ICOG CAMPUS

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MTP ACT 2021
CLINICAL IMPLEMENTATION

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ICOG & FOGSI PRESIDENT MESSAGE

Unsafe abortion is a tragedy. It is not simply a tragedy of circumstances, but one of a woman being deprived of one of her most basic Human rights - the right to control her body and her reproductive ability.

Unsafe Abortion cuts across age, demography and geography. The issues and the stigma which surrounds abortion lead to a low awareness of these problems which have significant effects on women's lives extending beyond the purely medical problems to their personal and social relationship and lives.

The implications of unsafe abortion are even resonant when you consider the fact that prevention of unsafe abortion is one the fastest and most scalable ways to reduce maternal mortality. Technology available is now safe, efficacious and cheap. It is of course not enough to simply provide the services but also provide them with care, quality and dignity. Post Abortion care has been shown to be a vital component of CAC.

FOGSIans across the country have gone above and beyond in this pandemic to minimise the impact of this crisis on SRHR issues and I believe that the country and the world owes a debt of gratitude to all FOGSIans and Healthcare providers.

I would like to congratulate Dr Bharti Maheshwari and her team for this excellent issue of ICOG Campus, highlighting MTP act 2021 with clinical implementation. I also congratulate ICOG team and contributors in ICOG campus.

DR. PARUL KOTDAWALA
(ICOG Chairperson)

ICOG, CHAIRPERSON MESSAGE

It is indeed a pleasure to put in front of you the next issue of ICOG focus. The focus this time is on the topic of 'MTP act 2021: Clinical implementation'. Many colleagues are not very clear about the recently updated MTP act, and this publication will be a great service to our colleagues in following the provisions of newer act in their clinical practice.

This issue of ICOG Focus is entirely due to the initiative of Dr. Bharti Maheshwari and I acknowledge her efforts to get this completed in time. We have some very senior and accomplished authors including Dr. P. K. Shah, Dr. Parag Biniwale, Dr. Niranjan Chauhan and Dr. Richa Sharma in addition to Dr. Bharti Maheshwari. Please keep this booklet on your office table as a ready reckoner, for instant reference in case of MTP.

With best wishes and regards

ICOG, VICE CHAIRPERSON MESSAGE

DR. SHEELA MANE
(ICOG Vice Chairperson)

Safe abortion practice is the need of hour as still 8 percent maternal mortality is due to unsafe abortion in India.

MTP includes not only medical factors but social and ethical also. MTP act Amendment-2021 is a boon for females in India as it gives extension of gestational age for termination in certain conditions.

This issue of ICOG campus focused on MTP act 2021 clinical implemetation is very needed at this time and will be useful for all FOGSIANS.

I congratulate Dr. Bharti Maheshwari for doing efforts and whole ICOG team and authors for their contribution.

Best wishes.

DR. SARITA BHALERAO
(ICOG Secretary)

ICOG, SECRETARY
MESSAGE

I would like to congratulate Dr. Bharti Maheshwari and her team for this excellent issue of ICOG campus on MTP.

MTP amendments are covered extremely well and the article will be of immense use to the practicing Gynaecologist. Methods of MTP have now become much safer and easier thanks to sonography and availability of Mifepristone and Misoprostol. My congratulations to all the contributors for their well researched articles.

I am certain that ICOG Fellows and Members will enjoy reading this issue and it will benefit them in their practice.

DR. PARAG BINIWALE
(ICOG Chairperson (Elect.)

ICOG, CHAIPERSON ELECT.

MESSAGE

Medical termination of pregnancy is one of the commonest procedures performed by obstetricians & Gynaecologists. Worldwide, millions of abortions are being performed, some by trained doctors while some are performed by unskilled personnel. It is important for all of us to understand minute details of MTP and related procedures. MTP law has been amended and all obstetricians should be aware of the changes that have taken place in the law. Understanding of this would certainly help women desirous of termination of pregnancy.

This issue of ICOG campus is a much needed possession for all clinicians as it gives all possible details related to MTP. I compliment the editor of this issue Dr. Bharti Maheshwari, our Governing council member and her colleagues for all efforts they have put in under guidance of Chairperson Dr. Parul Kotdawala & office bearers of ICOG.

Happy reading!

ICOG, VICE CHAIRPERSON ELECT.

MESSAGE

PROF. ASHOK KUMAR
(ICOG Vice Chairperson (Elect.)

Greetings to all ICOGians,

The objective of ICOG is to continue to promote education, training, research and spread of knowledge in the field of Obstetrics, Gynaecology, Reproductive health, Family Welfare and related areas.

In this ICOG Campus on "MTP Act 2021 clinical implementation" the contributors tried to cover all the aspects pertaining to Medical Termination of Pregnancy (MTP) including mandatory documents for MTP procedures under the MTP Act. MTP Act came into force in India on April 1, 1972 although the Parliament had passed the act on August 10, 1971. Since then it has been amended twice, in 2002 and 2021. The changes were made to further empower women by providing them access to safe abortion services and ensuring that dignity, autonomy, confidentiality and justice for women who need to terminate pregnancy.

I am sure that we will all learn a lot from this campus.

I, would like to congratulate the editor Prof (Dr.) Bharti Maheshwari for successfully putting forward all the amazing work and wish her all the best for the time ahead.

ISSUE EDITOR MESSAGE

PROF (DR.) BHARTI MAHESHWARI

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Abortion is legalised in country since 1971 in certain conditions to minimise unsafe abortions and protecting doctors but still 8 percent deaths are due to abortion related causes. Abortion is genuine in number of cases but is not for sex selection. According to statistics 9 percent of abortion are sex selective, 90 percent not. Therefore safe abortion services should not be jeopardized in preventing sex selection.

MTP act were processed through many amendments and recent one was held in 2021. It is our duty to implement MTP act in our clinical practice by updating ourselves and avoid litigation and inconvenience.

We already had FOGSI focus on MTP just before MTP act Amendment 2021 which has covered all issues related to MTP.

In this ICOG campus We have chapters on journey of MTP act in detail by Dr. Parag Biniwale, USG in MTP by Dr. P. K. Shah, MTP in 1st trimester by me and MTP in 2nd trimester by Dr. Richa Singh according to current MTP act with update on clinical methods and in last prevention and management of complications of MTP by Dr. Niranjan Chavan. We tried to give comprehensive recent updates on MTP which is very much desired by all clinicians.

I am grateful to all authors for contribution with FOGSI President Dr. Jaideep Tank, Secretary Dr. Madhuri Patel, ICOG Chairperson Dr. Parul Kotadwala, Vice Chairperson Dr. Sheela Mane and Secretary Dr. Sarita Bhalerao, ICOG Chairpersons Elect Dr. Parag Biniwale for continuous guiding and support. I am grateful to my mentor Padmashri Dr. Usha Sharma and other teachers who guided me.

I hope this ICOG Campus is going to be very informative and useful for all clinicians.

Thanks to FOGSI team for opportunity and all readers for love and affection always.

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MTP ACT - 2021 WITH JOURNEY OF 50 YEARS

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'But the fact of the matter is the ability to decide when and whether to have a child and is the biggest economic decision a woman makes over the course of her lifetime'

Governor Of Michigan Gretchen Whitmer On CNN

The need of procreation and childbirth can take a heavy toll on a woman's life and one of the most preventable episodes in her life is an unwanted pregnancy leading to unsafe abortion.

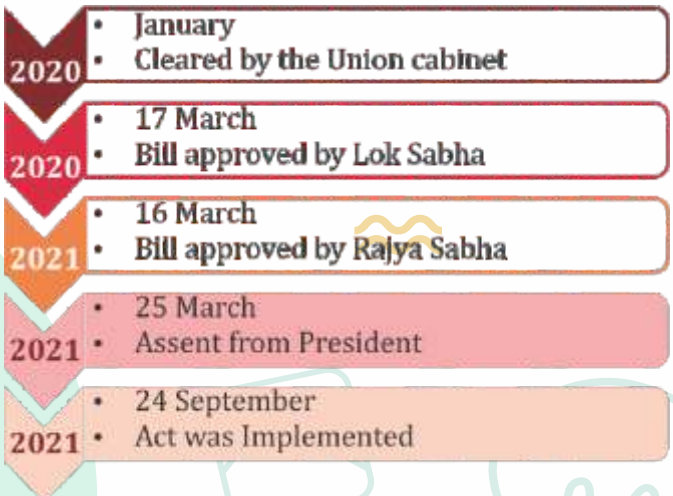
The Medical Termination of Pregnancy Act (1971), referred to as **The Principal Act** has defined termination of pregnancy as a procedure to terminate a pregnancy by using medical or surgical methods.

The government of India brought this historic move by amendment of MTP Act of 1971 so as to increase the ambit and access to safe abortion services and to ensure safety, dignity, autonomy and confidentiality and to give justice to women who need to terminate their pregnancies

This act is applicable to whole of India including Jammu and Kashmir. The MTP amendment act, 2021 is really appreciable as it has special considerations which were not addressed previously as per the principal act (1971). It includes substitution of certain sub sections and introduction of some newer clauses under some sections of the Principal Act.

The MTP amendment act 2021 was approved by the by Lok Sabha on 17th march 2020 and then by Rajya on 16th march 2021. It then got the assent from the president on 25th, march 2021 and then was implemented on 24th September, 2021.

MTP Amendment Bill



Why This Amendment?

48.5 million pregnancies occur annually in India and 44% are unintended. approximately 16 million (77%). approximately 16 million of these unwanted pregnancies result in abortion. 80 0,000 unsafe abortions occur every year in our country with 10% resulting in maternal deaths.[1]

Thousands of deaths were reported due to lack of abortion related facilities, lack of services, and knowledge in the general public. There is stigma around young unmarried women seeking abortions, and hence landing up with quacks for the same. In remote areas there are many quacks, healers, *Babas,* etc conducting abortions by herbal medicines, or some, *jadi-buti* or abdominal massages, inserting sharp objects in genitalia.[2]

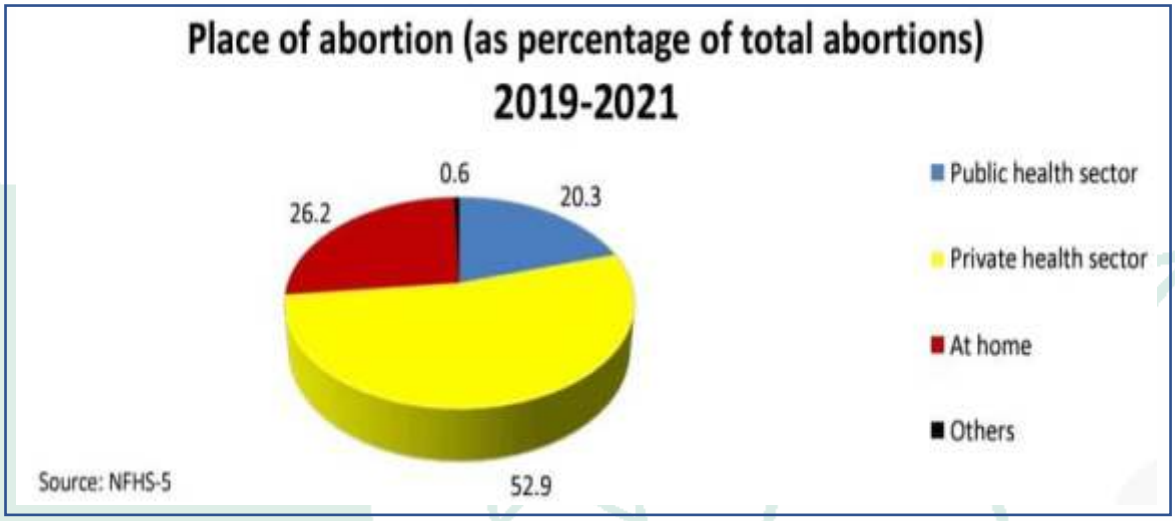
Second trimester abortions constitute 10-15% of induced abortions worldwide. Two third of all major abortion related complications are noticed in this group. Also due to advancement in technology and widespread introduction of antenatal screening for foetal anomalies, the detection rate of anomalies has increased leading to a greater number of terminations. So, there was a need for amendments in the MTP Act of 1971. There were several petitions received by the court seeking permissions for aborting pregnancies beyond 20 weeks to make an abortion safe and in tune with the changing times. This leads to wide prevalence of unsafe and illegal abortions in rural as well as in some urban areas, making it the third leading cause of maternal death in India. So MTP Act was enacted as a reproductive health care measure. After 1971, the MTP Amendment Act no 64, 2002 and the MTP Amendment Rules, 2003 was the first amendment FOGSI had a crucial role in the formatting of this Act and Rules.[3]

The salient features were

1. The word lunatic. was replaced by mentally ill person
2. The centre approval power was decentralised to District Level Committees
3. The registration process was simplified for those facilities providing first trimester abortions.
4. Early abortions by medication method was made more accessible by allowing RMPs to prescribe at their centres with a notional access to an MTP approved centre.

National Family Health Survey (NFHS-5), 2019-21: India[4]

Inspite of the progressive & Liberalization of MTP Act, 1971, the report noted that 53 per cent of all abortions were performed in private health facilities and 20 per cent were done in the public health sector. Around 27 per cent were performed at home by the women themselves.[4] Therefore the Amendment in the Act seemed appropriate.



