Economic & Social Affairs

Abortion Policies

A Global Review

Volume I

Afghanistan to France

A

Afghanistan
Albania
Algeria
Andorra
Angola
Antigua and Barbuda
Argentina
Armenia
Australia
Austria
Azerbaijan

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El Salvador
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Ethiopia

F

Fiji
Finland
France

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Department of Economic and Social Affairs
Population Division

Abortion Policies
A Global Review

Volume I
Afghanistan to France

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

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

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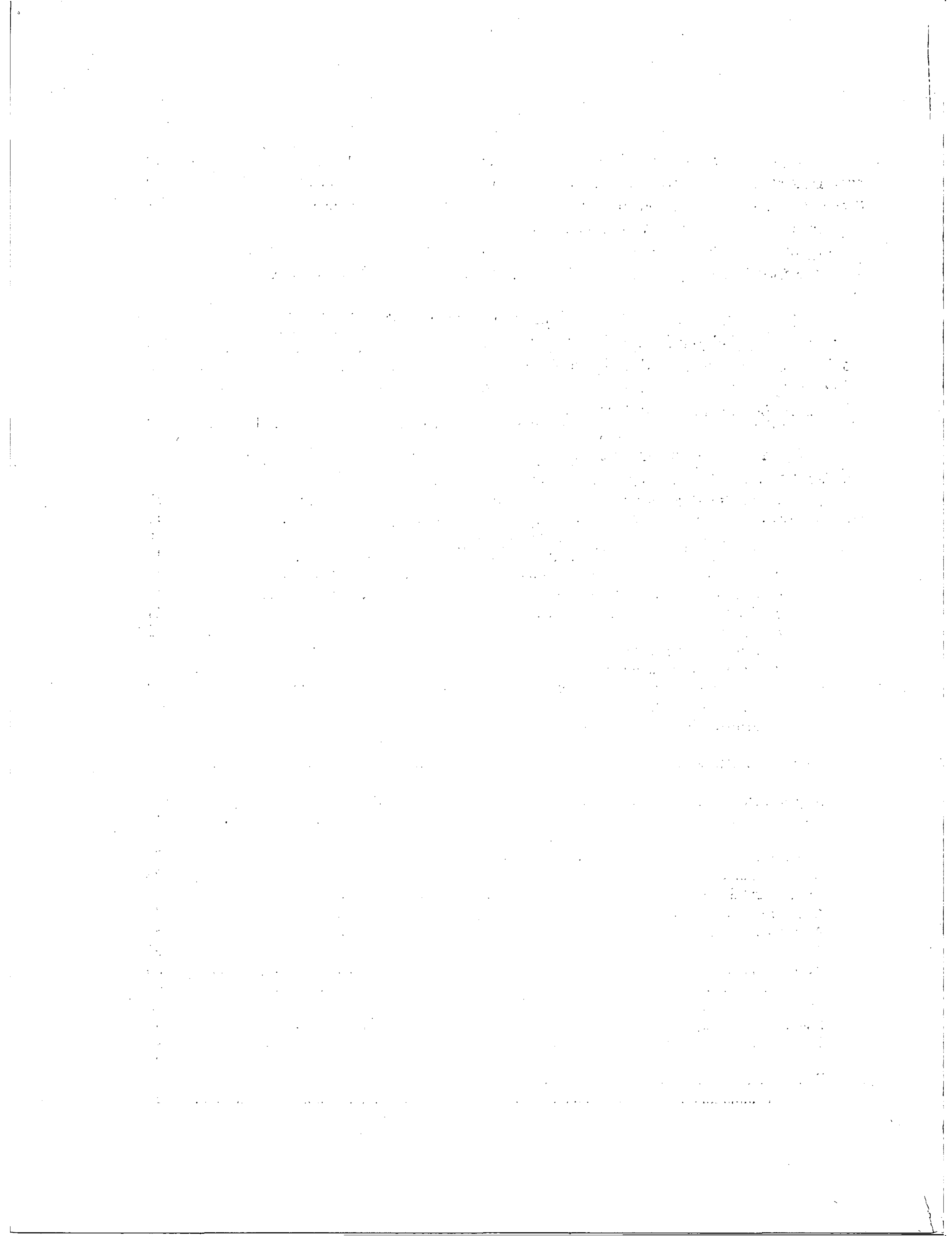
PREFACE

Abortion Policies: A Global Review presents, in three volumes, a country-by-country examination of national policies concerning induced abortion and the context within which abortion takes place. Comparable information is presented for all States Members of the United Nations and non-member States. The countries are arranged in alphabetical order: volume I covers Afghanistan to France; volume II covers Gabon to Norway; and volume III covers Oman to Zimbabwe. In volume I, the country names are those in use as of 31 December 1999.

This report was prepared by the Population Division of the United Nations Secretariat. The assessment was facilitated to a great extent by close cooperation among the United Nations bodies. The financial support of the United Nations Population Fund (UNFPA) is also gratefully acknowledged. Acknowledgement is also due to Reed Boland, who assisted the Population Division in the preparation of this report.

The availability of information on abortion policies varies widely from one country to another. As a result, data for some countries may be incomplete or almost entirely absent. Readers are therefore invited to send any information, comments or corrections they deem useful to the Director, Population Division, Department of Economic and Social Affairs, United Nations Secretariat, New York, NY 10017, United States of America.



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Explanatory notes

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

Various symbols have been used in the tables throughout this report, as follows:

Two dots (..) indicate that data are not available or are not separately reported.
An em dash (—) indicates that the population is less than 500 persons.
A hyphen (-) indicates that the item is not applicable.
A minus sign (-) before a figure indicates a decrease.
A full stop (.) is used to indicate decimals.
Use of a hyphen (-) between years, for example, 1995-2000, signifies the full period involved, from 1 July of the beginning year to 1 July of the end year.

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

Countries and areas are grouped geographically into six major areas: Africa, Asia, Europe, Latin America and the Caribbean, Northern America and Oceania. Those major areas are further divided geographically into 21 regions. In addition, for statistical convenience, the regions are classified as belonging to either of two general groups: more developed or less developed regions. The less developed regions include all regions of Africa, Asia (excluding Japan), Latin America and the Caribbean, Melanesia, Micronesia and Polynesia. The more developed regions comprise Northern America, Japan, Europe and Australia/New Zealand.

The group of least developed countries currently comprises 48 countries: Afghanistan, Angola, Bangladesh, Benin, Bhutan, Burkina Faso, Burundi, Cambodia, Cape Verde, the Central African Republic, Chad, the Comoros, the Democratic Republic of the Congo, Djibouti, Equatorial Guinea, Eritrea, Ethiopia, the Gambia, Guinea, Guinea-Bissau, Haiti, Kiribati, the Lao People's Democratic Republic, Lesotho, Liberia, Madagascar, Malawi, Maldives, Mali, Mauritania, Mozambique, Myanmar, Nepal, the Niger, Rwanda, Samoa, Sao Tome and Principe, Sierra Leone, Solomon Islands, Somalia, the Sudan, Togo, Tuvalu, Uganda, the United Republic of Tanzania, Vanuatu, Yemen and Zambia.

The following abbreviations are used in this volume:

ASFR	age-specific fertility rate
CDC	United States Centres for Disease Control and Prevention
CFA	Communauté financière africaine
GCC	Gulf Cooperation Council
HIV	human immunodeficiency virus
IPPF	International Planned Parenthood Foundation
IUD	intrauterine device
PAHO	Pan American Health Organization
PROFAMILIA	Asociación Pro-Bienestar de la Familia Colombiana (Colombia) Asociación Pro-Bienestar de la Familia (Dominican Republic)
TFR	total fertility rate
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USSR	the former Union of Soviet Socialist Republics
WHO	World Health Organization

INTRODUCTION

Although abortion is commonly practised throughout most of the world and has been practised since long before the beginning of recorded history, it is a subject that arouses passion and controversy. Abortion raises fundamental questions about human existence, such as when life begins and what it is that makes us human. Abortion is at the heart of such contentious issues as the right of women to control their own bodies, the nature of the State's duty to protect the unborn, the tension between secular and religious views of human life and the individual and society, the rights of spouses and parents to be involved in the abortion decision, and the conflicting rights of the mother and the foetus. Also central to the subject of abortion is one of the most highly controversial social issues of all, sexuality. Any discussion of abortion almost inevitably leads to a consideration of how a pregnancy came about and ways that the pregnancy could have been prevented by the use of contraceptive methods. As the new century begins, these questions and issues continue to occupy a significant place in public discourse around the world.

This study does not attempt to answer any of these questions or resolve these controversies. Rather, it aims at providing objective information about the nature of laws and policies relating to abortion at the end of the twentieth century. It consists of an analysis of abortion law and policy in all countries, both developed and developing. Included in this analysis is information on the social and political settings of these developments, the ways in which these laws and policies have been formulated, and how they have evolved over time. Where possible, data on the incidence of abortion have been cited. 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.

I. MAJOR DIMENSIONS OF ABORTION POLICY

A. PRACTICAL CHALLENGES

Preparing a worldwide overview of abortion law and policy and an analysis of recent developments involves a number of major challenges. Some are largely practical in nature. Legal materials in many countries, particularly in the developing countries, are difficult to obtain. The legal infrastructure of some countries is not well developed, laws in force have not been collected or brought up to date and information about laws is not widely disseminated even within the country. Other more pressing social and economic problems often consume scarce resources that otherwise might be devoted to the publication and consolidation of legislation and court decisions. Wars, civil disturbances, dramatic changes in Governments and even legal systems also contribute to this problem, making it difficult in a few countries even to ascertain what laws are in effect. In some countries language is also a barrier, as legislation is published in a vernacular that is not widely known outside the country or is not accurately translated. A further complication arises from the federal nature of certain countries. As the individual sub-jurisdictions—usually states—of these countries have their own separate laws, more than one abortion law may be in effect within a country. When the inevitable delays in the communication of legal and policy changes are taken into consideration, the challenge of compiling accurate information can be formidable.

Moreover, the legal provisions governing abortion in many countries are not always conveniently located within one text. The most common place in which such provisions appear is a country's criminal code or criminal laws relating to offences against persons, for abortion has, at least in the last two centuries, been considered a criminal offence of a highly serious nature. However, with the movement during the last half of the twentieth century to liberalize abortion laws, this is no longer invariably the case; consequently, legal provisions on abortion can be found in a variety of places. Some countries have incorporated liberalized abortion provisions into their criminal codes. Others have enacted special abortion laws that are separate from criminal codes. Thus it is possible for a criminal code to prohibit abortions, while a law on abortion will describe the circumstances under which abortions are allowed. In still other countries, public health codes or medical ethics codes may contain special provisions that clarify how to interpret an abortion law. For example, a medical ethics code may specify the circumstances under which it is ethically acceptable for a physician to perform an abortion. In a final group of countries, mostly common-law countries (see below), abortion may not be governed by a specific law, but by a court decision. In a few cases, the existence of multiple texts, each with conflicting provisions, can make it difficult to determine the exact nature of the law and policy concerning abortion in a specific country.

B. CONCEPTUAL CHALLENGES

1. *World legal systems*

Even when specific legal materials are available, other challenges abound. One major problem relates to the wide variations in the sources of abortion law. Although in recent years tentative efforts have been made to internationalize or standardize some aspects of law, most notably through international and regional bodies, abortion law, like most law in the countries of the world, is governed by widely differing legal systems. These systems are based on varying sets of principles; they formulate issues and define terms in dissimilar ways. Comparing the treatment of a specific topic under these systems is, of necessity, a hazardous undertaking.

In general, the majority of countries at the beginning of the twenty-first century adhere to one of three major legal systems: civil law, including what was once denominated "socialist law," common law and Islamic law. Civil law, which derives ultimately from Roman law, and more recently from the Napoleonic

Code enacted by the Government of France at the beginning of the nineteenth century, is a system based primarily on codified laws, such as civil codes, penal codes, family codes and commercial codes, each devoted to a specific topic. These codes have been designed by Governments to serve as a general guide to proper conduct for individuals, with the goal of protecting justice and morality in society as a whole. Civil law places an emphasis on social responsibility, and the rights of the person are viewed within a social context rather than as a separate and inalienable characteristic of individuals. Interpretation of the laws by judges plays a relatively minor role in shaping law under civil systems.

One major branch of civil law is socialist law, which was enacted in the twentieth century, after the First and Second World Wars, by the newly created Marxist States in Eastern Europe and parts of Asia. Like civil law, socialist law is based on codification, largely of Marxist and socialist principles, and allows judges little room for interpretation of laws, except to conform to those principles. It emphasizes primarily the good of society as a whole, not the rights of individuals, and establishes a sort of guide for conduct. It differs from the civil law model in that it was initially imposed as a means of radically transforming the economic and social bases of society, as well as the behaviour and attitudes of its people. It was only after this transformation occurred that it came to function as a means of preserving the order of society.

In contrast, common law has its origins not in codes, but in court determinations made by judges within the lands governed by the English crown. Law was viewed not primarily as a guide for conduct, but as a means of resolving disputes by individuals. It emphasized principles of self-reliance and individual rights such as property rights and freedom of contract more than the order and welfare of society. Under a common law system, law changes and progresses not primarily by means of enactment by the Government, but through the development of a body of court decisions containing the changing interpretations of judges as social conditions change. Although statutes are enacted under the common law system, judges are given much greater leeway than under the civil law system to interpret these statutes in novel ways. Hence, under the common law system, law is more fluid and less static than under the civil law system.

