Abortion Policies

A Global Review

Volume III

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Department for Economic and Social Information and Policy Analysis
Population Division

Abortion Policies

A Global Review

Volume III
Oman to Zimbabwe

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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.

The report has been edited and consolidated in accordance with United Nations practice.

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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 Member States and non-Member States of the United Nations. 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 31 December 1992.

Information on the abortion policies of four countries that gained independence following the publication of volume I (Armenia, Azerbaijan, Bosnia and Herzegovina, and Croatia) are included in volume II, as are the abortion policies of the Democratic People's Republic of Korea. In addition, the sections on the policies of Belarus and China, presented in volume I, were revised and included in volume II. Information on the abortion policies of three countries that gained independence following the publication of volume II (Andorra, the Czech Republic and Eritrea) are included in the present volume.

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 for Economic and Social Information and Policy Analysis, United Nations Secretariat, New York, NY 10017, United States of America.

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.

Reference to "tons" indicates metric tons, unless otherwise stated.

The term "billion" signifies a thousand million.

A hyphen between years (e.g., 1994-1995) indicates the full period involved, including the beginning and end years; a slash (e.g., 1994/95) indicates a financial year, school year 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:

ASFR	age-specific fertility rate
HIV	human immunodeficiency virus
HR	hospital admission records
IPPF	International Planned Parenthood Federation
IUD	intra-uterine device
MCH	maternal and child health
PAHO	Pan American Health Organization
PR	provider registration
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 both in remote rural societies and 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 and 1986; Glendon, 1987; Knoppers and Brault, 1989; and Sachdev, 1988.

[2] For example, Moore-Čavar, 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 laws, their importance has declined as aspects of the major legal systems have replaced or been incorporated into existent systems. Religious and customary laws 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 a legislature or parliament; 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 that 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 goal 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 application of the laws. Thus, interpretation of enacted law has played a limited role in socialist systems. To the extent that law has been interpreted, it has been 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 the 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 colonization. Thus, the countries colonized by Belgium, France, Germany, Italy, the Netherlands, Portugal and Spain inherited a version of the civil-law system of the mother country and of its 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. Despite recent events, socialist law still forms the basis of the legal systems in most countries of Eastern Europe. It is also the basis of the legal system in 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 concerning 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, those relating to the family and, in this case, abortion are influenced by religious and customary law.

Laws concerning abortion frequently appear to be inconsistent because they are addressed in multiple simultaneous codes. When abortion is considered a crime, it is addressed in a penal code. 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 those 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 covering the sphere of relations between those governing and those 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 Soviet republics, or what course the former USSR will take. A discussion of socialist law is included because it was the basis for abortion laws in Eastern Europe and in 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, which 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 that, 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 acceptance 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 Irish Chalking Act in 1803. This Act, in an early amendment of its section 58, punished a woman obtaining an abortion, whether self-induced or not, by life imprisonment (Francome, 1988).

The Act of 1803 and its amendments paved the way for the Offences Against the Person Act of 1861 (sections 58 and 59). This 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 is subject to three years in prison (Francome, 1988).

An important judicial precedent, the case of *Rex* v. *Bourne* in 1938, clarified the Act of 1861 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 offence 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 Act of 1861 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 Offences Against the Person Act of 1861 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 *Bourne* decision of 1938 or was modified on the basis of local court precedents. The wording of these laws is, in general, very similar to the Act of 1861, but there is ample variation in the penalties 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 an abortion and for any person performing an abortion. 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 a civil-law system. 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 about women's status, health and welfare, the Government of the former Union of Soviet Socialist Republics legalized abortion in 1920 (Law of 8 November). Abortion became available in the former Soviet republics if performed during the first trimester. In 1936, the abortion legislation was reversed for demographic considerations (Law of 27 June), permitting abortion only for serious therapeutic reasons. In 1955, the abortion law was liberalized once more in recognition of the increased maternal mortality and morbidity resulting from illegal induced abortion (Decree of 23 November). The Supreme Soviet made abortion available on demand in all the former Soviet republics during the first 12 weeks 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 permits abortion, however, when the pregnancy endangers the mother's life, regardless of the duration of gestation (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, including 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 the way in which 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 pregnant woman has tested positive for the human immunodeficiency virus (HIV), when she 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 given 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 to indicate that although it is 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 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 of 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 Andorra, which prohibits abortion on any ground. The Criminal Code of San Marino also prohibits abortion on any ground; however, legal interpretation generally permits this ground. Similarly, in the Philippines, the Penal Code generally prohibits abortion, but abortion may be justified under the principle of "defense of necessity", in order to save the life of the pregnant woman.

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 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 a list of conditions that are considered to fall under this category; in other countries, "physical health" is broadly defined and allows 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 involved 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, laws 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 when 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 Saint Vincent and the Grenadines.

A word should be added about *Rex* v. *Bourne* (1938) at this point. As previously mentioned, 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 only physical health. 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 is the case in most Latin American countries. It may be worded as "when necessary to defend the pregnant woman's honour", or simply, when the pregnancy is the result of sexual violence. Some specifically mention both rape and incest; others refer only to rape. 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, the Syrian Arab Republic, 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. In Zambia, for example, the woman's actual or reasonably foreseeable environment, or her age, must be taken into account in determining whether the pregnancy poses any risk to her life or to her mental or physical health, or poses a risk of injury to the mental or physical health of any of her existing children. The abortion law in the United Kingdom contains a similar provision. There are also instances, as in Saint Vincent and the Grenadines, in which abortion is not explicitly permitted on social and economic grounds but the law specifies that in the determination of whether continuation of the pregnancy would involve a risk of injury to the health of the woman, the woman's actual or reasonably foreseeable environment may be taken into consideration.

Although it may be difficult to detect major policy differences between 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, and the countries 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 to interpret the grounds 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 or economic grounds and those permitting abortion on request 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 Singapore, Sweden, Tunisia and Viet Nam have abortion on request, whereas in Hungary, a woman seeking an abortion must be in a crisis situation and must have a compulsory consultation with a nurse. In Italy, she must attest to her physician that continuation of the pregnancy or childbirth would seriously endanger her physical or mental health, based on broad considerations which include economic, social and family conditions.

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 request can usually be performed without the approval of authorities if it is done 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; it is divided into 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 contraceptives. 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 contraceptive methods are widely available and are 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, 1992.)

5. Total fertility rate

The total fertility rate (TFR) measures the number of children a woman would have during her lifetime if she were to follow current age-specific fertility rates. For most countries, the rates presented here are medium-variant estimates for the period 1990-1995 unless otherwise specified 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. For countries for which data for the period 1990-1995 were not available, data for the period 1985-1990 are provided.

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 in that age group. 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 in the United States of America) 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. Because people tend 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, 1989a).

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 and the Seventh Inquiry in 1992, conducted by the Population Division of the Department for Economic and Social Information and Policy Analysis of the United Nations Secretariat. If a Government did not respond to the Inquiry, statements made in official government documents and publications were reviewed in order to determine that Government's concern about 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 and Seventh United Nations Population Inquiries among Governments, conducted by the Population Division. If a Government did not respond to the Inquiry, statements made in official government documents and publications were reviewed in order to determine that Government's concern about complications of child-bearing and childbirth.

9. Maternal mortality rate[2]

Induced abortion accounts for a large percentage share of maternal mortality in developing countries, particularly in those 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[3] (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, the 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 reasons for unreliability of data, 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 of America, 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 lack information, rates for both the country and the region were included. Where both figures are available and it is thought that the country in question might have very deficient vital statistics, the regional figure provides an idea of 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. For most countries, all the measures are medium-variant estimates for the period 1990-1995 unless otherwise specified (taken from United Nations, 1995) and therefore permit cross-country comparisons. For countries for which data for the period 1990-1995 were not available, data for the period 1985-1990 are provided.

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 statistics agencies. In countries where abortion is available on request, 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 the number 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 was the case in the former 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 the 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 those cases in which an abortion resulted in complications are hospitalized. Furthermore, only hospital-based treatments are included. Deaths occurring before a hospital has been contacted also are unreported. Despite problems with underestimation of induced abortion, hospital admission records are useful because they give an indication 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 were conducted by Cook and Dickens. They surveyed all Commonwealth countries to inquire whether the *Bourne* case was applicable in each country in question. When a country responded in the affirmative, they considered that 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]Major sources of information on maternal mortality were WHO, 1991a and 1991b.

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

IV. COUNTRY PROFILES: OMAN TO ZIMBABWE

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 is not readily available.

FERTILITY AND MORTALITY CONTEXT

Government's view on fertility level:	Satisfactory
Government's intervention concerning fertility level:	To maintain
Government's policy on contraceptive use:	No support provided
Percentage of currently married women using modern contraception (under age 50,* 1988/89):	8
Total fertility rate (1990-1995):	6.7
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	111
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)	70
Western Asia (around 1988)	280
Female life expectancy at birth (1990-1995):	71.8

* Adjusted from source to exclude breast-feeding.

Oman

BACKGROUND

Abortion in Oman appears to have been regulated by Islamic religious law (shariah) since 1966, when the Muscat Penal Code and the Muscat Penal Regulation were repealed by the Muscat (Revoking) Order of 21 December 1966. According to Islamic law, abortion is not a criminal act if performed as a necessary treatment on a pregnant woman who is not yet quick with child. Islamic law distinguishes two stages in pregnancy, marked by the quickening, which is usually considered to occur around the fourth month of pregnancy. After that period, abortion is considered a criminal act. The current status of abortion in Oman, however, is unclear.

The Government seeks to maintain the rate of fertility, which is estimated at 7.2 children per woman for the period 1985-1990, although other estimates suggest that the rate may actually be higher. The Government has no official policy with regard to fertility regulation, although contraceptives are available through private hospitals, dispensaries and commercial outlets.

Government policy has focused mainly on improving the economic, social and health conditions of the Omani population. Whereas progress in achieving economic and social development goals was impressive during the 1970s and early 1980s, the steep fall of oil prices in 1986 resulted in a decline in per capita income, a large budget deficit and a slow down in the implementation of many of the development programmes. The oil reserves of Oman are forecast to be exhausted in another 20-25 years, constraining the ability of the country to diversify its economy from reliance upon oil production. In addition, population growth is expected to result in increasing pressure on the already scarce water resources. In December 1993, the Government conducted a population census; it was the first comprehensive census of Oman. As a result, the fifth five-year plan for the period 1996-2000 is expected to be the first economic plan to be based on accurate demographic data.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

Source: Population Policy Data Bank maintained by the Population Division of the Department for Economic and Social Information and Policy Analysis 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:

Information is not readily available.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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, 1990/91):	9
Total fertility rate (1990-1995):	6.2
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	64
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)	400
Southern Asia (around 1988)	570
Female life expectancy at birth (1990-1995):	59.0

Pakistan

BACKGROUND

Until 1990, abortion in Pakistan was regulated by the Penal Code of 1860 which had been developed for India by the British colonial government and was maintained by Pakistan following independence. According to this Code, abortion was a crime unless performed in good faith in order to save the pregnant woman's life. Article 312 of the Penal Code provided that any person performing an illegal abortion was subject to imprisonment for three years and/or a fine; if the woman was "quick with child", the penalty was imprisonment for up to seven years and a fine. The same penalty applied to a woman that wilfully induced her own miscarriage.

Following deliberations in 1989 by the Pakistani Supreme Court, which concluded that part of the Penal Code of 1860 was invalid because it was repugnant to the injunctions of Islam, Pakistan revised its criminal law, rewording a number of its provisions in accordance with Islamic law. In 1990, a Presidential Ordinance amended the Penal Code and replaced those sections concerning offences against the human body and, in particular, abortion. Although the Parliament had not ratified this new law as of mid-1993, the President has reissued the Ordinance at three-month intervals in order to keep its provisions in effect.

The new law provides that whoever causes a woman with child whose organs have not been formed to miscarry, if such miscarriage is not caused in good faith in order to save the life of the woman or to provide necessary treatment to her, is deemed to have caused a special Islamic crime, *isqat-i-haml*. The punishment for *isqat-i-haml* caused with the consent of the woman is imprisonment for up to three years. If the limbs or organs of the child have been formed, and if the miscarriage is not caused in good faith to save the life of the woman, the person is said to cause *isqat-i-janin* and is liable to one twentieth of the *diyat* (a compensation payable to the heirs of the victim by the offender and consisting of not less than 170,610 rupees or the value of 30.63 grams of silver) if the child is born dead, or to full *diyat* if the child is born alive but dies as a result of any act of the offender, or to imprisonment for up to seven years if the child is born alive but dies otherwise than as a result of any act of the offender. These provisions also apply to a woman that induces her own miscarriage. Under Islamic law, organs and limbs are deemed to be formed in a foetus by the fourth month of pregnancy.

To summarize, according to the new law, abortion is allowed during approximately the first four months of pregnancy to save the pregnant woman's life or to provide her with necessary treatment. After the fourth month, abortion is allowed only to save the woman's life. Although the extent of the "necessary treatment" is not specified by the law, its inclusion constitutes a liberalization compared to the Penal Code of 1860. The new law has been widely criticized, however, particularly for its lack of clarity as to the bounds of legality for performing therapeutic abortion. It is not clear, for example, whether the time-frame for therapeutic abortion must be calculated on the basis of Islamic law or of modern medicine, or what "necessary treatments" may actually include.

In part because of the lack of data on the incidence of induced abortion, illegal abortion has not been an area of major governmental concern in Pakistan. However, illegal abortion does take place and complications from septic abortions are believed to be a major cause of maternal mortality. Multiple unspaced pregnancies combined with poor maternal nutrition and scarce maternity services have resulted in high maternal mortality rates. Only 5-10 per cent of births occur in hospitals. Maternal mortality was estimated at about 400 deaths per 100,000 live births in 1987. According to a study conducted in a hospital at Karachi in 1985, about 300 maternal deaths per 100,000 live births were due to complications from abortion.

In spite of early efforts in family planning in Pakistan—a family planning association was established in 1953, the National Population Programme was begun in 1955 and the Population Welfare Programme has been part of the National Five-Year Plans since 1960—contraceptive prevalence remains very low and was estimated at about 14 per cent of married women of reproductive age as of 1993. The total fertility rate has stagnated since the late 1960s at about 6.0 children per woman. It is estimated that fewer than 5 per cent of the population have easy access to family planning services. However, although contraceptive use remains low, demand is increasing and the programme has succeeded in creating awareness and demand for family planning services.

Pakistan

Greatly concerned by the rapid population growth, the Government of Pakistan formulated a new population policy in 1991 which included an improved family planning programme. As of 1993, the Population Welfare Division was preparing a comprehensive programme for 1993-1998 which is directed to reducing the average annual rate of population growth from 2.9 to 2.6 per cent by the end of the plan period, mainly by increasing coverage of the family planning programme from 5 to 70 per cent in rural areas and from 54 to 100 per cent in urban areas.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
Karachi	1979-1983	70.0 abortions/100 deliveries	HR

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

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

Panama

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:

A multidisciplinary commission appointed by the Ministry of Health must authorize an abortion on the grounds of averting a health risk that would endanger the life of the mother or the foetus; in the case of rape, the authorities must be aware of the crime and the abortion must be performed within the first two months of pregnancy. An abortion must be performed by a physician in a government health-care centre.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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, 1984):	54
Total fertility rate (1990-1995):	2.9
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	83
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)	60
Central America (around 1988)	160
Female life expectancy at birth (1990-1995):	74.9

BACKGROUND

Abortion was generally illegal in Panama under the Criminal Code of 17 November 1922. Anyone that performed an abortion was subject to imprisonment for from 20 months to 3 years. A woman inducing her own miscarriage was subject to imprisonment for 8-30 months. Harsher penalties were prescribed for medical personnel that performed abortions and for the husband of the pregnant woman. Under the general principles of criminal law, abortion was permitted to save the life of the mother.

The Penal Code of 22 September 1982 modified the abortion law in Panama and prescribed new penalties for offenders. Any woman that induces her own miscarriage or consents to have another person induce an abortion may be imprisoned for from one to three years. Anyone inducing an abortion with the woman's consent is subject to imprisonment for from three to six years. The penalty for inducing an abortion without the woman's consent or against her will is imprisonment for from four to eight years. If the woman dies as a result of the abortion or the means used to induce the abortion, the penalty is 5-10 years in prison. These penalties are increased by one sixth if the person guilty of inducing the abortion is the woman's husband.

There is no penalty if a pregnancy is terminated, with the consent of the woman, in order to abort a foetus conceived as a result of rape, provided that the rape has been evidenced in a court proceeding. In such cases, the competent authorities must be aware of the crime and the abortion must be induced within the first two months of pregnancy. There is also no penalty if the abortion is induced, with the consent of the woman, because of a serious health risk that would endanger the life of the woman or the foetus. In such cases, a multidisciplinary commission appointed by the Ministry of Health must determine the gravity of the health risk and authorize an abortion. According to Ministry of Health resolution No. 02007 of 2 August 1988, the multidisciplinary commission is composed of representatives from various health professions as well as a lawyer from the legal department of the Ministry of Health. The resolution authorizes the commission to seek aid from other health professions and to establish rules approving therapeutic abortions.

On 21 April 1989, the Ministry of Health (resolution No. 1) approved the rules of the multidisciplinary commission established to authorize therapeutic abortions. In order for a petition for a therapeutic abortion to be considered, a written request must be submitted by the pregnant woman. This request must be accompanied by a medical record which specifies and supports the diagnosis motivating the petition and by laboratory tests and/or supplementary information confirming the request. Women that are minors or are incapacitated for legal reasons must have the consent of a legal representative. If necessary, the multidisciplinary commission may request the written opinion of other health professionals, who must cooperate with its members. In each region, the chief of gynaecology and obstetrics of each hospital must analyse the requests of patients in that region and verify the fulfilment of the requirements. The documents must be sent to the national commission, which must meet within the shortest possible time for review and a final decision. Once authorized by the commission, the abortion must be performed by a medical specialist in the state hospital of the health region where it is requested. A therapeutic abortion can never be performed without the written consent of the multidisciplinary commission.

The Government of Panama has strongly supported family planning and has been providing subsidized services since 1973. The Government promotes natural and modern methods of family planning through the Ministry of Health and a private family planning organization of the country, the Asociación Panameña para el Planeamiento de la Familia (APLAFA), which was founded in 1965. Adolescent fertility is viewed as a major concern by the Government and a programme of sex education in the schools has been implemented. Parental participation and dissemination of information on sex education through the press is also encouraged. Despite these efforts, it is estimated that more than 20 per cent of declared abortions in Panama involve adolescents. APLAFA

Panama

is confronting the problem of adolescent pregnancy with a wide range of activities which focus not only on the prevention of unwanted pregnancies but also on the provision of prenatal and postnatal care for those choosing to carry an unwanted pregnancy to term. The programme includes an educational component offering employment services and vocational training, social and recreational activities, as well as extensive reproductive health services. Efforts to promote family planning in Panama have been generally successful. Between 1965 and 1985, for example, the total fertility rate decreased from 6.0 to 3.0 children per woman. Sterilization is legal in Panama.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
National	1970	8.2 abortions/1,000 women aged 15-44	PR
National	1975	10.8 abortions/1,000 women aged 15-44	PR
National	1980	11.3 abortions/1,000 women aged 15-44	PR
National	1985	9.6 abortions/1,000 women aged 15-44	PR
National	1988	9.4 abortions/1,000 women aged 15-44	PR

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

Source: Population Policy Data Bank maintained by the Population Division of the Department of Economic and Social Information and Policy Analysis 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 legal abortion is permitted within 12 weeks of gestation. It should be performed by a registered physician in a government health-care institution.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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 (1990-1995):	4.9
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	42
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 (1989)	700
Oceania (around 1988)	600
Female life expectancy at birth (1990-1995):	56.7

Papua New Guinea

BACKGROUND

The Criminal Code (Ordinance No. 7 of 1902), which was adopted from the 1899 Criminal Code Act of Queensland as the law of the then British New Guinea, is still largely in effect. Under this Code, however, the circumstances in which an abortion may be performed are uncertain and clarification of the law is required. Section 285 of the Criminal Code defines abortion as being "not unlawful" if it is performed "for the preservation of the mother's life". Various interpretations of "preservation of the mother's life" may lead to abortions being performed on broad medical grounds, including the mother's physical and mental health. In any case, a legal abortion can only be performed within the first 12 weeks of gestation by registered physician(s) in a government health-care institution.

Sections 228 and 229 of the Criminal Code specify that a woman that unlawfully induces her own abortion is liable to seven years' imprisonment; the penalty for a physician or other person performing an "unlawful" abortion is imprisonment for up to 14 years.

To a large extent, abortion in Papua New Guinea is also regulated by customary law. In some parts of the country, abortion may not be regarded as wrong when the mother is unmarried or if the pregnancy is a result of an adulterous or incestuous relationship. Also, certain provisions of the Constitution of Papua New Guinea may override the provisions of the Criminal Code described above. For instance, certain constitutional provisions, especially those relating to the rights to privacy and the relevance of customs, require the court to take custom into account. Accordingly, if abortion is acceptable according to the accused's customs, the person may be exonerated. The opinion of the Justice Department is that if legally qualified physicians, in consultation with another physician, terminate a pregnancy for maternal health reasons, they should not be prosecuted. Induced abortion is practised in most of Papua New Guinea. It has been frequently done by such methods as ingestion of plant substances, binding the abdomen and heavy massage. Although the number of illegal abortions is unknown, the available evidence suggests that the practice is common and possibly increasing. There have been a relatively high incidence of septic and haemorrhagic complications from "spontaneous abortions", a high incidence of pelvic inflammatory disease and large numbers of patients with septic abortion and premature labour following unsuccessful illegal attempts at pregnancy termination.

As a result, there is increasing demand for legal and safe medical termination of pregnancy. A study conducted in 1984 found that, during the period from 1 January 1976 to 31 December 1983, there were 895 reported maternal deaths. The major causes of those deaths were puerperal sepsis, post-partum haemorrhage, associated medical and surgical complications and prolonged or obstructed labour and ruptured uterus. According to estimates from the same study, the maternal mortality rate varied from approximately 2 per 1,000 births in certain urban areas to about 20 in areas without access to health-care services.

As of 1992, Papua New Guinea had not implemented policies specifically designed to influence the rate of fertility. However, the Government has expressed concern about population issues and has initiated efforts, such as the Population Research Programme, to further study the effects of rapid population growth. Community-based family planning distribution programmes have been in operation for more than 15 years. The Government has been receiving international assistance to improve the health status of women and children through adequate maternal and child health and family planning care by focusing on the proper timing and spacing of births.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

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

Paraguay

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 is not readily available.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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, 1990):	35
Total fertility rate (1990-1995):	4.3
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	76
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)	300
South America (around 1988)	220
Female life expectancy at birth (1990-1995):	69.5

BACKGROUND

The Paraguayan Penal Code of 4 December 1909 prohibited abortion except to save the life of the mother. Anyone that performed an abortion, including the woman who terminated her own pregnancy or cooperated in such a termination, was subject to imprisonment. More severe penalties were imposed on members of the health professions, as well as on a husband that was guilty of terminating his wife's pregnancy. Although the Health Code of 15 December 1980 stipulates that unborn persons are entitled to the protection of their life and health by the State from the moment of conception, it appears that an abortion may be performed when there is an immediate acute danger to the life of the pregnant woman.

Clandestine abortion is common in Paraguay. It is estimated that approximately 26,000 illegal abortions are performed annually and that 35 per cent of Paraguayan women have had at least one abortion. Illegal abortion, together with a lack of adequate prenatal and obstetric care, has contributed to the high maternal mortality rate, an estimated 300 deaths per 100,000 live births in 1986. A 1984 survey of 714 women aged 15-49 years that sought family planning services at 10 clinics in Paraguay (five in the Asunción metropolitan area and five in the interior) indicated that 35 per cent of the women had a history of abortion and that the abortion rate was 140 per 1,000 pregnancies. A study conducted in 1979 on 3,800 Paraguayan women of reproductive age found that 30.7 per cent of the women had had an abortion, implying an abortion rate of 145 per 1,000 pregnancies.

Family planning services, which had been illegal or discouraged for decades in Paraguay, are now expanding, primarily through the efforts of the national family planning association, the Centro Paraguayo de Estudios de Población (CEPEP). Founded in 1966, CEPEP provides subsidized family planning services, operates clinics that offer gynaecological services and prenatal and postnatal care, and supply contraceptives. The association sponsors campaigns to involve rural community leaders in family planning and provides training to physicians in remote frontier regions. In an effort to increase public knowledge and to improve the image of family planning, CEPEP disseminates information in magazines and on radio and television programmes.

According to the Demographic and Health Survey of 1990, 93 per cent of women knew of at least one modern family planning method. Approximately 35 per cent of women in a union used a modern method of contraception. The most frequently used contraceptive methods were the pill (14 per cent), female sterilization (7 per cent), the intra-uterine device (6 per cent) and contraceptive injections (5 per cent). Thirteen per cent used a traditional method. It has been estimated that the family planning needs of approximately 131,000 women in a union, or one in five women of reproductive age, are not being met.

The Government of Paraguay considers the current rates of population growth and fertility to be satisfactory and pursues a policy of non-intervention. It has, however formulated policies to improve population welfare through improved health conditions and family planning activities, redistribution of income and increased employment. The Government has implemented programmes to promote responsible parenthood and to improve the provision of family planning services as an integral part of maternal and child health (MCH) care, primarily to promote child-spacing and maternal health. Family life education has been introduced into the school curricula, and information, education and communication programmes have been implemented. The public sector has provided natural family planning services as a health measure and as part of MCH care, while other modern methods of contraception are available on the commercial market. In 1988, the Government decided to expand the provision of family planning to include other methods. Although there are no specific legal provisions in regard to sterilization, it is believed that the law prohibiting corporal injury applies.

Paraguay

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
National	1971	18.2 abortions/100 live births	HR

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

Source: Population Policy Data Bank maintained by the Population Division of the Department for Economic and Social Information and Policy Analysis 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 physician, with the consent of the pregnant woman and after consultation with two physicians.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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, 1991/92):	33
Total fertility rate (1990-1995):	3.6
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	68
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)	300
South America (around 1988)	220
Female life expectancy at birth (1990-1995):	66.5

Peru

BACKGROUND

Under the Criminal Code of 11 January 1924, abortion was generally illegal in Peru. Anyone that unlawfully terminated a pregnancy, including the pregnant woman, was subject to imprisonment for a maximum of four years. Members of the medical profession were subject to more severe penalties. Under section 163 of the Criminal Code, abortion is lawful if it is necessary to save the life of the mother or to avoid serious and permanent injury to her health.

The Sanitary Code of 1969 states that human life and the right to health begin with conception; thus, health care during pregnancy covers both the mother and the foetus, because the unborn child has a right to health care. According to the Health Code, the process of gestation must terminate in birth, except in the case of an unavoidable natural occurrence or a danger to the life or health of the mother. Under the Code, therapeutic abortion based on moral, social or economic grounds and abortion as a means of birth control were also prohibited.

On 17 February 1977, a Ministerial Resolution established a health and population policy for Peru. The decree also instituted the Directorate of Health and Population within the Ministry of Health, required family planning to be totally integrated within health-care services, and prohibited abortion and sterilization.

Legislative Decree No. 121 of 12 June 1981, which amended section 21 of the Sanitary Code, permitted therapeutic abortion provided that it was performed by a physician with the consent of the pregnant woman and with the approval, after consultation, of two physicians if there was no other means of saving the life of the mother or of preventing serious or permanent harm to her health.

The National Population Policy Law, Legislative Decree No. 346 of 6 July 1985, guarantees the individual the right to life from the time of conception. According to section 6, abortion and sterilization are excluded as family planning methods.

The new Penal Code of 1991 contains some amendments to the abortion law. Although it adds no additional grounds for obtaining a legal abortion, it reduces the penalty imposed on a woman that consents to an abortion or induces her own miscarriage to a maximum of two years of imprisonment or community service for 52-104 days. The maximum sentence is also greatly reduced (to three months of imprisonment) when the pregnancy is the result of rape or "involuntary artificial insemination" outside of marriage and has been reported to the police; or when a medical diagnosis points to a probable risk of serious physical or mental defects in the child if it were born.

The Government of Peru considers the current rates of population growth and fertility to be too high. The National Population Policy Law of 1985 outlines a government plan of action concerning population, with the goals of promoting a balanced relation between population and socio-economic development and encouraging responsible parenthood. Since the formulation of the population policy, the Government has increasingly emphasized the crucial role of family planning in the development process, fixing a target fertility rate of 3.0 births per woman for the period 1995-2000 and a target rate of population growth of about 2 per cent per annum by the year 2000. The Directorate-General of Family Planning, within the Ministry of Health, oversees the national programme and the coordination of all activities in the public and private sectors. The main targets of family planning services are the poor living in the suburbs of Lima and in other urban areas. During the past few years, however, family planning activities have been hampered by political instability, a deteriorating economy, cuts in social spending and a cholera epidemic which has diverted scarce resources.

Although adolescent fertility is a major concern, access to contraception is forbidden to unmarried adolescents. Female sterilization is not considered to be a family planning method and is permitted only for health reasons.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
National	1977	13.7 abortions/100 live births	HR
National	1978	14.3 abortions/100 live births	HR

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

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

Philippines

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:

Authorization of an abortion requires consultation with a panel of professionals.

* General principles of the Penal Code permit abortion on these grounds.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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):	22
Total fertility rate (1990-1995):	3.9
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	28
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 (1989)	74
South-eastern Asia (around 1988)	340
Female life expectancy at birth (1990-1995):	67.0

BACKGROUND

Abortion in the Philippines is generally illegal. Under the abortion provisions of the Revised Penal Code of 1930, a person that intentionally performs an abortion with the consent of the pregnant woman is subject to a penalty of *prison correccional* (i.e., imprisonment for from six months to six years) in its medium or maximum period. A physician or midwife that performs an abortion is subject to the maximum period of this penalty, as well as suspension of the license to practise. A woman performing an abortion on herself to conceal her dishonour is subject to the minimum or medium of this penalty. A person performing an abortion without the consent of the pregnant woman is subject to a prison term of 6-12 years.

Although the Penal Code does not list specific exceptions to the general prohibition on abortion, under the general principle of necessity as set forth in article 11(4) of the Code, an abortion may be legally performed to save the pregnant woman's life.

In addition to these provisions, the new Constitution of 1986 stipulates that the State "shall equally protect the life of the mother and the life of the unborn from conception". This provision reinforces the provision contained in a Presidential Decree of 1975 establishing the Child and Youth Welfare Code, which stipulates that a child has the dignity and worth of a human being from the moment of conception and has the right to be born well.

Despite the severity of the law, abortion appears to be widely practised in the Philippines as a means of birth control and is rarely prosecuted. However, illegal abortion is performed in a climate of fear and shame resulting from strong cultural, religious and legal prohibitions. Surveys indicate that women resorting to abortion often are from economically disadvantaged groups and take this step because they are unable to provide for another child. Surveys also indicate a high incidence of repeat abortion. In a context of poor health conditions and widespread malnutrition, and where some 76 per cent of deliveries occur at home and only 21 per cent are attended by a physician, induced abortions are poorly performed and result in high maternal mortality and morbidity. Estimates of maternal mortality, which are believed to suffer from substantial underreporting, indicate a rate of 74 maternal deaths per 100,000 live births in 1989. Hospital surveys have found that about one third of maternal deaths occurring in hospitals can be attributed to induced abortion. The estimated number of abortions may be as high as 750,000 per annum.

The Government of the Philippines is greatly concerned about the high incidence of induced abortion and hopes to reduce illegal abortion by expanding family planning, and information, education and communication services. As early as 1972, the Revised Population Act referred to abortion as an unacceptable method of birth control, which should be discouraged and prevented. In 1988, a Presidential Proclamation on the Respect and Care for Life Week emphasized the constitutional provision that the State has an obligation to protect the life of the unborn from conception.

The national family planning programme in the Philippines has encountered many obstacles. Contraceptive use is relatively low and relies largely upon traditional methods. As of 1988, only 20 per cent of currently married women were using modern methods of contraception, whereas 16 per cent were using natural methods, mainly abstinence and rhythm. Access to family planning services is limited and adequate services are often not available. Indeed, after a first phase of expansion in the 1970s, the national family planning programme was largely neglected; and as of 1992, only about 2 per cent of field personnel in the Department of Health had been trained to provide family planning services. Moreover, according to the Republic Act of 1966, contraceptives can be sold only in licensed pharmacies and can only be purchased with a prescription from a qualified physician. Many women cannot afford contraceptives, and many encounter difficulties in obtaining access to Government-dispensed supplies.

In 1990, the Government launched a new family planning programme and established a number of incentives, including tax exemptions for couples that limited their family size to two children. However, the family planning

Philippines

programme encountered strong opposition from the Catholic Church. Following a series of negotiations, in 1990, the Catholic Bishops Conference of the Philippines seemed to sanction the Government's policy of providing support for artificial methods of contraception (the condom, the pill and the intra-uterine device, as well as sterilization) in exchange for the Government's commitment to promote natural methods of family planning. However, when the new Government planned to expand the national family planning programme in 1993, the Bishops strongly denounced it. The Government then made some concessions and an accord appeared to have been reached. The programme was launched but the Catholic Bishops Conference once again voiced its opposition and called for a boycott by health practitioners.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

Source: Population Policy Data Bank, Population Division, Department of Economic and Social Development, United Nations Secretariat. For additional sources, see 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	No
Rape or incest	Yes
Foetal impairment	Yes
Economic or social reasons	No
Available on request	No

Additional requirements:

An abortion must be performed by an obstetrician or gynaecologist that has passed the national proficiency tests. The abortion must be performed in a hospital or clinic with the consent of the pregnant woman or her parents or guardian if she is a minor. The procedure must be performed within the first 12 weeks of pregnancy, unless continued pregnancy would endanger the life or health of the pregnant woman.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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 (under age 45, 1977):	26*
Total fertility rate (1990-1995):	2.1
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	31
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 (1990)	13
Developed countries (around 1988)	26
Female life expectancy at birth (1990-1995):	76.1

* Excluding sterilization.

