DR ALPESH GANDHI
FOGSI PRESIDENT2020

FOGSI MTP COMMITTEE
BULLETIN 2020

DR MANDAKINI MEGH
ICOG CHAIRPERSON

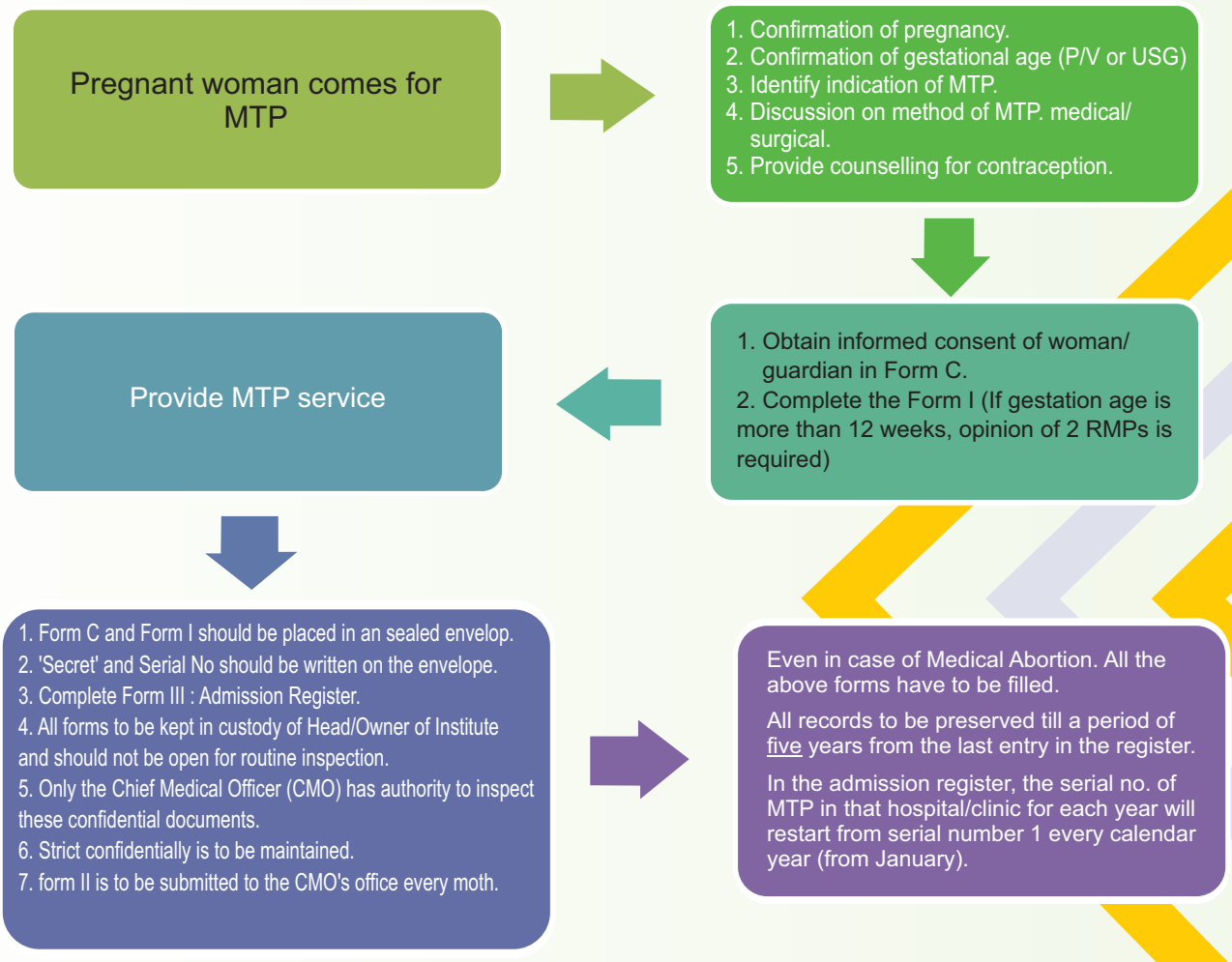
SAFE AND LEGAL ABORTION
AN UPDATE ON DOCUMENTATION INCLUDING ALL FORMS

DR ATUL GANATRA
VICE PRESIDENT

DR JAIDEEP TANK
SECRETARY GENERAL

EDITOR

PROF. BHARTI MAHESHWARI
FOGSI MTP COMMITTEE CHAIRPERSON



MANDATORY DOCUMENTATION UNDER THE MTP ACT

a) Form‘C’: Consent Form

b) Form I (Opinion Form): RMP shall certify this form within three hours from thetermination of pregnancy

c) Form II: Head of the hospital or owner of the place shall send a monthly statement of cases to the CMO of the district in this form

d) Form III (Admission Register): An approved site shall maintain case records in Form III. This register is kept for a period of five years from the date of last entry