Islamic law, known as Shariah, which can be viewed as an example of a larger category of religious law, differs in important ways from both civil law and common law. The primary difference is in its conception of law as inseparable from religion, so that no distinctions exist between the secular and the religious, as there are under the civil and common law systems. Law under Islam is based primarily on the text of the Quran, the holy book of Islam and the *sunnah*, the collection of acts and statements made by the prophet Mohammed, and is considered a guide for human conduct. Owing to its reliance on these texts, Islamic law is for the most part fixed and viewed as unchanging, except with respect to issues and situations not specifically encountered within the Quran and *sunnah*. In these cases, Islamic jurists engage in interpretation and employ deductive or analogical reasoning leading to consensus.

In practice, only in very few cases does the law of any individual country conform exactly to one of the above models. Most legal systems contain elements of more than one model, drawing as well on local indigenous legal traditions. Two recent trends tending to break down these distinctions between the systems are of particular significance. One is the tendency of common law and civil law systems to merge; countries that initially followed a common law tradition have engaged in greater efforts to codify laws, while countries that relied mainly on a civil law tradition have given greater interpretive powers to courts. This is especially evident at the end of the twentieth century as numerous civil law countries have established new constitutional courts with wide authority to rule on the validity of legislative enactments. The second is the collapse of the socialist Governments of the former Union of Soviet Socialist Republics and Eastern Europe since 1990 and the withering away of the particularly socialist elements of their law. Naturally, some countries have not followed these trends. For example, China, Cuba, Viet Nam and the Democratic People's Republic of Korea still maintain socialist legal systems. Yet, even in a number of these countries, the law, at least in commercial areas, is moving away from socialist principles as their Governments increasingly turn to capitalist models of economic development.

Moreover, laws in many countries, although based on one of the above models, have been strongly influenced by local legal and cultural traditions. Religions play or have played an important role in shaping legislation in a number of countries, particularly law relating to personal relationships, such as marriage, family interactions, children, and inheritance. Although not accepted as official law, canon law as developed by the Roman Catholic Church has been a significant force in countries with large Catholic populations such as Portugal, Spain and the countries of Latin America, as have Shintoism and Buddhism in Japan. Local customary law, as practised by indigenous populations before the advent of European colonialism, has played a similar role in many developing countries of Africa and Oceania. There, much of the law dealing with personal relationships—mostly family law—is based on the traditions of various ethnic groups.

One of the most challenging and complex problems that has faced many developing countries since their independence, with the exception of those in Latin America, is how to integrate and harmonize the various legal traditions in operation within their boundaries, including religious-based law, customary law, and the common law and civil law imposed by or imported from Western countries. Different strategies have been tried. Some have preserved religious and customary law within the sphere of personal relationships while relying on colonial-based law in other areas of life. Some, such as Indonesia, have tried to blend the two to form a unique national system. Some, including Turkey and Japan, have almost entirely adopted Western models similar to those of France, Germany and Switzerland. Owing to civil unrest and economic hardship, a few countries have not yet begun the process and have left colonial laws intact. Most recently, some countries, such as Afghanistan, Iran, Sudan and, increasingly, Pakistan, have moved to Islamic models.

Despite the hybrid nature of law in many countries, their legal systems can still be broadly categorized under the three major systems, resulting in great part from the phenomenon of colonialism, which was experienced by almost all developing countries from the sixteenth to the twentieth centuries. The United Kingdom of Great Britain and Northern Ireland and most of the countries once under its colonial rule have followed a common law path. Thus, Australia, Bangladesh, Canada, India, Ireland, Malaysia, New Zealand, Pakistan, Singapore and the United States of America as well as the Anglophone countries of Africa, the Caribbean and Oceania have adopted common law. Most of the remaining countries of Europe, including Belgium, France, Portugal and Spain and the developing countries formerly under their control, adhere to a civil law system. Among these countries are those of Latin America, non-Anglophone sub-Saharan Africa, the former Soviet Republics of Central and Western Asia, and various other developing countries. In addition, the law of a number of countries of Northern Africa and the Middle East has been significantly influenced by French civil law and, as noted above, Turkey and Japan have adopted civil law models. Islamic law is of greatest importance in the countries of Northern Africa and Western Asia, regions with predominantly Muslim populations, and strongly influences personal law in other countries such as Bangladesh, Indonesia, Malaysia and Pakistan.

2. *Abortion laws within legal systems*

The above differences in legal systems and in sources of laws have left a strong imprint on the abortion law of various countries. Most common law countries, other than the United States, have abortion laws that are based on various English laws and court decisions. Some take as their model the Offences Against the Person Act of 1861. Under this Act it was prohibited "unlawfully" to use any means to procure an abortion either for oneself or for another person or unlawfully to supply means for that end, and the prescribed punishment was imprisonment. Originally, this Act was interpreted as prohibiting all abortions, except those performed on the grounds of necessity, in order to save the life of the pregnant woman. Other countries follow the English court decision, *Rex* v. *Bourne*, in which it was held that abortions performed for serious physical or mental health reasons would not be considered "unlawful" under the 1861 Act. Still other countries have looked to the British Abortion Act of 1967, which sets forth broad health, foetal impairment, and socio-economic indications for abortions, in general until the twenty-fourth week of pregnancy.

The abortion laws of many civil law countries are based on the abortion provisions of the French Napoleonic Code of 1810, the 1939 French version of that Code or the 1979 abortion law of France. Under the 1810 Napoleonic Code, any person who by any means procured the abortion of a pregnant woman was punished with imprisonment, as was a pregnant woman who procured her own abortion, although it was understood that an abortion could be performed when necessary to save the life of the pregnant woman. To the provisions of the 1810 Code, the 1939 French Penal Code added language specifically allowing an abortion to be performed to save the life of the pregnant woman. The 1979 Law allows a woman who is in a state of distress to have an abortion performed on request during the first ten weeks of pregnancy after she undergoes counselling and waits a week, and later in pregnancy on other serious grounds. In contrast to the common law system, court interpretations of these laws play a minor role.

Unlike the situation in either the common law or civil law countries, no single abortion text or court case can be identified as the model for most modern Islamic abortion laws. The Quran and the *sunnah*, the two primary sources of Islamic law, do not deal specifically with abortion. Moreover, until recently, Islamic criminal laws were not always codified. Consequently, Islamic law adopts a number of approaches towards abortion, depending upon which of the five major schools of Islamic law is followed. In general, the attitude of Islamic law towards abortion is dependent upon whether the abortion is performed before ensoulment, the time at which a foetus gains a soul. This is most often viewed as occurring 120 days into a pregnancy, but is also interpreted as occurring at 40 days. Some schools permit abortion for justifiable reasons before ensoulment, while others generally prohibit it at all points of pregnancy. All schools, however, allow abortion at any time during pregnancy in order to save the life of the pregnant woman. In contrast to the situation under both common law and civil law, the punishment for abortion under classic Islamic law is payment of a sum of money to the relatives of the foetus. The amount of payment depends upon the stage of pregnancy reached at the time of the abortion. Before ensoulment, the foetus or embryo passes through a number of developmental stages; these are variously described in Arabic as "the lump" or "something that clings."

Owing to the different treatments of abortion in these three legal systems, a number of ambiguities arise in interpreting specific indications for abortion, making any comparison challenging. The most widely accepted indication for abortion—to save the life of the pregnant woman—provides a good example. Broadly speaking, this indication is valid in two categories of countries: those with abortion laws that specifically mention it and those with laws in which it is not mentioned but is inferred from the general criminal-law principles of necessity. In the latter, an abortion, although considered illegal, can be performed on the rationale that it is necessary to preserve a greater good, the life of the pregnant woman.

In practical terms, these two situations differ substantially. In the first, a physician contemplating the performance of an abortion is able to point to a specific legal provision authorizing such an act and be reasonably certain that he or she was acting within the law. In the second, no such certainty exists, only a general principle that could be raised as a defence if the physician were prosecuted for performing an illegal abortion. It would then be a matter for a court to determine after a trial. The result is that in the latter case, a physician would in general exercise much more caution in determining whether to perform an abortion to save the life of the pregnant woman.

A similar situation arises with respect to laws that permit an abortion to be performed to preserve the health of a pregnant woman. An important distinction holds between countries with laws that specifically state that an abortion is allowed to preserve the health of a pregnant woman and countries in which a court or courts have, through their interpretation of a law that lacks specific provisions, allowed such an abortion to take place. In the former, a physician can be reasonably certain of acting within the law; again, in the latter, he or she might have to rely on a court decision as a defence in criminal proceedings. Moreover, unless the court whose decision is being relied on is the highest court in the country, its ruling may not be definitive.

Even in common law countries, lower courts are not bound by the decision of another lower court, although they may pay it great heed. Indeed, one reason that the United Kingdom enacted the 1967 Abortion Act was to give statutory expression to *Rex* v. *Bourne* and ensure that it would be considered the law of the land. By means of this legislation, it hoped to provide physicians with greater guidance and legal security in the performance of legal abortions.

Additional ambiguities are connected with the health indication for abortion. One is that a number of countries use the term "health" in their abortion laws without specifying what it encompasses. Thus it is unclear whether they intend abortions to be allowed in cases of threat to mental and physical health or only physical health. If one follows the definition of health accepted by the World Health Organization, health is a very broad term—"a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity," then abortion for health reasons would be very common (WHO, 1994b). It is doubtful, however, that such an expansive definition of health was intended by many of the abortion laws enacted so long ago. The question arises as to whether health should be interpreted as historically understood or in the light of current thinking. Similarly, unless a country specifies that the threat must be serious or grave or permanently disabling, it is unclear what degree of threat to health is intended.

Other terms referring to health are even more ambiguous. Some countries allow abortions for "therapeutic" purposes or permit abortions for the purpose of "medical or surgical treatment." Others provide that the threat to health by continuation of the pregnancy must be greater than the threat posed by its termination. Statistically, during the first trimester, a pregnancy is always a greater threat to health than its termination; it is therefore difficult to determine how to interpret this phrase. A literal interpretation would allow abortion under most circumstances. Given such a lack of clarity in the laws, the designation of a country as allowing abortions for health purposes can cover a wide variety of situations. These range from allowing abortion only in cases that threaten permanent and serious damage to physical health, to cases that threaten mental health owing to socio-economic distress, to the case of "medical or surgical treatment", which is essentially abortion on request. Unless the issue has been the subject of litigation in the courts, or a target of significant legal analysis of the nature of the threat in legal commentaries, it is difficult to ascertain exactly what the circumstances must be to justify an abortion.

Procedural requirements to establish the presence of an indication for abortion are also a factor in determining the exact nature of an indication for abortion. In the context of the indication of health, it may be necessary for two or three physicians to attest to the threat to health. A great deal of difference exists between this and the situation in which the physician who is willing to perform the abortion is the only judge of whether the indication is present. In the context of abortions performed in cases of pregnancy due to rape or incest, a variety of mandated procedures also prevail. In some countries, the incident of rape or incest must be reported to police or judicial authorities, while in others the pregnant woman must only reasonably believe that the pregnancy was the result of rape or incest. Some specify no procedural requirements or, conversely, require a judicial determination that the pregnancy was the result of rape or incest. Such differences again produce a significant variation on the nature of the indication of pregnancy due to rape or incest in various countries.

The terminology employed under Islamic law presents another formidable challenge in comparing abortion laws. The principles underlying Islamic law differ fundamentally from those of common and civil law, which have at the most basic level a Western orientation; it is therefore difficult to compare laws under the two systems. An example of this problem involves the notion under Islamic law that the crime of abortion is punished not by imprisonment and government-imposed fines, but by the payment of compensation by the perpetrator of the crime to the relatives of the victim of the crime. In the context of abortion, this is entirely foreign to Western law. The problem is also illustrated in the definition of the stages of pregnancy. While Western law does recognize different stages of pregnancy, in present-day law they are almost exclusively

defined by weeks of gestation; under Islamic law they can be defined in more descriptive terms such as "the lump," "something that clings," "ensoulment," or "the forming of organs and limbs".

C. LAW AND POLICY VERSUS PRACTICE

Beyond these conceptual challenges, determining whether the written law or policy of a country conforms to the practice observed or inferred remains a major problem. In many countries where the performance of abortions is generally illegal, statistics indicate that large numbers are being carried out, most of them illegally, with few prosecutions. Of the approximately 50 million abortions carried out every year in the world, estimates place the number performed illegally at 40 per cent (WHO, 1994a). In these countries, law enforcement authorities ignore or tolerate the performance of illegal abortions or even unofficially license clinics for that purpose. A number of factors are responsible for this situation. Among these are the ease with which abortions can be performed, the lack of will or resources to prosecute, particularly in the light of more pressing social needs, and the clandestine nature of the procedure. In some countries where abortion is technically legal, access to authorized facilities and personnel may be limited, or resources to pay for the abortion may be lacking, resulting in more illegal abortions. In a few cases, although abortion is authorized, the Government may not have issued regulations allowing the law to be effectively implemented. In all of these situations, legal action is rarely taken except in the most egregious cases, usually involving the death of a pregnant woman. In some countries, the indifference to abortion is so great that most of those performing abortions or enforcing laws do not know what the provisions of the law actually are. The advent of new scientific developments such as RU 486, the so-called "abortion pill", which makes abortion even easier to perform without the need for special facilities, will in all probability only increase the gap between law and practice.

