers sex selection as a violation of women’s human rights. The practice has serious consequences for surviving girls and women. The act of sex selection constitutes discrimination against women as a community resulting in human rights violation...” (Chairperson’s speech at a conference on ‘Pre-natal Sex Selection – Issues, Concerns and Actions’, October 2010).

It is advisable to support rights language contained in international agreements (ICPD Programme of Action, Beijing Platform for Action, CEDAW etc) as these place rights in the context of discrimination and include sex selection among harmful practices that undermine rights to equality and non-discrimination.

6. **Violence against Women:** Sex selection is often referred to as a form of violence or the worst manifestation of gender-based violence. This can be interpreted as violence against the foetus and thus such communication is likely to be seen as against legal abortion. While sex selection itself should not be positioned as a form of violence, it can be articulated as contributing to **violence against women and girls as a consequence and therefore a risk factor for violence.**

If a reference to violence is made, it should be positioned as violence against womanhood, or violence against women as a community.

It should not be presented as violence against the foetus.

Maintaining Balance in Communication – Dos and Don’ts

For any communication to pass the test of being balanced, apply the three markers of:

1. **Language:** terminology does not jeopardise abortion;
2. **Imagery:** does not imply murder, and illegality of MTP, personify an unborn foetus; and
3. **Positioning:** does not imply sex selection and abortion as violence and does not refer to gender—biased sex selection as being about the right to life and the right to be born; does not undervalue women or girls by stressing on their instrumental value as wives or daughters-in-law, does not indulge in gender stereotyping.

At the same time, any opportunity to communicate on sex selection is also an opportunity to emphasise the legality of abortion and draw attention to the misuse of technology.


Following are some useful dos and don'ts.

DOs	DON'Ts
LANGUAGE	
<ul style="list-style-type: none"> ● Use terms like <i>ling janch</i>/sex determination and <i>ling chayan</i>/sex selection when referring to sex selection. ● Use the term <i>ling bhed</i>/gender discrimination/son preference when referring to the rejection of daughters: this draws attention to the underlying issues of discrimination that fuel sex selection. 	<ul style="list-style-type: none"> ● Do not make use of terms such as ‘female foeticide’ or <i>kanya bhrun batya</i>: these terms stigmatise abortion and imply it is not to be provided, endangering women who seek abortion for legal reasons.
IMAGERY	
<ul style="list-style-type: none"> ● Use images that celebrate the love, care and attachment associated with daughters. ● Use images that express joy and celebration linked to the birth of a girl child. 	<ul style="list-style-type: none"> ● Do not use images of foetuses being crushed, stabbed and strangled, daggers going through the stomach of a pregnant woman, blood being splattered. ● Do not use images of a female foetus speaking from the womb: This tends to ascribe life to the foetus and furthers the perception of ‘life being murdered’. This seriously jeopardises legal abortion. ● Do not use imagery that selectively emphasises on the value of women only as brides (like many men waiting to marry one woman): This further reinforces their devaluation in perceiving them as valuable only in their roles as brides. This takes the attention away from value of daughters in the family.

DOs	DON'Ts
POSITIONING	
<ul style="list-style-type: none"> ● National policy is to make abortion safe and widely available as per the law: Abortion is legal for a number of reasons but not for reasons of selecting the sex of the foetus. Even today, eight percent of maternal mortality is due to unsafe abortions. ● Safe abortion should not be jeopardised in preventing sex selection: Estimates indicate that about nine percent of abortions are sex selective and therefore ninety percent are not. ● Promote use of data related to sex ratio at birth and emphasise it as a more accurate indicator of the extent of sex selection. When using child sex ratio, be aware that this ratio also includes post birth factors that might skew the ratio, such as under-reporting, infanticide, selective neglect and resultant female mortality. This underscores the need to also work on some of these post birth contributors to an imbalance in child sex ratio. 	<ul style="list-style-type: none"> ● Do not discourage service providers from providing safe and legal abortion, through measures such as tracking of abortion outcomes or reviewing data for second trimester abortions. Quite obviously, half of the legal abortions will involve female foetuses and this will be true regardless of the sex ratio of that area or the level of compliance with the law. ● Do not imply that all women who previously have daughters are opting for an abortion for sex selection. Several studies have shown that education of the woman and unintended pregnancy are variables more closely correlated with opting for abortion as opposed to sex of the previous child. ● Do not use population sex ratio (number of females to 1,000 males in total population) to point to the problem of sex selection.

List of Abbreviations

AA	Appropriate Authority
CAC	Comprehensive Abortion Care
CEDAW	Convention on the Elimination of All Form of Discrimination against Women
CHC	Community Health Centre
CMO	Chief Medical Officer
CSB	Central Supervisory Board
DLC	District Level Committee
FOGSI	Federation of Obstetric and Gynaecological Societies of India
GBSS	Gender Biased Sex Selection
GoI	Government of India
ICPD	International Conference on Population and Development
IEC	Information Education and Communication
IVF	In Vitro Fertilisation
MMA	Medical Methods of Abortion
MoHFW	Ministry of Health and Family Welfare
MTP	Medical Termination of Pregnancy
NHM	National Health Mission
NHRC	National Human Rights Commission
PC&PNDT Act	Pre-Conception and Pre-Natal Diagnostic Techniques Act
PHC	Primary Health Centre
PNDT	Pre-Natal Diagnostic Techniques
RMNCH+A	Reproductive Maternal New-born Child Health and Adoloscents
RMP	Registered Medical Practitioner
UNFPA	United Nations Population Fund
USG	Ultrasonography



The handbook is disseminated by Ipas Development Foundation as part of our efforts to improve quality of comprehensive abortion care services and address gender biased sex selection in India.

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