Abortion Policies

A Global Review

Volume I

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United Nations

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Abortion Policies: A Global Review

Volume I
Afghanistan to France

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NOTE

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the Secretariat of the United Nations concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.

The designations "developed" and "developing" economies are intended for statistical convenience and do not necessarily express a judgement about the stage reached by a particular country or area in the development process.

The term "country" as used in the text of this publication also refers, as appropriate, to territories or areas.

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PREFACE

Abortion Policies: A Global Review presents, in three volumes, a country-by-country examination of national policies concerning induced abortion and the context within which abortion takes place. Comparable information is presented for all 166 Member States of the United Nations and 8 non-Member States. The countries are arranged in alphabetical order: volume I covers from Afghanistan to France, volume II from Gabon to Norway, and volume III from Oman to Zimbabwe. In volume I, the country names are those in use as of 1 December 1991.

Responsibility for this report rests with the United Nations Secretariat. The assessment was facilitated to a great extent, however, by the close cooperation among the United Nations bodies. In particular, the contribution of the United Nations Population Fund (UNFPA) in support of this publication is gratefully acknowledged. The assistance of national experts who reviewed early drafts of country profiles and provided additional information and comments is greatly appreciated.

Although for many countries current information on the status of abortion policy is relatively easy to obtain, for some countries that is not the case. Information on some countries is incomplete; in others it is noticeably lacking. Readers are therefore invited to send any information, comments or corrections they deem useful to the Director, Population Division, Department of Economic and Social Development, United Nations Secretariat, New York, N.Y. 10017.

CONTENTS

Explanatory notes

Symbols of United Nations documents are composed of capital letters combined with figures.

Reference to "dollars" ($) indicates United States dollars, unless otherwise stated.

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The term "billion" signifies a thousand million.

A hyphen between years (e.g., 1984-1985) indicates the full period involved, including the beginning and end years; a slash (e.g., 1984/85) indicates a financial year, school or crop year.

A point (.) is used to indicate decimals.

The following symbols have been used in the tables:

Two dots (..) indicate that data are not available or are not separately reported.

A dash (--) indicates that the amount is nil or negligible.

A hyphen (-) indicates that the item is not applicable.

A minus sign (-) before a number indicates a deficit or decrease, except as indicated.

Details and percentages in tables do not necessarily add to totals because of rounding.

The following abbreviations are used in this volume:

ADS	Asociación Demográfica Salvadoreña
AGFA	Afghan Family Guidance Association
APROFE	Asociación Pro-Bienestar de la Familia Ecuatoriana
ASFR	age-specific fertility rate
DPPA	Dominica Planned Parenthood Association
GACEPHA	Action Group of Out-patient Clinics Practising Abortion (Belgium)
HIV	human immunodeficiency virus
HR	hospital admission records
IPPF	International Planned Parenthood Federation
ISSS	Salvadoran Social Security Institute
IUD	intra-uterine device
MCH	maternal and child health
PAHO	Pan American Health Organization
PR	provider registration
SOCUDEF	Sociedad Científica de Cuba para el Desarrollo de la Familia
SP	surveys of providers
SW	surveys of women
TFR	total fertility rate
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
WHO	World Health Organization

INTRODUCTION

Induced abortion has attained high public visibility in many countries, both developed and developing. In some contexts, public concern has been voiced primarily because of the alarmingly high levels of maternal mortality and morbidity that have resulted from unsafe illegal abortion. In others, the visibility has resulted more from public debate concerning the legal status of abortion and the role the State should play in permitting or denying access to induced abortion. More often than not, both the concern with health consequences and the political controversy play an important part in the saliency of induced abortion in the public eye.

Induced abortion is one of the oldest methods of fertility control and one of the most widely used. Induced abortion is practised in remote rural societies as well as in large modern urban centres. It is practised in all regions of the world, although with differing consequences. In countries where abortion is legal and widely available, abortions pose a minimum threat to women's health. Where abortion is illegal, however, abortions are usually performed in substandard and unsanitary conditions, leading to a high incidence of complications and resulting chronic morbidity and often death.

Regional variations concerning the consequences of induced abortion are not due solely to differences in national abortion laws. Differences in interpretation by the local legal authorities and the extent to which the laws are enforced also affect the conditions under which abortions are performed. Although laws and policies are a product of the social, cultural, political and religious context in which they were developed, the same context also mediates the outcome of those policies. Thus, the consequences of induced abortion are the result of a complex interplay of factors.

As the topic of induced abortion has gained increased attention, the number of studies on the subject has multiplied. Some studies have focused on specific regions and/or legal traditions,[1] while others have taken a global approach.[2] Most studies document the current status of abortion laws and policies in various countries and analyse trends in legal reform. The legal aspects of abortion are, in general, the easiest to record because they are codified. More difficult to document are instances where policy deviates from legal precepts, and fewer studies address this aspect. Great strides have also been made in documenting the incidence of abortion and its consequences for women's health. Earlier studies focused on legal abortion because the data were more readily available, but more recent studies are attempting to document and to estimate the extent of illegal abortion in different contexts.

This study examines the major dimensions of induced abortion on a country-by-country basis, with the objective of providing information not only on the legal and policy status of abortion but on the ways in which abortion laws have evolved over time, the manner in which they have been interpreted and enforced and the context within which abortion usually takes place. Where possible, data on the incidence of induced abortion are included. Although information on the incidence of abortion and the setting within which abortion takes place are not the focus of the study, these data are provided to enrich the policy picture.

Several publications provide detailed analyses of the abortion situation in a variety of countries, but they focus on a limited number of countries, usually on those for which ample information is available. This publication is intended to serve as a reference book on abortion policy, providing pertinent information on induced abortion for every country in the world, even those for which data are scarce.

NOTES

[1] For example, Cairns, 1984; Cook and Dickens, 1979, 1986; Glendon, 1987; Knoppers and Brault, 1989; and Sachdev, 1988.

[2] For example, Moore-Cavar, 1974; Cook, 1989; David, 1983; Henshaw and Morrow, 1990; Lee and Larson, 1971; Liskin, 1980; Tietze and Henshaw, 1986; Royston and Armstrong, 1989; and UNFPA, 1979.

I. MAJOR DIMENSIONS OF ABORTION POLICY

Broadly speaking, the abortion policy of a country is the product of the social, political, economic and religious context in which it is embedded. More specifically, the nature of abortion laws and policies depends upon their legal heritage, that is, the legal system to which the country adheres, upon the interactions of that legal system with concurrent or prior legal systems and upon the ways in which laws are interpreted and enforced. Because a detailed analysis of the social, political, economic and religious factors affecting abortion policy is beyond the scope of this study, these dimensions of the policy context are mentioned to illustrate certain important points.

The majority of contemporary legal systems throughout the world have been shaped to some extent by one or more of the three main legal families: common law; civil law; or socialist law. For instance, Japan, whose Government formally embraces Buddhism and Shintoism, adopted a civil-law system based primarily on French civil law during the Meiji era in the late 1890s. Turkey, once the capital of the Islamic world, adopted a version of the Swiss Civil Code in 1926. Although other systems of law do exist, such as religious and customary law, their importance has declined as aspects of the major legal systems have replaced or been incorporated into extant systems. Religious and customary law have, however, had an important effect on the content of contemporary legal systems, particularly in the area of private law.[1]

Customary law and law linked to religion, such as Islamic, Hindu, Jewish and canon law, can have a significant influence on human behaviour and on the content of secular law even in countries where they are not enforced by the courts. For instance, the French Civil Code borrowed statutes on marriage and filiation from canon law (David and Brierley, 1978). The Islamic and Hindu systems, although not influential in many realms of public law,[2] have had considerable influence in the area of family law and law regulating interpersonal relations. The laws contained in the "personal statutes"[3] of the Koran and the Hindu Sastras regulate individual social behaviour; and in some Islamic countries, such statutes have even been codified.

The type of legal system to which a country adheres affects the content of its abortion laws, the flexibility with which they may be interpreted and the ease with which legislation may be introduced and modified. Law is developed in one of three ways: by statute law, passed by legislatures or parliaments; by case law, based on court precedents; or by administrative decree (Moore-Čavar, 1974). In the common-law system, law is defined primarily by judicial precedent, and judicial interpretation plays an important role in court decisions. Common law emerged originally as a means for judges to resolve individual disputes. Thus, its objective was to provide solutions to disputes rather than to define rules of conduct. Common law places greater emphasis on individual rights and self-reliance than does civil law. Private rights, such as the right to privacy, private property and freedom of contract, take precedence over social rights designed to protect social welfare (David and Brierley, 1978; Glendon, 1987).

In civil law, or Romano-Germanic law, as it is often called, law is conceptualized as a guide of conduct seeking to protect justice and morality. In general, civil law views individual rights within a social context, placing great emphasis on social responsibility (David and Brierley, 1978; Glendon, 1987). Law is defined primarily by statutes, and interpretation of enacted law usually plays a minor role.

Socialist law,[4] although included here as a distinct system, is not always considered a separate system of law because it formerly belonged to the Romano-Germanic group. In fact, it has retained the terminology and structure of the Romanist group (David and Brierley, 1978). As in the civil-law systems, legislation is the main source of socialist law, but the role of legislation differs. Because the primary aim of socialist Governments was to bring about radical change, the function of law was not to serve as a guide of conduct, as is the case in civil law, but rather actively to transform the economic forces of the country and the behaviour and attitudes of its people. The role of legislation was to create a new social order based on Marxist principles. The role of jurists

and judges was to ensure that the law should be interpreted in the manner intended by the authors. Because existing laws were few, judges were required to look to Marxist doctrine to determine the solution to a dispute. As the socialist legal system developed, the number and detail of laws increased, limiting the role of the judges to the application of the laws. Thus, interpretation of enacted law in current socialist systems plays a limited role. To the extent that law is interpreted, it is interpreted to protect Marxist principles.

Islamic law has had an important influence in abortion laws in many Islamic countries. Islamic law, known as the shariah ("the way to follow"), is also a codified system that specifies rules of conduct. Law is defined both by statutes (the "personal statutes" contained in the Koran and in the Sunna, the collection of acts and statements made by the Prophet), and by scholarly interpretation and analogical reasoning. As the Koran and Sunna do not cover all aspects of behaviour, Islamic scholars are called upon to rule on situations not covered by these works, through a process of interpretation employing deductive or analogical reasoning and leading to consensus. The interpretation adopted depends upon the school of Sunni or Shiah law followed (El-Kammash, 1971).

Lastly, a word must be added about cases where legal heritage has had limited effect on the content of abortion law and policy. Such is the case among a handful of countries where abortion policy has been introduced for primarily demographic considerations. Albania and Romania are examples of countries that had introduced highly restrictive abortion laws with pronatalist intentions. Recently, both countries liberalized their abortion laws. China is an example of the opposite policy, that is, a Government that permits abortion in an effort to achieve a drastic reduction in fertility.

In general, a codified system is more static than one based on judicial precedent. Common-law systems, in which the limits of the law are constantly being tested and extended through court precedents and changes in the interpretation of the law are routinely incorporated through court rulings, are more fluid than civil-law systems, in which legal codes take precedence. In legislation-based systems, such as civil-law and socialist-law systems, the degree to which interpretation of the law is permitted determines its openness to change. For instance, among the countries with a civil-law system, the Nordic countries have demonstrated greater flexibility to change than have the Iberian countries. In Islamic law systems, the school of Sunni or Shiah law to which the country adheres is also an important factor affecting the extent to which flexibility of interpretation is permitted.

The common-law, civil-law and socialist-law systems described above are the principal families of law in existence today. Most existing contemporary legal systems have drawn some or many elements from one or more of these families. Although these legal systems have been described in their pure form, in reality legal systems are hybrids of various systems. The trend has been for common-law and civil-law systems to merge. Countries with common-law legacies have adopted legal codes, and case law has been gaining importance in some civil-law systems.

The three systems, along with some religious legal systems such as Islamic and canon law, have influenced the content of most abortion laws today. Civil law, as it is known today, originated in continental Europe and, in many cases, was spread to other countries through the process of colonization. Thus, the countries colonized by Belgium, France, Germany, Italy, Portugal, Spain and the Netherlands inherited a version of their mother country's civil-law system and of their statutes concerning abortion. As a result, the legal codes of numerous countries in Africa, Asia, Latin America and Oceania are based on civil law. Common law, the legal system that developed in England, forms the basis of the legal codes of most Commonwealth countries and the United States of America. Common-law systems are found in anglophone Africa, Northern America, the Caribbean, Asia and Oceania. Socialist law forms the basis of the legal systems in most countries of Eastern Europe, as well as Cuba. Several countries that are considered socialist States do not adhere to the socialist legal system described above. Their legal systems are so varied that it is difficult to classify them under a single generic group. Likewise, the legal systems of some countries, such as Israel, the Philippines and South Africa, are hard to classify because they contain important elements from both civil-law and common-law systems, as well as religious law. Islamic law has shaped family law in many Islamic countries in Africa and Asia. Canon law, which

had an early influence on both common law and civil law, continues to exert its influence, particularly in predominantly Catholic countries.

Although many countries adopted the abortion laws of the colonial authority almost verbatim, others introduced important modifications. The version adopted by a country depended upon its indigenous legal systems and how those systems fit in with the law of the colonial authority. A common outcome is that different branches or sub-branches of law may be moulded by different legal systems. For instance, in many Muslim countries, numerous branches of law have been secularized. The main exceptions are laws dealing with the family and interpersonal relations, which are influenced by Islamic and customary law. Thus, although most laws in Bangladesh have been patterned after English common law, its laws relating to the family and, in this case, abortion are influenced by religious and customary law.

Laws concerning abortion frequently appear inconsistent because they are addressed in multiple simultaneous codes. When abortion is considered a crime, it is addressed in penal codes. However, States that address abortion in their penal code may permit abortion in some or all circumstances, that is, they define situations where abortion is considered lawful, in separate laws or decrees, or in statutes in health codes, social welfare codes and the section of civil codes covering personal statutes or those on relations between persons. Thus, while the penal code may express the punishments for the crime of abortion, the health code or instruction may specify the conditions under which abortion could be lawfully performed, and the social welfare code may stipulate under what conditions the State might pay for abortions.

Laws may also appear to be inconsistent within the same code because laws affecting the legality of abortion may not specifically address abortion. For instance, in many countries where abortion is strictly forbidden in any circumstance under the criminal code, other sections within the same code, that is, sections concerning the state of necessity, will permit abortion when the life of the pregnant woman is in immediate danger, because it can be justified as a defense of necessity (Glendon, 1987). In Egypt, for instance, sections 260-262 of the Penal Code forbid abortion in any circumstance. Section 61 of the Penal Code, however, provides that "a person who commits a crime in case of necessity to prevent a grave and imminent danger which threatens him or another person shall not be punished, on condition that he has not caused it on his own volition or prevented it by other means" (quoted in El-Moiz Nigm, 1986).

NOTES

[1] Private law includes spheres of law governing relations between private persons, such as laws on property, inheritance, marriage and filiation, and commercial law.

[2] Public law includes branches of law governing the sphere of relations between those who govern and those who are governed, such as criminal law, labour law, public international law, law of procedure, administrative law and constitutional law. In some Islamic countries, including Pakistan and Saudi Arabia, Islamic law has shaped criminal law.

[3] The "personal statutes" include the law of persons, family relations and inheritance.

[4] As of the preparation of this volume, it is unclear what changes will be introduced in the legal systems of the newly independent former Baltic republics, Estonia, Latvia and Lithuania, or what course the USSR will take. A discussion of socialist law is included because it has, to this date, moulded abortion laws in Eastern Europe and the USSR.

II. THE ORIGINS OF ABORTION LEGISLATION

The view that abortion is a reprehensible criminal act was first expressed explicitly in religious law. For example, the first collection of canon law, compiled in the twelfth century, considered abortion a homicide if it was performed after quickening. Quickening was assumed to take place 40 days after conception for the male foetus and 80 days after conception for the female foetus. In practice, however, movement of the foetus was taken as the sign that formation of the foetus had taken place; thus, abortion was sometimes performed as late as the fifth month of gestation. Except for a brief period in the mid-sixteenth century, when abortion could be punished by excommunication, the view that abortion was not a punishable act if it occurred in early pregnancy was held by the Christian Church until 1869, when the Pope decreed that quickening takes place at conception and for Roman Catholics, excommunication was once more the punishment for abortion (Paiewonsky, 1988).

The first instance of a secular law concerning abortion occurred in England in 1803 (Cook and Dickens, 1979; Francome, 1988). Before 1803, abortion was considered a common-law misdemeanor and was punishable only if performed after quickening. Although canon laws were influential in shaping the English abortion laws, other social and economic factors were equally influential. The early nineteenth century was a period of great economic and geographical expansion. It witnessed the rise of modern medicine and the introduction of sweeping public-health measures leading to dramatic improvements in public health. The growth of industrial capitalism led to the rise of the middle class, to its establishment as a political force and to the establishment of its moralistic values as the values of the time. This period was also one of colonial expansion, leading many States to adopt pronatalist policies in order to have the labour necessary to administer and to populate the new colonies (Paiewonsky, 1988). Repressive attitudes towards sexuality, combined with pronatalist policies, and mounting evidence that abortion was the cause of much maternal mortality and morbidity, resulted in the passage of the 1803 Irish Chalking Act, which, in an early amendment of its section 58, punished a woman obtaining an abortion, whether self-inflicted or not, by life imprisonment (Francome, 1988).

The 1803 Act and its amendments paved the way for the 1861 Offenses Against the Person Act (sections 58 and 59). The 1861 act stipulates that it is a felony punishable by life imprisonment for any woman "with child" unlawfully to procure or attempt to procure her own miscarriage and for any other person to do any similar act with similar intent "whether she be with child or not" (Cook and Dickens, 1982). The word "unlawfully" is not defined. A person supplying any instrument or poison to be used to induce an abortion is guilty of a misdemeanor and liable to three years in prison (Francome, 1988).

An important judicial precedent, the case of *Rex* v. *Bourne* in 1938, clarified the 1861 Act by specifying instances when abortion would be "lawful". In the *Bourne* case, a physician was accused of performing an abortion on a 14-year old girl who had been raped. Dr. Bourne was acquitted of the offense on the grounds that continuation of the pregnancy would have caused the girl to become a "mental wreck". The judge explained that the word "unlawfully" in the 1861 Act implied that abortion performed with the intent of preserving the woman's life or health was not a criminal act and that health included both mental and physical health (Cook and Dickens, 1982; Kloss and Raisbeck, 1973).

The 1861 Offenses Against the Person Act formed the basis of abortion law throughout the Commonwealth. In some countries, the Act was retained in its original form. In others, it was adopted including the 1938 *Bourne* decision or was modified on the basis of local court precedents. The wording of these laws is, in general, very similar to the 1861 Act, but there is ample variation in punishments for unlawful abortion (Cook and Dickens, 1979).

In civil law, the first widely adopted statute concerning induced abortion appeared in the Napoleonic Code of 1810.[1] It was enacted during the same period as the first abortion legislation in common law and was similarly influenced by canon law. The French Penal Code (section 317) prescribed harsh sentences for women procuring

abortions and for persons performing abortions. Subsequent reforms in 1920 and 1923 changed abortion from a crime to a misdemeanor, with reduced although still harsh sentences.

The Napoleonic Code forms the basis of abortion legislation in many countries with civil-law systems. Wide variation exists among the existing civil-law systems, with those of the Iberian Peninsula and Italy being more influenced by canon law and the Nordic systems being the most secular.

Reflecting its civil-law origins, socialist law prior to 1920 considered abortion a crime. Concerned with women's status, health and welfare, the Soviet Government legalized abortion in 1920. Abortion became available in the Soviet republics if performed during the first trimester (Law of 8 November 1920). In 1936, abortion legislation was reversed for demographic considerations (Law of 27 June 1936), permitting abortion only for serious therapeutic reasons. In 1955, abortion law was liberalized once more in recognition of the increased maternal mortality and morbidity resulting from illegal induced abortion (Decree of 23 November 1955). The Supreme Soviet made abortion available on demand in all the Soviet republics up to the twelfth week of pregnancy (Hecht, 1987). Not all socialist countries adhere to the Soviet law. However, the countries of Eastern Europe and Cuba do have similar legislation.

In Islamic law, abortion is addressed in the "personal statutes" of the Koran. Although the different schools of Islamic law differ somewhat in their interpretation, there are some commonalities. Islam forbids the killing of the soul, but the various schools of Islamic law disagree as to when a foetus acquires a soul. Some schools of Islam identify that time as 40 days after conception and others as 120 days. Most schools adhere to the 120-day definition. Some schools permit abortion prior to quickening only with justifiable grounds, and others forbid abortion even before quickening (that is, before the foetus acquires a soul). Islam permit abortion, however, when the pregnancy endangers the mother's life, regardless of gestation duration (El-Kammash, 1971).

NOTE

[1] The Napoleonic Code was not the first codification of civil law but was the first to be widely adopted (David and Brierley, 1978; Glendon, 1987). The Napoleonic Code, also known as the Code civil des Français, includes five codes promulgated in the first decade of the nineteenth century. The Napoleonic Code dealing with civil matters was promulgated in 1804. The Penal Code, containing punishments for the crime of abortion, was promulgated in 1810.

III. COUNTRY PROFILES: DESCRIPTION AND DISCUSSION OF VARIABLES

This chapter contains a detailed description of the variables included in the first page of each country profile. An attempt has been made to provide comparable information for each country. Because abortion laws can be complex and diverse, considerable space is dedicated to the description of how the legal grounds for abortion are coded. The section on abortion policy addresses the grounds on which abortion is permitted; it is followed by a short section describing any additional conditions required by the law. The causes and consequences of induced abortion differ from one country to another. In order to capture some of these differences, a number of fertility and mortality indicators are given in the following section. In the background section of each country profile, the national context is described in further detail. The last section provides statistics on induced abortion, when such data are available.

A. ABORTION POLICY

1. *Grounds on which abortion is permitted*

The most commonly cited grounds on which abortion is permitted include: *(a)* to save the life of the mother (life grounds); (*b*) to preserve her physical (narrow health grounds) and/or mental health (broad health grounds); (*c*) in cases of rape or incest (juridical grounds); (*d*) when foetal impairment is suspected (eugenic grounds); and (*e*) social or economic reasons (social grounds). These are the grounds coded in the first section. Although some countries include additional grounds, for example, when there is contraceptive failure, when the mother has tested positive for the human immunodeficiency virus (HIV), when the pregnant girl is a minor or when the pregnancy is the result of an illegitimate relationship, they are not coded in this variable because of their limited applicability. When they are applicable, however, these grounds are described in the section under "additional requirements" and are described in detail in the background section of the country profile. Because the wording of the laws differs substantially, the variation in language and interpretation of each of the grounds is also discussed in detail on the second page. When it is evident that policy deviates from law, an asterisk is placed next to the pertinent ground indicating that although unlawful, the legal or official interpretation usually allows the abortion to be performed on the particular ground. For example, in countries where abortion is considered unlawful in any circumstance but where performing an abortion to save the life of the pregnant woman is permitted in "defense of necessity", the ground to "save the life of the woman" is coded as not permitted but is followed by an asterisk.

Because some countries have both national and subnational abortion laws, and it is not always clear which takes precedence, the most liberal of the national or subnational laws was coded. A detailed description of the local laws is contained in the text.

To save the life of the woman

Permitting abortion to save the life of the pregnant woman is the most clearly interpreted ground. Although some countries go to some length to provide detailed lists of what they consider life-threatening conditions, there is, in general, a tacit agreement on the conditions that permit this ground to be invoked. Although it is true that there is some room for interpretation as to what can be considered life-threatening, which allows some courts to show greater leniency, it is less ambiguous than the other grounds usually considered. This ground is also the most universally permitted. A notable exception is Chile, which is reputed to have recently made its abortion laws more restrictive, forbidding abortion even when necessary to save the woman's life. The justification provided is that medical science has advanced so much that any health ground is unjustifiable.

To preserve the physical health of the woman

Performing an abortion on the ground that it is necessary to preserve the physical health of the pregnant woman or more precisely, in cases where the continuation of the pregnancy would involve a risk of injury to the physical health of the woman, is also permitted in a majority of countries. The term "physical health", however, has been variously defined. In some countries, the definition is narrow, often including lists of conditions that are considered to fall under this category; in other countries, the term "physical health" is broadly defined allowing much room for interpretation. Where possible, the range of interpretation allowed is discussed in the text. In general, Commonwealth countries permit a broader definition of health than do African or Latin American countries adhering to civil law.