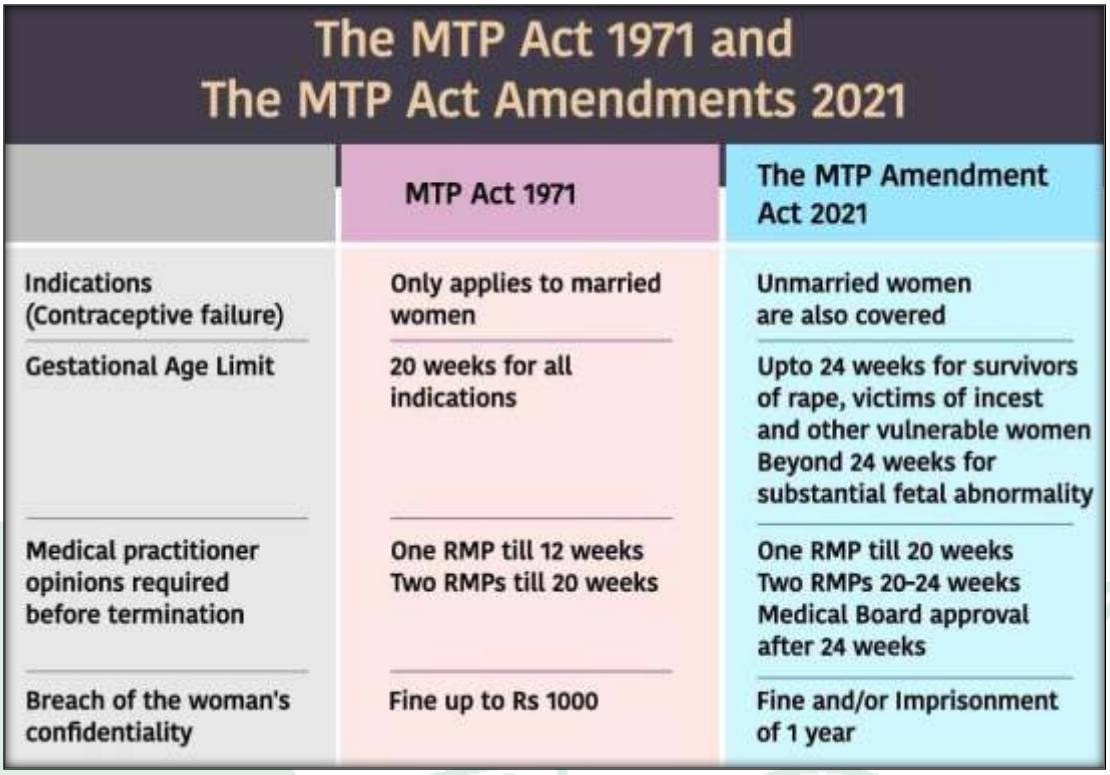
HIGHLIGHTS OF THE MTP AMMENDMENT ACT 2021

This act concerns half of the population i.e., women of India. It expands the access to safe and legal abortion services on the Therapeutic, Eugenic, Humanitarian, Social grounds to ensure universal access to Comprehensive abortion care.

THE KEY HIGHLIGHTS OF THIS ACT ARE:

1. The act of 1971 applies to married women, but the amendment allows **unmarried women** to medically terminate pregnancies under the indication of contraceptive failure, this means any woman irrespective of her marital status is eligible for termination of pregnancy under the indication of contraceptive failure.
2. Increasing the medical abortion timeline to **nine weeks** of gestational age.
3. It has **increased the upper gestational limit of MTP from 20-24 weeks** for special categories of women. These special categories include survivors of rape, incest, and other vulnerable group of women (like differently abled women and minors)
4. It allows abortion to be performed as per opinion of **1 RMP up to 20 weeks** and opinion **of 2 RMP's for certain categories of women up to 20-24 weeks of gestation.**
5. **Beyond 24 weeks** the termination can be performed in cases of **substantial foetal abnormalities** irrespective of the length of pregnancy based on the decision of **the Medical Board.**
6. **Focus is on privacy and confidentiality** as a RMP will only reveal the details about the termination only to a person authorised by law.

THE MTP ACT 1971 AND THE MTP ACT AMMENDMENTS OF 2021



TRAINING REQUIRED FOR MTP AS PER NEW MTP AMMENDMENT ACT 2021

'Registered Medical Practitioner **'(RMP)'** means 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 such experience or training in Gynaecology and Obstetrics as may be prescribed by rules made under the Act.

REQUIREMENTS AS PER RULE

a) RMP registered before 1971 and has three years of experience in Obstetrics and Gynaecology.

b) RMP has completed six months of house surgency in OBGY or if RMP had experience at any hospital for not less than one year in OBGY; or

c) Assisted 25 cases of MTP and done 5 cases of independent MTP for first trimester

ca) 3 months in OBGY or ten cases of independent MTP

d) Post graduate Diploma or Degree in OBGY

"(ca) A Registered Medical Practitioner shall have the following experience and training for conducting termination of pregnancy up to Nine weeks of gestation period by **medical methods of abortion**, namely: **-**

i) experience at any hospital for a period of not less than three months in the practice of obstetrics and gynaecology; or

ii) has independently performed ten cases of pregnancy termination by medical methods of abortion under the supervision of a Registered Medical Practitioner in a hospital established or maintained, or a training institute approved for this purpose, by the Government."[5]

TRAINING REQUIREMENT FOR THE PROCEDURE (RULE 4A)[6]

WEEKS	TRAINING
UPTO 9 WEEKS (MEDICAL METHOD OF TERMINATION)	a, b, c, ca, d
UPTO 12 WEEKS	a, b, c, d
12 to 20 WEEKs	a, b, & d
BEYOND 24 WEEKS	a, b & d (2 RMPs)

APPROVAL OF PLACE FOR MTP[7]

No place shall be approved under clause(b) of section 4

i) Unless the Government is satisfied that termination of pregnancies may be done therein under safe and hygienic conditions; and

ii) Unless the following facilities are provided therein, namely: **-**

In case of first trimester, that is, **up to 12 weeks of pregnancy: -**

1. A Gynaecology examination table/ labour table
2. Resuscitation and sterilization equipment
3. Drugs and parenteral fluids
4. Back up facilities for treatment of shock and facilities for transportation;

In case of second trimester, that is, **up to 24 weeks of pregnancy (Rule 5D)**:-

a) An operation table and instruments for performing abdominal or Gynaecological surgery;

b) Anaesthetic equipment, resuscitation equipment and sterilization equipment:

c) Drugs and parenteral fluids for emergency use notified by Government of India from time to time.

"In case of termination beyond **twenty-four weeks** of pregnancy: -

(a) an operation table and instruments for performing abdominal or gynaecological surgery;

(b) anaesthetic equipment, resuscitation equipment and sterilisation equipment;

(c) availability of drugs, parental fluids and blood for emergency use, as may be notified by the Central Government from time to time; and

d) facilities for procedure under ultrasound guidance.".

INDICATIONS FOR MTP

UPTO 20 WEEKS (LIKE MTP ACT OF 1971)

1. Therapeutic
2. Eugenic
3. Humanitarian
4. Social

In the amendment of MTP act 2021, any woman irrespective of marital status is eligible for MTP under the indication of contraceptive failure.

The word husband is replaced by **partner**

MTP BEYOND 20 WEEKS TILL 24 WEEKS

INDICATIONS (RULE 3B)[8]

a) survivors of sexual assault or rape or incest
b) minors
c) change of marital status during the ongoing pregnancy (widowhood or divorce)
d) women with physical deformities (major disability as per criteria laid down under the rights of persons with DISABILITIES ACT, 2016 (49 OF 2016)
e) mentally ill women including mental retardation
f) the foetal malformation that has substantial risk of being incompatible with life or if the child is born it may suffer from physical or mental abnormalities to be seriously handicapped
g) women with pregnancy in humanitarian settings or disaster or emergency situations as declared by government

Contraceptive failure is not an indication in this period of gestation

MTP BEYOND 24 WEEKS

- The foetal malformation has **substantial** risk of it being incompatible with life or if the child is born it may suffer from such physical or mental abnormalities to be seriously handicapped
- As decided by the Medical Board
- Only after due consideration and ensuring that the procedure would be safe for the woman at that gestational age

In this amendment there is **no provision** is given for the termination of the **late pregnancies (beyond 24 weeks)** which arise due to rape, in minors, change of marital status, mentally ill women, or with physical deformities etc, the board will not form the opinion and the only recourse is Writ petition in the court.

MEDICAL BOARD[9]

To terminate any pregnancy beyond 24 weeks of gestation the opinion of a Medical Board is required.

Every state government or union territory shall, by notification in the official gazette is supposed to constitute board to be called Medical Board for the purposes of termination of pregnancy beyond 24 weeks of gestation for foetal malformation.

THE MEDICAL BOARD SHALL CONSTIST OF THE FOLLOWING:

a) a Gynaecologist

b) a Paediatrician

c) a Radiologist or Sonologist

d) such other number of members as may be notified in the Official Gazette by the State Government or Union territory.

RULE 3A: THE POWERS OF MEDICAL BOARD

i) to allow or deny MTP beyond 24 weeks only after due consideration and ensuring that the procedure would be safe for the woman at that gestational age and whether the foetal malformation has substantial risk of being incompatible with life or if the child is born it may suffer from such physical or mental abnormalities to be seriously handicapped.

ii) co-opt other specialists in the Board and ask for any additional investigations If required, for deciding on the termination of pregnancy

FUNCTIONS OF MEDICAL BOARD

On receipt of the request for MTP beyond 24 weeks, the Medical Board shall

1. Examine the girl/woman and her reports
2. Provide the opinion of medical board in **form D** with regard to termination of pregnancy or rejection of request for termination **within three days** of receiving the request for MTP.
3. To ensure that MTP when advised by the medical board, is carried out with all safety and precautions along with appropriate counselling **within five days** of the receipt of the request.

While the girl/ woman is examined she is under great mental stress and it is desirable to provide a respectful environment when she is being examined. Prior to the examination the experts in the board should review the reports and all the investigations and the girl / woman should not be required to undergo repeated examinations.

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 registered.
- Mandatory documentation of consent, opinion, case recording and monthly reporting are not adhered to

"5A. (1) No registered medical practitioner shall reveal the name and other particulars of a woman whose pregnancy has been terminated under this Act except to a person authorised by any law for the time being in force.

(2) Whoever contravenes the provisions of sub-section

(3) shall be punishable with imprisonment which may extend to one year, or with fine, or with both

DOCUMENTATION:

FORM A: FORM OF APPLICATION FOR THE APPROVAL OF A PLACE (edited with 24 weeks)

FORM B: CERTIFICATE OF APPROVAL (no change)

FORMC C: CONSENT OF WOMAN (no change)

FORM D: MEDICAL BOARD REPORT FOR MTP BEYOND 24 WEEKS

FORM E: OPINION OF REGISTERED MEDICAL PRACTIONER (for MTP beyond 20 weeks

FORM D SAMPLE

"Form D

(See sub-clause (ii) of clause (b) of rule 3A)

Report of the Medical Board for Pregnancy Termination Beyond 24 weeks

Details of the woman seeking termination of pregnancy:

1. Name of the woman
2. Age:
3. Registration/Case Number:
4. Available reports and investigations:

S.No	Report	Opinion on the findings

5. Additional Investigations (if done):

S.No	Investigations done	Key findings

6. Opinion by Medical Board for termination of pregnancy:
   a) Allowed
   b) Denied

Justification for the decision:

7. Physical fitness of the woman for the termination of pregnancy:
   a. Yes
   b. No

Members of the Medical Board who reviewed the case:

S.No	Name	Signature

Date and Time:.....

FORM E SAMPLE

FORM E

Opinion Form of Registered Medical Practitioners

(For gestation age beyond twenty weeks till twenty-four weeks)

[See sub-rule (2) of rule 4A]

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 we are of opinion, formed in good faith, that it is necessary to terminate the pregnancy of _____

(Full name of pregnant woman in block letters)

resident of_____

(Full address of pregnant woman in block letters)

which is beyond twenty weeks but till twenty-four weeks under special circumstances as given below*.

*Specify the circumstance(s) from (a) to (g) appropriate for termination of pregnancy beyond twenty weeks till twenty-four weeks:

(a) Survivors of sexual assault or rape or incest

(b) Minors

(c) Change of marital status during the ongoing pregnancy (widowhood and divorce)

(d) Women with physical disabilities [major disability as per criteria laid down under the Rights of Persons with Disabilities Act, 2016 (49 of 2016)]

(e) Mentally ill women including mental retardation

(f) The foetal malformation that has substantial risk of being incompatible with life or if the child is born it may suffer from such physical or mental abnormalities to be seriously handicapped

(g) Women with pregnancy in humanitarian settings or disaster or emergency situations as declared by Government

We hear by give intimation that we terminated the pregnancy of the woman referred to above who bears the Serial No. _____ in the Admission Register of the hospital / approved place.

Signature of the Registered Medical Practitioner

Signature of the Registered Medical Practitioner

Place:
Date:

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

MTP IN MINOR GIRL

In a woman who is above 18 years of age, her pregnancy can be terminated with only her consent. But if she is below 8 years of age or mentally ill, a written consent of the guardian is required.

In case less than 18 years 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).

As per Rule 3B[10] of the Medical Termination of Pregnancy (Amendment) Rules, 2021, minors are recognized as a vulnerable category for termination of pregnancy beyond 20 weeks till 24 weeks of gestation and services are made more accessible to them.

