Kaleidoscope

Championing Reproductive Justice Centered Health Systems

Sexual and Reproductive Health (including Comprehensive Abortion Care) for Adolescents and Youth in Gujarat

A policy brief

Key Gaps, Challenges and Policy Priorities

1. Context

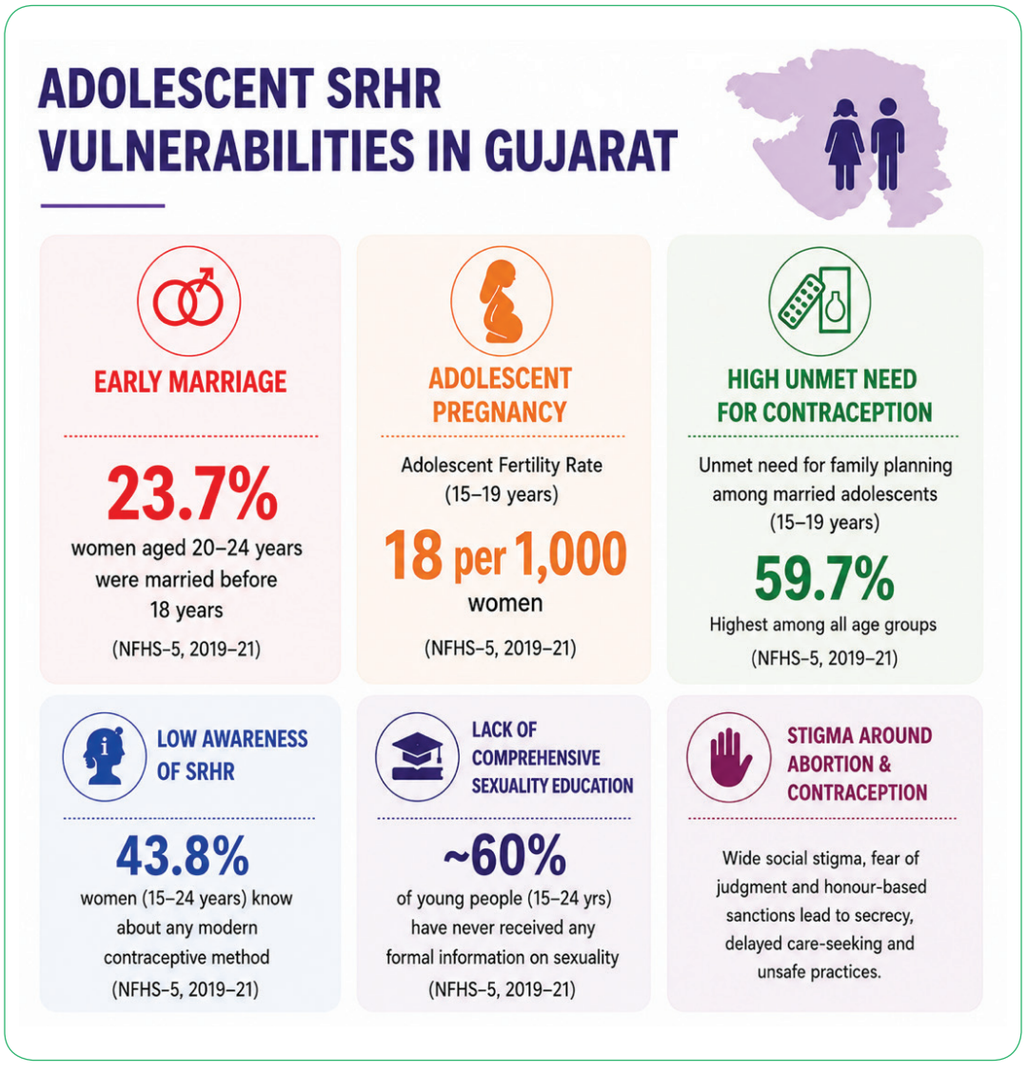
While Gujarat strives for sustainable development through its "Viksit Gujarat 2047" roadmap and has achieved significant economic growth, it has yet to translate this into equitable reproductive health outcomes.

