Kaleidoscope
Championing Reproductive Justice Centered Health Systems

The Abortion Landscape in Gujarat

Executive Summary

MAY 2026

40+ years of Sahaj
towards alternatives in health and development

arrow
asian-pacific resource & research centre for women

The Abortion Landscape in Gujarat Executive Summary

In India, abortion is legally permitted under the Medical Termination of Pregnancy (MTP) Act 1971, which allows termination of pregnancy under specific conditions related to the duration of pregnancy, risk to the physical or mental health of the woman, or foetal abnormalities. Yet, unsafe abortion[1] continues to be one of the important causes of maternal death in India, making it both a critical public health concern and a matter of social justice. In 2015, an estimated 15.6 million abortions occurred in the country, yet only about one in five were provided within health facilities that are more likely to meet basic medical standards. The gap between legal provisions and actual access to safe and legal abortion services is driven by uneven availability of health services, persistent stigma around abortion, low awareness of legal rights, provider biases, and conservative resistance (Godbole 2022).

When viewed through this lens, abortion incidence data from India highlights significant safety concerns.

The Kaleidoscope Initiative[2]

This report has been published as part of the Kaleidoscope Initiative, which is a multi-country initiative aimed at ensuring that comprehensive abortion care is accessible, stigma-free, and woman-centered.

In India, the project is currently being implemented at the national level as well as in select districts of Gujarat, Maharashtra and Tamil Nadu. In Gujarat, intensive work is happening across three districts: Dahod, Mahisagar and Vadodara.

This report describes the abortion landscape in Gujarat. The data sources used in this report include:

- Government data sources such as National Family Health Surveys
- Published studies, on the abortion landscape in Gujarat (2015-2025)
- National Health Mission's Reproductive and Child Health Budget data for 2020-2025
- Reports of stakeholder consultations at the state-level and in two districts (Dahod and Mahisagar) of Gujarat

1 According to the World Health Organization (WHO), an unsafe abortion occurs when individuals without the necessary skills, in environments that do not meet minimum medical standards, or both (WHO 2019), terminate a pregnancy.

2 The Kaleidoscope Initiative proposes to address the need for safe abortion services by investing in health system strengthening and community-driven to create sustainable conditions in which reproductive rights are protected, respected, and realized for all. Kaleidoscope Gujarat is The Initiative is being implemented across four countries – Benin, Kenya, Nepal and India.

Context in Gujarat

Gujarat is one of the economically stronger states of India, with a strong business culture, contributing 8.2% to the national GDP. In 2022, Gujarat ranked 25th among 36 Indian states and union territories in Human Development Index (as measured by the HDI), and its Gender Development Index (GDI) ranked 19th in 2017-18[3] (UNDP 2025, Government of India 2018). Compared with states with similar economic development, Gujarat also lags in health indicators, with higher infant (20/1000 in 2023), neonatal (16/1000 in 2021), and under-five mortality rates (24/1000 in 2021) (SRS 2025a, SRS 2025b). There are pronounced rural-urban and tribal-non-tribal divides in social and economic as well as health indicators.

While the public health infrastructure has expanded in recent years, it falls short of requirements. The same is true of human resources in health. Gujarat's health workforce density was estimated to be 42 per 10,000 population (World Bank and GoG 2023), falling short of the recommended 44.5 doctors, nurses/midwives per 10,000 population (WHO 2024). Shortages have also been reported across services such as blood banks, operating theatres, emergency services, and intensive care units, which may affect access to CAC (GoG 2025).

Furthermore, the distribution of health infrastructure and human resources remains uneven. Tribal areas face shortages of Community Health Centres (CHCs) and specialists. Around 33% of the state's residents are reported to travel more than 30 minutes to reach a Primary Health Centre, with even longer travel times in hilly tribal regions (World Bank and GoG 2023). The private sector dominates both outpatient (74%) and inpatient care (62%), as well as imaging and diagnostics (WHO 2024, GIDB 2024).

Reproductive Health Situation

Key reproductive health indicators for Gujarat improved over the last decade (2015-2025), like the total fertility rate (TFR) is 1.86, below replacement level, the proportion of institutional deliveries (94.3%) is high, (NFHS-5, Gujarat). Maternal Mortality Ratio (MMR) is 51 per 100,000 live births for 2021-23 (SRS 2025), signifying its achievement of the SDG goal of reducing MMR to below 70 per 100,000 by 2030. Unmet need for contraception declined sharply from 17% in 2015-16 (NFHS-4, Gujarat) to around 10% in 2019-21 (NFHS-5, Gujarat).