II. COUNTRY PROFILES: DESCRIPTION AND REVIEW OF VARIABLES

This chapter contains a detailed description of the variables identified on the first page of each country profile. An attempt was made to provide comparable information for each country. Abortion laws can be complex and diverse; consequently, considerable space is dedicated to the description of the coding of the legal grounds for abortion. The section on abortion policy addresses the grounds on which abortion is permitted, and 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, explanations of a number of reproductive health indicators are given below. In the background section that follows each country profile, abortion policies and their national context are described in further detail.

A. ABORTION POLICY

1. Grounds on which abortion is permitted

The most commonly cited instances in which abortion is permitted include the following:

a) Intervention to save the life of the woman (life grounds);
b) Preservation of the physical health of the woman (narrow health grounds);
c) Preservation of the mental health of the woman (broad health grounds);
d) Termination of pregnancy resulting from rape or incest (juridical grounds);
e) Suspicion of foetal impairment (foetal defect);
f) Termination of pregnancy for economic or social reasons (social grounds).

These are the grounds for abortion that are coded in the first section of each country profile. A few countries may recognize additional grounds for abortion, including the presence in the mother of the human immunodeficiency virus (HIV); the age of the mother, when the pregnant woman is a minor; or contraceptive failure. These categories have only limited applicability, and they are not coded in this variable. However, detailed descriptions are provided in the background section for the relevant country profiles. The exact wording of many laws differs significantly; therefore, variations in the language and interpretation of each of the grounds are also reviewed in detail on the second page. When it is evident that policy deviates from the exact wording of the law, an asterisk is placed next to the relevant item indicating that the legal or official interpretation usually allows the abortion to be performed on those particular grounds. For example, in countries where the performance of an abortion is specifically prohibited under all circumstances, but where performing an abortion to save the life of the pregnant woman is permitted under the general criminal law principle of "necessity", "saving the life of the woman" is coded as permitted but is followed by an asterisk.

In the limited number of countries where abortion law is determined at the local level rather than at the national level, the coded law is marked with an asterisk and an explanation is given below. Where local laws apply, a detailed description of this situation follows in the "Background" section of the text.

(a) Intervention to save the life of the woman

The performance of abortions is most commonly permitted on the grounds of saving the life of the pregnant woman. Although some countries provide detailed lists of what they consider life-threatening situations, in general, these situations are not specified but left to the judgement of the physician or physicians performing and/or approving the performance of the abortion. Almost all countries allow abortions to be performed to save the life of the pregnant woman either explicitly or under the general

criminal law principle of necessity. Exceptions may include Chile, El Salvador and Malta, all of which have amended their abortion laws to eliminate provisions permitting the performance of abortions on certain grounds. Nonetheless, even in these countries, it is unclear whether a defence of necessity would be rejected by a court in the most serious cases of a threat to the life of a pregnant woman.

(b) Preservation of the physical health of the woman

In the majority of countries, abortion is permitted when it is necessary to preserve the physical health of the pregnant woman. The term "physical health", however, has been defined in a number of different ways. In some countries, the definition is narrow, often encompassing lists of conditions that are considered to fall under this category; in other countries, the term "physical health" is broadly defined, allowing much room for interpretation. When possible, the permissible range of interpretations is reviewed in the text. In general, the countries of the British Commonwealth permit a broader definition of health than do the African or Latin American countries adhering to civil law.

In a number of countries, the abortion law does not specify whether the term "health" encompasses both physical and mental health, but merely provides that an 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. However, since the law does not make such a distinction, both physical and mental health have been coded as permitted, with an asterisk referring the reader to a footnote explaining this situation. Any distinctions in terms of actual practice are reviewed in the text.

(c) Preservation of the mental health of the woman

Many abortion laws specifically provide for the legal performance of abortions in cases involving a threat to the mental health of the pregnant woman. What constitutes a threat to "mental health," however, varies significantly. In some countries, no definition exists, while in others, most of them Commonwealth countries, mental health is defined to include emotional distress caused to children of the marriage or emotional distress caused to the pregnant woman as a result of her environment. In these cases, the country has been coded as permitting abortions for socio-economic reasons (see below).

Countries coded as permitting abortions to be performed on mental health grounds also include those British Commonwealth countries that have followed the ruling of the landmark British decision, *Rex v. Bourne*, in which it was held that, although the law may not specifically allow abortions to be performed for physical or mental health reasons, such abortions are considered lawful (see above). The extent to which an abortion is permitted on mental health grounds varies from country to country.

(d) Termination of a pregnancy resulting from rape or incest

Permitting abortions to be performed in cases of rape or incest is a common provision of the world's abortion laws. Even in countries with restrictive abortion legislation, such as the Latin American countries, abortion is often allowed on these grounds. Such justifications for the performance of abortions take several forms. Some countries specifically mention rape and incest in their legislation. Other countries refer to these as cases in which the pregnancy is the result of a "criminal offence", with no specification of the nature of the offence. This phrasing of the law is somewhat broader, encompassing statutory rape (consensual sex with a minor) as well as forced rape and incest. Procedural requirements also vary. Some countries require the case to be brought to court or reported to the authorities before permission for an abortion can be granted, thus discouraging many women from seeking to obtain an abortion on these grounds.

(e) Suspicion of foetal impairment

As is the case with the juridical grounds for abortion, abortions are often permitted on the grounds of foetal impairment in countries with restrictive abortion laws. Several countries specify the type and level of impairment necessary to justify this ground.

(f) Termination of pregnancy for 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 only imply them. For example, in Barbados, the abortion law specifies that, in determining whether the continuation of the pregnancy would involve a risk of injury to the health of the pregnant woman, the medical practitioner must take into account the "pregnant woman's social and economic environment, whether actual or foreseeable". In New South Wales, Australia, where similar wording is employed, reference is made to social and economic stresses. In other cases, as in South Australia and Belize, social and economic grounds are strongly implied: the determination of risk of injury to the health of the pregnant woman must take into account "the woman's actual or reasonably foreseeable environment". Other countries, such as Burundi and Ethiopia, do not permit abortions to be performed on social and economic grounds, but allow such grounds to be taken into consideration in sentencing. Most laws that permit abortions to be performed on social and economic grounds are interpreted quite liberally and, in practice, differ very little from laws that allow abortions on request.

(g) Availability upon request: abortion permitted on all grounds

In countries that allow abortions to be performed on request, a pregnant woman seeking an abortion is not required to justify her desire to have an abortion under the law. She needs only to find a physician who is willing to perform the abortion. In a number of countries, such as Albania, Belgium and France, she may be required to state that she is in a situation of crisis or distress. This requirement, however, is purely a formality and the decision to have the abortion is still completely her own so long as she finds a physician who agrees to perform the abortion. These countries have been coded with an asterisk. Even in countries where abortion is allowed on request, time limits are usually set for the performance of the abortion, often within the first trimester. After this stage of pregnancy, the woman must present a valid ground for the abortion to be permitted.

2. Additional requirements

This section concerns the additional procedural requirements that must be met before an abortion may be legally performed. It includes requirements relating to consent, personnel permitted to perform abortions, places where abortions may be performed, and the time limits within which abortions may be performed.

B. REPRODUCTIVE HEALTH CONTEXT

1. Government 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 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 policies on 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. *Percentage of currently married woman using modern 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. Women that have used a contraceptive method are at some time, on average, more likely to resort to abortion than those that have never used any contraceptive method. However, 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.

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 1995-2000 and are based on available data that have been adjusted to reflect rates for the same five-year period.

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. Many of these young mothers are unmarried, have no means of financial support and may face social disgrace as a result of the pregnancy. Consequently, many resort to abortion.

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

This variable indicates government views of existing health complications resulting from induced abortion and notes any expression of special concern. The information was obtained from government replies to the Eighth United Nations Inquiry among Governments on Population and Development in 1998, or from the Seventh Inquiry in1992. 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 concern about complications of childbearing and childbirth

This variable indicates whether the Government views existing health complications resulting from childbearing and childbirth with special concern. The information was obtained from the government reply to the Eighth 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 childbearing and childbirth.

9. Maternal mortality ratio

Induced abortion accounts for a large percentage of maternal mortality in developing countries, particularly in those with very restrictive abortion laws. 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 ratio measures the number of maternal deaths occurring in a given year per 100,000 live births during that year. Ideally, both that ratio 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 ratios and making comparisons across countries. Under-registration of maternal deaths varies by country, as does under-registration of the cause of death. Even in developed countries, such as the United States of America, maternal mortality has been found to be under-registered by as much as 27 per cent (PAHO, 1990). Under-registration of births is also

significant, and when the degree of under-reporting 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 the unreliability of data on maternal mortality and the lack of information for many countries, ratios for both the country and the region are included with each country profile. 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 1995-2000 unless otherwise specified and therefore permit cross-country comparisons.

III. COUNTRY PROFILES

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

Information not readily available.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Too high
Government intervention concerning fertility level:	No intervention
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women* using modern contraception (aged 15-44, 1972/73):	2
Total fertility rate (1985-1990):	6.9
Age-specific fertility rate (per 1,000 women aged 15-19):	153
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of childbearing and childbirth	..
Maternal mortality ratio (per 100,000 live births):	
National (1975)	1 700
Southern Asia (around 1983)	560
Female life expectancy at birth (1985-1990):	46

* Ever-married women.

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

Afghanistan

BACKGROUND

The Afghanistan Criminal Code of 7 October 1976 stipulates that the performance of an abortion is a criminal offense except to save the life of the mother. A person performing an illegal abortion is subject to imprisonment or payment of a fine. If the person performing the illegal abortion is a medical doctor, surgeon, pharmacist or nurse, he or she is subject to the maximum anticipated punishment for the crime. A woman who induces her own abortion or consents to its being induced is subject to a short term of imprisonment or payment of a fine.

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

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

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

A pregnant woman must receive counselling at least one week before the abortion is performed. An abortion must be performed by a physician specialist or obstetrician/gynaecologist in a public or private health institution.

*The pregnant woman must state that she has psychological and social problems.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Satisfactory
Government intervention concerning fertility level:	To maintain
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49):	..
Total fertility rate (1995-2000):	2.5
Age-specific fertility rate (per 1,000 women aged 15-19; 1995-2000):	34
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of childbearing and childbirth	..
Maternal mortality ratio (per 100,000 live births; 1990):	
National	65
Southern Europe	14
Female life expectancy at birth (1995-2000):	76

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

BACKGROUND

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

The restrictive nature of the law was largely a result of the population policy adopted by the Government of Albania, of which the law was an integral part. The Government pursued an aggressive pronatalist policy. It believed that a larger population was necessary in order to protect the country from foreign influences and exploit its natural resources, which were considered capable of supporting many more people. Prohibiting abortion was viewed as a way of maintaining a high birth rate. As part of the same policy, contraceptives were not imported into the country, and the sale of oral contraceptives was specifically prohibited.

This policy had dramatic health consequences. The maternal mortality ratio was the second highest in Europe, after Romania; an estimated 50 per cent of all pregnancies ended in abortion, mostly self-induced or performed under unsafe and unsanitary conditions. The number of premature births was also abnormally high.

By the late 1980s, the Government had recognized these realities and moved to counteract them. In 1989, the Ministry of Health issued a directive allowing abortions to be legally performed in cases of rape or incest or when the woman was under sixteen years of age. In 1991, it issued another directive legalizing, for the first time, abortion on family planning and social grounds. Under this measure, an abortion could be legally performed a) if a couple requested it because they did not want the child to be born; or b) if a pregnant woman requested it and the pregnancy resulted from extramarital relations. Performance of the abortion had to be approved by a committee, and the cost of the abortion was set at 100 new Albanian leks.

Since the broad legalization of abortion, the Government has taken additional steps to change the abortion law, as well as to encourage family planning. In 1992, the Council of Ministers issued a decision approving the voluntary interruption of pregnancy as a means of preventing unwanted pregnancies. The decision, however, was not directed primarily at abortion and contained no details on time limits, procedures, or required approvals. Rather, it addressed reproductive health in general. It established family planning as a basic human right from which all citizens should be able to benefit of their own free will and guaranteed couples the right to decide on the number of children they want. It approved a wide range of family planning activities, including birth spacing, use of contraceptives, treatment for sterility and for sexually transmitted diseases, and the provision of sex education both in and outside of schools. The decision called for contraceptives to be made available at pharmacies and family planning services to be provided at maternity clinics and women's health centers.

Motivated in part by the fragmentary nature of abortion regulations in the directives and the 1992 decision, the Government in 1995 enacted comprehensive abortion legislation. The legislation sets forth the circumstances under which exceptions will be made to the prohibition of abortion contained in the Penal Code of Albania, which was revised at approximately the same time. The new legislation represents, in some ways, a qualification of the blanket statement in the 1992 decision that abortion could be used as a means of preventing unwanted pregnancies. The first article of the law guarantees respect for any human being from the beginning of life and establishes abortion as an exception to this principle, when indispensable. The law

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

also clearly states that abortion will in no case be considered as a method of family planning. Nonetheless, the law also envisions a broad number of indications for the performance of legal abortions, including abortion at the woman's request, as long as certain procedural requirements are met.

Under the law, abortions can be performed through the twelfth week of pregnancy if a woman states that the pregnancy causes her psychological and social problems and she receives counselling on the following: the health hazards of abortion for future pregnancies and the biological problems of medical intervention; the rights of families and mothers and children as well as the assistance and benefits available to them, and the possibilities for adoption; the institutions and bodies that offer moral and financial support to women; and the names of clinics and hospitals performing abortions. The woman must also wait a week until the abortion is performed. When possible, the husband or parent is to participate in the decision.