In many cases, the law does not specify the aspects of health that are concerned but merely states that abortion is permitted when it averts a risk of injury to the pregnant woman's health. As a rule, the interpretation of health tends to be narrow, referring only to physical health. In some cases, however, it is not possible to determine if mental health is also implied. Nevertheless, permitting abortion on the ground of preserving the woman's mental health generally specify that ground.

To preserve the mental health of the woman

Many abortion laws specifically state that abortion is legally permitted in cases where the continuance of the pregnancy would involve risk of injury to the physical and mental health of the pregnant woman greater than if the pregnancy were terminated. The definition of "mental health" grounds varies significantly. Mental health is sometimes interpreted to include some or all of the other grounds to be discussed. It can refer to anything from psychological distress caused by the fact that the pregnancy was the result of rape or by the scientific opinion that there is a risk that the foetus may be mentally or physically impaired, to situations where the pregnancy is interpreted as causing mental distress because of the socio-economic context in which it occurred. This phrasing of the law is employed primarily in Commonwealth countries. Most other countries specify the grounds directly, that is, juridical, eugenic and/or social or economic grounds, rather than making reference to a catch-all term like "mental health". Some Commonwealth countries do, however, specify additional grounds, as is the case in Barbados and Belize.

A word should be added about *Rex v. Bourne* (1938) at this point. As mentioned previously, this was a landmark case in Commonwealth law. It set a judicial precedent that resulted in a broader definition of lawful abortion, extending it to include cases where abortion could be performed to safeguard the physical health of the pregnant woman and in order to "prevent her from becoming a mental wreck". The manner in which the Bourne decision was adopted by the colonial possessions of the United Kingdom of Great Britain and Northern Ireland often differs. Because the *Bourne* case is invoked only after a physician has been accused of performing an abortion (and perhaps arrested), many physicians do not want to risk arrest. Thus, in countries where arrest is a possibility, the *Bourne* case tends to be interpreted more narrowly, to include physical health only. Kenya is a case in point. In these instances, the law is coded as excluding the mental health ground.[1]

Pregnancy as a result of rape or incest

When a pregnancy is caused by rape or incest, abortion is often permitted even in countries with restrictive legislation, as in the case of most Latin American countries. It may be worded as "when necessary to defend the pregnant woman's honor", or simply, when the pregnancy is the result of sexual violence. Some specifically mention both rape and incest, others make reference to rape only. Because many countries require that the case be brought to court or be reported to the authorities before permission for abortion can be granted, many women are discouraged from opting for an abortion on this ground. Several countries that do not permit abortion on juridical grounds, for example, Brazil and Colombia, do apply reduced sentences when the abortion

was performed to defend the woman's honour. In many Commonwealth countries, no specific reference is made to juridical grounds because such cases are interpreted as falling within the mental health grounds.

Possibility of foetal impairment

As is the case with juridical grounds for abortion, eugenic grounds are often permitted in countries with restrictive abortion laws. In many Commonwealth countries, no specific reference is made to eugenic grounds because they are interpreted as causing the mother mental stress and are therefore considered to fall within the mental health grounds. Several countries specify the type and level of impairment necessary to justify this ground.

Economic or social reasons

The phrasing of laws permitting abortion on socio-medical, social or economic grounds varies widely. Some specifically mention social or economic conditions while others merely imply them. For instance, in Barbados, the law specifies that in the determination of whether the continuation of the pregnancy would involve a risk of injury to the health of the pregnant woman, the medical practitioner must take into account the "pregnant woman's social and economic environment, whether actual or foreseeable". In New South Wales, Australia, where a similar wording is employed, reference is made to social and economic stresses. In other instances, as in South Australia and Belize, the wording merely implies the social and economic dimension: the determination of risk of injury to the health of the pregnant woman must take into account "the woman's actual or reasonably foreseeable environment". In Belgium and France, social and economic grounds for abortion may be inferred. Abortion is permitted when a woman "in a state of distress as a result of her situation" requests a physician to terminate her pregnancy. There are also instances, as in Burundi and Ethiopia, when abortion is not permitted on social and economic grounds but when "social exigencies of the environment" in which the act took place must be given consideration in sentencing.

Although it may be difficult to detect major policy differences in countries in which abortion is permitted when necessary to preserve the physical and mental health of the pregnant woman and those grounds are interpreted very liberally, from those in which abortion is available for social or economic reasons, they are coded differently because they imply different legal approaches and philosophies. The ambiguity of the "mental health" ground leaves much room for interpretation, leading some countries very narrowly and others very liberally. With regard to social and economic grounds, however, liberal interpretation is the rule.

Available upon request: permitted on all grounds

The major difference between laws permitting abortion on social and economic grounds and those permitting abortion on demand is that a woman may simply request an abortion. She need not justify it in the eyes of the law. It must be noted that in many cases the difference may be purely in terms of the philosophical orientation of the law as women may have the same access to abortion in both situations. Thus, such countries as Austria, Canada, China, Cuba and Denmark have abortion on demand, whereas in Belgium, France and Finland, a woman seeking an abortion must consult with her physician, who must be convinced that carrying the pregnancy to term and having the child would cause her significant distress.

2. *Additional requirements*

This section concerns the additional legal requirements that must be observed to qualify for a lawful abortion. It may encompass consent clauses, personnel permitted to perform abortions and where they may be performed, and any gestation limits that need to be observed. For instance, abortion on demand can usually be performed without the approval of authorities if performed within a given gestation duration, usually 12 weeks.

B. FERTILITY AND MORTALITY CONTEXT

1. *Government's view of fertility level*

This variable identifies the Government's perception of the overall acceptability of aggregate national fertility, and is divided among three categories: "not satisfactory because too low"; "satisfactory"; and "not satisfactory because too high".

2. *Government's intervention concerning fertility level*

Governmental intervention concerning the level of fertility is classified as four types: (*a*) to raise the fertility level; (*b*) to maintain the fertility level; (*c*) to lower the fertility level; and (*d*) no intervention or no policy formulated.

3. *Government's policies concerning effective use of modern methods of contraception*

Four categories of governmental policy concerning individual fertility behaviour were adopted to categorize countries according to their level of support for modern methods of contraception:

(*a*) The Government limits access to information, guidance and materials in respect of modern methods of contraception that would enable persons to regulate their fertility more effectively and would help them achieve the desired timing of births and completed family size;

(*b*) The Government does not limit access to information, guidance and materials but provides no support--direct or indirect-- for their dissemination;

(*c*) The Government provides indirect support for the dissemination of information, guidance and materials by subsidizing the operating costs of organizations supporting such activities outside the Government's own services. The indirect support may take various forms, such as direct grants, tax reductions or rebates or assignment of special status;

(*d*) The Government provides direct support for the dissemination of information, guidance and materials within government facilities.

4. *Use of contraception*

The percentage of currently married women aged 15-49 years that use modern contraception provides an indication of the actual availability of contraception. Use of contraception is inversely associated with abortion at the aggregate level. A low availability of modern contraceptives tends to be correlated with high abortion rates. Conversely, when modern contraception is widely available and used effectively, abortion rates tend to be relatively lower. At the individual level, the use of contraception is positively associated with the practice of abortion. That is, women that have ever used a contraceptive method are, on average, more likely to resort to abortion than never-users. On the other hand, women that have had an abortion are more likely to use contraception than women that have never done so. It has been suggested that contraceptive use increases after an abortion because of the provision of contraceptives and counselling in abortion clinics.

Information on contraceptive use was obtained primarily from representative national sample surveys of women of reproductive age conducted by various governmental and non-governmental agencies. The data pertain to women currently married or in a consensual union (United Nations, forthcoming.)

5. Total fertility rate

The total fertility rate (TFR) measures the number of children a woman would have over her lifetime if she were to follow current age-specific fertility rates. TFRs presented are medium-variant estimates for the period 1985-1990 and are based on available data that have been adjusted to reflect rates for the same five-year period. Estimated rather than actual TFRs were used to permit comparisons across countries.

6. Age-specific fertility rate for women aged 15-19

The age-specific fertility rate (ASFR) for women aged 15-19 is an indicator of current rates of adolescent fertility. Specifically, the rate is the number of births to women aged 15-19 per 1,000 women aged 15-19. In general, adolescent fertility has been increasing in a number of countries in recent years. Because many of these young mothers are unmarried, have no means of economic support and may face social disgrace as a result of the pregnancy, many resort to abortion.

Adolescent abortion rates are high in developed countries, such as the United States of America, and in less developed regions, particularly in sub-Saharan Africa and the Caribbean. In developed countries, between 5 (in Japan) and 26 (in the United Kingdom and the United States) per cent of all legal abortions during the period from around 1985 to 1987 were to women aged 15-19 (Henshaw and Morrow, 1990). Estimates of abortion rates in many developing countries are unreliable because abortion is generally illegal and most abortions are not reported. However, estimates indicate very high rates of abortion. Studies of the hospital records of women hospitalized with complications arising from induced abortion have found that in 1977 the average age of abortion patients in the Congo was 22 years, and in Benin the average was 19 years.

ASFRs pertain to the years in which the data were gathered in each country. Comparable estimates of ASFR for women aged 15-19 years are not available. Given the tendency for people to round their age to digits ending in zero or five and because adolescent women giving birth tend to overstate their age, it is likely that many births occurring to women under age 20 are recorded as occurring at age 20, thus underestimating actual adolescent fertility (United Nations, 1989).

7. Government's concern about morbidity and mortality resulting from induced abortion

This variable indicates whether the Government views existing health complications due to induced abortion with special concern. The information was obtained from the Government's reply to the Sixth United Nations Population Inquiry among Governments in 1987, conducted by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. In cases where Governments did not respond to the Inquiry, statements made in official government documents and publications were reviewed in order to determine the Government's concern with morbidity and mortality resulting from induced abortion.

8. Government's concern about complications of child-bearing and childbirth

This variable indicates whether the Government views existing health complications due to child-bearing and childbirth with special concern. The information was obtained from the Government's reply to the Sixth Population Inquiry among Governments in 1987, conducted by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. In cases where Governments did not respond to the Inquiry, statements made in official government documents and publications were reviewed in order to determine the Government's concern with complications of child-bearing and childbirth.

9. Maternal mortality rate

Induced abortion is responsible for a large percentage share of maternal mortality in developing countries, particularly in countries with very restrictive abortion laws. As many as 54 per cent of all maternal deaths in Ethiopia and in Trinidad and Tobago have been attributed to abortion. In Matlab, Bangladesh, 31 per cent of maternal deaths were abortion-related. The corresponding figures are 37 per cent for Argentina and 18 per cent for the United States[2] (PAHO, 1990; Royston and Armstrong, 1989).

According to the World Health Organization (WHO), a maternal death is defined as "the death of a woman while pregnant or within 42 days of termination of pregnancy regardless of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes" (WHO, 1974, p. 764, cited in PAHO, 1990). Thus, maternal mortality rate measures the number of maternal deaths occurring in a given year per 100,000 live births during that year. Ideally, both that rate and the proportion of deaths attributable to abortion should be included. Because induced abortion is frequently performed illegally, however, only deaths occurring in hospitals are reported and even then the cause of death is often omitted. This practice greatly underestimates the number of deaths caused by abortion. Given these additional sources of unreliability, the proportion of deaths attributable to abortion was not included.

Caution should be exercised when examining maternal mortality rates and making comparisons across countries. Underregistration of maternal deaths varies by country, as does underregistration of cause of death. Even in developed countries, such as the United States, maternal mortality has been found to be underregistered by as much as 27 per cent (PAHO, 1990). Underregistration of births is also significant, and when the degree of underreporting of births and deaths differs, the direction of the bias will also differ. Limiting the puerperal period to 42 days also introduces a downward bias. Studies conducted in the United States have shown that 16 per cent of the "deaths associated with pregnancy, delivery, and the puerperium occur between 42 days and one year afterwards" (PAHO, 1990, p. 119). Given that data on maternal mortality are often unreliable and that many countries are lacking information, rates for both the country and the region were included. Where both figures are available and the country in question is suspected of having very deficient vital statistics, the regional figure provides an idea as to the extent of possible bias of the national figures.

10. Female life expectancy at birth

Female life expectancy at birth is included as a measure of women's overall health. The figure represents the number of years that a newborn female child would live, on average, if she were subjected during her lifetime to the risk of dying observed for each age group in the current year. All the measures are medium-variant estimates for the period 1985-1990 (taken from United Nations, 1991) and therefore permit cross-country comparisons.

C. STATISTICS ON INDUCED ABORTION

The most commonly employed sources of abortion statistics include official statistics provided by Governments on legal abortions performed, surveys of abortion service providers, hospital admission records on women admitted for abortion complications and household surveys containing information on women's pregnancy history. The last-named source may provide both period and lifetime abortion experience.

In general, countries with liberal abortion laws require that all abortions performed be reported to the Government. These statistics are usually published by national health statistical agencies. In countries where abortion is available on demand, where abortion services are sufficient and adequate and where there is compliance with reporting requirements, one may expect government figures to provide the most unbiased estimate of abortions performed. The same may be said of countries where abortion is de facto available for socio-economic reasons. If abortion is not readily available, even when legal, abortions may be sought in other

countries or in illegal facilities, in which case official figures would underestimate the actual number of women obtaining abortions. Insufficient access to legal abortion may be the result of burdensome procedures required to obtain an abortion (as is the case in the USSR) or of insufficient service availability, including both clinics and physicians (as in Zambia), or simply due to the refusal by available staff to perform the abortion on moral grounds (as in Austria).

Not all countries, however, require providers to register abortions performed in their facilities. In these cases, statistics are often available from other health agencies and associations or from individual surveys of abortion service providers. Surveys of providers are the next least biased source of abortion data. These surveys have been conducted in countries with liberal abortion laws which have no official reporting requirements. They have also been conducted where abortion is illegal in order to estimate abortion rates. Where abortion is legal, surveys of providers generally give good estimates of abortion rates. Where abortion is illegal, however, providers may not be willing to give the information in order to protect the women's confidentiality and to avoid prosecution. Moreover, non-medical providers may be difficult to identify. Women successfully inducing their own abortion are also missed.

Surveys of women, either as part of a general household survey or in a more specialized demographic or health survey, can also be a source of information on abortion. This category includes abortion statistics based on personal interviews with women in households or hospitals, or as participants in specific programmes, concerning their reproductive history, or more specifically, their abortion experience. This source is useful regardless of the legal status of abortion because it provides measures both of prevalence and of incidence. However, survey data have their drawbacks. Underreporting of induced abortion in surveys has been found to be considerable even when abortion is legal because of fear of social disapproval and poor recall. In addition, the statistics obtained from pregnancy histories are retrospective and are usually presented as lifetime measures rather than annual measures. These statistics were employed only when they were calculated as annual rates and when they were based on representative samples of the population.

Where abortion is illegal, the most commonly used source of information on abortion statistics is hospital admission records. Hospital admission records include all women admitted for treatment of complications of abortion, whether spontaneous or induced. In these cases, the underestimation of true induced abortion rates can be substantial, as only cases where abortions resulted in complications are hospitalized. Furthermore, only hospital-based treatments are included. Deaths occurring before a hospital has been contacted also go unreported. Despite problems with underestimation of induced abortion, hospital admission records are useful because they give an indication as to the minimum incidence of abortion in a given region.

In addition to the potential biases mentioned above, all measures miss self-induced abortion employing prostaglandins during very early pregnancy. They may also miss abortions performed by menstrual regulation because in some places it is considered a family planning method, not an abortifacient. The use of RU486, the Roussel-UCLAF "abortion pill", might also go undetected.

NOTES

[1] Most of the comparative studies on abortion law in Commonwealth countries have been conducted by Cook and Dickens. They surveyed all Commonwealth countries to inquire whether the *Bourne* case was applicable in each country in question. Thus, when countries responded in the affirmative, they considered the country to permit abortion on both physical and mental health grounds, regardless of whether a court precedent had been set in that country. That is, in some cases, mental health grounds are assumed to be permitted, when in fact no case has tested those grounds. In this publication, only those countries where local court precedents have tested the legality of mental health grounds are coded as permitting this ground.

[2] Figures for Argentina, Trinidad and Tobago, and the United States are for the late 1980s; for Matlab, Bangladesh, 1982, and for Ethiopia, 1987.

IV. COUNTRY PROFILES

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	No
To preserve mental health	No
Rape or incest	No
Foetal impairment	No
Economic or social reasons	No
Available on request	No

Additional requirements

Information not readily available.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Too high
Government's intervention concerning fertility level:	No intervention
Government's policy on contraceptive use:	Direct support provided
Percentage of currently married women* using modern contraception (aged 15-44, 1972/73):	1
Total fertility rate (1985-1990):	6.9
Age-specific fertility rate (per 1,000 women aged 15-19):	..
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	No
Complications of child-bearing and childbirth	Yes
Maternal mortality rate (per 100,000 live births):	
National (1975)	690
Southern Asia (around 1983)	650
Female life expectancy at birth (1985-1990):	42.0

*Ever-married women.

Afghanistan

BACKGROUND

The Afghanistan Criminal Code of 7 October 1976 declares abortion a criminal offense except when the mother's life is endangered by the pregnancy. A person performing an abortion can face imprisonment for up to 15 years, or a fine. A woman inducing her own abortion is subject to the same punishment.

Although use of modern contraceptive methods is negligible in Afghanistan, use of indigenous fertility regulation methods is widespread. However, almost 75 per cent of the indigenous methods recorded are intended to enhance fertility; only 6 per cent are abortifacients. Modern contraceptives are available at government clinics and through the Afghan Family Guidance Association (AFGA), which, in cooperation with the Ministry of Health, has developed a network of family planning clinics in government premises. The Ministry of Health is expected to support one half of the AFGA programme.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
Information not readily available.			

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	Yes
To preserve mental health	Yes
Rape or incest	Yes
Foetal impairment	Yes
Economic or social reasons	Yes
Available on request	Yes

Additional requirements

Therapeutic abortions must be approved by the district medical commission.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Satisfactory
Government's intervention concerning fertility level:	To maintain
Government's policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49):	..
Total fertility rate (1985-1990):	3.0
Age-specific fertility rate (per 1,000 women aged 15-19):	..
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of child-bearing and childbirth	..
Maternal mortality rate (per 100,000 live births):	
National	..
Developed countries (around 1983)	30
Female life expectancy at birth (1985-1990):	74.2

Albania

BACKGROUND

Until mid-1991, abortion was permitted only to save the life of the pregnant woman or when her physical health was seriously endangered. Abortions were performed for any of up to 30 medical indications. In practice, abortions were sometimes permitted on all but economic or social grounds. All therapeutic abortions had to be approved by the medical commission of the district. The Criminal Code of 15 June 1977 (section 95) punished repeat offenders or those performing an abortion that resulted in the woman's death or serious disruption of her health with eight years in prison. Otherwise, the punishment was re-education through work or detention for up to two years. A woman performing an abortion herself without help was punished by a social reprimand or by re-education through work.

The National Health Programme prepared in 1989 called for a 50 per cent reduction in the number of abortions by 1995. It was reported that one half of all abortions were self-induced.

In June 1991, prompted by the detrimental impact of illegal abortions on maternal and child health, the Ministry of Health issued a directive that significantly broadened the grounds on which abortions were permitted. Henceforth, abortion was to be permitted upon request by couples, as well as at the request of a pregnant woman when the pregnancy was conceived outside of marriage. The cost of an abortion was set at 100 new leks ($1 = 15 new leks).

It had been reported that maternal mortality was increasing and that over 50 per cent of those deaths were the result of complications following an illegal abortion. There were also indications of an increase in pregnancy-related diseases, such as eclampsia and anaemia.

Beginning in 1992, the Government is expected to receive international assistance, in order to strengthen gynaecological and obstetric care and to create a national family planning programme. Family planning services will be provided at all maternity clinics and women's health centres, and contraceptives will be available at pharmacies. One of the objectives is to reduce maternal mortality by 50 per cent. A family planning unit will be created within the Department of Maternal and Child Health and some 240 gynaecologists and 400 midwives will be trained.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	Yes
To preserve mental health	Yes
Rape or incest	No
Foetal impairment	No
Economic or social reasons	No
Available on request	No

Additional requirements

A physician must certify, after a medical examination carried out in conjunction with a medical specialist, that the procedure is required to save the woman's life or to preserve her physiological or mental equilibium. The procedure must be performed by a physician, in a specialized institution, with the consent of the pregnant woman. Therapeutic abortions must be performed before the foetus is viable.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Too high
Government's intervention concerning fertility level:	To lower
Government's policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49, 1986/87):	31
Total fertility rate (1985-1990):	5.4
Age-specific fertility rate (per 1,000 women aged 15-19, 1985):	43
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	No
Complications of child-bearing and childbirth	Yes
Maternal mortality rate (per 100,000 live births):	
National (1978)	136
Northern Africa (around 1983)	500
Female life expectancy at birth (1985-1990):	65.0

Algeria

BACKGROUND

The Algerian Criminal Code of 8 June 1966 (sections 304-307 and 309-313) prohibits abortion. The Public Health Code of 1976 (Ordinance No. 76-79 of 23 October 1976), however, specifies that abortion is lawful when it constitutes an essential therapeutic measure to save the life of the mother or to safeguard her seriously endangered health. Public Health Act No. 85-05 of 16 February 1985 liberalized abortion laws further by permitting abortion to preserve a woman's mental equilibrium if it is seriously jeopardized.

A woman inducing her own abortion is subject to imprisonment for from 6 to 24 months and a fine. Sentences for non-medical abortionists can range from one to five years and a fine. Medical practitioners performing abortions have received even harsher sentences. In addition to a fine and a prison sentence, they can be barred from the practice of their profession.

Abortion, when permitted, may only be performed by a physician in a specialized institution, after a medical examination carried out in conjunction with a medical specialist (Public Health Act No. 85-05 of 16 February 1985). The pregnant woman must consent to the abortion. A therapeutic abortion must be performed before the foetus is viable. Prior to 1985, abortions could only be performed with the consent of two physicians, including the performer, and after notification of administrative authorities.

A study of trends in maternal mortality in public sector institutions in Algeria found that the most important cause of maternal mortality was uterine perforation. It was estimated that about half of all uterine perforations resulted from poorly performed illegal abortions.

Although the Algerian Government currently provides family planning services in all government maternal and child health centres, it was not until the early 1980s that it officially endorsed family planning and ensured that the services should be available to the entire population. All health care, including contraception, is provided free of charge in public health facilities. Oral contraceptives are available at pharmacies on prescription.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	No*
To preserve mental health	No*
Rape or incest	No*
Foetal impairment	No*
Economic or social reasons	No
Available on request	No

Additional requirements

A therapeutic abortion requires the woman's consent and consultation with medical professionals. The abortion must be performed within the first trimester.

*Official interpretation generally permits these grounds.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Too high
Government's intervention concerning fertility level:	To lower
Government's policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49):	..
Total fertility rate (1985-1990):	6.4
Age-specific fertility rate (per 1,000 women aged 15-19):	..
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	Yes
Complications of child-bearing and childbirth	No
Maternal mortality rate (per 100,000 live births):	
National	..
Middle Africa (around 1983)	690
Female life expectancy at birth (1985-1990):	46.1

Angola

BACKGROUND

Prior to its independence in 1975, the abortion legislation in Angola was that of Portugal. The Portuguese laws were restrictive, permitting abortion only to save the life of the woman. Transgression of the law was also harshly punished.

Upon attaining independence, Angola adopted those same laws with the same harsh punishments. Unlawful abortion without the consent of the woman is punishable by imprisonment for a period of from two to eight years; the penalty for an abortion performed with the consent of the woman is punishable by a prison term of three years. A woman who induces her own abortion receives the same penalty. If the abortion was performed to conceal the pregnant woman's dishonour, the sentence is reduced to two years. If the abortion results in the death of the woman or serious injury to her, the penalty is increased by one third.

Abortions, are performed, however, on broad health grounds and juridical grounds, in government facilities in special circumstances. Government authorities are considering permitting economic grounds in very special circumstances.