However, the prevalence of early marriage (21.8%) still remains high (NFHS-5, Gujarat). Adolescent childbearing is higher in rural areas, with 6.7% of women aged 15-19 years having begun childbearing as compared to 2.6% in urban areas. The figure was 9% for women from Scheduled Tribes (STs), compared with 3.6% for other social groups (NFHS-5, Gujarat).

3 This is the latest year for which GDI data is available

The Abortion Landscape

The Gujarat state government issued a Safe Abortion Service Provision Order in 2021, outlining the state's commitment to providing CAC through public health facilities and approved private health facilities, by ensuring regular CAC training for providers and by providing equipment and supplies to the health facilities. Official websites indicate that CAC services are available at all levels of public health facilities.

Medical Method of Abortion (MMA), Manual Vacuum Aspiration (MVA) and Electrical Vacuum Aspiration (EVA) services up to 8 weeks of gestation and counselling on post-abortion contraception are to be provided at Primary Health Centres (PHCs), and up to 12 weeks at the higher-level Community Health Centres (CHCs). At CHCs and higher-level facilities, abortion services can be provided up to 20 weeks exclusively by gynaecologists (GoG, Department of Health and Family Welfare, n.d.). No information is available in the public domain on the status of Medical Boards and Committees for the registration of private health facilities.

NFHS-5 indicates that 2.1% of pregnancies ended in abortion in the five years preceding the survey, with higher proportions among adolescents. A 2015 study by the Guttmacher Institute had estimated the number of abortions in Gujarat to be around 810,000 – more than 20 times the official estimates five years later (Sahoo et al. 2018). HMIS data of 30,000 abortions in 2021-22 appears to be a gross under-estimate. The low HMIS figures may be because a majority of the abortions occur outside health facilities. This would confirm the Guttmacher Institute study's estimation that only 15% of all abortions in Gujarat were facility-based, and that most of the remaining were medical abortions outside health facilities (Sahoo et al. 2018).

While unintended pregnancy is the main cause for seeking abortions, social pressures such as son preference in the family/community, mistimed pregnancy, pregnancy resulting from sexual violence within or outside of marriage, etc., are important reasons behind women seeking abortions.

A range of barriers constrain women's access to safe abortion services. Comprehensive Sexuality Education (CSE) is unavailable for the most part, and knowledge of abortion legality and methods is poor. Further, only a small share of public facilities actually provides abortion services. An assessment of the sub-district and district hospitals showed that 38% of CHCs and about 20–35% of sub-district and district hospitals reported performing first-trimester abortions, and just 2–20% reported second-trimester services (Indian Association of Social and Preventive Medicine, Gujarat Chapter 2023). Government data also show a shortage of gynaecologists in many higher-level government facilities, and only a limited proportion of non-specialist providers are trained in abortion provision, including medical abortion. CAC availability in the private sector is hampered by the slow, cumbersome processes for registering private MTP facilities.

Low CAC budgets (approximately Rs 30 lakh, about 0.04% of RCH in 2025-26) accentuate the deficiencies in CAC provisioning. Even these modest funds have been underspent, including unutilised training budgets that were surrendered (RoPs and Supplementary RoPs of NHM Gujarat). A conservative cost estimate for 50,000 facility-based abortions based on the government's HMIS data suggests a requirement of around Rs 75 lakh annually—more than double the current CAC budget—without counting broader system strengthening or community outreach costs.

Denial or delay of MTP services, particularly for adolescents and second-trimester cases also happen due to confusion and anxiety among health service providers about penalisation under POCSO and PCPNDT Acts. The high costs of abortion services in the private sector (up to Rs 35,000 for second-trimester abortions) and the significant indirect costs involved in public care (travel, lost income, medicines) restrict access. There is a strong social stigma surrounding abortion, primarily when associated with pregnancies outside marriage, leading to blame, isolation, and, in some cases, suicidal distress among adolescents and tribal girls. For most women, self-use of medical abortion pills without adequate guidance remains the only viable option to terminate an unplanned pregnancy.

Key Findings and Implications for Action

Determinants of access to Comprehensive Abortion Care fall into three broad categories-

1) Demand for services which is determined by women's awareness about availability of services and their own reproductive rights,
2) Availability of quality services that are easily accessible, and
3) Women's agency to access the services which includes their autonomy, ability to make decisions about their own health, mobility, access to and control over money and other resources.