Abortions are available throughout pregnancy when a foetal defect is present and when continuation of the pregnancy would endanger the life or health of the woman, as determined by a commission of three physicians. An abortion may be performed through the twenty-second week of pregnancy, if the pregnancy is the result of rape or a sex crime or there are "social reasons" for terminating the pregnancy, as determined by a three-member commission consisting of a physician, a social worker, and a lawyer. Records on abortions are to be kept anonymously, and physicians performing an abortion are required to provide information about family planning services and advice on contraceptive methods. Advertising and propaganda on medicaments and products causing abortion are prohibited. Finally, the law specifies that family planning is a national duty.

The effects of the law on the performance of abortions in Albania is difficult to ascertain. The country is the poorest in Europe and since the fall of the Communist Government in 1990 has experienced continuing periods of political unrest and a shrinking economy. According to recent estimates, some 21,000 abortions are still performed each year, resulting in an abortion rate of 27.2. As in much of Eastern Europe, it appears that women still rely upon abortion as a means of planning births.

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

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

An abortion must be performed by a physician or surgeon in a specialized institution. Therapeutic abortions must be performed before the foetus is viable.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Too high
Government intervention concerning fertility level:	To lower
Government policy on contraceptive use:	Direct support provided
Percentage of currently married* women using modern contraception (aged 15-49, 1995):	52
Total fertility rate (1995-2000):	3.8
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	25
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of childbearing and childbirth	
Maternal mortality ratio (per 100,000 live births; 1990):	
National	160
Northern Africa	340
Female life expectancy at birth (1995-2000):	70

* Ever married

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

BACKGROUND

The Algerian Criminal Code of 8 June 1966 (Articles 304-313) prohibits abortion unless it is performed as an indispensable measure to save the life of the mother. The Public Health Code of 1976 (Ordinance No. 76-79 of 23 October 1976, Articles 28 and 414), however, specifies that abortion is lawful when performed before foetal viability as an essential therapeutic measure to save the life of the mother or to safeguard her seriously endangered health. The Law on the Protection and Promotion of Public Health (Act No. 85-05 of 16 February 1985, Article 72) liberalized abortion laws further by also permitting abortion to be performed as an essential measure to preserve a woman's mental equilibrium when it is seriously jeopardized.

A woman inducing or agreeing to the inducement of her own abortion is subject to imprisonment for a period of 6 to 24 months and a fine. The person who performs the abortion is subject to imprisonment for one to five years and a fine. If that person is a medical practitioner, he or she can also be suspended from practising his or her profession.

Legal abortions may only be performed by a physician or surgeon in a specialized institution, after a medical consultation with a professional colleague (Public Health Code) and an examination carried out in conjunction with a medical specialist (Law on the Protection and Promotion of Public Health). As stated above, a therapeutic abortion must be performed before the foetus is viable.

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

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

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

Andorra

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

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Satisfactory
Government intervention concerning fertility level:	No intervention
Government policy on contraceptive use:	No support provided
Percentage of currently married women* using modern contraception :	..
Total fertility rate (1995-2000):	..
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	9.5
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of childbearing and childbirth	..
Maternal mortality ratio (per 100,000 live births; 1990):	
National	..
Western Europe	..
Female life expectancy at birth (1995-2000):	..

* Ever married.

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

BACKGROUND

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 Bishop of Seo de Urgel in Spain. The legal system in Andorra is based on French and Spanish civil codes.

Although the Penal Code of 11 July 1990 contains no explicit exceptions to the prohibition of abortion, under the general criminal law principles of necessity, an abortion can be performed to save the life of the pregnant woman. According to the Code, a pregnant woman who performs an abortion or consents 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' 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 who customarily, 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' 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' 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' imprisonment.

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

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

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

* The abortion law does not expressly allow abortions to be performed to save the life of the woman, but the general principles of criminal legislation allow abortions to be performed for this reason on the ground of necessity.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Too high
Government intervention concerning fertility level:	No intervention
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49):	..
Total fertility rate (1995-2000):	6.8
Age-specific fertility rate (per 1,000 women aged 15-19; 1995-2000):	25
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	Yes
Complications of childbearing and childbirth	Yes
Maternal mortality ratio (per 100,000 live births; 1990):	
National	..
Middle Africa	950
Female life expectancy at birth (1995-2000):	48

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

Angola

BACKGROUND

Prior to the independence of Angola in 1975, abortion legislation in this country was the same as that of Portugal, which was restrictive. No stated exceptions existed to the general prohibition on the performance of abortions, although the general principles of criminal legislation allowed abortions to be performed to save the life of a pregnant woman on the grounds of necessity. Transgression of the law was also harshly punished.

After independence, Angola retained this abortion law with its harsh punishments. An abortion performed without the consent of the pregnant woman is punishable by imprisonment for a period of two to eight years; an abortion performed with the consent of the woman is punishable by imprisonment for up to three years. A woman who induces her own abortion is subject to the same penalty. If the abortion was performed to conceal the pregnant woman's dishonour, the maximum penalty is reduced to two years. If the abortion results in the death of the woman or serious injury to her, the penalty is increased by one third.

Despite the restrictive nature of Angola's abortion law, it is reported that under special circumstances, abortions are performed on broad health as well as juridical grounds in government facilities.

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

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

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

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

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Satisfactory
Government intervention concerning fertility level:	No intervention
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-44, 1988):	53
Total fertility rate (1995-2000):	..
Age-specific fertility rate (per 1,000 women aged 15-19; 1995-2000):	22
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	Yes
Complications of childbearing and childbirth	..
Maternal mortality ratio (per 100,000 live births):	
National (1986)	88
Caribbean (1990)	400
Female life expectancy at birth (1995-2000):	..

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

Antigua and Barbuda

BACKGROUND

Only limited abortion information is available for Antigua and Barbuda. Under the Offences Against the Person Act of 1873 (cap. 58, part IX, sections 53-54), abortion is considered an offence in all cases. The general criminal law principles of necessity, however, allow an abortion to be performed to save the life of the pregnant woman. Moreover, under the Infant Life Preservation Act of 1937, no person shall be found guilty of the offence of destroying a child capable of being born alive if the act was done in good faith for preserving the life of the mother. This Act is generally understood as applying to an unborn child of at least 28 weeks' duration.

Most countries of the British Commonwealth, whose legal systems are based on British common law, follow the holding of the 1939 English *Rex v. Bourne* decision in determining whether an abortion performed for health reasons is lawful. In the *Rex v. Bourne* decision, a physician was acquitted of the offence of performing an abortion in the case of a woman who had been raped. The court ruled that the abortion was lawful because it had been performed to prevent the woman from becoming "a physical and mental wreck", thus setting a precedent for future abortion cases performed on the grounds of preserving the pregnant woman's physical and mental health. However, in Antigua and Barbuda, although it is a Commonwealth country, the *Bourne* decision is not applicable.

In 1984, the Government began providing family planning services free of charge in all its maternal and child health clinics. Family planning services have also been available through the Antigua Planned Parenthood Association since the 1970s. Laws limit access to family planning services for adolescents without parental consent. A family life education programme that includes sex education and education for family life and responsible parenthood is being introduced in school curricula.

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

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

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

* The Penal Code allows abortions to be performed for health reasons but does not differentiate between physical and mental health. In addition, controversy exists as to whether the Penal Code allows abortions to be performed in all cases of rape or only in cases of the rape of a woman who is an idiot or insane.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Satisfactory
Government intervention concerning fertility level:	No intervention
Government policy on contraceptive use:	No government support
Percentage of currently married women using modern contraception (aged 15-49):	..
Total fertility rate (1995-2000):	2.6
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	65
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	Yes
Complications of childbearing and childbirth	..
Maternal mortality ratio (per 100,000 live births, 1990):	
National	100
South America	200
Female life expectancy at birth (1995-2000):	77

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

BACKGROUND

Decree No. 3992/84 of 21 December 1984 approving the ordered text of Law No. 11179, the Penal Code (Articles 85-88) prohibits abortion except when performed to prevent endangerment of the mother's life or health, when this cannot be achieved by other means, or if the pregnancy results from a rape or an attack on the chastity of a woman who is an idiot or insane. The latter indication for abortion has been a matter of some controversy. It is unclear from the language whether it permits abortions in the case of pregnancies that result from rape as well as pregnancies that result from an attack on the chastity of a woman who is an idiot or insane or only in the case of pregnancies that result from the rape or attack on the chastity of a woman who is an idiot or insane. The latter opinion is held by the majority of commentators, particularly since an earlier version of the Code clearly permitted abortion when the pregnancy resulted from rape, provided criminal proceedings had been initiated. In 1984, this version was replaced with the current version.

Abortions must be performed by a licensed physician and with the consent of the pregnant woman, or her legal representative, in the case of a rape or attack on the chastity of a woman who is an idiot or insane. A person inducing an abortion is subject to imprisonment for a period of 3-10 years if the abortion is performed without the woman's consent and for 15 years if the woman dies. If the abortion is induced with the woman's consent, the person is subject to one to four years' imprisonment, or six years' imprisonment if the woman dies. A woman inducing her own abortion or consenting to its inducement is subject to one to four years' imprisonment. Physicians, surgeons, midwives and pharmacists performing unlawful abortions are also subject to suspension from practising their profession for a period of time twice as long as the prison term to which they have been sentenced.

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

The high incidence of abortion has been partly attributed to both the limited availability of contraceptive methods and limited access to information about contraception. Family planning activities were prohibited by the military Government in 1974 and remained so until 1986, when Decree No. 2274 (5 December 1986) was introduced, repealing the 1974 decree. The 1986 decree stipulated that the Ministry of Health and Social Action should develop and implement programmes to improve maternal and child health. Resolutions No. 463/88 of 23 November 1988 and No. 8535 of 2 August 1996 went a step further, approving the development of a reproductive health programme. The programme's primary objective is to provide women of high reproductive risk with family planning information and services.

Despite advancements in the legal climate concerning access to contraception, the Government has not passed legislation permitting the implementation of those resolutions. Thus, although family planning is now legal and available in the private sector, it is not easily available to women who, for economic reasons, must rely upon the public sector.

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

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

An abortion requires the consent of the pregnant woman; it is authorized 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 if authorized by a commission of local physicians.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Too low
Government intervention concerning fertility level:	To raise
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49, 1990):	12
Total fertility rate (1995-2000):	1.5
Age-specific fertility rate (per 1,000 women aged 15-19; 1995-2000):	41
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of childbearing and childbirth	..
Maternal mortality ratio (per 100,000 live births; 1990):	
National	50
Western Asia	320
Female life expectancy at birth (1995-2000):	74

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

Armenia

BACKGROUND

As in all of the former USSR, Armenia, known prior to 1992 as the Armenian Soviet Socialist Republic, was subject to the abortion legislation and regulations of the former Union of Soviet Socialist Republics. As a result, abortion practices in Armenia were similar to those throughout the former USSR.

The description given below pertains to the situation in Armenia prior to independence. Since independence, no changes have been made in the abortion law.

The Soviet Decree of 27 June 1936 prohibited the performance of abortions except in the case of a danger to life, a serious threat to health, or the existence of a serious disease that could be inherited from the parents. The abortion had to be performed in a hospital or maternity home. Physicians who performed abortions outside a hospital or without the presence of one of these indications were subject to one to two years' imprisonment. If the abortion was performed under unsanitary conditions or by a person with no special medical education, the penalty was no less than three years' imprisonment. A person who induced a woman to have an abortion was subject to two years' imprisonment. A pregnant woman who underwent an abortion was subject to a reprimand and the payment of a fine of up to 300 roubles in the case of a repeat offence.

In an edict of 23 November 1955, the Government of the former USSR repealed the general prohibition on the performance of abortions contained in the 1936 Decree. Other regulations, also issued in 1955, specified that abortions could be performed freely during the first 12 weeks of pregnancy, if no contraindication existed, and after that point, when the continuance of the pregnancy and the birth would harm the mother (interpreted to include foetal handicap). The abortion had to be performed in a hospital by a physician and, unless the mother's health was threatened, a fee was charged. Persons who performed an abortion illegally were subject to criminal penalties established by criminal laws such as the Criminal Code. For example, if the abortion was not performed in a hospital, a penalty of up to one year's imprisonment could be imposed and if it was performed by a person without an advanced medical degree, a penalty of up to two years' imprisonment was possible. In the case of repeat offences or the death or serious injury of the pregnant woman, a higher penalty of up to eight years' imprisonment could be imposed. A woman who underwent an illegal abortion was not penalized.

Despite the approval of the 1955 edict and regulations, the problem of illegal abortions did not entirely disappear in the former USSR. This situation resulted in part from the Government's conflicted attitude towards contraception. Although at times it manifested support for contraception, it did little to make contraception available and in 1974 effectively banned the widespread use of oral contraceptives. The result was a reliance on abortion as the primary method of family planning.

Concerned with the high rate of illegal abortions, in 1982 the Government issued a decree allowing abortions for health reasons to be performed through the twenty-eighth week of pregnancy. The Government continued to extend the circumstances under which legal abortions were available, and on 31 December 1987 it issued another decree establishing a broad range of non-medical indications for abortions performed on request through the twenty-eighth week of pregnancy. These included the death of the husband during pregnancy; imprisonment of the pregnant woman or her husband; deprivation of maternity rights; multiparity (the number of children exceeds five); divorce during pregnancy; pregnancy following rape; and child disability in the family. Moreover, the order provided that, with the approval of a commission, an abortion could performed on any other grounds.