Essential Protocols of Safe and Legal Abortion

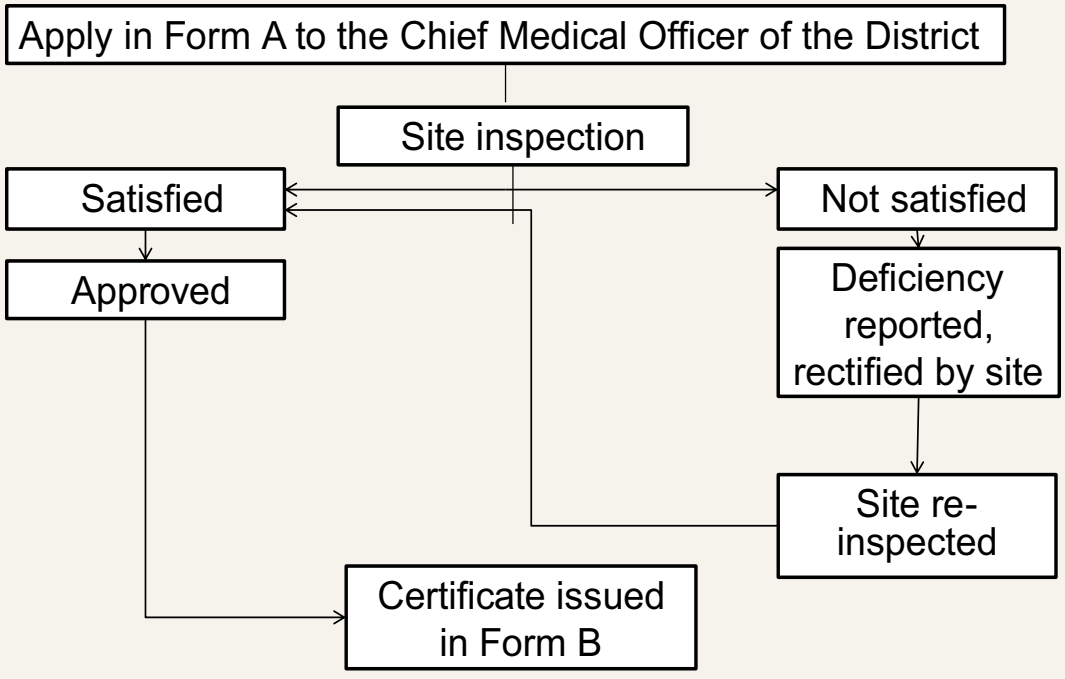
- It is performed by a Registered Medical Practitioner as defined under the MTP Act
- It is performed at an approved site under the Act and recorded in Form III
- Other requirements of the Act such as consent (Form C), opinion of RMP (Form I), monthly reporting (Form II) etc. are fulfilled
- The pregnancy is within the gestation limit approved by the law

The provider will get the protective cover of this legislation only when he or she fulfills the above mentioned requirements completely

MTP Site Approval

- **All private sites need approval before starting abortion services**
- **Public sector sites do not need separate approval, provided they have the required infrastructure**
- **Approval of private sites is granted at the district level by the District Level Committee (DLC)**

4.14: Private MTP Site Approval Process



The Medical Termination of Pregnancy Rules, 2003

FORM A

[Refer sub-rule (2) of rule 5]

FORM OF APPLICATION FOR THE APPROVAL OF A PLACE UNDER CLAUSE (B) OF SECTION 4

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

(i) Gynecological examination / labour table.

(ii) Resuscitation equipment.

(iii) Sterilization equipment.

(iv) Facilities for treatment of shock, including emergency drugs.

(v) Facilities for transportation, if required.

CATEGORY B

(i) As operation table and instruments for performing abdominal or gynecological surgery.

(ii) Drugs and parents fluid in sufficient supply for emergency cases.

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

Place : .....

Dater : .....