Adolescents constitute nearly 19.8% of the Gujarat's population, slightly higher than the national average of 19.6% (Census 2011), yet this group remains among the least visible in health system design. They are disproportionately affected by low awareness of Sexual and Reproductive Health Rights (SRHR), unintended pregnancy and unmet need for contraception, with an induced abortion rate of 6.1%, nearly three times the state average of 2.1%. In Gujarat, only 67% women (aged 15-24) used hygienic methods of menstrual protection (NFHS 5).

Programmes like Rashtriya Kishor Swasthya Karyakram (RKSK) and SABLA (Rajiv Gandhi Scheme for Empowerment of Adolescent Girls) aim to improve health, nutrition and sexual and reproductive health, including access to information for adolescents. However, access to these programmes remains uneven with adolescents and youth from disenfranchised communities.

The education system plays a critical role in shaping adolescents' understanding of SRHR. Schools are the primary spaces through which youth could access information on puberty, menstruation, reproductive health, consent, conception and contraception.

In 2007, the state withdrew from the national Adolescent Education Program (AEP), and currently it does not have a formal state-wide policy on Comprehensive Sexuality Education (CSE). As a result, many young women become vulnerable lacking access to accurate information, support systems and informed reproductive choices, resulting in many cases of domestic violence, coercion, and sexual abuse.



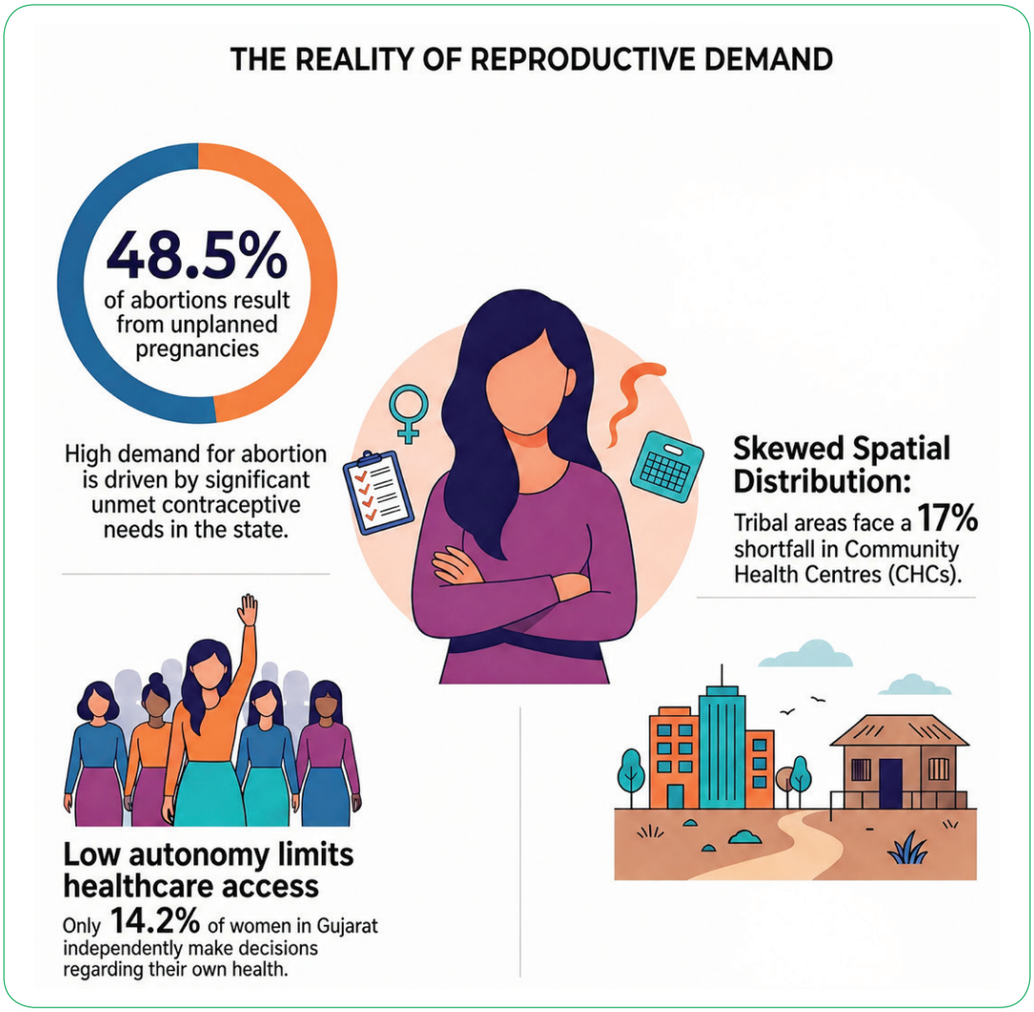
Although abortion is legal under the Medical Termination of Pregnancy (MTP) Act, multiple structural and systemic factors, including high unmet need for contraception, early marriage and childbearing, gender inequality, stigma surrounding sexuality and abortion, shortages of trained providers, weak public-sector availability of services, and fear generated by overlapping legal frameworks such as the Protection of Children from Sexual Offences (POCSO) Act and Pre-Conception and Pre-Natal Diagnostic Techniques Act (PCPNDT), Acts, collectively limit access to safe abortion care. Adolescents, young women, tribal populations, and economically vulnerable groups continue to bear the burden of these structural inequalities.