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

This extension of the grounds for abortion after the first twelve weeks of pregnancy, combined with the ambivalent attitude of the Government towards contraception, led to a dramatic increase in the number of officially reported abortions. Other factors resulting in a high incidence of abortion have included shortages of high-quality modern contraceptives and reliance upon less dependable traditional methods; among couples, a lack of knowledge 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 USSR amounted to only 11 per cent of demand; intrauterine 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 Armenia, 12 per cent of all women aged 15-49 years regularly used contraception, 10 per cent sometimes used contraception, 60 per cent did not use any contraceptive method and 18 per cent knew nothing about contraception.

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

ABORTION POLICY

Grounds on which abortion is permitted*

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

Additional requirements

Consent of the woman is required in all states and territories. In South Australia, the Australian Capital Territory, and the Northern Territory, abortion requires the consent of two physicians and must be performed in a hospital.

* The grounds on which abortion is permitted vary by jurisdiction, with Tasmania having the most restrictive law and Western Australia the most liberal.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Satisfactory
Government intervention concerning fertility level:	No intervention
Government policy on contraceptive use:	Indirect support provided
Percentage of currently married women using modern contraception (aged 20-49; 1986):	76
Total fertility rate (1995-2000):	1.8
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	20
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	No
Complications of childbearing and childbirth	No
Maternal mortality ratio (per 100,000 live births; 1990):	
National	9
Oceania	10
Female life expectancy at birth (1995-2000):	81

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

BACKGROUND

Restrictions on abortion in Australia vary by jurisdiction, each of which has its own criminal law system. Despite this fact, the actual abortion laws in effect in the various states have, until recently, been quite uniform. Most are based on the Offences Against the Person Act 1861 (United Kingdom), which prohibits the performance of "unlawful" abortions, with either a statutory or case law qualification that an abortion will not be unlawful if performed to preserve the pregnant woman's life or health, as determined by a physician. Depending on the state concerned, life or health is interpreted with varying degrees of liberality. In Victoria and Queensland, case law either suggests or explicitly states that abortions can be performed to preserve a woman from serious danger to her life or physical or mental health. In New South Wales, case law provides for the same indications and also states that socio-economic factors can be considered. The abortion law of the Australian Capital Territory, where the criminal law of New South Wales is applicable, presumably allows abortion to be performed on the same grounds. In Tasmania, however, the legal situation is less clear. It could be argued that the law permits abortions to be legally performed only to preserve the life of the pregnant woman or that it also permits abortions in cases of a threat to health.

South Australia and the Northern Territory have enacted legislation modeled on the 1967 Abortion Act of the United Kingdom. Abortions can be legally performed in these jurisdictions if the risk to the pregnant woman's life or to her physical or mental health is greater than it would be if the pregnancy were not terminated and in cases where a substantial risk exists that the child will be seriously physically or mental handicapped. The abortion must be approved by two medical practitioners and must be performed in a hospital. In addition, in the Northern Territory, it must be performed during the first fourteen weeks of pregnancy, except in the case of a threat to life or physical or mental health, or a risk of serious injury.

The maximum prison terms for persons performing illegal abortions under these laws range from seven years to life imprisonment. Women inducing their own abortion are subject to different penalties. The laws of some states explicitly require the consent of the woman; none require the consent of the spouse, and in 1989 the Family Court of Australia denied an injunction sought by a husband to prevent his wife from having an abortion. Parental consent is required if the female is under age 16 in the Northern Territory. Government health insurance benefits, available to all citizens of Australia, cover legal abortions.

Western Australia, however, has a somewhat different law. In 1998 the state enacted legislation repealing restrictions on the performance of abortions in early pregnancy. The legislation was prompted by two events: 1) the arrest and prosecution of two physicians who performed abortions in a free-standing clinic; and 2) the subsequent decision of many physicians performing abortions in Western Australia to stop their practice until the legal situation was clarified. Negative reaction to the possibility of abortion prosecutions and the prospect of abortions ceasing to be performed was so great that, within four months, the legislature voted to allow abortions to be performed on request under certain circumstances.

Under the old law in Western Australia, an abortion was illegal unless it was performed for the preservation of the mother's life and was reasonable, taking into consideration the patient's state at the time and all the circumstances of the case. A physician convicted of performing an illegal abortion was subject to up to fourteen years' imprisonment. Case law was not available to help determine which abortions would be considered "reasonable."

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

Under the new law, abortions can be legally performed through the twentieth week of pregnancy if the pregnant woman gives her informed consent. In order to give informed consent, she must be provided by a physician other than the one performing the abortion with counselling on the following: 1) the medical risks of termination of pregnancy and of carrying the pregnancy to term; 2) the opportunity to be referred to appropriate and adequate counselling about matters relating to termination of pregnancy and carrying the pregnancy to term; and 3) the fact that counselling will be available should she wish it upon termination of the pregnancy or after carrying the pregnancy to term. Abortions may be performed after the twentieth week of pregnancy if the pregnant woman has a severe medical condition that warrants the abortion as determined by two physicians. The penalty for the performance of an illegal abortion is a fine of $50,000.

Although the indications for abortion in Australia, except for Western Australia, are somewhat restrictive, the practice of abortion in large parts of the country is much more liberal. Since the early 1970s, there have been almost no prosecutions for the performance of abortions. Prosecutions are deemed politically unwise and difficult to win given that what is involved is the reliability of a physician's judgement as to the state of the pregnant woman's health. In large metropolitan areas, abortions are available virtually on request, and in New South Wales, Victoria and Western Australia, free-standing clinics specializing in the operation have been established. On the other hand, the phenomenon of abortion tourism is also widespread, as women from more restrictive jurisdictions travel to the more liberal jurisdictions for abortions. For example, until recently 90 per cent of all women in the Australian Capital Territory (ACT) seeking abortions traveled to Sydney in New South Wales for the operation, in part due to an ACT law requiring all abortions to be performed in hospitals. As of the mid 1990s, some 92,000 abortions were performed in Australia per year, a ratio of approximately one abortion per live birth.

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

Austria

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

An abortion is available on request during the first three months of pregnancy if performed by a physician after a previous medical consultation. If necessary to avert serious danger to the woman's life or physical or mental health; if a serious danger exists that the child may be afflicted with a serious physical or mental defect; or if the woman is under 14 years of age, an abortion may be performed after the first trimester.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Too low
Government intervention concerning fertility level:	To raise
Government policy on contraceptive use:	Indirect support provided
Percentage of currently married women using modern contraception (marriage cohorts of 1974 and 1977; 1981/1982):	71
Total fertility rate (1995-2000):	1.4
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	18
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	No
Complications of childbearing and childbirth	No
Maternal mortality ratio (per 100,000 live births; 1990):	
National	10
Western Europe	17
Female life expectancy at birth (1995-2000):	80

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

BACKGROUND

Austria liberalized its abortion law in 1974 through a reform of Sections 96-98 of the Austrian Penal Code (Federal Law of 23 January 1974). An abortion is available on request during the first trimester of pregnancy if performed by a physician after a previous medical consultation. After the first trimester, an abortion is permitted only if performed by a physician when necessary to avert a serious danger, which cannot be avoided by any other means, to the life or physical or mental health of the pregnant woman; when a serious danger exists that the child may be afflicted with a serious physical or mental defect; or when a woman under 14 years of age becomes pregnant. An abortion may be performed at any time during pregnancy by any person when it is carried out to save the pregnant woman from immediate danger to her life, which cannot otherwise be averted, under circumstances in which medical aid was not available in time. An abortion must be performed with the pregnant woman's consent unless it is performed to save the pregnant woman from immediate danger to her life, which cannot otherwise be averted, under circumstances in which the consent of the pregnant woman cannot be obtained in time.

The Federal Law of 1974 was challenged in court on the grounds that it violated provisions of the Austrian Constitution and European Convention on Human Rights protecting human life. However, the Austrian Constitutional Court dismissed the complaint on 11 October 1974, holding that the protection for life guaranteed by the Austrian Constitution applied only to protection from acts performed by public authorities and not to acts of private individuals such as physicians carrying out abortions. It also ruled that the provisions protecting life in the European Convention of Human Rights did not apply to a foetus.

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

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

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

An abortion requires the consent of the pregnant woman; it is authorized 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 if authorized by a commission of local physicians.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	No official position
Government intervention concerning fertility level:	To maintain
Government policy on contraceptive use:	..
Percentage of currently married women using modern contraception (aged 15-49, 1990):	7
Total fertility rate (1995-2000):	2.0
Age-specific fertility rate (per 1,000 women aged 15-19; 1995-2000):	17
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of childbearing and childbirth	..
Maternal mortality ratio (per 100,000 live births; 1990):	
National	22
Western Asia	320
Female life expectancy at birth (1995-2000):	74

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

Azerbaijan

BACKGROUND

As in all of the former USSR, Azerbaijan, known prior to 1992 as the Azerbaijan Soviet Socialist Republic, was subject to the abortion legislation and regulations of the former Union of Soviet Socialist Republics. As a result, abortion practices in Azerbaijan were similar to those throughout the former USSR.

The description given below pertains to the situation in Azerbaijan prior to independence. Since independence no changes have been made in the abortion law.

The Soviet Decree of 27 June 1936 prohibited the performance of abortions except in the case of a danger to life, a serious threat to health, or the existence of a serious disease that could be inherited from the parents. The abortion had to be performed in a hospital or maternity home. Physicians who performed abortions outside a hospital or without the presence of one of these indications were subject to one to two years' imprisonment. If the abortion was performed under unsanitary conditions or by a person with no special medical education, the penalty was no less than three years' imprisonment. A person who induced a woman to have an abortion was subject to two years' imprisonment. A pregnant woman who underwent an abortion was subject to a reprimand and the payment of a fine of up to 300 roubles in the case of a repeat offence.

In an edict of 23 November 1955, the Government of the former USSR repealed the general prohibition on the performance of abortions contained in the 1936 Decree. Other regulations, also issued in 1955, specified that abortions could be performed freely during the first twelve weeks of pregnancy, if no contraindication existed, and after that point, when the continuance of the pregnancy and the birth would harm the mother (interpreted to include foetal handicap). The abortion had to be performed in a hospital by a physician and, unless the mother's health was threatened, a fee was charged. Persons who performed an abortion illegally were subject to criminal penalties established by criminal laws such as the Criminal Code. For example, if the abortion was not performed in a hospital, a penalty of up to one year's imprisonment could be imposed, and if it was performed by a person without an advanced medical degree, a penalty of up to two years' imprisonment was possible. In the case of repeat offences or the death or serious injury of the pregnant woman, a higher penalty of up to eight years' imprisonment could be imposed. A woman who underwent an illegal abortion was not penalized.

Despite the approval of the 1955 edict and regulations, the problem of illegal abortions did not entirely disappear in the former USSR. This situation resulted in part from the Government's conflicted attitude towards contraception. Although at times it manifested support for contraception, it did little to make contraception available and in 1974 effectively banned the widespread use of oral contraceptives. The situation was also due in part to a revived pronatalist approach to childbearing adopted at times by the Government, which looked unfavourably on abortion. The result was a reliance on abortion as the primary method of family planning.

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

Concerned with the high rate of illegal abortions, in 1982 the Government issued a decree allowing abortions for health reasons to be performed through the twenty-eighth week of pregnancy. The Government continued to extend the circumstances under which legal abortions were available, and on 31 December 1987 it issued another decree setting out a broad range of non-medical indications for abortions performed on request through the twenty-eighth week of pregnancy. These were: the death of the husband during pregnancy; imprisonment of the pregnant woman or her husband; deprivation of maternity rights; multiparity (the number of children exceeds five); divorce during pregnancy; pregnancy following rape; and child disability in the family. Moreover, the order provided that, with the approval of a commission, an abortion could performed on any other ground.

This extension of the grounds for abortion after the first twelve weeks of pregnancy, combined with the ambivalent attitude of the Government towards contraception, led to a dramatic increase in the number of officially reported abortions. Other factors resulting in a high incidence of abortion have included shortages of high-quality modern contraceptives and reliance upon less dependable 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 USSR amounted to only 11 per cent of demand; intrauterine devices (IUDs), 30 per cent; and pills, 2 per cent. Data from the 1990 all-union sample survey of contraceptive use indicate that, in Azerbaijan, 6.5 per cent of all women aged 15-49 years regularly used contraception, 10.1 per cent sometimes used contraception, 41.9 per cent did not use any contraceptive method and 35.3 per cent knew nothing about contraception.

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

Bahamas

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

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

*Legal interpretation generally permits these grounds.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Too high
Government intervention concerning fertility level:	To lower
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-44; 1988):	62
Total fertility rate (1995-2000):	2.6
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	69
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of childbearing and childbirth	..
Maternal mortality ratio (per 100,000 live births, 1990):	
National	100
Caribbean	400
Female life expectancy at birth (1995-2000):	77

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

BACKGROUND

The Penal Code of the Bahamas of 1924, as revised (Sections 316, 330, and 334), provides that any act done in good faith and without negligence for the purposes of medical or surgical treatment of a pregnant woman is justifiable although it causes or is intended to cause abortion or miscarriage or premature delivery or the death of the child. Although the Code does not define what constitutes medical or surgical treatment, in practice, the law is interpreted very liberally. Abortions are reportedly performed on the grounds of foetal deformity and rape or incest, as well as on health grounds.

Abortions are usually performed within the first trimester, although they are often allowed up to 20 weeks of gestation. The abortion must be performed in a hospital by a licensed physician. Government hospitals bear the cost for non-paying patients. Violation of the law is punished by imprisonment for 10 years (Penal Code, Section 316).