The Rule 6 (7) (medical aid and care) under the POCSO Rules, provides that if a minor is found to be pregnant, then the Registered Medical Practitioner shall counsel the minor, and her parents or guardians, or support person, regarding the various lawful options available to the minor as per the Medical Termination of Pregnancy Act 1971, and the Juvenile Justice (Care and Protection of Children) Act 2015 (2 of 2016)

CONCLUSION

This new MTP Act Amendment will contribute towards ending preventable maternal mortality and to help meet the sustainable development goals (SDGs) 3.1, 3.7, 5.6

The Principal Act was also a progressive act one at that time. But a woman had to knock the doors of the court for the permissions of the honourable court to terminate her pregnancy due to substantial abnormalities detected after 20 weeks.

The amendments after 50 years are a welcome step and this amendment is a mirror of the changing norms of the society and destigmatising the termination of pregnancy. it is an appreciable legislation passed by Indian government.

If one does not support legal abortion,

In effect, one is supporting illegal abortion'

Prof. Arulkumaran[11]

All of us should disseminate this information so that more n more women can get access to safe abortion services. The MTP services should be affordable and easily available along with the contraceptive awareness.

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3) Ibid.
4) National Family Health Survey (NFHS-5), 2019-21: India
5) MTP Amendments Rules 2021, The Gazette of India, NEW DELHI, THURSDAY, MARCH 25, 2021/CHAITRA 4, 1943 (SAKA)
6) Ibid.
7) Ibid.
8) Ibid.
9) Ibid.
10) Government of India ministry of health and family welfare department of health and family welfare Lok Sabha starred question no.186 to be answered on the 10th December, 2021
11) FOGSI Focus on Medical Termination of Pregnancy (MTP) recent update on Clinical & Legal Aspects.

ROLE OF ULTRASOUND IN MTP

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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. 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[1]. Despite abortion being legal, the high estimated prevalence of unsafe abortion demonstrates a major public health problem in India[2]. It is unfortunate that women continue to face severe complications which are totally preventable through just ensuring easy access to safe abortion services. 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.

It is imperative to understand that it is not mandatory or binding upon the clinician to advise/perform ultrasound before undergoing MTP[3].Clinical finding of intrauterine pregnancy is enough to perform MTP-both medical and surgical. There are certain situations though where ultrasound can be useful before, during or after MTP.

L.M.P. & physical examination alone, without the routine use of Ultrasound, are highly effective for the determination of a women's eligibility for early medical termination of pregnancy[4].

Ultrasound scanning should be provided in a setting and manner sensitive to women's situation. Before ultrasound is undertaken, women must be asked whether they would wish to see the image or not. All ultrasounds must be registered under Pre-Conception and Pre-Natal Diagnostic Techniques (PC&PNDT) (Prohibition of Sex Selection) Act as applicable for all other ultrasounds of pregnant women.

According to the American Institute of Ultrasound in Medicine (AIUM), in collaboration with the American College of Obstetrics and Gynecology and the American College of Radiology, a "limited ultrasound examination" is performed when a specific question requires investigation[5].

A limited ultrasound exam must include the following:

(1) A full scan of the uterus in both the transverse and longitudinal planes to confirm an intrauterine pregnancy;

(2) Evaluation of embryo/fetal number;

(3) Measurements to document gestational age;

(4) Evaluation of pregnancy landmarks, such as yolk sac or the presence or absence of fetal/embryonic cardiac activity; and

(5) Placental location in second trimester

(6) When clinically indicated, evaluation of other pelvic structures (i.e., adnexal structures and the cul de sac) should be performed and documented or an appropriate referral should be made for further evaluation.

(7) When a patient with a prior uterine scar is found to have placenta previa or a low anterior placenta, or when other placental abnormality is suspected, additional sonographic imaging should be performed on-site or an appropriate referral made[6].

Ultrasound prior to MTP could be beneficial in following scenarios:

1.Documentation of pregnancy when there is a doubt about the presence of a pregnancy. 2.Dating of pregnancy when it is felt that the patient is not sure of her dates or the clinical examination does not correspond to history (period of amenorrhoea).

3.Diagnosis of co-existing mass like fibroid, helping determine its size & location.

4.Diagnosis of congenital uterine anomalies.

5.Diagnosis of Extrauterine gestation, Vesicular mole & Missed abortion.

6. Suspicion of Scar Ectopic

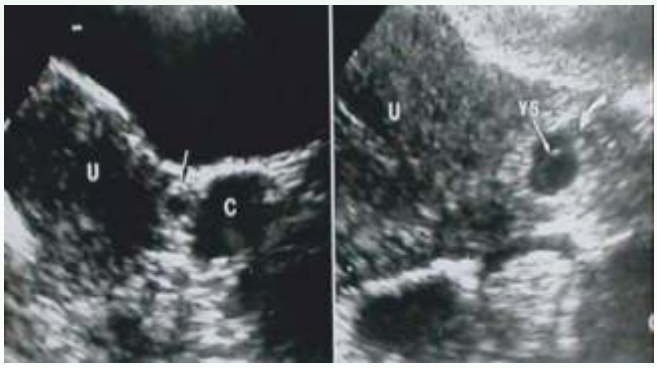

Fig. 1: Ectopic Pregnancy (TAS, TVS)

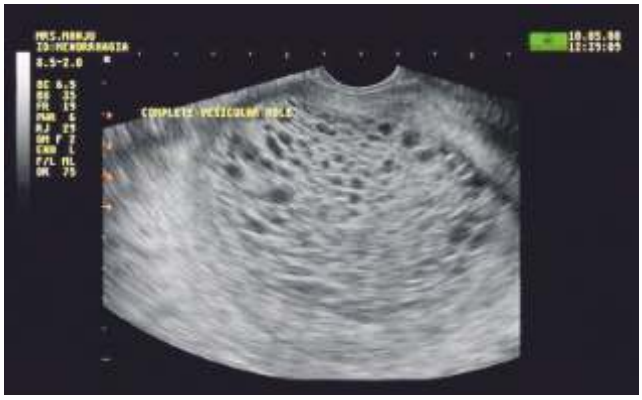

Fig. 2: Complete Vesicular Mole (TVS)

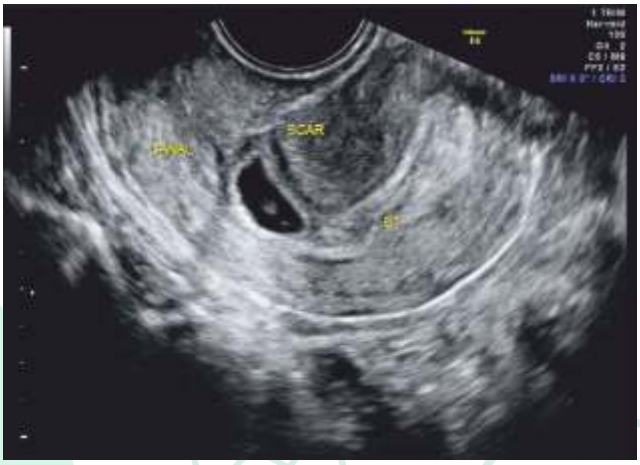

Fig 3: Scar Ectopic Pregnancy (TVS)

Missing an ectopic: There is a major fear amongst many service providers. However a large study done by Gynuity Health Projects, New York[7] showed that ectopic pregnancy was diagnosed very infrequently following medical abortion procedures, occurring in only 10 of 44,789 (0.02%) women. This eliminates the need of mandatory ultrasound before all medical abortions. However if the patient does not bleed 6 hrs. to 8 hrs. after the misoprostol dose then a suspicion of ectopic pregnancy must be made & appropriate diagnostic facility should be restored to. Seeking a second opinion and repeating scans before making a diagnosis in cases of miscarriage and ectopic gestation should be embedded in clinical practice to avoid medico-legal hassles. Performing dating USG before a first trimester uterine evacuation does not improve outcome or safety & it does not affect the rate of missed ectopic pregnancies (0.25%) or reduce incomplete abortions or ongoing pregnancy rates[8].

Torrential or intractable hemorrhage during surgical evacuation could lead to suspicion of cervical pregnancy which can be diagnosed with ultrasound. (Fig 4)

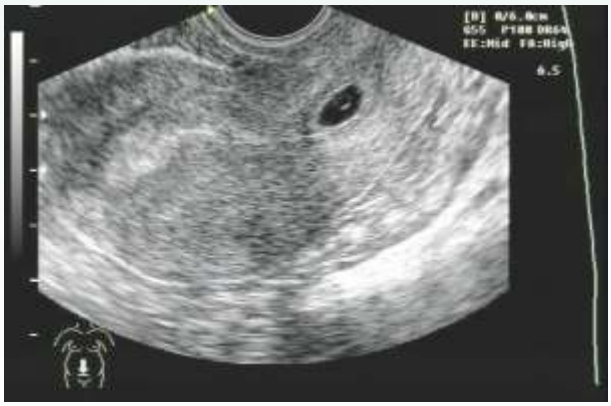

Fig 4 : Cervical ectopic pregnancy (TVS)

Ultrasound following medical or surgical MTP could be beneficial in following scenarios.

1.Incomplete evacuation
2.Failed medical abortion
3.Ruling out Gestational Trophoblastic disease
4.Patients after surgical evacuation presenting with symptoms suggestive of perforation.
5.Post MTP suspicion of heterotopic pregnancy or extrauterine gestation.

1. Incomplete Evacuation

Hyperechogenic shadows inside the uterine cavity with collection of fluid (bleeding) as an hypoechoic area can be seen. (Fig 5)

Cowett et al suggested that the mean endometrial thickness 24 hours after using misoprostol in women with a complete medical abortion may range from 7.6 to 29 mm[9,10]. One week after the abortion, the mean thickness was 11.3 mm but ranged from 1.6 to 24.9 mm. A thickness of more than 15 mm as suspicious for incomplete abortion. However if the thickness is more that 15 mm & the patient is clinically asymptomatic with no P/V bleeding she need not be subjected to vacuum aspiration even if the endometrial thickness is more than 15 mm. It is normal to visualize clot and debris in the uterus. Ultrasonographic assessment of retained products of conception (RPOC) focused on the depth of vascularity in combination with its size of affects to be essential in determining women with RPOC who are at high risk of severe post-partum (second trimester abortion) hemorrhage[11].

The final decision to intervene should be made on clinical signs and symptoms, such as ongoing or heavy bleeding, rather than on ultrasound findings.

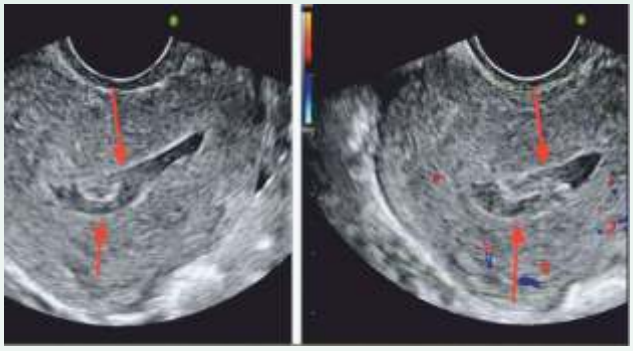

Fig 5: Retained products of conception

2.Intact Gestational Sac

Occasionally an intact sac is found on day 14 without cardiac activity (Fig. 6). Management in this situation can be expectant, or may involve a repeat dose of misoprostol or aspiration curettage.

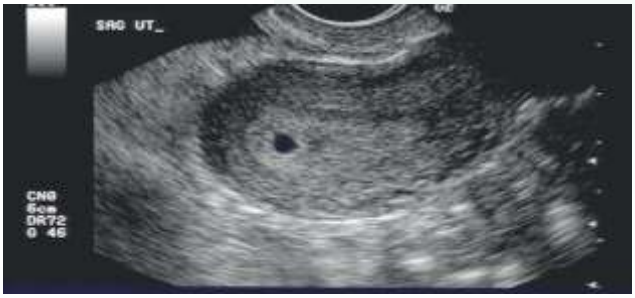

Fig 6: Intact Gestational Sac

3.Failure of medical abortion.

Presence of cardiac activity 2 weeks after the dose of misoprostol indicates failed medical abortion(Fig 7). If patient complains of continuation of amenorrhoea or pregnancy symptoms USG can confirm or rule out continuation of pregnancy

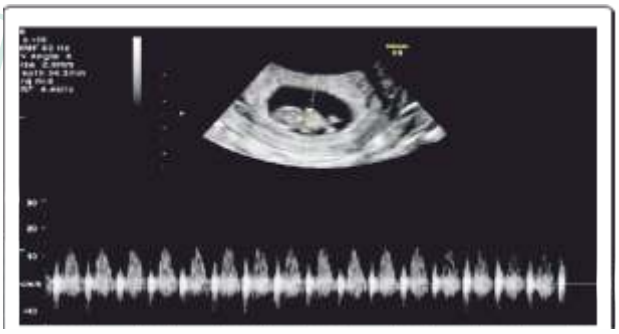

Fig 7: Cardiac activity in failed medical abortion.