Poland

BACKGROUND

Until 1932, abortion was prohibited in Poland. On 11 July 1932, the restrictive legislation was modified, permitting abortion when a pregnancy endangered the life or health of the woman or resulted from rape or incest. The law required that a legal abortion be performed by a physician with the consent of two other physicians.

A law adopted by the Polish Parliament (Sejm) on 27 April 1956 (Law No. 61) further liberalized the abortion laws by permitting abortion on medical grounds, if the pregnancy resulted from a criminal act or because of "difficult living conditions". Although abortion was not explicitly permitted on eugenic grounds, serious defects of the unborn child often constituted "difficult living conditions" for the pregnant woman.

The procedural requirements that must be observed to qualify for a lawful abortion have repeatedly been amended (1956, 1959, 1969, 1981 and 1990). According to the amendment passed in 1990 (Ordinance of 30 April of the Ministry of Health and Social Welfare), abortion was available on social and juridical grounds during the first trimester of pregnancy; thereafter, a legal abortion was permitted only if the pregnancy endangered the life or health of the woman. The written consent of the pregnant woman or of her parents (or guardian) if she was a minor was required. A legal abortion could only be performed by an obstetrician/gynaecologist that had passed the national proficiency tests (specialization at the first or second degree level) unless the mother's life was in immediate danger.

When the abortion was requested because of "difficult living conditions", the 1990 Ordinance required a woman desiring to terminate her pregnancy to obtain the approval of a certified gynaecologist/obstetrician and to provide certificate(s) confirming her unfavourable social circumstances. The physician was also obliged to inform the patient of the risks of undergoing the procedure, to consider and discuss with her the reasons that forced her to seek an abortion and, if possible, attempt to dissuade her from her intention. If the woman decided to proceed with the abortion, the physician was required to educate her on preventive birth control methods and on the need for a post-abortion examination and to direct her to a hospital where the procedure could be performed. If a woman intended to terminate her pregnancy and her circumstances justified the issuance of a ruling permitting an abortion, the physician was required to seek the opinion of a committee consisting of a physician with a specialization at the first or second degree level in obstetrics and gynaecology, a physician in general practice and a psychologist selected from a State-approved list.

An abortion sought on these grounds could be denied if the procedure posed a risk to the woman's health, if the pregnancy exceeded 12 weeks' duration or if the physician did not consider the woman's personal circumstances to be sufficient grounds for an abortion. A woman whose request for an abortion was denied could, however, appeal the decision before a medical commission made up of three physicians, at least two of whom were required to have specialties at the first or second degree level in obstetrics and gynaecology. The Ordinance also contained a conscientious objector clause giving physicians the right to decline involvement in abortion procedures, except in cases where failure to perform an abortion directly threatened the woman's life.

Obtaining an abortion in Poland became extremely difficult following the announcement in December 1991 of the Code of Medical Ethics adopted by the Second National Congress of Polish Physicians. According to the Code, medical procedures that posed a risk of death to the foetus were admissible solely for the purpose of saving the mother's life and health or when the pregnancy was the result of a criminal act. The identification of developmental anomalies or genetic disorders did not constitute a basis for termination of pregnancy. Consequently, many hospitals stopped performing the procedure.

In February 1993, the Parliament approved and the President signed a new law on Family Planning, Protection of the Human Foetus and Conditions for Legal Abortions. Under the new legislation, abortion is permitted only when the pregnancy threatens the life or health of the mother, when prenatal testing determines that there is serious and irreversible malformation of the foetus or when the pregnancy is the result of rape or incest. The law does not

provide punishment for the woman even if the abortion is self-induced. However, physicians face two years of imprisonment for carrying out an illegal abortion. Included in the law is a commitment to introducing sex education in school curricula. The new law represents a compromise, given that the draft legislation as originally submitted to the Parliament would have banned virtually all abortions—the only exception being when the life of the mother was at risk. Following the passage of the 1993 legislation, there were reports of an increase in "abortion tourism", i.e., of Polish women seeking an abortion in neighbouring countries with less restrictive abortion legislation.

In June 1994, the Parliament approved an amendment to the 1993 legislation which would have permitted abortion on socio-economic grounds. The President of Poland, however, refused to sign the new law and thus the 1993 legislation remains in effect.

It is difficult to determine the number of abortions being carried out in Poland. Official abortion statistics may have greatly underestimated the true extent of abortion, because it is not known how many abortions are performed in private out-patient clinics. Although there were 123,000 officially reported abortions in 1987, some estimates suggest that the actual number of abortions performed may have been from three to four times the official number. The suspected high incidence of abortion is due to a number of factors, including shortages of low-cost, high-quality modern contraceptives, reliance upon less reliable religion-sanctioned natural methods of fertility control and a lack of comprehensive sex education programmes.

The Government of Poland considers the rates of fertility and population growth to be satisfactory. However, it is concerned about the high level of induced abortions and the lack of popularity of contraceptives. Government policy is to encourage the well-being of the family as a whole. Towards this end, the Government has created an extensive system of social benefits, including maternity leave, a three-year leave for child-rearing, an annual leave of up to 60 days for taking care of sick children, birth grants, family allowances for low-income families, and loans and scholarships to assist student marriages. An alimony fund provides a minimum income to divorced mothers not receiving alimony. Moreover, family life education courses have been established in schools.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
National	1965	24.3 abortions/1,000 women aged 15-44	PR
National	1970	20.0 abortions/1,000 women aged 15-44	PR
National	1975	17.6 abortions/1,000 women aged 15-44	PR
National	1980	16.7 abortions/1,000 women aged 15-44	PR
National	1985	16.7 abortions/1,000 women aged 15-44	PR
National	1986	15.9 abortions/1,000 women aged 15-44	PR
National	1987	14.9 abortions/1,000 women aged 15-44	PR
National	1988	12.7 abortions/1,000 women aged 15-44	PR
National	1989	9.5 abortions/1,000 women aged 15-44	PR
National	1990	6.8 abortions/1,000 women aged 15-44	PR
National	1991	3.6 abortions/1,000 women aged 15-44	PR

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

Portugal

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:

An abortion must be performed by, or under the direction of, a physician within the first 12 weeks of gestation on the grounds of preserving the woman's physical or mental health or in the case of rape; or within 16 weeks if there is a risk that the child will be born with an incurable disease or malformation. The existence of these circumstances must be certified in writing by a physician other than the one performing the procedure. This certification must be accompanied by the written consent of the woman requesting the abortion, not less than three days prior to the date of the procedure; women under age 16 must have the consent of the husband, parents or, in their absence, any relative. Abortions must be performed in an official or officially approved health-care establishment.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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, 1979/80):	33
Total fertility rate (1990-1995):	1.5
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	27
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 (1992)	10
Developed countries (around 1988)	26
Female life expectancy at birth (1990-1995):	78.1

BACKGROUND

The Portuguese Criminal Code of 16 September 1886 prohibited abortion. Any person that terminated a pregnancy, including the pregnant woman, was subject to imprisonment for from two to eight years. According to section 358 of the Code, the woman was subject to imprisonment under a less severe regimen if she committed the offence to conceal her dishonour.

Termination of pregnancy was permitted to save the life of the mother, despite the fact that there was no specific provision for such cases in the Criminal Code. Decree Law No. 40,651 of 21 June 1956, which approved the statutes of the Order of Physicians, stated that the physician should observe absolute respect for human life from the moment of conception and expressly prohibited abortion. However, even prior to the subsequent constitutional changes in Portugal, medical indication to save the life of the mother was recognized in legal doctrine. Portuguese Law No. 6/84 of 11 May 1984 liberalized abortion in Portugal, permitting the termination of pregnancy executed by, or under the direction of, a physician in an official or officially approved health-care establishment, and with the consent of the pregnant woman. Abortion could be performed provided that, based on the current state of medical knowledge and experience: (*a*) it was the only means of eliminating a risk of death or serious permanent damage to the physical or mental health of the mother; (*b*) it would avert a risk of death or serious damage to the physical or mental health of the mother and the procedure was performed during the first 12 weeks of gestation; (*c*) there were substantial grounds for believing that the child would be born with a serious or incurable disease or malformation and the procedure was performed during the first 16 weeks of gestation; or (*d*) there were significant indications that the pregnancy resulted from rape and the procedure was performed during the first 12 weeks of gestation. Prior to the abortion, a physician other than the one performing the procedure must sign a medical certificate attesting to the existence of circumstances that render an abortion permissible. In cases of rape, the verification of circumstances depends upon evidence of criminal involvement. The abortion must be performed with the consent of the pregnant woman; the woman, or someone on her behalf, must sign a document to this effect not less than three days prior to the date of the procedure.

In case of emergency, if it is imperative that the abortion be performed immediately to save the life of the mother or to avert a serious threat to her life or lasting damage to her physical or mental health, the prescribed time-limit may be waived, as well as the required consent of the woman if she is unable to express her consent and if it may reasonably be assumed that she would normally have granted it. In such cases, the circumstances must be recorded on the medical certificate. If the pregnant woman is under age 16 or is incompetent, the written consent may be provided, in order of priority, by her competent and non-separated husband, her legal representative, a competent ascendant or descendant or, in their absence, by any relative. If no such person can be found to consent to the woman's abortion and if the procedure must be performed as a matter of urgency, the physician may decide how to proceed, according to his own conscience, while, if possible, consulting one or more other physicians. The circumstances must be recorded on the medical certificate.

Physicians that fail to obtain the required documents justifying the legal voluntary termination of pregnancy, prior to or after the procedure, may be subject to imprisonment for a maximum of one year.

Any person procuring an abortion by any means without the consent of the pregnant woman may be subject to imprisonment for from two to eight years. A person procuring an abortion by any means with the consent of the pregnant woman, other than in cases permitted by law, may be subject to a maximum of three years in prison. A pregnant woman that consents to the inducement of an abortion by a third party or induces her own miscarriage, with or without the help of a third party, other than on the grounds permitted by law, also may be subject to a maximum of three years in prison. If an abortion is induced by a third party or by the pregnant woman herself, other than in cases permitted by law, but is performed to avoid the social reprobation of the woman or on grounds constituting significant mitigating circumstances in favour of the person responsible, the penalty may not exceed one year. The maximum penalty applicable may be increased by one third if an abortion performed or the methods employed, on grounds other than those permitted by law, result in the death of the pregnant woman or in serious

injury to her body or her physical or mental health, and the person that procured the abortion was in a position to have foreseen the inevitable consequences of his or her conduct. The increased penalty is also applicable to any person habitually engaging in the illicit practice of abortion or inducing illicit abortion for profit.

Few family planning activities were available in Portugal prior to 1976, when the law forbidding the advertising of contraceptives was repealed and the Secretary of State for Health officially pledged that family planning services would be made available in all health centres throughout the country. The rapid development of family planning programmes in Portugal has contributed to the decline in infant and maternal mortality.

The Government considers the rates of population growth and fertility to be satisfactory and does not intervene with respect to these variables, although various indirect measures have been implemented within the sphere of family policy. These measures, which are intended to protect maternity and paternity and to strengthen the family unit, include a maternity benefit of 100 per cent of earnings payable during 30 days before and 60 days after confinement, a marriage grant, a birth grant, a nursing allowance for up to 10 months and a family allowance for each child. The Government provides direct support for contraceptives and permits sterilization for women over age 25.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

Source: Population Policy Data Bank maintained by the Population Division of the Department for Economic and Social Information and Policy Analysis 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	Yes
Economic or social reasons	No
Available on request	No

Additional requirements:

A medical commission consisting of three medical specialists, one of whom must be a specialist in gynaecology and the others in obstetrics, are required by law to recommend the procedure before any induced abortion can be performed. All induced abortions must be performed in a government hospital. The consent of both spouses is required for an abortion on eugenic grounds.

FERTILITY AND MORTALITY CONTEXT

Government's view on fertility level:	Satisfactory
Government's intervention concerning fertility level:	To maintain
Government's policy on contraceptive use:	No support provided
Percentage of currently married women using modern contraception (under age 50,* 1987):	29
Total fertility rate (1990-1995):	4.4
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	69
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 Asia (around 1988)	280
Female life expectancy at birth (1990-1995):	73.3

* Adjusted from source to exclude breast-feeding.

Qatar

BACKGROUND

Abortion is generally illegal in Qatar. Law No. 2/1983 of 22 February 1983 governing the practice of the professions of physician, surgeon and dentist, under section 17, prohibits the performance of an abortion on a pregnant woman except to save her life. However, provided that the pregnancy is of less than four months' duration, an abortion will be authorized in the following cases: (*a*) if continuation of the pregnancy would cause certain and serious harm to the mother's health; or (*b*) if there is evidence that the child would be born with serious and incurable physical malformations or mental deficiency, and both spouses consent to the abortion.

By law, a medical commission consisting of three medical specialists, one of whom must be a specialist in gynaecology and the others, in obstetrics, must recommend the procedure before any induced abortion can be performed. All abortions must be performed in a government hospital.

The Government of Qatar considers the rate of population growth of its nationals to be too low. A rapidly increasing native-born population is considered to be a means of reducing future dependency upon foreign workers, who currently constitute more than 50 per cent of the total population. The Government of Qatar has one of the most advanced and extensive welfare systems in the Persian Gulf region. The provision of family allowances for each child, which are granted to male heads of households employed in the public sector, and of free schooling and health services is consistent with the Government's desire to increase the size of the native-born population. Although the Government does not actively sponsor or support contraceptive use, no major restrictions are placed on the practice of contraception.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

Source: Population Policy Data Bank maintained by the Population Division of the Department for Economic and Social Information and Policy Analysis 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	No
Available on request	No

Additional requirements:

An abortion can be performed by a physician within 28 weeks of pregnancy. The consent of the pregnant woman is required, as well as that of her spouse if she is married.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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 15-44, 1991):	70
Total fertility rate (1990-1995):	1.8
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	6
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)	32
Eastern Asia (around 1988)	120
Female life expectancy at birth (1990-1995):	73.7

Republic of Korea

BACKGROUND

Sections 269 and 270 of the Criminal Code of the Republic of Korea of 1953 strictly prohibited abortion on any grounds. In 1973, however, the Maternal and Child Health Law established exemptions from this prohibition. According to this law, a physician may perform an abortion if the pregnant woman or her spouse suffers from an eugenic or hereditary mental or physical disease specified by Presidential Decree, if the woman or her spouse suffers from a communicable disease specified by Presidential Decree, if the pregnancy results from rape or incest or if continuation of the pregnancy is likely to jeopardize the mother's health. In all other circumstances, a pregnant woman inducing her own miscarriage or any person performing an abortion is subject to imprisonment for one year or a fine. The penalties for medical personnel are increased to imprisonment for up to two years.

The legal situation of abortion in the Republic of Korea is the result of a long evolution. After the Government established a national family planning programme in 1962 as part of its socio-economic development strategy, abortion became a common practice despite the legal prohibition, mainly because a large number of physicians were willing to perform abortions and the officials were reluctant to enforce the law. A majority of women strongly supported abortion, as indicated by a 1971 national survey, in which 81 per cent of the women reported a strong preference for legalizing abortion. Moreover, since 1962, the medical profession has favoured legalizing induced abortion. However, the Government's attempts to liberalize the abortion law in order to reduce the gap between law and practice encountered opposition. After various failed attempts, on 30 January 1973, the Government enacted the Maternal and Child Health Law, which still appears to be in effect.

The passage of the 1973 law had only a limited effect because prior to its enactment, most women in the Republic of Korea did not realize that abortion was illegal and abortions were widely performed. Between 1964 and 1971, the percentage of women that had had an abortion increased from 7 to 24; in 1985, the percentage rose to 53. About 50 per cent of all pregnancies ended in abortion in 1984. The abortion rate among married women aged 15-44 increased from 30 per cent in 1973 to 53.9 in 1991. The total abortion rate has increased steadily from 0.7 per woman in 1963 to 2.9 in 1978, declining to 2.1 in 1984 and 1.6 in 1987, due to the increased use of contraception, especially sterilization. However, statistics on the actual number of abortions performed may be underestimated, as reporting is not mandatory and most abortions are performed in private clinics. The recent trend towards a decline in the incidence of abortion is counterbalanced by an increase in the age-specific abortion rate for women in their twenties; most of these women use abortion as a means of contraception.

In fact, many women in the Republic of Korea use abortion not as a backup for contraceptive failure but as a primary method of birth control, as is shown by the high rates of repeat abortion. The overall behavioural pattern is for couples to achieve the desired number of children (usually two) and then to practise contraception—including resorting to abortion—to prevent subsequent births. Although the induced abortion rate has been declining mainly due to increased contraceptive usage, the principal reason women reported for having an abortion in the National Fertility and Family Health Survey of 1985 was to prevent subsequent births (61.3 per cent), followed by birth-spacing (15.1) , mother's health and foetal impairment (7.3), unwanted pregnancy (5.7) and other reasons (10.6).

In the 1970s, 84 per cent of induced abortions in the Republic of Korea were performed in clinics by private physicians. Costs are subsidized for indigent women, as well as in cases where sterilization is also performed at the time of abortion or the pregnancy was due to failure of an intra-uterine device.

The long-term population goal of the Republic of Korea had been to achieve replacement-level fertility by 1991. Priority was given to raising contraceptive prevalence, which was as high as 77 per cent in 1990. By 1992, however, the total fertility rate was 1.6 children per woman, well below replacement level. As a result, the population programme has shifted its emphasis from a policy of modifying fertility levels to maintaining the level

and improving the quality of family planning programmes. Future programmes will focus on improving maternal and child health care through prevention of unwanted pregnancies and induced abortions, and sex education for adolescents. Until recently, the Government offered family planning services free of charge. The Government has now decided to impose user fees for family planning services, to eliminate the incentive schemes for the one-child family and to support instead a two-child policy.

INCIDENCE OF ABORTION

Place	*Year*		*Measurement*	*Coverage*
National	1983	25.4	abortions/1,000 married women aged 15-44	PR
National	1984	21.4	abortions/1,000 married women aged 15-44	PR
National	1985	18.3	abortions/1,000 married women aged 15-44	PR
National	1986	19.1	abortions/1,000 married women aged 15-44	PR
National	1987	17.6	abortions/1,000 married women aged 15-44	PR
National	1988	14.0	abortions/1,000 married women aged 15-44	PR
National	1989	6.4	abortions/1,000 married women aged 15-44	PR

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

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

Republic of Moldova

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 if performed by a licensed physician in a hospital or other recognized medical institution. Abortion is available on request during the first 12 weeks of gestation. Thereafter, induced abortion is available within 28 weeks from conception on judicial, genetic, vital, broad medical and social grounds, as well as for personal reasons with the special authorization of a commission of local physicians.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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, 1990):	15
Total fertility rate (1985-1990):	2.6
Age-specific fertility rate (per 1,000 women aged 15-19, 1985-1990):	49
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 (1990)	44
Developed countries (around 1988)	26
Female life expectancy at birth (1985-1990):	71.0

BACKGROUND

As was the case with all of the former Soviet republics, the Republic of Moldova, known prior to 1992 as the Moldavian Soviet Socialist Republic, observed the abortion legislation and regulations of the former Union of Soviet Socialist Republics. As a result, abortion practices in the Republic of Moldova were similar to those throughout the former USSR.

The description given below pertains to the situation in the Republic of Moldova prior to independence.

The Soviet law of 27 June 1936 prohibited induced abortion in most circumstances, permitting it only for vital and eugenic reasons. Physicians and non-medical personnel that performed abortions in hospitals or as part of an out-patient service were subject to a maximum of three years in prison. A husband, relative or physician that pressured a woman into having an abortion could be sentenced to a maximum of two years in prison. The pregnant woman could be prosecuted by public trial and/or be required to pay a large fine.

In a decree of 23 November 1955, the Soviet Government repealed the prohibition of abortion. Regulations issued in 1956 and subsequently in 1982 specified that abortions could be performed during the first 12 weeks of gestation, although not less than six months after a woman's previous abortion. An abortion was considered illegal if not performed in a hospital or if the person performing the abortion did not have an advanced medical education. The maximum penalty for an illegal abortion was set at eight years in a labour camp.

In 1974, the Ministry of Public Health of the USSR published a document entitled "On the side-effects and complications of oral contraceptives", in which the mass use of oral contraception was de facto prohibited. On 5 June 1987, in Order No. 757, the Ministry of Public Health legalized and officially permitted the provision of early vacuum aspirations in any clinic regardless of the place of residence of the woman. Vacuum aspiration had been the method of induced abortion provided during the first 20 days of pregnancy with the obligatory diagnosis of pregnancy.

During the 1980s, the Ministry of Public Health continued its efforts to decrease the number of illegal abortions by formally broadening the grounds on which abortions were legal and increasing their availability. Most of the later changes, however, were not followed by a simultaneous increase in actual accessibility of abortion services. On 31 December 1987, the Ministry of Public Health published Order No. 1342, which permits induced abortion during the first 28 weeks of gestation on judicial, genetic and broad medical and social grounds (for example, more than five children in the family), as well as on request with the special authorization of a commission of local physicians.

The high incidence of abortion has been attributed to a number of factors, including shortages of high-quality modern contraceptives and reliance upon less reliable traditional methods, a lack of knowledge among couples of contraception and of the detrimental health consequences of frequent abortions and the absence of adequate training for physicians, nurses, teachers and other specialists. In 1989, the availability of condoms in the entire former Soviet Union amounted to only 11 per cent of demand; intra-uterine devices, 30 per cent; and pills, 2 per cent. Data from the All-Union sample survey of contraceptive use conducted in 1990 indicate that, in the Republic of Moldova, 15 per cent of all women aged 15-49 years regularly used contraception, 7 per cent sometimes used contraception, 63 per cent did not use any contraceptive method and 11 per cent knew nothing about contraception.

In 1989, a total of 90,860 induced abortions were registered in the Republic of Moldova, giving an abortion rate of 93.0 per 1,000 women aged 15-44 years, one of the highest rates in the former Soviet Union. The actual figure is much higher, because this total does not include most abortions performed in departmental health services and commercial clinics, early vacuum aspirations and self-induced abortions. In 1988, 4 per cent of all induced abortions were performed on primigravidae. In that same year, only 0.1 per cent of all induced abortions were early

vacuum aspiration. In 1989, illegal abortions calculated on the basis of their registered complications accounted for 13 per cent of all abortions and 22 per cent of all abortions among primigravidae. Among women under age 17, they accounted for 18 per cent of all induced abortions.

Maternal mortality rates in the Republic of Moldova were 64 and 35 per 100,000 births in 1980 and 1988, respectively. In 1988, 32 per cent of all maternal deaths were due to criminal abortion.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
National	1970	101.8 abortions/1,000 women aged 15-44	PR
National	1975	102.2 abortions/1,000 women aged 15-44	PR
National	1980	100.9 abortions/1,000 women aged 15-44	PR
National	1985	106.9 abortions/1,000 women aged 15-44	PR
National	1988	98.1 abortions/1,000 women aged 15-44	PR
National	1989	93.0 abortions/1,000 women aged 15-44	PR
National	1990	82.7 abortions/1,000 women aged 15-44	PR
National	1991	72.7 abortions/1,000 women aged 15-44	PR

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

Source: Population Policy Data Bank maintained by the Population Division of the Department for Economic and Social Information and Policy Analysis 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:

Abortion is permitted on request during the first trimester of pregnancy. Thereafter, a legal abortion can only be performed for therapeutic reasons. A legal abortion must be performed by an obstetrician-gynaecologist in a hospital or dispensary.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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 15-44,[a] 1978):	5[b]
Total fertility rate (1990-1995):	2.1
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	57
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 (1990)	83
Developed countries (around 1988)	26
Female life expectancy at birth (1990-1995):	73.1

[a] Use since last pregnancy (since marriage, if no pregnancy).
[b] Excluding sterilization.

Romania

BACKGROUND

Abortion was first legalized in Romania in 1957 when the Government issued a decree permitting abortion on request during the first trimester of pregnancy. Abortion was liberalized in order to protect women's health and to provide reproductive freedom. In 1966, concerned about the low rate of population growth, the Romanian Government introduced a number of measures to increase the fertility rate. These measures included making abortion legally available only in certain limited circumstances, imposing a ban on the sale and importation of contraceptives and increasing allowances for large families. Council of State Decree No. 770 of 29 September 1966 restricted abortion to women whose life would be endangered by the pregnancy or who suffered from a serious physical or mental disability. Abortion was also permitted if one parent suffered from a serious hereditary disease or a disease likely to cause serious congenital malformations, if the pregnancy resulted from rape or incest, or if the mother was over age 45 (subsequently lowered to age 40 in 1972 and raised to 42 in 1984), or for a woman that had given birth to at least four children that were under her care.

A legal abortion had to be performed within the first trimester of pregnancy by a specialist in obstetrics and gynaecology in a specialized health-care unit, with the approval of a medical board. Women that obtained an illegal abortion, as well as the persons performing it, were subject to fines and imprisonment.

The sudden imposition of severe restrictions on access to legal abortion and modern contraception had an immediate if somewhat short-term impact on fertility levels in Romania. The crude birth rate increased from 14.3 per 1,000 population in 1966 to 27.4 in 1967 and 26.7 in 1968. The number of abortions declined sharply from 973,000 in 1966 to 206,000 in 1967. However, the birth rate began to decrease once again in 1967 and reached the 1966 level (14.3 births per 1,000) in 1983. Despite Government restrictions on abortion, the abortion ratio also began to increase in 1967, due in part to the existence of an underground illegal abortion network.

Sensing that its demographic policies had been ineffective, the Government of Romania commenced a new campaign in 1984 to increase the birth rate and restrict abortion. A directive issued by the Central Committee of the Romanian Communist Party in March 1984 required women of reproductive age to undergo a monthly gynaecological exam at their place of employment. Pregnant women were monitored until delivery, married women that did not conceive were kept under surveillance and a special tax was levied on unmarried persons over 25 years of age, as well as on childless couples that did not have a medical reason for being childless. Any evidence of a miscarriage would trigger a police investigation.

In 1985, access to abortion was further restricted. The age limit allowed for a legal abortion was increased from 42 to 45 years or older, whereas having four children was no longer sufficient grounds for obtaining an abortion on request. Decree Number 411 of 26 December 1985 stated that to qualify for an abortion, a woman must have given birth to a minimum of five children that were currently under her care.

As a result of the restrictive reproductive health policies enforced in Romania between 1966 and 1989, maternal mortality reached heights unprecedented in Europe (the maternal mortality rate rose from 85 deaths per 100,000 live births in 1965 to 170 in 1983). Moreover, illegal and unsafe abortion was the major cause of maternal mortality, accounting for more than 80 per cent of maternal deaths between 1980 and 1989. Furthermore, unofficial estimates suggest that nearly 20 per cent of women of reproductive age may have become infertile because, on average, a woman may have undergone at least five illegal abortions by age 40.

On 26 December 1989, one of the first acts of the new transitional Government of Romania was to remove the restrictions on the sale and importation of contraceptives and to legalize abortion (effective 1 January 1990). Abortion is currently available on request during the first 12 weeks of pregnancy, although only on therapeutic grounds when gestation exceeds 12 weeks. As a consequence of this legal change in Romania, the abortion rate increased precipitiously, while the maternal mortality rate declined dramatically. The abortion rate rose from 39 abortions per 1,000 women aged 15-44 years in 1989 to 199 in 1990. Although the abortion rate fell somewhat

to 172 abortions per 1,000 women aged 15-44 years in 1991, it is still one of the highest in the world. This legislative change has also had a beneficial effect on women's health, as shown by the decline in maternal mortality from 169 deaths per 100,000 live births in 1989 to 83 in 1990. Moreover, in 1990, 69 per cent of maternal deaths were attributed to induced abortion, compared with 87 per cent in 1989.

Since the revolution in December 1989, the Romanian Ministry of Health has made concerted efforts to improve women's reproductive health and to reduce the incidence of abortion. The implementation of a family planning and sex education programme and the manufacture of locally produced contraceptives are top priorities of the Ministry of Health. However, in its efforts to improve and strengthen reproductive health services, the Government faces major challenges, including the need to educate the population in general and health professionals in particular about contraception. Because the policies pursued by the previous Government prohibited contraception, family planning and sex education, many Romanian women know very little about modern family planning methods; and most believe that modern contraceptives have adverse side-effects. Moreover, because of a lack of experience with modern methods of contraception, many members of the Romanian medical profession have been reluctant to accept the safety of modern contraceptives, and many are unaware of the improvements made in recent years to certain methods, such as oral contraceptives.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
National	1965	251.7 abortions/1,000 women aged 15-44	PR
National	1970	64.0 abortions/1,000 women aged 15-44	PR
National	1975	77.1 abortions/1,000 women aged 15-44	PR
National	1980	90.2 abortions/1,000 women aged 15-44	PR
National	1985	63.9 abortions/1,000 women aged 15-44	PR
National	1986	38.5 abortions/1,000 women aged 15-44	PR
National	1987	37.8 abortions/1,000 women aged 15-44	PR
National	1988	38.0 abortions/1,000 women aged 15-44	PR
National	1989	39.1 abortions/1,000 women aged 15-44	PR
National	1990	199.3 abortions/1,000 women aged 15-44	PR
National	1991	172.4 abortions/1,000 women aged 15-44	PR

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

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

Russian Federation

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 if performed by a licensed physician in a hospital or other recognized medical institution. Abortion is available on request during the first 12 weeks of gestation. Thereafter, induced abortion is available within 28 weeks from conception on judicial, genetic, vital, broad medical and social grounds, as well as for personal reasons with the special authorization of a commission of local physicians.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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, 1990):	22
Total fertility rate (1985-1990):	2.1
Age-specific fertility rate (per 1,000 women aged 15-19, 1985-1990):	50
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 (1991)	52
Developed countries (around 1988)	26
Female life expectancy at birth (1985-1990):	74.4

BACKGROUND

As was the case with all of the former Soviet republics, the Russian Federation, known prior to 1992 as the Russian Soviet Socialist Republic, observed the abortion legislation and regulations of the former Union of Soviet Socialist Republics. As a result, abortion practices in the Russian Federation were similar to those throughout the former USSR.

The description given below pertains to the situation in the Russian Federation prior to independence.

Traditionally, the provision of abortion in Russia was illegal and prohibited by law. Capital punishment for provision of induced abortion was introduced in Russia in 1649 and was abolished in the eighteenth century. In the Russian Penal Code of 1895, the punishment for induced abortion was established as loss of all rights and imprisonment for from four to six years for both the pregnant woman and the abortion provider.

The beginning of the twentieth century was characterized by a broad political movement in Russian society for the legalization of induced abortion. Abortion was legalized on 16 November 1920, when the law "On artificial interruption of pregnancy" went into effect abolishing all punishment for induced abortion. It was the first experience in the world with the legalization of abortion on request. Abortions could only be performed by licensed physicians and were free of charge in government hospitals. The provision of abortions outside of hospitals, by paramedics or for a fee was all illegal.

In 1924, however, new regulations introduced a high fee for induced abortion performed in state hospitals and established special commissions to limit free abortions in state hospitals. Private commercial clinics specializing in performing induced abortions were established. The legalization of induced abortion in the early 1920s had some very important and long-term consequences: it contributed to the reorientation and to the adaptation of public-health services towards the use of induced abortion as the principal and least expensive method of fertility control. Couples became accustomed to the use of both legal and illegal induced abortion as the simplest, most effective and most readily available method of birth control. In the late 1920s and early 1930s, a number of restrictions were introduced to counteract the widespread use of abortion; for example, there was a de facto restriction of access to abortion for Communist party members. Regulations issued in 1935 forbade termination of the first pregnancy except for medical reasons, within the first trimester of pregnancy or if the interval since the last induced abortion was less than six months.

The Soviet law of 27 June 1936 prohibited induced abortion in most circumstances, permitting it only for eugenic reasons. Physicians and non-medical personnel that performed abortions in hospitals or as part of an out-patient service were subject to a maximum of three years in prison. A husband, relative or physician that pressured a woman into having an abortion could be sentenced to a maximum of two years in prison. The pregnant woman could be prosecuted by public trial and/or be required to pay a large fine.

In a decree of 23 November 1955, the Soviet Government repealed the prohibition of abortion. Regulations issued in 1956 and subsequently in 1982 specified that abortions could be performed during the first 12 weeks of gestation, although not less than six months after a woman's previous abortion. An abortion was considered illegal if not performed in a hospital or if the person performing the abortion did not have an advanced medical education. The maximum penalty for an illegal abortion was set at eight years in a labour camp.

In 1974, the Ministry of Public Health of the USSR published a document entitled "On the side-effects and complications of oral contraceptives", in which the mass use of oral contraception was de facto prohibited. On 5 June 1987, in Order No. 757, the Ministry of Public Health legalized and officially permitted the provision of early vacuum aspirations in any clinic regardless of the place of residence of the woman. Vacuum aspiration had been the method of induced abortion provided during the first 20 days of pregnancy with the obligatory diagnosis of pregnancy.

Russian Federation

During the 1980s, the Ministry of Public Health continued its efforts to decrease the number of illegal abortions by formally broadening the grounds on which abortions were legal and increasing their availability. Most of the later changes, however, were not followed by a simultaneous increase in actual accessibility of abortion services. On 31 December 1987, the Ministry of Public Health published Order No. 1342, which permits induced abortion during the first 28 weeks of gestation on judicial, genetic and broad medical and social grounds (for example, more than five children in the family), as well as on request with the special authorization of a commission of local physicians.

The high incidence of abortion has been attributed to a number of factors, including shortages of high-quality modern contraceptives and reliance upon less reliable traditional methods, a lack of knowledge concerning contraception and the detrimental health consequences of frequent abortions, and the absence of adequate training for physicians, nurses, teachers and other specialists. In 1989, the availability of condoms in the entire former Soviet Union amounted to only 11 per cent of demand; intra-uterine devices (IUDs), 30 per cent; and pills, 2 per cent. Data from the All-Union sample survey of contraceptive use conducted in 1990 indicate that in the Russian Federation, 22 per cent of all women aged 15-49 years regularly used contraception, 10 per cent sometimes used contraception, 57 per cent did not use any contraceptive method and 6 per cent knew nothing about contraception. Sample survey data show that in 1984 in Moscow, of every 100 contraceptive users, 29 per cent used the rhythm method, 26 per cent used condoms, 26 per cent practised coitus interruptus, 9 per cent used IUDs, 5 per cent used the vaginal douche method and 4 per cent used other methods, indicating the prevalence of traditional contraceptive methods.