Bahamas has the highest health expenditure per capita of the Latin America and Caribbean region (US$ 567 per capita in 1998). Family planning services have been available in all Government clinics since 1997 and at the Bahamas Planned Parenthood Association clinic. Services offered include a full range of contraceptive methods, as well as counselling, education, information and physical tests. In 1997 the Government also established a programme to improve the quality of prenatal and neonatal health care. Sex and family life education is now mandatory in school curricula. The Government has recently changed the regulations regarding adolescent pregnancy; girls can now attend school both during their pregnancy and after delivery.

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

Bahrain

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

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

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Satisfactory
Government intervention concerning fertility level:	No intervention
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49; 1995):	61
Total fertility rate (1995-2000):	2.9
Age-specific fertility rate (per 1,000 women aged 15-19; 1995-2000):	21.8
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of childbearing and childbirth	..
Maternal mortality ratio (per 100,000 live births; 1990):	
National	60
Western Asia	320
Female life expectancy at birth (1995-2000):	75.3

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

BACKGROUND

The Penal Code of 20 March 1976 (Sections 321-323) allows abortions to be performed under broad conditions. Abortion is unlawful only if carried out by a pregnant woman on herself without the knowledge and counselling of a physician, or if carried out by another person without the consent of the woman. In the first case, the performance of the abortion is punished with up to six months' imprisonment or a fine of up to fifty dinars. In the second case, the person performing the abortion is liable to up to 10 years' imprisonment.

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

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

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

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

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

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Too high
Government intervention concerning fertility level:	To lower
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 10-49; 1996/97):	49*
Total fertility rate (1995-2000):	3.11
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	115.0
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	...
Complications of childbearing and childbirth	...
Maternal mortality ratio (per 100,000 live births; 1990):	
National	850
South-central Asia	560
Female life expectancy at birth (1995-2000):	58.2

*Preliminary or provisional.

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

BACKGROUND

Abortion law in Bangladesh is based on the Penal Code of India of 1860. The Penal Code (sections 312-316) permits abortion only for the good faith purpose of saving the life of the woman. The law was temporarily waived in 1972 for women who were raped during the war that resulted in the separation of East and West Pakistan and the creation of Bangladesh. Despite the restrictive nature of the law, "menstrual regulation" services have been available in the Government's family planning programme. The Government does not feel that this service conflicts with current abortion laws as it provides menstrual regulation as a family planning method, not as an abortifacient. Furthermore, because criminal law requires that pregnancy be established for the purpose of prosecuting the offense of abortion, the use of menstrual regulation makes it virtually impossible for the prosecutor to obtain the required proof. Menstrual regulation is available on request until eight weeks after the last menstrual period.

A person who performs an illegal abortion (an abortion not performed for the good faith purpose of saving the life of the woman or by using menstrual regulation) before the woman is quick with child is subject to up to three years' imprisonment or a fine or both penalties. If the abortion is performed after quickening has occurred, the person is subject to up to seven years' imprisonment and a fine. A woman who performs an abortion on herself is subject to the above penalties. If an abortion is performed without the woman's consent at any point during the pregnancy, the person performing it is subject to up to 10 years' imprisonment and to a fine. If the abortion is performed with the woman's consent and results in her death, the penalty is up to 10 years' imprisonment and payment of a fine. If the woman has not consented and death results, the penalty may be increased.

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

An important justification for the provision of menstrual regulation as a public health measure has been the high rate of hospitalization owing to complications of induced abortion and the high level of maternal mortality resulting from septic abortion. Slightly over half of all admissions to gynaecology units of large urban hospitals result from complications of induced abortion, and it has been estimated that about one quarter of all maternal deaths are due to unsafe abortion.

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

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

Authorization by a physician is required when gestation is 12 weeks or less. If gestation is of more than 12 but less than 20 weeks' duration, the procedure must be authorized by two physicians. If gestation is of more than 20 weeks' duration, authorization of three physicians is required. The woman must receive counselling prior to the procedure. All abortions must be performed by a medical practitioner. When gestation is of more than 12 weeks' duration, the abortion must be performed in a Government-approved hospital.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Satisfactory
Government intervention concerning fertility level:	No intervention
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-44, 1988):	55.0
Total fertility rate (1995-2000):	1.5
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	44
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	Yes
Complications of childbearing and childbirth	..
Maternal mortality ratio (per 100,000 live births, 1990):	
National	43
Caribbean	400
Female life expectancy at birth (1995-2000):	79

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

Barbados

BACKGROUND

Abortion laws were significantly liberalized in Barbados in 1983, with the introduction of the Medical Termination of Pregnancy Act (Act No. 4 of 11 February 1983) and the 1983 Regulations to that Act. The Government had been concerned with the high morbidity and mortality resulting from unsafe illegal abortions. Prior to 1983, abortion legislation was based on the Offences Against the Person Act of 1868 (sections 61 and 62), which permitted abortion only to save the life of the pregnant woman, and the application of the *Rex v. Bourne* decision, which interpreted the 1868 Act to allow abortion to preserve the physical and mental health of the pregnant woman (see Antigua and Barbuda). The 1983 Act permits abortion on broad health grounds. It stipulates that an abortion can be performed if a medical practitioner is of the opinion formed in good faith that (a) the continuance of the pregnancy would involve risk to the life of the pregnant woman or grave injury to her physical or mental health; or (b) a substantial risk exists that if the child were born, it would suffer such physical or mental abnormalities as to be seriously handicapped. The 1983 Act also allows abortions on juridical and socio-economic grounds. It specifies that when determining if the continuation of the pregnancy would involve a risk of injury to the health of the pregnant woman, "the medical practitioner must take into account the pregnant woman's social and economic environment, whether actual or foreseeable,"and that the written statement of a pregnant woman that she reasonably believes that her pregnancy was caused by an act of rape or incest is sufficient to constitute grave injury to her mental health. If the pregnant woman is under 16 years of age or of unsound mind, the approval of her parent or guardian is required.

Abortions may be performed within the first 12 weeks of pregnancy with the authorization of a physician. If the pregnancy is of more than 12 weeks' but less than 20 weeks' duration, the procedure must be authorized by two physicians; if more than 20 weeks, it must be authorized by three physicians. In the latter case, the abortion may be performed only if immediately necessary to save the life of the pregnant woman or to prevent grave permanent injury to the physical health of the woman or her unborn child. An abortion of a pregnancy of more than 12 weeks' duration must be performed in a Government-approved hospital. In cases where the termination of pregnancy is immediately necessary to save the life of the pregnant woman or prevent grave permanent injury to her physical or mental health, the following requirements may be waived: (a) authorization by additional physicians; (b) consent of parent or guardian; and (c) performance of the abortion in a Government-approved hospital. Abortions must be performed by medical practitioners, who are required to counsel women requesting an abortion or ensure that they are provided with counselling. Women must be informed as to the alternatives to abortion and the nature and possible effects of the procedure. They must also be advised on methods of contraception, the availability of family planning services and the means to confront the social and psychological consequences of terminating pregnancy.

Adolescent pregnancy rates are high in Barbados, with 40 per cent of pregnancies occurring in women under age 20. The Barbados Family Planning Association has expressed concern that many schoolgirls, often under the age of consent, are obtaining abortions. Family planning services have been offered free of charge at Government clinics since 1995 and at low cost through the Barbados Family Planning Association. The Government also provides clinic-based family life education and school outreach programmes for adolescents in an effort to reduce teenage pregnancy.

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

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

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

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Too low
Government intervention concerning fertility level:	To raise
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-44; 1988):	50
Total fertility rate (1995-2000):	1.4
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	36
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of childbearing and childbirth	..
Maternal mortality ratio (per 100,000 live births, 1990):	
National	37
Eastern Europe	62
Female life expectancy at birth (1995-2000):	74

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

BACKGROUND

As in all of the republics of the former USSR, Belarus, known prior to 1991 as the Byelorussian Soviet Socialist Republic, was subject to the abortion legislation and regulations of the former Union of Soviet Socialist Republics. As a result, abortion practices in Belarus were similar to those throughout the former USSR.

The description given below pertains to the situation in Belarus prior to independence. Since independence no changes have been made in the abortion law.

The Soviet Decree of 27 June 1936 prohibited the performance of abortions except in cases of a danger to life, a serious threat to health or the existence of a serious disease that could be inherited from the parents. The abortion had to be performed in a hospital or maternity home. Physicians who performed abortions outside a hospital or without the presence of one of these indications were subject to one to two years' imprisonment. If the abortion was performed under unsanitary conditions or by a person with no special medical education, the penalty was no less than three years' imprisonment. A person who induced a woman to have an abortion was subject to two years' imprisonment. A pregnant woman who underwent an abortion was subject to a reprimand and the payment of a fine of up to 300 roubles in the case of a repeat offence.

In an edict of 23 November 1955, the Government of the former USSR repealed the general prohibition on the performance of abortions contained in the 1936 Decree. Other regulations, also issued in 1955, specified that abortions could be performed freely during the first twelve weeks of pregnancy, if no contraindication existed. After that point, abortions could be performed when the continuance of the pregnancy and the birth would harm the mother (interpreted to include foetal handicap). The abortion had to be performed in a hospital by a physician and, unless the mother's health was threatened, a fee was charged. Persons who performed an abortion illegally were subject to criminal penalties established by criminal laws such as the Criminal Code. For example, if the abortion was not performed in a hospital, a penalty of up to one year's imprisonment could be imposed and if it was performed by a person without an advanced medical degree, a penalty of up to two years' imprisonment was possible. In the case of repeat offences or the death or serious injury of the pregnant woman, a higher penalty of up to eight years' imprisonment could be imposed. A woman who underwent an illegal abortion was not penalized.

Despite the approval of the 1955 edict and regulations, the problem of illegal abortions did not entirely disappear in the former USSR. This situation resulted in part from the Government's conflicted attitude towards contraception. Although at times it manifested support for contraception, it did little to make contraception available and in 1974 effectively banned the widespread use of oral contraceptives. The situation was also in part the result of a revived pronatalist approach to childbearing adopted at times by the Government, which looked unfavourably on abortion. The result was a reliance on abortion as the primary method of family planning.

Concerned with the high rate of illegal abortions, in 1982 the Government issued a decree allowing abortions for health reasons to be performed through the twenty-eighth week of pregnancy. The Government continued to extend the circumstances under which legal abortions were available, and on 31

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

December 1987 it issued another decree establishing a broad range of non-medical indications for abortions performed on request through the twenty-eighth week of pregnancy. These included the death of the husband during pregnancy; imprisonment of the pregnant woman or her husband; deprivation of maternity rights; multiparity (the number of children exceeds five); divorce during pregnancy; pregnancy following rape; and child disability in the family. Moreover, the order provided that, with the approval of a commission, an abortion could performed on any other grounds.

This extension of the grounds for abortion after the first twelve weeks of pregnancy, combined with the ambivalent attitude of the Government towards contraception, led to a dramatic increase in the number of officially reported abortions. Other factors resulting in a high incidence of abortion have included shortages of high-quality modern contraceptives and reliance upon less dependable traditional methods; among couples a lack of knowledge 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 USSR amounted to only 11 per cent of demand; intrauterine devices (IUDs), 30 per cent; and pills, 2 per cent. Data from the 1990 all-union sample survey of contraceptive use indicate that, in Belarus, 13 per cent of all women aged 15-49 years regularly used contraception, 9.8 per cent sometimes used contraception, 60.4 per cent did not use any contraceptive method and 11.8 per cent knew nothing about contraception.

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

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

The woman must certify in writing that she is determined to have an abortion and the physician must be convinced of her determination. The woman must receive counselling at least six days prior to the procedure. The procedure must be performed by a physician under good medical conditions in a health-care establishment with the proper information department.

* The Law requires a woman seeking an abortion to state that she is in a state of distress as a result of her situation; the decision to have an abortion, however, is entirely the decision of the woman.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	No official position
Government intervention concerning fertility level:	No intervention
Government policy on contraceptive use:	Indirect support provided
Percentage of currently married women* using modern contraception (aged 20-40, 1991):	79
Total fertility rate (1995-2000):	1.6
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	11
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	No
Complications of childbearing and childbirth	No
Maternal mortality ratio (per 100,000 live births; 1990):	
National	10
Western Europe	17
Female life expectancy at birth (1995-2000):	81

* Flemish population.

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

BACKGROUND

The abortion law in Belgium was significantly liberalized on 3 April 1990, when the Belgian Parliament approved a law amending the 1867 Penal Code. Under the abortion provisions of that Code, which were based on the Napoleonic Penal Code of 1810, adopted by Belgium upon independence, no stated exceptions to a general prohibition of the performance of abortions were included, although the general principles of criminal legislation allowed abortions to be performed to save the life of the pregnant women on the grounds of necessity. In such a case, the medical code required that three physicians agree that a state of necessity existed and that the abortion be performed in an approved institution or hospital with the informed consent of the pregnant woman. Transgression of the law was severely punished. An additional law enacted in 1923 added language to the Penal Code prohibiting the provision of information concerning abortion.

Attempts to liberalize the abortion law of Belgium began in 1971. From that time until the Law of 3 April 1990 was enacted, dozens of legislative proposals permitting abortions to be performed under various circumstances were introduced, always to be rejected or allowed to expire. Although the law remained unchanged, prosecution was rare, and those prosecuted were most often given short or suspended sentences or, in some cases, acquitted.