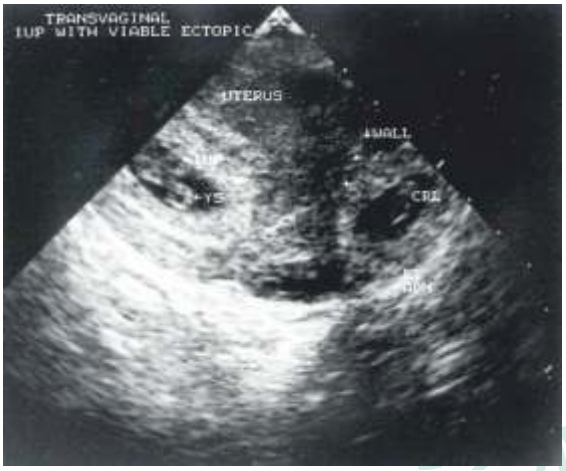

Fig. 8: Heterotropic Pregnancy (TVS)

The use of intraoperative continuous USG guidance is associated with a significant reduction in the complications of surgical terminations of pregnancy in the first trimester and appears to be safer than the conventional procedure without USG[12].

In sonographic images, there is of particular importance in vascularity (amount of flow) and vascular pattern (spot, strip-or circumferential flow) to differentiate between Retained products of conception (RPOC) alone & RPOC with Placenta Accreta Spectrum (PAS). All hypervascular RPOC cases had placenta accreta or increta by histopathological confirmation, not RPOC alone. There is need to emphasize the diagnosis of PAS in RPOC patients after first trimester termination[13].

Conclusion :

A . It is not mandatory to perform ultrasound before a medical termination of pregnancy.

B. There are certain situations where ultrasound may be helpful before, during and after a surgical abortion.

C. Ultrasound may be performed for dating a pregnancy with irregular cycles, lactation amenorrhoea, clinical discrepancy or uncertainty in examination and to exclude an ectopic gestation before a medical termination of pregnancy.

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MTP IN 1ST TRIMESTER

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Approach to case of MTP:

Pregnant women come for MTP.

1. Confirmation of pregnancy
2. Confirmation of gestational age (P/V or USG).
3. Identify indications of MTP.
4. Discussion on method of MTP (medical/surgical)

1. Obtain informed consent of women/guardian in form C.
2. Complete the form I (If gestation age is more than 20 weeks, opinion of two RMP's is required).

Provide MTP service.

1. Form C and Form I should be placed in a sealed envelope.
2. Secret and serial num should be written on the envelope.
3. Complete Form III: Admission register.
4. All forms to be kept in the custody of owner/ head of institute and should not be opened for routine inspection.
5. Only the Chief Medical Officer (CMO) has authority to inspect these confidential documents.
6. Strict confidentiality must be maintained.
7. Form II must be submitted to CMO's office every month.

1. Even in the case of medical abortions all the above forms must be filled.
2. All records to be preserved till a period of five years from the last entry in the register.
3. In the admission register, the serial number of MTP in that hospital for each year will restart from serial number 1 every calendar year.

Counselling :

Pre -procedure counselling:

If found eligible for MTP, explain to her, in simple language :

- The range of accessible choices of MTP techniques based on gestation and the MTP technique chosen by her.
- The likely risks associated with the procedure.
- The care required after the procedure.
- That this will not affect her future fertility, if performed under safe conditions.
- The immediate risk of pregnancy if no contraceptive method is used, as fertility can return within 10 days after the first trimester abortion and in something like four weeks after a second trimester.
- She should wait for at least six months prior to attempting to conceive again.
- Need and schedule for a follow-up.
- Help the woman to sign the consent.
- Discuss various contraceptive methods including their advantages.

COUNSELLING -If the woman is not ready to accept a contraceptive method:

- Do not refuse MTP, as she might go elsewhere, probably to an illegal abortion provider, and suffer complications.
- Guarantee the woman that she will not be refused MTP.
- Wait for a chance to counsel her after the procedure., call her for follow-up in seven days and counsel her again. Make a note on assessment findings, procedure, contraception or refusal to acknowledge contraception and counsel given (including referral).

Post-procedure counselling:

Critical steps during post-procedure counselling:

1. Continue to ensure privacy and confidentiality.
2. Intercourse should be avoided till bleeding stops.
3. Review in emergency in case of:
    i. Severe abdominal pain, Heavy vaginal bleeding, Fever, fainting, abdominal distention or severe vomiting
    ii. Follow-up visit within seven days after first trimester abortion and within two weeks after second trimester or later abortions.
    iii. If the patient refused contraception, counsel her again during follow up visit.

Abdominal tubectomy can be securely performed simultaneously with most pregnancy termination techniques. In any case, laparoscopic tubal ligation ought to be done solely after the primary trimester careful early abortions.

Clinical Assessment :

Clinical assessment for reasonableness to go through end of pregnancy is basic to stay away from complications while giving early abortions services. The assessment assists with distinguishing the one who needs reference for the strategy at a more elevated level of facility, which is better prepared and can deal with inconveniences, if any. Clinical assessment gives the accompanying information.

1. Confirmation of pregnancy.
2. Exact period of gestation.
3. Woman's general health condition.
4. Associated gynaecological disorders and infection.
5. Associated medical problems.

Components of Clinical Assessment:

A. History taking
B. Physical examination
C. Pelvic examination
D. Laboratory investigations

The assessment should ideally be led where the women and the provider shouldn't be visible or heard by others .

Methods of Abortion for Termination of Pregnancy :

Medical Methods of Abortion for Termination of Pregnancy in the First Trimester

Introduction : Medical methods of abortion (MMA) is a non-surgical termination of early pregnancy using a combination of drugs.

i. Description:
Medical methods of abortion include the use of mifepristone and misoprostol to induce and complete the abortion process.

ii. Mechanism of action :
- Mifepristone is a derivative of norethindrone with antiprogestin action. It binds to progesterone receptors in the endometrium and decidua, resulting in necrosis and detachment of POCs.
- It also softens the cervix and causes mild uterine contractions. Mifepristone sensitizes the uterus to the effect of prostaglandin.
- Misoprostol is a prostaglandin E1 analogue which binds to myometrial cells, causing strong myometrial contractions and cervical softening and dilatation. This leads to the expulsion of conceptus from the uterus.
- It is stable at room temperature and well absorbed from the gastro- intestinal tract and vaginal mucosa.
- Being selective for PGE1 receptors, there are no significant effects on bronchi and blood vessels, minimising its side-effects, as compared to other prostaglandins.

iii. Gestation limit :
A combination of mifepristone and misoprostol is approved for the termination of pregnancy up to nine weeks (63 days) LMP.

iv. Safety and efficacy :
A mix of mifepristone and misoprostol has a triumph pace of 95-close to 100% for early abortions. Mifepristone followed by misoprostol is a protected strategy to end pregnancy as long as the contraindications are not dismissed. MMA disappointment cases can introduce.

MMA failure cases can present as:

i. Heavy bleeding.
ii. Incomplete abortion.
iii. Continuation of pregnancy. 0.1-0.2% women may require blood transfusion following heavy bleeding.

Protocols for Mifepristone and Misoprostol:

Day 1-200mg oral mifepristone.

Day 3-800mcg oral misoprostol.

Day 15-Follow up, confirm and ensure completion of procedure.

Role of ultrasound examination

- **1.may be helpful for accurate dating** when there is a discrepancy in the size of the uterus by LMP and bimanual examination.

2However, this test is **not a mandatory** requirement for the provision of MTP. Where it is available, it can also be used to **detect ectopic pregnancies** along with quantitative βHCG measurements.

3.Since it is an obstetric USG, it must be done in accordance with the **Pre-Conception Pre-Natal Diagnostic Techniques (PCPNDT) Act.**

1st Visit -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 phone 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 counselling and services

Advantages and Limitations of MMA:

Advantages of MMA :

- Safe procedure with less complications and high success rate.
- Offers more privacy.
- Feasible with minimum technical assistance

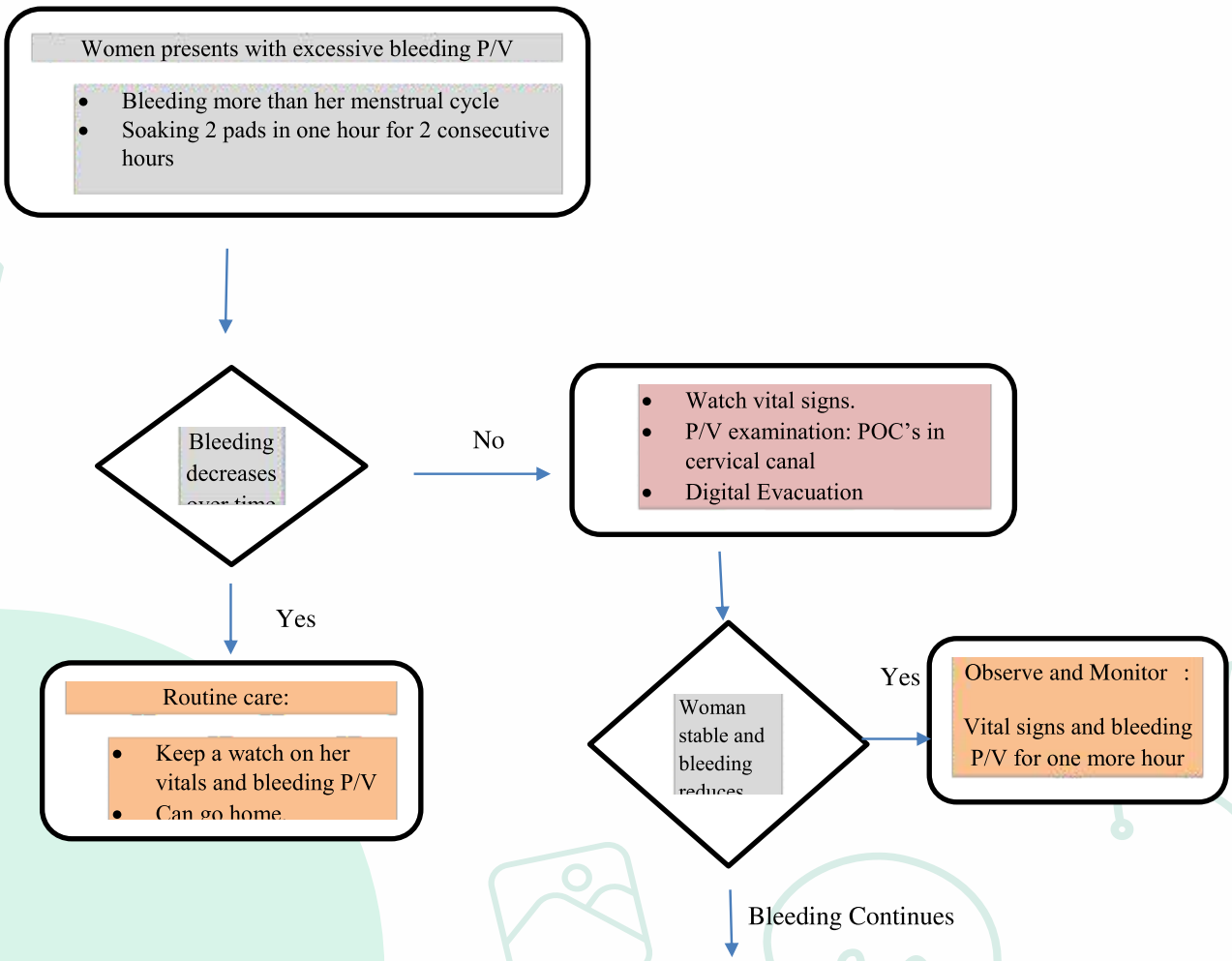
Limitations of MMA :

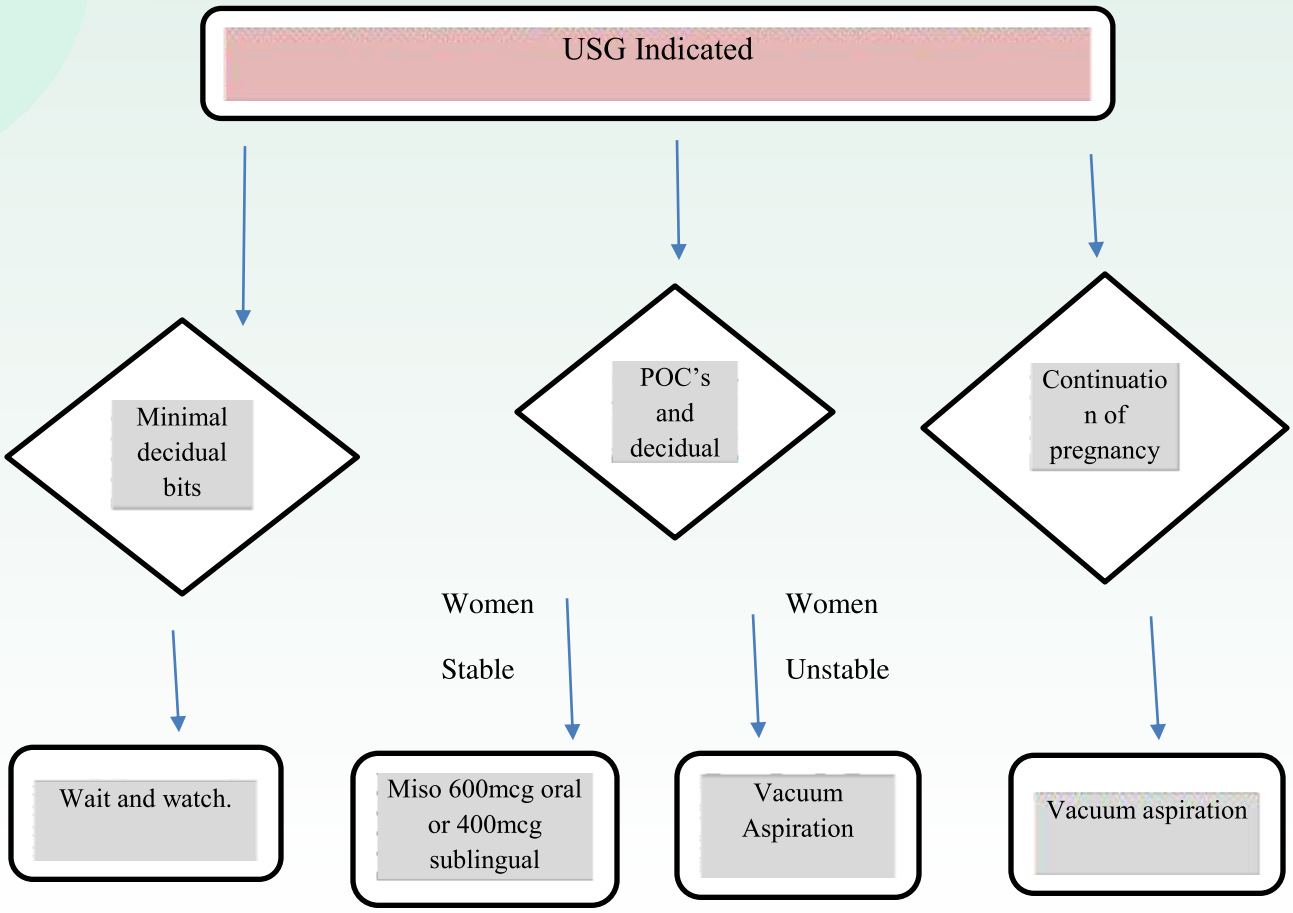
- Generally, three visits required (if misoprostol is regulated at home, a minimum of two visits required).
- Entire cycle takes more time, duration of bleeding can be 8-13 days. However, the bleeding decreases when the POC removal process is complete.
- Drugs used for termination may have side-effects.
- Potential risk of foetal malformation in situations where pregnancy continues due to the failure of MMA.