Key Findings and Conclusions are as follows:

1. NFHS-5 indicates that 2.1% of pregnancies ended in abortion in the five years preceding the survey, with higher proportions among adolescents (6.1%). HMIS data of 30,000 abortions in 2021-22 appears to be a gross under-estimate. A 2015 study by the Guttmacher Institute had estimated the number of abortions in Gujarat to be around 810,000 – more than 20 times the official estimates five years later.
2. The status of fertility indicators in Gujarat (NFHS- 5 data) points towards a high demand for abortion services.
3. Access to safe abortion services is severely compromised despite the MTP Act and its 2021 amendments. The Guttmacher Institute study estimates that only 15% of all abortions in Gujarat were facility-based, and that most of the remaining were medical abortions outside health facilities.
4. Very few public sector health facilities can offer access to first-trimester MTPs and even fewer to second-trimester MTPs. The Guttmacher study in 2015 noted 9% of PHCs and 38% of other public health facilities provided abortions, and 13% of public and 24% of private facilities offered second-trimester abortion.
5. Access to abortion services is also restricted because the state stringently enforces the PCPNDT Act, and confusion and anxiety about penalisation under POCSO and PCPNDT enforcement contribute to denial or delay of services, particularly for adolescents and second-trimester cases.
6. There are serious data gaps. The HMIS data on the number of MTPs and other details are not available in the public domain since 2021-22. Private sector data on MTPs provided is not available. No data is available on number of medical officers trained for MTP. There is little data on the number of women experiencing complications post-abortion and treatment-seeking pathways for these.
7. The demand side barriers include
    - The unavailability of Comprehensive Sexuality Education (CSE) and low levels of knowledge of abortion legality and methods.
    - A strong social stigma surrounding abortion, primarily when associated with pregnancies outside marriage, leading to blame, isolation, and, in some cases, suicidal distress among adolescents and tribal girls.
    - High costs of abortion services in the private sector (up to Rs 35,000 for second-trimester abortions) and the significant indirect costs involved in public care (travel, lost income, medicines) restrict access.

Key Recommendations for the Health Department in Gujarat

1. Improve access to safe abortion services by ensuring that each level provides the service mandated in the CAC guidelines – information, counselling and referrals through the ASHAs and the Female Health Workers, medical abortion pills through PHCs with trained MTP providers, first and second trimester MTPs through CHCs and sub district and district hospitals.
2. Focus on the inequitable distribution of health infrastructure and human resources to make equitable public health services a reality for the most marginalized population groups.
3. Ensure adequate training of abortion service providers by strengthening the training centres and ensuring value clarification and gender sensitization of service providers on all reproductive and sexual health issues.
4. Institutionalise standard operating procedures to facilitate immediate provision of services to adolescents and young people, navigating the POCSO Act.
5. Improve the functioning of the district level MTP Committees so that private service providers can be registered expeditiously.
6. Improve data systems so that updated data is available for analysis and planning and can lead to improved access of CAC especially for vulnerable groups.
7. Ensure that IEC cells in the districts undertake campaigns around adolescent SRHR and safe abortion services so that unwanted pregnancies can be prevented and early abortion services sought from qualified providers.
8. Strengthen RKSK across the state so that adolescents' SRHR needs are satisfied. Ensure convergence with School Health Programmes to facilitate life skills education and body literacy.

Key Recommendations for Civil Society Organisations

1. Increase awareness in communities, including adolescent girls and women about body literacy – menstruation, conception, contraception etc.
2. Engage with the School Health Programme and the RKSK and support the government staff in gender sensitive and young people centred implementation of the programmes.
3. Facilitate meaningful participation of young people and women in all programmes so that the programmes become responsive to their needs.
4. Increase awareness of the provisions of the MTP Act and the recent amendments amongst frontline workers of all departments. And also the POCSO Act and the PCPNDT Act.
5. Undertake sensitisation of the police and protection staff so that young people's access to SRH services is not hampered.
6. CSOs need to work on campaigns to reduce the social stigma around SRHR and abortion.

• • •

40+ years of

Sahaj

towards alternatives in health and development

For more details contact

1 & 2, Shree Hari Apartments,
Behind Express Hotel,
Alkapuri, Vadodara - 390007

0265-2342539

sahajkaleidoscope2025@gmail.com
sahajsm.acc@gmail.com

www.sahaj.org.in

sahaj.shishumilap

sahaj.vadodara