The 1990 law permits abortion to be performed in the first 12 weeks of pregnancy when a woman who is "in a state of distress as a result of her situation" requests a physician to terminate her pregnancy. The woman is the sole judge of whether she is in distress. Aside from informing the woman as to the risks of undergoing the procedure and the various possibilities for taking care of the child, if born, the physician needs only to be convinced of the pregnant woman's determination to terminate her pregnancy.

After 12 weeks of pregnancy, an abortion may be performed only if two physicians agree that continuance of the pregnancy would gravely endanger the woman's health or when it is certain that the child, if born, would be affected by a particularly serious pathological condition, recognized as incurable at the time of diagnosis.

Regardless of length of gestation, all abortions must be performed by a physician under good medical conditions, in a health-care establishment that has an information department that provides the woman seeking the abortion with detailed information regarding the rights, assistance and benefits guaranteed by the law to families, unmarried and married mothers and their children, as well as regarding the possibilities offered by the adoption of the child, if born, and that grants her, at the physician's or her own request, assistance and advice on available resources to resolve the psychological and social problems posed by her situation. In addition, the physician or any qualified member of the health-care establishment must ensure that she is provided with information on contraception. An abortion may be performed six days following the woman's counselling, at the earliest. She must certify in writing, on the date of the intervention, that she is determined to terminate her pregnancy.

Anyone performing an illegal abortion is subject to imprisonment for three months to one year and to payment of a fine of 200-500 Belgian francs (BF), under section 350 of the Penal Code. A woman voluntarily obtaining an illegal abortion is subject to imprisonment for 1 to 12 months and to payment of a fine of BF 50-200 (section 351). If the illegal abortion results in the woman's death the person performing the abortion is subject to solitary confinement if the woman consented and to ten to fifteen years' forced labour if she did not.

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

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

Belize

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

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

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Too high
Government intervention concerning fertility level:	No intervention
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-44, 1991):	47
Total fertility rate (1995-2000):	3.7
Age-specific fertility rate (per 1,000 women aged 15-19, 1994-2000):	99
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of childbearing and childbirth	..
Maternal mortality ratio (per 100,000 live births, 1990):	
National	..
Central America	140
Female life expectancy at birth (1995-2000):	76

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

BACKGROUND

Abortion in Belize is governed by sections 108-110 of the Criminal Code, Ordinance No. 33 of 18 December 1980. Abortion is considered an offence except when performed "by a registered medical practitioner, if two registered medical practitioners are of the opinion, formed in good faith (a) that the continuance of the pregnancy would involve risk to the life of the pregnant woman, or injury to the physical and mental health of the pregnant woman or any existing children of her family, greater than if the pregnancy were terminated; or (b) that there is a substantial risk, if the child were born, that it would suffer from such physical or mental abnormalities as to be seriously handicapped." In determining whether the continuance of a pregnancy would involve a risk of injury to health, the Code also provides that account may be taken of the pregnant woman's actual or reasonably foreseeable environment; consequently, abortions can be performed on socio-economic grounds.

Despite the broad circumstances under which abortions can be legally performed, penalties imposed in cases of illegal abortions are severe. The person performing the abortion, including a pregnant woman who performs an abortion on herself, is liable to imprisonment for life.

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

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

Benin

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

The attending physician or surgeon must seek the opinion of two consulting physicians, one of whom must be selected from the list of experts attached to the civil court, who, after an examination of the case and a discussion, must certify in writing that the life of the mother cannot be safeguarded except by the therapeutic intervention in question. The procedure must be performed by a physician.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Satisfactory
Government intervention concerning fertility level:	No intervention
Government policy on contraceptive use:	Indirect support provided
Percentage of currently married women using modern contraception (aged 15-49, 1996):	16
Total fertility rate (1995-2000):	5.8
Age-specific fertility rate (per 1,000 women aged 15-19):	116
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of childbearing and childbirth	..
Maternal mortality ratio (per 100,000 live births; 1990):	
National	990
Western Africa	1 020
Female life expectancy at birth (1995-2000):	55

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

BACKGROUND

Abortion law in Benin is governed by the Penal Code, which is based on the Napoleonic Penal Code of 1810, as amended in 1958 when Benin gained its independence from France. Although the Code contains no expressed exceptions to the prohibition of abortion, under general criminal law principles of necessity, an abortion can be performed to save the life of the pregnant woman. Moreover, Section 37 of the Code of Medical Deontology (Ordinance No. 73-14 of 8 February 1973) permits an abortion to be performed if it is the sole means available to save the life of a pregnant woman. The attending physician or surgeon must seek the opinion of two consulting physicians, one of whom must be selected from the list of experts attached to the civil court, who, after an examination of the case and a discussion, must certify in writing that the life of the mother cannot be safeguarded except by the therapeutic intervention in question.

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

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

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

Bhutan

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

The exact status of abortion law in Bhutan is unclear. Because the official State religion of Bhutan is Buddhism, which disapproves of abortion, it is probable that the procedure is allowed only to save the life of the pregnant woman.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Satisfactory
Government intervention concerning fertility level:	No intervention
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women* using modern contraception (aged 15-49; 1994):	19
Total fertility rate (1995-2000):	5.5
Age-specific fertility rate (per 1,000 women aged 15-19; 1995-2000):	70.8
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of childbearing and childbirth	..
Maternal mortality ratio (per 100,000 live births; 1990):	
National	1 600
South-central Asia	560
Female life expectancy at birth (1995-2000):	62.0

* all women

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

BACKGROUND

Only limited information is readily available on population issues in Bhutan. Since none of the sources makes any reference to abortion policy or practice, the exact status of abortion law in Bhutan is unclear. However, the official State religion of Bhutan is Buddhism, and since Bhuddism disapproves of abortion, it is probable that the procedure is allowed only to save the life of the pregnant woman.

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

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

Bolivia

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

An abortion must be performed by a physician, and judicial authorization must be obtained. If the abortion is performed in the case of rape or incest, legal action must have been initiated.

* The Code does not specify whether preservation of health includes both physical and mental health.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	No official position
Government intervention concerning fertility level:	No intervention
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49, 1994):	45
Total fertility rate (1995-2000):	4.4
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	79
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	Yes
Complications of childbearing and childbirth	Yes
Maternal mortality ratio (per 100,000 live births; 1990):	
National (1990)	650
South America (1990)	200
Female life expectancy at birth (1995-2000):	63

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

BACKGROUND

In Bolivia, the performance of an abortion by a physician is not punished (a) when the abortion is the result of the crime of rape, abduction not followed by marriage, statutory rape or incest; or (b) when the abortion is performed for the purpose of preventing any danger to the life or the health of the mother, and this danger cannot be prevented by other means (Penal Code, the ordered text under Law No. 1768 of 10 March 1997, Articles 263-269). In both cases, judicial authorization must be obtained and, in the case of (a), a legal action must have been initiated. The Code does not specify whether danger to health includes danger to physical and mental health.

A person who performs an illegal abortion with the consent of the pregnant woman or when the woman is under sixteen years of age is punishable by one to three years' imprisonment. If the pregnant woman does not consent, the punishment is two to six years' imprisonment. A pregnant woman who consents to the performance of an illegal abortion is punishable by one to three years' imprisonment. Higher penalties are imposed on the person performing the abortion if the injury or death of the pregnant woman occurs or if the person performs abortions on a regular basis. A reduced sentence is imposed if the abortion was performed, with the pregnant woman's consent, to save her honour.

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

In 1982, however, the Government became so concerned about the growing number of unsafe abortions and resulting maternal mortality that it reversed the 1977 decree. On 15 March 1982, the Government issued new regulations concerning family health activities in the country. The 1982 regulations permit the provision of family planning information and some services as part of a post-partum programme. Post-abortion patients are also included. In 1986, the Government of Bolivia issued a child-spacing policy, stating that it was the responsibility of the Government to provide family planning information and services to high-risk women. In 1996, the Government issued the Integral Women's Health Programme. It foresaw the provision of family planning services, information and gynaecological services to all women, as well as comprehensive assistance to pregnant women, including prenatal care, assistance to delivery, post-partum care and information.

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

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

An abortion must be performed in a hospital or other authorized health-care facility. If the woman is a minor, the approval of her parents or guardian is required, unless she is 16 or more years of age and earns 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.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	..
Government intervention concerning fertility level:	..
Government policy on contraceptive use:	..
Percentage of currently married women using modern contraception:	..
Total fertility rate (1995-2000):	1.3
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	28
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of childbearing and childbirth	..
Maternal mortality ratio (per 100,000 live births; 1990):	
National	..
Southern Europe	14
Female life expectancy at birth (1995-2000):	76

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

Bosnia and Herzegovina

BACKGROUND

Beginning in 1952, abortion legislation in the former Socialist Federal Republic of Yugoslavia went through a process of liberalization in response to the significant increase in illegal abortions associated with high levels of maternal morbidity and mortality. The subsequent changes in the abortion laws were expressly directed at 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' duration, a requirement that had been a practical and psychological obstacle to abortion. 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

Bosnia and Herzegovina achieved independence from the former Yugoslavia in 1991 and adopted a new Constitution. However, abortion is still regulated by the Law of 7 October 1977 passed by the former republic to implement article 191 of the Federal Constitution of the former Yugoslavia of 21 February 1974, which proclaims that "it is a human right to decide on the birth of children". Under the Law of 7 October 1977, of Bosnia and Herzegovina, 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 is 16 years of age or over and earns 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 psychologist, is required. The commission may consent to an abortion when it is medically established that it would otherwise be impossible to save the woman's life or prevent damage to her health, whether it should be during pregnancy, delivery or post-partum; when the probability that the child would be born with a serious congenital physical or mental defect is medically established; or when the conception is a consequence of a criminal act of rape, criminal act of sexual intercourse with an incompetent person, criminal act of sexual intercourse in consequence of abuse of authority, criminal act of sexual intercourse with a child or criminal act of incest. 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 woman who is seriously endangered.

Penal provisions are imposed on medical organizations that violate provisions of the law. The Criminal Code provides sanctions for the performance of illegal abortions; a woman, however, is never held criminally responsible for inducing her own abortion or for cooperating in such a procedure.

Family planning services have 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 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. A major area of concern for Bosnia and Herzegovina is the high rate of abortion among adolescents, compared with the relatively low overall incidence of abortion, particularly in comparison with the other republics of the former Yugoslavia.

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

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

An abortion must be carried out by a registered medical practitioner in a government hospital or registered private hospital or clinic approved for that purpose. An abortion performed in the case of rape or incest or foetal impairment must be approved in writing by two practitioners.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Too high
Government intervention concerning fertility level:	To lower
Government policy on contraceptive use:	Direct support
Percentage of currently married women using modern contraception (aged 15-49, 1988):	32
Total fertility rate (1995-2000):	4.4
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	72
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	Yes
Complications of childbearing and childbirth	Yes
Maternal mortality ratio (per 100,000 live births; 1990):	
National	250
Southern Africa	260
Female life expectancy at birth (1995-2000):	48

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

BACKGROUND

Until 1991, abortion was governed by the provisions of the Penal Code of Botswana, enacted in 1964 and modeled on the Offences Against the Person Act 1861 (United Kingdom). No exceptions were expressed to a general prohibition on the performance of abortions, although under the general criminal principles of necessity, an abortion was allowed if performed in order to save the pregnant woman's life. Persons who performed abortions and women who consented to them were subject to imprisonment.

In the 1980s, following requests from members of the medical profession for re-evaluation of the law, the Government began drafting a bill to this end, which it sent to Parliament in 1990. The Government's action was based on its concern for the health of women, as evidenced by high rates of maternal mortality and morbidity. Some 3,700 women were officially treated for the complications of illegal abortion in 1992; at least 14 per cent of maternal mortality was estimated to result from unsafe abortion; and some 200 deaths per year were attributed to illegally performed abortions. Despite determined opposition, the bill was approved by Parliament and signed by the President of Botswana in October 1991.

The new law adds language to the Penal Code, setting forth exceptions to the general prohibition against the performance of abortions. Under it there are three exceptions: (a) when the medical practitioner carrying out the abortion is satisfied that the pregnancy is the result of rape, defilement, or incest; (b) when the continuance of the pregnancy would involve risk to the life of the pregnant woman or injury to her physical or mental health; and (c) when established evidence shows that there is substantial risk that the child would suffer from or later develop such serious physical or mental abnormality or disease as to be seriously handicapped. The abortion must be carried out within the first sixteen weeks of pregnancy by a registered medical practitioner in a Government hospital or registered private hospital or clinic approved for that purpose, and in the cases of (b) and (c) two practitioners must approve the abortion in writing.

Despite the enactment of this legislation, which is one of the most liberal in sub-Saharan Africa, concerns persist about the effects of unsafe abortion on women's health. A recent report issued by the Botswana Department of Women's Affairs concluded that bureaucratic delays and "far-flung health clinics" still encouraged illegal backstreet abortions. Although data is lacking, reports indicate that, despite the new abortion law, illegal abortions are still common and extremely risky and that physicians often refuse to authorize abortions in situations that clearly fall within those intended by the law. The difficulties have been attributed to the lack of clear procedures to be followed in obtaining permission for an abortion; the uncooperative attitude of many physicians; the absence of a definition of "acceptable evidence" that a pregnancy is the result of rape, defilement, or incest; the failure of the law to address the legal situation of minors seeking an abortion; the scarcity of approved places where abortions can be legally performed; the shortage of medical practitioners to perform abortions; and the difficulty of access experienced by many rural women. The report of the Department of Women's Affairs called for amendment of the law, including the replacement of the two-physician approval requirement with a one-physician requirement, and the provision of more accessible, safe and adequate facilities for the performance of abortion. Whether the report will prompt re-evaluation of the law is unclear, given the controversial nature of abortion in Botswana.