Complications:

Appropriate case determination, satisfactory advising and ideal reference are the way into the progress of medical methods of abortion.

i. Heavy bleeding .
ii. Incomplete abortion .





Algorithm for Management of Excessive Bleeding during MMA process

Documentation/Reporting of MMA Procedure :

Since MMA goes under the domain of the MTP Act, the documentation is like that expected for the VA technique.

It is compulsory to fill and record data for abortion cases, performed by MMA:

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

M.M.A CARD

Name of Health Centre: .....

.....

Name of Doctor : .....

Mobile Number : ..... Ph. No.: .....

	Day 1	Day 3	Day 15
Date			

In case of emergency, immediately contact

Name of Health Centre: .....

Phone Number: .....

Expected Symptoms:

During medical methods of abortion, you may experience one or more of the following symptoms which are self-limiting:

- More than normal menstrual bleeding
- Pain/cramps in the abdomen
- Fever/chills/ rigors
- Nausea or vomiting
- Diarrhoea
- Headache
- Dizziness

If you experience any of the following symptoms, immediately contact a doctor at the health centre:

Excessive bleeding – Soaking 2 or more thick pads per hour for 2 consecutive hours.

No bleeding within 24 hours after taking second drug.

Persistent fever and foul smelling vaginal discharge after taking second drug.

This chart will help you to assess your health during the 15 days of medical abortion process. Put a (✓) against the symptoms that you experience each day during these 15 days:

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

Note: Please visit the health centre for your scheduled day 3 and day 15 visit, or in case of any emergency situation. You may take support of an ASHA worker for visiting the health centre.

Vacuum Aspiration Techniques in the First Trimester :

Introduction to Vacuum Aspiration:

Vacuum aspiration is a strategy by which the contents in the uterus are evacuated through a cannula that is connected to a vacuum source. The term 'vacuum aspiration' incorporates both Manual Vacuum aspiration and Electric Vacuum.

Differences between Vacuum aspiration and Dilatation and curettage:

	Vacuum Aspiration	Dilatation and Curettage
Incidence of excessive bleeding, cervical and vaginal injury, uterine perforation	Lesser	2-4 times higher than VA
Dilatation required for the procedure	Lesser	Greater
Pain control medication	Lower Level	Higher Level
Recover period and hospital stay	Lesser	More
Post-procedure bleeding	Lesser	More

Indications, Contraindications and Special Precautions :

Indications for using vacuum aspiration :

Vacuum aspiration can be used for:

- Induced abortion of up to 12 weeks gestation/uterine size.
- Incomplete abortion, missed abortion of up to 12 weeks gestation/uterine size.
- Hydatidiform Mole of up to 12 weeks gestation/uterine size.
- Removal of decidua with surgical management of an ectopic pregnancy

Contraindications for vacuum aspiration :

- Presence of acute cervical, vaginal or pelvic infection.
- Suspicion of perforation.
- Suspicion of ectopic pregnancy

Types of Vacuum aspiration:

Vacuum aspiration can be performed using either MVA or EVA. The primary difference between the two Vacuum aspiration options is the source of the vacuum. MVA utilizes a handheld, portable aspirator though EVA utilizes an electrically operated device which is alluded to as the EVA or suction machine.

The preferred size of the cannula as per the gestation age/uterine size are:

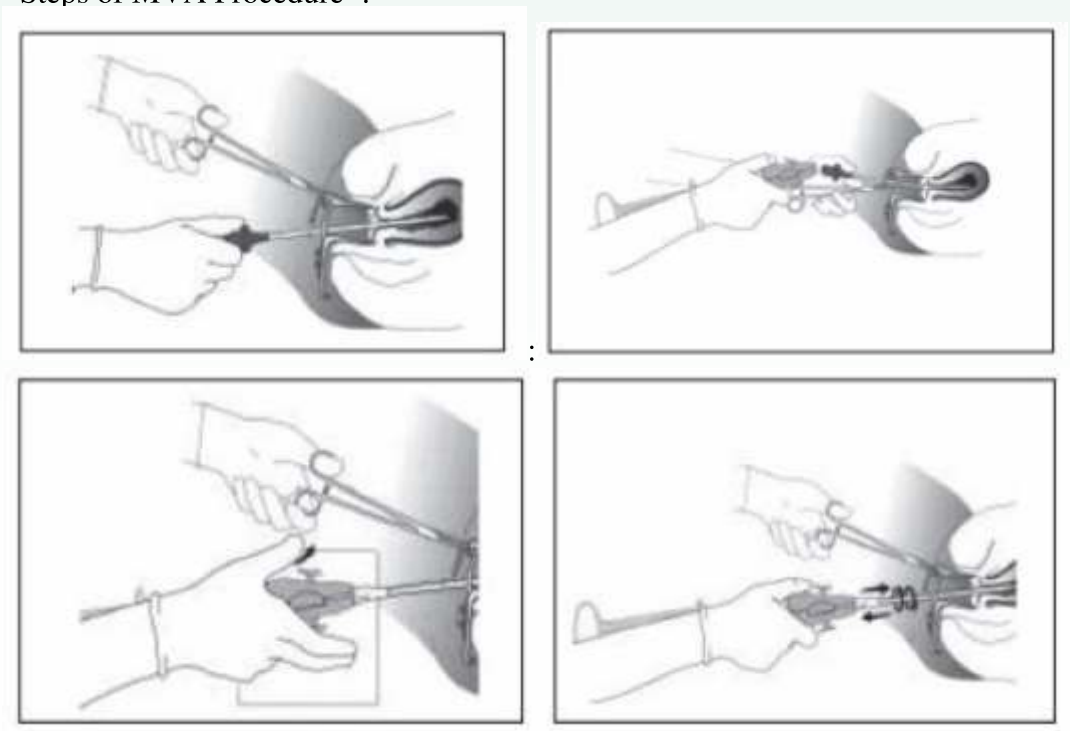
Uterine Size	Preferred Cannula Size
4-6 weeks LMP	4-6mm
7-9 weeks LMP	6-10mm
9-12 weeks LMP	8-12mm

Preparation for the procedure :

- Part preparation.
- Obtain informed consent for the procedure in Form C.
- Fulfilling requirements of the MTP Act and Rules.
- A dose of oral analgesic/antispasmodic should be given an hour before the procedure.
- Administer a single dose of prophylactic antibiotic such as oral.
- Ampicillin/Azithromycin 1gm and Metronidazole 800mg.

Procedure for Manual Vacuum Aspiration :

Steps of MVA Procedure :



:

- Prepare the instruments.
- Check the vacuum retention of the aspirator, prepare the woman.
- Ensure informed consent; ask the woman to empty her bladder. Perform cervical antiseptic preparation.
- Follow a no-touch technique.
- Perform a pelvic examination to confirm the assessment findings. Administer the paracervical block.
- Inject 2-4ml lignocaine at 4 and 8 o'clock positions, after aspirating.
- Use positive, respectful, supportive reassurance.
- Dilate the cervix.
- Gently dilate the cervix until the cannula fits snugly, insert the cannula and attach the aspirator Suction of uterine contents.
- Rotate the cannula in both direction and use an in and out motion, inspect the tissue.
- Empty the aspirator into a container and look for the POC. Complete the concurrent procedures.
- Assess the bleeding.
- Provide contraception instrument processing.

Post-procedure Care Immediately Following the Procedure :

i. Check the woman's vital signs.
ii. Evaluate abdominal pain.
iii. Observe bleeding per vaginum, which should decrease over.
iv. Vomiting /nausea

Follow-up Care After a vacuum aspiration procedure :
follow-up visit within one to two weeks.

During the follow-up visit:

- Assess the physical status and vital signs.
- Check bleeding per vaginum.
- Inquire about fever, pelvic or abdominal pain or cramps.
- Counsel regarding contraception.

Complications :

Complications during the procedure :

1. Haemorrhage :

Most important complication

Symptoms of haemorrhage :

i. Heavy bright red vaginal bleeding with or without passage of clots.
ii. Pallor

Management of Hemorrhage :

Rule outsources of bleeding.

i. If there is cervical injury-Apply pressure and suture it with chromic catgut or absorbable no.1-0 suture.
ii. If bleeding is from uterine cavity-Uterine massage should be done, uterotonics should be given.
iii. If bleeding continues or evacuation is incomplete, repeat vacuum aspiration should be done.

2. Uterine perforation :

Symptoms and signs of shock :

i. Rapid pulse and falling blood pressure.
ii. Severe abdominal pain.
iii. Abdominal rigidity and distension.
iv. Shoulder pain

Management of perforation :

Stop the procedure quickly and remove the instruments.

- Trendelenburg position (elevate the foot end of the bed and lower the head end) if there is hypotension.
- Start intravenous fluids (RL or NS).
- If the perforation is with a cannula/dilator of less than 8mm, either complete the procedure immediately under USG/laparoscopic guidance or after 48 hours, if she is stable. If intestine or omentum is seen on cannula, start an intravenous infusion and antibiotics.

- If properly equipped with complete laparotomy facilities, perform MTP in the facility itself under USG/laparoscopic guidance or refer to a higher level.
- Facility during transport, a trained healthcare provider should accompany the woman, continue oxygen, IV therapy, keep the woman warm and keep her feet elevated.

3. Fainting or syncope.
4. Shock

Delayed Complication :

i. Incomplete abortion.
ii. Infection / sepsis.

Remote Complication:

i. menstrual disturbance.
ii. Infertility.
iii. Recurrent abortion.
iv. Ectopic pregnancy.

Obstetrics complication :

Psychosomatic condition.

MTP In Minor :

- Must inform police as per POCSO Act.
- Can do procedure with consent of adult guardian.
- Clinical procedure is the same as nulliparous cervix.
- Pre and post procedure counselling.
- Proper pain management

POCSO Act :

- Reporting requirement for minors seeking termination of pregnancy under Protection of Children Against Sexual Offences Act, 2012 Protection of Children Against Sexual Offences requires anyone who knows that a sexual offence has been resolved to report the case to the appropriate authorities (either the Local Police or Special Juvenile Police) or to the concerned authority in the Hospital responsible for medico-lawful cases to report the same.
- Medical practitioners must remember that while finishing the reporting formalities, it is also important to ensure that services are offered to the client and all documentation is kept up with according to the arrangement of the laws.
- The Special Juvenile Police Unit or Local Police have to further report the matter to the Child Welfare Committee in 24 hours.
- Medical practitioners are not obligated to file an FIR or to conduct the investigation; the provider's duty is to only inform the authorities when providing services to a minor including abortion services under the existing provisions of MTP Act.
- Legal proceedings, if any, can continue simultaneously and should not be a hinderance in the process.

Documentation/Reporting of MTP Cases :

It is mandatory to fill and record information for abortion cases, performed by any method, in the following forms:

i. Form C – Consent form.
ii. RMP Opinion Form:
   a. Form I -opinion form (up to 20 weeks of pregnancy termination, Signed by 1 RMP).
   b. Form E - for 20 to 24 weeks pregnancy termination (signed by 2 RMP).
   c. Form D - beyond 24 weeks of pregnancy termination- approval of medical board required.
iii. Form II - has to be submitted at the end of month by the head of institutions.
iv. Form III (admission register)- must maintained till 5 Years, confidential document.
v. Form B -site approval certificate must display at the working place.