Despite economic and social pressures resulting from its long-lasting civil war and a severely weakened infrastructure, the Angolan Government is committed to providing family planning services as a preventive and health promotion measure. Family planning services were introduced in the Government's maternal and child health services in 1986. They are available free of charge in government clinics.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
Information not readily available.			

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	No
To preserve mental health	No
Rape or incest	No
Foetal impairment	No
Economic or social reasons	No
Available on request	No

Additional requirements

A therapeutic abortion requires the authorization of a panel of physicians. As a rule, the abortion must be performed within the first 16 weeks of gestation, although it can be performed later in very exceptional circumstances.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Satisfactory
Government's intervention concerning fertility level:	No intervention
Government's policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-44, 1981):	37
Total fertility rate (1985-1990):	..
Age-specific fertility rate (per 1,000 women aged 15-19):	..
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	Yes
Complications of child-bearing and childbirth	..
Maternal mortality rate (per 100,000 live births):	
National (1986)	88
Caribbean (around 1983)	220
Female life expectancy at birth (1985-1990):	..

Antigua and Barbuda

BACKGROUND

Only limited abortion information is available on Antigua and Barbuda. Abortion is considered an offense, according to the Offences against the Person Act of 1861 (cap. 58, part IX, sections 53-54), and is only allowed when a panel of physicians determines that the pregnancy poses serious danger to the woman's life. As a rule, abortions are permitted only within the first 16 weeks of pregnancy, although in exceptional cases they can be performed later.

Most Commonwealth countries, whose legal systems are based on common law, consider the 1938 *Bourne* case in England to apply in the determination of whether an abortion is lawful. In the *Bourne* case, a physician was acquitted of an offence for performing an abortion on a woman who had been raped. The court ruled that the abortion was lawful because it had been performed to prevent the woman from becoming "a physical and mental wreck", thus setting a precedent for future abortion cases performed on the grounds of preserving the pregnant woman's physical and mental health. In Antigua and Barbuda, however, an abortion performed on the grounds of preserving the woman's mental health is considered an offence.

Family planning services are available through the Antigua Planned Parenthood Association and through government clinics.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	Yes
To preserve mental health	No
Rape or incest	No
Foetal impairment	No
Economic or social reasons	No
Available on request	No

Additional requirements

An abortion must be performed by a licensed physician with the consent of the pregnant woman.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Satisfactory
Government's intervention concerning fertility level:	No intervention
Government's policy on contraceptive use:	Indirect support provided
Percentage of currently married women using modern contraception (aged 15-49):	..
Total fertility rate (1985-1990):	3.0
Age-specific fertility rate (per 1,000 women aged 15-19, 1980):	82
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	Yes
Complications of child-bearing and childbirth	Yes
Maternal mortality rate (per 100,000 live births):	
National (1986)	55
South America (around 1983)	280
Female life expectancy at birth (1985-1990):	74.0

Argentina

BACKGROUND

The Criminal Code of 1921 (sections 85-88), amended in 1967 (Law 17567 of the Penal Code of 6 December 1967, section 86), in 1984 (Decree No. 3992 of 21 December 1984) and in 1989, prohibits abortion except when performed to avert a danger to the mother's life or health that could not be averted by any other means. An earlier version of the Code (the 1967 amendment) permitted abortion when the pregnancy resulted from rape, provided criminal proceedings had been initiated. In 1984, the clause permitting abortion on the grounds of rape (section 86) was modified to permit abortion only if the victim of rape was mentally ill or retarded. Subsequently, however, a national court judgement (2 June 1989) outlawed abortion on rape grounds altogether.

Abortions must be performed by a certified physician and with the consent of the pregnant woman. A person inducing an abortion may be punished by imprisonment for a period of 3-10 years if the abortion is performed without the woman's consent and 15 years if the woman dies. If the abortion is induced with the woman's consent, the punishment is from one to four years in prison, six years if the woman dies. A woman inducing her own abortion is subject to up to four years in prison. Licensed physicians performing unlawful abortions can have their practice interrupted for a period of time twice as long as the prison term to which they have been sentenced.

Despite the restrictive nature of its abortion laws, Argentina has one of the highest abortion ratios in the world, with one abortion estimated to occur for every two live births. Induced abortion accounted for 38 per cent of all maternal deaths in Buenos Aires in 1985. Studies have found abortion to be the most important cause of maternal death in all groups over 20 years of age. Prosecution for unlawful abortion is rare. The requirement of legal proof of pregnancy as a precondition for prosecution allows abortion to be performed despite current prohibitions.

The high incidence of abortion has been blamed for the insufficient availability of contraceptive methods and of access to information about contraception. Family planning activities were prohibited by the military Government in 1974 and remained so until 1986, when Decree No. 2274 (5 December 1986) was introduced, repealing the 1974 decree. The 1986 decree stipulated that the Ministry of Health and Social Action should develop and implement programmes to improve maternal and child health. Resolution No. 463/88 of 23 November 1988 went a step further, approving the development of a reproductive health programme. Its primary objective is to provide women of high reproductive risk with family planning information and services. Despite advancements in the legal climate concerning access to contraception, however, the Government has not passed legislation permitting the implementation of those resolutions. Thus, although family planning is now legal and available in the private sector, it is not easily available to women who, for economic reasons, must rely upon the public sector.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
Information not readily available			

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	Yes
To preserve mental health	Yes
Rape or incest	Yes
Foetal impairment	Yes
Economic or social reasons	Yes
Available on request	No

Additional requirements

Consent of the woman is required in all states and territories. In South Australia and in the Northern Territory, abortion requires the consent of two physicians. All states and territories require that abortions be performed in hospitals by licensed physicians. In South Australia and the Capital Territory, abortions must be performed in prescribed hospitals. In South Australia and the Northern Territory, two medical practitioners must certify that the abortion was necessary to save the woman's life or to preserve her physical and mental health.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Satisfactory
Government's intervention concerning fertility level:	No intervention
Government's policy on contraceptive use:	Indirect support provided
Percentage of currently married women using modern contraception (aged 15-49):	..
Total fertility rate (1985-1990):	1.8
Age-specific fertility rate (per 1,000 women aged 15-19, 1983):	26
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	No
Complications of child-bearing and childbirth	No
Maternal mortality rate (per 100,000 live births):	
National (1988)	5
Oceania (around 1983)	..
Female life expectancy at birth (1985-1990):	79.5

Australia

BACKGROUND

Restrictions on abortion vary by state in Australia. In Victoria, the Australian Capital Territory and New South Wales, abortion comes under common law; in Tasmania, Queensland and Western Australia, it comes under the Criminal Code; and in South Australia and the Northern Territory, under amendments to the Criminal Code.

Only the South Australian (Criminal Law Consolidation Act, 1935-1966, amended by Act No. 109 of 1969) and Northern Territory laws (Criminal Law Consolidation Act, 1876-1969, amended by Ordinance No. 6, section 79A, of 1974) define lawful abortion. In other states and territories, the grounds are derived from judicial interpretations. Given that the states vary in terms of the cases testing the legality of the grounds for abortion, it is difficult to say definitively which state has the most liberal interpretation of the law.

All states permit abortion to save the life of the pregnant woman. All states except Tasmania (Criminal Code Act of 1924) and Western Australia (Criminal Code Act of 1913) permit abortion on mental and physical health grounds. Although in Queensland, section 282 of the Criminal Code (Criminal Code Act of 1899, sections 224-226 and 282) permits abortion only when necessary to preserve the life of the pregnant woman, the courts apply the British *Rex v. Bourne* case (1938) in the acquittal of the defendants, indirectly permitting abortion on the grounds of preserving the woman's physical and mental health. (In the *Bourne* case, a physician was acquitted of an offence of performing an abortion on a woman who had been raped, in order to save her from becoming a "physical and mental wreck").

The most liberally stated laws are those of the Capital Territory and New South Wales (Crimes Act of 1900), which permit abortion to preserve the physical and mental health of the pregnant woman, where social and economic stresses may be taken into account in the determination of risk to physical and mental health. Thus, interpretation of the law would allow eugenic and juridical grounds as well. South Australia also has liberal laws. The law specifies that abortion is permitted to preserve the physical and mental health of the pregnant woman or if the foetus has the possibility of being seriously handicapped. In the case of South Australia, the law notes that "in determining whether the continuance of a pregnancy would involve such risk of injury to the physical or mental health of a pregnant woman...account may be taken of the pregnant woman's actual or reasonably foreseeable environment". Although social and economic grounds are not mentioned directly, the law may interpret them as health grounds.

The Northern Territory permits abortion on eugenic grounds as well as on broad health grounds. In Victoria (Crimes Act of 1958), the law permits abortion on broad physical and mental health grounds. Common-law judgements in Victoria have invoked the *Bourne* case and have given health grounds a very liberal interpretation. No state has made specific provisions for cases where pregnancy results from rape or incest.

The maximum prison terms for persons performing illegal abortions range from 10 to 15 years. Women inducing their own abortion have different punishments.

Some states require the consent of the woman; none requires the consent of the spouse. Parental consent is required if the female is under age 14 years in New South Wales or under age 16 in the Northern Territory. Specifications as to whether a physician has to perform the abortion and the maximum period of gestation allowed for abortion also vary by state. Authorization by two physicians is required in South Australia and the Northern Territory. South Australia allows up to 28 weeks of gestation. In the Northern Territory, abortions may be performed up to the twenty-third week of gestation in emergencies, but if treatment is not immediately necessary, only 14 weeks of gestation are allowed. In South Australia and the Capital Territory, the abortion must be performed in a prescribed hospital. Other states have no legal requirements as to where abortions are to be performed. The Australian Government Health Insurance benefits, available to all citizens, cover legal abortions.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
South Australia	1970	6.0 abortions/1,000 women aged 15-44	PR
South Australia	1980	13.9 abortions/1,000 women aged 15-44	PR
South Australia	1984	13.2 abortions/1,000 women aged 15-44	PR
National	1980	13.9 abortions/1,000 women aged 15-44	PR
National	1984	15.2 abortions/1,000 women aged 15-44	PR
National	1985	15.6 abortions/1,000 women aged 15-44	PR
National	1986	16.4 abortions/1,000 women aged 15-44	PR
National	1987	16.3 abortions/1,000 women aged 15-44	PR
National	1988	16.6 abortions/1,000 women aged 15-44	PR

NOTES: PR: provider registration; SP: survey of providers; SW: survey of women; HR: hospital admission records. For a detailed description of these abbreviations and information on sources of data, see technical notes in annex I.

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

Austria

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	Yes
To preserve mental health	Yes
Rape or incest	Yes
Foetal impairment	Yes
Economic or social reasons	Yes
Available on request	Yes

Additional requirements

An abortion is available on request if gestation is 12 weeks or less after medical consultation. If necessary to avert serious danger to the woman's life or health, if there is suspicion of foetal impairment or if the woman is a minor (under 14 years of age), an abortion may be performed after the first trimester. All abortions must be performed by a licensed physician.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Satisfactory
Government's intervention concerning fertility level:	No intervention
Government's policy on contraceptive use:	Indirect support provided
Percentage of currently married women* using modern contraception (aged 15-49, 1981/1982):	56
Total fertility rate (1985-1990):	1.5
Age-specific fertility rate (per 1,000 women aged 15-19, 1985):	22
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	No
Complications of child-bearing and childbirth	No
Maternal mortality rate (per 100,000 live births):	
National (1987)	5
Developed countries (around 1983)	30
Female life expectancy at birth (1985-1990):	77.8

*Marriage cohorts of 1974 and 1978.

BACKGROUND

Austria decriminalized abortion in 1974 through a reform of section 144 of the Austrian Penal Code (Federal Law 23 January 1974 of the Criminal Code, sections 96-98). An abortion is available on request during the first trimester of pregnancy after a medical consultation. After the first trimester, an abortion is permitted only on medical grounds, that is, when necessary to preserve the pregnant woman's physical or mental health, in cases of foetal impairment or if the pregnant woman is under 14 years of age. Furthermore, the abortion must be performed with the pregnant woman's consent.

The Federal Law of 1974 was contested on the grounds that it violated provisions protecting life under the Austrian Constitution. However, the Austrian Constitutional Court dismissed the complaint on 11 October 1974, explaining that the provisions protecting life do not apply to the foetus.

Theoretically, all women have access to legal and risk-free abortion. However, income and availability of services pose important restrictions on access to abortion. The Government only subsidizes abortions performed on medical grounds. In addition, private clinics charge such high prices that some women find it is less expensive to go abroad to get an abortion. Access is also limited by the fact that many physicians refuse to perform abortions because they object for moral and/or religious reasons.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

Bahamas

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	Yes
To preserve mental health	Yes
Rape or incest	No*
Foetal impairment	No*
Economic or social reasons	No
Available on request	No

Additional requirements

An abortion must be authorized and must be performed by a licensed physician in a hospital.

*Legal interpretation generally permits these grounds.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Satisfactory
Government's intervention concerning fertility level:	No intervention
Government's policy on contraceptive use:	Indirect support provided
Percentage of currently married women using modern contraception (aged 15-49):	..
Total fertility rate (1985-1990):	..
Age-specific fertility rate (per 1,000 women aged 15-19, 1985):	68
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of child-bearing and childbirth	..
Maternal mortality rate (per 100,000 live births):	
National (1987)	69
Caribbean (around 1983)	220
Female life expectancy at birth (1985-1990):	..

BACKGROUND

The Bahamian Penal Code (cap. 48, sections 341, 353 and 357) permits abortion to save the life of the pregnant woman and to preserve her physical and mental health. In practice, the law is interpreted very liberally. Abortions performed on the grounds of foetal deformity, rape or incest may be interpreted as producing a risk to the woman's mental health.

Abortions are usually performed within the first trimester, although up to 20 weeks of gestation are often allowed. The abortion must be performed in a hospital by a licensed physician. Government hospitals bear the cost for non-paying patients.

Transgression of the law is punished by imprisonment for 10 years (Penal Code of 1924 effective 1 January 1927, chapter 77, section 316).

Family planning services are available in some government clinics and at the Bahamas Planned Parenthood Association clinic.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

Bahrain

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	Yes
To preserve mental health	Yes
Rape or incest	No
Foetal impairment	Yes
Economic or social reasons	No
Available on request	No

Additional requirements

An abortion requires authorization by a panel of physicians. Only a licensed physician may perform abortions.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Satisfactory
Government's intervention concerning fertility level:	No intervention
Government's policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49):	..
Total fertility rate (1985-1990):	4.1
Age-specific fertility rate (per 1,000 women aged 15-19):	..
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of child-bearing and childbirth	..
Maternal mortality rate (per 100,000 live births):	
National (1982-1986)	27
Western Asia (around 1983)	340
Female life expectancy at birth (1985-1990):	72.9

BACKGROUND

The Criminal Code (sections 201-203), which was promulgated in 1956 and adopted at the time Bahrain proclaimed its independence, forbids abortion except to save the life of the pregnant woman or to preserve her mental and physical health and in the case of known foetal deformity. Transgression of the law is punishable by 10 years in prison for the abortionist, up to five years of imprisonment for a woman inducing her own abortion and up to three years and/or a fine for a person supplying any material knowing it will be used in performing an abortion.

A provision of Decree-Law No. 24 of 1977 prohibits midwives from performing abortions. Abortions must be performed by a licensed physician after consultation with a panel of physicians.

Bahrain was the first Gulf State to provide official family planning services. The Ministry of Health provides family planning services in all health centres, maternity hospitals, post-natal clinics and child welfare clinics. Contraceptives are provided free of charge. Sterilization is also available at government facilities. The Bahrain Family Planning Association, founded in 1976, primarily provides information, education and training.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

Bangladesh

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	No
To preserve mental health	No
Rape or incest	No
Foetal impairment	No
Economic or social reasons	No
Available on request	No

Additional requirements

A therapeutic abortion requires the approval of two physicians and must be performed by a qualified physician in a hospital. No approval is required in the case of menstrual regulation, as the procedure is considered a family planning method rather than an abortive technique. Menstrual regulation may be performed, within six weeks of gestation, by paramedical personnel on an out-patient basis.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Too high
Government's intervention concerning fertility level:	To lower
Government's policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49, 1989):	22*
Total fertility rate (1985-1990):	5.5
Age-specific fertility rate (per 1,000 women aged 15-19, 1983):	239
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	Yes
Complications of child-bearing and childbirth	Yes
Maternal mortality rate (per 100,000 live births):	
National (1985)	600
Southern Asia (around 1983)	650
Female life expectancy at birth (1985-1990):	50.4

*Preliminary or provisional.

BACKGROUND

Abortion laws in Bangladesh originated from the Indian Penal Code of 1860. The Penal Code (sections 312-316) permits abortion only to save the life of the pregnant woman. The law was temporarily waived in 1972 for women who were raped during the War of Liberation. Despite the restrictive nature of the law, "menstrual regulation" services have been available in the Government's family planning programme. The Government does not feel that this service conflicts with current abortion laws as it provides menstrual regulation as a family planning method, not as an abortifacient. Furthermore, because section 312 of the Penal Code requires that pregnancy be established for prosecution to take place, menstrual regulation makes it virtually impossible for the prosecutor to obtain the required proof. Menstrual regulation is available on request as long as gestation is not more than six weeks.

If proof of transgression of the law is obtained (that is, the abortion was performed for non-therapeutic purpose, without the use of menstrual regulation), the penalty for the person performing it, including a woman inducing her own abortion, is up to three years in prison and/or a fine. If performed after quickening has occurred, the sentence is seven years and/or a fine; it is 10 years if performed without the consent of the woman or if she dies.

Legal abortions must be performed by a qualified physician in a hospital. Menstrual regulation, however, can be performed on an out-patient basis and may be performed by a trained paramedic. In practice, many providers of menstrual regulation have received only informal training. Training in menstrual regulation and services is provided by the Government in seven government medical colleges, two district hospitals and a large family planning clinic.

An important justification for the provision of menstrual regulation as a public-health measure has been the high rates of hospitalization due to complications of induced abortion and the high levels of maternal mortality resulting from septic abortion. Slightly over half of all admissions to gynaecology units of large urban hospitals resulted from complications of induced abortion, and it has been estimated that about one quarter of all maternal deaths are due to unsafe abortion. Access to menstrual regulation is very limited in rural areas. Indigenous induced abortion is reported to be commonly practised in rural areas. One study conducted in rural Bangladesh noted that 94 per cent of the women obtaining abortions were currently married.

Bangladesh

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
National	1975	0.3 abortion/1,000 women aged 15-44	PR
National	1977	0.4 abortion/1,000 women aged 15-44	PR
National	1979	0.6 abortion/1,000 women aged 15-44	PR
National	1980	1.6 abortions/1,000 women aged 15-44	PR
National	1981	2.3 abortions/1,000 women aged 15-44	PR
National	1982	3.1 abortions/1,000 women aged 15-44	PR
National	1983	2.9 abortions/1,000 women aged 15-44	PR
National	1984	3.4 abortions/1,000 women aged 15-44	PR
National	1987	3.5 abortions/1,000 women aged 15-44	PR
National	1988	3.4 abortions/1,000 women aged 15-44	PR

NOTES: PR: provider registration; SP: survey of providers; SW: survey of women; HR: hospital admission records. For a detailed description of these abbreviations and information on sources of data, see technical notes in annex I.

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	Yes
To preserve mental health	Yes
Rape or incest	Yes
Foetal impairment	Yes
Economic or social reasons	Yes
Available on request	No

Additional requirements

Authorization by a physician is required when gestation is 12 weeks or less. If gestation is greater than 12 weeks but less than 20, the procedure must be authorized by two physicians. If gestation is greater than 20 weeks, authorization by three physicians is required. The woman must receive counselling prior to the procedure. A written statement by the woman is required when the grounds are rape or incest. All abortions must be performed by a medical practitioner. When gestation is greater than 12 weeks, the abortion must be performed in a Government-approved hospital.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Satisfactory
Government's intervention concerning fertility level:	To maintain
Government's policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49, 1980/81):	45
Total fertility rate (1985-1990):	1.8
Age-specific fertility rate (per 1,000 women aged 15-19, 1980):	71
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	Yes
Complications of child-bearing and childbirth	Yes
Maternal mortality rate (per 100,000 live births):	
National (1984)	71
Caribbean (around 1983)	220
Female life expectancy at birth (1985-1990):	76.9

Barbados

BACKGROUND

Abortion laws were significantly liberalized in Barbados in 1983, with the introduction of the Medical Termination Pregnancy Regulation Act (Act No. 4 of 11 February 1983). The Government had been concerned with the high morbidity and mortality resulting from unsafe illegal abortions. Prior to 1983, abortion legislation was based on the Offenses Against the Person Act of 1868 (sections 61 and 62), which only permitted abortion to save the life of the pregnant woman and to preserve her physical and mental health. The 1983 Act permits abortion on broad physical and mental health grounds and in the case of suspected foetal deformity. The Act specifies that when determining whether the continuation of the pregnancy would involve a risk of injury to the health of the pregnant woman, "the medical practitioner must take into account the pregnant woman's social and economic environment, whether actual or foreseeable". When abortion is requested on the grounds of rape or incest, a written statement by the pregnant woman indicating that the pregnancy resulted from rape or incest is required. Pregnancy resulting from rape or incest is considered sufficient to constitute the element of grave injury to mental health. If the female is under 16 years of age or of unsound mind, parental approval is required.

Abortions may be performed within the first 12 weeks of pregnancy with the authorization of a physician. If the pregnancy is more than 12 weeks but less than 20 weeks, the procedure must be authorized by two physicians, and if more than 20 weeks, it must be authorized by three physicians. In cases where the termination of pregnancy is immediately necessary, the requirements of additional medical opinions, written statements in cases of rape and the stipulation that it be performed in a Government-approved hospital may be waived. An abortion taking place after the twelfth week of gestation must be performed in a Government-approved hospital. Abortions must be performed by medical practitioners, who are required to counsel women requesting an abortion. Women must be informed as to alternatives to abortion and the nature of the procedure and must be advised on how to deal with the social and psychological consequences of terminating pregnancy.

Adolescent pregnancy rates are high in Barbados. Forty per cent of pregnancies occur to women under age 20. The Family Planning Association has expressed concern that many young schoolgirls are obtaining abortions and that many are under the age of consent. Family planning services are offered free of charge at government clinics and at low cost by the Barbados Family Planning Association.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	Yes
To preserve mental health	Yes
Rape or incest	Yes
Foetal impairment	Yes
Economic or social reasons	Yes
Available on request	Yes

Additional requirements

Medical consultation is required if gestation is greater than 12 weeks. The abortion must be performed by a licensed physician in a hospital or other approved establishment, with the consent of the woman.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Satisfactory
Government's intervention concerning fertility level:	To maintain
Government's policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49):	..
Total fertility rate (1985-1990):	2.4*
Age-specific fertility rate (per 1,000 women aged 15-19, 1985/86):	44*
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	Yes
Complications of child-bearing and childbirth	Yes
Maternal mortality rate (per 100,000 live births):	
National (1988)	25
Developed countries (around 1983)	30
Female life expectancy at birth (1985-1990):	74.2*

*Estimate based on data pertaining to the USSR, as separate tabulations for Belarus are not readily available.

Belarus

BACKGROUND

The Union of Soviet Socialist Republics was the first country to legalize abortion. Abortion became available on demand in the Soviet republics in 1920 if performed within the first trimester in a hospital (Law of 8 November 1920). The measure was introduced in an effort to improve women's status and welfare. In 1936, however, abortion legislation was reversed in order to increase population growth (Law of 27 June 1936). Abortion was only permitted to save the life of the pregnant woman or in cases where foetal deformity was suspected. The abortion had to be performed within the first trimester. Offending physicians were subject to imprisonment for from one to two years. Punishment was up to three years in prison for abortionists who were not qualified physicians.

In 1955, in recognition of the increased maternal mortality and morbidity resulting from illegal induced abortion, the Supreme Soviet made abortion legal again (Decree of 23 November 1955). Abortion is authorized when performed by a physician, in a hospital or other medical institution according to instructions provided by the Ministry of Health. An abortion is available on demand in the Soviet republics up to the twelfth week of pregnancy. Thereafter, special authorization is required. An abortion may not be performed if the procedure poses a risk to the mother's health or if she has undergone an abortion within the prior six months. There is no information readily available on punishment for transgression of the law.