In 1990, a total of 3.9 million induced abortions were registered in the Russian Federation, giving an abortion rate of 119.6 per 1,000 women aged 15-44 years, one of the highest in the world. The actual figure is believed to be much higher, because this total does not include most abortions performed in departmental health services and commercial clinics, early vacuum aspirations and self-induced abortions. In 1988, 5 per cent of all induced abortions were performed on primigravidae and 6 per cent of all induced abortions were vacuum aspirations. In 1989, illegal abortions, calculated on the basis of their registered complications, accounted for 11 per cent of all abortions and 16 per cent of all abortions among primigravidae. Among women under age 15, they accounted for 18 per cent of all induced abortions. The total abortion rate (the number of abortions a woman can be expected to have during her lifetime) is thought to be somewhere between 3.3 and 4.5 abortions per woman. The abortion ratio in 1990 (the number of abortions per known pregnancy) was 0.66, implying that the total number of abortions in the Russian Federation is almost double the number of births.

Maternal mortality rates in the Russian Federation were 68 and 50 per 100,000 births in 1980 and 1988, respectively, one of the highest rates in the former Soviet Union; in 1988, 32 per cent of all maternal deaths were due to unknown or "other" causes.

As a means of improving the demographic situation, the Committee for the Family and Demographic Policies, under the Council of Ministers of the Russian Federation, formulated the State Programme on Family Planning for the period 1991-1995. The Programme is designed to modify the attitudes of citizens, to make the people aware of their right to family planning, to protect the reproductive health of individuals and couples and to enable them to have children that are desired and healthy. The Programme provides the basis for regional programmes and accommodates demographic and religious diversity by integrating the activities of various organizations, cooperatives and other institutions. A family planning programme is to be introduced, the training of family planning experts will be reorganized and training programmes will be expanded and broadened in medical and teaching colleges and in physician and teacher retraining faculties. Local production of contraceptives, including IUDs, will be expanded. It is hoped that these measures will reduce the incidence of abortion by 15-20 per cent and lower maternal mortality by 5-6 per cent.

In 1992, it was reported that the only two condom factories in the Russian Federation had ceased production, as they could no longer afford to import latex, while the only factory manufacturing IUDs was closed down because of complaints concerning the quality of its products. No contraceptives have been imported from Western countries since 1990.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
National	1970	156.5 abortions/1,000 women aged 15-44	PR
National	1975	149.5 abortions/1,000 women aged 15-44	PR
National	1980	140.2 abortions/1,000 women aged 15-44	PR
National	1985	147.1 abortions/1,000 women aged 15-44	PR
National	1988	121.0 abortions/1,000 women aged 15-44	PR
National	1989	131.5 abortions/1,000 women aged 15-44	PR
National	1990	119.6 abortions/1,000 women aged 15-44	PR
National	1991	109.2 abortions/1,000 women aged 15-44	PR

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

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

Rwanda

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 physician in a public hospital or other authorized health-care facility. Two physicians must confirm in writing that continuation of the pregnancy would seriously endanger the woman's health.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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, 1992):	13
Total fertility rate (1990-1995):	8.5
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	76
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)	210
Eastern Africa (around 1988)	680
Female life expectancy at birth (1990-1995):	47.7

BACKGROUND

Law 21-77, which constitutes the Criminal Code of Rwanda, derives from section 327 of the Penal Code of 1940 of the then Belgian Congo, adopted by the former colony of Ruanda-Urundi. The law prohibits abortion except when performed in order to safeguard the health of the pregnant woman, if she would be seriously endangered by continuation of the pregnancy. In such cases, a second medical opinion is required and the intervention must be performed by a physician in a public hospital or other authorized health-care facility.

Any person that induces an abortion is subject to imprisonment for 5-10 years if the pregnant woman does not consent and for from two to five years if the woman consents. A person that is employed in a health or sanitary profession and performs an abortion may be suspended from practice for from one to five years or, in the case of repeat offenders, for life. A woman inducing her own miscarriage or consenting to an abortion is liable to imprisonment for from two to five years. The advertisement of abortifacients is also punishable under the criminal code by imprisonment for a term of between eight days and one year and/or a fine of 1,000-10,000 Rwanda francs (RF).

Illegal abortions are performed in Rwanda, usually by means of plant extracts or heavy massages. However, abortion is not reported to be widespread. When abortion does occur, it appears to be mainly limited to unmarried women. Rather than relying upon contraception or abortion, women in Rwanda space their births by means of such traditional practices as abstinence due to mourning rites or prolonged breast-feeding.

Family planning efforts in Rwanda date back 30 years. The first family planning programme offering modern contraception was established in 1962, but family planning goals were included for the first time in the Five-Year Plan for the period 1977-1981. In 1974, the Government of Rwanda established the Scientific Council for Socio-demographic Problems, which proposed the creation of an institution that would address population issues on a permanent basis. In 1981, the National Population Office (ONAPO) was established to implement population programmes and to begin a programme to integrate family planning services into all of the health-care facilities in Rwanda.

The Government of Rwanda has long been aware of the major threat that population growth poses for the development of the country. Nevertheless, the Government's actions have been constrained by the strong pronatalist sentiments of its population and by the opposition of religious groups to family planning. The pressure of population on agricultural land has gradually brought about a change in attitude, and family planning is now considered to be a key element in national development. Religious groups have also acknowledged demographic problems in Rwanda and have begun to soften their opposition. In 1990, the family planning programme was expanded and a national population policy and plan of action were adopted, with the goal of reducing the population growth rate from 3.7 to 2.0 per cent by the year 2000. Related goals were to increase the contraceptive prevalence rate from 2 to 48 per cent and to decrease the total fertility rate from 8.6 to 4.0 births per woman.

Currently, however, Rwanda is facing other overwhelming problems caused by the outbreak of civil war, which led to the death of more than 500,000 people and a massive exodus from the country. The infrastructure must be rebuilt and returning refugees must be integrated.

Rwanda

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

Source: Population Policy Data Bank maintained by the Population Division of the Department for Economic and Social Information and Policy Analysis 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:

Legal abortions are usually performed within 28 weeks of gestation.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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,* 1984):	37
Total fertility rate (1990-1995):	..
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	..
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	..
Caribbean (around 1988)	260
Female life expectancy at birth (1990-1995):	..

* All sexually active women.

Saint Kitts and Nevis

BACKGROUND

Abortion law in Saint Kitts and Nevis derives from the English Offences against the Person Act of 1861, cap. 56, sections 53 and 54, under which abortions are prohibited. However, legal opinion follows the holding of the British Court decision on *Rex* v. *Bourne* (1938), under which abortions can be performed to save the mental and physical health of the pregnant woman. Legal abortions are usually performed within 28 weeks of gestation.

The Government of Saint Kitts and Nevis considers the rates of population growth and fertility to be too high and has a policy of intervention directed to reducing those rates. It is extensively involved in family planning and provides contraceptives through the national family planning programme. The Saint Kitts and Nevis Family Planning Association, which was founded in 1966, complements the Government's family planning efforts by distributing contraceptives to government clinics and promoting family planning by means of radio, television and newspapers.

The Government of Saint Kitts and Nevis is especially concerned about the problem of teenage pregnancy and its social consequences. In response to those concerns, the Government has introduced specialized family life education and family planning programmes directed to the youth of the country.

INCIDENCE OF ABORTION

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

Source: Population Policy Data Bank maintained by the Population Division of the Department for Economic and Social Information and Policy Analysis 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:

Information is not readily available.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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):	46
Total fertility rate (1990-1995):	..
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	..
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	..
Caribbean (around 1988)	260
Female life expectancy at birth (1990-1995):	..

* Including visiting unions.

Saint Lucia

BACKGROUND

Abortion law in Saint Lucia derives from the 1861 English Offences against the Person Act (cap. 56, sections 53 and 54), under which abortions are prohibited. However, general legal opinion follows the holding of the British court decision on *Rex* v. *Bourne* (1938), under which abortion can be performed to save the mental and physical health of the pregnant woman.

Adolescent fertility is a major concern in Saint Lucia. Although the birth rate is relatively low, the incidence of adolescent pregnancies and births has been increasing. It is estimated that teenage fertility accounts for about 27 per cent of all births in the country. Therefore, the family planning programme places particular emphasis on adolescents.

The Government of Saint Lucia directly supports the provision of contraceptives. Activities of the Saint Lucia Family Planning Association complement the government family planning project. A Contraceptive Prevalence Study conducted in the early 1980s found that 90 per cent of women of child-bearing age knew of at least one contraceptive method and 34 per cent were currently using a contraceptive method. Oral contraceptives were the best known method. The study also found that more than 50 per cent of women knew of the condom, injection, the intra-uterine device and female sterilization. In 1987, the Saint Lucia Family Planning Association observed that the main obstacles to delivering family planning services were traditional and religious practices, the mountainous topography that made some rural villages inaccessible and the high rate of illiteracy in the country.

The Government of Saint Lucia has expressed concern about its rapid population growth, emphasizing that the rate is too high for a small island State that is heavily dependent upon agriculture. The government response to this concern was the establishment of the Population Planning Unit, which is charged with monitoring population trends and advising the Government on strategies to reduce the population growth rate.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

Source: Population Policy Data Bank maintained by the Population Division of the Department for Economic and Social Information and Policy Analysis 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	No
Available on request	No

Additional requirements:

The procedure must be performed by a medical practitioner in an approved hospital or other establishment and two medical practitioners must certify that the legal grounds for abortion have been met. The pregnant woman's actual or reasonably foreseeable environment may be taken into account when deciding the legality of an abortion on health grounds.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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):	55
Total fertility rate (1990-1995):	..
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	..
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	..
Caribbean (around 1988)	260
Female life expectancy at birth (1990-1995):	..

* Including visiting unions.

Saint Vincent and the Grenadines

BACKGROUND

Abortion law in Saint Vincent and the Grenadines, as in most Commonwealth Caribbean countries, was based on English common law (Indictable Offences Ordinance, cap. 6, sections 98-100), which considered abortion a criminal offence. The British judicial decision on *Rex* v. *Bourne* in 1938, which permitted abortion to save the life of the mother or to protect her physical or mental health, was also applied in Saint Vincent and the Grenadines. In 1977, the Minister of Health established a committee to examine the abortion law. The Saint Vincent Medical Association recommended a change in the law to allow for a broad range of indications for the medical termination of pregnancy.

This recommendation was incorporated into the new Criminal Code of 1988 (Act No. 23). Under the Code, any person that, with intent to induce the miscarriage of a woman, whether or not she is pregnant, unlawfully administers or causes her to take any poison or other noxious item, uses force of any kind or uses any other means is guilty of an offence and is subject to imprisonment for 14 years. Such a person is not guilty of an offence if the pregnancy is terminated by a medical practitioner in a hospital or other establishment approved by the Senior Medical Officer, after two medical practitioners, acting in good faith, state that continuation of the pregnancy would involve risk to the life of the pregnant woman or injury to her physical or mental health, or to that of any of her existing children, greater than if the pregnancy were terminated; or would involve a substantial risk that, if the child were born, it would be seriously handicapped with a physical or mental abnormality. The woman's actual or reasonably foreseeable environment may be taken into consideration when deciding whether continuation of the pregnancy would involve risk of injury to her health. In an emergency, the registered medical practitioner may perform an abortion without the second opinion of another medical practitioner, if he or she believes that termination of pregnancy is immediately necessary to save the life of the woman or to prevent grave permanent injury to her physical or mental health. The requirement that the abortion be performed in an approved hospital or other establishment is also waived for the emergency termination of pregnancy.

A person attempting to induce abortion following rape or incest is not guilty of an offence, regardless of whether any person has been charged with the rape or incest that resulted in the pregnancy, provided the abortion is performed in a hospital or other approved establishment.

A pregnant woman that, in attempting to induce her own miscarriage, unlawfully administers to herself any poison, uses force or any other means or permits any such thing or means to be administered or used on her is guilty of an offence and may be imprisoned for seven years. A person that unlawfully supplies poison or other noxious things for any person or uses force or any instrument, knowing that it will be unlawfully used to induce the miscarriage of any woman, whether or not she is pregnant, is guilty of an offence and is subject to imprisonment for five years.

The Government of Saint Vincent and the Grenadines considers the rates of population growth and fertility to be too high and believes that the current population growth rate will severely strain the limited natural resources of the country. The Government's population policy is directed to reducing the rate of population growth to 0.7 per cent by the year 2030. Strongly committed to family planning, the Government seeks to lower fertility levels through a national family planning programme in which the Ministry of Health provides free family planning services in all health-care centres. Adolescent fertility is viewed as a major concern and special emphasis is placed on youth, for whom outreach programmes have been developed. Family planning is a priority in the training of health-care personnel and in health education. The Ministry of Health also conducts an education programme for parents, which includes workshops on sexuality, family planning, family life education and communication skills.

The Government directly supports the provision of modern methods of contraceptives, a wide range of which are available to men and women, including adolescents, regardless of marital status. Female sterilization is permitted upon the assurance that the woman will not want more children, with the consent of the spouse and upon consideration of the woman's age and marital status.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

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

Samoa

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:

Information is not readily available.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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 (1990-1995):	..
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	..
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)	400
Oceania (around 1988)	600
Female life expectancy at birth (1990-1995):	..

BACKGROUND

Only limited information is available on abortion practices in Samoa. A review of abortion laws in the Commonwealth countries undertaken in the late 1970s suggests that abortion in Samoa was regulated by sections 73A-73D of the Crimes Amendment Act of 1969. The law was based on the application of the British judicial decision on *Rex* v. *Bourne* in 1938 rather than on any specific statute. Under the law, abortion was illegal except when performed to preserve the mother's life and/or physical and mental health.

It has been observed that induced abortion has been socially acceptable in Samoa and often has been performed in cases of rape or incest. Findings from the Western Samoa Family Planning Knowledge, Attitude and Practice Survey (KAP), in 1971 show that induced abortion, although illegal, was considered permissible by 34 per cent of the unmarried women surveyed, by 28 per cent of the married women and by 15 per cent of the husbands.

There are no reliable estimates on the frequency of induced abortion in Samoa. One study conducted in 1973 found that the high fertility of Samoan women had been held in check to some extent by abortion, especially induced abortion. According to another study conducted in 1984, the estimated total abortion rate in Samoa, including both spontaneous and induced abortions, was about 11 per 1,000 pregnancies.

Since the early 1970s, the Samoan Government has made efforts to control the high natural growth rate of its population. In 1971, the Government created the Family Welfare Programme incorporating family planning as an integral part of maternal and child health (MCH) services. High priority has been given to improving maternal and child health, largely through child-spacing. Other non-governmental organizations, such as the Samoa Planned Parenthood Association, have been active in strengthening and developing MCH care and family planning services, in collaboration with the government programme. In 1977, 13 per cent of women of reproductive age (15-49) practised family planning.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

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

San Marino

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.

* Legal interpretation generally permits this ground.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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 (1990-1995):	..
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	..
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 1988)	26
Female life expectancy at birth (1990-1995):	..

BACKGROUND

According to articles 153 and 154 of the Penal Code of San Marino, abortion is prohibited in all circumstances. However, the Code has been interpreted to permit abortion in order to save the woman's life. The pregnant woman and anyone that participates in performing an abortion may be imprisoned. Harsher penalties are imposed if the abortion is performed for economic gain or if the woman dies or is seriously injured. The penalty is further increased if the person performing the abortion is a health professional. Penalties are less severe if the woman acted to protect her honour.

When the Penal Code of San Marino was modified in 1974, a proposal was submitted for liberalization of the abortion law, which included six grounds on which abortion would have been permitted. Following a lengthy discussion, the Government decided to defer modification of the abortion law in order to permit further debate; the two articles on abortion were maintained unaltered. As of 1993, no new law had been enacted.

San Marino, a small enclave within the territory of Italy, relies upon Italy for some functions. It is therefore likely that women in San Marino desiring an abortion can seek one in neighbouring Italy, which has a more liberal law.

One of the questions raised when the modification of the Penal Code occurred was whether a new abortion law would require new programmes on sex education. A programme of health education, including sex education, was subsequently implemented; it also includes information on contraceptive use.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

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

Sao Tome and Principe

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:

An abortion may be performed during the first 12 weeks of pregnancy. The decision whether there are grounds to perform an abortion is made by the physician that will perform the abortion. A waiver must be signed by the pregnant woman or by her parents if she is a minor (under 18 years of age).

* Official interpretation generally permits these grounds.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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 (1990-1995):	..
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	..
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of child-bearing and childbirth	Yes
Maternal mortality rate (per 100,000 live births):	
National	..
Middle Africa (around 1988)	710
Female life expectancy at birth (1990-1995):	..

BACKGROUND

Sao Tome and Principe achieved independence from Portugal on 12 July 1975, inheriting the Portuguese legal system. The Portuguese Penal Code of 1886, which has never been repealed, prohibits abortion on all grounds. The Penal Code provides for imprisonment for from two to eight years for anyone performing an abortion, including the pregnant woman. Penalties are less severe, however, if the woman committed the offence in order to conceal her dishonour. However, the de facto policy is more liberal and abortion is allowed during the first 12 weeks of pregnancy on medical grounds and in cases of rape, incest or foetal impairment. The decision whether there are grounds to perform an abortion is made by the physician that will perform the abortion. A waiver must be signed by the pregnant woman or by her parents if she is under 18 years of age.

Sao Tome and Principe, an island State, is classified among the least developed countries. National development plans have mainly been directed to promoting economic development and improving the health status of the population. The Government of Sao Tome and Principe is concerned about the large number of induced abortions and attributes this situation to the deficiency of the family planning programme. The Government supports family planning activities principally to improve maternal and child health (MCH) and family life conditions. The Government is receiving international assistance for a population programme that has as its immediate goals to expand the provision of integrated MCH and family planning, to increase the contraceptive prevalence rate from 7.6 to 20 per cent, to lower the incidence of abortion and to expand population education and family life education programmes.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

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

Saudi Arabia

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 legal abortion must be performed in a government hospital. A panel of three medical specialists appointed by the hospital director must sign a recommendation before an abortion can be performed. Written consent must be obtained from the patient and her husband or her guardian, using a standard Government-approved form.

FERTILITY AND MORTALITY CONTEXT

Government's view on fertility level:	Satisfactory
Government's intervention concerning fertility level:	To maintain
Government's policy on contraceptive use:	Major restrictions
Percentage of currently married women using modern contraception (aged 15-49):	..
Total fertility rate (1990-1995):	6.4
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	124
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	..
Western Asia (around 1988)	280
Female life expectancy at birth (1990-1995):	70.9

BACKGROUND

Induced abortion is generally illegal in Saudi Arabia. However, in accordance with article 24 of the Rules of implementation for Regulaticns of the practice of medicine and dentistry, Ministerial Resolution No. 288/17/L of 26 June 1989, induced abortion may be performed to save the woman's life, and "if the pregnancy is less than four months old and it is proven beyond doubt that continued pregnancy gravely endangers the mother's health".

Resolution No. 140 by the Committee of Senior Ulema stipulates that a pregnancy cannot be aborted at any stage except when "legally (according to Islamic Laws) justified and within very narrow limitations".

The Saudian Arabian law on abortion refers to three stages of pregnancy. Within the first 40 days of gestation, an abortion may be allowed if it is deemed necessary to accomplish a legal benefit or to prevent an expected harm. It is not allowed, however, for other reasons mentioned in Islamic law. At the embryo stage, an abortion will not be allowed unless an approved medical committee decides that continuation of the pregnancy endangers the woman's safety and could possibly lead to her death, and if all means to eliminate the danger have been exhausted to no avail. After four months of pregnancy, abortion is not allowed unless a panel of approved specialists states that continuation of the pregnancy will cause the woman's death and all means to eliminate the danger have been exhausted.

Under these conditions, aborion is allowed "to avoid the gravest of two dangers and to accomplish the better of two benefits".

The Government of Saudi Arabia has not formulated a comprehensive policy that specifically considers population issues. However, because the Government views its population problems in the context of ensuring national identity and meeting its labour force requirements, it considers the rate of population growth to be too low and intervenes to increase population growth among its nationals. The Government views its comparatively high level of fertility as satisfactory.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

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

Senegal

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:

The physician performing the abortion must obtain the written advice of two consulting physicians, one of whom must be taken from a list of experts provided by the Court. The physicians must attest to the fact that the life of the woman cannot be saved by any means other than the intervention contemplated.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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, 1992/93):	5
Total fertility rate (1990-1995):	6.1
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	155
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 (1981-1985)	600
Western Africa (around 1988)	760
Female life expectancy at birth (1990-1995):	50.3

BACKGROUND

The Criminal Code of Senegal is based on article 317 of the French Penal Code of 1810, as amended by the Law decree of 1939. According to this Code, abortion is illegal except to save the life of the pregnant woman when it is seriously endangered. The physician performing the abortion must obtain the written approval of two consulting physicians, one of whom must be taken from a list of experts provided by the Court. The physicians must attest to the fact that the life of the woman cannot be saved by any means other than the intervention contemplated. Anyone performing an abortion outside the provisions of the law is subject to imprisonment for from one to five years and to a fine of 20,000-100,000 CFA francs (CFAF). Penalties are increased to imprisonment for 5-10 years and CFAF 50,000-500,000 in the case of a habitual abortionist. A woman that induces her own miscarriage is subject to imprisonment for from six months to two years and a fine of up to CFAF 100,000.

In March 1971, the Parliament declared that it favoured family planning; in April 1974, the Ministry of Health announced the establishment of a new family planning association. In 1980, Law No. 80-49 of 24 December inserted a new article in the Penal Code—prescribing penalties only for incitement to perform abortion and the display or distribution of abortifacients—and repealed the French anticontraception law of 1920, which prohibited the advertisement and distribution of contraceptives. The National Population Council was established in 1980 and a family planning programme was initiated and integrated into maternal and child health services. In 1982, the first seminar on Islam and family planning to be held in Senegal was convened; it recognized the compatibility of Islam with family planning and recommended increased accessibility to contraception, according to the Islamic teaching that one must not have more children than one is able to protect and care for. This view was consistent with the Government's new approach to population issues and with the formulation of a comprehensive population policy in 1988. It was only in 1991 that an action programme was adopted, which included a programme for the promotion of women in development, an information programme for adolescents and a more effective strategy for the national family planning programme that involved locally adapted initiatives designed to overcome specific obstacles, as well as attempts to coordinate the activities of the different donors.

Adolescent abortion is estimated to be quite high in Senegal and surveys have shown that as many as 12 per cent of secondary-school girls have had an abortion. Estimates of the prevalence of clandestine abortions are uncertain, as women suffering from the complications of illegal abortion are usually unwilling to divulge the reasons and the means used. The Government has expressed concern about the number of induced abortions, as they are a major cause of maternal mortality and morbidity. To reduce rates of maternal mortality and morbidity, programmes are under way for training of personnel, renovation of health centres, research and procurement of contraceptives.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

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

Seychelles

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:

Abortion is legal in Seychelles during the first 16 weeks of gestation on the grounds of saving the life of the mother, preserving her physical and mental health, foetal impairment and rape or incest. The abortion must be performed in Victoria Hospital by a consulting gynaecologist after the proper authorizations based on medical or legal grounds have been obtained.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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 (1990-1995):	..
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	..
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	..
Eastern Africa (around 1988)	680
Female life expectancy at birth (1990-1995):	..

BACKGROUND

According to the Termination of Pregnancy Act (No. 5 of 1981), abortion is legal in Seychelles if performed by a qualified physician under the following conditions: there is a greater risk to the life or health of the woman if the pregnancy continues than if she has an abortion; there is a substantial risk that the child would be born seriously handicapped; the pregnancy is the result of rape or incest; or the woman is mentally unfit to take care of a child.

An abortion may only be performed at Victoria Hospital by a consulting gynaecologist. In case of risk to the life or health of the woman or risk that the child would be born seriously handicapped, the Director of Health Services, a consulting gynaecologist and the woman's personal physician must certify the medical grounds. In the case of rape or incest or mental unsuitability to care for a child, a judge must certify the legal grounds. Abortions may be performed during the first 16 weeks of gestation; they can be performed later only in exceptional cases.

In 1990, there were 9 therapeutic abortions for every 100 live births in Seychelles. However, the rate for 1989, when the known number of illegal abortions with complications (treated in the hospital) is included, was almost 21 abortions per 100 live births.

The Government of Seychelles considers its rates of fertility and population growth to be too high. Concern about the increasing birth rate in the 1960s led to the implementation of family planning services, which came under direct supervision of the Government in 1978. Services have been provided within the context of the maternal and child health programme in government clinics and social centres and by community health nurses in outlying rural areas. In an effort to lower the high rate of teenage pregnancy, family life and sex education programmes have been integrated into the school curricula. Sterilization is legal in Seychelles.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
National	1985	13.4 abortions/1,000 women aged 15-44	PR
National	1990	9.2 abortions/1,000 women aged 15-44	PR

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

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

Sierra Leone

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:

Information is not readily available.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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 (1990-1995):	6.5
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	212
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 (1980)	450
Western Africa (around 1988)	760
Female life expectancy at birth (1990-1995):	44.6

BACKGROUND

The English Offences Against the Person Act of 1861, which prohibits abortion, was adopted in Sierra Leone on 15 June 1939. Penalties are imposed on anyone performing an illegal abortion, any woman inducing her own miscarriage or anyone supplying instruments intended to procure an abortion. Sierra Leone, however, follows the decision on *Rex* v. *Bourne* (1938), which permits abortion to save the life or preserve the physical or mental health of the pregnant woman. A law introduced in 1988 to regulate the practice of pharmacy (Pharmacy and Drugs Act of 1988) prohibits any advertisement of drugs or services that could be used to terminate or influence the course of a human pregnancy.

The high incidence of induced abortion is a growing concern in Sierra Leone. The problem is more acute among young women, whose high rates of pregnancy force many to seek abortions. It is estimated that 80 per cent of all legal abortions are performed on women aged 15-24. Complications of induced abortion are the most important cause of hospitalization and maternal mortality in Sierra Leone, a situation that has placed strains on an already overburdened health-care system.

Both knowledge and availability of family planning services are limited, particularly in rural areas, and birth-spacing in the form of post-partum abstinence is the main contraceptive method. It is estimated that only 5 per cent of married women use modern contraceptives. In 1992, the Ministry of Health began to play a major role in promoting family planning by including it as a part of maternal and child health services. The Government is committed to integrating population components into development planning. As a result, the National Population Commission was created in 1982 and a national population programme framework (National Population Policy Paper) was formulated in 1989. In 1992, the Government requested international assistance in developing and implementing action plans for different areas of its population programme.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

Source: Population Policy Data Bank, Population Division, Department for Economic and Social Information and Policy Analysis, United Nations Secretariat. For additional sources, see reference section.

Singapore

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:

A legal abortion requires the written consent of the pregnant woman. Abortion is available on request within 24 weeks of gestation unless the procedure is immediately necessary to save the life or to prevent grave permanent injury to the physical or mental health of the pregnant woman. A legal abortion is restricted to citizens of Singapore, wives of Singapore citizens and women that have resided in Singapore for a minimum duration of four months. The qualifications required of physicians performing abortion at different stages of pregnancy are defined: if gestation does not exceed 16 weeks, the physician should have a minimum of 24 months' experience in a recognized obstetrics and gynaecological unit; thereafter, additional specialist qualifications are required. A legal abortion must be performed in a government hospital or other approved institution.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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 15-44, 1982):	73
Total fertility rate (1990-1995):	1.8
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	11
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)	10
South-eastern Asia (around 1988)	340
Female life expectancy at birth (1990-1995):	77.4

BACKGROUND

Until 1969, abortion legislation in Singapore was based on British laws adopted in the nineteenth century. Abortion was a criminal act punishable under sections 312-316 of the Penal Code. However, a legal abortion was permitted if performed in good faith to preserve the life of the pregnant woman. The first legislative act designed to liberalize abortion laws was passed on 29 December 1969; known as the 1969 Abortion Act, it came into effect on 20 March 1970. The Act permitted abortion to save the life of the pregnant woman or to preserve her physical or mental health, or the pregnancy resulted from rape or incest or the pregnant woman was mentally ill or retarded. Abortion was also permitted when foetal impairment was suspected and on social or economic grounds.

Abortions on socio-economic or juridical grounds could be performed only within 16 weeks of gestation. However, a legal abortion could be permitted on eugenic or medical grounds up to 24 weeks of pregnancy. Thereafter, an abortion could only be performed if the abortion was immediately necessary to save her life or to prevent grave permanent injury to her physical or mental health.

A legal abortion required the approval of a Board composed of 11 members (Termination of Pregnancy Authorization Board). Section 5(3) of the Abortion Act, however, permitted a physician to perform an abortion without the Board's authorization if, after consulting another physician, both reached the conclusion that continuance of the pregnancy would involve risk to the life of the pregnant woman or serious injury to her physical or mental health. However, the Act also provided that the Board must be notified of any abortions performed in these circumstances within a two-week period.

The 1969 law required the written consent of all married women regardless of their age and of unmarried women that were at least 18 years of age. The consent of parents/guardians was required for all unmarried women under age 18. The Board was authorized to grant abortions to unmarried women under age 18 if they had no parents/guardians or were mentally ill or retarded.

The Abortion Act of 1974 (Penal Code, chapter 119, sections 312-316) liberalized abortion laws in Singapore. The Act states that a person shall not be guilty of an offence under the law relating to abortion when a pregnancy is terminated by a registered physician acting on the request of a pregnant woman and with her written consent. The Termination of Pregnancy Authorization Board was also abolished under the new Act. The new Act allows abortion to be performed within 24 weeks of pregnancy in all cases; beyond that time, abortion is permitted only to save the life of the pregnant woman. The Act also abolished the consent requirements. Abortion is restricted to citizens of Singapore, wives of Singapore citizens and women that have resided in the country for at least four months. This restriction does not apply when an abortion is immediately necessary to save the life of the pregnant woman.

The 1974 Act contains a conscience clause permitting medical personnel to be excused from legal liability for non-participation in medically indicated procedures, unless the abortion is immediately necessary to save the life or to prevent grave permanent injury to the physical or mental health of the pregnant woman. Violations of the Act constitute offences punishable by imprisonment for up to three years and/or a fine.

Under the 1974 Abortion Act, a legal abortion must be performed in a government hospital or in an approved institution. The regulations define the qualifications required of physicians performing an abortion at different stages of pregnancy. If gestation did not exceed 16 weeks, the physician had to have a minimum of six months' experience in a recognized obstetrics and gynaecological unit; thereafter, additional specialist qualifications were required. However, if the abortion consisted solely of the administration of drugs and did not entail any surgical procedures, it was not necessary for the physician to have the prescribed qualifications or experience, nor for treatment to be carried out in a government hospital or approved institution. The cost of an abortion carried out in a government hospital was 5 Singapore dollars (S$). Any additional hospital costs were borne by the patient.

Singapore

Since the early 1980s, the Government of Singapore has imposed a number of requirements in order to improve supervision of physicians and institutions involved in pregnancy termination. The Abortion (Amendment) Act of 1980 and the Abortion (Amendment) Regulations of 1981 require that all physicians that want to perform abortions must be authorized by the Health Ministry. The new legislation imposes further requirements on physicians seeking approval to perform abortions. The 1981 (Amendment) Regulations stipulate that institutions involved in pregnancy termination should seek certification every two years, while the Abortion (Amendment) Regulations of 1982 specify that these institutions must seek certification annually.

With the introduction of mandatory counselling prior to and following abortion, as required by the Termination of Pregnancy Regulations of 1 October 1987, the regulations concerning legal abortions were slightly tightened. In addition, a waiting period of at least 24 hours following counselling, before the abortion can be performed was introduced. Pre-abortion counselling is intended to provide women with the information that may allow them to continue their pregnancy. Women choosing to have an abortion are counselled after the procedure to discourage them from seeking repeat abortions.

The 1987 Regulations also require that a medical practitioner terminating a pregnancy not exceeding 16 weeks must be registered under the Medical Regulation Act and have at least 24 months' experience in an obstetric and gynaecological unit of a recognized hospital, while a pregnancy of no more than 24 weeks must be terminated by a medical practitioner that holds the degree of Master of Medicine (Obstetrics and Gynaecology) of the University of Singapore or the National University of Singapore or is a Member or Fellow of a Royal College of Obstetricians and Gynaecologists.

The Government's concern about below-replacement fertility has led it to implement a number of measures designed to reverse this trend. In 1987, to encourage women to have at least three children, it offered new incentives in the form of tax deductions and rebates, improved maternity leave benefits, child-care subsidies and priority in housing and school registration.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
National	1980	28.4 abortions/1,000 women aged 15-44	PR
National	1981	28.8 abortions/1,000 women aged 15-44	PR
National	1982	28.6 abortions/1,000 women aged 15-44	PR
National	1983	28.1 abortions/1,000 women aged 15-44	PR
National	1984	32.4 abortions/1,000 women aged 15-44	PR
National	1985	34.1 abortions/1,000 women aged 15-44	PR
National	1986	33.1 abortions/1,000 women aged 15-44	PR
National	1987	30.1 abortions/1,000 women aged 15-44	PR
National	1988	28.2 abortions/1,000 women aged 15-44	PR
National	1989	28.6 abortions/1,000 women aged 15-44	PR
National	1990	25.7 abortions/1,000 women aged 15-44	PR
National	1991	24.4 abortions/1,000 women aged 15-44	PR

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

Source: Population Policy Data Bank maintained by the Population Division of the Department for Economic and Social Information and Policy Analysis 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:

Abortion is allowed within 12 weeks of gestation upon written request of the pregnant woman. An abortion may be performed on request only if at least six months have elapsed since a previous abortion, except in the case of a woman that has had two other births or is 35 years of age or older, or in the case of rape. A woman must receive counselling before an abortion is performed. Parental consent is required for minors under 16 years of age; for minors between 16 and 18 years of age, the physician must inform the parents following the intervention. Second-trimester abortion is allowed only for medical and eugenic reasons and in cases of rape or other sexual crimes.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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 15-44, 1991):	41
Total fertility rate (1990-1995):	..
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	..
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 1988)	26
Female life expectancy at birth (1990-1995):	..