WHO CAN PROVIDE MEDICAL METHOD AND SITE ELIGIBILITY--

- **Provider's eligibility**: Only an RMP, as under the MTP Act, can prescribe MMA drugs
- **Site eligibility**: Medical Methods of Abortion up to seven weeks of gestation can be provided by an RMP under the MTP Act, from **an OPD clinic with established linkage to an approved si**te. However, a certificate to this effect by the owner of the approved site has to be displayed at the OPD clinic

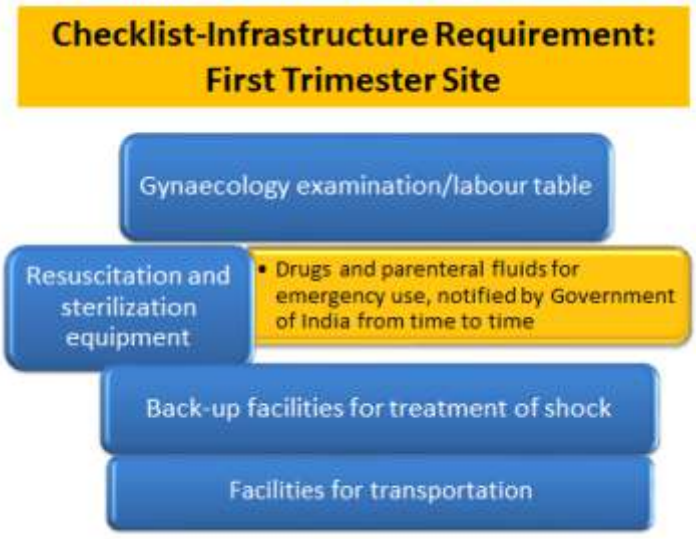
All the records of pregnancy termination have to be maintained for MMA also (Consent Form, RMP Opinion Form, Admission Register and Monthly Reporting Form

Documentation for Other Types of Abortion-

- Types: Spontaneous, Inevitable, Incomplete and Missed: **None of these come under the purview of the MTP Act.**

Documentation:

- Form I not required
- Consent as taken for any other procedure and not on Form C
- Procedure not recorded in Admission Register (Form III) but in Labour (OT) Procedure Register



- **Useful DOs DON'Ts**
- POSITIONING BY NHM
- 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 abou t nine percent of abortions are sex selective and therefore ninety percent are not.


सुरक्षित हो गर्भपात,
बेटी बचाओ के साथ

DAINIK MEERUT NEWS

MTP IN 2ND TRIMESTER

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Director Professor, Dept. Obstetrics & Gynecology,
UCMS & GTB Hospital Delhi
MTP Committee Chairperson FOGSI (2021-2025)

Places where 2nd trimester MTP can be done:

1. District Hospital –for MTP upto 24 weeks
2. Medical College – for MTP at any POG (upto 24 weeks & beyond)

Provider's eligibility – who can do and who can give the opinion for MTP beyond 12 weeks

- RMP with PG Degree or Diploma in Obstetrics & Gynecology
- RMP with MBBS degree and either of following
  6 months of completed house surgency or 1 year of experience in obstetrics & Gynecology having all the facilities

Always admit the Patient for 2nd trimester MTP.

Recommended methods for second Trimester Medical termination of Pregnancy are medical, mechanical and surgical.

Medical	Mechanical method	Surgical
Mifepristone and misoprostol regime Misoprostol alone regime	Foley;s supplemented by oxytocics	Dilatation and Evacuation (D & E) Hysterotomy

Extra amniotic ethacridine instillation or hypertonic saline are no more recommended.

Mifepristone and misoprostol for termination of Second trimester Pregnancy is not yet approved by DCGI. However, WHO recommends this method as the safest method for 2nd trimester MTP

D& E should not be done after 15 weeks gestational age.

Hysterotomy – is the last choice and must be considered if all the medical methods have failed or if the patient is having excessive bleeding, rupture uterus, unstable or in abnormal pacentation.

Thorough clinical assessment of the woman must be done, with detailed history
General physical examination for the general condition of the woman and pelvic examination.

Investigations (Recommended)

1. Hemoglobin
2. Routine Urine Examination
3. Blood Group: ABO Rh
4. USG – to know congenital fetal anomalies, uterine anomalies, gestational age, abnormal placentation, gestational age, any other abdominal or pelvic pathologies.
5. Other investigations must be done as per the case and as per PAC

Components of 2nd trimester MTP

1. **Admit the Patient**
2. High risk consent
3. Consent for MTP (Form C)
4. Pre- anesthetic check up
5. Counseling for surgical termination if there is failure of medical method or in case of complications eg. Bleeding, patient is unstable, rupture uterus etc.
6. Availability of Attendant

2nd Trimester MTP - drug regimen

Gestational age	Combination regimen		Misoprostol only regimen
	Tab.Mifipristone	Tab. Misoprostol D-2 or D-3	
12 – 24 weeks	D-1 200 mg oral once	400 µg B,PV,SL and repeat 3 hourly	400 µg B,PV,SL and repeat 3 hourly
25 – 28 Weeks		200 µg B,PV,SL and repeat 3 hourly	200 µg B,PV,SL and repeat 3 hourly
Beyond 28 weeks		100 µg B,PV,SL and repeat 3 hourly	100 µg B,PV,SL and repeat 3 hourly

- There is **NO** Maximum dose of misoprostol. If an abortion is not complete after 5 doses, continue the doses or give rest for 12 hours and start again
- or rest for 12 hours and start again
- Minimum interval between mifipristone & misoprostol to be 24 hrs
- Misoprostol is not contraindicated in grand multipara.
- Routine aspiration after medication abortion is not required or recommended
- Combination regimen of mifepristone-misoprostol is slightly more effective than misoprostol alone
- Misoprostol is SAFE below 28 weeks EVEN with history of Cesarean Delivery
- Misoprostol is not recommended in women ≥28 weeks gestational age with a prior Cesarean Delivery

Mechanical Method Supplemented by Oxytocics

Foley's catheter –

1. Insert just beyond internal os in extra amniotic space
2. Instill 5-10 ml of saline in the balloon (according to the capacity of the ballon)
3. Apply traction – tape

4. retain for at least 4 to 6 hours or till Foleys falls off , get cx dilatation upto 2 -2.5 cms
5. supplement by oxytocics

Monitoring

Woman's vital signs must be monitored every 4 hrly (initially) and every 2 hrly , once there are strong uterine contractions

Always examine the fetus and placenta - to confirm that the expulsion is complete

Points to remember

Routine USG should not be used to screen for incomplete abortion; as USG appearances correlate poorly with retained POCs

Routine uterine curettage following complete expulsion of the fetus and placenta is unwarranted

As misoprostol with or without mifepristone results in low rates (< 10%) of retained placenta

Uterine evacuation by vacuum aspiration (or curettage, where aspiration is unavailable) to remove the placenta should only be performed

- Heavy bleeding
- Fever
- Retained placenta, beyond 3–4 hours of expulsion of fetus

Trouble-shooting during Second Trimester Termination by Medical Methods

If membranes are ruptured before cervical dilatation
Use misoprostol - Bucally or sublingual

If Placenta -not expelled within ½ hour of fetal expulsion

- Repeat the dose of misoprostol
- 20 U oxytocin in 500-ml, 5% Dextrose or Ringer Lactate @ 50 ml/h
- Cord traction method: While awaiting placental expulsion, periodically apply slight tension on the cord, avoiding the tearing of the cord

If fetal expulsion does not occur within 24 hours from the initial dose
Re-evaluate, do USG to rule out

- Wrong dates and diagnosis
- Rupture uterus
- Abdominal pregnancy

• **If patient is Stable** –give rest (12 hours, minimum is recommended by FIGO 2023) & individualize the treatment. Either repeat the same regime or terminate surgically
[There are no studies that directly compare repeating the same regimeto changing to a different regime]

• **If the patient is Unstable** – Stabilize and terminate the pregnancy surgically

MTP Act amendment 2021 has permitted MTP upto 24 weeks pregnancy and in cases of fetal congenital anomalies, pregnancy can be terminated after 24 weeks gestational age, with the approval of medical board.

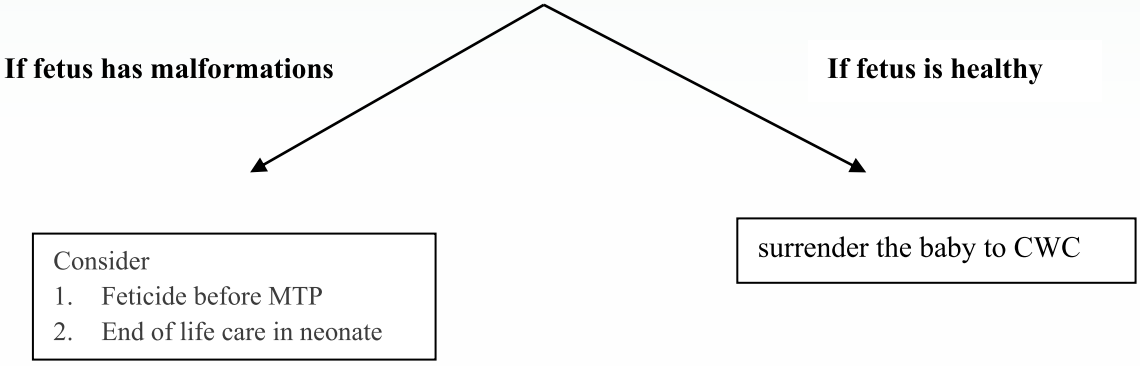
Advanced pregnancy termination with uterotonic agents have their inherent risk for the occurrence of a live birth, which can be the source of emotional anguish for women and the wastage of healthcare resources.

- ***Two options can be considered before MTP in an anomalous fetus***

1. Feticide before MTP
2. End of life care in neonate

NOTE : In case a healthy pregnancy is terminated after the period of viability, after court's & medical board decision (eg sexual assault victim carrying normal fetus and is beyond 24 weeks gestation, then in such cases patient party have to file a writ petition and then court may direct any medical board to take the decision).This unwanted child can be surrendered to the Child welfare committee (CWC) and the child will be under Child care institution (CCI) and later following due procedure, can be legally free for adoption.

Fig.1 MTP after the period of viability



Couple should be informed about the options and the risks, a written and informed consent should be obtained **before admitting the patient for MTP**. Their socio-cultural, ethical, and legal perspectives must always be taken into consideration

Feticide before MTP or induced fetal cardioplegia must be considered if MTP is decided for the malformed fetus, beyond the period of viability. Accordingly couple must be counseled and their choice must be clearly documented, before MTP is started.

The Ministry of Health and FamilyWelfare in its guidance note for medical boards has recommended procedure to stop heart beats as per the Royal College of Obstetricians and Gynaecologists (RCOG) guidelines (M12015/58/2017-MCH, dated 14/08/2017 by Ministry of Health and Family Welfare, GOI)

Couple should be informed about the options, risks & benefits of the procedure. Written and informed consent should be obtained

Their socio-cultural, ethical, and legal perspectives must always be taken into consideration

Feticide should only be performed in tertiary referral centers, by a Gynecologist, capable of performing feticide or a fetal medicine specialists with the appropriate level of training, using aseptic conditions and with continuous ultrasound. The PCPNDT act will be applicable while performing feticide

Procedure

1. Use lidocaine as a local anaesthesia over the skin of the injection site
2. Ultrasound guidance
3. Spinal needle (20 - 22 gauge, with adequate length) to slowly inject the medication (use the smallest effective dose) Table 1
4. In the case of multiple gestations, inject each sac/ fetus separately to induce asystole
5. Confirm asystole;

Can be **confirmed immediately** with intrafunic or intracardiac injection

And **24 hours after** using intrafetal or intra-amniotic digoxin injection, another injection may be administered if needed

6. Ensure haemostasis
7. Apply dressing over the injection site

Table 1- Doses,routes,efficacy of different feticide drugs

Injection of Potassium chloride (KCl) (intrafunic or intracardiac)	**Injection of Digoxin (intra-amniotic or intrafetal)**	**Injection of Lidocaine (intra-cardiac or intra-thoracic**
Highly effective	Digoxin has a higher failure rate than KCl when used to induce intrauterine fetal asystole	Lidocaine is rapidly effective
Administered on the day of the abortion or one day prior	Digoxin requires time for fetal absorption one day before misoprostol regardless of whether or not mifepristone is also used)	Administered on the day of abortion or one day prior
Asystole is immediately observed at the time of the injection	Asystole is usually confirmed before initiation of abortion	Cardiac cessation is observable within approximately 5 minutes
Requires expertise	technically easier to use and does not require USG if administered intra-amniotically Digoxin has demonstrated safe maternal serum levels at or below therapeutic digoxin levels	Precise intracardiac injection requires more expertise than intrathoracic placement both methods are highly effective Lidocaine presents minimal maternal risks It may be a safe alternative in settings where digoxin or KCL are not available
4 to 6 mEq	1 to 2 mg	200 to 240 mg

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PREVENTION AND MANAGEMENT OF COMPLICATIONS DURING MTP

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Introduction

Government of India has made an act to regulate the abortion. **This act is 'The Medical Termination of Pregnancy Act, 1971'** which was amended in 2021 stipulating a ceiling of 20 weeks, for termination of pregnancy, beyond which abortion of a fetus is statutorily impermissible. The amendment expands the access to safe and legal abortion services on therapeutic, eugenic, humanitarian and social grounds to ensure universal access to comprehensive care[2].

Amendment now gives the option of MTP to unmarried/ married women for failure of Contraceptive Method or Device.