The USSR has one of the highest abortion rates in the world. Contraceptives are of relatively inferior quality and are in short supply. Contraceptives have only been available in pharmacies. Both health personnel and the general population have little knowledge about family planning methods. Given the lack of choice, women have relied upon induced abortion as the main method of birth control. Although in 1985, six of the 15 Soviet republics had higher abortion rates than Belarus, the figure of 80.0 abortions per 1,000 women aged 15-49 is still exceedingly high. The figure is more alarming when one considers that the figure excludes illegal abortions and abortions performed by vacuum aspiration. In about 10 per cent of all abortions, vacuum extraction is used; such abortions are performed up to the twentieth day of a missed period on an ambulatory basis. Illegal abortion rates are estimated to be as high as legal abortion. Extremely cumbersome administrative procedures and low quality of available services have led many women to seek illegal abortions from private physicians. Maternal mortality rates in Belarus are among the lowest of the Soviet republics.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
Belarus	1975	78.7 abortions/1,000 women aged 15-49	PR
Belarus	1980	81.1 abortions/1,000 women aged 15-49	PR
Belarus	1985	80.0 abortions/1,000 women aged 15-49	PR

NOTES: PR: provider registration; SP: survey providers; SW: survey of women; HR: hospital admission records. For a detailed description of these abbreviations and information on sources of data, see technical notes in annex I.

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	Yes
To preserve mental health	Yes
Rape or incest	Yes
Foetal impairment	Yes
Economic or social reasons	Yes
Available on request	No

Additional requirements

The woman must certify in writing that she is determined to have an abortion and the physician must be convinced of her determination. The woman must receive counselling prior to the procedure. The procedure must be performed by a physician under good medical conditions. Gestation must be 12 weeks or less.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Satisfactory
Government's intervention concerning fertility level:	No intervention
Government's policy on contraceptive use:	Indirect support provided
Percentage of currently married women* using modern contraception (aged 20-44, 1982):	63
Total fertility rate (1985-1990):	1.6
Age-specific fertility rate (per 1,000 women aged 15-19, 1983):	16
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	No
Complications of child-bearing and childbirth	No
Maternal mortality rate (per 100,000 live births):	
National (1986)	3
Developed countries (around 1983)	30
Female life expectancy at birth (1985-1990):	78.1

*Flemish population.

Belgium

BACKGROUND

Abortion laws were significantly liberalized in Belgium on 3 April 1990, when the Belgian Parliament repealed section 353 of the Penal Code of 1867 that banned all abortions without exception. The new law also amended sections 348-352 of the Code. Abortion legislation in Belgium was based on the Napoleonic Penal Code of 1810, which was adopted in 1867 after Belgium gained independence from France. Abortion was prohibited in any circumstance, subject to the defense of necessity. The law viewed abortion as justified by necessity when three physicians certified that the pregnancy constituted an immediate and serious threat to the health of the pregnant woman. Transgression of the law was severely punished. An additional law enacted in 1923 went so far as to prohibit the provision of information concerning abortion or contraception or the facilitation of their access.

Attempts to liberalize the law began in 1971. Since then, 15 laws permitting abortion have been proposed and defeated. Although the laws remained unchanged, prosecution was rare and those prosecuted were usually acquitted on the grounds that the laws were in the process of being revised.

The new law permits abortion in the first 12 weeks of pregnancy when a woman who is "in a state of distress as a result of her situation" requests a physician to terminate her pregnancy. The woman is the sole judge of whether she is in distress. Aside from informing the woman as to the risks of undergoing the procedure and the alternatives to abortion, the physician need only be convinced of the pregnant woman's determination to terminate her pregnancy.

After 12 weeks of pregnancy, abortion is legal only if two physicians agree that the woman's health is in danger or if the foetus is believed to be seriously impaired.

Regardless of gestation length, all abortions must be performed by a physician under good medical conditions, in an establishment that has an information department able to provide the woman seeking abortion with the information she needs. After being counselled, the woman must be given six days to reach a decision. She must certify in writing, on the date of the intervention, that she is determined to terminate her pregnancy.

Anyone performing an illegal abortion may be punished by imprisonment for from three months to one year and a fine of 200-500 Belgian francs (BF), under section 350 of the Penal Code. A woman voluntarily obtaining an illegal abortion is subject to imprisonment for from 1 to 12 months and a fine of BF 50-200 (section 351). If the illegal abortion results in the woman's death and the woman had consented to the abortion, the abortionist is punished by imprisonment. If the woman did not consent, the abortionist is subject to 10-15 years of forced labour.

Although abortion was illegal prior to 1990, abortion services were available to women at university hospitals and from private physicians and clinics affiliated with the Action Group of Out-patient Clinics Practising Abortion (GACEPHA), a local initiative to provide abortion services.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
National	1985	5.1 abortions/1,000 women aged 15-44	SP
National	1985	9.4 abortions/100 live births	SP

NOTES: PR: provider registration; SP: survey of providers; SW: survey of women; HR: hospital admission records. For a detailed description of these abbreviations and information on sources of data, see technical notes in annex I.

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

Belize

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	Yes
To preserve mental health	Yes
Rape or incest	Yes
Foetal impairment	Yes
Economic or social reasons	Yes
Available on request	No

Additional requirements

An abortion must be performed by a registered physician and authorized by two registered physicians.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Satisfactory
Government's intervention concerning fertility level:	No intervention
Government's policy on contraceptive use:	Indirect support provided
Percentage of currently married women using modern contraception (aged 15-44):	42
Total fertility rate (1985-1990):	4.5
Age-specific fertility rate (per 1,000 women aged 15-19, 1986-1990):	136
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of child-bearing and childbirth	..
Maternal mortality rate (per 100,000 live births):	
National (1986)	65
Central America (around 1983)	240
Female life expectancy at birth (1985-1990):	..

BACKGROUND

Abortion law in Belize is based on Ordinance No. 33 of the Criminal Code of 18 December 1980 (sections 108-110 of title IX). Abortion is considered illegal except when performed "by a registered medical practitioner, if two registered medical practitioners are of the opinion, formed in good faith, that the continuance of the pregnancy would involve risk to the life of the pregnant woman, or injury to her physical and mental health of the pregnant woman or any existing children of her family, greater than if the pregnancy were terminated". The law also states that suspicion of foetal physical or mental deformity is grounds for abortion. A second clause stipulates that in determining whether the continuance of a pregnancy would pose a risk of injury to health, account may be taken of the pregnant woman's actual or reasonably foreseeable environment. Given the wording of the law, legal interpretation is likely to permit abortion on the grounds of rape and incest, and for specified social and economic grounds.

Despite the apparently liberal stance on abortion, penalties for offenders are very severe. The penalty for anyone performing an illegal abortion is 14 years of imprisonment. A woman causing her own illegal abortion is subject to life imprisonment.

Maternal morbidity is a frequent cause of hospitalization (excluding normal deliveries) in Belize. In 1985 and 1987, complications of childbirth were the most important cause of hospitalization at Belize City Hospital. Hospitalization due to complications of induced abortion was the third most frequent cause of hospitalization in 1985 and the second most important cause in 1987. The Government began providing family planning as part of its maternal and child health programme in the mid-1980s. Thirty-eight per cent of users of contraceptives obtain them in government facilities. The Government provides mainly intra-uterine devices (IUD) and sterilization. Family planning services are also provided by the Belize Family Life Association, which was founded in 1985.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

Benin

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	No
To preserve mental health	No
Rape or incest	No
Foetal impairment	No
Economic or social reasons	No
Available on request	No

Additional requirements

A committee of three physicians, including the performer and one who must be selected from the list of experts attached to the civil courts, must certify in writing that the abortion is necessary to save the life of the pregnant woman. The procedure must be performed by a qualified physician.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Satisfactory
Government's intervention concerning fertility level:	No intervention
Government's policy on contraceptive use:	Indirect support provided
Percentage of currently married women using modern contraception (aged 15-49, 1981/82):	0.5*
Total fertility rate (1985-1990):	7.1
Age-specific fertility rate (per 1,000 women aged 15-19):	..
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of child-bearing and childbirth	..
Maternal mortality rate (per 100,000 live births):	
National	..
Western Africa (around 1983)	700
Female life expectancy at birth (1985-1990):	47.6

*Women who have not resumed sexual relations since last pregnancy are not counted as users of contraception.

BACKGROUND

Abortion law in Benin was modelled after the Napoleonic Penal Code of 1810. Upon attaining independence in 1958, Benin adopted the Code with some amendments. Abortion was forbidden on all grounds. The law was amended again in 1973 (Ordinance No. 73-14 of 8 February 1973 of the Code of Medical Deontology, section 37), permitting abortion only when necessary to save the life of a pregnant woman. The attending physician or surgeon must seek the opinion of two consulting physicians, one of whom must be selected from the list of experts attached to the civil court, who, after an examination of the case, must certify in writing that the procedure is necessary to save the life of the mother. Although the law is restrictive, an abortion brought about as a secondary effect of therapy is excused by the legal system.

The high incidence of induced abortion is a growing concern in Benin. The problem is particularly acute among young high school and university students. A retrospective study of abortion cases in the largest maternity hospital at Cotonou found the average age of abortion patients to be 19 years. For 36 per cent of patients, the pregnancy was not their first.

Although Benin has retained the French anticontraception laws of 1920, they are not enforced. The laws have, however, indirectly constrained the growth of family planning programmes. Although services are provided in government health centres and the medical and nursing schools, and through the private sector, service delivery is logistically weak.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

Bhutan

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Information not readily available
To preserve physical health	
To preserve mental health	
Rape or incest	
Foetal impairment	
Economic or social reasons	
Available on request	

Additional requirements

Information not readily available.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Satisfactory
Government's intervention concerning fertility level:	No intervention
Government's policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49):	..
Total fertility rate (1985-1990):	5.5
Age-specific fertility rate (per 1,000 women aged 15-19):	..
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of child-bearing and childbirth	..
Maternal mortality rate (per 100,000 live births):	
National (1984)	1,710
Southern Asia (around 1983)	650
Female life expectancy at birth (1985-1990):	47.1

BACKGROUND

Only limited information is readily available on population issues in Bhutan. None of the sources available makes any reference to abortion policy and practice.

There is some information on the poor state of maternal health in Bhutan. Fewer than 20 per cent of pregnant women receive any prenatal care and only 5 per cent of deliveries take place in hospitals. There is a significant shortage of health facilities and personnel. Maternal and child health and family planning services are provided in the Government's basic health units which, although not numerous, are distributed throughout the country. The family planning programme has been in operation since 1974.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

Bolivia

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	Yes
To preserve mental health	No
Rape or incest	Yes
Foetal impairment	No
Economic or social reasons	No
Available on request	No

Additional requirements

An abortion must be authorized by a government official and must be performed by a licensed physician.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Too high
Government's intervention concerning fertility level:	No intervention
Government's policy on contraceptive use:	No support provided
Percentage of currently married women using modern contraception (aged 15-49, 1989):	12
Total fertility rate (1985-1990):	6.2
Age-specific fertility rate (per 1,000 women aged 15-19, 1984-1989):	94
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	Yes
Complications of child-bearing and childbirth	Yes
Maternal mortality rate (per 100,000 live births):	
National (1973-1977)	480
South America (around 1983)	280
Female life expectancy at birth (1985-1990):	55.4

BACKGROUND

In Bolivia, abortion is permitted only to save the pregnant woman's life, to preserve her health or when the pregnancy resulted from incest or rape (Decree Law No. 10,426 of 23 August 1972, sections 263, 266 and 267). Transgression of the law by either an abortionist or the woman is punishable by from one to three years of imprisonment. Persons regularly performing abortions can be sentenced to from one to six years in prison.

Although no official statistics are available on the number of illegal abortions performed in Bolivia, hospital-based data and surveys suggest a very high incidence of illegal abortion. At La Paz, one survey of women aged 15-44 reported that 20 per cent of respondents had had at least one induced abortion in their lifetime. Others suggest this figure to be as high as 50 per cent. A study of maternal mortality conducted in 1980 in hospitals in 8 of the 12 Bolivian health units found that 27 per cent of all maternal deaths were caused by septic abortion.

The Bolivian Government has been traditionally opposed to the provision of family planning. Only minimal contraceptive services were provided at public clinics. In response to pressure from the Catholic Church and to the disclosure that census population figures in 1976 were 1 million short of population projections, the Government introduced a decree in 1977 forbidding the provision of family planning services in public institutions (Presidential Resolution No. 184393 of 5 August 1977). Thereafter, the few services available were provided by the private sector.

In 1982, however, the Goverment became so concerned about the growing number of illegal, unsafe abortions and the resulting maternal mortality, that it reversed the 1977 decree. On 15 March 1982, the Government issued new regulations concerning family health activities in the country. The 1982 regulations permit the provision of family planning information and some services as part of their post-partum programme. Post-abortion patients are also included. In 1986, the Bolivian Government issued a child-spacing policy, stating that it was the Government's responsibility to provide family planning information and services to high-risk women. Despite these changes, however, contraceptive prevalence remains low and abortion rates high.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
National	1972	20.2 abortions/100 live births	HR

NOTES: PR: provider registration; SP: survey of providers; SW: survey of women; HR: hospital admission records. For a detailed description of these abbreviations and information on sources of data, see technical notes in annex I.

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

Botswana

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	No
To preserve mental health	No
Rape or incest	No
Foetal impairment	No
Economic or social reasons	No
Available on request	No

Additional requirements

An abortion must be performed, with the consent of the woman, in a hospital and must be authorized by two medical practitioners.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Too high
Government's intervention concerning fertility level:	To lower
Government's policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49, 1988):	32
Total fertility rate (1985-1990):	7.1
Age-specific fertility rate (per 1,000 women aged 15-19, 1983-1988):	125
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	Yes
Complications of child-bearing and childbirth	Yes
Maternal mortality rate (per 100,000 live births):	
National (1980)	250
Southern Africa (around 1983)	570
Female life expectancy at birth (1985-1990):	61.5

BACKGROUND

The Botswana Penal Code of 1964 (Law No. 2 of 10 June 1964, sections 155, 156 and 236) prohibits abortion except when necessary to save the life of the pregnant woman. An abortion must be carried out in a hospital or clinic with the approval of two medical practitioners and with the consent of the woman. Anyone who unlawfully administers medication or supplies any instrument to a woman to procure miscarriage, whether or not she is pregnant, is subject to several years of imprisonment. A woman who induces her own abortion is sentenced to three years of imprisonment.

A bill that has been under consideration in Parliament since 1990 would permit abortion if performed within the first 16 weeks of gestation, if continuance of the pregnancy would involve risk to the life of the pregnant woman or injury to her physical or mental health; if the pregnancy is the result of rape, defilement or incest; or if the child, if born, would suffer from a serious physical or mental abnormality or disease. The bill has been the subject of heated debate.

The Government has expressed particular concern about the high levels of maternal mortality due to unsafe abortion. The problem appears to be significant among teenage schoolgirls, where high rates of pregnancy have led many young girls to seek abortions. The percentage of women giving birth between the ages of 15 and 19 increased from 15 per cent in 1971 to 23 per cent in 1984. Fifty-six per cent of female secondary school students dropped out of school in 1986 because they became pregnant.

Although family planning services are available free of charge at government clinics, the services emphasize birth-spacing and thus do not adequately address the needs of young unmarried women. Although services have been provided by the Government since 1967, service delivery is hampered by inadequate supply systems, with services being available only on set days and times, and supplies often running out. Thus, contraceptive continuation rates are low.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

Brazil

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	No
To preserve mental health	No
Rape or incest	No
Foetal impairment	No
Economic or social reasons	No
Available on request	No

Additional requirements

An abortion must be performed by a physician after consultation with and agreement by another physician.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Satisfactory
Government's intervention concerning fertility level:	No intervention
Government's policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-44, 1986):	56
Total fertility rate (1985-1990):	3.5
Age-specific fertility rate (per 1,000 women aged 15-19, 1981-1986):	81
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of child-bearing and childbirth	..
Maternal mortality rate (per 100,000 live births):	
National (1984)	120
South America (around 1983)	280
Female life expectancy at birth (1985-1990):	67.6

BACKGROUND

Sections 124, 125, 128 and 130 of the Brazilian Penal Code (Decree Law 2848 of 7 December 1940), including supplementary provisions of 3 October 1941 and 9 December 1941 (Decree Laws 3688 and 3914), and amendments made in 1969 (Decree Law No. 1004 of 21 October 1969) and 1973 (Law No. 6016 of 31 December 1973), declare abortion a criminal offense except when the pregnancy seriously endangers the life of the pregnant woman. An abortion must be performed by a physician after consultation with and agreement by another physician. Article 20 of the Decree Law of 3 October 1941 prohibited the advertising of a process, substance or object designed to cause an abortion or to prevent pregnancy. Decree Law 4113 of 14 February 1942 went even further: it prohibited physicians, nurses and hospitals from providing information on or treatment for the interruption or prevention of pregnancy.

The Government began to shift away from its strict pronatalist stance in the mid-1970s. Although prohibitions of abortion remained intact, the advertising of contraceptives was decriminalized on 4 December 1979 (Law 6734). Furthermore, in July 1977, the Ministry of Health created a national programme directed to preventing high-risk pregnancies. The programme, however, never received any funding and was never implemented. Similar programmes were subsequently designed, with a greater emphasis on women's health. As before, the Government failed to implement them. Efforts to ease restrictions on abortion began in 1975 and to date have been unsuccessful.

Illegal abortion in Brazil is punishable by at least four years of imprisonment for the physician; the penalty is higher if valid consent was not obtained, if the woman is injured or dies, or if the woman is under 14 years of age. The woman faces imprisonment for at least four years; the penalty is 6-24 months of imprisonment if the abortion was intended to avoid dishonour.

Despite current legal restrictions, abortion is widely practised in Brazil. Estimates of the number of illegal abortions performed each year range from 0.5 million to 4 million. The majority of women seeking abortions are married. Prosecution for unlawful abortion is rare. The requirement of legal proof of pregnancy as a precondition for prosecution allows abortion to be performed despite current prohibitions.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

Brunei Darussalam

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	No
To preserve mental health	No
Rape or incest	No
Foetal impairment	No
Economic or social reasons	No
Available on request	No

Additional requirements

No additional information readily available.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Satisfactory
Government's intervention concerning fertility level:	No intervention
Government's policy on contraceptive use:	No support provided
Percentage of currently married women using modern contraception (aged 15-49):	..
Total fertility rate (1985-1990):	..
Age-specific fertility rate (per 1,000 women aged 15-19):	..
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of child-bearing and childbirth	..
Maternal mortality rate (per 100,000 live births):	
National	..
South-eastern Asia (around 1983)	420
Female life expectancy at birth (1985-1990):	..

BACKGROUND

Abortion is forbidden in Brunei Darussalam except to save the life of the pregnant woman. Unlawful abortion is punishable by up to three years in prison and/or a fine. If performed when the foetus is viable, imprisonment may be extended to seven years, plus a fine. A woman performing her own abortion may be sentenced to up to 10 years in prison.

If the abortionist causes the death of the pregnant woman, imprisonment is extended to 10 years. If performed without the woman's consent and she dies, the transgression is punishable by 15 years in prison.

Although the Government is implementing a policy to provide health for everyone by the year 2000 through a system of maternal and child health clinics, including 26 located in rural areas, the services do not include family planning. Only information on birth-spacing is provided.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

Bulgaria

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	Yes
To preserve mental health	Yes
Rape or incest	Yes
Foetal impairment	Yes
Economic or social reasons	Yes
Available on request	Yes

Additional requirements

An abortion on request requires authorization by a local obstetrician, who must certify in writing, after examining the woman, that gestation is not more than 12 weeks and that the woman suffers no illness that the abortion may aggravate. Medically indicated abortion, where gestation is under 20 weeks, is allowed only if a medical committee (including the head of the obstetric department and two physicians) certifies in writing that the pregnancy poses a threat to the life or health of the pregnant woman or if the foetus may be severely impaired. Abortions must be performed in authorized obstetric hospitals and clinics by physicians specialized in obstetrics and gynaecology.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Too low
Government's intervention concerning fertility level:	To raise
Government's policy on contraceptive use:	Direct support provided
Percentage of currently married women* using modern contraception (aged 18-44, 1976):	7
Total fertility rate (1985-1990):	1.9
Age-specific fertility rate (per 1,000 women aged 15-19, 1986):	81
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of child-bearing and childbirth	..
Maternal mortality rate (per 100,000 live births):	
National (1988)	9
Developed countries (around 1983)	30
Female life expectancy at birth (1985-1990):	75.0

*Women in first marriage.

BACKGROUND

Abortion has been legal in Bulgaria since 27 April 1956, when the Ministry of Public Health declared that all women wanting to terminate a pregnancy had the right to do so except if the woman had had an abortion less than six months before or if gestation was greater than 12 weeks. Abortion was permitted only on therapeutic grounds when gestation was longer than 12 weeks. Abortions had to be performed in authorized hospitals.

In response to declining birth rates, the Bulgarian Government restricted access to abortion in February 1968 (Decree No. 188 of the Ministry of Public Health and Social Welfare). Abortion was restricted for childless women, except when a commission certified that the procedure was to preserve the life or health of the woman. Women with only one or two children were actively discouraged from aborting, although they could obtain an abortion with the commission's approval. Approval was also given when the pregnancy was the result of rape, when the woman was an unmarried minor and in cases of extreme poverty. Women over 45 years of age or those with at least three children could obtain an abortion on demand without the authorization of the commission. However, if gestation was greater than 10 weeks or the woman had aborted within the prior six months, abortion was only permitted on therapeutic grounds.

In April 1973 the restrictions were extended (Decree No. 0-27 of the Ministry of Public Health), denying childless women and women with only one child access to abortion. Exceptions were made only in the case of rape or incest, if the woman was a minor or over 45 years of age with at least one child or for serious medical reasons. Restrictions were somewhat relaxed in 1974, permitting abortion if the woman was unmarried, regardless of parity. Termination of pregnancy on request could only be performed if pregnancy duration did not exceed 10 weeks at the time the examination was performed.

Currently, according to Decree No. 2 of 1 February 1990 of the Ministry of Health and Social Welfare, abortion is available on request to all women as long as gestation is not more than 12 weeks and the abortion does not pose a danger to her health. Beyond the first 12 weeks of gestation, abortion is only permitted for a number of medical indications as authorized by a medical committee, including the head of the obstetric department and two physicians. If gestation is greater than 20 weeks, however, abortion is only permitted to save the life of the woman or in cases of severe foetal impairment. All restrictions concerning child-bearing history, age and marital status were removed.

All abortions must be performed in authorized obstetric hospitals and clinics by certified obstetricians. Only abortions obtained on therapeutic grounds, when the pregnancy is the result of rape or when the woman is a minor are performed free of charge.

Abortion has been employed as a principal method of birth control in Bulgaria. About one half of all pregnancies are terminated artificially. It has one of the highest abortion rates in the world.

Bulgaria

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
National	1960	29.0 abortions/1,000 women aged 15-44	PR
National	1970	63.2 abortions/1,000 women aged 15-44	PR
National	1980	76.7 abortions/1,000 women aged 15-44	PR
National	1984	61.9 abortions/1,000 women aged 15-44	PR
National	1985	64.4 abortions/1,000 women aged 15-44	PR
National	1986	65.5 abortions/1,000 women aged 15-44	PR
National	1987	64.7 abortions/1,000 women aged 15-44	PR

NOTES: PR: provider registration; SP: survey providers; SW: survey of women; HR: hospital admission records. For a detailed description of these abbreviations and information on sources of data, see technical notes in annex I.

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations. For additional sources, see list of references.

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	No
To preserve mental health	No
Rape or incest	No
Foetal impairment	No
Economic or social reasons	No
Available on request	No

Additional requirements

Additional information is not readily available.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Too high
Government's intervention concerning fertility level:	To lower
Government's policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49):	..
Total fertility rate (1985-1990):	6.5
Age-specific fertility rate (per 1,000 women aged 15-19):	..
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	Yes
Complications of child-bearing and childbirth	Yes
Maternal mortality rate (per 100,000 live births):	
National (1986)	810
Western Africa (around 1983)	700
Female life expectancy at birth (1985-1990):	48.9

Burkina Faso

BACKGROUND

Abortion legislation in Burkina Faso is based on the French Napoleonic Code of 1810. The Penal Code of 1984 (section 317, introduced in 1923 and amended in 1939, 1947, 1955, 1958 and 1968) prohibits abortion except when necessary to save the life of a pregnant woman. The penalty for transgression of the law is from one to five years of imprisonment and a fine for the abortionist. The penalty for persons routinely performing abortions is 5-10 years in prison and a fine twice as large as that for the first transgression. For the woman, the penalty is imprisonment for from six months to two years and a fine that is one fifth the amount to be paid by the person performing the abortion. Medical personnel performing abortions or aiding an abortionist can be suspended for a period of five years.