Slovakia

BACKGROUND

Abortion in Slovakia is still regulated by the law of 23 October 1986 of the former Slovak Socialist Republic. Abortion is allowed within 12 weeks of gestation upon written request of the pregnant woman. An abortion may be performed on request only if at least six months have elapsed since a previous abortion, except in the case of a woman that has had two other births or who is 35 years of age or older, or in the case of rape. A woman must receive counselling before an abortion is performed. Parental consent is required for minors under 16 years of age; for minors between 16 and 18 years of age, the physician must inform the parents following the intervention. Second-trimester abortion is allowed only for medical and eugenic reasons and in cases of rape or other sexual crimes.

Attempts have been made to restrict abortion in Slovakia. In January 1991, the Parliament of Czechoslovakia adopted a bill of rights containing the provision that human life is "worthy of protection" even before birth, which was a compromise in language between pro-choice and anti-abortion forces. Concerned about the high rates of induced abortion, the Government established an advisory commission in March 1991 to review the abortion law with a view to decreasing the incidence of abortion. The Commission recommended that the absolute prohibition of abortion should be avoided, that abortion should not be Government-supported except to save the woman's life or in cases of sexual crimes and that the law should also serve an educational function..

One of the last acts of the Parliament of Czechoslovakia was to revise legislation concerning health care. Under the new legislation which entered into force following the division of the country into the Czech Republic and Slovakia in January 1993, abortions that are not performed on therapeutic grounds are considered non-essential and thus are not covered by national health insurance. The cost of such of a procedure is approximately $115, representing one month's average salary. Prior to the new law, an abortion performed up to the eighth week of pregnancy or on medical grounds had been free of charge; in all other cases, a fee of 500 Czechoslovak koruny (Kčs) had been charged in order to discourage late termination of pregnancy.

Although contraceptives are free of charge and widely available, a study conducted in 1991 in the former Czechoslovakia found low rates of contraceptive prevalence (only 52 per cent of women in union), widespread distrust of oral contraceptives and a dominant role of religion in influencing contraceptive decisions. The study found that 28 per cent of women used barrier methods, 17 per cent used intra-uterine device and 7 per cent used oral contraception. For these reasons, abortion rates were high; in 1988, they averaged 48.7 abortions per 1,000 women aged 15-44 (or 76.2 per 100 live births) in the former Czechoslovakia and 51.2 in Slovakia. The Government is currently attempting to modify contraceptive behaviour through improved access to contraceptives and sex education programmes.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
National	1985	40.5 abortions/1,000 women aged 15-44	PR
National	1986	44.2 abortions/1,000 women aged 15-44	PR
National	1987	50.7 abortions/1,000 women aged 15-44	PR
National	1988	51.2 abortions/1,000 women aged 15-44	PR
National	1989	48.1 abortions/1,000 women aged 15-44	PR
National	1990	47.4 abortions/1,000 women aged 15-44	PR

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

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

Slovenia

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 in a hospital or other authorized health-care facility. If the woman is a minor, approval of her parents or guardian is required, unless she has been recognized as fully competent to earn her own living. After the first 10 weeks of pregnancy, special authorization by a commission composed of a gynaecologist-obstetrician, a general physician or a specialist in internal medicine and a social worker or a psychologist is required.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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, 1976):	66
Total fertility rate (1990-1995):	..
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	..
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 (1990)	9
Developed countries (around 1988)	26
Female life expectancy at birth (1990-1995):	..

BACKGROUND

Slovenia achieved independence from the former Socialist Federal Republic of Yugoslavia in 1991 and ratified a new constitution. However, abortion is still regulated by the Law of 7 October 1977 passed by the former Yugoslavia to implement article 191 of the Federal Constitution of Yugoslavia of 21 February 1974, which proclaims that "it is a human right to decide on the birth of children". According to the law of Slovenia, abortion is allowed on request during the first 10 weeks of pregnancy. The intervention must be performed in a hospital or other authorized health-care facility. If the woman is a minor, approval of her parents or guardian is required, unless she has been recognized as fully competent to earn her own living. After the first 10 weeks of pregnancy, special authorization by a commission, composed of a gynaecologist-obstetrician, a general physician or a specialist in internal medicine and a social worker or a psychologist, is required. The Commission decides on the basis of the existence of medical, eugenic, juridical, economic or social grounds. The woman can appeal to the Commission of Second Instance if the Commission of First Instance rejects her request. After 20 weeks of gestation, abortion may be allowed only to save the life or preserve the health of a seriously endangered woman.

In ratifying the new Slovene Constitution in 1991, a compromise was reached whereby the right to bear a child was modified to refer to child-bearing as a liberty, thus raising the possibility that this was a precursor to more restrictive legislation on abortion. Furthermore, the new law on Provision of Health Care of 1992 contains a conscience clause, allowing a physician to refuse to perform any medical procedure. A revision of the Medical Code of Ethics under discussion in 1992 included a conscience clause that a physician could invoke in order to be exempted from performing an abortion or sterilization if no medical emergency existed.

Penal provisions are imposed on medical organizations and persons that violate provisions of the law. A woman, however, is never held criminally responsible for inducing her own abortion or for cooperating in such a procedure.

Beginning in 1952, abortion legislation in the former Yugoslavia was liberalized in response to the significant increase in illegal abortions associated with high levels of morbidity and mortality. The subsequent changes in the abortion laws—general principles were adopted at the federal level and laws were implemented at the local level—were expressly directed to facilitating access to legal abortion in order to discourage illegal practices. For instance, a significant decline in the number of illegal abortions is attributed to the decision in 1969 to eliminate the requirement of a commission's approval for termination of pregnancies of less than 10 weeks, a requirement which had been a practical and psychological obstacle to abortion. The policy of liberalizing legal regulations with regard to abortion was facilitated by increased numbers of medical facilities, better access to information on abortion services and higher levels of education. Although abortion rates continued to be high, the former Government essentially achieved its objective: illegal abortions were practically eliminated and the country experienced a significant decline in maternal morbidity and mortality related to abortion. For example, in Slovenia, mortality associated with abortion declined from 52 per 100,000 abortions in 1960 to 5 per 100,000 in 1976.

High rates of abortion, as well as a high rate of repeat abortions, an increase in second-trimester abortions and an increase in abortions among adolescents, were problems experienced throughout the former Yugoslavia. These trends demonstrated that women relied upon abortion as a contraceptive method, with consequent health risks. Slovenia, however, has a very low incidence of second-trimester abortions; during the period 1965-1980, they accounted for only 1.7-3.4 per cent of all legal abortions. As concerns its overall abortion rate, Slovenia is in the middle range among the former Yugoslav republics.

Family planning services had been a part of the regular medical services in the former Yugoslavia since the mid-1950s. A family planning institution was established in 1963 at the national and local levels, and the Family Planning Association, affiliated with the International Planned Parenthood Federation, has existed since 1966. However, sex education in the schools and family planning counselling had not been systematically developed, and family planning had encountered continuing resistance throughout the country. As a result, insufficient knowledge

and fear of modern methods of contraception is widespread. According to official data, the percentage of married women using any method of contraception in Slovenia increased slightly between 1970 and 1976—from 63.8 to 65.9. However, withdrawal accounted for 43.5 per cent of the total, hormonal contraceptives for 25 per cent and intra-uterine devices for 13 per cent. It is estimated that contraceptive practices were similar in the 1980s.

In the late 1980s, the former Government indicated deep concern about the high abortion rates and low rates of usage of modern contraceptive methods. In the Resolution on Population, Development and Family Planning of 1989, which set out general principles and directions with regard to population matters, special emphasis was given to fertility and family planning. The resolution, while reconfirming the right of each person to decide freely on the number and spacing of children, as established in the Constitution of 1974, was directed to attaining replacement-level fertility in all areas of the country. In part to reduce the incidence of abortion and in part to reduce fertility in some republics, specific measures to disseminate contraceptive information and supplies more widely were taken at the federal level. Social welfare measures, such as prolonged maternity leave, child allowances and child-care facilities, were also strengthened in areas of the country where fertility was below replacement level. In the former Yugoslavia, the republics and autonomous provinces were responsible for implementing within their borders the general principles of population policy adopted by the Federal Assembly. However, the republics and autonomous provinces often abstained from executing federally adopted policies. Concerned by the declining rate of fertility, which fell to 1.6 children per woman in 1989, Slovenia had, prior to independence, implemented measures to halt the decline.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
National	1980	47.7 abortions/1,000 women aged 15-44	PR
National	1981	49.2 abortions/1,000 women aged 15-44	PR
National	1982	50.6 abortions/1,000 women aged 15-44	PR
National	1983	47.0 abortions/1,000 women aged 15-44	PR
National	1984	46.3 abortions/1,000 women aged 15-44	PR
National	1985	44.9 abortions/1,000 women aged 15-44	PR
National	1986	44.7 abortions/1,000 women aged 15-44	PR
National	1987	41.8 abortions/1,000 women aged 15-44	PR
National	1988	40.8 abortions/1,000 women aged 15-44	PR
National	1989	38.8 abortions/1,000 women aged 15-44	PR
National	1990	35.9 abortions/1,000 women aged 15-44	PR

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

Source: The Population Policy Data Bank maintained by the Population Division of the Department for Economic and Social Information and Policy Analysis 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:

Two physicians must approve an abortion in order for it to be performed. In addition, written consent of the patient's spouse or next of kin is required before any operation can be performed. Parental consent is required if the girl is a minor. There is no time-limit for an abortion to be performed except the one imposed by medical practice, which is usually the first trimester of pregnancy, in order to avoid serious medical risk to the mother. Abortion is free of charge when performed at a government hospital.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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 (1990-1995):	5.4
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	99
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	..
Oceania (around 1988)	600
Female life expectancy at birth (1990-1995):	72.7

Solomon Islands

BACKGROUND

Abortion in the Solomon Islands is regulated by the Penal Code of 1963, chapter 5, which makes abortion generally illegal. According to the law, any person performing an abortion or supplying instruments for that purpose, as well as the pregnant woman, is liable to be prosecuted for a felony. However, the Penal Code also specifies that "no person shall be guilty of an offence—unless it is proved that the act which caused the death of the child was not done in good faith for the purpose of preserving the life of the mother". In this case, two physicians must approve an abortion in order for it to be performed. In addition, written consent of the patient's spouse or next of kin is required before any operation can be performed. Parental consent is required if the girl is a minor. There is no time-limit for an abortion to be performed except that imposed by medical practice, which is usually the first trimester of pregnancy, in order to avoid serious medical risk to the mother. Abortion is free of charge when performed at a government hospital.

Two legal systems, customary and general law, exist side by side in the Solomon Islands, According to custom, a birth is a gift of God and as such is generally accepted even if not desired. In addition, among the native population, the stigma attached to out-of-wedlock pregnancies is less than in many other cultures, and adoption is a common solution for unplanned births. Demand for abortion is therefore relatively low. On the other hand, it has been recognized that frequent pregnancies with short birth intervals and subsequent complications are a major cause of maternal morbidity and mortality. Fertility levels in the Solomon Islands remain high, with the total fertility rate estimated at 5.4 births per woman for the period 1990-1995.

Since the 1970s, the Government has sought to reduce the rate of population growth (which was estimated at 3.4 per cent for the period 1970-1975), mainly through family planning. The family planning programme, which is directed both to improving the health of mothers and children and to reducing population growth, has achieved significant progress. A national population policy was approved by the Government in 1987. In recent years, the Solomon Islands Plannted Parenthood Association has successfully introduced community-based contraceptive distribution programmes in a few areas on a pilot basis. Although there is growing acceptance of family planning among community and traditional leaders, some religious leaders and groups still remain opposed to it. As a result, the Government is developing information programmes to increase awareness of the negative effects of rapid population growth and closely spaced pregnancies.

INCIDENCE OF ABORTION

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

Source: Population Policy Data Bank maintained by the Population Division of the Department for Economic and Social Information and Policy Analysis 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:

Information is not readily available.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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 (1990-1995):	7.0
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	208
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)	1,100
Eastern Africa (around 1988)	680
Female life expectancy at birth (1990-1995):	48.6

Somalia

BACKGROUND

The Somalia Penal Code of 16 December 1962 (articles 418-422 and 424) prohibits abortion except when the woman's life is endangered by the pregnancy. The penalty for performing an abortion without the woman's consent is imprisonment for from three to seven years; if the abortion results in injury to the woman, the prison term is up to eight years; and if the woman dies, it is 10-15 years. Anyone performing an abortion on a woman who is incapable of giving consent, or whose consent is extorted by violence, threat, undue influence or fraud, may be imprisoned for from three to seven years.

The penalty for performing an abortion with the woman's consent is from one to five years in prison; if the abortion causes injury to the woman, the term is from two to six years; and if the abortion results in her death, it is from four to eight years. A woman consenting to or inducing her own abortion may be imprisoned for from one to five years. Any person assisting a pregnant woman in obtaining an abortion may be imprisoned for from six months to two years.

The Somalia Penal Code stipulates that if an abortion is performed to safeguard one's honour or that of a near relative, the penalty may be reduced by from one half to two thirds. Any physician or medical practitioner that performs an illegal abortion with or without the consent of the pregnant woman may receive a harsher penalty and repeat offenders may be barred from medical practice.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

Source: Population Policy Data Bank maintained by the Population Division of the Department for Economic and Social Information and Policy Analysis 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	No
Available on request	No

Additional requirements:

A legal abortion must be performed by a physician in a government hospital or other approved medical institution with the permission of the hospital superintendent. Abortion requires the approval of two independent physicians (besides the physician performing the abortion), one of whom must be a psychiatrist if abortion is sought on mental health grounds or a district surgeon if the pregnancy resulted from unlawful intercourse. One of the consenting physicians must have practised medicine for at least four years. The law prohibits consenting physicians from participating or assisting in the abortion. Authority for an abortion on the grounds of rape, incest or intercourse with a mentally retarded woman may not be granted without a certificate from the local magistrate.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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 (under age 50, 1988):	48
Total fertility rate (1990-1995):	4.1
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	72
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 (1980-1982)	-84
Southern Africa (around 1988)	270
Female life expectancy at birth (1990-1995):	65.9

South Africa

BACKGROUND

Up to 1975, abortion law in South Africa was governed by Roman-Dutch common law, which permitted abortion only when the life of the mother would be endangered by continuation of the pregnancy. In practice, however, physicians often performed abortions on other grounds without prosecution by law enforcement agencies. In 1968, for example, it was estimated that at least 28 per cent of therapeutic abortions were performed for reasons other than saving the life of the mother.

The Abortion and Sterilization Act of 1975 (Act No. 2 of 1975) extended the grounds under which a legal abortion can be obtained in South Africa. The 1975 Act permits abortion if continuation of the pregnancy would endanger the life of the pregnant woman or would constitute a threat to her physical or mental health. Abortion is also permitted if there is substantial risk that the child will be born with severe mental or physical defects, or if the pregnancy resulted from rape, incest or intercourse with a mentally handicapped woman.

A legal abortion requires the approval of two independent physicians (besides the physician performing the abortion), one of whom must be a state psychiatrist if the abortion is sought on mental health grounds or a district surgeon if the pregnancy resulted from unlawful intercourse. In addition, one of the physicians must have practised medicine for at least four years. The law prohibits the consulting physicians from participating or assisting in the abortion.

When abortion is requested because the pregnancy resulted from unlawful intercourse, the magistrate in whose district the offence is alleged to have occurred must provide the hospital superintendent with a certificate attesting to the fact that the alleged offence was reported to the police, or if no complaint was lodged, that there was a good and acceptable reason for it. The magistrate must also certify that after examining all relevant police documents and after interrogating the woman or any other person that might be considered necessary, he is satisfied that unlawful intercourse did indeed take place. If the pregnancy resulted from incest, the magistrate must certify that the woman concerned is within the prohibited degree related to the person with whom she is alleged to have committed incest. Furthermore, the woman must submit a signed affidavit or provide a statement under oath stating her belief that the pregnancy resulted from unlawful intercourse.

A legal abortion must be performed by a registered physician in a government hospital or institution designated for that purpose by the Minister of Health. The written authority of the person in charge of the institution (or his nominee) is required, and such person granting the authority must report all the relevant facts to the Secretary of Health within 21 days after the operation. The report must include the name, age, marital status and race of the patient, the place and date of the abortion, the names and qualifications of the consulting physicians, the name of the magistrate who issued the certificate granting the authority to perform the abortion and the name of the physician performing the abortion. The hospital superintendent must also maintain a file with similar data.

The abortion law of South Africa specifies that physicians and nurses that, on grounds of conscience, do not wish to assist with an abortion, are not obliged to do so.

Anyone that contravenes the law concerning abortion is penalized. Procuring an abortion in contravention of the provisions of the Act is a serious offence, entailing imprisonment for up to five years and/or a fine not exceeding 5,000 rand.

Since the abortion law was liberalized in 1975, the total number of legal abortions performed annually in South Africa has ranged from a low of 347 to a high of 689 during the period 1976-1985. Approximately one half of the legal abortions performed between 1983 and 1985 were on grounds of preserving the mental health of the pregnant woman, 32 per cent on grounds of foetal deformity, 13 per cent to save the life or to preserve the physical health of the mother and 6 per cent on juridical grounds.

The number of abortions performed in South Africa is believed to be much higher than those figures indicate: it has been estimated that at least 200,000 illegal abortions are performed annually. Moreover, South African women sometimes travel to the United Kingdom to obtain an abortion; between 500 and 800 abortions involving South African women were performed in the United Kingdom between 1973 and 1976.

The South African Government views the fertility rates as unsatisfactory because they are too high. It has expressed particular concern about the high level of adolescent fertility and illegal abortion. The Government's target is to reduce the total fertility rate from 4.2 births per woman in 1990-1995 to 2.1 by 2010 and to increase contraceptive use to 80 per cent of fertile women. The Government supports family planning services, and contraceptives are provided free of charge at all government medical establishments.

INCIDENCE OF ABORTION

Place	*Year*		*Measurement*	*Coverage*
National	1985	0.1	abortions/1,000 women aged 15-44	PR
National	1986	0.1	abortions/1,000 women aged 15-44	PR
National	1987	0.1	abortions/1,000 women aged 15-44	PR

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

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

Spain

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:

An abortion must be performed by or under the supervision of a physician in an approved public or private health centre or establishment, provided the pregnant woman gives her express consent and one of the legal indications for abortion is met. A qualified specialist, other than the physician performing or supervising the abortion, must certify that the abortion is necessary to avoid a serious risk to the physical or mental health of the pregnant woman. If the pregnancy is a result of rape, the rape must first be reported to the police and the abortion must be performed within the first 12 weeks of pregnancy. In case of foetal impairment, two specialists from an approved health centre, other than the physician performing or supervising the abortion, must certify that the foetus, if carried to term, would suffer from severe physical or mental defects. Such an abortion must be performed within the first 22 weeks of pregnancy. In case of an emergency involving a risk to the life of the mother, an abortion may be performed without the expressed opinion of the physician and without the consent of the woman. All abortions must be reported to the national health authorities.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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 18-49, 1985):	38
Total fertility rate (1990-1995):	1.4
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	15
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 1988)	26
Female life expectancy at birth (1990-1995):	80.5

BACKGROUND

According to Spanish legislation enacted in 1870 and re-enacted in 1944, all terminations of pregnancy were prohibited except those performed to save the life of the mother. Abortion continued to be generally illegal in Spain under the Criminal Code as promulgated by Decree No. 691 of 28 March 1963; it was permitted only to save the life of the pregnant woman. Anyone that performed an abortion illegally was subject to imprisonment for from six months to six years. Similar penalties were prescribed for a woman that induced her own miscarriage. Physicians and midwives that performed abortions were subject to harsher penalties. In 1983, abortion was decriminalized in certain cases; and in 1984, the Spanish Constitutional Court ruled that a Spanish woman that had an abortion abroad did not commit a crime. In 1985, the Court held that the 1983 amendment was unconstitutional. Controversy arose over the wording "all have the right to life", suggesting that constitutional protection extended to prenatal life. It was argued that the word "person" has only postnatal application and that the unborn are given less protection than persons with regard to right to life. It was felt that the State's constitutional obligation to safeguard prenatal life was not adequately protected under the terms of the 1983 law.

On 5 July 1985, new abortion legislation was adopted (Organic Law No. 9 of 1985), permitting abortion if performed by or under the direction of a physician in an approved public or private health centre or establishment, provided that the woman gave her express consent to the procedure and one of the following conditions was met:

(*a*) The abortion was necessary to avert a serious risk to the physical or mental health of the pregnant woman, in accordance with an opinion expressed prior to the abortion by a physician, other than the one performing the abortion or under whose direction the abortion was to be performed, who held an appropriate specialist qualification;

(*b*) The pregnancy was the result of rape, provided that the rape had been reported to the police and the abortion was performed within the first 12 weeks of pregnancy; or

(*c*) The foetus, if carried to term, would suffer from severe physical or mental defects, provided that the abortion was performed within the first 22 weeks of pregnancy and the medical opinion, communicated prior to the abortion, was expressed by two specialists of an approved public or private health centre or establishment, neither of whom was the physician performing or under whose direction the abortion was to be performed.

A pregnant woman is not subject to a penalty, even if the abortion is not performed in an approved public or private health centre or establishment, or if the prescribed medical opinions have not been expressed. In the case of an emergency that involves a risk to the life of the pregnant woman, an abortion may be performed without the expressed opinion of a physician and without the consent of the woman.

The Order of 31 July 1985 on the practice of abortion in health centres or establishments stipulated the minimum staff and resource requirements for accreditation and the guidelines for specialists and methods employed in the diagnosis of serious physical or psychic handicaps in the foetus. The Order also called for the creation of a commission of evaluation to facilitate the performance of all legal provisions, provide advice whenever problems surfaced and gather statistical information. It also required health centres and establishments to keep clinical histories and documents that record the consent of the woman to an abortion.

By Order of the Ministry of Health of 16 June 1986, all voluntary interruptions of pregnancy carried out in conformity with Organic Law No. 9 of 1985 must be reported to the national health authorities by the Ministry of Health of each Autonomous Community upon receipt of a form filled out by the physician performing the abortion. In order to preserve the confidentiality of the pregnant woman, the form does not require the woman to provide her name; moreover, no individualized data obtained in the forms can be made public. The national health authorities are required to provide local authorities with information concerning abortions, specifying the characteristics of the women on whom abortions are performed.

Spain

Crown Decree No. 2409/1986 of 21 November 1986 repealed the Order of 31 July 1985 and set forth new provisions for the legal performance of voluntary termination of pregnancy in accredited health centres. Among the various provisions, section 4 requires accredited public and private health centres and establishments to retain the case history and the assessments, reports and other documents required for the legal practice of abortion, and the form indicating the express consent of the pregnant woman. This information must be kept confidential. Section 5 states that the health authority in each Autonomous Community is responsible for assuring the availability of the necessary services, including access to the emergency diagnostic techniques needed for abortion to be performed within the established time-limits. Section 6 states that in cases where the abortion is performed to avert a serious danger to the life or physical or mental health of the pregnant woman, physicians in the corresponding specialty are considered accredited in respect of the opinion. When the abortion is performed on the grounds of foetal impairment, the opinion is to be issued by two medical specialists on the staff of a public or private health centre or of an establishment accredited for that purpose. This accreditation, granted to centres equipped to undertake the prescribed diagnostic procedures, is to be granted by the competent agency of the Autonomous Community and is distinct from and independent of the accreditation for performing abortion. Section 9 requires health professionals to inform applicants for abortion of the medical, psychological and social consequences of continuation of pregnancy and of its termination, as well as of the existence of social assistance and family counselling available to applicants. Applicants must also be informed of the various requirements that must be fulfilled, the date of the abortion and the name of the health centre or establishment where it can be performed. A woman must immediately be notified if abortions are not carried out in the department that she attends, so that she may have sufficient time to consult another physician. The confidentiality of consultations must be guaranteed in all cases.

In January 1991, the Supreme Court of Spain sanctioned abortion for the first time on social grounds. The Court dismissed a criminal case brought against a married couple and the friend who helped them, concluding that if the woman had been forced to give birth, her right to the free development of her person would have been violated. The Court pointed to the fact that the couple could not support another child and that the woman was suffering both physically and mentally. This decision, however, does not mean that the abortion law in Spain has changed, especially since the Court upheld the conviction of the physician. It indicates that, in some cases, if a court so chooses, it may exonerate a pregnant woman from guilt on the basis of social grounds. A draft Penal Code published in February 1992 permits abortions to be performed on socio-economic grounds.

In July 1994, a bill that would permit abortion on request after a compulsory three-day waiting period was submitted to the Parliament. An abortion under this indication would have to be performed in a private clinic.

There are no public clinics that offer family planning and abortion services; as a result, most abortions in Spain are performed in private clinics. In 1988, an estimated 94 per cent of all abortions were carried out in private clinics. Approximately 85 per cent of the abortions performed in private clinics are performed on the grounds of averting severe danger to the woman's physical or mental health (especially mental health), which may conceal reasons prohibited by law. The relatively large proportion of hospitals where only a few abortion procedures are performed reflects a general tendency in those institutions to perform abortions only on medical indications.

The Government of Spain considers fertility to be an individual matter and has no explicit policy of intervention with regard to population growth and fertility, although it is aware that various social and economic policies designed to improve the situation of families with children and working mothers can have an impact on demographic trends. The Government desires to achieve lower levels of infant and maternal mortality through an improved health-care system, including maternal health care during pregnancy. Health promotion activities include programmes connected with family planning and sex education. In fact, Government priorities are directed towards improving the health situation in the country through a network of family planning centres. The Government believes that instruction, information and assistance should be made accessible to the entire population so that couples may decide the number and spacing of their children. Contraception was legalized in Spain in 1978 and sterilization has been permitted since 1983.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
National	1987	2.0 abortions/1,000 women aged 15-44	PR
National	1988	3.1 abortions/1,000 women aged 15-44	PR
National	1989	3.6 abortions/1,000 women aged 15-44	PR
National	1990	4.3 abortions/1,000 women aged 15-44	PR
National	1991	4.8 abortions/1,000 women aged 15-44	PR

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

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

Sri Lanka

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:

The Penal Code contains no procedural requirements for the legal termination of pregnancy, except that the pregnant woman's consent is necessary. There are no provisions specifying the qualifications of those authorized to perform abortions nor the type of facilities in which the procedures are to be performed.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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):	41
Total fertility rate (1990-1995):	2.5
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	33
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 (1987)	80
Southern Asia (around 1988)	570
Female life expectancy at birth (1990-1995):	73.8

* Excluding areas containing roughly 15 per cent of the population.

BACKGROUND

Abortion is generally illegal in Sri Lanka under the Penal Code of 1883, which is based on the Indian Penal Code. Section 303 of the Penal Code states that anyone voluntarily causing a woman with child to miscarry is subject to imprisonment for up to three years and/or a fine, unless the miscarriage was caused in good faith in order to save the life of the mother. The penalty is imprisonment for up to seven years if the woman is "quick with child", a term which, while not defined in the Code, refers to an advanced stage of pregnancy when there is perception of foetal movement, as opposed to "woman with child", which simply refers to "being pregnant". A woman that induces her own miscarriage is subject to similar penalties. According to section 304 of the Penal Code, a person that causes a woman to miscarry without her consent, whether or not she is quick with child, is subject to imprisonment for up to 20 years. Section 305 of the Penal Code describes acts committed, with or without the consent of the woman, with intent to cause a miscarriage that results in her death, even if the person committing the act did not know that it probably would cause death. Section 306 of the Penal Code states that anyone that before the birth of a child, commits any act with the intent of preventing that child from being born alive, or causing it to die after its birth, will be imprisoned for up to 10 years or fined or both, unless the act was caused in good faith for the purpose of saving the life of the mother.

In 1973, the abortion legislation of the country was studied by a committee of the Medical Legal Society of Sri Lanka, which recommended that the law be extended to allow for abortions that would prevent grave injury to the physical and mental health of the mother, in cases where pregnancy resulted from rape or incest and where there was substantial risk that the child, if born, would suffer from severe physical or mental abnormalities which would cause it to be seriously handicapped for life. The final report of the Committee did not introduce rape or incest as legal grounds for abortion.

Despite rigid statutory provisions, Sri Lankan women from higher income households that desire to terminate their pregnancies find little or no difficulty in doing so. They often consult psychiatrist for severe mental depression combined with suicidal tendencies. The psychiatrist may advise an abortion in order to save the life of the mother and the pregnancy may then be terminated in a private or government hospital by a qualified medical practitioner. Women from middle-income and lower income households, however, must often resort to abortions performed by "back-door abortionists" under primitive and unhygienic conditions, resulting in high maternal mortality and chronic ill health.

Although any abortion wilfully induced without the specific intent to save the life of the mother constitutes illegal abortion in Sri Lanka, in practice, indictment for criminal abortion rarely occurs and convictions are even rarer. The incidence of abortion is believed to be considerably higher than is commonly acknowledged. A rural survey suggests that 54 abortions per 1,000 population are performed each year.

The Government of Sri Lanka considers the rates of fertility and population growth to be too high and hopes to achieve a target of replacement-level fertility before the year 2000. Recognizing the importance of a reduction in fertility in the enhancement of socio-economic development, the Government has sought to strengthen and expand the delivery of family planning services, to provide incentives for controlling population growth and to promote population education. Family planning services are part of a comprehensive family health programme which provides a variety of subsidized clinical and contraceptive services. Existing maternal and child health and family planning services are being enhanced, especially in rural and poor urban areas.

Sri Lanka

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

Source: Population Policy Data Bank maintained by the Population Division of the Department for Economic and Social Information and Policy Analysis 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	No
Economic or social reasons	No
Available on request	No

Additional requirements:

Information is not readily available.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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, 1989/90):	6*
Total fertility rate (1990-1995):	6.1
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	106
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 (1988-89)	550
Northern Africa (around 1988)	360
Female life expectancy at birth (1990-1995):	53.0

* Data refer to Northern Sudan.

Sudan

BACKGROUND

Under the Sudan Penal Code of 1 August 1925 (sections 262-267), abortion was prohibited except when performed to save the life of the pregnant woman. In 1991, criminal legislation designed to conform to the principles of Islamic law was enacted, somewhat liberalizing the existing abortion legislation. Provision was made for two new indications for the legal performance of abortion. A person is not liable to punishment if the pregnancy is the result of rape and the abortion is performed within the first 90 days of the pregnancy, or if it can be proved that the embryo was dead in the mother's womb. As of 1991, the new legislation did not apply to Southern Sudan.

Under the 1925 Code, transgression of the law was harshly punished. A person performing an abortion with the woman's consent was subject to imprisonment for a term not exceeding three years and/or a fine; the person performing the abortion was subject to a prison term of up to seven years and/or a fine if the pregnancy had proceeded to the "quickening" stage and up to 10 years and/or a fine if the abortion resulted in the death of the pregnant woman. A woman inducing her own miscarriage was subject to imprisonment for up to three years and/or a fine. However, an unmarried woman that induced her own miscarriage to conceal her dishonour could receive a reduced sentence of two years in prison and/or a fine. The penalty was harsher if the abortion was performed without the consent of the pregnant woman. A person performing an abortion without the woman's consent could be imprisoned for up to 10 years or be subject to life imprisonment if the abortion resulted in her death. A person that used force and in the process caused a woman to miscarry could be imprisoned for a term not exceeding three years and/or a fine, and to a term not exceeding five years and/or a fine if the offender was aware that the woman was pregnant.

Based on the 1991 legislation, all illegal abortions are punishable by imprisonment for up to three years and/or a fine. The new legislation also introduced the concept of personal compensation for all illegal abortions. Notwithstanding the imprisonment or fine imposed on the person performing the illegal abortion, the family of the aborted foetus has a right to receive compensation from that person.

Information on the incidence of induced abortion in the Sudan is scarce. However, a survey conducted at Khartoum between 1974 and 1976 found that the largest proportions of gynaecological admissions were due to complications of induced abortion. A similar observation has been made in Southern Sudan. Indeed, studies have found abortion to be one of the major causes of maternal death in the Sudan.

The Government of the Sudan provides direct access to modern methods of family planning. Family planning services were introduced in the country in 1965 when the Sudan Family Planning Association was founded. The maternal and child health (MCH) and family planning project within the Ministry of Health was established in 1975 and the Sudan Fertility Control Association in 1976. The Sudan Family Planning Association and the Sudan Fertility Control Association provide family planning services throughout the country. The main rationale for family planning is to improve MCH. Family planning services are provided free of charge and there are no legal restrictions on the importation of contraceptives. Recent studies show that the level of contraceptive use is low but has increased slightly. The percentage of women using modern methods of contraception in Northern Sudan rose, for example, from 4 per cent in the Sudan Fertility Survey in 1977-1978 to 6 per cent in the Sudan Demographic and Health Survey in 1989.

INCIDENCE OF ABORTION

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

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

Suriname

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 is not readily available.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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 (1990-1995):	2.7
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	62
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	..
South America (around 1988)	220
Female life expectancy at birth (1990-1995):	72.8

BACKGROUND

The Criminal Law of Suriname forbids abortion or the deliberate termination of life. Abortion, whether induced by the woman herself or performed by a health professional, with or without the permission of the pregnant woman, is considered illegal. The provision of an abortifacient is classified as a misdemeanor or lesser crime.