Despite legal provisions under the MTP Act and the 2021 amendments, Comprehensive Abortion Care in Gujarat remains inaccessible for many adolescents and young women. This results in delayed care-seeking, increased reliance on self-managed abortion without adequate clinical support, and persistent inequities in reproductive health outcomes.

Nearly one in five women (21.8%) in Gujarat are married before the age of 18**,** initiating early exposure to pregnancy risk (NFHS 5). At the same time, only 14.5% of women report independent decision-making over their health, resulting in restricted reproductive autonomy. This is further compounded by nutritional vulnerability, with approximately 65% of women of reproductive age being anaemic**.**

These vulnerabilities do not work in isolation. Early marriage, low autonomy, lack of body literacy, gender inequality, poor nutrition, and limited access to contraception together create a context where unintended pregnancies are more likely, thereby increasing the demand for safe, legal, and accessible Comprehensive Abortion Care.

In this context, strengthening Comprehensive Abortion Care (CAC) and Sexual and Reproductive Health becomes a necessary response to structural inequities in gender, nutrition, and health systems, aligned with the SDG commitment to “leave no one behind”.



2. Key Findings

2.1 Health System and Policy Gaps Affecting CAC Delivery

Per capita health expenditure in Gujarat is lower than the national average, resulting in underinvestment in critical health infrastructure required for safe abortion services, including operating theatres, intensive care units, and blood banks. Comprehensive Abortion Care receives a relatively small share of the National Health Mission (NHM) budget.

Gujarat continues to face significant shortages of specialists, particularly at Community Health Centres (CHCs), Sub-District Hospitals (SDHs), and District Hospitals. There is an estimated 33% shortfall of specialists at SDHs and 24% at district hospitals, which limits the availability of safe abortion services, especially for complications and second-trimester care.

Overall, Gujarat has only about 6% of India's qualified doctors and remains below the WHO-recommended health workforce density norms. Meeting these standards would require a 90–143% increase in health workforce capacity, indicating a significant systemic constraint that affects CAC service delivery and quality.

While the state has a surplus of Sub-Centres (SCs) and Primary Health Centres (PHCs) overall, tribal areas face shortfalls in SCs, PHCs, and Community Health Centres (CHCs), and urban areas also report PHC shortages. The average coverage area of SCs and PHCs exceeds the national norm, requiring women to travel long distances to access services.