Numerous clandestine abortions have been performed in recent years and have resulted in high rates of maternal mortality. Concerned with high rates of adolescent pregnancy and maternal morbidity and mortality, the Government passed an Act that would introduce family planning services as a component of primary health care.

Up to 1986, access to contraception and abortion was limited by the Government's adherence to the French Law of 31 July 1920, which prohibited the importation, sale and advertisement of contraceptives, as well as imposed stringent restrictions on abortion. On 24 October 1986, the Government adopted a national family planning policy and repealed the French anticontraception laws and sections of the Public Health Code of 28 December 1970 pertaining to contraception. No changes were introduced concerning abortion legislation.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	Yes
To preserve mental health	No
Rape or incest	No
Foetal impairment	No
Economic or social reasons	No
Available on request	No

Additional requirements

An abortion must be performed in a hospital by a certified physician after the concurrence of another qualified physician, with the written consent of the pregnant woman.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Too high
Government's intervention concerning fertility level:	To lower
Government's policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49, 1987):	1
Total fertility rate (1985-1990):	6.8
Age-specific fertility rate (per 1,000 women aged 15-19, 1982-1987):	52
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	Yes
Complications of child-bearing and childbirth	Yes
Maternal mortality rate (per 100,000 live births):	
National	..
Eastern Africa (around 1983)	660
Female life expectancy at birth (1985-1990):	49.2

Burundi

BACKGROUND

The Penal Code of 30 January 1940 prohibits abortion except to save the life of the pregnant woman or to prevent serious and permanent injury to her health (sections 165 and 166, amended 4 April 1981, Law 1/6, section 357). The law also stipulates that in any sentence resulting from prosecution under the provisions of sections 353-356, "account shall be taken of the social exigencies of the environment in which the act was committed". An explanatory clause to the law clarifies that although the Government does not intend to liberalize abortion, it believes it would be wrong to "ignore certain social necessities, such as the situation of distress of the pregnant woman".

As mentioned above, penalties for transgression of the law depend upon the "social exigencies in which the act was committed". Prior to 1981, penalties were imprisonment for from 2 to 10 years for the abortionist. A woman who induced her own abortion was subject to imprisonment for from two to five years.

Burundi has relatively high fertility, with a total fertility rate of 6.8 for the period 1985-1990, and extremely low contraceptive prevalence, with only 1 per cent of women using a modern contraceptive method. In 1984, the Government adopted a policy to slow population growth and stated that the policy would be implemented by means of a broad family planning programme that would incorporate not just birth limitation but women and child health concerns. Although its implementation began slowly, services are now being delivered in government facilities. Although no data are available on maternal mortality, figures available for the early 1980s show that 7 per cent of the women admitted to maternity wards arrived with complications of induced abortion.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	No
To preserve mental health	No
Rape or incest	No
Foetal impairment	No
Economic or social reasons	No
Available on request	No

Additional requirements

Additional information is not readily available.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	..
Government's intervention concerning influence fertility level:	..
Government's policy on contraceptive use:	Major restrictions
Percentage of currently married women using modern contraception (aged 15-49):	..
Total fertility rate (1985-1990):	4.7
Age-specific fertility rate (per 1,000 women aged 15-19):	..
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of child-bearing and childbirth	..
Maternal mortality rate (per 100,000 live births):	
National	..
South-eastern Asia (around 1983)	420
Female life expectancy at birth (1985-1990):	49.9

Cambodia

BACKGROUND

Only limited information is available on Cambodia. Abortion is forbidden except to save the life of the pregnant woman. Information is not readily available on the punishment for those performing illegal abortions nor on the incidence of abortion.

During the 1960s, the population of Cambodia grew at a rapid rate. Despite the impression that the country was underpopulated, the Government decided in 1972 to create a Family Planning Division within the Maternal and Child Protection Service of the Ministry of Health. Given the political turmoil at the time, delays in its implementation were significant. The massive number of deaths due to civil conflict, famine and disease and the flight of refugees to surrounding countries, led to an actual population decline of 2 million during the decade. This decimation of the population led Governments during that period to adopt a pronatalist stance. Thus, abortion remained illegal (except to save the life of the pregnant woman) throughout the period, and family planning services were virtually unavailable. Since 1980, death rates have declined and a small baby boom has ensued. The birth rate in 1988 was estimated at 43 per 1,000. Howeyer, family planning services are still unavailable.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
Information not readily available.			

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	Yes
To preserve mental health	No
Rape or incest	Yes
Foetal impairment	No
Economic or social reasons	No
Available on request	No

Additional requirements

An abortion must be performed by a qualified medical practitioner. Two consultant physicians must certify that the abortion is necessary to save the live of the pregnant woman or to prevent grave danger to her health. In cases of rape, the public prosecutor's office must verify the facts of the case before the abortion can lawfully be performed.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Too high
Government's intervention concerning fertility level:	To lower
Government's policy on contraceptive use:	No support provided
Percentage of currently married women using modern contraception (aged 15-49, 1978):	0.6
Total fertility rate (1985-1990):	6.9
Age-specific fertility rate (per 1,000 women aged 15-19):	..
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	Yes
Complications of child-bearing and childbirth	Yes
Maternal mortality rate (per 100,000 live births):	
National (1978)	303
Middle Africa (around 1983)	690
Female life expectancy at birth (1985-1990):	54.0

Cameroon

BACKGROUND

Until recently, the Government's policy concerning fertility was considerably pronatalist. Cameroon adhered to the French anticontraception laws of 1920, which prohibited the importation, sale and advertisement of contraceptives, as well as imposed stringent restrictions on abortion. The laws, however, were not strictly enforced, as contraceptives were available in the black market. In 1980, the law was changed to permit the sale and advertisement of contraceptives; the abortion laws remained unchanged. However, illegal abortions are easily obtained.

Abortion is illegal in Cameroon except when performed to save the life of the pregnant woman or to prevent grave injury to her health (Penal Code of 1965, section 339, amended on 28 September 1972). Abortion is also permitted when the pregnancy is the result of rape. Two physicians must certify that the pregnancy poses a risk to the life of the woman, and the abortion must be performed by a qualified physician. In cases of rape, the public prosecutor's office must verify the facts of the case before abortion can lawfully be performed. The Criminal Code (Law 65-LF-24 of 12 November 1965, and Law 67-LF-1 of 12 June 1967, section 337) states that anyone performing an illegal abortion is subject to from one to five years in prison and a fine. A woman inducing her own abortion can be punished by from two weeks to one year of imprisonment and/or a fine. Physicians who perform illegal abortions are subject to heavier penalties.

A law introduced in 1980 to regulate the practice of pharmacy (Law 80-10 of 14 July 1980, section 78) restricts access to abortion even further by limiting access to abortifacients, allowing their purchase only by prescription from a registered doctor. Further, it prohibits any advertisement or display of any medicine or object capable of inducing an abortion. Transgression of the law is punishable by imprisonment for from three months to two years and/or a fine.

Induced abortion and its complications constitute a serious problem in Cameroon. A study conducted at the main maternity hospital found that 32 per cent of emergency hospital admissions were due to complications of induced abortion. Induced abortion is a particularly serious problem among adolescents. Access to contraception is limited for all women but is particularly more acute for teenagers. Contraceptives in Cameroon are available in pharmacies but on prescription only. A restricted number of small private facilities offer family planning services and their coverage is limited. In 1978, only 36 per cent of the women interviewed in a household survey could name a contraceptive method.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	Yes
To preserve mental health	Yes
Rape or incest	Yes
Foetal impairment	Yes
Economic or social reasons	Yes
Available on request	Yes

Additional requirements

Given the absence of abortion legislation, abortion is available on request with no stipulations as to who must perform it and where.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Satisfactory
Government's intervention concerning fertility level:	No intervention
Government's policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49, 1984):	69
Total fertility rate (1985-1990):	1.6
Age-specific fertility rate (per 1,000 women aged 15-19, 1987):	23
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	Yes
Complications of child-bearing and childbirth	Yes
Maternal mortality rate (per 100,000 live births):	
National (1988)	5
Developed countries (around 1983)	30
Female life expectancy at birth (1985-1990):	80.3

Canada

BACKGROUND

Canadian abortion laws have undergone significant changes in the past two decades. Prior to 1969, abortion was permitted when "in good faith, [it] was considered necessary to preserve a woman's life" (Criminal Code of 1955, section 251). In response to the mounting public debate, the Canadian Government reviewed its abortion laws in 1967 and passed a new bill in August 1969 (section 237) which liberalized previous laws. Under the new act, abortion was permitted if the continuation of the pregnancy "would be likely to endanger the woman's life or health". Although the new law broadened the grounds under which abortion was permitted, it also imposed some restrictions. The new law required that an abortion be carried out in an approved hospital which had a therapeutic abortion committee of no fewer than three qualified physicians (not including the one performing the abortion). The abortion had to be requested in writing by the physician and forwarded to the committee. This meant that women were required to have from three to seven contacts with health professionals before a procedure could be performed.

The new bill, however, had no effect on existing abortion practice, as the wording of it permitted varied interpretations. Furthermore, very few hospitals (only 10 per cent in Quebec) had an abortion committee. The law was considered to be basically unenforceable. Recognizing this, the Government of Quebec made abortion available in free-standing clinics in 1973, exempting one quarter of the Canadian population from the restrictions imposed by the Criminal Code. Amidst continuing public debate on the legal status of abortion, the Canadian Supreme Court struck down the restrictive 1969 laws on 31 January 1988 on the grounds that it infringed on the principles of life, liberty and security of person contained in the Canadian Charter of Rights and Freedoms. Earlier, in 1984, the Saskatchewan Court had ruled that a foetus was not a person within the meaning of the law and thus was not protected by the Canadian Charter of Rights and Freedoms.

After the 1988 ruling, the House of Commons made several attempts to pass an abortion law that would please both anti- and pro-abortion groups; and on 3 November 1989, a new bill was passed by the Commons. The bill repealed sections 287 and 288 of the Criminal Code and replaced them with a bill that permitted abortion only when the "health or life of the woman would be likely to be threatened". The bill specified that the term "health" included physical, mental and psychological health. Although the bill did not specifically address eugenic, juridical or socio-economic grounds for abortion, it permitted the physician to interpret these grounds as causing injury to the woman's psychological health. Transgression of the law was to be punished by two years in prison. On 31 January 1990, however, the Canadian Senate declined to approve the bill that had been approved by the House of Commons. The current Government has announced that it will not introduce any new abortion legislation, leaving abortion legislation in the hands of provincial courts.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
National	1971	6.6 abortions/1,000 women aged 15-44	PR
National	1973	8.9 abortions/1,000 women aged 15-44	PR
National	1975	9.6 abortions/1,000 women aged 15-44	PR
National	1977	10.6 abortions/1,000 women aged 15-44	PR
National	1979	11.6 abortions/1,000 women aged 15-44	PR
National	1981	11.1 abortions/1,000 women aged 15-44	PR
National	1983	10.2 abortions/1,000 women aged 15-44	PR
National	1985	10.2 abortions/1,000 women aged 15-44	PR
National	1987	10.2 abortions/1,000 women aged 15-44	PR

NOTES: PR: provider registration; SP: survey providers; SW: survey of women; HR: hospital admission records. For a detailed description of these abbreviations and information on sources of data, see technical notes in annex I.

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

Cape Verde

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	Yes
To preserve mental health	Yes
Rape or incest	Yes
Foetal impairment	Yes
Economic or social reasons	Yes
Available on request	No

Additional requirements

An abortion can be performed on any grounds if gestation is within 12 weeks. Thereafter, it can be performed only if the continuation of the pregnancy poses a risk of death or serious and permanent injury to the physical and mental health of the pregnant woman, or if the foetus is suspected of having serious handicaps or of acquiring a serious hereditary illness. An abortion requires the woman's written consent and a certification by a medical commission. It must be performed in a hospital, with "medical assistance".

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Too high
Government's intervention concerning fertility level:	To lower
Government's policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49):	..
Total fertility rate (1985-1990):	5.6
Age-specific fertility rate (per 1,000 women aged 15-19):	..
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	Yes
Complications of child-bearing and childbirth	..
Maternal mortality rate (per 100,000 live births):	
National (1980)	107
Western Africa (around 1983)	700
Female life expectancy at birth (1985-1990):	67.0

BACKGROUND

In the late 1970s and early 1980s, the Government of Cape Verde became alarmed at the increase in the number of abortions performed and the considerable impact they were having on women's health. The number of abortions performed in the maternal and child health programme increased eightfold between 1978 and 1984. The Goverment subsequently enacted abortion legislation on 31 December 1986, which practically permits abortion on demand during the first 12 weeks of pregnancy. The only prerequisites are the woman's written consent to the abortion and approval by a medical commission. Abortion must be performed in a hospital, with "medical assistance". After the first trimester, abortion is only permitted if the pregnancy poses a risk to the woman's life or physical and mental health, if foetal deformity is suspected or to prevent the probable transmission to the foetus of a serious hereditary or contagious disease.

Compared with other countries in the region, health services in Cape Verde have greater coverage and are of higher quality. Family planning is provided as part of the Government's maternal and child health programme. Although services have been provided in some government centres since 1978 and are offered free of charge, not all islands have access to the services. Contraceptive prevalence for women aged 15-49 was estimated to be 7 per cent in 1987.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

Central African Republic

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	No*
To preserve physical health	No
To preserve mental health	No
Rape or incest	No
Foetal impairment	No
Economic or social reasons	No
Available on request	No

Additional requirements

Not applicable.

*General principles of criminal law permit these grounds.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Too high
Government's intervention concerning fertility level:	No intervention
Government's policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49):	..
Total fertility rate (1985-1990):	6.2
Age-specific fertility rate (per 1,000 women aged 15-19):	..
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	Yes
Complications of child-bearing and childbirth	Yes
Maternal mortality rate (per 100,000 live births):	
National (1983)	600
Middle Africa (around 1983)	690
Female life expectancy at birth (1985-1990):	51.0

BACKGROUND

The Criminal Code (Law No. 61-239 of 18 July 1961, section 190) prohibits abortion in any circumstance. Although the law makes no specific provision concerning abortion on the grounds of saving the life of the mother, those grounds are permitted under the general principles of criminal law. Anyone performing, or attempting to perform, an illegal abortion, with or without the woman's consent, is subject to a sentence of from one to five years in prison and a fine. Physicians and paramedical practitioners face the same sentences and are barred from practice for at least five years.

The current abortion laws are based primarily on economic rather than moral grounds. Low population density has been identified by the Government as an important impediment to development. Nevertheless, it also recognizes that existing social problems are being exacerbated by the high rates of unwanted fertility. Thus, since 1987, the Government has endorsed family planning as a measure to improve women's health. At that time, it formulated a national maternal and child health and family planning programme and officially recognized the national International Planned Parenthood Federation affiliate, which had been operating for some time.

Despite restrictive legislation, illegal abortion continues to be performed in the Central African Republic. As is the case in several African countries, adolescent pregnancy rates are high, as are abortion rates for that age group. One study conducted at Bangui among secondary students aged 18 and 19 noted that 44 per cent of the female students interviewed had undergone an abortion.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

Chad

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	No
To preserve mental health	No
Rape or incest	No
Foetal impairment	No
Economic or social reasons	No
Available on request	No

Additional requirements

Three physicians must certify that the woman's life is endangered, including the performing physician. One of the physicians must be registered with the Government as an expert. Consent of the woman is required unless she is incapable of providing it.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Satisfactory
Government's intervention concerning fertility level:	No intervention
Government's policy on contraceptive use:	Indirect support provided
Percentage of currently married women using modern contraception (aged 15-49):	..
Total fertility rate (1985-1990):	5.9
Age-specific fertility rate (per 1,000 women aged 15-19):	..
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of child-bearing and childbirth	..
Maternal mortality rate (per 100,000 live births):	
National (1972)	960
Middle Africa (around 1983)	690
Female life expectancy at birth (1985-1990):	47.1

BACKGROUND

Although the Chadian Government repealed the French anticontraception laws of 1920 seven years after independence and replaced them with a Criminal Code (Ordinance No. 12-67 of 9 June 1967), it did not significantly alter the content of the 1920 laws. The French laws outlawed the importation, sale and advertisement of contraceptives and also imposed stringent restrictions on abortion. The new laws adopted by the Chadian Government (Law No. 28, sections 95-100, regulating the exercise of pharmacy and introduced in 1965) imposed the same restrictions on contraceptives and abortifacients.

Section 296 of the Criminal Code introduced in 1967 prohibits abortion except when it is necessary to save the life of the pregnant woman. Anyone performing an illegal abortion is subject to from one to five years in prison and a fine. If the person frequently performs abortions, punishment is from 5 to 10 years in prison. A woman who induces her own abortion is subject to imprisonment for from two months to two years, plus a fine. Physicians and paramedical practitioners face the same sentences and can be forbidden to practise for from five years to life.

Although both abortion and use of contraception are illegal, both are available in Chad. Illegal abortion is common, and although there have been cases where illegal abortion is tried in the Chadian courts, the majority of cases have been ignored by the judicial system. Modern contraceptive methods are available by prescription only. The Government officially endorsed family planning only in 1985 and has plans for repealing the 1965 laws. Although the Government has requested foreign assistance to integrate family planning into its maternal and child health programme, to date only the information and education component has been implemented. The International Planned Parenthood Federation was requested to assist in the establishment of a family planning association in 1988.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

Chile

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	No
To preserve physical health	No
To preserve mental health	No
Rape or incest	No
Foetal impairment	No
Economic or social reasons	No
Available on request	No

Additional requirements

Not applicable.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Satisfactory
Government's intervention concerning fertility level:	No intervention
Government's policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49):	..
Total fertility rate (1985-1990):	2.7
Age-specific fertility rate (per 1,000 women aged 15-19, 1986):	59
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	Yes
Complications of child-bearing and childbirth	Yes
Maternal mortality rate (per 100,000 live births):	
National (1987)	48
South America (around 1983)	280
Female life expectancy at birth (1985-1990):	75.1

BACKGROUND

Although under the Chilean Penal Code (12 November 1874, sections 342-345) abortion is a criminal offense on all grounds, the Health Code (Decree No. 725 of 11 December 1967, section 119) did permit therapeutic abortion to save the life of the woman or to preserve her health. The performing physician was required to obtain the written consent of two expert physicians.

On 15 September 1989, however, the Government of Chile repealed section 119 of the Health Code and replaced it with a law that prohibits abortion in any circumstance (Law No. 18,826). The justification provided for the new restrictions is that, given the advances in modern medicine, health grounds are no longer relevant. Also, the Chilean Civil Code protects life from the time of conception; and the Government felt that rather than protecting life, therapeutic abortion authorized death and it was thus deemed unconstitutional.

According to the Penal Code, anyone who performs an abortion with the woman's consent is subject to up to three years in prison. If the abortion is performed without the woman's consent, imprisonment is longer. A woman inducing her own miscarriage is subject to from three to five years in prison. Harsher penalties are imposed on physicians, especially if the abortion is done without the woman's consent. Although the penalties are harsh, many of those accused of performing abortions are acquitted because physical proof of abortive manipulations, such as traumatic injury to internal organs, is necessary to obtain a conviction.

Since 1988, there have been some attempts to increase the penalties for abortion and to make them equal to the penalties for infanticide and homicide offenses. To date, these attempts have been unsuccessful.

Despite these restrictions, Chile has had very high rates of abortion during the last three decades. In fact, high rates of abortion and resulting high rates of maternal mortality led the Chilean Government to be one of the first Latin American countries to give official support to family planning activities. Surveys conducted in the early 1960s indicated that one of every four women in Chile had undergone an abortion. After the introduction of family planning in the mid-1960s, fertility dropped considerably, as did the incidence of induced abortion and maternal mortality due to complications of abortion. Deaths from illegal abortion declined from 118 to 24 per 100,000 live births between 1964 and 1979. Current rates, however, are still considered to be too high. Maternal deaths due to abortion are also viewed as too high, with abortion complications accounting for up to 40 per cent of all maternal deaths.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
Santiago	1950	42.3 abortions/1,000 women aged 15-44	HR
Santiago	1964	50.9 abortions/1,000 women aged 15-44	HR
National	1969	18.5 abortions/100 births	HR
National	1983	13.4 abortions/100 births	HR

NOTES: PR: provider registration; SP: survey providers; SW: survey of women; HR: hospital admission records. For a detailed description of these abbreviations and information on sources of data, see technical notes in annex I.

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

China

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	Yes
To preserve mental health	Yes
Rape or incest	Yes
Foetal impairment	Yes
Economic or social reasons	Yes
Available on request	Yes

Additional requirements

An abortion can be performed on request within six months of gestation, with the consent of the family and spouse. Second-trimester abortions must be performed in a hospital or clinic.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Too high
Government's intervention concerning fertility level:	To lower
Government's policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49, 1988):	70
Total fertility rate (1985-1990):	2.4
Age-specific fertility rate (per 1,000 women aged 15-19, 1986):	9
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	Yes
Complications of child-bearing and childbirth	Yes
Maternal mortality rate (per 100,000 live births):	
National (1984)	44
Eastern Asia (around 1983)	55
Female life expectancy at birth (1985-1990):	70.9

BACKGROUND

In contrast to most countries, the Chinese Government endorses the use of abortion as a means of birth control and permits it on request. Moreover, the Government provides the services free of charge and allows the woman 14 days of paid sick leave for a first-trimester abortion or 30 days if the pregnancy is terminated after the first trimester. In early abortions, vacuum aspiration is performed by paramedical personnel. Second-trimester abortions are performed in a hospital by a physician. Abortions are performed on request within six months of gestation.

Although the Maoist regime was at first pronatalist, 1953 census figures led the Government to reverse its position: it introduced and supported the use of contraception and abortion to control population growth. Although reliance upon abortion has varied over time and by region due to variations in the degree of enforcement of Government's policy, the central role it plays in the population policy of China has remained firm.

In 1974, in order to play a more decisive role on population matters, the Chinese Government transferred control of its population control programme from the Ministry of Health to the central Government and began to incorporate population activities in the planning of its national economy. The planned birth model was introduced, birth quotas were set and a persuasion-education model of communication was implemented. Before 1974, abortion was employed as a backup measure in cases of contraceptive failure; after that date, it was relied upon to meet the birth quota requirements.

At first, birth quotas were set at two births per couple. In 1979, the Chinese Government introduced the one-child policy and increased even further the role that abortion played in the implementation of policy. Policy stipulated that women who had "unplanned" (unauthorized) pregnancies should seek an abortion. Although enforcement of the one-child policy was somewhat lenient in 1980 and 1981, it became relatively strict in 1982 and 1983. During that period, there were a number of campaigns to encourage abortion, sterilization and intra-uterine device insertion. In 1983, a nationwide campaign was carried out, including mandatory sterilization for couples with two or more children, abortion for "unplanned" pregnancies and IUD insertions for women with one child.

Between 1984 and 1986, enforcement again became somewhat lenient. Abortion and sterilization campaigns were practically eliminated, and second births began to be allowed in specific circumstances in rural areas. Furthermore, the population programme began to rely upon contraception rather than abortion. The relaxation of controls was believed to have resulted in a rise in population growth rates between 1985 and 1987, which in turn led to a renewal and strengthening of policy enforcement.

Thus, since 1979, although the force with which the birth planning policy has been implemented has varied, family planning has always been mandatory and more than two children are officially discouraged. The birth planning policy has been implemented primarily through a nationwide family planning programme that includes a strong information/education component, free contraceptive services and a system of economic and social incentives and disincentives, which vary by province and between rural and urban areas. Because of difficulties in implementation, enforcement in rural areas generally has been more lax. Although some have accused the family planning programme of employing coercive methods, the Government has never sanctioned the use of coercion.