Anyone intentionally interfering with a pregnancy, providing treatment or subjecting a woman to treatment that would interfere with or terminate her pregnancy is subject to a maximum penalty of three years in prison or a fine of 3,000 guilders (Sf). The penalty for a person that commits such an offence for profit or engages in the practice of terminating pregnancies professionally, or is a medical practitioner, midwife or pharmacist, may be increased by one third. A professional that terminates a pregnancy may forfeit his right to practise his profession. A person intentionally causing an abortion or the death of a foetus without the consent of the pregnant woman is subject to a maximum penalty of 12 years in prison; if the action leads to the death of the woman, the penalty is a maximum of 15 years in prison. A person intentionally causing an abortion or the death of a foetus with the consent of the pregnant woman is subject to a maximum penalty of four years and six months in prison; if the action leads to the death of the woman, the penalty is a maximum of six years in prison. If the person found guilty of causing an abortion or the death of a foetus is a medical practitioner, midwife or pharmacist, the penalty may be increased by one third and the person may be barred from practising his or her profession.

A woman that intentionally induces her own abortion or causes the death of a foetus, or has someone do it for her, may be imprisoned for a maximum of three years.

Although abortion is prohibited and no grounds for legal abortion exist under the Criminal Code, the procedure may be performed under the medical professional code if there is immediate acute danger to the life of the woman.

Although the provision of contraceptives and contraceptive information is illegal under the country's Criminal Law, the laws are not enforced and there has been no legal interference with the activities of the country's family planning organization, the Stichting Lobi (LOBI), which works to integrate family planning into the Government's primary health-care system and to include sex education in the school curriculum. The Stichting Lobi, which was founded in 1969, operates clinics, provides family planning services through private physicians, offers medical/clinical services, conducts sex education classes in schools, offers counselling services, trains health workers, educates patients at prenatal clinics and conducts a wide range of community education activities. It is also involved in various research projects to assess attitudes and constraints on contraceptive use, and it sponsors media campaigns on family planning.

The Government of Suriname considers the current rate of fertility and population growth to be satisfactory. Although it has no official population policy, the Government supports the availability of accessible and affordable health services, focusing on the development of primary health care and supporting the provision of contraceptives.

Suriname

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

Source: Population Policy Data Bank maintained by the Population Division of the Department for Economic and Social Information and Policy Analysis 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:

Although there are no legal provisions specifying by whom or where a legal abortion must be performed or the gestational limits to be observed, practice suggests that legal abortions are performed by registered physicians in government hospitals, private clinics or other approved institutions and may be performed up to 20 weeks of gestation.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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):	17
Total fertility rate (1990-1995):	4.9
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	121
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)	120
Southern Africa (around 1988)	270
Female life expectancy at birth (1990-1995):	59.8

* Including never-married women who have a child.

Swaziland

BACKGROUND

Abortion legislation in Swaziland is based on Roman-Dutch common law, which prohibits abortion except when performed in good faith to save the life of the pregnant woman. In practice, however, abortions are sometimes performed on the grounds of medical necessity (physical, mental or eugenic) or when the pregnancy is the result of rape.

There are no legal provisions on the professional qualifications required to perform an abortion or where the procedure must be conducted, nor any gestational limits to be observed. Abortions are usually performed by a registered physician in a government hospital or other approved institution and may be performed within 20 weeks of gestation. Swazi physicians generally seek permission from the Ministry of Health prior to performing an abortion. Although this permission is not a legal requirement, it is a precaution that physicians have chosen to take in order to protect themselves and to prove their good faith. It appears that the only requirement for a legally justified abortion is that the person performing the abortion must both be satisfied that the woman's physical or mental health is endangered by the birth and must act in good faith (not for economic gain or to support a movement for abortion law reform or other non-therapeutic motive). There are no data concerning the number of legally induced abortions, but it is believed that the numbers are small.

The high incidence of illegal abortion is a growing concern in Swaziland. Induced abortion is a particularly significant problem among teenage girls. Faced with the prospect of an unwanted pregnancy, many teenage girls resort to abortion to avoid expulsion from school. Unmarried teenage women are more likely to have unwanted pregnancies because of the barriers they face in obtaining contraceptives. For example, it is reported that health workers often require proof of the husband's authorization before dispersing contraceptives, even though this is not a legal requirement.

The Government recognizes that the current levels of population growth and fertility are too high and the Government's goal is to reduce the level of fertility in order to improve family well-being and maternal and child health. Contraceptives are provided at all government health-care centres. The national family planning programme, which was launched in 1973, provides family planning services at all its service delivery centres and mobile units. The family planning programme has achieved a certain measure of success. The Family Health Survey in 1988 showed that more than 80 per cent of women knew at least one effective contraceptive method. In addition, 17 per cent of all women reported use of a modern contraceptive method in 1988, up from about 5 per cent in 1985.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

Source: Population Policy Data Bank maintained by the Population Division of the Department for Economic and Social Information and Policy Analysis 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:

Abortion is legal in Sweden on a wide variety of grounds, including on request, up to 18 weeks of gestation, provided that the procedure will not seriously endanger the woman's life or health. For pregnancies between 12 and 18 weeks of gestation, the pregnant women is required to discuss the abortion with a social worker; after 18 weeks, permission must be obtained from the National Board of Health and Welfare. The abortion must be performed by a licensed medical practitioner and, except in cases of emergency, in a general hospital or other approved health-care establishment. Abortion is subsidized by the Government.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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 20-44, 1981):	72
Total fertility rate (1990-1995):	2.1
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	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 (1989)	5
Developed countries (around 1988)	26
Female life expectancy at birth (1990-1995):	80.8

Sweden

BACKGROUND

Inducing abortion was considered a crime in Sweden at the beginning of the twentieth century, and both the sale of contraceptives and dispensing information on contraceptives were banned by law in 1910. In 1938, the first Abortion Act in Sweden permitted the termination of pregnancy under certain conditions. This Act, which remained in force with some minor amendments until 1975, provided that abortion, although forbidden in principle, could be permitted for eugenic, humanitarian or medical reasons. Abortion was restricted to cases of hereditary disease, rape or incest, or those where the pregnant woman had a serious medical condition (for example, severe heart disease or tuberculosis) or was in poor physical health due to frequent child-bearing. The approval of the National Board of Health and Welfare or the joint approval by two physicians was required for an abortion prior to 20 weeks of gestation; after this period, the abortion had to be approved by the National Board. Abortion was prohibited after 24 weeks of gestation, except when the woman's life or health was at risk. Women that did not meet the requirements and wished to terminate their pregnancies resorted to illegal abortions.

The 1938 Act was amended in 1946 to permit abortion to be performed on socio-medical grounds—interpreted as physical or mental risk to the pregnant woman or the likelihood of such risk if she were to bear the child. The amendment stipulated that a woman seeking an abortion had to consult a social worker, who would investigate the woman's situation and help her prepare the application. Social workers were expected to offer social and economic assistance so that a woman could reconsider her decision or provide her with support if the application for abortion was refused by the physicians or the National Board. In 1963, the Abortion Act was amended again to include "injury to the foetus" as a ground for the termination of pregnancy.

In 1965, a government committee was assigned to study the application of the 1938 Abortion Act and to consider alternatives for future legislation. The committee's report proposed that a woman should have an unconditional right, without any time-limit, to decide whether to terminate her pregnancy. The report also contained many suggestions about family planning services in the public-health system.

The final version of the committee's recommendations was approved by the Swedish Parliament and became known as the Swedish Abortion Law of 14 June 1974. The law, which came into effect in 1975, permits the interruption of pregnancy on request, provided there are no medical contraindications (that is, that the procedure will not seriously endanger the woman's life or health), within 18 weeks of gestation. For pregnancies between 12 and 18 weeks of gestation, the pregnant woman is required to discuss the abortion with a social worker. An abortion may be performed only on Swedish citizens or residents, or in cases where the National Board of Health and Welfare grants the authorization on special grounds. Only persons licensed to practise medicine may perform an abortion. Except in cases of emergency, the procedure must be carried out in a general hospital or in another health-care establishment approved by the National Board of Health and Welfare. Abortion is provided free of charge up to 18 weeks of pregnancy.

Abortion after 18 weeks of gestation is legal only if the National Board of Health and Welfare authorizes the procedure based on substantive grounds. A threat to the life or health of the mother, or eugenic, juridical, socio-economic and other grounds, may justify the authorization of an abortion if they can be determined to be substantive grounds. In cases of emergency, a physician may perform an abortion without such authorization. However, the authorization may not be granted if there are grounds for assuming that the foetus is viable. The Abortion Law makes no specific provision for consent.

Non-physicians that perform or attempt to perform an abortion are subject to a fine or imprisonment for a maximum of one year. This penalty does not apply to a woman that terminates her own pregnancy or cooperates in such a termination.

Since the new Abortion Act went into effect in 1975, the procedure for having an abortion in Sweden has been simplified, making it possible for more women to obtain an abortion early in their pregnancy. Ninety-five per cent

of abortions are performed within 12 weeks of gestation. Since 1975, between 30,000 and 37,000 abortions have been performed annually in Sweden, constituting 18-21 abortions per 1,000 women aged 15-44 years, or 24-26 per cent of known pregnancies. Illegal abortion is not known to exist in Sweden.

The Government of Sweden considers the rates of fertility and population growth to be satisfactory. The Government does not have an explicit population policy to achieve specific demographic objectives and does not intervene to influence the rates. Population is integrated within development planning and various Government agencies are responsible for taking population variables into account. The Swedish social welfare system lessens the financial burdens of child-bearing and child-rearing. Maternity and paternity leave is available for up to 290 days, during which time 90 per cent of wages are paid. Sixty days of paid leave are also provided annually if a family is caring for a sick child. A system of family allowances pays 750 Swedish kronor (Skr) a month until the child reaches the age of 16 for one child, SKr 1,500 for two children, SKr 2,625 for three children, SKr 4,125 for four children and SKr 6,000 for five children. Family planning services, integrated within maternal and child health care, have been established throughout the country. The emphasis is on preventive measures and the reduction of the number of abortions. Sterilization is available upon request in Sweden to those over 25 years of age and with medical approval to those under age 25.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
National	1970	10.2 abortions/1,000 women aged 15-44	PR
National	1975	20.3 abortions/1,000 women aged 15-44	PR
National	1980	20.7 abortions/1,000 women aged 15-44	PR
National	1985	17.7 abortions/1,000 women aged 15-44	PR
National	1986	18.9 abortions/1,000 women aged 15-44	PR
National	1987	19.8 abortions/1,000 women aged 15-44	PR
National	1988	21.4 abortions/1,000 women aged 15-44	PR
National	1989	21.5 abortions/1,000 women aged 15-44	PR
National	1990	21.2 abortions/1,000 women aged 15-44	PR
National	1991	20.4 abortions/1,000 women aged 15-44	PR

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

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

Switzerland

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 performed by a physician, with the woman's written consent, and except in an emergency, with the written approval of a second physician. Swiss law does not set a time-limit for therapeutic abortion, nor does it require compulsory counselling or a waiting period before an abortion can be performed.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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 (1980*):	65
Total fertility rate (1990-1995):	1.7
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	5
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 (1990)	6
Developed countries (around 1988)	26
Female life expectancy at birth (1990-1995):	81.2

* Sample of husbands and wives married between 1970 and 1979.

BACKGROUND

The Swiss Penal Code prohibits abortion except for therapeutic termination of pregnancy on medical grounds. The law, which became effective in 1942, is one of the oldest in Europe and applies to all 26 cantons of Switzerland. Under article 120 of the Penal Code, a pregnancy may be terminated by a licensed physician, with the woman's written consent, in order to avoid a danger to her life, or in the case of a serious, otherwise unavoidable danger of severe or lasting injury to her health. Abortion is not permitted on eugenic or socio-economic grounds, nor is it permitted on request. In cases of rape, however, an abortion may sometimes be performed by the extension of the definition of medical grounds to include rape. Before performing an abortion, the physician must obtain written consent from the pregnant woman; if she is incapable of giving consent, her legal representative must provide the written consent. The physician must also obtain a written opinion from a second physician who is familiar with the woman's condition and who is designated by the authorities in the canton where the woman resides or where the abortion will be performed. In case of an emergency, an abortion may be performed without a consenting second opinion, with the stipulation that the physician notify the cantonal authorities within 24 hours following the operation. A physician that fails to notify the authorities after performing an emergency abortion may be fined or imprisoned for up to three months.

Swiss law does not provide a time-limit for therapeutic abortion, nor is parental consent required for minors. In practice, however, physicians are reluctant to perform an abortion during the second trimester; these abortions are almost always performed in hospitals by prostaglandin procedures.

Under article 118 of the Swiss Penal Code, a woman inducing an abortion or having it induced is subject to a prison term of from three days to three years. Based on several federal court rulings, any person that attempts to perform an abortion on a woman that is not actually pregnant is also subject to punishment. Article 119 states that any person performing an abortion on a consenting woman may be imprisoned for up to five years. Performing an abortion on a woman without her consent is punishable by up to 10 years of imprisonment; the sentence is a minimum of three years if the person performing the abortion does so for economic gain.

Although the provisions of the Swiss Penal Code are highly restrictive and have not changed since 1942, they are subject to differences in interpretation; some cantons are known for their liberal interpretations of the law, while others remain quite restrictive.

Given that the wording of the Swiss abortion law leaves room for interpretation and the fact that the cantons are authorized to designate the physicians that can provide a second opinion, abortion practices began to evolve differently in the various cantons soon after the enactment of the Penal Code. In fact, within a few years of its enactment, six cantons already had very liberal abortion practices. The interpretation of the law has become increasingly liberal over the years. Currently, psychosocial grounds for the termination of pregnancy are broadly accepted, accounting for more than 95 per cent of abortions. Indeed, in the more liberal cantons, it is rare for a woman requesting an abortion to be refused; virtually any woman wishing to terminate her pregnancy is able to have a legal abortion. Over the past 20 years, more cantons have pursued a liberal interpretation, while those which were previously restrictive have shifted to a somewhat more moderate position. In a few cantons, however, it is not possible to obtain a legal abortion. In some cantons, abortions are performed by physicians (both gynaecologists and general practitioners) in their private offices or in private clinics under local anaesthesia and on an out-patient basis. In other cantons, abortions are performed mainly in public hospitals or private clinics, usually under general anaesthesia, with a hospital stay of from one to three (or more) days.

Prior to the 1970s, Swiss abortion practices were among the most liberal in Western Europe. As a result, pregnant women from other countries sought safe, legal abortions in the Swiss cantons where "health" was interpreted more broadly. Attempts in the 1970s to reformulate Swiss abortion law along the lines of the more liberal abortion legislation then being adopted in other Western European countries were not successful. The debate on whether to relax or restrict the abortion law, which lasted more than 15 years, had very little impact at the

legislative level. Two laws were passed in 1981, however, one obliging cantons to create counselling services for pregnant women, the other ordering health insurance to reimburse (without exception) the cost of legal abortion.

Prior to the enactment of the Swiss Penal Code, illegal abortion was seldom prosecuted, despite the fact that it was widely practised. In 1929, there were 72 convictions in Switzerland; after the passage of the abortion law in 1942, the number rose sharply and peaked in 1950 with 667 convictions. Subsequently, the increasingly liberal interpretation of the law resulted in a decline in the number of prosecutions of illegal abortion; in the late 1960s, there were, on average, 150 prosecutions per annum and after the initiation of public discussions to decriminalize abortion in 1971, prosecutions declined further to only a few each year. Very few illegal abortions were being performed in Switzerland in the early 1990s, with most of them consisting of abortions performed by physicians that failed to obtain the mandatory second opinion. There are no reported cases of women entering hospitals in Switzerland as a result of complications following clandestine abortions. Since 1973, there have been no reported deaths resulting from abortion.

The Government of Switzerland considers the rate of population growth to be satisfactory but the fertility level to be too low. The Government intends indirectly to increase the fertility rate by establishing an atmosphere of economic security and well-being for children and families in all socio-economic sectors. Family assistance services, family counselling, marriage guidance centres and pregnancy advisory services were expanded in the 1980s. Maternity allowances introduced in 1987 include an entitlement of 16 weeks beginning at the time of confinement. A system of family allowances exists at both the federal and the cantonal level, with the amount varying according to region, occupation, canton and number of children.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
National	1970	12.1 abortions/1,000 women aged 15-44	PR
National	1980	12.7 abortions/1,000 women aged 15-44	PR
National	1985	9.9 abortions/1,000 women aged 15-44	PR
National	1986	9.6 abortions/1,000 women aged 15-44	PR
National	1987	8.4 abortions/1,000 women aged 15-44	PR
National	1988	8.6 abortions/1,000 women aged 15-44	PR
National	1989	8.6 abortions/1,000 women aged 15-44	PR
National	1990	8.7 abortions/1,000 women aged 15-44	PR

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

Source: Population Policy Data Bank maintained by the Population Division of the Department for Economic and Social Information and Policy Analysis 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:

Authorization for an abortion must be issued by two physicians. Written consent is required from the woman and her spouse or guardian.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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, 1978):	15
Total fertility rate (1990-1995):	6.2
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	112
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 (1990)	143
Western Asia (around 1988)	280
Female life expectancy at birth (1990-1995):	69.2

Syrian Arab Republic

BACKGROUND

Induced abortion is generally illegal in the Syrian Arab Republic. The law clearly forbids physicians or midwives to perform an abortion by any means whatsoever, except if continuation of the pregnancy endangers the woman's life. Where such a danger exists, an abortion may be performed provided that: (*a*) it is carried out by a medical specialist with the agreement of another physician; (*b*) a certificate is drawn up before the operation to the effect that the abortion is absolutely necessary; (*c*) a written record is prepared with at least four copies, signed by the two physicians, the patient and the spouse or guardian, and with a copy being retained by the patient's family and each of the physicians.

Penalties are reduced for abortion in certain circumstances. Article 531 of the Penal Code states that a woman aborting herself to save her honour and a guilty person under article 528 and 529 acting with the purpose of saving the honour of the descendant or relative to the second degree shall benefit from mitigating circumstances. The penalty for violators is from one to three years of imprisonment for the performer if he or she is not a medical specialist and up to three years for the woman. Physicians and pharmacists that perform an abortion receive harsher penalties.

Data on the incidence of induced abortion in the Syrian Arab Republic are scarce. However, one study of family formation and pregnancy outcome conducted in 1981 found that out of 31,567 pregnancies reported by 5,621 women, 9.6 per cent terminated in abortion.

The Government's involvement in family planning began in 1974, when it announced plans to integrate family planning into its health-care programme by establishing the Family Planning Unit as a component of its maternal and child health (MCH) programme. The Family Planning Unit works in collaboration with the Syrian Family Planning Association, which began providing family planning services in the Syrian Arab Republic in 1974. The Government supports family planning activities through a network of MCH centres. It sets no major limits on contraceptives and directly supports their use. National statistics report 94,513 new acceptors and 460,258 clinic visits to the family planning programme in 1988, numbers which have risen steadily over the years. In 1988, 71 per cent of new acceptors chose oral contraceptives, 17 per cent used an intra-uterine device and 11 per cent chose other methods. Efforts are under way to provide a wider mix of contraceptives and to reduce the dependence upon oral contraceptives. To improve the success of the family planning programme, local leaders have been consulted, greater use has been made of traditional birth attendants, cooperation has been encouraged among a wide variety of organizations, such as women and youth groups; and literacy and agricultural extension programmes have been used to disseminate information.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

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

Tajikistan

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 if performed by a licensed physician in a hospital or other recognized medical institution. Abortion is available on request during the first 12 weeks of gestation. Thereafter, induced abortion is available within 28 weeks from conception on judicial, genetic, vital, broad medical and social grounds, as well as for personal reasons with the special authorization of a commission of local physicians.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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, 1990):	15
Total fertility rate (1985-1990):	5.4
Age-specific fertility rate (per 1,000 women aged 15-19, 1985-1990):	38
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 (1991)	53
Developed countries (around 1988)	26
Female life expectancy at birth (1985-1990):	71.9

Tajikistan

BACKGROUND

As was the case with all of the former Soviet republics, Tajikistan, known prior to 1992 as the Tajik Soviet Socialist Republic, observed the abortion legislation and regulations of the former Union of Soviet Socialist Republics. As a result, abortion practices in Tajikistan were similar to those throughout the former USSR.

The description given below pertains to the situation in Tajikistan prior to independence.

The Soviet law of 27 June 1936 prohibited induced abortion in most circumstances, permitting it only for vital and eugenic reasons. Physicians and non-medical personnel that performed abortions in hospitals or as part of an out-patient service were subject to a maximum of three years in prison. A husband, relative or physician that pressured a woman into having an abortion could be sentenced to a maximum of two years in prison. The pregnant woman could be prosecuted by public trial and/or be required to pay a large fine.

In a decree of 23 November 1955, the Soviet Government repealed the prohibition of abortion. Regulations issued in 1956 and subsequently in 1982 specified that abortions could be performed during the first 12 weeks of gestation, although not less than six months after a woman's previous abortion. An abortion was considered illegal if not performed in a hospital or if the person performing the abortion did not have an advanced medical education. The maximum penalty for an illegal abortion was set at eight years in a labour camp.

In 1974, the Ministry of Public Health of the USSR published a document entitled "On the side- effects and complications of oral contraceptives", in which the mass use of oral contraception was de facto prohibited. On 5 June 1987, in Order No. 757, the Ministry of Public Health legalized and officially permitted the provision of early vacuum aspirations in any clinic regardless of the place of residence of the woman. Vacuum aspiration had been the method of induced abortion provided during the first 20 days of pregnancy with the obligatory diagnosis of pregnancy.

During the 1980s, the Ministry of Public Health continued its efforts to decrease the number of illegal abortions by formally broadening the grounds on which abortions were legal and increasing their availability. Most of the later changes, however, were not followed by a simultaneous increase in actual accessibility of abortion services. On 31 December 1987, the Ministry of Public Health published Order No. 1342, which permits induced abortion during the first 28 weeks of gestation on judicial, genetic and broad medical and social grounds (for example, more than five children in the family), as well as on request with the special authorization of a commission of local physicians.

The high incidence of abortion has been attributed to a number of factors, including shortages of high-quality modern contraceptives and reliance upon less reliable traditional methods, a lack of knowledge among couples of contraception and of the detrimental health consequences of frequent abortions and the absence of adequate training for physicians, nurses, teachers and other specialists. In 1989, the availability of condoms in the entire former Soviet Union amounted to only 11 per cent of demand; intra-uterine devices, 30 per cent; and pills, 2 per cent. Data from the All-Union sample survey of contraceptive use conducted in 1990 indicate that in Tajikistan, 15 per cent of all women aged 15-49 years regularly used contraception, 6 per cent sometimes used contraception, 59 per cent did not use any contraceptive method and 18 per cent knew nothing about contraception.

In 1989, a total of 59,494 induced abortions were registered in Tajikistan, giving an abortion rate of 49.5 per 1,000 women aged 15-44 years. The actual figure is much higher, because this total does not include most abortions performed in departmental health services and commercial clinics, early vacuum aspirations and self-induced abortions. In 1988, 4 per cent of all induced abortions were performed on primigravidae and 2 per cent of all induced abortions were vacuum aspirations. In 1989, illegal abortions, calculated on the basis of their

registered complications, accounted for 40 per cent of all abortions and 61 per cent of all abortions among primigravidae. Among women under age 17, they accounted for 24 per cent of all induced abortions.

Maternal mortality rates in Tajikistan were 94.2 and 43.6 per 100,000 births in 1980 and 1988, respectively, one of the highest rates in the former Soviet Union. In 1988, 65 per cent of all maternal deaths were due to unknown or "other" causes.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
National	1970	66.8 abortions/1,000 women aged 15-44	PR
National	1975	59.1 abortions/1,000 women aged 15-44	PR
National	1980	49.8 abortions/1,000 women aged 15-44	PR
National	1985	43.8 abortions/1,000 women aged 15-44	PR
National	1988	40.9 abortions/1,000 women aged 15-44	PR
National	1989	49.5 abortions/1,000 women aged 15-44	PR
National	1990	47.0 abortions/1,000 women aged 15-44	PR
National	1991	44.4 abortions/1,000 women aged 15-44	PR

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

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

Thailand

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:

A legal abortion must be performed by a physician.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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, 1987):	66
Total fertility rate (1990-1995):	2.2
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	20
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)	37
South-eastern Asia (around 1988)	340
Female life expectancy at birth (1990-1995):	71.9

BACKGROUND

Sections 302-305 of the Thai Penal Code of 1956 (Law of 2,499 Buddhist Era) generally regulate abortion in Thailand. According to the Code, abortion is prohibited except when necessary to save the life or health of a pregnant woman or when the pregnancy is a result of rape or certain other crimes. The law requires that a legal induced abortion be performed by a physician.

The penalty for transgression of the law is imprisonment for up to three years and/or a fine of up to 6,000 baht (B) for a woman that induces her own miscarriage or allows other person to procure an abortion for her (section 301); for a person performing an abortion with the consent of the woman, the penalty is imprisonment for up to five years and/or a fine of up to B10,000 (section 302). The penalty for the person performing the abortion is increased to imprisonment for up to seven years and/or a fine of up to B14,000 if the abortion was procured without the woman's consent (section 303). If other grave bodily harm to the woman was caused by an abortion, the person performing the abortion may be subject to imprisonment for up to seven years and/or a fine of up to B14,000 if the woman consented to the abortion or to imprisonment for up to 10 years and/or a fine of up to B20,000 if the abortion was performed without her consent. If an abortion causes the death of the woman, the offender that procured the abortion with the woman's consent is subject to imprisonment for up to 10 years and/or a fine of up to B20,000 or to imprisonment of up to 20 years and/or a fine of B10,000-14,000 if she did not consent to the abortion.

In practice, the law is not rigorously enforced. The prevalence of illegal abortion has been widely documented, particularly in the rural areas of the country. One estimate suggests that, in the late 1970s, at least 300,000 illegal abortions were performed in rural Thailand. Most illegal abortions are performed by non-medical personnel, such as self-trained practitioners, within the first trimester of pregnancy. Whereas abortions can be obtained in urban hospitals using vacuum curretage, the most frequently used procedure in rural areas is traditional massage abortion, followed by uterine injections. Some studies have shown that for a majority of women in rural areas, the stated reason for obtaining an abortion was to limit family size. A significant proportion of women also expressed the need for child-spacing.

Although maternal mortality in Thailand has been considerably reduced over the past two decades, wide disparities remain between urban and rural areas with regard to maternal and child health care. Because the increasing number of illegal abortions are performed under unsanitary conditions by unqualified practitioners, hospitalization for complications from illegal abortion has been rising in many hospitals in Thailand. One study conducted in 1981 found that in Ramathibodi Hospital at Bangkok, one fourth of maternal deaths were due to complications from induced abortions improperly performed outside the hospital. In another study conducted in 1979 on the health consequences of induced abortion in north-eastern Thailand, the abortion rate in the rural province of Chayapoom was estimated to be as high as 107 per 1,000 women of reproductive age (15-49); the same study estimated a complication rate of about 25 per cent. An increasing trend has also been observed for adolescent pregnancies and abortions in Thailand. A 1982 study indicated that more than 25 per cent of the women that received abortions were aged 15-20 years.

Since the 1960s, the Government of Thailand has sponsored an active and effective national family planning programme. The service network of the Thai Family Planning Programme has tried to provide complete, accessible family planning services free of charge. At least two thirds of married Thai women of reproductive age are currently using contraception. Consequently, fertility has fallen dramatically in Thailand, in both urban and rural areas. Despite the ready availability of contraceptives, however, several studies have shown that a significant proportion of abortion patients were not practising any method of contraception prior to the most recent abortion. The Government has attempted to direct family planning programmes increasingly towards the poor and uneducated in order to ensure access to contraceptive services by these high-risk groups.

Thailand

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
National	1972/73	12.5 abortions/100 live births	HR

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

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

The former Yugoslav Republic of Macedonia

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 in a hospital or other authorized health-care facility. If the woman is a minor, approval of her parents or guardian is required, unless she has been recognized as fully competent to earn her own living. After the first 10 weeks of pregnancy, special authorization by a commission composed of a gynaecologist-obstetrician, a general physician or a specialist in internal medicine and a social worker or a psychologist is required.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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 (1990-1995):	..
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	..
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 (1990)	11
Developed countries (around 1988)	26
Female life expectancy at birth (1990-1995):	..

The former Yugoslav Republic of Macedonia

BACKGROUND

The former Yugoslav Republic of Macedonia achieved independence from the former Socialist Federal Republic of Yugoslavia in 1993 and ratified a new constitution. However, abortion is still regulated by the Law of 7 October 1977 passed by the former Yugoslavia to implement article 191 of the Federal Constitution of Yugoslavia of 21 February 1974, which proclaims that "it is a human right to decide on the birth of children". According to the law of the former Yugoslav Republic of Macedonia, abortion is allowed on request during the first 10 weeks of pregnancy. The intervention must be performed in a hospital or other authorized health-care facility. If the woman is a minor, approval of her parents or guardian is required, unless she has been recognized as fully competent to earn her own living. After the first 10 weeks of pregnancy, special authorization by a commission, composed of a gynaecologist-obstetrician, a general physician or a specialist in internal medicine and a social worker or a psychologist, is required. The Commission decides on the basis of the existence of medical, eugenic, juridical, economic or social grounds. The woman can appeal to the Commission of Second Instance if the Commission of First Instance rejects her request. After 20 weeks of gestation, abortion may be allowed only to save the life or health of a seriously endangered woman. For women with at least three children, abortions are performed free of charge.

Penal provisions are imposed on medical organizations and persons that violate provisions of the law. A woman, however, is never held criminally responsible for inducing her own abortion or for cooperating in such a procedure.

Beginning in 1952, abortion legislation in the former Yugoslavia was liberalized in response to the significant increase in illegal abortions associated with high levels of morbidity and mortality. The subsequent changes in the abortion laws—general principles were adopted at the federal level and laws were implemented at the local level—were expressly directed to facilitating access to legal abortion in order to discourage illegal practices. For instance, a significant decline in the number of illegal abortions is attributed to the decision in 1969 to eliminate the requirement of a commission's approval for termination of pregnancies of less than 10 weeks, a requirement which had been a practical and psychological obstacle to abortion. The policy of liberalizing legal regulations with regard to abortion was facilitated by increased numbers of medical facilities, better access to information on abortion services and higher levels of education. Although abortion rates continued to be very high, the former Government essentially achieved its objective: illegal abortions were practically eliminated and the country experienced a significant decline in maternal morbidity and mortality related to abortion. For example, in the former Yugoslav Republic of Macedonia, mortality associated with abortion declined from 35 per 100,000 abortions in 1969 to 3 per 100,000 in 1986.

High rates of abortion, as well as a high rate of repeat abortions, an increase in second-trimester abortions and an increase in abortions among adolescents, are problems experienced throughout the former Yugoslavia. These trends demonstrated that women relied upon abortion as a contraceptive method, with consequent health risks.

Family planning services had been a part of the regular medical services in the former Yugoslavia since the mid-1950s. A family planning institution was established in 1963 at the national and local levels, and the Family Planning Association, affiliated with the International Planned Parenthood Federation, has existed since 1966. However, sex education in the schools and family planning counselling had not been systematically developed, and family planning had encountered continuing resistance throughout the country. As a result, insufficient knowledge and fear of modern methods of contraception is widespread. According to official data, the percentage of married women using any method of contraception in the former Yugoslav Republic of Macedonia increased from 42.3 to 66.8 per cent between 1970 and 1976. However, withdrawal accounted for 76 per cent of the total. It is estimated that contraceptive practices were similar in the 1980s.

In the late 1980s, the former Government indicated deep concern about the high abortion rates and low rates of usage of modern contraceptive methods. In the Resolution on Population, Development and Family Planning

of 1989, which set out general principles and directions with regard to population matters, special emphasis was given to fertility and family planning. The resolution, while reconfirming the right of each person to decide freely on the number and spacing of children, as established in the Constitution of 1974, was directed to attaining replacement-level fertility in all areas of the country. In part to reduce the incidence of abortion and in part to reduce fertility in some republics, specific measures to disseminate contraceptive information and supplies more widely were taken at the federal level. Social welfare measures, such as prolonged maternity leave, child allowances and child-care facilities, were also strengthened in areas of the country where fertility was below replacement level. In the former Yugoslavia, the republics and autonomous provinces were responsible for implementing within their borders the general principles of population policy adopted by the Federal Assembly. However, the republics and autonomous provinces often abstained from executing federally adopted policies. Implementation of population policies, in particular, was often hampered by the sensitivity of demographic issues in maintaining the fragile equilibrium between individual republics and the national minorities.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
National	1983	66.3 abortions/1,000 women aged 15-44	PR
National	1984	65.2 abortions/1,000 women aged 15-44	PR
National	1985	64.5 abortions/1,000 women aged 15-44	PR
National	1986	65.2 abortions/1,000 women aged 15-44	PR
National	1987	68.0 abortions/1,000 women aged 15-44	PR
National	1988	56.6 abortions/1,000 women aged 15-44	PR

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

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

Togo

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:

The decision to interrupt a pregnancy is made under the authority of the physician, who requires the permission of the family of the pregnant woman in order to proceed. The intervention may take place up to the third month of pregnancy.

* Official interpretation generally permits these grounds.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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, 1988):	3
Total fertility rate (1990-1995):	6.6
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	126
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of child-bearing and childbirth	Yes
Maternal mortality rate (per 100,000 live births):	
National (1987)	420
Western Africa (around 1988)	760
Female life expectancy at birth (1990-1995):	56.8

BACKGROUND

In 1981, the Government of Togo enacted a new criminal code explicitly repealing the French Penal Code of 1810, which was in force at the time of independence and which generally prohibited abortion. The new Code omits reference to abortion when performed with the consent of the pregnant woman. This has been interpreted as meaning that abortion can be performed on certain grounds.

Abortion is reported to be possible up to the third month of pregnancy when the woman's life or health would be endangered by continuation of the pregnancy, as well as on other grounds, such as foetal impairment and rape or incest. The decision to interrupt a pregnancy is made under the authority of the physician, who requires the permission of the family of the pregnant woman in order to proceed.