Signature of the owner of the place

4.16 Form B : Site Approval Certificate

FORM B

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

CERTIFICATE OF APPROVAL

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

As read within upto ..... weeks

Name of the Place .....

Address and other descriptions .....

.....

Name of the owner .....

Place : .....

Dater : .....

To the Government of the .....

Consent for MTP

- In case of a woman more than 18 years, married/unmarried, only the consent of the woman is required to terminate pregnancy
- In case of a minor (less than 18 years) or a mentally ill person, consent of a guardian is required
- Guardian means a caretaker willing to be responsible for the woman.
- Spousal consent is not mandatory
- CONSENT HAS TO BE TAKEN ON FORM C
- MOST IMPORTANT MEDICOLEGAL DOCUMENT

FORM C

[Refer 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 of 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 / mentally ill person at .....

(Place of termination of my pregnancy)

Place :
Date : Signature

RMP OPINION FORM

FORM I

[Refer regulation 3]

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

_____
(Full address of the Registered Medical Practitioner)

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

_____
(Full address of the Registered Medical Practitioner)

hereby certify that *I/We am/are of opinion, formed in good faith, that it is necessary to terminate the pregnancy of

_____
(Full name of pregnant woman in block letters)

resident of _____
(Full name of pregnant 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 Registered of the hospital/approved place.

Signature of the Registered Medical Practitioner

Signature of the Registered Medical Practitioner

Place : _____
Date : _____

* Strike out whichever is no applicable.
**of the reasons specified items (i) to (v) write the one which is appropriate.

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

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

Place: _____
Date: _____

Signature of the Registered Medical Practitioner/Practitioners

FORM II

[Refer Regulation 4(5)]

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

Signature of the Officer In-charge with date

Form III: Admission Register

Admission Register

Name of Facility_____ Month _____Year _____

S.No.	Date of Admission	Name of the patient	Wife/daughter of	Age (in years)	Religion	Address	Duration of pregnancy	reasons for which pregnancy is terminated	Date of termination of pregnancy	Date of discharge of patient	Result & remarks	Name of Registered Medical Practitioner(s) by whom the opinion is formed	Name of Registered Medical Practitioner(s) by whom pregnancy is terminated
1	2	3	4	5	6	7	8	9	10	11	12	13	14

Violation of the MTP Act

The following offences can be punished with rigorous imprisonment for two to seven years:

- Any person terminating a pregnancy who is not a registered medical practitioner as under the MTP Act
- Terminating a pregnancy at a place which is not approved
- Mandatory documentation of consent, opinion, case recording and monthly reporting are not adhered to

• **In case less than 18 yrs seeking termination service provider has to report the case to the appropriate authorities** (either the Local Police or Special Juvenile Police) or to the concerned authority in the Hospital responsibility for medico legal cases to report the same under **POCSO ACT (Protection of Children Against Sexual Offences).**

Documentation/Reporting Requirement for MEDICAL METHOD

1. Form I – Opinion Form
2. Form II – Monthly Reporting Form (to be sent to the district authorities)
3. Form III – Admission Register for case records
4. Form C – Consent Form

First Visit /Day 1 /Day of Mifepristone Administration	2nd visit-3rd day	3rd visit-15th day
1. Detailed history. 2. Counselling including general and method specific counselling. 3. Physical and pelvic examination. 4. Contraceptive options. 5. Investigations (Injection Anti D 50 mcg if Rh negative). 6. Informed consent. 7. Mifepristone 200 mg orally. 8. Give contact address and phones number of the facility where woman can go in case of an emergency. 9. complete the follow-up card.	1. Note any history of bleeding / pain or any other side effects after mifepristone. 2. Misoprostol 400 mcg (Two tablets of 200 mcg) oral/vaginal. 3. Observe for four to six hours in the clinic / hospital. 4. Prescribe drug for pain relief. 5. Perform bimanual examination just before discharging her from the facility, to rule out expulsion of POC. 6. Inform the woman about warning signs. 7. She must keep filling the card.	1. Note relevant history. 2. Carry out pelvic examination to ensure completion of abortion process. 3. Advise USG if pelvic examination does not confirm the expulsion of POC or completion of abortion process or if bleeding continues. 4. Ask the woman to report back if there are no periods within six weeks. 5. Reinforce contraceptive counseling and services.

Followup Card

एम.एम.ए. कार्ड

स्वास्थ्य केंद्र का नाम : .....

डॉक्टर का नाम : .....