Early abortion services are relatively more accessible at primary-level facilities closer to communities, but access to second-trimester abortion remains severely limited across higher referral facilities. Only 4% of CHCs, 6% of Sub-District Hospitals, and 20% of District Hospitals provide second-trimester abortion services, making access difficult for women requiring later-stage procedures (NFHS 5).

Provider readiness is limited. Less than one-fifth of medical officers in CHCs, SDHs, and DHs are trained in MTP, and acute shortages of specialists are a problem at higher-level facilities. This often forces women to travel long distances to access care.

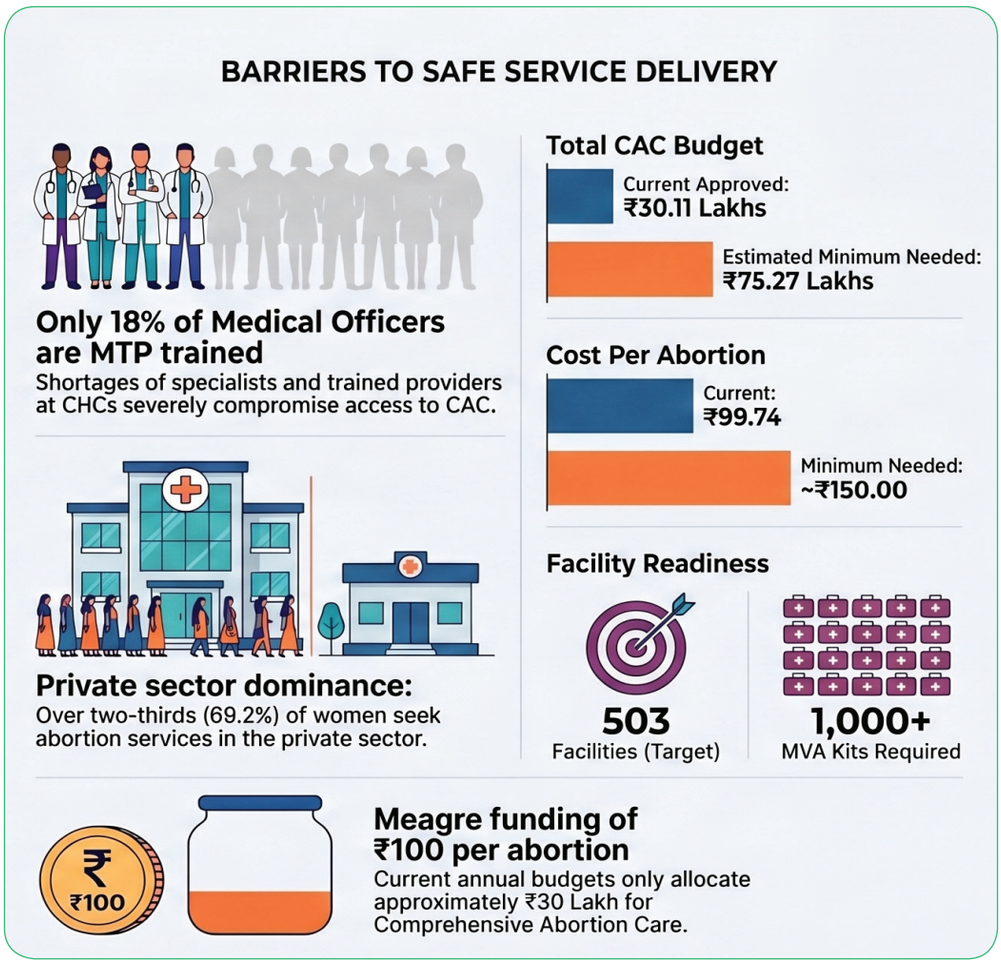
As a result, most abortions occur in private facilities or outside of health facilities with self-administered medical abortion.