Illegal abortion appears to occur in Togo, and backstreet interventions are reported to be performed outside authorized facilities. The practice is not widespread, however, due to the existence of customary, traditional, moral and religious practices that strongly condemn abortion. In a 1975 survey, only 6 per cent of women reported that they would resort to induced abortion for unwanted pregnancy, although the strong social disapproval of abortion suggests that the incidence may be widely underreported.

The French anticontraception law of 1920 forbidding the advertisement, manufacture, transport, sale and importation of contraceptives has apparently not been repealed in Togo. However, it does not appear to be enforced. The Togolese Association for Family Welfare, an affiliate of the International Planned Parenthood Federation, was given legal status in 1976 and participated in the Government's national family planning programme. In 1989, the Programme national du bien-être familial received the United Nations Population Award in recognition of its achievements in the family planning field. However, surveys show a widespread lack of knowledge of family planning methods among Togolese. Abstinence is still the most frequently used method of spacing births. Moreover, many of the women attempting to space births do so by moving away from their husbands.

The Government of Togo has expressed deep concern about the growing number of teenage pregnancies. In a 1984 decree, the President of Togo established that "Whosoever makes a girl pregnant if she is a regular member of a school or training college . . ." is subject to imprisonment for from six months to three years and to a fine of 500,000 CFA francs. Adolescents are also a target group for the family planning programme, although only married couples appear to have relatively easy access to family planning services in Togo.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

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

Tonga

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 is not readily available.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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 (1990-1995):	..
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	..
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	..
Oceania (around 1988)	600
Female life expectancy at birth (1990-1995):	..

Tonga

BACKGROUND

Sections 94-96 of the Criminal Offences Act (cap. 15) regulate abortion in Tonga. The limited information available suggests that abortion is generally prohibited except when continuation of the pregnancy poses a risk to the mother's life.

Since the 1960s, the Government has strongly supported maternal and child health care and family planning. Two voluntary organizations, the Tonga Family Planning Association and the Catholic Family Planning Centre, have been offering family planning services throughout most of the country. As of the mid-1980s, however, only about 28 per cent of women of reproductive age practised family planning. It has been suggested that the major reasons for the relatively low contraceptive usage include lack of information, cost of travel, fear of side-effects and social disapproval.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

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

Trinidad and Tobago

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:

Information is not readily available.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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):	44
Total fertility rate (1990-1995):	2.7
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	72
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)	111
Caribbean (around 1988)	260
Female life expectancy at birth (1990-1995):	73.9

* Including visiting unions.

BACKGROUND

Abortion is generally illegal in Trinidad and Tobago under the Offences Against the Person Ordinance of 3 April 1925, Trinidad and Tobago Revised Ordinances, 1950. However, the courts have adopted the ruling in *Rex* v. *Bourne* (1938), widely followed throughout the British Commonwealth, which authorizes the lawful termination of pregnancy not only to save the life of the mother but also to preserve her physical or mental health. Although no time-limits are specified, the abortion law as clarified by the Ministry of Health states that in cases involving a threat to the life of the mother or preservation of her physical or mental health, it is obvious that the sooner the operation is performed, the better.

Any woman inducing her own abortion is subject to imprisonment for four years. A person performing an illegal abortion is subject to the same penalty, while anyone supplying the means to procure an abortion is subject to a maximum of two years in prison. Although statistics on abortion in Trinidad and Tobago are not accurate, the practice is believed to be widespread and abortion is a major cause of maternal mortality and hospital admissions.

The Government of Trinidad and Tobago considers the rates of fertility and population growth to be too high, and its population policy since the late 1960s has consisted primarily of a national family planning programme designed to lower fertility, reduce excessive pressure on natural resources and ease the resulting problems of housing, unemployment and unequal income distribution. The national family planning programme has been directed to expanding integrated maternal and child health and information and education programmes at the community level. In 1988, a total of 103 government centres provided family planning services throughout the country. According to the Demographic and Health Survey conducted in 1987 by the Family Planning Association of Trinidad and Tobago, knowledge of modern methods of contraception is nearly universal, with 83 per cent of women in a union having used a method at some time and 44 per cent practising contraception. Oral contraceptives, the condom and female sterilization are the most widely used methods of contraception among couples in Trinidad and Tobago.

Trinidad and Tobago

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
Port-of- Spain	1971	35.0 abortions/100 deliveries	HR

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

Source: Population Policy Data Bank maintained by the Population Division of the Department for Economic and Social Information and Policy Analysis 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:

The intervention must be performed during the first trimester of pregnancy by a physician legally practising his profession in a hospital, health-care establishment or authorized clinic.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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):	40
Total fertility rate (1990-1995):	3.4
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	23
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 (1988)	70
Northern Africa (around 1988)	360
Female life expectancy at birth (1990-1995):	68.7

Tunisia

BACKGROUND

According to section 214 of the Penal Code as amended in 1973, abortion is permitted on request within the first three months of pregnancy. The only consent required is that of the pregnant woman. The intervention must be performed by a physician legally practising his profession, in a hospital, health-care establishment or authorized clinic. Beyond the third month, abortion may be authorized when the mother's health or mental equilibrium would be endangered by continuation of the pregnancy or on the grounds of foetal impairment. In these cases, the attending physician must present a report to the physician that will perform the abortion.

In 1965, Tunisia was the first Muslim country to liberalize its abortion law. The Tunisian Code of 1913 and the ensuing legislative decrees of 1920 and 1940 all prohibited abortion. The law of 1965 amended the 1940 Code, decriminalizing abortion if a couple had at least five living children and the woman had been pregnant for less than three months. With the further amendment of the Penal Code in 1973, the family size requirement was dropped, allowing abortion on request for all women. Abortion is subsidized by the Government in the same way as all other medical services, and it is performed without charge in public hospitals for those entitled to receive free health care.

The liberalization of abortion in the penal law is only one element of the global policy of the Tunisian Government with regard to fertility and population growth. Tunisia was the first country in Africa to have an official national policy directed to reducing fertility as a means of improving socio-economic development. After Tunisia attained independence from France in 1956, the Government enacted a number of legislative changes in order to change public opinion concerning the status of women. Legislation enacted in 1956 provided equal rights for women, while the Personal Status Code abolished polygamy and repudiation, introduced women's right to divorce and set a minimum age at marriage. In 1961, the Government added to its goals the reduction of fertility and passed a law which repealed the French anticontraception law of 1920, stating that the importation, sale and advertising of contraceptives would be henceforth regulated by the legislation governing other pharmaceutical products. In 1964, the minimum age at marriage was raised, the number of children entitled to receive family allowances was limited to four and the National Family Planning Programme was implemented in a few regions, before being implemented throughout the country in 1966. In 1965, the first liberalization of abortion took place; however, the law was soon considered to be too restrictive and not in conformity with the family planning and fertility objectives of the country. In 1973, when the new abortion law was approved, the Office national de la famille et de la population was created to direct the family planning programme and was also charged with conducting demographic research and with informing and educating the public about family planning and family health. Subsequently, in 1988, the number of children entitled to receive family allowances was further limited to three. All along, legislative action was complemented by other measures intended to raise the status of the woman and decrease fertility, such as providing schooling for both sexes, affirming the right of women to practise contraception and using the media to encourage family planning. In the Eighth Plan, for the period 1992-1996, the Government has identified the demographic targets of increasing contraceptive prevalence from 53 per cent in 1991 to 64 by 2001 and of reducing the total fertility rate to 2.6, with the view of achieving a rate of 2.1 by 2026.

Through its comprehensive approach, the Tunisian Government has achieved significant results, with the total fertility rate decreasing from 7.2 children per woman in 1966 to 3.4 in 1991. Despite the success of the national family planning programme, however, acceptors enter the programme at a relatively advanced age, indicating that contraception and abortion are used mainly to prevent subsequent births once the desired number of children has been reached. The average Tunisian acceptor of family planning is aged 30 years; has 3.7 living children and has been married nine years. Although high parity is no longer a requirement to obtain an abortion, the majority of women have four or more children when they seek an abortion.

Since its liberalization in 1973, abortion has been practised by an increasing number of women and is currently the third most commonly used method of birth control, after intra-uterine devices and oral contraceptives. The proportion of abortions per 1,000 births increased from 63.3 in 1974 to 94 in 1983, and thereafter stabilized. The overall rate of about 14 abortions per 1,000 women of reproductive age is relatively modest, despite the liberal law

and Government-supported services. Official statistics, however, omit legal abortions performed in the private sector. In 1980, these abortions were estimated to account for 15-20 per cent of the total number of reported abortions.

Although there was little religious opposition to the liberalization of abortion in 1973, it is often difficult for a woman openly to seek a legal abortion. Surveys have shown that people continue to be misinformed about the availability of abortion. Moreover, abortion for unmarried women continues to be a taboo subject in traditional communities. Therefore, illegal abortion continues to be practised, especially in the case of extramarital pregnancy and in rural areas. Illegal abortions are often self-induced, either by vegetable products, by drugs obtained from pharmacists or by vinegar or salt injections.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
National	1975	13.7 abortions/1,000 women aged 15-44	PR
National	1980	15.1 abortions/1,000 women aged 15-44	PR
National	1985	13.6 abortions/1,000 women aged 15-44	PR
National	1986	13.6 abortions/1,000 women aged 15-44	PR
National	1987	13.8 abortions/1,000 women aged 15-44	PR
National	1988	13.6 abortions/1,000 women aged 15-44	PR
National	1989	12.1 abortions/1,000 women aged 15-44	PR
National	1990	11.1 abortions/1,000 women aged 15-44	PR
National	1991	10.8 abortions/1,000 women aged 15-44	PR

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

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

Turkey

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:

Abortion is available on request during the first 10 weeks of pregnancy. Thereafter, a legal abortion is permitted only to save the life or health of the pregnant woman and in cases of foetal impairment. The procedure must be performed by a gynaecologist with additional training in abortion procedures. The pregnant woman must consent to the abortion. Parental consent is required if the pregnant woman is a minor. If a woman has a legal guardian because she is either a minor or is mentally incompetent, the consent of the guardian, of a justice of the peace and of the woman must be obtained. The law requires that a married woman obtain spousal authorization prior to obtaining an abortion. The consent requirements are waived if the woman's life is in immediate danger.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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):	31
Total fertility rate (1990-1995):	3.5
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	56
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 (1989)	146
Western Asia (around 1988)	280
Female life expectancy at birth (1990-1995):	70.0

BACKGROUND

Until 1983, abortion in Turkey was permitted only to save the life or preserve the physical or mental health of the pregnant woman, in cases of foetal impairment or if the pregnancy resulted from rape or other crimes (Law No. 557 of 1 January 1965).

Anyone performing an illegal abortion was subject to imprisonment for from two to five years. A woman inducing her own abortion was subject to from one to four years in prison, while a woman consenting to an abortion performed by another person was subject to a term of from one to five years. Any person performing an abortion without the woman's consent was subject to imprisonment for 7-12 years; a similar penalty was applied if the consenting woman was under 14 years of age or if her consent was obtained by violence, threat or deception.

The growing incidence of unsafe abortion in Turkey and the resulting morbidity and mortality led the Government to make abortion legal and widely available in the early 1980s. The Population Planning Law of 24 May 1983 (Law Number 2827, sections 5 and 6) liberalized abortion. Abortion is currently permitted on the request of the pregnant woman within 10 weeks of pregnancy. Thereafter, abortion is permitted to save the life or preserve the health of the woman and in cases of foetal impairment. The existence of these indications must, however, be confirmed by a specialist in obstetrics and gynaecology and by a specialist in another related field. This requirement is waived if the pregnancy poses an immediate risk to the woman's life or health, provided that the performing physician informs the Directorate of Health and Welfare in provincial centres, or government physicians in local towns, of the name and address of the patient, the intervention performed and the justification for the intervention, either prior to the procedure or within 24 hours following the abortion.

A legal abortion must be performed by a gynaecologist with additional training in abortion procedures. The pregnant woman must consent to the abortion, and parental consent is required if she is a minor. If the pregnant woman has a legal guardian because she is a minor or is mentally incompetent, the consent of her legal guardian and of a justice of the peace, as well as her consent, must be obtained. The current law requires married women to obtain spousal authorization prior to obtaining an abortion. The consent requirements are waived, however, if the pregnancy poses immediate danger to life or to vital organs of the woman.

Despite the liberal nature of abortion laws in Turkey, the number of legal abortions performed in the country has been sharply restricted by the requirement that the procedure be carried out only by or under the supervision of gynaecologists with additional training in abortion procedures. This factor is especially critical in rural Turkey, where medical specialists of any type are scarce or non-existent. Many rural health facilities that are without a trained specialist are excluded from providing services. Consequently, a rural Turkish woman seeking an abortion within the 10-week gestational limit may not be able to obtain one.

Although abortion has been legal in Turkey only since 1983, several studies indicate that abortion has been widely practised in the country for a considerable period. The Turkish Fertility Survey, which was conducted in 1978 before abortion became widely available, found that 34 per cent of Turkish women had had at least one induced abortion by the time of the survey. The Turkish Population and Health Survey in 1983 found that 37 per cent of ever-married women had had at least one abortion and estimated that 12 per cent of all pregnancies were artificially terminated. More recently, the Population and Health Survey conducted in 1988 found that 24 per cent of the respondents had had at least one induced abortion. Several studies have shown that urban women with higher educational levels are more likely to have had an abortion than less educated rural women.

The Turkish Government considers the rates of fertility and population growth to be too high. In 1982, the Government adopted a population policy providing family planning as a means of improving family health and welfare. In addition to legalizing abortion, the Population Planning Law of 24 May 1983 legalized all family planning services, including permitting sterilization with spousal consent.

Turkey

Although Turkey has a socialized public-health system that provides free medical care to all of its citizens that require it, traditional and religious attitudes have prevented modern family planning methods from becoming widely accepted. The Turkish Population and Health Survey (1988) found that 63 per cent of married women were using a method of family planning, with about one third of the users relying upon traditional contraceptive methods. Withdrawal was the most widely used method (26 per cent), followed by the intra-uterine device (14 per cent), condoms (7 per cent) and the pill (6 per cent). The major reasons cited for non-use of contraception were concerns about side-effects, opposition from husbands and lack of contraceptive knowledge.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
National	1985	3.3 abortions/1,000 women aged 15-44	PR
National	1986	4.3 abortions/1,000 women aged 15-44	PR
National	1987	4.0 abortions/1,000 women aged 15-44	PR
National	1988	3.6 abortions/1,000 women aged 15-44	PR
National	1989	3.5 abortions/1,000 women aged 15-44	PR
National	1990	3.4 abortions/1,000 women aged 15-44	PR
National	1991	2.8 abortions/1,000 women aged 15-44	PR

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

Source: Population Policy Data Bank maintained by the Population Division of the Department for Economic and Social Information and Policy Analysis 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 if performed by a licensed physician in a hospital or other recognized medical institution. Abortion is available on request during the first 12 weeks of gestation. Thereafter, induced abortion is available within 28 weeks from conception on judicial, genetic, vital, broad medical and social grounds, as well as for personal reasons with the special authorization of a commission of local physicians.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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, 1990):	12
Total fertility rate (1985-1990):	4.6
Age-specific fertility rate (per 1,000 women aged 15-19, 1985-1990):	21
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 (1991)	46
Developed countries (around 1988)	26
Female life expectancy at birth (1985-1990):	68.6

Turkmenistan

BACKGROUND

As was the case with all of the former Soviet republics, Turkmenistan, known prior to 1992 as the Turkmen Soviet Socialist Republic, observed the abortion legislation and regulations of the former Union of Soviet Socialist Republics. As a result, abortion practices in Turkmenistan were similar to those throughout the former USSR.

The description given below pertains to the situation in Turkmenistan prior to independence.

The Soviet law of 27 June 1936 prohibited induced abortion in most circumstances, permitting it only for vital and eugenic reasons. Physicians and non-medical personnel that performed abortions in hospitals or as part of an out-patient service were subject to a maximum of three years in prison. A husband, relative or physician that pressured a woman into having an abortion could be sentenced to a maximum of two years in prison. The pregnant woman could be prosecuted by public trial and/or be required to pay a large fine.

In a decree of 23 November 1955, the Soviet Government repealed the prohibition of abortion. Regulations issued in 1956 and subsequently in 1982 specified that abortions could be performed during the first 12 weeks of gestation, although not less than six months after a woman's previous abortion. An abortion was considered illegal if not performed in a hospital or if the person performing the abortion did not have an advanced medical education. The maximum penalty for an illegal abortion was set at eight years in a labour camp.

In 1974, the Ministry of Public Health of the USSR published a document entitled "On the side-effects and complications of oral contraceptives", in which the mass use of oral contraception was de facto prohibited. On 5 June 1987, in Order No. 757, the Ministry of Public Health legalized and officially permitted the provision of early vacuum aspirations in any clinic regardless of the place of residence of the woman. Vacuum aspiration had been the method of induced abortion provided during the first 20 days of pregnancy with the obligatory diagnosis of pregnancy.

During the 1980s, the Ministry of Public Health continued its efforts to decrease the number of illegal abortions by formally broadening the grounds on which abortions were legal and increasing their availability. Most of the later changes, however, were not followed by a simultaneous increase in actual accessibility of abortion services. On 31 December 1987, the Ministry of Public Health published Order No. 1342, which permits induced abortion during the first 28 weeks of gestation on judicial, genetic and broad medical and social grounds (for example, more than five children in the family), as well as on request with the special authorization of a commission of local physicians.

The high incidence of abortion has been attributed to a number of factors, including shortages of high-quality modern contraceptives and reliance upon less reliable traditional methods, a lack of knowledge among couples of contraception and of the detrimental health consequences of frequent abortions and the absence of adequate training for physicians, nurses, teachers and other specialists. In 1989, the availability of condoms in the entire former Soviet Union amounted to only 11 per cent of demand; intra-uterine devices, 30 per cent; and pills, 2 per cent. Data from the All-Union sample survey of contraceptive use conducted in 1990 indicate that in Turkmenistan, 12 per cent of all women aged 15-49 years regularly used contraception, 8 per cent sometimes used contraception, 55 per cent did not use any contraceptive method and 23 per cent knew nothing about contraception.

In 1989, a total of 39,068 induced abortions were registered in Turkmenistan, giving an abortion rate of 48.9 per 1,000 women aged 15-44 years, one of the lowest rates in the former Soviet Union. The actual figure is much higher, because this total does not include most abortions performed in departmental health services and commercial clinics, early vacuum aspirations and self-induced abortions. In 1988, 4 per cent of all induced abortions were performed on primigravidae. On that same year, 25 per cent of all abortions were early vacuum

aspirations. In 1989, illegal abortions, calculated on the basis of their registered complications, accounted for 26 per cent of all abortions and 45 per cent of all abortions among primigravidae. Among women under age 17, they accounted for 27 per cent of all induced abortions.

Maternal mortality rates in Turkmenistan were 40.8 and 33.4 per 100,000 births in 1980 and 1988, respectively. In 1988, 14 per cent of all maternal deaths were due to criminal abortion.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
National	1970	74.8 abortions/1,000 women aged 15-44	PR
National	1975	68.1 abortions/1,000 women aged 15-44	PR
National	1980	55.9 abortions/1,000 women aged 15-44	PR
National	1985	44.1 abortions/1,000 women aged 15-44	PR
National	1988	45.4 abortions/1,000 women aged 15-44	PR
National	1989	48.9 abortions/1,000 women aged 15-44	PR
National	1990	43.5 abortions/1,000 women aged 15-44	PR
National	1991	40.9 abortions/1,000 women aged 15-44	PR

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

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

Tuvalu

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 is not readily available.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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 (1990-1995):	..
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	..
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	..
Oceania (around 1988)	600
Female life expectancy at birth (1990-1995):	..

BACKGROUND

Little information exists on the legal status and incidence of abortion in Tuvalu. Although the 1982 Penal Code does not contain a section on abortion, two sections (214 and 215) concern the destruction of the life of a child capable of being born alive, which could be applicable to abortion. Based on these sections, it appears that no one will be guilty of an offence unless it is proved that the act that caused the child's death was not done in good faith for the purpose of preserving the mother's life.

Fertility levels are relatively low in Tuvalu compared with other countries in the region. This is largely attributable to a long-standing tradition of family planning. The Family Planning Association was established as early as the late 1960s. The Government has been making efforts to integrate family planning into its maternal and child health services. Family planning programmes are being carried out throughout the country, with each island having its own nurse who is responsible for teaching and encouraging couples to use family planning methods. In 1983, a contraceptive prevalence rate of 30 per cent was reported. The Government acknowledges that existing family planning programmes need to be broadened to include single men and women, because the number of births to single mothers has been increasing. Moreover, family planning education is necessary in order to overcome the continuing lack of awareness with regard to the availability of family planning services.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

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

Uganda

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 legal abortion must be performed by a registered physician. Although the law does not require the approval of a committee, the consent of two physicians is usually sought before a legal abortion can be performed.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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, 1988/89):	3
Total fertility rate (1990-1995):	7.3
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	188
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)	300
Eastern Africa (around 1988)	680
Female life expectancy at birth (1990-1995):	42.9

BACKGROUND

The Ugandan Penal Code of 15 June 1950 (chapter 106, sections 136-138 and 217) declares abortion to be a criminal offence except when performed to save the life or to preserve the physical or mental health of a pregnant woman. Anyone that induces an illegal abortion is subject to imprisonment. A woman inducing her own abortion is subject to imprisonment for from one to seven years. Any person that unlawfully administers medication, uses force of any kind or employs any other means to a pregnant woman with the intention of procuring an abortion is subject to imprisonment for 1-14 years. Anyone that destroys a viable foetus or conceals the birth of a child is also subject to imprisonment. A legal abortion must be performed by a registered physician. Although the law does not require the authorization of a panel of physicians, the consent of two physicians is usually sought before an abortion.

Illegal abortions are common in Uganda. Indeed, the Government has expressed concern over the high incidence of illegal abortions and the resulting high rates of maternal morbidity and mortality. Induced abortion has been ranked as the second leading cause of maternal mortality in the main referral hospital in Uganda. Illegal abortion is more prevalent among young women. A survey carried out in 1988 among women aged 15-24 years found that 23 per cent of all the women that had ever been pregnant had had one or more abortions. The high level of induced abortion among young women in Uganda has led the Government to establish family life education programmes in primary and secondary schools.

The Government is in the process of formulating an explicit population policy. It recognizes the negative consequences of rapid population growth on per capita incomes and on the provision of social services. Consequently, the Government has formulated a number of policies directed to decreasing mortality and fertility. The main focus of these policies is to strengthen maternal and child health and family planning services and to expand population and family life education campaigns. One objective is to increase the contraceptive prevalence rate from 5 to 20 per cent by the year 2000.

Contraceptive services in Uganda are available at government clinics and at clinics operated by the Family Planning Association of Uganda. The Demographic and Health Survey conducted in 1988-1989 found that although knowledge of contraception in the country was high, contraceptive use was quite low, more than 80 per cent of currently married women knew at least one contraceptive method, whereas only 22 per cent had ever used a method and only 5 per cent were currently using a modern method of family planning. The reasons most commonly cited by Ugandan women for non-use of contraception were fear of side-effects, religious reasons, lack of knowledge and partner's disapproval.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
Kampala	1967	13.1 abortions/100 deliveries	HR
Kampala	1968	13.7 abortions/100 deliveries	HR
Kampala	1969	14.5 abortions/100 deliveries	HR

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

Ukraine

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 if performed by a licensed physician in a hospital or other recognized medical institution. Abortion is available on request during the first 12 weeks of gestation. Thereafter, induced abortion is available within 28 weeks from conception on judicial, genetic, vital, broad medical and social grounds, as well as for personal reasons with the special authorization of a commission of local physicians.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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 15-49, 1990):	15
Total fertility rate (1985-1990):	2.0
Age-specific fertility rate (per 1,000 women aged 15-19, 1985-1990):	53
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 (1990)	32
Developed countries (around 1988)	26
Female life expectancy at birth (1985-1990):	74.8

Ukraine

BACKGROUND

As was the case with all of the former Soviet republics, Ukraine, known prior to 1992 as the Ukrainian Soviet Socialist Republic, observed the abortion legislation and regulations of the Union of Soviet Socialist Republics. As a result, abortion practices in Ukraine were similar to those throughout the former USSR.

The description given below pertains to the situation in Ukraine prior to independence.

The Soviet law of 27 June 1936 prohibited induced abortion in most circumstances, permitting it only for vital and eugenic reasons. Physicians and non-medical personnel that performed abortions in hospitals or as part of an out-patient service were subject to a maximum of three years in prison. A husband, relative or physician that pressured a woman into having an abortion could be sentenced to a maximum of two years in prison. The pregnant woman could be prosecuted by public trial and/or be required to pay a large fine.

In a decree of 23 November 1955, the Soviet Government repealed the prohibition of abortion. Regulations issued in 1956 and subsequently in 1982 specified that abortions could be performed during the first 12 weeks of gestation, although not less than six months after a woman's previous abortion. An abortion was considered illegal if not performed in a hospital or if the person performing the abortion did not have an advanced medical education. The maximum penalty for an illegal abortion was set at a maximum of eight years in a labour camp.

In 1974, the Ministry of Public Health of the USSR published a document entitled "On the side-effects and complications of oral contraceptives", in which the mass use of oral contraception was de facto prohibited. On 5 June 1987, in Order No. 757, the Ministry of Public Health legalized and officially permitted the provision of early vacuum aspirations in any clinic regardless of the place of residence of the woman. Vacuum aspiration had been the method of induced abortion provided during the first 20 days of pregnancy with the obligatory diagnosis of pregnancy.

During the 1980s, the Ministry of Public Health continued its efforts to decrease the number of illegal abortions by formally broadening the grounds on which abortions were legal and increasing their availability. Most of the later changes, however, were not followed by a simultaneous increase in actual accessibility of abortion services. On 31 December 1987, the Ministry of Public Health published Order No. 1342, which permits induced abortion during the first 28 weeks of gestation on judicial, genetic and broad medical and social grounds (more than five children in the family), as well as on request with the special authorization of a commission of local physicians.

The high incidence of abortion has been attributed to a number of factors, including shortages of high-quality modern contraceptives and reliance upon less reliable methods, a lack of knowledge among couples of contraception and of the detrimental health consequences of frequent abortions and the absence of adequate training for physicians, nurses, teachers and other specialists. In 1989, the availability of condoms in the entire former Soviet Union amounted to only 11 per cent of demand; intra-uterine devices, 30 per cent; and pills, 2 per cent. Data from the All-Union sample survey of contraceptive use conducted in 1990 indicate that in Ukraine, 15 per cent of all women aged 15-49 used some form of contraception regularly, 9 per cent occasionally used contraception, 62 per cent did not use any contraception, and 10 per cent knew nothing about contraception. Sample survey data for 1988 show that at Kiev, the capital of Ukraine, among sexually active women under 20 years of age, 8 per cent used modern contraceptives, 10 per cent had had an abortion, 4 per cent used a combination of abortion and contraceptives, and 78 per cent did not use any contraceptive method.

In 1989, a total of 1,058,414 induced abortions were registered in Ukraine, giving an abortion rate of 98.3 per 1,000 women aged 15-44 years. The actual figure is much higher, because this total does not include most abortions performed in departmental health services and commercial clinics, early vacuum aspirations and self-induced abortions. In 1988, 5 per cent of all induced abortions were performed on primigravidae and 17 per cent of all induced abortions were vacuum aspirations. In 1989, illegal abortions, calculated on the basis of their

Ukraine

registered complications, accounted for 12 per cent of all abortions and 20 per cent of all abortions among primigravidae. Among women under age 17, they accounted for 15 per cent of all induced abortions.

Maternal mortality rates in the Ukraine were 44.8 and 38.2 per 100,000 births in 1980 and 1988, respectively. In 1988, 27 per cent of all maternal deaths were due to unknown or "other" causes.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
National	1970	106.4 abortions/1,000 women aged 15-44	PR
National	1975	105.1 abortions/1,000 women aged 15-44	PR
National	1980	106.9 abortions/1,000 women aged 15-44	PR
National	1985	111.2 abortions/1,000 women aged 15-44	PR
National	1988	101.5 abortions/1,000 women aged 15-44	PR
National	1989	98.3 abortions/1,000 women aged 15-44	PR
National	1990	93.3 abortions/1,000 women aged 15-44	PR

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

Source: Population Policy Data Bank maintained by the Population Division of the Department for Economic and Social Information and Policy Analysis 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 gynaecologist may perform the abortion with the approval of a physician familiar with the condition that make the abortion necessary and with the written consent of the woman's husband or guardian.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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 (1990-1995):	4.5
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	72
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 Asia (around 1988)	280
Female life expectancy at birth (1990-1995):	74.1

United Arab Emirates

BACKGROUND

According to the Penal Code of 20 December 1987, abortion is generally illegal in the United Arab Emirates. A person that provides means to interrupt the pregnancy or materially performs the abortion is subject to up to five years in prison. The maximum penalty is increased to seven years if the abortion is performed without the woman's consent. However, Federal Law No. 7 of 1975 on the practice of human medicine permits abortion when continuation of the pregnancy would endanger the life of the pregnant woman. In these circumstances, a gynaecologist may perform an abortion with the approval of a physician familiar with the conditions rendering the abortion necessary and with the written consent of the woman's husband or guardian.

Although the Government has not adopted an official population policy, population variables have been included in planning activities and specific population issues have been addressed, such as achieving high levels of health care and facing the sensitive issue of increasing the size of national population in relation to the expatriate population. The United Arab Emirates does not have an official family planning programme, although access to contraceptive methods is not officially restricted except to unmarried adolescents.

INCIDENCE OF ABORTION

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

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

United Kingdom of Great Britain and Northern Ireland

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	Yes
Available on request	No

Additional requirements:

Abortion is legal in England, Wales and Scotland when two registered medical practitioners (only one in an emergency) certify that the required medical grounds as set forth in the Abortion Act of 1967 have been met. The termination of pregnancy must be carried out (except in an emergency) in a National Health Service hospital or in a nursing home, private hospital or other approved place. Abortion is legal within 24 weeks of gestation. The consent of the spouse is not a prerequisite of the medical termination of pregnancy. The Abortion Act of 1967 does not apply in Northern Ireland.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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 16-49, 1986):	78*
Total fertility rate (1990-1995):	1.9
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	34
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 (1990)	8
Developed countries (around 1988)	26
Female life expectancy at birth (1990-1995):	78.7

* Data refer to Great Britain.

United Kingdom of Great Britain and Northern Ireland

BACKGROUND

According to English common law, it was not considered murder to kill a child in the womb, although it was a criminal misdemeanour to do so after quickening, the time when movement was felt. In 1861, the Offences Against the Persons Act decreed that it was a criminal offence punishable by life imprisonment for any pregnant woman unlawfully to procure or attempt to procure her own miscarriage, or for any other person to do the same. The statute made no provision for an exemption from criminal liability, even if the abortion was necessary to save the life of the mother. The Infant Life (Preservation) Act of 1929 made it a crime of child destruction to kill a viable foetus (gestation age of 28 weeks or more) unless the act that caused the death of the child was done in good faith for the sole purpose of preserving the life of the mother. The judicial decision of 1938 in *Rex* v. *Bourne* broadened the concept of health, permitting abortion in order to preserve the physical or mental health of the mother. Neither the Offences Against the Persons Act of 1861 nor the Infant Life (Preservation) Act of 1929 applied in Scotland. Abortion was defined as a criminal offence by Scottish common law, but prosecutions typically were not brought in cases where the operation had been performed for "reputable medical reasons", a term that was never officially or judicially defined. In Northern Ireland, the law was the same as in England and Wales until 1968.

The abortion law in effect in England, Scotland and Wales is regulated by the Abortion Act of 1967, as amended by the Human Fertilization and Embryology Act of 1990, which permits abortion to be performed on broad grounds, as certified by two physicians. These grounds are: (*a*) that the pregnancy has not exceeded its 24 weeks and continuance of the pregnancy would involve a risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family; (*b*) or that the termination is necessary to prevent grave permanent injury to the physical or mental health of the woman; (*c*) or that the continuance of the pregnancy would involve risk to the life of the woman, greater than if the pregnancy were terminated; (*d*) or that there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped. In assessing the risk to the health of the woman and her existing children, physicians may take into account the woman's "actual or reasonably foreseeable environment". Due to this provision and a broad interpretation about what constitutes threat to health, abortions are available virtually on request in the United Kingdom.

Within the National Health Service, the provision of abortion services, as with other medical services, is controlled by the individual health-care authorities. Approval to perform abortions in private medical facilities is vested in the Secretary of State for Health. Currently, there is no statutory duty on the part of the Health Authorities to provide a particular level of abortion service. Traditionally, the provision of abortion services, as part of the gynaecological services, has been a matter for local determination by the Health Authorities according to local circumstances.

Except in cases of emergency, a legal abortion must be obtained in National Health Service hospitals or in approved institutions operating as private abortion clinics. The abortion is available free of charge through the National Health Service, or it may be paid for privately. The abortion must be performed by a registered medical practitioner; however, a nurse may also induce the abortion if delegated by a physician. The consent of the spouse is not a prerequisite of the termination of pregnancy; a husband has no right, enforceable at law or in equity, to prevent his wife from having a legal abortion.

A total of 174,276 legal abortions were performed in England and Wales in 1987, the great majority of the procedures taking place before the thirteenth week of gestation. The greatest number of abortions (55,307) were among women aged 20-24, followed by those aged 16-19 (38,482) and those aged 30-34 (21,270). The majority of women having abortions were single. A total of 69,505 abortions were performed in National Health Service hospitals; vacuum aspiration was the most frequent method. The overwhelming majority of abortions were approved on the grounds that the pregnancy would pose a risk to the woman's physical or mental health. The complication rate was 5.3 per 1,000 procedures; there was one abortion-related death.