मोबाईल नम्बर : ..... फोन न .....

	दिन 1	दिन 3	दिन 15
दिनांक			

आपातकालीन स्थिति में तुरंत संपर्क करें

स्वास्थ्य संस्था का नाम : .....

फोन न : .....

सामान्य लक्षण:

औषधीय गर्भपात के दौरान आप निम्न में से एक या एक से अधिक प्रभाव महसूस कर सकती हैं। ये थोड़े समय के लिए ही होते हैं और प्रक्रिया पूरी होने के बाद खत्म हो जाते हैं:

- आपकी साधारण माहवारी से ज्यादा खून गिरना
- पेट में दर्द या ऐंठन
- बुखार या सर्दी
- मतली या उल्टी
- दस्त

यह चार्ट औषधि द्वारा गर्भपात प्रक्रिया के 15 दिनों के दौरान आपको अपनी सेहत का ब्यौरा रखने में सहायता करेगा। इन 15 दिनों के दौरान, प्रतिदिन आपको जो भी लक्षण महसूस हों आप उस खाने में ✓ का निशान बना दें।

प्रक्रिया के दौरान →	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
चक्कर आना															
सामान्य रूप से खून गिरना															
ज्यादा खून गिरना															
मतली/उल्टी होना															
दर्द/ऐंठन होना															
बुखार/सर्दी लगना															

नोट: तीसरे एवं पन्द्रहवे दिन की नियमित जाँच के लिए तथा आपातकालीन स्थिति में जननी एक्सप्रेस वाहन का उपयोग निःशुल्क उपलब्ध है। आप आवश्यकता पड़ने पर आशा कार्यकर्ता से भी सम्पर्क कर सकते हैं।

अगर आपको निम्न से कोई भी लक्षण महसूस हो तो स्वास्थ्य केंद्र में डॉक्टर से तुरंत संपर्क करें:

लगातार दो घंटो तक ज्यादा खून जाना जिसमें हर घंटे में 2 या उससे ज्यादा मैक्सी सेनेटरी पैड इस्तेमाल करने पड़े

दूसरी दवा लेने के 24 घंटो तक भी बिल्कुल खून न जाना

दूसरी दवा लेने के बाद लगातार बुखार व गोनि से बदबूदार रिसाव

FOGSI MEDICAL TERMINATION OF OF PREGNANCY COMMITTEE 2018-2020

MTP & PCPNDT RULES "KNOW & FOLLOW"

CHAIRPERSON

PROF. BHARTI MAHESHWARI

(MD, FICOG, FIAOG, FIME)

Ph. : 9924856780

E-mail : bhartinalok123@gmail.com

बेटी बचाओ, बेटी पढ़ाओ

The Medical Termination of Pregnancy Rules, 2003

FORM A

[Refer sub-rule (2) of rule 5]

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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

(i) Gynecological examination / labour table.

(ii) Resuscitation equipment.

(iii) Sterilization equipment.

(iv) Facilities for treatment of shock, including emergency drugs.

(v) Facilities for transportation, if required.

CATEGORY B

(i) As operation table and instruments for performing abdominal or gynecological surgery.

(ii) Drugs and parents fluid in sufficient supply for emergency cases.

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

Place : .....

Dater : .....

Signature of the owner of the place

4.16 Form B : Site Approval Certificate

FORM B

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

CERTIFICATE OF APPROVAL

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

As read within upto ..... weeks

Name of the Place .....

Address and other descriptions .....

.....

Name of the owner .....

Place : .....

Dater : .....

To the Government of the .....

FORM C

[Refer 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 of 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 / mentally ill person at .....
(Place of termination of my pregnancy)

Place :
Date : Signature

RMP OPINION FORM

FORM I

[Refer regulation 3]

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

_____
(Full address of the Registered Medical Practitioner)

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

_____
(Full address of the Registered Medical Practitioner)

hereby certify that *I/We am/are of opinion, formed in good faith, that it is necessary to terminate the pregnancy of

_____
(Full name of pregnant woman in block letters)

resident of _____
(Full name of pregnant 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 Registered of the hospital/approved place.

Signature of the Registered Medical Practitioner

Signature of the Registered Medical Practitioner

Place : _____
Date : _____

* Strike out whichever is no applicable.
**of the reasons specified items (i) to (v) write the one which is appropriate.

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

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

Place: _____
Date: _____

Signature of the Registered Medical Practitioner/Practitioners