- Increased the upper gestation limit from 20 to 24 weeks to rape survivors, victims of incest and other vulnerable women (differently-abled women, minors, among others).
- And MTP for foetus even beyond 24 week having substantial genetic abnormalities.
- The 'name and other particulars of a woman whose pregnancy has been terminated shall not be revealed', violators will be punished by fine and imprisonment.

Medical Termination of Pregnancy (MTP) is a procedure of abortion or terminating pregnancy using only medications. Pregnancy can be terminated with medical management in the early stages of pregnancy (7-9 weeks) otherwise, surgical procedure is needed.

There can be numerous complications regarding the medical termination of pregnancy. First of all pregnancy test is conducted or ,an ultrasound examination is done to check the age of the pregnancy, also to confirm if the pregnancy is not outside the uterus (ectopic pregnancy) or it's not molar pregnancy. Tests for anaemia, sexually transmitted diseases or other health complications are done.

Complications

The total abortion-related complication rate is estimated to be about 2%.

Most complications are considered minor such as:

- Pain,
- Bleeding
- Infections
- Post-anesthesia complications.

Others are major, including:

- Uterine atony and subsequent hemorrhage,
- Uterine perforation,
- Injuries to adjacent organs (bladder or bowels),
- Cervical laceration,
- Failed abortion,

- Septic abortion, and
- Disseminated intravascular coagulation (DIC)[5]

The incidence of abortion-related emergency department visits within six weeks of the initial abortion procedure is about 40%.

There are three major mechanisms by which abortion complications can be classified.

Infection can be the result of a **failure to exercise universal precautions prior to the procedure**, such as hand washing, surgical glove use, proper sterilization of the field, use of non-sterile instruments, as well as the presence of a pre-existing infectious process in a patient such as cervicitis or endometritis. The risk of death from septic abortion increases with the progression of gestation.

Prevention and control of infections

Since abortion procedures involve contact with blood and bodily fluids, all clinical and support staff must adhere to standard precautions for infection prevention and control to protect both themselves and patients.

Standard precautions (also known as universal precautions) include:

- Applied in all situations involving potential contact with blood, body fluids (excluding sweat), non-intact skin, and mucous membranes.
- Followed regardless of infection status or diagnosis to prevent disease transmission between patients and healthcare workers[4].

Key measures :

1. Hand hygiene: Hand washing with soap and running water before and after patient contact, even when gloves are used.
2. Gloves: Worn and replaced between patient contacts and after vaginal or rectal examinations. Hands should be washed after glove removal.
3. Personal protective equipment (PPE): Gowns, gloves, masks, and protective eyewear should be used appropriately. Sterile booties do not significantly reduce infection rates and add cost.
4. Aseptic technique: Clean the cervix with antiseptics (e.g., betadine) before surgical abortion procedures.
5. Safe handling of sharps: Proper disposal of blades and needles.
6. Instrument processing: Ensure correct handling, sterilization, and disposal of instruments and materials.

Incomplete evacuation of the products of conception leads to the collection of blood in the uterus, causing overdistention and atony which results in haemorrhage. It can also lead to infection and possible sepsis.

Injury from the surgical procedure itself depends upon the method used and includes vaginal or cervical lacerations, as well as uterine, bowel, or bladder injury.

Pain

Bleeding and cramping pain are the most commonly observed side effects of medical abortion, affecting nearly all patients. Appropriate pre-procedural counseling regarding the process can significantly enhance pain tolerance, as pain perception is modulated by psychological factors such as fear, anxiety, and emotional state. Analgesic agents like acetaminophen, ibuprofen, or paracetamol—administered alone or in combination with opioids such as codeine or oxycodone—are effective for managing pain.

In cases where pain persists despite the use of standard analgesics for several hours, further clinical assessment is warranted to rule out complications such as ectopic pregnancy, infection, or incomplete abortion.

Bleeding

Pre-abortion counseling should highlight that post-abortion bleeding is typically heavier than a normal menstrual period and may include the expulsion of tissue or clots. It is advised that patients contact healthcare providers if bleeding exceeds two sanitary pads per hour for two consecutive hours. The need for blood transfusion and emergency curettage is rare, occurring in less than 1% of cases. Bleeding duration is variable, typically ranging from 9 to 13 days. Counseling should also emphasize that even with prolonged bleeding, significant hemoglobin decline is uncommon in medically managed abortions.

Emergency evaluation of bleeding should involve:

- Determining the stage of the abortion process and medications administered.
- Quantifying bleeding, including pad use, clot passage, and soakage levels.
- Assessing whether the bleeding is intermittent or continuous.
- Evaluating the patient's physical activity levels.
- Reviewing any medications or substances used by the patient.
- Monitoring for symptoms such as dizziness, weakness, or fatigue.

Indications for surgical intervention include:

- Persistent or recurrent heavy bleeding unresponsive to medical management.
- Signs of orthostatic hypotension or hemodynamic instability.
- Hemoglobin levels below 7 g/dL, especially with ongoing hemorrhage.
- Patient preference for surgical evacuation.
- Challenges in accessing emergency care services.

Failed/Incomplete Abortion

A failure of medical abortion is diagnosed when transvaginal ultrasonography (TVS) detects fetal cardiac activity two weeks after administration of mifepristone or methotrexate. Surgical evacuation is indicated in 0.1–0.5% of patients for cases of incomplete abortion, missed abortion, or continuing pregnancy.

Clinicians must differentiate between incomplete abortion and the normal post-abortion course. Heterogeneous intracavitary echoes on ultrasound, due to the presence of blood clots and decidual tissue following expulsion, are common and should not be misinterpreted as incomplete abortion. Conservative management is appropriate in such cases, with patients reassured and followed until normal menstruation resumes in 4–6 weeks.

Gastrointestinal Side Effects

Medications used in medical abortion are associated with mild gastrointestinal adverse effects. Nausea is the most frequently reported symptom, followed by vomiting and diarrhea, although these are less common. These side effects are generally self-limiting and do not require therapeutic intervention. Gastrointestinal disturbances are attributed to the prostaglandin analogues used in the regimen, with higher incidence observed with oral administration compared to intravaginal routes.

Headache, Dizziness, and Thermoregulatory Changes

Headaches and dizziness are typically mild and transient. Dizziness, unless secondary to excessive blood loss, can be managed conservatively through rest, hydration, and slow positional changes, with assistance for ambulation if necessary.

Transient thermoregulatory symptoms such as hot flushes, sensations of warmth, or transient fever are common and generally resolve spontaneously. Persistent fever may indicate infection and should prompt further investigation.

Endometritis

Endometritis is an uncommon complication of medical abortion, largely because the procedure does not involve instrumentation of the cervix or uterine cavity. Any genital tract infection identified during the pre-abortion evaluation should be treated promptly[6].

Patients presenting with persistent pelvic pain, irregular bleeding, fever, foul-smelling discharge, or adnexal tenderness following pregnancy expulsion should be evaluated for endometritis or incomplete abortion. Clinical examination may reveal uterine enlargement, tenderness, and softening. Ultrasonography is useful in such cases, and infection should be managed with a combination of doxycycline and metronidazole. Current evidence does not support the routine use of prophylactic antibiotics in medical abortion.

Teratogenicity

It is critical to counsel patients regarding the need for surgical abortion if pregnancy continues following medical abortion. While no evidence suggests teratogenicity of mifepristone, methotrexate, an antimetabolite, may cause fetal malformations when used in high doses for chemotherapy. Data on teratogenic effects of low-dose methotrexate are limited. Misoprostol, when used in the first trimester, has been associated with congenital anomalies, possibly due to decreased uterine blood flow during organogenesis.

Goralez et al. reported seven cases of limb anomalies, including four cases with Mobius syndrome, characterized by mask-like facies, bilateral 6th and 8th cranial nerve palsy, and often accompanied by micrognathia.

Healthcare providers must thoroughly inform women about the potential teratogenic risks of these medications and emphasize the necessity of surgical evacuation in cases of ongoing pregnancy.

Evaluation

The following lab tests are helpful in the evaluation of post-abortion complications:

- **Complete blood count (CBC)** to assess a drop in haemoglobin/haematocrit which may be indicative of ongoing haemorrhage.
- Complete metabolic panel to assess any **renal, hepatic, or electrolyte abnormalities**.
- **Beta-human chorionic gonadotropin (Beta-hCG)** to establish a baseline to monitor the predicted decline in level or to compare with the pre-existing level.
- **Coagulation profile**, especially if a patient is expected to go to the operating room.
- Blood type/Rh with antibody screen to establish the need for Anti-D and/or for possible impending blood transfusion.
- **Blood cultures** if sepsis is suspected.
- If DIC is suspected, **fibrinogen, fibrin-split products, and d-dimer** should be obtained.

Imaging Studies

- Abdominal X-rays should be obtained to rule out bowel perforation.

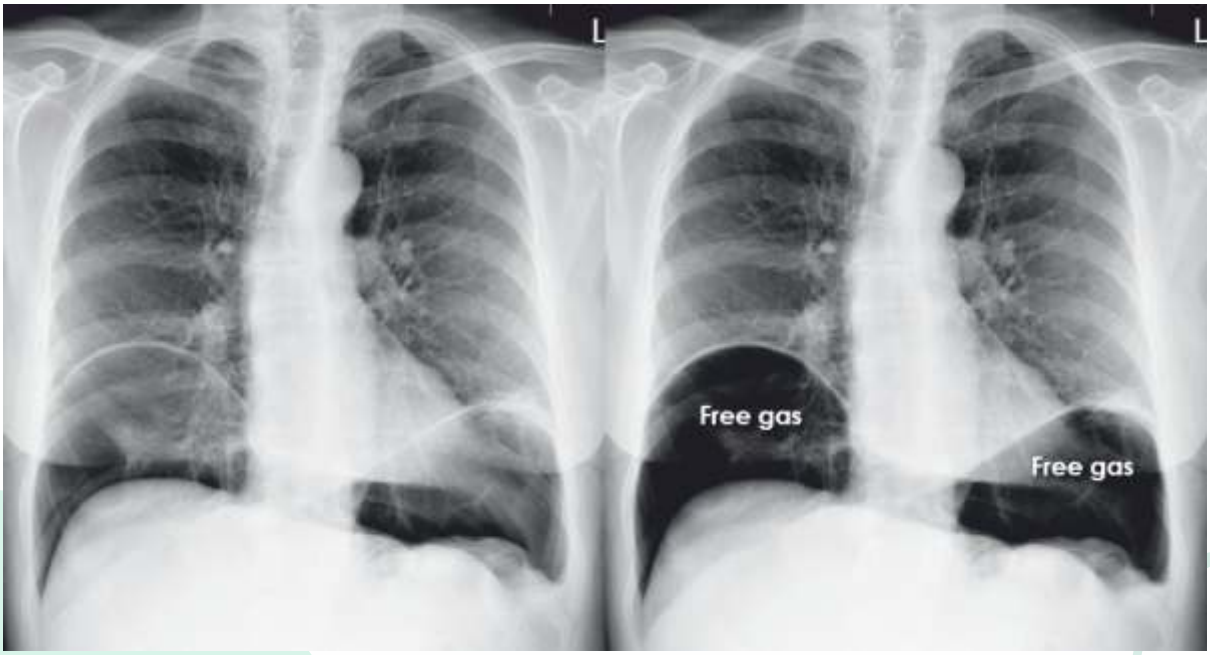


FIG 1 – Abdominal X Ray showing Bowel Perforation.

- Pelvic ultrasound (US) should be done to rule out an ectopic pregnancy.
- Computed tomography (CT) scan should be done to assess for fluid collection in the pelvis, retained by-products, and adnexal mass.

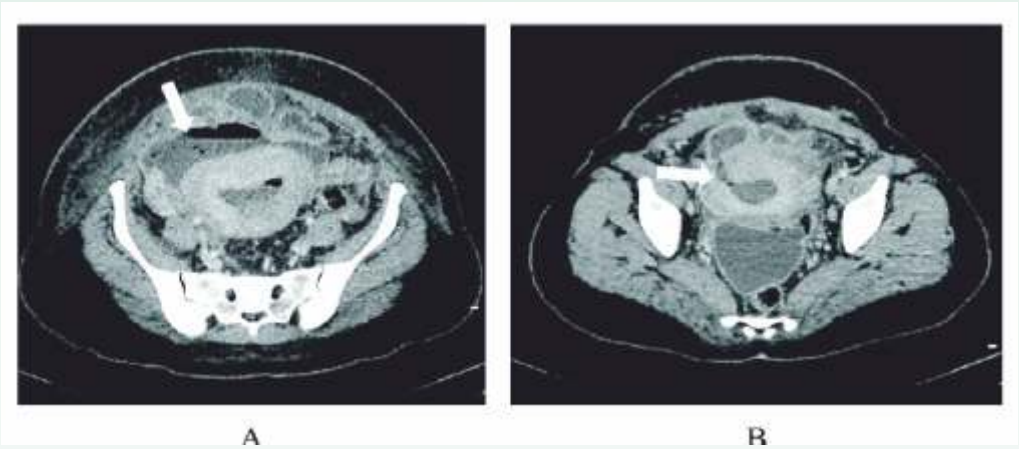


FIG- 2 Computed tomography demonstrating a) fluid collection anterior to the uterus that communicates with the endometrial cavity and b) defect in the anterior wall of the uterus

Treatment / Management

As always, ABC is first.

The patient's hemodynamic status must be assessed immediately, and intravenous access obtained.

If the patient exhibits **signs of volume depletion**, the practitioner must start resuscitation with intravenous crystalloid fluids and assess the volume of blood loss.