United Kingdom of Great Britain and Northern Ireland

The Abortion Act of 1967 does not apply in Northern Ireland. Under sections 58 and 59 of the Offences Against the Persons Act of 1861, it is an offence unlawfully to procure a miscarriage, punishable by a maximum sentence of life imprisonment. Terminations of pregnancy are carried out on therapeutic grounds to preserve the life of the mother or to prevent serious damage to her physical or mental health. The decision to terminate a pregnancy is ultimately based on professional judgement. Such a decision is usually made following consultation with two physicians and with the informed consent of the pregnant woman. Although abortions are performed each year in Northern Ireland within the legal guidelines, the fear of possible accusation of acting illegally and the fact that abortion is an emotionally charged issue in Northern Ireland prevents medical staff from revealing precise data on abortions. The Department of Health and Social Services does not supply official statistics. In Northern Ireland, a woman faced with an unwanted pregnancy that does not fulfil the stated requirements can choose: (*a*) to carry the pregnancy to term; (*b*) to seek an illegal abortion and risk endangering her health and life; or (*c*) to travel to England, where abortion is legal. Many women choose the third option.

Since abortion was legalized in Great Britain, many women from other countries have travelled to England for a safe, legal abortion. Described in the abortion statistics as "non-residents", these women come from Northern Ireland, as well as from other European countries, including France, Germany, Ireland, Italy and Spain. Others have travelled from as far away as South Africa and the United States of America. The numbers of women travelling to England to obtain an abortion has declined as abortion has been legalized and laws have been reformed in other countries (5,000 non-resident women had a legal abortion in England in 1969, the first full year that abortion was legal in Great Britain; the number peaked in 1973 at 53,600 non-resident abortions). In 1987, there were 18,100 abortions performed on non-resident women.

In July 1991, the United Kingdom became the second country, France being the first, to approve the use of RU486, the abortion pill. The distribution of the pill is subject to strict controls, confining its use to National Health Service gynaecological units.

The Government of the United Kingdom considers the rates of fertility and population growth to be satisfactory. The Government has no explicit policy of intervention with respect to fertility rates, since it believes that decisions concerning fertility and child-bearing should be left to the individual. The Government provides individuals with information and the necessary means for family planning and funds health programmes to improve the prevention, diagnosis and treatment of illness. The Government has also taken steps to reduce the increasing abortion rate due to unwanted fertility among young unmarried women and to encourage greater male responsibility with regard to contraception. Family planning services, including sterilization, are widely available free of charge through the National Health Service. To determine strategies for reducing the high rate of unplanned and unwanted pregnancies, a working group of the Royal College of Obstetricians and Gynaecologists was established in 1989. Among the group's recommendations issued in 1991 were: to improve sex education; to increase the availability of family planning services; to require physicians that offer family planning services to receive special training in contraceptive provision; and to make post-coital contraception more widely available.

United Kingdom of Great Britain and Northern Ireland

INCIDENCE OF ABORTION

Place	*Year*		*Measurement*	*Coverage*
National	1970	8.6	abortions/1,000 women aged 15-44	PR
National	1975	10.4	abortions/1,000 women aged 15-44	PR
National	1980	11.8	abortions/1,000 women aged 15-44	PR
National	1985	13.9	abortions/1,000 women aged 15-44	PR
National	1986	12.7	abortions/1,000 women aged 15-44	PR
National	1987	13.3	abortions/1,000 women aged 15-44	PR
National	1988	14.3	abortions/1,000 women aged 15-44	PR
National	1989	14.5	abortions/1,000 women aged 15-44	PR
National	1990	14.8	abortions/1,000 women aged 15-44	PR
National	1991	14.4	abortions/1,000 women aged 15-44	PR

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

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

United Republic of Tanzania

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:

Two physicians must certify that the abortion is necessary in order to preserve the life of the pregnant woman.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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, 1991):	6.6
Total fertility rate (1990-1995):	6.8
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	147
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)	342
Eastern Africa (around 1988)	680
Female life expectancy at birth (1990-1995):	52.3

United Republic of Tanzania

BACKGROUND

Abortion legislation in the United Republic of Tanzania is based on the English Offences Against the Person Act of 1861 and the Infant Life Preservation Act of 1929. The Revised Penal Code of Tanzania (chapter 16, sections 150-152) prohibits abortion except when necessary to preserve the life of the pregnant woman. A legal abortion requires the consent of two physicians.

Any person that unlawfully performs an abortion, whether the woman is pregnant or not, is subject to imprisonment for 14 years. A woman inducing her own abortion is subject to a prison term of seven years. Any person that supplies anything whatsoever intended for procuring an abortion may be imprisoned for three years.

Although abortion is restricted by law, there is overwhelming evidence that it is widely practised in the country. The Government has expressed concern about the high incidence of illegal abortion because of its effect on maternal morbidity and mortality. Studies show that illegal abortion is one of the major causes of maternal mortality. A study conducted in the Southern Highlands in 1983 estimated that 17 per cent of maternal deaths were directly associated with abortion. Another study carried out in the Kilimanjaro region suggested that about 21 per cent of maternal deaths were related to abortion. In a study undertaken in 1987 at Muhimbili Medical Centre, the teaching hospital in Dar es Salaam, it was determined that in a random sample of 300 women admitted to the hospital for early pregnancy loss, 31 per cent had had an induced abortion.

With the adoption of a national population policy in 1992, the Government has committed itself to dealing with the adverse consequences associated with high rates of population growth. Among the objectives of the Government's population programmes are to promote the improvement of maternal and child health and welfare through the prevention of illness and premature death and to establish an appropriate information, education and communication programme which will encourage the provision and use of services related to family planning and responsible parenthood. To meet the unmet demand for family planning services, estimated to be 30 per cent of married women in 1991, a programme has been established to raise the contraceptive prevalence rate. The programme components include community-based distribution of contraceptives, family planning services in workplaces, male involvement in family planning and in-school and out-of-school family life education. Work was under way in 1993 to establish a National Family Planning Centre. The Centre is expected to provide training in family planning skills to physicians and nurse-tutors, who in turn will train medical personnel throughout the country.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
Kilimanjaro	1971/77	8.9 abortions/100 deliveries	HR

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

Source: Population Policy Data Bank maintained by the Population Division of the Department for Economic and Social Information and Policy Analysis 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:

Abortion is available in all states on request prior to foetal viability. After foetal viability, a state may prohibit abortion only if it provides exceptions for endangerment to the woman's life or health. Although federal law grants a woman the constitutional right to terminate her pregnancy before foetal viability, individual states are permitted to impose restrictions on abortion throughout pregnancy if they do not unduly burden a woman's right to choose.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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, 1988):	69
Total fertility rate (1990-1995):	2.1
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	58
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 (1990)	8
Developed countries (around 1988)	26
Female life expectancy at birth (1990-1995):	79.3

United States of America

BACKGROUND

In the United States of America, abortions before "quickening" were permitted by traditional common law until 1845, when the first of many states passed laws prohibiting all or most abortions. By the early 1960s, 41 states permitted abortion only if the life of the pregnant woman was threatened by continuation of the pregnancy, while the remaining states permitted abortion only if the woman's life or physical health was in jeopardy.. In the mid-1960s, when the pregnant woman's mental health gained acceptance as a valid justification for abortion, more legal abortions were performed, a trend that accelerated with the passage of liberalized abortion legislation in various states. In the five years leading up to the landmark Supreme Court decision of January 1973, which legalized abortion throughout the United States, 18 states had reformed or repealed their anti-abortion legislation. In the other 32 states and the District of Columbia, laws remained on the statute books that made abortion a crime unless performed to save the life or health of the woman.

In 1973, two decisions of the Supreme Court of the United States (*Roe* v. *Wade* and *Doe* v. *Bolton*) legalized abortion nationwide. In those cases, the Court ruled that a woman's decision to have an abortion in the first trimester of pregnancy should be exclusively between herself and her physician, but that individual states could regulate abortion in the second trimester in ways designed to preserve and protect the woman's health; and that after foetal viability, or the third trimester of pregnancy, the states could regulate or even proscribe abortion unless the procedure was necessary to preserve the life or health of the mother. Lastly, the Supreme Court held that a foetus was not a person and was therefore not entitled to protection guaranteed by the United States Constitution until it reached the point of viability. Viability was defined as occurring between 24 and 28 weeks of gestation.

The effect of *Roe* v. *Wade* on women in the United States seeking to terminate pregnancies was profound. After *Roe*, abortion procedures in the United States became widely available, legal, safe and simple. Within a few years of the decision, data indicated that the mortality rate for women undergoing legal abortions was 10 times lower than the mortality rate for women that had illegal abortions and five times lower than the rate for women undergoing childbirth.

The *Roe* v. *Wade* decision also had an immediate impact on the abortion debate. The right-to-life movement, which had existed in a nascent form prior to *Roe*, became very active after ruling, and with the reversal of *Roe* as its ultimate objective. The right-to-life movement also began a campaign directed to creating as many legal barriers to abortion as possible. The abortion-rights movement was similarly engaged and campaigned to make safe and legal abortion available throughout the country.

These two opposing movements have been involved in constant legal and political battles over the abortion issue ever since, and their representatives have regularly appeared before the United States Supreme Court to argue cases concerning the nature and meaning of the constitutional protection afforded by the *Roe* decision. Over the years, the rulings of the Supreme Court have cut back on the constitutional guarantees in *Roe* v. *Wade*. The first of these significant decisions was the *Webster* ruling of 3 July 1989 (*Webster* v. *Reproductive Health Services*). By a vote of 5 to 4, the Supreme Court upheld a Missouri statute that barred the use of public funds, employees or buildings for abortions and required abortion providers to conduct tests to determine whether a foetus believed to be at least 20 weeks old was viable.

By upholding the Missouri law requiring physicians to conduct extensive viability tests on women at least 20 weeks pregnant before performing an abortion, the *Webster* decision weakened the trimester framework established in *Roe* v. *Wade*. Furthermore, the Court signalled its willingness to give individual states far greater latitude in placing restrictions on a woman's right to have an abortion. Following the *Webster* decision, restrictive statutes were introduced in a number of state legislatures. For example, within five months of the decision, Pennsylvania enacted a law requiring that a woman notify her husband, receive state-prepared information concerning adoption and child-support alternatives from her physician and delay the procedure for a minimum of 24 hours before obtaining an abortion. Kansas, Mississippi, North Dakota and Ohio likewise imposed similar restrictions requiring anti-abortion information to be provided and mandatory delays. Louisiana, Utah and the territory of Guam went even further and enacted sweeping criminal abortion bans with exceedingly narrow

exceptions. Other states, such as Connecticut, moved in the opposite direction by enacting legislation guaranteeing a woman the right to an abortion under the state law.

Abortion law in the United States is currently governed by the Supreme Court decision of 29 June 1992 (*Planned Parenthood of Southeastern Pennsylvania* v. *Casey*). The Supreme Court ruling in *Casey* reaffirmed the holding in *Roe* v. *Wade* that a woman has a constitutional right to obtain an abortion prior to foetal viability and that a state may prohibit abortion thereafter only if it provides exceptions for endangerment to the woman's life or health. Although the *Casey* ruling left no doubt that laws prohibiting abortion were unconstitutional, the Court rejected the trimester framework set forth in *Roe* and held that states have legitimate interests in protecting the health of the woman and the life of the unborn child from the outset of pregnancy.

The Supreme Court decision in *Casey* also adopted a more lenient standard for analysing the constitutionality of abortion restrictions than had been articulated in previous rulings. The Court ruled that a state may act to regulate abortion throughout pregnancy if it does not "unduly burden" a woman's right to choose. "Undue burden" was defined as a substantial obstacle in the path of a woman seeking an abortion before the foetus attains viability. In applying the "undue burden" standard, the Court in *Casey* upheld portions of the Pennsylvania abortion law that had required a woman to delay an abortion for 24 hours after hearing a state-prepared presentation on adoption and child-support alternatives and required teenagers to obtain the consent of one parent or the approval of a judge before obtaining an abortion. The only provision in the Pennsylvania statute struck down by the *Casey* decision was a husband notification requirement, which the Court found to be an "undue burden" on a married woman's right to obtain an abortion.

Following the *Casey* decision, states where court cases are pending or where similar statutes remain on the books (e.g., Illinois, Maine, Michigan, Mississippi, North Dakota and Ohio) may begin to enforce statutes that currently exist but have not been enforced. However, since the Supreme Court attempted to make it clear in *Casey* that a sweeping criminal ban on abortion would likely fail the "undue burden" test, states will currently be unable to ban abortions altogether.

Abortion restrictions in the United States continue to vary by state. Thirty-five states have laws that prevent a minor from obtaining an abortion without parental consent or notice. In 18 of these states, the laws are currently enforced with a judicial bypass provision that provides that a judge may waive parental notification and permit an abortion after a hearing. Three states have laws that prevent a minor from obtaining an abortion without parental notice unless the physician waives the requirement. Two states require that minors receive counselling that includes discussion of the possibility of consulting her parents before obtaining an abortion.

Thirty states have abortion-specific "informed" consent laws, many of which require that women be given anti-abortion information and state-prepared materials intended to discourage them from obtaining an abortion. Eleven states (Delaware, Idaho, Indiana, Maine, Massachusetts, Mississippi, North Dakota, Ohio, Pennsylvania, South Dakota and Tennessee) have specific mandatory waiting periods of at least 24 hours between the time such lectures or materials are disseminated and the time an abortion may be performed, but only the Mississippi law is currently being enforced. Kansas and Kentucky also have mandatory waiting periods of eight and two hours, respectively, but the Kentucky law is not being enforced.

Forty-three states and the District of Columbia have laws requiring an abortion to be performed by a physician. Alternatively, Kentucky permits first-trimester abortions to be performed by a licensed physician or by the woman herself upon the advice of a licensed physician, but requires that abortions after the first trimester be performed only by a licensed physician.

The Missouri law prohibits public employees from participating in the performance of abortion. Alabama, Missouri, North Dakota and Pennsylvania prohibit the use of public facilities for the provision of abortion services. Thirty states and the District of Columbia do not provide Medicaid funding for abortion unless a woman's life is in danger, whereas eight states provide public funding in certain limited circumstances, such as when the pregnancy results from rape or incest. Only 13 states fund most or all abortions.

United States of America

The new presidential administration that came into office in January 1993 took swift action on the issue of federal limitations on abortions, thus suggesting that the abortion debate may have taken a new direction. On 22 January 1993 (the twentieth anniversary of *Roe* v. *Wade*), and only a few days into the new presidency, the policies of the previous administrations that were intended to discourage women from obtaining abortions were rescinded. First, the President of the United States lifted restrictions on abortion counselling at federally financed family planning clinics that had been in effect since 1988, as well as the ban on federal research using foetal tissue from aborted foetuses that was imposed in 1989. Another Presidential order allowed physicians at United States military hospitals to resume performing abortions for armed services personnel and for their dependants that paid the cost. Federally financed abortions for military personnel have been barred since 1979 except in cases where the life of a pregnant woman was in danger. A fourth order cleared the way for United States funds to flow to international efforts providing abortions and other family planning services. Previously, the Government's "1984 Mexico City Policy" stipulated that the United States Government would not support international programmes that offered abortion services. Lastly, the President directed the Department of Health and Human Services to review the import ban on the French-made abortion pill, RU486, and to rescind it if there were grounds for doing so.

Despite the fact that abortion has been legal in the United States since 1973, economic forces, political pressures, geography and the shortage of physicians trained and willing to perform abortions constitute a major barrier to women's access to abortion services. This problem is more acute among low-income women and women living in rural areas where there are few clinics or hospitals that provide abortion services. For many low-income women, abortion has effectively been out of reach since 1977, when Congress barred the use of federal funds to pay for abortions; and as of 1992 only 13 state governments paid for abortions for low-income women. In June 1993, the House of Representatives endorsed a continuation of the long-standing ban on federal funding of abortions for indigent women under the Medicaid programme, adding exceptions only for cases of rape or incest to the previous exception of life endangerment. Although a law went into effect in October 1993, requiring state Medicaid programmes to pay for the abortions of low-income women in cases of rape or incest, at least six states have indicated that they would flout the new law. Obstetrics-gynaecology residency programmes have made abortion an elective or have stopped offering abortion training altogether. Also, some physicians are opposed to the practice of abortion.

In 1988, as in previous years, the majority of abortions in the United States were obtained by young women; 26 per cent were under age 20 and 58 per cent were under age 25. Most of the women, 83 per cent, were unmarried. The proportion of repeat abortions among total abortions has continued to rise, reaching 43 per cent in 1988.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
National	1975	21.7 abortions/1,000 women aged 15-44	PR
National	1976	24.2 abortions/1,000 women aged 15-44	PR
National	1977	26.4 abortions/1,000 women aged 15-44	PR
National	1978	27.7 abortions/1,000 women aged 15-44	PR
National	1979	28.8 abortions/1,000 women aged 15-44	PR
National	1980	29.3 abortions/1,000 women aged 15-44	PR
National	1981	29.3 abortions/1,000 women aged 15-44	PR
National	1982	28.8 abortions/1,000 women aged 15-44	PR
National	1983	28.5 abortions/1,000 women aged 15-44	PR
National	1984	28.1 abortions/1,000 women aged 15-44	PR
National	1985	28.0 abortions/1,000 women aged 15-44	PR
National	1986	27.4 abortions/1,000 women aged 15-44	PR
National	1987	26.9 abortions/1,000 women aged 15-44	PR
National	1988	27.3 abortions/1,000 women aged 15-44	PR
National	1989	26.9 abortions/1,000 women aged 15-44	PR
National	1990	27.5 abortions/1,000 women aged 15-44	PR
National	1991	26.4 abortions/1,000 women aged 15-44	PR

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

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

Uruguay

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 carried out within the first three months of pregnancy. The penalty for undergoing an abortion may be reduced or waived if the pregnancy results from rape or when there is economic hardship.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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 15-49):	..
Total fertility rate (1990-1995):	2.3
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	60
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 (1990)	36
South America (around 1988)	220
Female life expectancy at birth (1990-1995):	75.7

BACKGROUND

Under the Criminal Code of 4 December 1933, abortion is generally illegal in Uruguay. Anyone that performs an abortion is subject to imprisonment for 6-24 months. A woman inducing her own miscarriage can be imprisoned for from three to nine months. According to section 328 of the Criminal Code, an abortion may be performed by a physician within the first three months of pregnancy if the procedure is done to save the woman's life. Abortion is also permitted, on a case-by-case basis, if the woman's condition is serious enough to warrant termination of the pregnancy in order to preserve her physical health. If the pregnancy results from rape, the penalty for abortion may be waived. In cases where the pregnant woman is faced with serious economic hardship, abortion is punishable by a reduced prison term (from one third to one half of the usual sentence), or the penalty may be waived altogether.

Uruguay is believed to have a high rate of abortion, most of which is illegal. In fact, abortion is a major source of fertility control in the country, as well as the single most important cause of maternal mortality. Despite the lack of precise statistics on abortion, the most conservative estimates indicate that there are at least as many abortions as live births.

The Government of Uruguay considers the rates of fertility and population growth to be too low. A number of incentives to increase fertility levels are provided, including a maternity benefit of 100 per cent of wages payable for up to 12 weeks (which can be extended up to an additional five months if confinement occurs after the expected date or in case of illness), a family allowance of not less than 8 per cent of the monthly minimum wage and nursing breaks for working mothers. The Government provides support for modern methods of contraception.

The Asociación Uruguaya de Planificación Familiar e Investigaciones sobre Reproducción Humana (AUPFIRH) was founded in 1961 as the first family planning association in South America. It cooperates with local public-health authorities in service-delivery programmes to poor urban and rural areas, operating mobile clinics to reach remote areas and directing a community-based contraceptive distribution programme. AUPFIRH offers family planning services in many government health-care facilities and manages a women's programme and an adolescent centre where teenage mothers are given social, medical and legal aid. It also discusses adolescent and women's issues in the media, holds sex education training workshops and offers courses for parents, teachers and institutional and community leaders.

Unmet demand for family planning and sex education has contributed to high rates of unwanted pregnancies, adolescent pregnancies, induced abortions and infertility due to sexually transmitted diseases. To respond to these problems, a project is under way to provide training in sex education, reproductive health and income-generating skills for women, while another project is examining adolescents' knowledge and attitudes concerning sexuality and reproduction.

INCIDENCE OF ABORTION

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

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

Uzbekistan

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 if performed by a licensed physician in a hospital or other recognized medical institution. Abortion is available on request during the first 12 weeks of gestation. Thereafter, induced abortion is available within 28 weeks from conception on judicial, genetic, vital, broad medical and social grounds, as well as for personal reasons with the special authorization of a commission of local physicians.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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, 1990):	19
Total fertility rate (1985-1990):	4.4
Age-specific fertility rate (per 1,000 women aged 15-19, 1985-1990):	40
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 (1991)	33
Developed countries (around 1988)	26
Female life expectancy at birth (1985-1990):	71.5

BACKGROUND

As was the case with all of the former Soviet republics, Uzbekistan, known prior to 1992 as the Uzbek Soviet Socialist Republic, observed the abortion legislation and regulations of the former Union of Soviet Socialist Republics. As a result, abortion practices in Uzbekistan were similar to those throughout the former USSR.

The description given below pertains to the situation in Uzbekistan prior to independence.

The Soviet law of 27 June 1936 prohibited induced abortion in most circumstances, permitting it only for vital and eugenic reasons. Physicians and non-medical personnel that performed abortions in hospitals or as part of an out-patient service were subject to a maximum of three years in prison. A husband, relative or physician that pressured a woman into having an abortion could be sentenced to a maximum of two years in prison. The pregnant woman could be prosecuted by public trial and/or be required to pay a large fine.

In a decree of 23 November 1955, the Soviet Government repealed the prohibition of abortion. Regulations issued in 1956 and subsequently in 1982 specified that abortions could be performed during the first 12 weeks of gestation, although not less than six months after a woman's previous abortion. An abortion was considered illegal if not performed in a hospital or if the person performing the abortion did not have an advanced medical education. The maximum penalty for an illegal abortion was set at eight years in a labour camp.

In 1974, the Ministry of Public Health of the USSR published a document entitled "On the side- effects and complications of oral contraceptives", in which the mass use of oral contraception was de facto prohibited. On 5 June 1987, in Order No. 757, the Ministry of Public Health legalized and officially permitted the provision of early vacuum aspirations in any clinic regardless of the place of residence of the woman. Vacuum aspiration had been the method of induced abortion provided during the first 20 days of pregnancy with the obligatory diagnosis of pregnancy.

During the 1980s, the Ministry of Public Health continued its efforts to decrease the number of illegal abortions by formally broadening the grounds on which abortions were legal and increasing their availability. Most of the later changes, however, were not followed by a simultaneous increase in actual accessibility of abortion services. On 31 December 1987, the Ministry of Public Health published Order No. 1342, which permits induced abortion during the first 28 weeks of gestation on judicial, genetic and broad medical and social grounds (for example, more than five children in the family), as well as on request with the special authorization of a commission of local physicians.

The high incidence of abortion has been attributed to a number of factors, including shortages of high-quality modern contraceptives and reliance upon less reliable traditional methods, a lack of knowledge among couples of contraception and of the detrimental health consequences of frequent abortions and the absence of adequate training for physicians, nurses, teachers and other specialists. In 1989, the availability of condoms in the entire former Soviet Union amounted to only 11 per cent of demand; intra-uterine devices (IUDs), 30 per cent; and pills, 2 per cent. Data from the All-Union sample survey of contraceptive use conducted in 1990 indicate that in Uzbekistan, 19 per cent of all women aged 15-49 years regularly used contraception, 9 per cent sometimes used contraception, 50 per cent did not use any contraceptive method and 17 per cent knew nothing about contraception. Sample survey data for 1988 show that at Tashkent, the capital of Uzbekistan, for every 100 contraceptive users, 64 per cent used condoms, 20 per cent practised coitus interruptus and 15 per cent used spermicides; IUDs and pills were not used.

In 1989, a total of 226,276 induced abortions were registered in Uzbekistan, giving an abortion rate of 51.6 per 1,000 women aged 15-44 years. The actual figure is much higher, because this total does not include most abortions performed in departmental health services and commercial clinics, early vacuum aspirations and self-induced abortions. In 1988, 4 per cent of all induced abortions were performed on primigravidae while 7.3 per cent of all abortions were early vacuum aspirations. In 1989, illegal abortions calculated on the basis of their registered

Uzbekistan

complications, accounted for 27 per cent of all abortions and 60 per cent of all abortions among primigravidae. Among women under age 17, they accounted for 44 per cent of all induced abortions.

Maternal mortality rates in Uzbekistan were 46.4 and 38.9 per 100,000 births in 1980 and 1988, respectively. In 1988, 5 per cent of all maternal deaths were due to unknown or "other" causes.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
National	1970	67.3 abortions/1,000 women aged 15-44	PR
National	1975	58.2 abortions/1,000 women aged 15-44	PR
National	1980	48.1 abortions/1,000 women aged 15-44	PR
National	1985	52.1 abortions/1,000 women aged 15-44	PR
National	1988	55.3 abortions/1,000 women aged 15-44	PR
National	1989	51.6 abortions/1,000 women aged 15-44	PR
National	1990	47.3 abortions/1,000 women aged 15-44	PR

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

Source: The Population Policy Data Bank maintained by the Population Division of the Department for Economic and Social Information and Policy Analysis 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:

Information is not readily available.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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 (1990-1995):	..
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	..
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	..
Oceania (around 1988)	600
Female life expectancy at birth (1990-1995):	..

Vanuatu

BACKGROUND

Subsections (1) and (2) of section 117 of the Vanuatu Penal Code Amendment, Act No. 17 of 7 August 1981, declare that no woman should intentionally produce her own miscarriage and no person should intentionally produce the miscarriage of a woman. In either case, the penalty is imprisonment for up to two years. Subsections (3) and (4) in the same section specify that it would be a defence against any charge under subsections (1) or (2) if the person charged could show that the miscarriage procured constituted a termination of pregnancy for good medical reasons; moreover, no prosecution should be commenced without the consent in writing of the Public Prosecutor.

Family planning has been included in the health policies of Vanuatu since it attained independence in 1980. Currently, health and family planning services are organized at the district level and are free of charge. The Family Planning Association of Vanuatu assists in the distribution of contraceptives to government centres and mission health centres. Despite these efforts, however, contraceptive prevalence has been relatively low in Vanuatu. Although not entirely representative, a maternal and child health survey conducted in 1983 provided rough estimates of the rate of contraceptive prevalence, ranging from about 16.5 per cent in the Northern District to 28 per cent in the Southern District and to 34 in Central District I. Even among urban women, the overall proportion of current contraceptive users was 27.7 per cent. The preference for large families is one of the obstacles to achieving greater acceptance of family planning among women in Vanuatu.

Among the available contraceptive methods, injectable Depo-Provera was the most commonly used contraceptive method in the late 1970s and early 1980s. However, the Government banned its importation in 1983 on the grounds of health concerns; consequently the family planning programme became inactive. By 1990, however, a resurgence of interest in family planning, combined with a number of health concerns, such as poor maternal health, led to the establishment of the Family Health Project. One of the objectives of the project is the improvement of family planning services by enhancing the quality of care; offering a wider range of family planning methods, including long-acting contraceptives; and facilitating access to family planning services, particularly in rural areas.

INCIDENCE OF ABORTION

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

Source: Population Policy Data Bank maintained by the Population Division of the Department for Economic and Social Information and Policy Analysis 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 may be performed only with the written consent of the woman, her husband or her legal representative. The procedure must be carried out in a suitable environment, using all possible scientific resources.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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, 1977):	38
Total fertility rate (1990-1995):	3.1
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	71
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 (1990)	200
South America (around 1988)	220
Female life expectancy at birth (1990-1995):	73.5

Venezuela

BACKGROUND

Under the Criminal Code of 2 June 1964, abortion is generally illegal in Venezuela. A physician may perform an abortion if it is the only means of saving the life of the pregnant woman. In addition, the Code of Medical Ethics of 1971 prohibits induced abortion at any stage of pregnancy, except for "therapeutic purposes". Therapeutic abortion may be performed only with the written consent of the woman, her husband or her legal representative. In case of emergency, however, the favourable opinion of another physician may suffice, if this can be obtained. A therapeutic abortion must be performed in a suitable environment, using all possible scientific resources. The physician selected to perform the abortion must inform the relatives if the pregnant woman is suffering major obstetric complications and must clearly explain the procedure to be followed, with a view to obtaining their consent. In the event of a divergence of opinion, the physician must, where possible, transfer the case to another professional practitioner; otherwise, except in an emergency, the physician must request the relatives of the woman to make a written statement that they do not consent to the proposed procedure.

Anyone inducing an abortion illegally is subject to imprisonment for 12-30 months. The sentence may be increased when the person guilty of inducing the abortion is the woman's husband or a medical practitioner. A woman that intentionally induces her own abortion may be imprisoned for from six months to two years.

Proposals to reform the Venezuelan Penal Code, which were introduced in the National Congress in 1986, included recommendations to permit abortion on therapeutic grounds to preserve the physical and mental health of the mother, in cases of rape or incest, for eugenic reasons, in cases where either of the parents suffers from oligophrenia or epilepsy and a foetal injury is suspected, according to the opinion of three specialists; and in cases where the mother has suffered any sickness or exposure to radiation which might produce mental or physical defects in the foetus. These proposals, however, have not been incorporated into the Penal Code.

According to official data, complications from illegal abortions, which are often performed with unsterilized instruments by untrained persons, accounted for 24.6 per cent of all maternal deaths in Venezuela during the period 1980-1983.

Although the Government of Venezuela has never actively pursued a policy to modify fertility levels, it has permitted the gradual expansion of family planning for health-related reasons. The health-related aims of the national maternal and child health and family planning programme include providing safe and efficient contraceptives to help women avoid unwanted pregnancies; and contributing to the reduction of fertility rates among high-risk groups, such as adolescents and women with pregnancies spaced less than two years apart. Sterilization is permitted in Venezuela only for medical or eugenic reasons. The Government views the high incidence of illegitimate births, abortion and irresponsible parenthood as social problems that can be alleviated through the increased provision of family life education and family planning services. In 1987, the Government created the Ministry of the Family, the first and only institution of its type in Latin America, to coordinate sectoral programmes dealing with youth, women and the elderly. A project promoting family life and sex education in the informal sector was begun through the Ministry of Youth in 1987. Recognizing the social and health problems associated with adolescent child-bearing, the Government established the permanent Commission for the Prevention of Adolescent Pregnancy.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
National	1972	18.9 abortions/100 live births	HR

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

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

Viet Nam

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:

A legal abortion must be performed by a physician.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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):	35
Total fertility rate (1990-1995):	3.9
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	5
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 (1989)	120
South-eastern Asia (around 1988)	340
Female life expectancy at birth (1990-1995):	66.0

BACKGROUND

The limited information available on the legal status of induced abortion in Viet Nam indicates that abortion on request had been available in the Democratic Republic of Viet-Nam since at least 1971 and in the entire country since its unification in 1975. Previously, abortions could be performed in the Republic of South Viet-Nam only for narrowly interpreted medical indications, due to the existence of a 1933 decree enforcing a French law prohibiting abortion and the use of contraception. The Law on the Protection of Public Health (30 June 1989) clearly states that "women shall be entitled to have an abortion if they so desire". According to Decision No. 162 of the Council of Ministers in January 1989, the State will supply, free of charge, birth control devices and public-health services, including induced abortion, to eligible persons that register to practise family planning. A legal abortion must be performed by a physician.

Emphasis on family planning varied greatly between the northern and southern provinces of Viet Nam before unification. Beginning in 1962, in the northern province, the government planning policy was directed to reducing the rate of population growth. The use of certain relatively permanent contraceptive methods, such as the intra-uterine device (IUD), was promoted. Abortion on request (with the husband's consent) was available during the first trimester of pregnancy and was usually performed by vacuum curettage. In contrast, the family planning programme in the southern province began in the late 1960s largely in response to concern over maternal and infant mortality and the increasing numbers of illegal abortions. However, family planning clinics offered services only to women with at least five living children up until the early 1970s. Even when family planning services were later expanded to include women with one living child, a marriage or cohabitation certificate was required to obtain services. In the mid-1970s, the Government of the Republic of South Viet-Nam stated that family planning had been adopted as an official policy, but inadequate medical facilities made it impossible to implement an effective family planning programme.

Since the unification of Viet Nam, family planning has been considered a major national priority. In 1982, various family planning measures were adopted by the Government, including the use of abortion. After 1983, limiting families to two children became obligatory. Incentives for contraceptive and abortion acceptors, as well as penalties for family planning violations, were further increased in 1985, in an effort to promote implementation of family planning. The target is a total fertility rate of 3.1 births per woman by the year 2000 and 2.1 by 2010.

The Demographic and Health Survey conducted in 1988 indicated that contraceptive awareness is very high in the country, particularly in regard to IUD, the predominantly used method, which was known by more than 90 per cent of the women. Almost 70 per cent of the women mentioned pregnancy termination or menstrual regulation as contraceptive methods, although these are viewed by the Government as backup methods for terminating unwanted pregnancies rather than as family planning methods. According to the survey, 38 per cent of married women aged 15-44 reported currently using a modern method of contraception. Of these women, 89 per cent used IUD, 6 per cent had been sterilized, 3 per cent were using condoms and 1 per cent relied upon oral contraceptives. The survey also found that 4 per cent of the women interviewed had had a pregnancy terminated and 3 per cent had resorted to menstrual regulation. There appears to be a substantial unmet demand for family planning, given the reliance upon pregnancy termination and menstrual regulation, the relatively moderate level of usage of modern contraceptive methods and the significant number of women not using contraceptives that do not desire another birth.

Viet Nam

INCIDENCE OF ABORTION

Place	*Year*		*Measurement*	*Coverage*
National	1987	58.5	abortions/1,000 women aged 15-44	PR
National	1988	71.3	abortions/1,000 women aged 15-44	PR
National	1989	70.0	abortions/1,000 women aged 15-44	PR

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

Source: Population Policy Data Bank maintained by the Population Division of the Department for Economic and Social Information and Policy Analysis 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:

Information is not readily available.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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, 1991-1992):	6
Total fertility rate (1990-1995):	7.2
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	134
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 (1985)	330
Western Asia (around 1988)	280
Female life expectancy at birth (1990-1995):	53.0

Yemen

BACKGROUND

Currently, induced abortion is generally illegal in Yemen, being permitted only to save the life of the mother. Prior to unification of the country in May 1990, both the Yemen Arab Republic and Democratic Yemen also prohibited abortion except when continuation of the pregnancy would endanger the life of the mother.