China

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
National	1971	23.1 abortions/1,000 women aged 15-44	PR
National	1973	28.5 abortions/1,000 women aged 15-44	PR
National	1977	27.7 abortions/1,000 women aged 15-44	PR
National	1979	38.2 abortions/1,000 women aged 15-44	PR
National	1980	44.8 abortions/1,000 women aged 15-44	PR
National	1981	39.5 abortions/1,000 women aged 15-44	PR
National	1982	54.9 abortions/1,000 women aged 15-44	PR
National	1983	61.5 abortions/1,000 women aged 15-44	PR
National	1984	36.6 abortions/1,000 women aged 15-44	PR
National	1987	38.8 abortions/1,000 women aged 15-44	PR

NOTES: PR: provider registration; SP: survey providers; SW: survey of women; HR: hospital admission records. For a detailed description of these abbreviations and information on sources of data, see technical notes in annex I.

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	No*
To preserve physical health	No
To preserve mental health	No
Rape or incest	No
Foetal impairment	No
Economic or social reasons	No
Available on request	No

Additional requirements

An abortion requires the woman's consent.

*Legal interpretation generally permits these grounds.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Satisfactory
Government's intervention concerning fertility level:	To lower
Government's policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49, 1990):	56
Total fertility rate (1985-1990):	3.1
Age-specific fertility rate (per 1,000 women aged 15-19, 1981-1986):	78
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	Yes
Complications of child-bearing and childbirth	Yes
Maternal mortality rate (per 100,000 live births):	
National (1984)	107
South America (around 1983)	280
Female life expectancy at birth (1985-1990):	71.1

Colombia

BACKGROUND

Despite some reforms introduced in 1980 (Criminal Code enacted by Decree No. 100 of 23 January 1980), the Criminal Code of Colombia declares abortion illegal in all circumstances. Nevertheless, the Code contains an exculpatory clause (section 25(5)), which essentially justifies abortion to save the life of the pregnant woman.

Penalties vary according to the circumstances in which the abortion is performed. A woman who procures her own abortion, or a person performing an abortion with the consent of the woman, is subject to from one to three years in prison (section 343). The sentence is greater when the abortion is performed without the consent of the woman or when the woman is under 14 years of age (section 344). In these cases, the sentence is imprisonment from 3 to 10 years.

Although in essence the previous Criminal Code drafted in 1936 differed only slightly from the current code, it imposed somewhat harsher punishments. One important change, however, was that although previously there had been sentence attenuation and possible pardon when an abortion was performed to save the honour of a wife, sister or daughter, that clause was removed in the new code. The new code instead explicitly addresses cases where the pregnancy is the result of rape and provides for a reduced sentence for performing an abortion on those grounds.

Since 1974, four attempts have been made in the National Congress to liberalize the abortion law but all have been disposed of without discussion in the Senate. In 1990, a law was proposed that specifies that the State would recognize the right of all pregnant women voluntarily to interrupt the pregnancy within the first trimester of gestation.

Despite the current restrictions on abortion in Colombia, it is widely practised. Although official abortion statistics are not available after 1974, it was estimated that in 1975, 18 per cent of all pregnancies ended in illegal abortion. Estimates in the late 1980s placed this figure at 25 per cent. In addition, 60 per cent of all maternal deaths in the late 1980s in Colombia were due to induced abortion. However, prosecution for unlawful abortion is relatively rare.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
National	1972	18.2 abortions/100 live births	HR
National	1975	21.8 abortions/100 live births	HR

NOTES: PR: provider registration; SP: survey providers; SW: survey of women; HR: hospital admission records. For a detailed description of these abbreviations and information on sources of data, see technical notes in annex I.

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	Yes
To preserve mental health	No
Rape or incest	No
Foetal impairment	No
Economic or social reasons	No
Available on request	No

Additional requirements

It is necessary to have the written certification of two physicians that there are serious medical reasons to interrupt the pregnancy.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Too high
Government's intervention concerning fertility level:	To lower
Government's policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49):	..
Total fertility rate (1985-1990):	7.0
Age-specific fertility rate (per 1,000 women aged 15-19):	..
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	Yes
Complications of child-bearing and childbirth	Yes
Maternal mortality rate (per 100,000 live births):	
National (1980)	50
Eastern Africa (around 1983)	660
Female life expectancy at birth (1985-1990):	54.5

Comoros

BACKGROUND

Act No. 82-03P/AF (19 November 1982) of the Comoros Penal Code declares abortion to be illegal. An abortion is only permitted for serious medical reasons attested to in writing by at least two physicians. Anyone performing or assisting in an abortion, with or without the consent of the woman, and regardless of whether she is pregnant, is subject to from one to five years in prison and a fine. If the person regularly performs abortions, imprisonment is to be five years and a fine of at least twice the amount as a first-time offender. A woman inducing her own abortion is subject to from six months to two years in prison, plus a fine. Physicians, pharmacists and paramedics assisting in or an performing abortion also face suspension of at least five years and in some cases may be barred from practice for life.

The Government recognizes the complications of poorly performed abortions to be an important health problem. The Government provides family planning services in its maternal and child health (MCH) programme. Services are available in all MCH centres and maternity wards.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	Yes
To preserve mental health	No
Rape or incest	No
Foetal impairment	No
Economic or social reasons	No
Available on request	No

Additional requirements

An abortion requires authorization by a committee of physicians.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Too low
Government's intervention concerning fertility level:	No intervention
Government's policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49):	..
Total fertility rate (1985-1990):	6.3
Age-specific fertility rate (per 1,000 women aged 15-19):	..
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	Yes
Complications of child-bearing and childbirth	Yes
Maternal mortality rate (per 100,000 live births):	
National (1971)	900
Middle Africa (around 1983)	690
Female life expectancy at birth (1985-1990):	55.3

Congo

BACKGROUND

Congolese abortion laws, which are based on the French Penal Code of 1810 (section 317), consider abortion to be an illegal act unless it is performed to save the life of the pregnant woman or to preserve her health.

Clandestine abortion is widely practised in the Congo. Several studies have documented the high incidence of abortion in various areas of the country. Many of the women obtaining abortion are young and unmarried. One study noted the average age for women hospitalized with complications of incomplete abortion to be 22 years. The Government recognizes the problems caused by the health conditions under which they are performed. In response to the high rates of maternal mortality and infertility caused by complications of induced abortion, the Government requested international assistance in 1979 to integrate family planning services into its maternal and child health programme. In 1988 the Government officially recognized the Association congolaise pour le bien-être familial, an affiliate of the International Planned Parenthood Federation. Although the French anticontraception laws of 1920 are still in effect, the Government permits access to contraception by prescription. Contraceptives are available in government and private clinics, as well as in pharmacies.

Since the early 1980s, there has been some discussion about reforming current abortion laws. Although the Government is aware that the law is becoming increasingly unenforceable, given the large number of abortions that are currently performed, it feels legalization is out of the question because it perceives the country to be underpopulated. Although legal restrictions have not been eased, abortions are performed in some government hospitals. In addition, some health areas have come to permit abortions on socio-economic grounds when recommended by a social worker.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
Information not readily available.			

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	Yes
To preserve mental health	No
Rape or incest	No
Foetal impairment	No
Economic or social reasons	No
Available on request	No

Additional requirements

An abortion requires the approval of two physicians, including the attending physician, and the written consent of the woman, her husband or legal representative. The procedure must be performed by a physician, or if no physician is available, an authorized midwife.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	High
Government's intervention concerning fertility level:	To lower
Government's policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-44, 1986):	58
Total fertility rate (1985-1990):	3.3
Age-specific fertility rate (per 1,000 women aged 15-19, 1984):	96
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	Yes
Complications of child-bearing and childbirth	Yes
Maternal mortality rate (per 100,000 live births):	
National (1988)	18
Central America (around 1983)	240
Female life expectancy at birth (1985-1990):	77.0

Costa Rica

BACKGROUND

The Costa Rican Penal Code of 4 May 1970 (sections 118-122) permits an abortion only to save the life of the pregnant woman or to avert a danger to her health where said danger cannot be averted by any other means. The abortion can only be performed after obtaining the written consent of the pregnant woman, her husband or a legal representative, and after prior consultation with two additional physicians (Code of Medical Ethics of 18 August 1970). The abortion must be performed by a physician or if a physician is not available, by a midwife.

Illegal abortion is punishable by imprisonment for a period of from one to three years if the abortion is performed with the woman's consent. The same punishment is applied to a woman who induces her own abortion. If the abortion is performed before the end of the second trimester of gestation, the punishment may be reduced by from six months to two years. Section 120 of the Penal Code provides for a reduced sentence of from three months to two years in cases where the abortion has been performed to safeguard the woman's honour.

Studies disagree as to the extent of illegal abortion that is practised in Costa Rica. Household surveys conducted in the early 1980s estimate that about 11 per cent of pregnancies end in abortion. Induced abortion, however, tends to be seriously underreported in household surveys. Ethnographic studies suggest that as many as 20-30 per cent of pregnancies end in abortion. The Costa Rican Government is aware of the incidence of illegal abortion and is very concerned about the resulting high rates of maternal mortality and morbidity.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
National	1972	14.4 abortions/100 births	HR

NOTES: PR: provider registration; SP: survey providers; SW: survey of women; HR: hospital admission records. For a detailed description of these abbreviations and information on sources of data, see technical notes in annex I.

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	No
To preserve mental health	No
Rape or incest	No
Foetal impairment	No
Economic or social reasons	No
Available on request	No

Additional requirements

An abortion requires the authorization of two consulting physicians in addition to the performing physician who must certify that there is no other way to save the woman's life. The abortion must be performed by a physician in a hospital.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Satisfactory
Government's intervention concerning fertility level:	To raise
Government's policy on contraceptive use:	Indirect support provided
Percentage of currently married women using modern contraception (aged 15-49, 1980/81):	0.5
Total fertility rate (1985-1990):	7.4
Age-specific fertility rate (per 1,000 women aged 15-19):	..
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of child-bearing and childbirth	..
Maternal mortality rate (per 100,000 live births):	
National	..
Western Africa (around 1983)	700
Female life expectancy at birth (1985-1990):	54.2

Côte d'Ivoire

BACKGROUND

Abortion laws in Côte d'Ivoire are based on the French Penal Code of 1810. The Code was amended in 1958 and again in 1981, but the amendments did not result in any significant changes with regard to abortion. They did, however, repeal the French anticontraception law of 1920, which prohibited the importation, advertisement and sale of contraceptives and incitement to abortion. The Penal Code of 31 July 1981 (Law No. 81-640, sections 366-369) also prohibits abortion except when necessary to avert serious danger to the woman's life. The attending physician must consult with two additional physicians, who must certify that the abortion is necessary to save the life of the woman. Should there be no other resident physicians at the venue where the procedure is to be performed, however, the attending physician can certify the procedure as necessary. The law also prohibits incitement to abortion by means of written or oral advertisement, or the sale of any substance or object to be used to perform an abortion.

Anyone who performs or attempts to cause an abortion, with or without the consent of the woman, is subject to from one to five years in prison and a fine. A person habitually performing abortions is subject to 5-10 years in prison and a fine at least seven times greater than that for first-time offenders. A woman subjecting herself to an abortion, whether self-induced or not, is punished by from six months to two years in prison, plus a fine. Health professionals that encourage abortion are subject to the same punishments as those performing them. Incitement to abortion by means of public speeches, sale or advertisement of substances or objects employed to perform abortion is punished by from six months to three years in prison and a fine.

Illegal abortion is considered a growing problem in Côte d'Ivoire, particularly among the young. Up to 1981, when the French anticontraception laws were repealed, contraceptives were illegal. Although the Government does not provide contraception as part of its health services, it permits the provision of contraceptives through private sector sources. Government clinics do, however, provide prescriptions for contraceptives on demand. The Association ivoirienne de bien-être familiale, an affiliate of the International Planned Parenthood Federation, was officially established in 1979. To date, however, it has had only an educational and informational role. Most international assistance has been in training, seminars, development of educational materials and strategies, and research. As a result, contraceptive use is limited.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
Information not readily available.			

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	Yes
To preserve mental health	Yes
Rape or incest	Yes
Foetal impairment	Yes
Economic or social reasons	Yes
Available on request	Yes

Additional requirements

An abortion requires the consent of the pregnant woman. If she is unmarried and under 16 years of age, parental permission is required. If gestation is greater than 10 weeks, authorization by health authorities is required. The abortion must be performed by a physician in an official health centre.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Satisfactory
Government's intervention concerning fertility level:	No intervention
Government's policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49, 1987):	68
Total fertility rate (1985-1990):	1.8
Age-specific fertility rate (per 1,000 women aged 15-19, 1986):	81
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	Yes
Complications of child-bearing and childbirth	Yes
Maternal mortality rate (per 100,000 live births):	
National (1987)	49
Caribbean (around 1983)	220
Female life expectancy at birth (1985-1990):	77.0

Cuba

BACKGROUND

In pre-revolutionary Cuba, abortion laws were modelled after the 1870 Spanish Penal Code and were very restrictive. Some restrictions were removed in 1936 with the introduction of the Social Defense Code, which permitted abortion when necessary to save the life of a pregnant woman, to preserve her health, in cases of rape or incest or in cases of suspected foetal impairment. Authorization by two physicians was required. However, abortion was easily available in private clinics at a reasonable cost.

In the early years after the revolution (1959-1964), enforcement of abortion laws was somewhat stricter. Stricter enforcement, combined with the emigration of a substantial proportion of the physicians from Cuba, contributed to an increase in the number of abortions performed by unqualified personnel. The resulting rise in maternal mortality led the Cuban Government to amend the Social Defense Code in 1964. The Government adopted the World Health Organization definition of health, which includes criteria relating to physical, mental and social well-being. The amendment permitted a more liberal interpretation of the laws, allowing the institutionalization of induced abortion by the National Health System. Thus, since 1965, abortion has been available on request up to the tenth week of gestation through the National Health System. Abortion is also available at later stages, although only under government control.

The new Penal Code adopted in 1979 defines the conditions under which abortion would be considered illegal and establishes punishments for those performing an illegal abortion as defined in the Social Defense Code (section 433). It also defines as "illegal" an abortion performed without the consent of the woman, abortions performed in violation of health regulations concerning abortion, abortion performed for profit and abortions not performed in an official establishment or not performed by a physician. An abortion performed in violation of health regulations is punishable by from three months to one year in prison. That performed for monetary gain or not performed by a physician in official facilities is punishable by from two to five years in prison. The same sentence is given when an abortion is performed without the woman's consent. The presence of more than one of these conditions carries a much harsher sentence.

If gestation is 10 weeks or less, menstrual regulation is employed. Women require no confirmation of pregnancy and minors do not require parental consent. Menstrual regulation is performed on an out-patient basis in hospitals and clinics. Gestations of 10-12 weeks require confirmation of pregnancy. The pregnant woman must be examined by a gynaecologist and must receive counselling from a social worker. Women under 16 years of age must have parental consent. Second-trimester abortion requires, in addition to the conditions of first-trimester abortion, that the case be authorized by a committee of obstetricians, psychologists and social workers.

Between 1968 and 1974, the rate of legal abortion quadrupled, rising from 16.7 to 69.5 legal abortion per 1,000 women of reproductive age. Since then, abortion rates have fluctuated between 47 and 62 abortions per 1,000 women. Although an increase in contraceptive use in Cuba has reduced abortion rates in the past 15 years, levels remain fairly high. Part of the reason is that contraceptive failure is significant. Despite the fact that abortion has been legal in Cuba since the late 1960s, induced abortion was still the leading cause of maternal death among women aged 20-34 between 1979 and 1982.

Contraception is widely available in Cuba in all government health centres and one private agency (Sociedad Científica de Cuba para el Desarrollo de la Familia, SOCUDEF), which receives the full support of the Government. Although most of its financial support comes from the Ministry of Health, it also receives funds from the International Planned Parenthood Federation. It is estimated that approximately 70 per cent of Cuban women of reproductive age are currently using a contraceptive method.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
National	1968	16.7 abortions/1,000 women aged 15-44	PR
National	1970	40.2 abortions/1,000 women aged 15-44	PR
National	1972	54.9 abortions/1,000 women aged 15-44	PR
National	1974	69.5 abortions/1,000 women aged 15-44	PR
National	1976	61.5 abortions/1,000 women aged 15-44	PR
National	1978	52.9 abortions/1,000 women aged 15-44	PR
National	1980	47.2 abortions/1,000 women aged 15-44	PR
National	1982	55.3 abortions/1,000 women aged 15-44	PR
National	1984	58.7 abortions/1,000 women aged 15-44	PR

NOTES: PR: provider registration; SP: survey providers; SW: survey of women; HR: hospital admission records. For a detailed description of these abbreviations and information on sources of data, see technical notes in annex I.

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Cyprus

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	Yes
To preserve mental health	Yes
Rape or incest	Yes
Foetal impairment	Yes
Economic or social reasons	No*
Available on request	No

Additional requirements

Certification by two physicians is required for all grounds except rape. In the case of rape, certification by a physician and a police authority is necessary. Consent of next of kin is required, as is the case for all operations. An abortion can only be performed by a licensed physicians.

*Legal interpretation generally permits these grounds.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Too low
Government's intervention concerning fertility level:	To raise
Government's policy on contraceptive use:	Indirect support provided
Percentage of currently married women using modern contraception (aged 15-49):	..
Total fertility rate (1985-1990):	2.3
Age-specific fertility rate (per 1,000 women aged 15-19, 1986):	28
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	No
Complications of child-bearing and childbirth	Yes
Maternal mortality rate (per 100,000 live births):	
National	..
Western Asia (around 1983)	340
Female life expectancy at birth (1985-1990):	78.2

BACKGROUND

The Criminal Code of Cyprus (sections 167-169 and 169A), amended in 1974 (Law No. 59) and 1986 (Law No. 186), permits abortion to save the life of the pregnant woman, or to prevent physical, mental or psychological injury that would be suffered by her or by any existing child she may have, greater than if the pregnancy were terminated. Cyprus also permits abortion if the foetus is believed to be physically or mentally impaired or if the pregnancy resulted from rape or in circumstances in which the pregnancy would seriously jeopardize the social status of the woman or of her family. Although the law does not specifically address socio-economic grounds, in practice "mental and psychological injury" is generally interpreted as including socio-economic grounds. The 1986 amendment essentially rephrases the 1974 amendment, which liberalized the previous restrictive laws that permitted abortion only on therapeutic grounds.

Any person performing an unlawful abortion is subject to 14 years in prison. A woman inducing her own abortion can be sentenced to seven years in prison. Any person supplying an object or substance with the intent to procure an abortion is subject to three years in prison. An abortion must be performed by a licensed physician. Two licensed physicians must attest that the conditions for legal abortion have been met. In the case of rape, the competent police authority must certify that the pregnancy would jeopardize the woman's or the family's social status. This certification must be confirmed by a physician. Certification by two physicians is also required. Although not specified by law, in practice abortion is performed within 28 weeks of gestation.

Prior to the liberalization of abortion laws in Cyprus, laws were not strictly enforced. Abortion could be obtained in private clinics. Most abortion clients were married women with multiple births or young unmarried women.

The Government pursues a pronatalist policy. The Government does not provide family planning services in its clinics. It has, however, officially recognized the private Family Planning Association of Cyprus. Although the Association's primary activity is educational, it does have clinics where family planning services are provided.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

Czechoslovakia

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	Yes
To preserve mental health	Yes
Rape or incest	Yes
Foetal impairment	Yes
Economic or social reasons	Yes
Available on request	Yes

Additional requirements

An abortion requires the consent of the woman and authorization by her gynaecologist. If gestation is more than 12 weeks, the abortion requires authorization by a medical commission. Except when medically indicated, an abortion must be performed within the first trimester, in a hospital, by a licensed gynaecologist. Therapeutic abortion is permitted up to 26 weeks.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Satisfactory
Government's intervention concerning fertility level:	To maintain
Government's policy on contraceptive use:	Direct support provided
Percentage of currently married women* using modern contraception (aged 18-44, 1977):	49
Total fertility rate (1985-1990):	2.0
Age-specific fertility rate (per 1,000 women aged 15-19, 1986):	51
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	No
Complications of child-bearing and childbirth	No
Maternal mortality rate (per 100,000 live births):	
National (1988)	13
Developed countries (around 1983)	30
Female life expectancy at birth (1985-1990):	75.0

*Women in first marriage.

BACKGROUND

Abortion laws in Czechoslovakia have repeatedly been amended, with the general trend being towards liberalization. Law No. 86/1950 of the Penal Code (sections 227-229), effective August 1950, permitted abortion to save the life of the pregnant woman or to preserve her health. Transgression of the law was punishable by one year in prison for the woman and 10 years for the abortionist. In 1957, the negative consequences for women's health resulting from clandestine abortion led the Government to specify the conditions under which abortion could be performed. Law No. 68 of 19 December 1957 specified that a commission of four, including the physician, must authorize the abortion and that authorization would be given primarily on medical grounds. Transgression of the law by the woman was no longer punished, and the sentence for the person performing the abortion was reduced to a maximum of five years.

Between 1957 and 1983, a series of changes was introduced which specified in greater detail when an abortion could be performed and the procedures to be followed by the woman and the authorizing commission. In addition to permitting abortion on medical grounds, the amendments allowed abortion when the woman was too young (under 16 years of age) or too old (over 45 years of age, subsequently changed to 40 and then to 35), had too many children (three or more, later changed to two or more) or was unmarried, or if the pregnancy was the result of rape or another reprehensible crime. Authorization would not be granted if it was found that the woman had a condition that would accentuate the risks of the abortion or if she had undergone an abortion in the past year. Exceptions to the latter rule were made when the pregnancy resulted from contraceptive failure. Abortion could only be performed up to 12 weeks of gestation, except to save the life of the pregnant woman or in the case of known foetal impairment. In the latter case, up to 24 weeks and exceptionally up to 26 weeks of gestation were allowed.

The size of the commission that was to assess whether abortion was warranted was reduced from four to three members in December 1962. The commission included a gynaecologist, a social worker and a deputy from the National Committee. Only abortions performed on medical grounds or in cases of economic duress were performed free of charge.

The most recent amendment was made effective in 1987 (passed on 20 October 1986 in the Czech Socialist Republic and on 23 October 1986 in the Slovak Socialist Republic). It abolished the abortion commissions, leaving the decision to be made between the woman and her doctor. Under current laws, a woman makes a written request to her gynaecologist, whereby the physician will inform her of the possible consequences of the procedure and of available methods of birth control. If gestation is under 12 weeks and there are no health contraindications for the procedure, the doctor specifies the health centre where the procedure is to be performed. If gestation is over 12 weeks or if there are other contraindications, the request is reviewed by a medical committee. Women who have had an abortion within six months are not permitted to undergo the procedure unless they have had two deliveries, are at least 35 years of age or the pregnancy was the result of a rape. The pregnancy can be terminated beyond the first trimester only if the woman's life or health is endangered or in the case of suspected foetal impairment. If the woman is under 16 years of age, consent of her legal representative is required. If the woman is between 16 and 18 years of age, her legal representative must be notified. An abortion must be performed in a hospital.

Early pregnancy terminations employ the vacuum aspiration method. This type of abortion can be performed up to six weeks of gestation for primiparae and eight weeks for multiparous women. Three fourths of all pregnancy terminations in 1988 employed this method.

Through the years, abortion has remained the preferred method of birth control in Czechoslovakia. Part of the reason was that abortion was free but contraceptives were not and were also difficult to obtain. The new 1986 law attempts to reduce the use of abortion by providing contraception (excluding condoms) free of charge and discouraging abortion by charging a fee for abortions performed after eight weeks of gestation. The fee can be waived only if the abortion is medically indicated. Between 1986 and 1987, however, the number of abortions performed increased by 25 per cent.