2.2 Legal and Regulatory Contradictions

POCSO and PCPNDT Acts create confusion around access to services, confidentiality, reporting, and documentation, especially in adolescent cases.

Mandatory reporting under POCSO and strict scrutiny under PCPNDT often lead to fear among providers, resulting in defensive practices, delays, or reluctance to provide services.

Together, these contradictions reduce service availability in public facilities, pushing girls and women to rely on private or self-managed abortion, and weaken accurate reporting of adolescent cases. They also reduce trust in the health system and delay timely care.



2.3 Barriers for Adolescents and Young Women

Adolescents and young women face limited access to sexual and reproductive health education, resulting in low awareness of contraception, reproductive health rights, and the legal status of abortion services.

Low awareness and incomplete knowledge of contraception, along with low use of modern contraceptive methods among adolescents and young people, remain significant concerns. These issues are further compounded by inadequate capacity among frontline workers and educators to provide SRHR information and counselling. Poor menstrual hygiene management and unequal access to hygienic menstrual products, particularly in rural and tribal areas, also continue to affect adolescent health and well-being. Additionally, rural–urban and tribal disparities limit access to SRHR services, counselling, and reproductive healthcare information.

Stigma and shame associated with premarital sexuality and abortion, along with fear of judgment from family, community, and health providers, often lead to delayed care-seeking or avoidance of formal health services.

In addition, the use of medical abortion drugs without a prescription, combined with fear of identity disclosure, acts as a significant barrier to timely and safe abortion care. The lack of safe spaces for adolescents within communities also adds to the problem.

> *"Unwanted pregnancies have higher death rates due to excessive bleeding. When they come to us, they never admit they took pills... but we know. Pills are freely available in every corner."*
>
> *- (MO, Urban Hospital, Dahod)*
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> *"For the girl, it becomes a crime—not by law, but by society. She cannot talk to her parents, she cannot talk to us, and she suffers alone."*
>
> *- (A participant from the consultation at Dahod)*
>
> *"The girl came from a poor, widowed mother's family. She had no one to speak to, and the boy, too, had no courage to approach his family. They felt completely trapped."*
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> *- (THO, Dahod during the consultation at Dahod)*

3. Policy Recommendations

- Strengthen adolescent SRH components under Rashtriya Kishor Swasthya Karyakram (RKSK) by explicitly including body literacy and comprehensive sexuality education, prevention of unintended pregnancy, contraception, CAC awareness (including the provisions of the MTP and POCSO Acts), and safe abortion referral pathways. There is a need to go beyond the current focus on menstrual hygiene.
- Ensure convergence with School Health Programmes to facilitate life skills education and body literacy.
- Develop a Comprehensive Sexuality Education (CSE) policy and programme for the state.
- Integrate Comprehensive Abortion Care information and referral linkages within Rajiv Gandhi Scheme for Empowerment of Adolescent Girls (SABLA) to address unintended pregnancy risks among adolescent girls.
- Ensure convergence of RKSK and SABLA with facility-based CAC services so that adolescents identified through outreach programmes can be linked to confidential care in public health facilities.
- Include adolescents with disabilities, mental health conditions, and LGBTQIA+ identities explicitly within RKSK and SABLA outreach strategies to reduce exclusion from SRH and CAC services.

- Strengthen capacity building of RKSK frontline workers (ASHAs, ANMs, peer educators) to provide non-judgmental counselling on contraception, unintended pregnancy, and safe abortion options, and to undertake campaigns at the community level to reduce stigma around reproductive and sexual health.
- Develop standardised SRHR modules within RKSK and SABLA that move beyond menstruation hygiene to include rights-based reproductive health education and CAC awareness.
- Establish monitoring indicators under RKSK, SABLA, to track adolescent awareness, referral uptake, and access to reproductive health services, including CAC.

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