The Government of Democratic Yemen considered growth rates to be satisfactory but expressed concern about the high fertility rate. As a result of its belief that population issues should be viewed comprehensively within the framework of economic and social development, the Government's policy was directed to improving socio-economic conditions as a means of resolving population problems. The Government provided family planning services and population information and education.

Although the Government of the Yemen Arab Republic did not have an explicit population policy, it considered fertility reduction necessary to achieve social and economic development objectives. The Government encouraged family planning activities mainly to improve maternal and child health and family well-being. It established the Yemeni Family Care Association, which provided prenatal services and information on birth control. The Government directly supported the provision of contraceptives and the training of family planning volunteers. It also encouraged women's participation in the labour force and supported raising the educational status of women.

On 22 May 1990, the Yemen Arab Republic and Democratic Yemen united to become the State of Yemen. The new Government recognized that a deeper understanding of the relations between population and development, as well as the means of influencing those relations, was critical to the future development of the country. Faced with a number of serious population problems, including the negative effects of high fertility on women's health due to frequent child-bearing, the Government endorsed the National Population Strategy in 1991. It seeks to influence those population variables which determine the balance between population and resources in order to create more favourable conditions for sustainable development. The Government has specified a number of targets, including a contraceptive prevalence rate of 35 per cent and a total fertility rate of 6.0 births per woman by the year 2000.

INCIDENCE OF ABORTION

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

Source: Population Policy Data Bank maintained by the Population Division of the Department for Economic and Social Information and Policy Analysis 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 must be performed in a hospital or other authorized health-care facility. If the woman is a minor, approval of her parents or guardian is required, unless she has been recognized as fully competent to earn her own living. After the first 10 weeks of pregnancy, special authorization by a commission composed of a gynaecologist-obstetrician, a general physician or a specialist in internal medicine and a social worker or a psychologist is required.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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 (under age 45, 1976):	12
Total fertility rate (1990-1995):	1.9
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	38
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 (1990)	10
Developed countries (around 1988)	26
Female life expectancy at birth (1990-1995):	75.0

Yugoslavia

BACKGROUND

To implement article 191 of the Federal Constitution of Yugoslavia of 21 February 1974, which proclaims that "it is a human right to decide on the birth of children", the eight territorial units of the former Socialist Federal Republic of Yugoslavia took legislative action between 1977 and 1979 concerning the legal status of abortion.

According to these laws, which are all similar in nature, abortion is allowed on request during the first 10 weeks of pregnancy. The intervention must be performed in a hospital or other authorized health-care facility. If the woman is a minor, approval of her parents or guardian is required, unless she has been recognized as fully competent to earn her own living. After the first 10 weeks of pregnancy, special authorization by a commission, composed of a gynaecologist-obstetrician, a general physician or a specialist in internal medicine and a social worker or a psychologist, is required. The Commission decides on the basis of the existence of medical, eugenic, juridical, economic or social grounds. The woman can appeal to the Commission of Second Instance if the Commission of First Instance rejects her request. After 20 weeks of gestation, abortion may be allowed only to save the life or health of a seriously endangered woman.

Penal provisions are imposed on medical organizations and persons that violate provisions of the law. A woman, however, is never held criminally responsible for inducing her own abortion or for cooperating in such a procedure.

Beginning in 1952, abortion legislation in the former Yugoslavia was liberalized in response to the significant increase in illegal abortions associated with high levels of morbidity and mortality. The subsequent changes in the abortion laws—general principles were adopted at the federal level and laws were implemented at the local level—were expressly directed to facilitating access to legal abortion in order to discourage illegal practices. For instance, a significant decline in the number of illegal abortions is attributed to the decision in 1969 to eliminate the requirement of a commission's approval for termination of pregnancies of less than 10 weeks, a requirement which had been a practical and psychological obstacle to abortion. The policy of liberalizing legal regulations with regard to abortion was facilitated by increased numbers of medical facilities, better access to information on abortion services and higher levels of education. Although abortion rates continued to be very high, the former Government essentially achieved its objective: illegal abortions were practically eliminated and the country experienced a significant decline in maternal morbidity and mortality related to abortion. For example, mortality associated with abortion declined from 180 per 100,000 abortions in 1960 to 11 per 100,000 in 1976.

High rates of abortion, as well as a high rate of repeat abortions, an increase in second-trimester abortions and an increase in abortions among adolescents, are problems experienced throughout the country. These trends demonstrated that women relied upon abortion as a contraceptive method, with consequent increased health risks.

Family planning services have been part of the regular medical services in Yugoslavia since the mid-1950s. A family planning institution was established in 1963 at the national and local levels, and the Family Planning Association, affiliated with the International Planned Parenthood Federation, has existed since 1966. However, sex education in the schools and family planning counselling have not been systematically developed, and family planning has encountered continuing resistance throughout the country. As a result, insufficient knowledge and fear of modern methods of contraception is widespread. According to official data, the percentage of married women using any method of contraception in Yugoslavia decreased slightly between 1970 and 1976—from 56.2 to 52.9. However, withdrawal accounted for 66.7 per cent of the total. It is estimated that contraceptive practices were similar in the 1980s.

In the late 1980s, the former Government indicated deep concern about the high abortion rates and low rates of usage of modern contraceptive methods. In the Resolution on Population, Development and Family Planning of 1989, which set out general principles and directions with regard to population matters, special emphasis was given to fertility and family planning. The resolution, while reconfirming the right of each person to decide freely

on the number and spacing of children, as established in the Constitution of 1974, was directed to attaining replacement-level fertility in all areas of the country. In part to reduce the incidence of abortion and in part to reduce fertility in some republics, specific measures to disseminate contraceptive information and supplies more widely were taken at the federal level. Social welfare measures, such as prolonged maternity leave, child allowances and child-care facilities, were also strengthened in areas of the country where fertility was below replacement level. In the former Yugoslavia, the republics and autonomous provinces were responsible for implementing within their borders the general principles of population policy adopted by the Federal Assembly. However, the republics and autonomous provinces often abstained from executing federally adopted policies. Implementation of population policies, in particular, was often hampered by the sensitivity of demographic issues in maintaining the fragile equilibrium between individual republics and the national minorities.

Given the persistence of wide regional differences in fertility, the Government of Yugoslavia reiterated in 1993 that it sought to harmonize rates of fertility throughout the country and to achieve a net reproduction rate of approximately 1.0. Measures have been designed with the goal of encouraging the three-child family, while discouraging higher order births. Family allowances for the third child are not subject to an income test and maternity allowances are provided for the third child in areas of the country experiencing negative population growth.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
National	1983	100.4 abortions/1,000 women aged 15-44	PR
National	1984	103.3 abortions/1,000 women aged 15-44	PR
National	1985	103.1 abortions/1,000 women aged 15-44	PR
National	1986	101.5 abortions/1,000 women aged 15-44	PR
National	1987	97.6 abortions/1,000 women aged 15-44	PR
National	1988	91.4 abortions/1,000 women aged 15-44	PR
National	1989	90.1 abortions/1,000 women aged 15-44	PR

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

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

Zaire

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 is not readily available.

* Legal interpretation permits these grounds.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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 (1990-1995):	6.7
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	231
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	..
Middle Africa (around 1988)	710
Female life expectancy at birth (1990-1995):	53.2

BACKGROUND

The general prohibition of abortion contained in the Belgian Penal Code of 1867 was incorporated into the Penal Code of Zaire in 1885. In 1933, a decree established the prohibition of the sale, display, distribution, manufacture, importation and advertisement of contraceptives and abortifacients. These laws have never been abrogated. Therefore, under article 165 livre II of the Penal Code, which is still in force, anyone performing an abortion may be imprisoned for 2-10 years. A woman that induces her own miscarriage is subject to imprisonment for from two to five years.

A decree establishing a code of medical ethics, however, allows therapeutic abortion. The conflict in the legal status of abortion is clarified by legal interpretation which reportedly considers abortion to be legal not only to save the life of the pregnant woman but also when there is a serious danger to her physical or mental health. Based on this interpretation, it is also possible to perform an abortion for foetal impairment when there is the likelihood that the child will be born with a serious and incurable disease. Moreover, it is reported that in practice abortion is also tolerated when the family's socio-economic conditions are inadequate to support another child.

Nevertheless, considerable numbers of clandestine abortions, especially among urban adolescents and single women, take place in Zaire. A majority of the patients hospitalized from complications following induced abortion are young, single urban residents. The high incidence of induced abortion has been one of the driving forces behind the family planning programme, which began in Zaire in 1973 with the Desirable Births Programme. In 1982, family planning services were officially integrated within primary health care and sex education was introduced in the school curricula. One of the aims of the Desirable Births Programme is to reduce the incidence of induced abortion, infanticide, child abandonment and malnutrition due to numerous and closely spaced pregnancies through the spread of contraception. The programme has encountered strong resistance. The traditional pattern of marital relations, based on prolonged post-partum abstinence and polygamy, is considered by some to be threatened by the availability of family planning. Although a new family code, enacted in 1987, enhances the status of the woman, contraceptive prevalence is still very low. The resistance of some government officials and political leaders to family planning has led to widespread lack of information concerning both contraception and legal abortion.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
Kinshasa	1972	7.2 abortions/100 deliveries	HR

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

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

Zambia

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	Yes
Available on request	No

Additional requirements:

An abortion requires the consent of three physicians, one of whom must be a specialist in the branch of medicine related to the woman's reason for seeking an abortion. However, the requirement may be waived if the abortion is immediately necessary to save the life or prevent grave permanent injury to the physical or mental health of the woman. A legal abortion must be performed by a registered physician in a government hospital or other approved institution unless the patient's life is in danger.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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, 1992):	9
Total fertility rate (1990-1995):	6.3
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	137
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)	151
Eastern Africa (around 1988)	680
Female life expectancy at birth (1990-1995):	44.8

BACKGROUND

Zambia has one of the most liberal abortion laws in sub-Saharan Africa. The Termination of Pregnancy Act of 1972 permits abortion if continuation of the pregnancy involves risk to the life or injury to the physical or mental health of the woman, or if there is substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be severely handicapped. A legal abortion can also be obtained if continuation of the pregnancy involves a risk of injury to the physical or mental health of any of her existing children. Section 3(2) of the Act further stipulates that the woman's actual or reasonably foreseeable environment or age may be taken into account in determining whether the pregnancy poses any risk to her life or her mental or physical health, or poses a risk of injury to the mental or physical health of any of her existing children.

Anyone that induces an illegal abortion is subject to imprisonment. A woman inducing her own abortion is subject to from one to seven years in prison. A person performing an illegal abortion is subject to 1-14 years in prison.

A legal abortion must be performed by a licensed physician in a government hospital or other institution unless the patient's life is in danger. Three physicians must consent to an abortion; one must be a specialist in the branch of medicine in which the patient is specifically required to be examined. Thus, a woman seeking an abortion for mental health reasons must be examined by a psychiatrist, while one with a specific medical condition must be examined by a specialist in that area of medicine. This requirement may be waived if the performance of an abortion is immediately necessary to save the life of the pregnant woman.

Despite the liberal nature of its abortion law, complicated procedural requirements and inadequate services limit the number of legal abortions performed in Zambia. For example, the University Teaching Hospital is the only facility at Lusaka where a legal abortion can be obtained. Moreover, such facilities are almost non-existent in the rest of the country because of a scarcity of gynaecologists at provincial hospitals. The requirement that three physicians consent to the abortion is also difficult to satisfy because many hospitals do not have three physicians. Moreover, some physicians are reluctant to sign the forms for religious and personal reasons, whereas crowded hospitals make it difficult to obtain timely appointments with physicians. These obstacles force many women to induce their own abortion and then proceed to a hospital for emergency medical treatment. In 1976, a total of 173 legal abortions were performed at the University Teaching Hospital at Lusaka, whereas 1,000 cases of illegally induced abortions were admitted to the same hospital.

The Government has expressed concern about the high incidence of illegal abortion in Zambia. Many studies have also shown that illegal abortion is one of the major causes of maternal mortality in the country. A study conducted at the University Teaching Hospital between 1982 and 1983 found that 18 per cent of all maternal deaths were due to complications from incomplete induced abortions.

Attitudes towards population growth rates and fertility among Zambian leaders have ranged until recently from pronatalist to *laissez-faire*. The formulation of a population policy was not a priority in the decade following independence because it was felt that the country was relatively large (about 750,000 square kilometres) in relation to its population size (8.4 million in 1990). In the mid-1980s, however, two major developments forced the Government to change its attitude towards population policy. The first was the release of the 1980 census, which provided evidence of high fertility and rapid population growth. The other factor was a stagnating economy. Although Zambia had been experiencing a series of economic problems since the mid-1970s, they became more severe during the 1980s. Indeed, per capita income in the 1980s was lower than it had been at the time of independence in 1964. Following these developments, the National Commission for Development Planning drafted a national population policy in 1986, which was ultimately adopted in 1989.

Zambia

The overall objective of the Government's population policy was to improve the level of living and the quality of life of all Zambians. The policy called for sustained measures to reduce the total fertility rate from 7.2 to 4.0 by the year 2015 and to reduce the population growth rate from 3.7 to 2.5 per cent per annum during the same period. The Government seeks to provide family planning services to at least 30 per cent of all adults in need of them by the end of the century. Use of modern methods of contraception is low in Zambia; only 9 per cent of women of reproductive age were using modern contraceptive methods as of 1992.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
National	1978	11.5 abortions/100 live births	HR
National	1980	13.1 abortions/100 live births	HR
National	1981	11.9 abortions/100 live births	HR
National	1982	13.1 abortions/100 live births	HR
National	1983	14.2 abortions/100 live births	HR
National	1984	14.7 abortions/100 live births	HR
National	1985	14.9 abortions/100 live births	HR
National	1986	12.7 abortions/100 live births	HR
National	1987	12.6 abortions/100 live births	HR
National	1988	11.9 abortions/100 live births	HR

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

Source: Population Policy Data Bank maintained by the Population Division of the Department for Economic and Social Information and Policy Analysis 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	Yes
Economic or social reasons	No
Available on request	No

Additional requirements:

A legal abortion must be performed by a physician in a designated institution with the permission of the superintendent of the institution . If the pregnancy resulted from unlawful intercourse, a magistrate of a court in the jurisdiction where the abortion will be performed must certify that the alleged intercourse was reported to the police and that pregnancy may have resulted from it. When the abortion is requested because the pregnancy poses a threat to the life or physical health of the pregnant woman, or on grounds of foetal impairment, two physicians that are not members of the same practice must certify to the relevant hospital superintendent that one of these conditions exists. However, if the woman's life is in danger, a physician can perform the abortion in a place other than a designated institution and without a second medical opinion.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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, 1988-1989):	36
Total fertility rate (1990-1995):	5.3
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	95
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 (1981)	77
Eastern Africa (around 1988)	680
Female life expectancy at birth (1990-1995):	57.3

Zimbabwe

BACKGROUND

Prior to the enactment of the Termination of Pregnancy Act of 1977, abortion legislation in Zimbabwe was governed by Roman-Dutch common law, which permitted abortion only to save the life of the pregnant woman. The Termination of Pregnancy Act (No. 29 of 1977) extended the grounds under which a legal abortion can be obtained in Zimbabwe. The Act permits abortion if continuation of the pregnancy constitutes a serious threat to the life of the woman or permanent impairment to her physical health, or if there is serious risk that if the child were born, it would suffer from grave physical or mental defects so as to be severely handicapped. The Act stipulates that the threat to the pregnant woman must be one of permanent impairment of her physical health and not her mental health. Abortion is also permitted if there is a reasonable possibility that the foetus was conceived as a result of unlawful intercourse. According to the Act, rape, incest or intercourse with a mentally handicapped woman constitute unlawful intercourse.

A legal abortion must be performed by a physician in a designated institution and with the permission of the superintendent of the institution. If the pregnancy resulted from unlawful intercourse, a magistrate of a court in the jurisdiction where the abortion will be performed must certify that the alleged intercourse was reported to the police and that pregnancy may have resulted from it. When the abortion is requested because the pregnancy poses a threat to the life or the physical health of the woman, or on grounds of foetal deformity, two physicians that are not members of the same practice must certify to the relevant hospital superintendent that one of these conditions exists. If the abortion is immediately necessary, however, the physician can perform the abortion in a place other than a designated institution and without a second medical opinion, provided that a report on the intervention is submitted to the Secretary of Health within the following 48 hours.

The law in Zimbabwe concerning abortion contains a conscientious objection clause permitting physicians, nurses and other health-care personnel to decline involvement in non-emergency abortion services.

Any person that violates the abortion law is guilty of an offence and is liable to a fine not exceeding 5,000 Zimbabwe dollars or to imprisonment for a period not exceeding five years, or both.

The Government has expressed concern about the high level of induced abortion in Zimbabwe. Studies indicate that complications from unsafe, illegal abortions are a major and growing public health concern. Although reliable national estimates are not readily available, records obtained from Harare Hospital show that the number of admissions for abortion complications have increased over time and have resulted in high rates of maternal mortality. It is projected that the demand for abortion may increase in the future because of the erosion of traditional cultural values in the wake of rural-urban migration, the increased need to limit family size, delay in the age at marriage due to increased educational opportunities for women and the fact that contraceptives are not readily available to women under 18 years of age.

Zimbabwe has one of the most successful family planning programmes in sub-Saharan Africa. Its contraceptive prevalence rate is one of the highest in the region and the percentage of users has been increasing. The percentage of currently married women using a method of contraception increased from 39 to 43 per cent between 1984 and 1988. Moreover, 84 per cent of users were relying upon modern methods of contraception as of 1988. Zimbabwe was also the first sub-Saharan African country to experience a fertility decline; the total fertility rate declined from 6.5 to 5.5 births per woman between 1984 and 1988. The Government's target is to reduce fertility to 4.5 births per women by 1996.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available

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

V. ADDITIONAL COUNTRY PROFILES

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:

Information is not readily available.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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 (1990-1995):	..
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	..
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 1988)	26
Female life expectancy at birth (1990-1995):	..

Andorra

BACKGROUND

The Principality of Andorra was created in 1278 when Spain and France settled a land dispute by sharing sovereignty over Andorra. It is a co-principality under the formal sovereignty of the President of France and the Spanish Bishop of Seo de Urgel. The legal system in Andorra is based on French and Spanish civil codes.

Under the Penal Code of 11 July 1990, abortion is prohibited on all grounds. According to the Code, a pregnant woman that performs an abortion or gives her consent to an abortion will incur a penalty of up to two and one half years of imprisonment. If another person performs an abortion with the consent of the woman, the maximum applicable penalty will be four years of imprisonment. The penalty will be imprisonment for up to six years if the perpetrator is a physician, medical practitioner or health officer, or a person that habitually, or with the intent of profit performs abortive practices. An abortion performed without the consent of the woman is punishable by a maximum of 10 years of imprisonment. If abortive practices performed on a woman actually or supposedly pregnant result in serious injuries or the death of the woman, the maximum applicable penalty will be 12 years of imprisonment. Any person offering his own or another's services for the performance of an abortion or providing means or suggesting abortive procedures is subject to up to three years of imprisonment.

INCIDENCE OF ABORTION

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

Source: Population Policy Data Bank maintained by the Population Division of the Department for Economic and Social Information and Policy Analysis 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:

Abortion is allowed within 12 weeks of gestation upon written request of the pregnant woman. An abortion may be performed on request only if at least six months have elapsed since a previous abortion, except in the case of a woman that has had two other births or is 35 years of age or older, or in the case of rape. A woman must receive counselling before an abortion is performed. Parental consent is required for minors under 16 years of age; for minors between 16 and 18 years of age, the physician must inform the parents following the intervention. Second trimester abortion is allowed only for medical and eugenic reasons and in cases of rape or other sexual crimes.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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, 1991):	53
Total fertility rate (1985-1990):	1.9
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	..
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 1988)	26
Female life expectancy at birth (1990-1995):	..

Czech Republic

BACKGROUND

Abortion in the Czech Republic is still regulated by the Law of 20 October 1986 of the former Czech Socialist Republic. That law is identical to the Law on Abortion of the Slovak Socialist Republic of 23 October 1986. Abortion is allowed within 12 weeks of gestation upon written request of the pregnant woman. An abortion may be performed on request only if at least six months have elapsed since a previous abortion, except in the case of a woman that already has had two other births or is 35 years of age or more, or in case of rape. A woman must receive counselling before an abortion is performed. Parental consent is required for minors under 16 years of age; for minors between 16 and 18 years of age, the physician must inform the parents following the intervention. Second-trimester abortion is allowed only for medical and eugenic reasons and in case of rape or other sexual crimes.

Attempts have been made to restrict abortion in the Czech Republic. In January 1991, the Parliament of Czechoslovakia adopted a bill of rights containing the provision that human life is "worthy of protection" even before birth, which was a compromise in language between pro-choice and pro-life forces. Concerned about the high rates of induced abortion, the Government established an Advisory Commission in March 1991 to review the abortion law with a view to decreasing the incidence of abortion. The Commission recommended that the absolute prohibition of abortion should be avoided, that abortion should not be Government-supported except to save the woman's life or in case of sexual crimes and that the law should also serve an educational function.

One of the last acts of the Parliament of Czechoslovakia was to revise legislation concerninng health care. Under the new legislation, which entered into force following the division of the country into the Czech Republic and Slovakia in January 1993, abortions that are not performed on therapeutic grounds are considered non-essential and thus are not covered by national health insurance. The cost of such a procedure is approximately $115, representing one month's average salary. Prior to the new law, an abortion performed up to the eighth week of pregnancy or on medical grounds had been free of charge; in all other cases, a fee of 500 Czechoslovak Koruny (Kčs) had been charged in order to discourage late interruption of pregnancy.

Although contraceptives are free of charge and widely available, a study conducted in 1991 in the former Czechoslovakia found low rates of contraceptive prevalence (only 52 per cent of women in union), a widespread distrust of oral contraceptives and a dominant role of religion in influencing contraceptive decisions. The study found that 28 per cent of women used barrier methods, 17 per cent used intra-uterine device and 7 per cent used oral contraception. For these reasons, abortion rates were high, 48.7 abortions per 1,000 women aged 15-44 years in 1988 in the former Czechoslovakia and 58.2 in the Czech Republic. The Government is currently attempting to modify contraceptive behaviour through improved access to contraceptives and sex education programmes.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*
National	1985	45.4 abortions/1,000 women aged 15-44	PR
National	1986	45.2 abortions/1,000 women aged 15-44	PR
National	1987	57.3 abortions/1,000 women aged 15-44	PR
National	1988	58.2 abortions/1,000 women aged 15-44	PR
National	1989	56.5 abortions/1,000 women aged 15-44	PR
National	1990	55.9 abortions/1,000 women aged 15-44	PR

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

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

Eritrea

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. The consent of the woman is also required.

FERTILITY AND MORTALITY CONTEXT

Government's view on 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 (1990-1995):	..
Age-specific fertility rate (per 1,000 women aged 15-19, 1990-1995):	..
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 1988)	680
Female life expectancy at birth (1990-1995):	..

BACKGROUND

According to the most recent information available, abortion practice in Eritrea is still governed by the abortion law of Ethiopia. Since gaining its independence from Ethiopia in April 1993, Eritrea has sought to adopt progressively a new system of regulations; however, the Penal Code has not yet been revised. The Ethiopian Penal Code of 1957 prohibits abortion except when it is performed to save the pregnant woman from grave and permanent danger to her life or health which cannot be averted in any other way. Performing an abortion is punishable by imprisonment for up to five years. A grave state of physical or mental distress, especially following rape or incest, or caused by extreme poverty, is considered to be an extenuating factor at the time of sentencing. The danger to the pregnant woman's life or health must be certified in writing by a registered physician and the concurrent opinion of a second qualified physician is required. The pregnant woman, or if she is incapable, her next of kin, is required to give consent to the intervention.

Although the sale of contraceptives was not prohibited by law in Ethiopia (as was the advertisement of contraceptives), contraceptive prevalence has been very low and illegal abortion has been widespread. A number of studies have found that up to half of all maternal deaths were due to septic abortions. In 1990, the Government of Ethiopia undertook several steps towards establishment of a family planning policy. Family planning services have been available in government clinics since 1988, as part of a national health-care programme. Although the Government of Eritrea has affirmed its interest in population-related matters, its efforts have been concentrated on the reorganization of the country after independence. The formulation of population policies is still at an early stage.

INCIDENCE OF ABORTION

Place	*Year*	*Measurement*	*Coverage*

Information not readily available.

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

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 data and the type of data obtained.

CZECH REPUBLIC

The estimates are based on the numbers of abortions and female age distributions obtained from *Statistiká Ročenka* CSSR (Czechoslovakia, various years) and *Statistiká Ročenka Ceské Republiky* (Czech Republic, various years).

PAKISTAN

The figures were obtained from a World Health Organization report on the frequency and mortality of unsafe abortion (WHO, 1990). The data are based on abortion, excluding legal abortions, performed in hospitals at Karachi.

PANAMA

The figures were derived from unpublished tabulations of the Contraloría General de la República (Panama, 1990).

PARAGUAY

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 services in Paraguay. The figure includes both induced and spontaneous abortion.

PERU

The figures were obtained from a World Health Organization report on the frequency and mortality of unsafe abortion (WHO, 1990). The data are based on hospital admissions records for admissions for complications from abortion (including spontaneous induced, illegal, septic, complete and incomplete).

POLAND

The estimated rates are based on numbers of abortions and female age distributions derived from various issues of the United Nations *Demographic Yearbook* and from the United Nations assessment in 1992. The figures of abortions for 1965-1975 were taken from de Guibert-Lantoine and Monnier (1992) because the numbers of abortions in the United Nations *Demographic Yearbook* up to 1978 include "other abortions" (women admitted to hospitals for treatment of complications of spontaneous or illegal induced abortions) and differ from the figures shown for the following years. The statistics for Poland may underestimate the incidence of abortion because procedures performed at private outpatient clinics are underreported.

REPUBLIC OF KOREA

The rates are based on numbers of abortions obtained from Ross and others (1992) and on female age distributions from the United Nations assessment in 1992.

REPUBLIC OF MOLDOVA

The estimates are based on numbers of abortions and female age distributions obtained from *Naselenie SSSR, 1987* and *1988*; and *Demographichesky Ezhegodnik SSSR, 1990* (USSR, State Committee on Statistics, 1988, 1989, 1990); and from the Statistical Committee of the Commonwealth of Independent States. The rates include officially registered abortions and exclude illegal abortions. After 1988, the data include early-stage abortions performed by vacuum aspiration.

ROMANIA

The estimates are based on numbers of abortions up to 1990, de Guibert-Lantoine and Monnier (1992); and for 1991, reported by country and on age-female distributions, from the United Nations assessment in 1992 and reported by country.

RUSSIAN FEDERATION

The estimates are based on numbers of abortions and female age distributions obtained from *Naselenie SSSR, 1987* and *1988*; and *Demographichesky Ezhegodnik SSSR, 1990* (USSR, State Committee on Statistics, 1988, 1989, 1990); and from the Statistical Committee of the Commonwealth of Independent States. The rates include officially registered abortions and exclude illegal abortions. After 1988, the data include early-stage abortions performed by vacuum aspiration.

SEYCHELLES

The rates are based on numbers of abortions and female age distributions derived from the United Nations *Demographic Yearbook, 1991* and on those received from the country.

SINGAPORE

The rates are based on numbers of abortions derived from various issues of the United Nations *Demographic Yearbook* and female age distributions from the United Nations assessment in 1992.

SLOVAKIA

The estimates are based on the numbers of abortions and female age distributions obtained from various issues of *Statistika Ročenka*, CSSR (Czechoslovakia , various) and *Statistiká Ročenka Slovenske* (Slovakia, various years).

SLOVENIA

Abortion rates are based on numbers of abortions and female age distributions obtained from the Federal Statistical Office and the Federal Institute for Health Care of the former Socialist Federal Republic of Yugoslavia and received from Slovenia.

SOUTH AFRICA

The data were obtained from Henshaw and Morrow (1990). The number of legal abortions performed each year is recorded in the annual reports of the Department of Health. These figures, however, underestimate the total number of induced abortions in the country since a significant number of them are performed illegally and not recorded.

SPAIN

The rates are based on numbers of abortions obtained from the Council of Europe (1993) and female age distributions from the United Nations assessment in 1992.

SWEDEN

The rates are based on numbers of abortions derived from various issues of the United Nations *Demographic Yearbook* and from de Guibert-Lantoine and Monnier (1992); and on female age distributions from the United Nations assessment in 1992 and various issues of the *Demographic Yearbook.*

SWITZERLAND

The rates are based on numbers of abortions obtained from *L' Association suisse pour ledroit à l'avortment et à la contraception (1991)* and female age distributions from the United Nations assessment in 1992.

TADJIKISTAN

The estimates are based on numbers of abortions and female age distributions obtained from *Naselenie SSSR, 1987* and *1988*; and *Demographichesky Ezhegodnik SSSR, 1990* (USSR, State Committee on Statistics, 1988, 1989, 1990); and from the Statistical Committee of the Commonwealth of Independent States. The rates include officially registered abortions and exclude illegal abortions. After 1988, the data include early-stage abortions performed by vacuum aspiration.

THAILAND

The figures were obtained from a World Health Organization report on the frequency and mortality of unsafe abortion (Who, 1990). The data are based on admissions for complications from abortion (illegal) and a 10 per cent complication rate, for women in age group 15-45.

THE FORMER YUGOSLAV REPUBLIC OF MACEDONIA

Abortion rates are based on numbers of abortions and female age distributions obtained from the Federal Statistical Office and the Federal Institute for Health Care of the former Socialist Federal Republic of Yugoslavia.

TRINIDAD AND TOBAGO

The data were obtained from a World Health Organization report on the frequency and mortality of unsafe abortion (WHO, 1990). The data are based on abortions, excluding legal abortions, performed in hospitals at Port-of-Spain.

TUNISIA

Up to 1988, the rates are based on numbers of abortions obtained from various issues of the United Nations *Demographic Yearbook.* For 1989-1991, numbers of abortions were derived from Boukhris (1992). Female age distributions were used from the United Nations assessment in 1992.

TURKEY

The rates are based on numbers of abortions obtained from the Council of Europe (1993) and female age distributions from the United Nations assessment in 1992.

TURKMENISTAN

The estimates are based on numbers of abortions and female age distributions obtained from *Naselenie SSSR, 1987* and *1988*; and *Demographichesky Ezhegodnik SSSR, 1990* (USSR, State Committee on Statistics, 1988, 1989, 1990); and from the Statistical Committee of the Commonwealth of Independent States. The rates include officially registered abortions and exclude illegal abortions. After 1988, the data include early-stage abortions performed by vacuum aspiration.

UGANDA

The figures were obtained from the World Health Organization report on the frequency and mortality of unsafe abortion (WHO, 1990). The data are based on abortions, excluding legal abortions, performed in hospitals at Kampala.

UKRAINE

The estimates are based on numbers of abortions and female age distributions obtained from *Naselenie SSSR, 1987* and *1988*; and *Demographichesky Ezhegodnik SSSR, 1990* (USSR, State Committee on Statistics, 1988, 1989, 1990); from *Narodnoe Hozyaistvo Ukrainskoi SSR v 1989 godu, Narodne Gospodarstvo Ukraini u 1991 rotsi* (Ukraine, Ministry of Statistics, 1990, 1992); and from the Statistical Committee of the Commonwealth of Independent States. The rates include officially registered abortions and exclude illegal abortions. After 1988, the data include early-stage abortions performed by vacuum aspiration.

UNITED KINGDOM

The rates are based on numbers of abortions and female age distributions derived from various issues of the United Nations *Demographic Yearbook*. The figures are given for residents only. These are effectively data for Great Britain, as no legally induced abortions are performed in Northern Ireland.

UNITED REPUBLIC OF TANZANIA

The figures were obtained from the World Health Organization report on the frequency and mortality of unsafe abortion (WHO, 1990). The figure is based on abortions, excluding legal abortions, performed in hospitals at Kilimanjaro.

UNITED STATES OF AMERICA

Up to 1988, the rates are based on numbers of abortions derived from a publication of the Department of Health and Human Services (Ventura and others, 1992) and on de Guibert-Lantoine and Monnier (1992); and on female age distributions from the United Nations assessment in 1992 and from United States of America (1992). For 1989-1991, the rates were obtained from the Alan Guttmacher Institute.

UZBEKISTAN

The estimates are based on numbers of abortions and female age distributions obtained from *Naselenie SSSR, 1987* and *1988*; and *Demographichesky Ezhegodnik SSSR, 1990* (USSR, State Committee on Statistics, 1988, 1989, 1990); and from the Statistical Committee of the Commonwealth of Independent States. The rates include officially registered abortions and exclude illegal abortions. After 1988, the data include early-stage abortions performed by vacuum aspiration.

VENEZUELA

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 services in Venezuela. The figure includes both induced and spontaneous abortion.

VIET NAM

The rates are based on numbers of abortions obtained from Ross and others (1992) and female age distributions from the United Nations assessment in 1992.

YUGOSLAVIA

Abortion rates are based on numbers of abortions and female age distributions obtained from the Federal Statistical Office and the Federal Institute for Health Care.

ZAIRE

The rate was obtained from a World Health Organization report on the frequency and mortality of unsafe abortion (WHO, 1990). The figure is based on abortions, excluding legal abortions, performed in hospitals at Kinshasa.

ZAMBIA

The statistics were extracted from monthly returns submitted by hospitals and health centres. Therefore, they may not present a complete picture of abortion in Zambia. The data were provided by J. P. Mbanda, Central Statistics Office, Lusaka, Zambia.

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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 and the Seventh United Nations Population Inquiry among Governments and from other materials in the Population Policy Data Bank maintained by the Population Division of the Department for Economic and Social Information and Policy Analysis of the United Nations Secretariat.

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[a]All countries covered in chapters IV and V are listed alphabetically in the reference list.

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