Czechoslovakia

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
National	1957	2.7 abortions/1,000 women aged 15-44	PR
National	1958	22.8 abortions/1,000 women aged 15-44	PR
National	1965	26.3 abortions/1,000 women aged 15-44	PR
National	1970	32.3 abortions/1,000 women aged 15-44	PR
National	1975	25.9 abortions/1,000 women aged 15-44	PR
National	1980	31.0 abortions/1,000 women aged 15-44	PR
National	1983	33.1 abortions/1,000 women aged 15-44	PR
National	1985	36.0 abortions/1,000 women aged 15-44	PR
National	1986	37.3 abortions/1,000 women aged 15-44	PR
National	1987	46.7 abortions/1,000 women aged 15-44	PR
National	1988	48.7 abortions/1,000 women aged 15-44	PR

NOTES: PR: provider registration; SP: survey providers; SW: survey of women; HR: hospital admission records. For a detailed description of these abbreviations and information on sources of data, see technical notes in annex I.

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see the reference section.

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	Yes
To preserve mental health	Yes
Rape or incest	Yes
Foetal impairment	Yes
Economic or social reasons	Yes
Available on request	Yes

Additional requirements

An abortion must be performed by a physician in a state or communal hospital or in a clinic attached to a hospital. If gestation is greater than 12 weeks and the pregnancy does not pose serious risk to the life or physical or mental health of the woman, where this risk is based solely or principally on circumstances of a medical character, the abortion must be approved by a committee.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Too low
Government's intervention concerning fertility level:	To raise
Government's policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 18-44, 1975):	59*
Total fertility rate (1985-1990):	1.5
Age-specific fertility rate (per 1,000 women aged 15-19, 1987):	10
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of child-bearing and childbirth	..
Maternal mortality rate (per 100,000 live births):	
National (1988)	3
Developed countries (around 1983)	30
Female life expectancy at birth (1985-1990):	78.3

*Percentage using method other than sterilization within the past two months.

Denmark

BACKGROUND

Up to 1939, abortion was illegal in Denmark except when necessary to avert a serious danger to the pregnant woman's life or health. By 1973, abortion was available on demand up to the first trimester of pregnancy. Abortion legislation passed in the interim period (laws passed in 1939, 1956 and 1970) essentially introduced and broadened social grounds for abortion, culminating in the 1973 laws which permitted abortion on demand. Although socio-medical grounds were permitted in the earlier years, applications for termination of pregnancy had to be evaluated by committees consisting of the director of the maternity aid institution and two physicians, preferably a gynaecologist and a psychiatrist. According to the 1970 law (Law No. 120 of 24 March 1970), a woman could obtain an abortion on health grounds, if she was over 38 years of age, if she already had four children under 18 years of age who resided with her or if granted permission by one of the committees. However, 96 per cent of applications for abortion were approved and after three years the law became irrelevant. A new law was introduced in 1973.

Law No. 350 of 13 June 1973 (sections 1-12) entitles women domiciled in Denmark to abortion on demand during the first 12 weeks of pregnancy after the submission of an application for abortion and after being informed of the risks involved by the procedure and of other alternatives to abortion. After the twelfth week of pregnancy, abortion is available without special authorization only when "necessary to avert a risk to her life or of serious deterioration to her physical or mental health, and this risk is based solely or principally on circumstances of a medical character". Abortion is available after the twelfth week of gestation when authorized by a committee. The committee may grant authorization when pregnancy, childbirth or child care entails" a risk of deterioration of the woman's health on account of an existing or potential physical or mental illness or infirmity" or as a consequence of the conditions under which she is living; when the pregnancy resulted from a criminal act; when foetal impairment is suspected; if the woman is incapable of giving proper care to the child; or if "it can be assumed that pregnancy, childbirth, or care of a child constitute a serious burden to the woman, which cannot otherwise be averted". The composition of the committees was modified to include instead a social worker from the local social welfare centre and two physicians.

Abortion must be performed by a physician in a state or communal hospital or in a clinic attached to a hospital. Performing an abortion beyond the twelfth week of gestation without prior committee authorization when required is punishable by up to two years in prison, or in the case of mitigating circumstances, by a fine. If the abortionist is not a physician, the penalty can be up to four years in prison. Failure to comply with the other set procedures is punishable by a fine.

The incidence of legal abortion increased with liberalization of the law and then declined. The number of legal abortions per 1,000 women aged 15-44 increased from 12.9 in 1972, the year prior to liberalization, to 27.0 in 1975. The incidence of legal abortion gradually declined thereafter to 18.4 in 1984. Women aged 18-24 showed the highest abortion rates throughout the period 1974-1985. The greatest reduction was observed in women aged 15-17 and those between 30 and 39 years of age. Single women and women under age 20 have the highest abortion rates.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
National	1970	9.4 abortions/1,000 women aged 15-44	PR
National	1972	12.9 abortions/1,000 women aged 15-44	PR
National	1973	16.2 abortions/1,000 women aged 15-44	PR
National	1974	24.2 abortions/1,000 women aged 15-44	PR
National	1975	27.0 abortions/1,000 women aged 15-44	PR
National	1977	24.4 abortions/1,000 women aged 15-44	PR
National	1980	21.4 abortions/1,000 women aged 15-44	PR
National	1984	18.4 abortions/1,000 women aged 15-44	PR
National	1986	17.7 abortions/1,000 women aged 15-44	PR
National	1987	18.3 abortions/1,000 women aged 15-44	PR

NOTES: PR: provider registration; SP: survey providers; SW: survey of women; HR: hospital admission records. For a detailed description of these abbreviations and information on sources of data, see technical notes in annex I.

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see the list of references.

Djibouti

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Information not readily available
To preserve physical health	
To preserve mental health	
Rape or incest	
Foetal impairment	
Economic or social reasons	
Available on request	

Additional requirements

Information not readily available.

FERTILITY AND MORTALITY CONTEXT

Government view's of fertility level:	Satisfactory
Government's intervention concerning fertility level:	No intervention
Government's policy on contraceptive use:	No support provided
Percentage of currently married women using modern contraception (aged 15-49):	..
Total fertility rate (1985-1990):	6.6
Age-specific fertility rate (per 1,000 women aged 15-19):	..
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of child-bearing and childbirth	..
Maternal mortality rate (per 100,000 live births):	
National	..
Eastern Africa (around 1983)	660
Female life expectancy at birth (1985-1990):	48.7

BACKGROUND

Only limited information is available on women's health and population issues in Djibouti. None of the available sources makes any reference to abortion policy and practice. Given that Djibouti was a French colony and later a protectorate, one is led to assume that following independence in 1977 and the subsequent adoption of a new Constitution in 1981, it adopted a version of the French anticontraception laws forbidding contraception and abortion. However, Djibouti is a Muslim country and thus likely to adhere to Islamic laws concerning abortion. The Islamic religion forbids abortion after the foetus has acquired a soul. There is, however, some disagreement as to when the acquisition of a soul occurs. Some schools of Islam identify that time as 40 days after conception and others place it at 120 days. Likewise, there is disagreement as to whether abortion is allowed before the foetus acquires a soul. In general, aborting before viability carries religious liability, not penal liability, unless the abortion is performed without the husband's or both parents' consent. The Islamic religion, however, does permit abortion when the pregnancy endangers the mother's life, regardless of gestation duration.

Although the Government does not provide family planning services in its clinics, it does not prohibit access to family planning services and information on contraceptives. In 1986, the Government called for the formulation and implementation of national population policies and programmes to reduce high rates of population growth.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

Dominica

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	No
To preserve mental health	No
Rape or incest	No
Foetal impairment	No
Economic or social reasons	No
Available on request	No

Additional requirements

An abortion must be authorized and performed by a licensed physician in a hospital.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Too high
Government's intervention concerning fertility level:	To lower
Government's policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-44, 1981):	47
Total fertility rate (1985-1990):	..
Age-specific fertility rate (per 1,000 women aged 15-19):	..
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of child-bearing and childbirth	..
Maternal mortality rate (per 100,000 live births):	
National (1987)	62
Caribbean (around 1983)	220
Female life expectancy at birth (1985-1990):	..

BACKGROUND

Dominica inherited the British common-law system. The Offences against the Person Act (cap. 44, sections 56 and 57), permits abortion only when necessary to save the life of the pregnant woman. Although many Commonwealth countries consider the English 1938 *Bourne* case to apply in the determination of whether an abortion was lawful, no case has been tried in Dominica that would test the legality of health grounds. In the *Bourne* case, a physician was acquitted of an offence for performing an abortion on a woman who had been raped. The court ruled that the abortion was lawful because it had been performed to prevent the woman from becoming "a physical and mental wreck", thus setting a precedent for future abortion cases performed on the grounds of preserving the pregnant woman's physical and mental health.

Information on penalties for transgression of the law is not readily available.

Family planning services are available through the Government's maternal and child health programme clinics and the Dominica Planned Parenthood Association (DPPA) programmes. Up to 1989, DPPA provided only information and education on family planning. In 1989, however, it introduced clinical services and a community-based distribution programme. Its programme is complementary to the Government's services. A major thrust is being given by both public and private sectors to family planning education and services for adolescents as there is concern with the high incidence of teenage pregnancy. Thirty per cent of all births are estimated to occur to adolescent mothers.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

Dominican Republic

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	No*
To preserve physical health	No
To preserve mental health	No
Rape or incest	No
Foetal impairment	No
Economic or social reasons	No
Available on request	No

Additional requirements

Not applicable.

*General principles of criminal law permit these grounds.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Too high
Government's intervention concerning fertility level:	To lower
Government's policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49, 1986):	47
Total fertility rate (1985-1990):	3.8
Age-specific fertility rate (per 1,000 women aged 15-19, 1981-1986):	104
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	Yes
Complications of child-bearing and childbirth	Yes
Maternal mortality rate (per 100,000 live births):	
National (1984)	74
Caribbean (around 1983)	220
Female life expectancy at birth (1985-1990):	68.1

BACKGROUND

The Penal Code of 1948 (section 317) forbids abortion in any circumstance. Under the general principles of criminal legislation, however, under "defense of necessity", abortion is permitted to save the life of the pregnant woman. Thus, in practice, both the legal and medical professions consider abortion performed to save the life of the woman to be legal in the Dominican Republic.

The abortion laws in the Dominican Republic are based on the French Napoleonic Code of 1832. The law punishes the abortionist, the woman and any person who initiates or encourages the contact between the woman and the person performing the abortion. The abortionist and the woman found guilty of inducing an abortion are subject to from two to five years in prison, and the liaison can be punished by a sentence of from six months to two years. If the person performing the abortion belongs to the medical or paramedical profession, the sentence is from 5 to 20 years of public labour (*trabajos publicos*).

The incidence of induced abortion is high in the Dominican Republic. Studies conducted in the early 1970s noted that women often preferred to rely upon abortion instead of modern contraceptives to regulate their fertility because of fear of side-effects. So widespread was its use that the Government revealed in 1972 that the 56,000 women enrolled in the state family planning programme had admitted to a total of 52,000 abortions. Based on public sector birth statistics, the number of induced abortion for 1984 was estimated to be about 60,000, or about 40 abortions per 1,000 women of reproductive age. Including private sector data increases that figure to just under 50 per 1,000. Although these figures are rough estimates, they do provide a figure for the minimum number of abortions that take place.

Despite its illegality, abortion is performed without impunity in both private hospitals and clinics, as well as in more clandestine and unsafe circumstances, for example, when self-induced or induced by a midwife. In private hospitals and clinics physicians generally classify abortion as therapeutic when performed to save the life of the woman, but many are performed on eugenic and health grounds. So generalized is this practice that many physicians believe abortion is legal on therapeutic grounds and some public hospitals have gone as far as to develop procedures and regulations to consider and authorize the abortion. Basically, the procedure entails obtaining the written authorization of another medical colleage and/or placing the decision in the hands of a panel of physicians. Once authorized, legal authorities are notified that the abortion will be performed. In private clinic settings, a medical colleague is consulted. Sometimes, the abortion is performed with only the consent of the spouse.

Clandestine abortion is reported to be widely performed, with extremely few cases being brought to the attention of the courts. Those which have been tried have generally been cases where the woman died from the procedure.

Dominican Republic

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
National	1984	11.2 abortions/100 births	HR
National	1985	10.3 abortions/100 births	HR

NOTES: PR: provider registration; SP: survey providers; SW: survey of women; HR: hospital admission records. For a detailed description of these abbreviations and information on sources of data, see technical notes in annex I.

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	Yes
To preserve mental health	No
Rape or incest	Yes, but conditional
Foetal impairment	No
Economic or social reasons	No
Available on request	No

Additional requirements

Consent of the legal representative of the pregnant woman is required if she is retarded or insane. The abortion must be performed by a physician with the consent of the woman or that of her husband if she is unable to.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Too high
Government's intervention concerning fertility level:	To lower
Government's policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49, 1989):	41
Total fertility rate (1985-1990):	4.3
Age-specific fertility rate (per 1,000 women aged 15-19, 1982-1987):	91
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	Yes
Complications of child-bearing and childbirth	Yes
Maternal mortality rate (per 100,000 live births):	
National (1983)	174
South America (around 1983)	280
Female life expectancy at birth (1985-1990):	67.6

Ecuador

BACKGROUND

Sections 441-447 of the Ecuadorian Penal Code of 1971 permit abortion only when necessary to save the life of the pregnant woman or to preserve her health, or when the pregnancy is the result of a violent crime committed on a retarded or demented woman. In the latter case, the retarded woman can obtain an abortion as long as her legal representative consents to it. Anyone performing an abortion without the consent of the pregnant woman is subject to imprisonment for from three to six years. If performed with the woman's consent, the abortionist is liable to from two to five years in prison. If the woman dies, the abortionist may be incarcerated for up to six years if she consented to the procedure and for up to 12 years if she did not. If the woman induces the abortion, she will be punished by a sentence of from one to five years in prison. If she has done so to hide her dishonour, the sentence is reduced to from six months to two years. Medical and paramedical personnel performing abortion are subject to harsher penalties.

Although abortion is only permitted on therapeutic and conditioned juridical grounds, it is widely practised in Ecuador. The few studies available examining the incidence and prevalence of abortion do not distinguish between spontaneous and induced abortion and do not employ representative samples of the population. The scanty information available, however, suggests that the actual levels of induced abortion are greatly underestimated. Nevertheless, despite this high incidence, mortality associated with abortion is slightly lower than in other countries in the region. One study found that the most common causes of maternal mortality, which was placed at 200 per 100,000 live births, were post-partum haemorrhage and eclampsia, not complications of induced abortion. Data indicate that abortion is the fourth leading cause of maternal death.

On 4 June 1984, Ecuador adopted a new Constitution whereby it established that life begins at conception and guarantees state protection for the child from the moment of conception (section 25). The Constitution of 1984 also guarantees couples the right to determine the number of children they want (section 24). The constitutional right to determine family size, however, had been granted previously in the Constitution of January 1978. Family planning has been available in government clinics since 1968 and in the private sector clinics of the Asociación Pro-Bienestar de la Familia Ecuatoriana (APROFE) since 1967. A number of other private organizations also provide family planning services. With 41 per cent of currently married women using a modern contraceptive method, Ecuador has the highest contraceptive prevalence rate of the Andean countries with significant indigenous populations.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
National	1972	16.2 abortions/100 births	HR

NOTES: PR: provider registration; SP: survey providers; SW: survey of women; HR: hospital admission records. For a detailed description of these abbreviations and information on sources of data, see technical notes in annex I.

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	No*
To preserve physical health	No*
To preserve mental health	No
Rape or incest	No
Foetal impairment	No
Economic or social reasons	No
Available on request	No

Additional requirements

A committee of physicians must certify that the pregnancy poses a serious risk to the pregnant woman's life or health. The husband's consent is required.

*General principles of law permit these grounds.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Too high
Government's intervention regarding fertility level:	To lower
Government's policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49, 1988/89):	35
Total fertility rate (1985-1990):	4.5
Age-specific fertility rate (per 1,000 women aged 15-19, 1983-1988):	83
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	No
Complications of child-bearing and childbirth	Yes
Maternal mortality rate (per 100,000 live births):	
National (1982)	318
Northern Africa (around 1983)	500
Female life expectancy at birth (1985-1990):	60.3

Egypt

BACKGROUND

The Egyptian Penal Code of 1937 (sections 260-264) prohibits abortion in all circumstances. Under the general principles of criminal law, however, abortion is permitted to save the life of the pregnant woman, that is, where defense of necessity is justified. Article 61 of the Penal Code provides that "a person who commits a crime in case of necessity to prevent a grave and imminent danger which threatens him or another person shall not be punished, on condition that he has not caused it on his own volition or prevented it by other means". Although in general "defense of necessity" justifies abortion to prevent a life-threatening situation, in Egypt it is sometimes interpreted to include cases where the pregnancy may cause serious risks to the health of the mother.

Anyone who induces an abortion, including the pregnant woman, is subject to imprisonment. Physicians and pharmacists who perform an abortion are subject to harsher punishment, including hard labour. The intent to commit the act is not sufficient to be convicted of the offence of abortion. The prosecution has to prove the pregnancy of the woman, the interruption of pregnancy, the illegal means to interrupt the pregnancy and the intent to do so. Given these requirements, it is difficult for the prosecution to procure the evidence necessary for a conviction of the crime of abortion.

Although Islamic law generally forbids abortion only after the foetus is formed, an event that is said to occur not before 120 days after conception, the Egyptian courts have ruled that the foetus is created at conception.

Information on incidence of induced abortion is scarce. A national Survey on Pregnancy Wastage and Infant Mortality conducted in 1980 reported 10.8 induced and spontaneous abortions per 100 live births.

Egypt was the first Arab country to adopt a national population policy. The Government adopted a policy to reduce fertility in 1962 and established the Supreme Council for Family Planning in 1965. In 1973, the responsibility for the delivery of family planning services was transferred to the Ministry of Health. Contraception is also available through a number of private sector agencies. The Egyptian Family Planning Association has been providing services since 1958. The private sector is an important provider of services in Egypt. The Demographic and Health Survey conducted in 1988 noted that 35 per cent of married women were using a modern contraceptive.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
Information not readily available.			

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	No
To preserve mental health	No
Rape or incest	Yes
Foetal impairment	Yes
Economic or social reasons	No
Available on request	No

Additional requirements

An abortion requires the consent of the pregnant woman or that of her legal representative if she is a minor or incompetent. The abortion must be performed by a physician on the basis of a prior favourable medical report.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Too high
Government's intervention concerning fertility level:	To lower
Government's policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-44, 1988):	43
Total fertility rate (1985-1990):	4.9
Age-specific fertility rate (per 1,000 women aged 15-19, 1984-1985):	129
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	Yes
Complications of child-bearing and childbirth	Yes
Maternal mortality rate (per 100,000 live births):	
National (1984)	68
Central America (around 1983)	240
Female life expectancy at birth (1985-1990):	66.5

El Salvador

BACKGROUND

Sections 161-169 of the Salvadoran Penal Code of 1973 (Decree No. 270 of 3 February 1973) prohibit abortion except when necessary to save the life of the pregnant woman, when the pregnancy is the result of rape or when serious foetal deformity is suspected. Neither an abortion induced unintentionally by the woman herself nor an attempt by a woman to induce an abortion is a criminal offence. A woman successfully inducing her own abortion, however, is subject to imprisonment for a term of from one to three years. A person performing an illegal abortion is sentenced to from two to four years in prison. Because prosecution of offenders requires proof of pregnancy, however, such prosecution is rare.

An abortion must be performed by a qualified physician and with the consent of the pregnant woman. A second opinion, that is, a prior medical report, is required to certify that the woman's life is endangered by the pregnancy. If the woman is a minor or is incompetent to give consent, her spouse or legal representative must consent to the abortion.

Prior to 1973, abortion was prohibited on all grounds. However, because there was evidence that its practice was widespread and that its contribution to rates of maternal mortality was large (at least 11 per cent of all maternal deaths in 1973 and 1974 were reportedly due to complications of induced abortion), the Government moved to liberalize abortion laws. The Contraceptive Prevalence Survey conducted in 1975 found that close to 20 per cent of all ever-married women surveyed had had at least one abortion (induced or spontaneous) in their lifetime. The proportion that had undergone an abortion was slightly higher in rural areas. The National Fertility Survey conducted in 1978 obtained the same results.

Menstrual regulation is available in El Salvador and is openly performed for legal abortion. Family planning services have been available through the Ministry of Health and the Salvadoran Social Security Institute (ISSS) since 1968 and 1969, respectively, and through the Asociación Demográfica Salvadoreña (ADS), the private affiliate of the International Planned Parenthood Federation, since 1966. Sterilization accounted for 73 per cent of contraceptive use in 1985.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
National	1972	10.4 abortions/100 births	HR

NOTES: PR: provider registration; SP: survey providers; SW: survey of women; HR: hospital admission records. For a detailed description of these abbreviations and information on sources of data, see technical notes in annex I.

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Information not readily available
To preserve physical health	
To preserve mental health	
Rape or incest	
Foetal impairment	
Economic or social reasons	
Available on request	

Additional requirements

Information not readily available.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Too low
Government's intervention concerning fertility level:	To raise
Government's policy on contraceptive use:	No support provided
Percentage of currently married women using modern contraception (aged 15-49):	..
Total fertility rate (1985-1990):	5.9
Age-specific fertility rate (per 1,000 women aged 15-19):	..
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of child-bearing and childbirth	..
Maternal mortality rate (per 100,000 live births):	
National	..
Middle Africa (around 1983)	690
Female life expectancy at birth (1985-1990):	47.6

Equatorial Guinea

BACKGROUND

Information on the legal status of abortion and on the incidence of abortion in Equatorial Guinea is not readily available. Given that up until 1968 Equatorial Guinea was a Spanish colony, it is likely that it inherited Spanish colonial laws which prohibit abortion in all circumstances.

A census conducted in 1983 revealed that fertility in Equatorial Guinea is somewhat lower than in other African countries and that growth has been slow. Maternal and child health services were non-existent prior to 1985. Since then, 27 maternal and child health centres have been established. Family planning services are also unavailable in Equatorial Guinea. A project was initiated in 1990 to organize and deliver family planning services in the recently established maternal and child health programme.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	Yes
To preserve mental health	Yes
Rape or incest	Yes
Foetal impairment	Yes
Economic or social reasons	Yes
Available on request	Yes

Additional requirements

An abortion requires the consent of the pregnant woman; it is authorized when performed by a physician in a hospital or other medical institution. An abortion is available on demand to the twelfth week of pregnancy. Thereafter, special authorization is required.

FERTILITY AND MORTALITY CONTEXT

Policy regarding access to contraception:	No major restrictions
Government's view of fertility level:	..
Government's intervention concerning fertility level:	..
Government's policy on contraceptive use:	..
Percentage of currently married women using modern contraception (aged 15-49):	..
Total fertility rate (1985-1990):	2.4*
Age-specific fertility rate (per 1,000 women aged 15-19, 1985/86):	44*
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of child-bearing and childbirth	..
Maternal mortality rate (per 100,000 live births):	
National (1988)	23.4
Developed countries (around 1983)	30
Female life expectancy at birth (1985-1990):	74.2*

*This estimate is based on data pertaining to the USSR, as separate tabulations for Estonia are not available.

Estonia

BACKGROUND

Prior to September 1991, the abortion laws of Estonia were those of the USSR. In 1939, when Estonia was incorporated into the USSR, abortion was available on demand in the Soviet republics. An abortion had to be performed within the first trimester in a hospital (Law of 8 November 1920). In 1936, however, abortion legislation was reversed in order to increase population growth (Law of 27 June 1936). Thereafter, abortion was only permitted to save the life of the pregnant woman or in cases where foetal deformity was suspected, and it had to be performed within the first trimester. Offending physicians were subject to imprisonment from one to two years. The punishment for abortionists who were not qualified physicians was up to three years in prison.

In 1955, in recognition of the increased maternal mortality and morbidity resulting from illegal induced abortion, the Supreme Soviet made abortion legal again (Decree of 23 November 1955). An abortion was authorized when performed in a hospital or other medical institution by a physician according to instructions provided by the Ministry of Health. It was available on demand up to the twelfth week of pregnancy. Thereafter, special authorization was required. An abortion could not be performed if the procedure posed a risk to the mother's health or if she had undergone an abortion within the prior six months. Information on changes in the abortion laws of Estonia since it regained its independence is not yet available.