The potential for blood transfusion must be anticipated. The patient's vital signs, the rate of bleeding, and the overall condition must be monitored constantly for improvement or deterioration.

Consider oxytocin administration if **uterine atony** is highly suspected.

If the bleeding persists**, DIC (Disseminated Intravascular Coagulation)** should be considered, and the patient should be prepared for transfer to the operating room/intensive care unit.

In addition to volume resuscitation, patients with a triad of pain, bleeding, low-grade fever should be treated for pain with either non-steroidal anti-inflammatory drugs or opioids, and broad-spectrum antibiotics must be started immediately, preferably intravenously.

In most cases, the patient will require the **evacuation of blood clots and/or retained products of conception**.

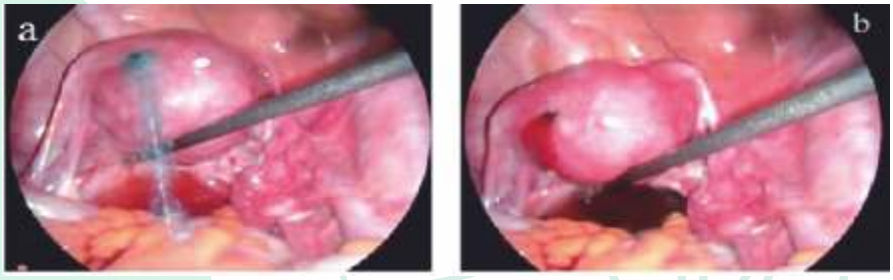
Uterine Perforation

Cervical dilatation and curettage (D&C) are among the most commonly performed gynaecological procedures worldwide despite being highly invasive. This procedure is most widely used for surgical termination of pregnancy.

If **uterine perforation or bladder or bowel injury** are suspected, patients need hemodynamic resuscitation and expedited transfer to the operating room followed by Laparoscpy SOS Exploratory Laparotomy.

The diagnosis of uterine perforation can be clinically suspected if the patient presents acute abdominal pain, heavy vaginal bleeding or any sign of internal bleeding such as hypotension or tachycardia imagistic detection of peritoneal free fluid.

The clinical manifestations can range broadly from mild to severe, depending on the size and cause of the uterine wall injury and related to the location of the perforation most frequent on the body of the uterus, followed by the anterior wall (40%), the cervix (36%) and lastly the fundus of the uterus (13%).



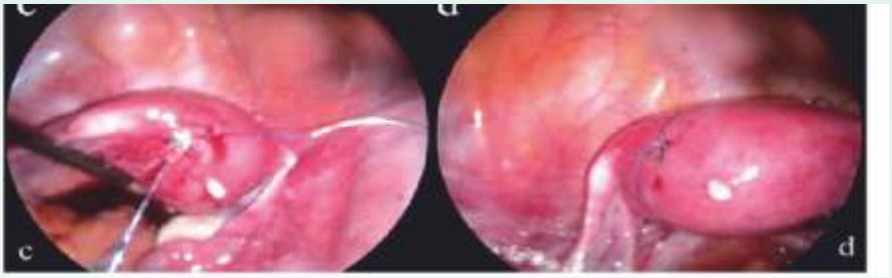


FIG 3- a: Uterine perforation from the fundus b: Bleeding from the perforation site c and d: Intracorporeal suture to control the bleeding and restore the uterine wall integrity[8].

A transvaginal ultrasound examination can show the presence of a discontinuity in the uterine serosa with a hyperechoic mass protruding in the wall of the uterine body and cavity extending from the uterine fundus to the cervical external os.

When recognised, uterine perforation can be treated conservatively if the patient's general condition is good, there is no profuse bleeding, and there are no estimated risks related to lesions of the abdominal viscera. Conservative management usually includes hospitalisation, placement of a urinary catheter, antibiotic therapy and vital signs monitoring to detect possible bleeding, peritonitis or intestinal obstruction

Bowel and bladder perforation requires prompt medical intervention due to the risk of peritonitis, sepsis, and other complications. Treatment typically involves :

1. Stabilization: Initial management includes fluid resuscitation, blood pressure support, and broad-spectrum antibiotics to prevent infection.

2. Surgical Intervention:

- Bowel Perforation: Emergency surgery (e.g., laparotomy) is often needed to repair the perforation or resect the damaged bowel section, followed by anastomosis or the creation of a stoma.

- Bladder Perforation: Depending on severity, surgical repair may involve either open or laparoscopic procedures. For smaller perforations, catheterization might allow healing without surgery.

3. Postoperative Care-Includes monitoring for infection, ensuring bowel and bladder function recovery, and addressing potential complications such as abscess formation or fistula development.

If a **septic abortion** is suspected, sepsis treatment must be instituted according to institutional guidelines. Broad-spectrum antibiotics must be initiated as early as the diagnosis is considered, and arrangements need to be made to transfer the patient to the operating room.

In a hemodynamically stable patient, pelvic ultrasonography should be obtained to look for retained products of conception, failed abortion, continued pregnancy, or ectopic pregnancy.

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DOCUMENTATION WITH FORMS

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MMA Card

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

M.M.A CARD

Name of Health Centre: .....

.....

Name of Doctor : .....

Mobile Number : ..... Ph. No.: .....

	Day 1	Day 3	Day 15
Date			

In case of emergency, immediately contact

Name of Health Centre: .....

Phone Number: .....

Expected Symptoms:

During medical methods of abortion, you may experience one or more of the following symptoms which are self-limiting:

- More than normal menstrual bleeding
- Pain/cramps in the abdomen
- Fever/chills/ rigors
- Nausea or vomiting
- Diarrhoea
- Headache
- Dizziness

If you experience any of the following symptoms, immediately contact a doctor at the health centre:

Excessive bleeding – Soaking 2 or more thick pads per hour for 2 consecutive hours.

No bleeding within 24 hours after taking second drug.

Persistent fever and foul smelling vaginal discharge after taking second drug.

This chart will help you to assess your health during the 15 days of medical abortion process. Put a (✓) against the symptoms that you experience each day during these 15 days:

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

Note: Please visit the health centre for your scheduled day 3 and day 15 visit, or in case of any emergency situation. You may take support of an ASHA worker for visiting the health centre.

Form C

(See rule 9)

I……..daughter / wife of……

aged about…….years of …… (here state the permanent address) at present residing at……..

do hereby give my consent to the termination of my pregnancy at……

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

Place:

Date: Signature

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

I……son/ daughter/wife of……

aged about……..years of……..at

(Permanent address)

present residing at……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 pregnancy)

Place:

Date: Signature

FORM I

RMP Opinion Form

(For gestation age upto twenty weeks)

[See Regulation 3]

I _____

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

_____

(Full address of the Registered Medical Practitioner)

hereby certify that I am of opinion, formed in good faith, that it is necessary to terminate the pregnancy of _____

(Full name of pregnant woman in block letters)

resident of_____

(Full address of pregnant woman in block letters)

for the reasons given below*.

I hereby give intimation that I terminated the pregnancy of the woman referred to above who bears the Serial No. _____ in the Admission Register of the hospital/approved place.

Place:

Date:

Signature of the Registered Medical Practitioner

*of the reasons specified items (a) to (e) write the one which is appropriate:

a. in order to save the life of the pregnant women,
b. in order to prevent grave injury to the physical and mental health of the pregnant woman,
c. in view of the substantial risk that if the child was born it would suffer from such physical or mental abnormalities as to be seriously handicapped,
d. as the pregnancy is alleged by pregnant woman to have been caused by rape,
e. as the pregnancy has occurred as a result of failure of any contraceptive device or methods used by a woman or her partner for the purpose of limiting the number of children or preventing pregnancy.

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

Place:

Date: Signature of the Registered Medical Practitioner

FORM E

Opinion Form of Registered Medical Practitioners
(For gestation age beyond twenty weeks till twenty-four weeks)
[See sub-rule (2) of rule 4A]

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 we are of opinion, formed in good faith, that it is necessary to terminate the pregnancy of

_____
(Full name of pregnant woman in block letters)

resident of _____
(Full address of pregnant woman in block letters)

which is beyond twenty weeks but till twenty-four weeks under special circumstances as given below*.

*Specify the circumstance(s) from (a) to (g) appropriate for termination of pregnancy beyond twenty weeks till twenty-four weeks:

(a) Survivors of sexual assault or rape or incest
(b) Minors
(c) Change of marital status during the ongoing pregnancy (widowhood and divorce)
(d) Women with physical disabilities [major disability as per criteria laid down under the Rights of Persons with Disabilities Act, 2016 (49 of 2016)]
(e) Mentally ill women including mental retardation
(f) The foetal malformation that has substantial risk of being incompatible with life or if the child is born it may suffer from such physical or mental abnormalities to be seriously handicapped
(g) Women with pregnancy in humanitarian settings or disaster or emergency situations as declared by Government

We hear by give intimation that we terminated the pregnancy of the woman referred to above who bears the Serial No. _____ in the Admission Register of the hospital / approved place.

Signature of the Registered Medical Practitioner

Signature of the Registered Medical Practitioner

Place:
Date:

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

FORM D

(See sub-clause (ii) of clause (b) of rule 3A)

Report of the Medical Board for Pregnancy Termination Beyond 24 weeks

Details of the woman seeking termination of pregnancy:

1. Name of the woman:
2. Age:
3. Registration/Case Number:
4. Available reports and investigations:

S.No	Report	Opinion on the findings

5. Additional Investigations (if done):

S.No	Investigations done	Key findings

6. Opinion by Medical Board for termination of pregnancy:
   a) Allowed
   b) Denied

   Justification for the decision:

7. Physical fitness of the woman for the termination of pregnancy:
   a. Yes
   b. No

Members of the Medical Board who reviewed the case:

S.No	Name	Signature

Date and Time: ……

FORM III

[Refer Regulation 5]

Admission Register

(To be destroyed on the expiry of five years from the date of the last entry in the Register)

Name of the Facility_____ **Month**_____ **Year**_____

S. No.	Date of Admission	Name of the Patient	Wife / Daughter of	Age	Religion	Address	Duration of Pregnancy	Reasons on which Pregnancy is terminated	Date of termination of Pregnancy	Date of discharge of patient	Result & Remarks	Name of Registered Medical Practitioner(s) by whom the opinion is formed *(For pregnancy beyond 24 weeks mention the names of Medical Board members)*	Name of Registered Medical Practitioner(s) by whom Pregnancy is terminated	Method of MTP (MVA/ EVA/ MMA/ D&C/ Others)	Post Abortion Contraception (Tubal Ligation (TL)/IUCD/ OCP/ Injectables/ Others/ None)
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**

FORM II

[Refer Regulation 4(5)]

Month & Year: .....

1. Name of the State:

2. Name of Hospital/approved place:

3. Duration of pregnancy: *(Give total number only under each sub-head)*

(a) Upto 9 weeks (Medical Methods of Abortion Only):
(b) Upto 12 weeks (Surgical Methods of Abortion Only):
(c) Between 12-20 weeks:
(d) Between 20 -24 weeks:
(e) Beyond 24 weeks:

4. Religion of woman: *(Give total number under each sub-head)*

(a) Hindu:
(b) Muslim:
(c) Christian:
(d) Others:

5. Termination with acceptance of contraception: *(Give total number under each sub-head)*

(a) Sterilization:
(b) IUCD:
(c) OCP/Injectable Contraceptive:
(d) Others:

6. Reasons for termination: *(Give total number under each sub-head)*

A. Up to 20 weeks of gestation

(a) Danger to the life of the pregnant woman:
(b)Grave injury to the physical and mental health of the pregnant woman:
(c) Pregnancy caused by rape:
(d) Substantial risk that if the child was born, it would suffer from such physical or mental abnormalities as to be seriously handicapped:
(e) Failure of any contraceptive device or method:

B. Between 20-24 weeks of gestation

(a) Survivors of Sexual Assault/Rape/Incest:
(b) Minors:
(c) Change of marital status during the ongoing pregnancy (widowhood and divorce):
(d) Women with physical disabilities [major disability as per criteria laid down under the Rights of Persons with Disabilities Act, 2016 (49 of 2016)]:
(e) Mentally ill women including mental retardation:
(f) The foetal malformation that has substantial risk of being incompatible with life or if the child is born it may suffer from such physical or mental abnormalities to be seriously handicapped:
(g) Women with pregnancy in humanitarian settings or disasters or emergency situations as declared by Government:

C. Beyond 24 weeks of gestation

(a) The foetal malformation that has substantial risk of being incompatible with life or if the child is born it may suffer from such physical or mental abnormalities to be seriously handicapped:

Signature of the Officer In-charge with Date

FORM A

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

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

Category of approved place:

(A) Pregnancy can be terminated up to twelve weeks

(B) Pregnancy can be terminated up to twenty-four weeks

(i) Name of the place (in capital letters): …….

(ii) Address in full: ……...

(iii) Non-Government or Private or Nursing Home or Other Institutions:

(iv) State, if the following facilities are available at the place:

CATEGORY A

(i) Gynaecological examination or labour table.

(ii) Resuscitation equipment.

(iii) Sterilization equipment.

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

(v) Facilities for transportations, if required.

CATEGORY B

(i) An operation table and instruments for performing abdominal or gynaecological surgery.

(ii) Drugs and parental fluids in sufficient supply for emergency cases.

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

Place: ……

Date: …….

Signature of the owner for the place

The site approved by the committee receives the approval in Form B

FORM B

[See 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 :

Date : To the Government of the…….

(Issue Editor)

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