The USSR has one of the highest abortion rates in the world. Contraceptives are of very inferior quality and are in short supply. Contraceptives have been available in pharmacies only in the past three years. Both health personnel and the general population have little knowledge about family planning methods. Given the lack of choice, women have relied upon induced abortion as the main method of birth control. Abortion rates in Estonia are very high, among the highest of the Soviet republics. In 1985, Estonia (formerly the Estonian Soviet Socialist Republic) had an official abortion rate of 91.4 per 1,000 women aged 15-49 years. The true figure is even higher, as illegal abortions and abortions performed through vacuum aspiration are not included in these calculations. Vacuum aspiration is used for about 10 per cent of all abortions; such procedures are performed on an ambulatory basis up to the twentieth day of a missed period. Illegal abortion rates are estimated to be as high as legal abortion. Extremely cumbersome administrative procedures and low quality of available services have led many women to seek an illegal abortion from private physicians.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
National	1975	107.1 abortions/1,000 women aged 15-49	PR
National	1980	96.7 abortions/1,000 women aged 15-49	PR
National	1985	91.4 abortions/1,000 women aged 15-49	PR

NOTES: PR: provider registration; SP: survey of providers; SW: survey of women; HR: hospital admission records. For a detailed description of these abbreviations and information on sources of data, see technical notes in annex I.

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	Yes
To preserve mental health	No
Rape or incest	No
Foetal impairment	No
Economic or social reasons	No
Available on request	No

Additional requirements

A registered physician must certify in writing, after obtaining concurrence of a second qualified physician, that the abortion is necessary to avert injury to the woman's life or health. Consent of the woman is also required.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Too high
Government's intervention concerning fertility level:	No intervention
Government's policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49):	..
Total fertility rate (1985-1990):	6.8
Age-specific fertility rate (per 1,000 women aged 15-19):	..
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	Yes
Complications of child-bearing and childbirth	Yes
Maternal mortality rate (per 100,000 live births):	
National	..
Eastern Africa (around 1983)	660
Female life expectancy at birth (1985-1990):	45.6

Ethiopia

BACKGROUND

The Ethiopian Penal Code of 1957 (sections 528-535) permits abortion only when necessary to "save the pregnant woman from grave and permanent danger to life or health which is impossible to avert in any other way". Although the Code permits neither broad health grounds nor juridical or socio-economic grounds, it does consider a "grave state of physical or mental distress, especially following rape or incest, or because of extreme poverty" to be extenuating circumstances in sentencing. Anyone performing an unlawful abortion may be punished by imprisonment for up to five years. A woman who induces her own abortion is subject to the same punishment. A registered physician must certify in writing, after obtaining concurrence of a second qualified physician, that the abortion was necessary to avert injury to the woman's life or health. Consent of the woman is also required.

Although therapeutic abortion is permitted, cumbersome administrative restrictions limit the number of abortions performed legally on those grounds. Thus, many women resort to illegal abortion. Studies on levels and causes of maternal mortality carried out in the mid-1980s reported abortion to be the major cause of maternal death. Induced abortion has been estimated to account for between 30 and 40 per cent of maternal deaths.

Although family planning services are available in Ethiopia, contraceptive prevalence is low. No national contraceptive prevalence surveys have been conducted to date. However, a survey conducted in north-western Ethiopia estimated the contraceptive prevalence of women aged 15-49 to be below 14 per cent. According to the Penal Code of 1957, contraceptives are available only on prescription. However, they can be bought without prescription in pharmacies and some street vendors sell condoms. The Family Guidance Association of Ethiopia has been providing services since 1966. It received official recognition in 1974 and has since been providing services in government clinics. However, the Government has been providing family planning services in its own clinics since 1988, as part of a national comprehensive health programme initiative.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	Yes
To preserve mental health	Yes
Rape or incest	No*
Foetal impairment	No*
Economic or social reasons	No*
Available on request	No

Additional requirements

An abortion must be authorized by a physician and performed by a licensed physician in a hospital.

*Legal interpretation generally permits these grounds.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Too high
Government's intervention concerning fertility level:	To lower
Government's policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49, 1974):	35
Total fertility rate (1985-1990):	3.2
Age-specific fertility rate (per 1,000 women aged 15-19):	..
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	Yes
Complications of child-bearing and childbirth	Yes
Maternal mortality rate (per 100,000 live births):	
National (1986)	68
Oceania (around 1983)	..
Female life expectancy at birth (1985-1990):	66.0

Fiji

BACKGROUND

The Fijian Penal Code (cap. 11, sections 165-167 and 265) permits abortion when necessary to save the life of the pregnant woman and to preserve her physical and mental health. A case tried in 1976 (*Emberson* v. *Emberson*, Criminal Case No. 16 of 1976) clarified the law further by specifying that abortion is permitted when the performing physician has formed an opinion "in good faith" that the abortion was necessary to preserve the pregnant woman's mental and physical health, "taking into account the social circumstances of the patient". Thus, in practice the law is interpreted very liberally. An abortion may be performed on the grounds of foetal deformity, rape or incest as they may be interpreted as producing a risk to the woman's mental health; it may also be performed in cases of economic duress.

Those performing an illegal abortion may be punished by imprisonment for up to 14 years. The same punishment may be applied to someone supplying instruments to perform the abortion. A woman attempting to induce her own abortion regardless of whether she succeeds, may be punished by a sentence of up to seven years in prison.

Family planning services have been available in Fiji since 1962, when the Government officially introduced the services in 12 of its health centres. The Family Planning Association of Fiji has been in operation since 1963. Thirty-five per cent of married women of reproductive age were using modern contraception in 1974. Sterilization accounted for 46 per cent of contraceptive use. There is evidence, however, that in the late 1970s contraceptive prevalence declined, resulting in higher birth rates. In response to this decline in family planning programme effectiveness, the Government gave top priority to the family planning programme in its Development Plan for 1986-1990.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
Information not readily available.			

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

Finland

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	Yes
To preserve mental health	Yes
Rape or incest	Yes
Foetal impairment	Yes
Economic or social reasons	Yes
Available on request	No

Additional requirements

An abortion must be authorized by a physician and performed by a licensed physician in a hospital.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Satisfactory
Government's intervention concerning fertility level:	No intervention
Government's policy on contraceptive use:	Direct support provided
Percentage of currently married women* using modern contraception (aged 18-44, 1977):	77
Total fertility rate (1985-1990):	1.6
Age-specific fertility rate (per 1,000 women aged 15-19, 1986):	13
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	No
Complications of child-bearing and childbirth	No
Maternal mortality rate (per 100,000 live births):	
National (1987)	5
Developed countries (around 1983)	30
Female life expectancy at birth (1985-1990):	78.8

*Women in first marriage.

Finland

BACKGROUND

The Abortion Act of 1970 liberalized abortion laws in Finland. Prior to 1970, abortion was permitted on broad health grounds (to preserve the physical and mental health of the pregnant woman), on eugenic grounds and on juridical grounds. It was also permitted if the pregnant woman was under 16 years of age at the time of conception (Law of 1 June 1950). Dissatisfaction with the 1950s laws, fuelled in part by the rise of the women's liberation movement and other liberal political trends, led to the implementation of the new 1970 law.

The 1970 Abortion Act (Law No. 239 of 24 March 1970, sections 1-16) permits abortion at the request of the pregnant woman in the following circumstances: if the pregnancy or delivery would "endanger her life or health on account of a disease, physical defect or weakness in the woman"; if delivery and care of the child would place a strain on her, given her living conditions; if the pregnancy is the result of an act "committed in gross violation of the woman's freedom of action"; or if, due to disease or mental disturbance, the parents are unable to care for the child. In all of these cases, the written recommendation of two physicians is required. When the pregnancy is the result of rape, however, the abortion can only be performed if legal action in respect to the crime has been taken or if clear evidence of the crime has been obtained by police inquiry. An abortion is also permitted if the woman is under 17 years of age or if she is over 40 or already has four children. In such cases, the recommendation of the performing physician is sufficient to approve the abortion. Lastly, the law also permits an abortion when there is reason to believe that the foetus will be seriously impaired. In this case, authorization must be given by the State Medical Board.

An abortion must be performed within the first trimester of gestation, except in cases of "a disease or physical defect in the woman" that might endanger her health (Law No. 564 of 14 July 1978 amending section 5 of Law of 1970). It is permitted up to the twentieth week if the woman is under 17 years of age or when there are "other special reasons". A further exception was added (Law No. 572 of 12 July 1985) which permits abortion up to the twenty-fourth week of gestation if amniocentesis or ultrasonic examination has established that the embryo is seriously impaired.

An abortion must be performed by a licensed physician in a hospital approved by the State Medical Board. Exceptions may only be made in emergencies. The woman herself should apply for the procedure. Women are to be given information on the risks of the procedure prior to the termination of pregnancy and are to receive information on contraception after the procedure has taken place.

Anyone performing an illegal abortion is subject to a fine and a sentence of up to one year in prison. Anyone making a false statement or notification concerning an abortion shall be liable to the same punishment.

Although the incidence of abortion increased immediately after the liberalization of the abortion laws, reaching a peak of 22.4 abortions per 1,000 women aged 15-44 in 1973, the number of abortions performed began to decline thereafter. Ten years later, in 1983, 12.1 abortions per 1,000 women aged 15-44 were being performed. By 1987, the corresponding figure was 11.7 per 1,000. The decline in abortion has been noted in all age groups although in age group 15-19 the decline has been minimal. In fact, the abortion rates for ages 17-19 are the highest of all age groups. Incidence of abortion for this age group is almost twice as high as that of women aged 25-29. The Government has made special efforts to reduce teenage fertility and abortion.

Eighty per cent of abortions in 1982 were performed on social grounds. Another 16-18 per cent were performed on women that were minors or over 40 years of age, or had at least four children. Seventy-seven per cent of all abortions in 1983 were first-time abortions, suggesting abortion is used primarily as a backup measure, not as a contraceptive. Only 5 per cent of the women aborting in 1983 had previously undergone two or more abortions.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
National	1968	6.0 abortions/1,000 women aged 15-44	PR
National	1970	13.8 abortions/1,000 women aged 15-44	PR
National	1972	20.4 abortions/1,000 women aged 15-44	PR
National	1973	22.4 abortions/1,000 women aged 15-44	PR
National	1975	20.4 abortions/1,000 women aged 15-44	PR
National	1977	16.7 abortions/1,000 women aged 15-44	PR
National	1979	14.7 abortions/1,000 women aged 15-44	PR
National	1981	12.9 abortions/1,000 women aged 15-44	PR
National	1983	12.1 abortions/1,000 women aged 15-44	PR
National	1985	12.4 abortions/1,000 women aged 15-44	PR
National	1987	11.7 abortions/1,000 women aged 15-44	PR

NOTES: PR: provider registration; SP: survey providers; SW: survey of women; HR: hospital admission records. For a detailed description of these abbreviations and information on sources of data, see technical notes in annex I.

Source: The Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat. For additional sources, see list of references.

France

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	Yes
To preserve physical health	Yes
To preserve mental health	Yes
Rape or incest	Yes
Foetal impairment	Yes
Economic or social reasons	Yes
Available on request	No

Additional requirements

An abortion must be performed before the end of the tenth week of gestation by a physician in an approved hospital. Beyond the tenth week of gestation, it may only be performed when the pregnancy poses a grave danger to the woman's health or on eugenic grounds. In this case, two physicians must attest to the woman's health risk.

FERTILITY AND MORTALITY CONTEXT

Government's view of fertility level:	Too low
Government's intervention concerning fertility level:	To raise
Government's policy on contraceptive use:	Indirect support provided
Percentage of currently married women using modern contraception (aged 18-49, 1988):	64
Total fertility rate (1985-1990):	1.8
Age-specific fertility rate (per 1,000 women aged 15-19, 1987):	10
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	No
Complications of child-bearing and childbirth	No
Maternal mortality rate (per 100,000 live births):	
National (1988)	9
Developed countries (around 1983)	30
Female life expectancy at birth (1985-1990):	80.0

BACKGROUND

Law No. 75-17 of 17 January 1975 liberalized abortion laws in France. Prior to 1975, France adhered to the 1920 antiabortion law, which prohibited anyone from advertising, inciting or performing an abortion and punished not only the person performing it but anyone providing any object, substance or medicine intended for that purpose. Law 75-17 was introduced for a five-year trial period and was adopted as a permanent law by the Parliament in December 1979, with some amendments.

Although the law begins by specifying that "the law guarantees the respect of every human being from the commencement of life", it states that abortion is considered lawful, if the termination of pregnancy is performed before the end of the tenth week of gestation by a physician in an approved hospital. A woman who is "in situation of a distress" because of her pregnancy may request her physician for an abortion. The physician must inform the woman about the risks involved and provide her with a guide to family rights and assistance should she decide not to terminate the pregnancy. The woman must consult with an appropriate social welfare or family counselor about the interruption of pregnancy and if she still desires to terminate the pregnancy, she should renew her request in writing, not sooner than one week from the time of the first request. If the woman is a minor, consent by her legal representative is required. With the written request in hand, the physician may perform the procedure, provided the pregnancy is not more than 10 weeks.

If the pregnancy poses a grave danger to the woman's health or there is a strong probability that the foetus may be severely impaired, abortion is permitted at any time during pregnancy provided two physicians certify, after an examination, that the health of the mother or foetus is at risk.

Law No. 79-1204 of 31 December 1979 amended the 1975 law. Many of the amendments introduced serve to clarify the procedures to be followed in the application of the law. Others are designed to ensure that women desiring to terminate a pregnancy are fully informed as to the prevention of pregnancy and alternatives to abortion. The 1979 law specifies that should the one-week waiting period for consultation cause the 10-week gestation period to be exceeded, the physician may accept the renewed request as early as two days after the initial request. The law clarifies that if the woman is a minor, both she and her legal representative must consent to the procedure.

The 1979 law also amends section 317 of the Penal Code, which punishes a person performing or attempting to perform an abortion on a pregnant or supposedly pregnant woman, with or without her consent, by imprisonment for from one to five years and a fine of 1,800-100,000 French francs. If the abortionist is a regular perpetrator, imprisonment is for 5-10 years and a fine of F 18,000-250,000. A woman who obtains an abortion or induces it herself is subject to imprisonment from six months to two years and a fine of F 360-20,000.

Subsequent amendments include Decree No. 80-285 of 17 April 1980, which identifies the establishments required to have facilities to perform abortion and to provide information and medical procedures related to birth control, among which are included regional hospital centres and general hospital centres; Decree No. 88-59 of 18 January 1988, which adds public hospital establishments with surgical or obstetric units to this list; and, the most important amendment to the law, Law No. 82-1172 of 31 December 1982, which extends social security coverage to 70 per cent of the costs of care and hospitalization associated with lawful termination of pregnancy.

Although there is evidence that legal abortion rates have been declining in France since 1983, the number of French nationals having an abortion outside the country has not declined. Part of the problem is that women are often unable to obtain the abortion before the 10-week deadline, because of the numerous administrative procedures that are required. Furthermore, as a survey conducted in 1980 found women reported that the public services had not responded adequately to requests for abortion. Physicians opposed to abortion frequently delayed their diagnosis of pregnancy and the facilities available were insufficient to satisfy demand. Women interviewed also considered information on contraception to be insufficient. The

fact that section 647 of the Health Code prohibits any direct or indirect advertising of abortion, even when it is legally permitted, deters access to abortion even further.

The approval in late 1988 of the Roussel-UCLAF "abortion pill" RU486, may facilitate access to abortion for many women. Currently, use of the drug is closely regulated. Ministry of Health circular No. 90-06 of 22 February 1990 outlines the procedures to be followed with regard to the use and distribution of RU486. The treatment cannot be used after the forty-ninth day of amenorrhoea and it must be taken in the presence of a physician. The patient must be examined by a physician 48 hours afterwards to be administered a prostaglandin, and one week later to verify the termination of pregnancy. Currently, one quarter of all legal abortions employ RU486.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
National	1976	12.3 abortions/1,000 women aged 15-44	PR
National	1978	13.6 abortions/1,000 women aged 15-44	PR
National	1980	15.3 abortions/1,000 women aged 15-44	PR
National	1981	15.9 abortions/1,000 women aged 15-44	PR
National	1982	15.8 abortions/1,000 women aged 15-44	PR
National	1983	15.7 abortions/1,000 women aged 15-44	PR
National	1984	15.4 abortions/1,000 women aged 15-44	PR
National	1985	14.6 abortions/1,000 women aged 15-44	PR
National	1986	13.9 abortions/1,000 women aged 15-44	PR
National	1987	13.3 abortions/1,000 women aged 15-44	PR
National	1988	13.2 abortions/1,000 women aged 15-44	PR

NOTES: PR: provider registration; SP: survey providers; SW: survey of women; HR: hospital admission records. For a detailed description of these abbreviations and information on sources of data, see technical notes in annex I.

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ANNEX

Technical notes

The most commonly employed sources of abortion statistics include provider registration (PR), surveys of providers (SP), surveys of women (SW) and hospital admission records (HR). A detailed description of each source of data and its deficiencies is included in the main text in the section concerning statistics on induced abortion. These notes describe, for each country for which abortion data were obtained, the source of the data and the type of data obtained.

AUSTRALIA

National statistics for Australia were obtained from Tietze and Henshaw (1986) and from Henshaw and Morrow (1990). They are official records provided by the Commonwealth Department of Health. They include only abortions paid by the National Health Insurance Plan and therefore underestimate the true level by the proportion performed by the private sector.

Statistics on South Australia were obtained from Hart and Macharper (1987). The data, provided by the Public Health Service, were obtained from questionnaires completed, as statutory requirement, by all operating practitioners in South Australia. Only South Australia requires notification of all abortions performed and thus provides the most complete statistics in Australia. Furthermore, because abortion law is very liberal in South Australia (it is permitted on socio-economic grounds), the degree to which actual figures underestimate the true levels of induced abortion is minimal.

BANGLADESH

The data for Bangladesh were obtained from Tietze and Henshaw (1986) and Henshaw and Morrow (1990). The figures include all menstrual regulations reported to the Bangladesh Association for Prevention of Septic Abortion. The reporting period ends 30 June. In Bangladesh, abortion is only permitted when necessary to save the life of the pregnant woman. Menstrual regulation, however, is officially offered as a family planning method, not as an abortifacient. Because menstrual regulations must be performed at a very early stage of gestation, many women resort to illegal abortion. The figures given here exclude illegal abortions.

BELARUS

Abortion rates for Belarus were obtained from a summary of a presentation made by A. A. Popov of the Institute of Socio-economic Studies of Population, Academy of Sciences of the USSR, Moscow. The presentation was made at a World Health Organization European region seminar on the health benefits of family planning, held at Alma-Ata in 1990. The summary appears in the WHO newsletter *Entre nous*, No. 16 (September 1990). The rates include officially registered abortions and exclude illegally performed abortions. Also excluded are abortions performed by vacuum extraction; such procedures represent 10 per cent of all abortions performed in the USSR. Figures for 1988 exclude abortions performed in some specialized administrations.

BELGIUM

The data for Belgium, which are based on a survey of abortion providers, were obtained from Henshaw and Morrow (1990). The rate of 5.1 abortions per 1,000 women aged 15-44 increases to 7.5 when abortions performed on Belgian women outside the country are included.

Bolivia

The data were obtained from Viel (1988). The abortion ratio represents the number of hospitalized abortions per number of births among the beneficiaries of the social security services in Bolivia. The figure includes both induced and spontaneous abortions.

Bulgaria

Abortion on request was legal in Bulgaria prior to 1968 and after 1974. Thus, except for the figure for 1970, data can be expected to be fairly complete. The data include abortions performed for medical reasons and on request. The figures were obtained from Tietze and Henshaw (1986) and Henshaw and Morrow (1990). Figures from 1977 onward were obtained from government responses to a questionnaire from the Alan Guttmacher Institute.

Canada

The data were obtained from Henshaw and Morrow (1990) and Tietze and Henshaw (1986). They are official records of the Canadian Government of all abortions performed for therapeutic reasons.

Chile

All data available in Chile are based on hospitalization records and include both spontaneous and induced abortions. Figures for Santiago and the national figure for 1969 were obtained from Viel (1988) and the figure for 1983 from Espinoza (1985). The Santiago figures are based on hospitalization statistics provided by the Ministry of Health. The figure for 1969 is also based on hospitalizations for complications of abortion but includes only the beneficiaries of the social security services in Chile.

China

Chinese data on abortion is considered to be fairly reliable. If anything, they may be overestimating true abortion rates, as abortion records are the basis on which the health department is reimbursed for procedures performed by the planned births office. However, given scarce resources, the planned births office was careful not to overpay. Abortion rates were obtained from Tietze and Henshaw (1986) and Henshaw and Morrow (1990). The figure for 1987 has not been verified and may be innaccurate.

Colombia

Data available are based on hospitalization records. The figure for 1972 was obtained from Viel (1988) and includes only social security beneficiaries. It includes both spontaneous and induced abortion. The figure for 1975 was obtained from Uriza Gutiérrez (1982) and includes only induced abortions.

Costa Rica

The data were obtained from Viel (1988). The abortion ratio represents the number of hospitalized abortions per number of births among the beneficiaries of the social security services in Costa Rica. The figure includes both induced and spontaneous abortion.

Cuba

Abortion rates were obtained from Hollerbach (1988). Statistics on abortion come from the Cuban Ministry of Public Health. Only legal abortions are included.

Czechoslovakia

The data were obtained from Tietze and Henshaw (1986) and from Henshaw and Morrow (1990). They include all legal abortions performed. Abortion was illegal prior to 1958 and thus the figure for 1957 is considerably lower than other rates. Data for 1988 were obtained from information provided by Zdenek Pavlik.

Denmark

Figures were obtained from Tietze and Henshaw (1986) and from Henshaw and Morrow (1990). They include all legal abortions performed. Although the law was not liberalized until 1973 (the law went into effect on 1 October), figures for 1971 and 1972 reflect an already changing interpretation of the 1970 laws. The 1970 laws required committee aproval for abortion. Nevertheless, 96 per cent of the applications were approved. Illegal abortions are still being performed in Denmark. However, the majority of abortions are legal and thus the figures do not represent gross understimations of actual abortion rates.

Dominican Republic

Figures for the number of births and abortions employed to calculate this ratio were obtained from Paiewonsky (1988). The figures represent all births and hospitalizations due to complications of abortion (both induced and spontaneous) that occurred in all health centres of the Secretaría de Estado de Salud Pública y de Asistencia Social in 1984 and 1985.

Ecuador

The data were obtained from Viel (1988). The abortion ratio represents the number of hospitalized abortions per number of births among the beneficiaries of the social security services in Ecuador. The figure includes both induced and spontaneous abortion.

El Salvador

The data were obtained from Viel (1988). The abortion ratio represents the number of hospitalized abortions per number of births among the beneficiaries of the social security services in El Salvador. The figure includes both induced and spontaneous abortion.

Estonia

Abortion rates for Estonia were obtained from a summary of a presentation made by A. A. Popov of the Institute of Socio-economic Studies of Population, Academy of Sciences of the USSR, Moscow. The presentation was made at a World Health Organization European region seminar on the health benefits of family planning, held at Alma-Ata in 1990. The summary appears in the WHO newsletter *Entre nous*, No. 16 (September 1990). The rates include officially registered abortions and exclude illegally performed abortions. Also excluded are abortions performed by vacuum extraction; such procedures represent 10 per cent of all abortions performed in the USSR. Figures for 1988 exclude abortions performed in some specialized administrations.

Finland

The figures were obtained from Henshaw and Morrow (1990). They include all legal abortions performed. The law was liberalized in 1970; thus, the figures show a steady rise from that date up to 1973. Abortion rates declined from 1973 to the present and stabilized at about 12.0. All figures are based on official records kept by abortion providers in fulfilment of the law. Although illegal abortions are still being performed in Finland, since 1970 the majority of abortions have been legal and thus the figures do not represent gross underestimations of actual abortion rates.

FRANCE

Figures were obtained from Henshaw and Morrow (1990). They include all legal abortions performed. It has been reported, however, that all figures are incomplete. Illegal abortions continue to be performed in France. Figures for 1987 and 1988 are provisional.

REFERENCES

The references for this volume are divided into two sections: the first contains the general references used for the introductory chapters as well as for background information throughout the volume; the second contains the references used in the individual country profiles. The latter references are presented by country. Unless otherwise indicated, data used in the country profiles were taken from replies to the Sixth United Nations Population Inquiry among Governments and from other materials in the Population Policy Data Bank maintained by the Population Division of the Department of International Economic and Social Affairs of the United Nations Secretariat.

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