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

Brazil

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

An abortion must be performed by a physician. If an abortion is performed in the case of a pregnancy resulting from rape, the consent of the pregnant woman must be obtained or, if she is incompetent, the consent of her legal representative.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	No official position
Government intervention concerning fertility level:	No intervention
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49; 1996):	77
Total fertility rate (1995-2000):	2.3
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	72
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	Yes
Complications of childbearing and childbirth	Yes
Maternal mortality ratio (per 100,000 live births; 1990):	
National	220
South America	200
Female life expectancy at birth (1995-2000):	71

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

BACKGROUND

The legality of the performance of abortion in Brazil is governed by the Brazilian Penal Code, dating from 1940. Under the Code, a physician may perform an abortion when it is the only means to save the life of the pregnant woman or when the pregnancy is the result of rape. In the latter case, the pregnant woman must consent or, if she is incompetent, her legal representative must consent. The Code replaced legislation dating from 1890 that expressed no exceptions to a general prohibition of abortion, but was understood to allow abortion to save the life of the pregnant woman under the general criminal law principles of necessity. In addition, Article 20 of the Decree Law of 3 October 1941, as amended by Law No. 6734 of 4 December 1979, prohibits the advertising of a process, substance or object designed to cause an abortion or to prevent pregnancy.

Illegal abortion in Brazil is punishable by one to four years of imprisonment for the person performing the abortion; the penalty is higher if the pregnant woman's consent is not obtained, if the woman suffers serious injury or dies, or if the woman is under 14 years of age. Abortion performed by a pregnant woman on herself or performed by another person with her consent is punishable by one to three years' imprisonment. Efforts to ease restrictions on abortion began in 1975 and to date have been unsuccessful. At present, there are eight legal proposals related to abortion; some of them seek to expand the legal framework and others to protect medical actions related to objections of conscience.

Despite the restrictive nature of Brazil's abortion law, abortions are widely performed. According to most recent estimates, approximately 1 to 4 million women a year obtain abortions in Brazil. The majority of women seeking abortions are married. Prosecution for unlawful abortion is rare. The requirement of legal proof of pregnancy as a precondition for prosecution allows abortion to be performed despite current prohibitions. Moreover, although not authorized to do so by the law, judges in approximately 350 cases in recent years have allowed abortions to be performed in cases of severe foetal defect.

Although the public health system has expanded its support of legal abortion services since 1994, increasing from 2 locations to 12, and has improved the quality of post-abortion care, the great majority of abortions are still carried out illegally under unsafe medical conditions. In practice, few women are able to obtain legal abortions owing to the resistance of hospitals. Most hospitals require a legal decision on the cause of pregnancy before they will perform an abortion. Consequently, mortality and morbidity resulting from abortion appear to be high. In the mid-1980s, for example, the percentage of maternal deaths related to abortion in one hospital was estimated to be 44 per cent; in 1997, the state of São Paulo published statistics indicating that between January and September of 1997, 24,000 cases of post-abortion complications were treated in the State's health care system.

A recent legal development relating to abortion in Brazil involves the drug Cytotec, a prostaglandin, that was introduced in Brazil for the treatment of ulcers. In addition to the effect that it produces on ulcers, the drug also causes uterine muscles to contract and is sometimes employed to induce childbirth and abortion. In some countries, in fact, the drug has recently been used in conjunction with mifepristone or RU-486, to terminate early pregnancies. Owing to its abortive properties, Cytotec began to be widely used in Brazil to induce illegal abortions. Such use was particularly easy since the drug was sold without restriction in drugstores and pharmacies. By the end of 1991, almost 600,000 boxes of twenty-eight pills each were being sold each year, with estimates that between 34 and 72 per cent of all women admitted to hospitals in selected cities for complications resulting from abortion had used this drug to induce abortion.

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

Brazil

Near the end of 1991, the Government of Brazil took steps to end the use of Cytotec for the performance of illegal abortions. Acting in part in response to a campaign of a number of groups against the drug, the federal Ministry of Health issued an order placing Cytotec in a category of drugs that could be sold only in authorized drugstores; these drugstores were required to retain a copy of the physician's prescription for official use. State Governments adopted similar measures. In Rio de Janeiro, use of the drug was limited to hospitals; in Ceará, its sale was completely prohibited; and in São Paulo, sales through drugstores were restricted to use for gastrointestinal purposes and drugstores were required to keep detailed records on the patient, prescribing physician and indications for the use of the drug. Use of Cytotec for gynaecological reasons in hospitals in São Paulo required the permission of health officials. Approval of the regulations has dramatically decreased the sale of Cytotec, although its effect on the number of abortions performed in Brazil is unknown at this time.

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

Brunei Darussalam

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

None is specified by the Penal Code.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Satisfactory
Government intervention concerning fertility level:	No intervention
Government policy on contraceptive use:	No support provided
Percentage of currently married women using modern contraception (aged 15-49):	..
Total fertility rate (1995-2000):	2.8
Age-specific fertility rate (per 1,000 women aged 15-19):	33
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of childbearing and childbirth	..
Maternal mortality ratio (per 100,000 live births; 1990):	
National	60
South-eastern Asia	440
Female life expectancy at birth (1995-2000):	78

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

BACKGROUND

The performance of abortions is prohibited by the Penal Code of Brunei Darussalam (Articles 312-316), except if caused for the good faith purpose of saving the life of the woman. Unlawful abortion is punishable by up to three years in prison and/or a fine. If performed when the woman is "quick with child," the person performing the abortion may be punished by up to ten years' imprisonment and a fine. A woman performing her own abortion is subject to these same penalties.

If the person performs the abortion without the consent of the pregnant woman at either stage of pregnancy, he or she may be punished by up to ten years' imprisonment and a fine. If the death of the woman results, the penalty increases to a maximum of ten years' imprisonment if the woman had consented to the abortion and fifteen years' imprisonment when she had not. The Code does not define the term "quick", but it is usually considered to refer to the approximate mid-point of pregnancy.

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

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

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

Medically indicated abortion, when the pregnancy is between 12 and 20 weeks in duration, is allowed only if the woman is suffering from a proven, documented case of a disease that could endanger the life of the pregnant woman or child, as determined by a special medical commission. If the pregnancy is of greater than 20 weeks' duration, abortion is permitted only if the woman's life is in danger or evidence of severe foetal impairment is found. Abortions must be performed in specialized obstetric/gynaecological hospitals and clinics, or in hospitals with such specialized departments, by an obstetrician/gynaecologist and, in the case of medically indicated abortions, a medical specialist in resuscitation.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Too low
Government intervention concerning fertility level:	To raise
Government policy on contraceptive use:	Indirect support provided
Percentage of currently married women* using modern contraception (aged 18-44, 1976):	7
Total fertility rate (1995-2000):	1.2
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	49
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of childbearing and childbirth	..
Maternal mortality ratio (per 100,000 live births):	
National (1990)	27
Developed countries (around 1983)	62
Female life expectancy at birth (1985-1990):	75.0

*Women in first marriage.

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

Bulgaria

BACKGROUND

Abortion has been legal in Bulgaria since 27 April 1956, when the Ministry of Public Health issued instructions providing that all women wanting to terminate a pregnancy had the right to do so if their pregnancy was of less than 12 weeks' duration and they had not had an abortion within the prior six months. After 12 weeks of pregnancy, abortion was permitted only on therapeutic grounds. Abortions had to be performed in authorized hospitals.

In response to declining birth rates, the Government of Bulgaria restricted access to abortion in February 1968 (Decree No. 188 of the Ministry of Public Health and Social Welfare). Abortion was prohibited for childless women except when medically indicated or in the presence of special circumstances of a grave nature. Women with only one or two children were to be actively discouraged from aborting, although they were to be given approval by a special medical board if they persisted. A special board could give approval when the pregnancy was the result of rape, when the woman was under 16 years old (subject to parental consent), when she had been made pregnant by a person whom she could not marry because he was a close relative or when there were serious social indications. Women over 45 years of age or those with at least three children could obtain an abortion on request. However, an abortion could not be obtained on request if the pregnancy was of greater than 10 weeks' duration or the woman had obtained an abortion within the prior six months. An abortion was to be authorized by a special board for medical reasons (including foetal defect) at any time during pregnancy.

In April 1973 the restrictions were extended (Decree No. 0-27 of the Ministry of Public Health), denying childless women and women with only one child access to abortion. Exceptions were made only in the case of rape or incest; if the woman was an unmarried person under the age of 18 with no living children; if she was over 45 with at least one living child; or if a disease endangering the life of the woman or the viability of her offspring was present. Restrictions were somewhat relaxed in 1974, permitting abortion if the woman was unmarried, regardless of parity. Termination of pregnancy on request could only be performed if the duration of the pregnancy did not exceed 10 weeks at the time the examination was performed.

Currently, according to Decree No. 2 of 1 February 1990 of the Ministry of Health and Social Welfare, abortion is available on request to all women as long as the duration of the pregnancy does not exceed 12 weeks and the abortion does not pose a danger to her health. Between the twelfth and twentieth weeks of pregnancy, abortion is permitted only if the woman is suffering from a proven, documented case of a disease that could endanger the life of the pregnant woman or child, as determined by a special medical commission. If the pregnancy is of greater than 20 weeks' duration, abortion is permitted only if the woman's life is in danger or evidence is found of severe foetal impairment. All restrictions concerning childbearing history, age and marital status were removed by this Decree.

All abortions must be performed in specialized obstetric/gynaecological hospitals and by an obstetrician/gynaecologist in clinics or hospitals with such specialized departments and, in the case of medically indicated abortions, a medical specialist in resuscitation. As of 1991, abortions were free of charge only if performed for medical reasons or performed on women under the age of 16 or over the age of 35.

Family planning services are provided in Bulgaria in health centres and hospitals, although contraceptives are often in irregular supply. A national family planning programme is being developed.

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

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

Two physicians must attest that the continuance of the pregnancy endangers the health of the woman or that a strong possibility exists that the unborn child will be afflicted with a condition of exceptional seriousness recognized as incurable at the time of diagnosis. Cases of rape or incest must be established by the State prosecutor, and the abortion must be performed during the first 10 weeks of pregnancy.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Too high
Government intervention concerning fertility level:	To lower
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49; 1993):	8
Total fertility rate (1995-2000):	6.6
Age-specific fertility rate (per 1,000 women aged 15-19; 1995-2000):	157
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	Yes
Complications of childbearing and childbirth	Yes
Maternal mortality ratio (per 100,000 live births; 1990) :	
National (1986)	930
Western Africa	1 020
Female life expectancy at birth (1985-1990):	45

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

BACKGROUND

Until the mid-1990s abortion legislation in Burkina Faso was based on the French Napoleonic Code of 1810. The most recent version of this legislation which was found in the Penal Code of 1984, contained no explicit exceptions to a general prohibition on the performance of abortions. However, under the general principles of criminal law relating to necessity, an abortion could be performed to save the life of the pregnant woman. Persons performing abortions and a pregnant woman consenting to the performance of an abortion were subject to imprisonment and fines, and medical personnel performing abortions or assisting in abortions were subject to suspension from the practice of their profession. This restrictive approach to abortion was in conformity with the Government's restrictive approach to other procedures for preventing births. At the beginning of the 1980s, for example, French legislation dating from 31 July 1920 prohibiting contraception and propaganda on contraception was also still in effect.

In 1986, the Government of Burkina Faso repealed the 1920 law as well as similar provisions contained in the Public Health Code and adopted a policy of national family planning as a component of primary health care. The Government's primary motivation was a concern with the rate of adolescent pregnancy and maternal mortality and morbidity. The abortion provisions of the Penal Code remained unchanged, however, and as late as 1994, the Government approved a new Public Health Code that specifically prohibited the performance of abortions except to save the life of the pregnant woman.

In 1996 the Government reversed this policy on abortion. Again, its primary motivation was a concern for maternal health. Recent statistics had indicated, for example, that 5 per cent of all women admitted to maternity wards in hospitals in Burkina Faso had serious complications resulting from illegally induced abortions. Of these, 70 per cent were between the ages of 16 and 24 and 80 per cent were students or unemployed. In addition, 6 to 7 per cent of women treated in selected health services had died from haemorrhage, pelviperitonitis, septicemia, renal failure or hepatitis associated with illegal abortions, and 35 per cent of women seeking treatment for infertility reported a history of illegal abortion.

To give legal expression to this policy reversal, the Government significantly amended the abortion provisions of the new Penal Code promulgated at the end of 1996. Under the amended Code, abortion is still generally classified as a crime, and a person who carries out an abortion is subject to one to five years' imprisonment and imposition of a fine of 300,000 to 1,500,000 CFA francs. However, important exceptions to this general prohibition have been created. Voluntary interruption of pregnancy is allowed at all times during pregnancy if two physicians attest that the continuance of the pregnancy endangers the health of the woman or that a strong possibility exists that the unborn child will be afflicted with a condition of exceptional seriousness recognized as incurable at the time of diagnosis. Moreover, in a case of rape or incest established by the State prosecutor, a woman is authorized to request a physician to perform an abortion during the first 10 weeks of pregnancy.

The exact scope of these new abortion provisions is not entirely clear from their wording. Although there is little doubt about the nature of the indications for abortion in cases of foetal defect and rape or incest, the contours of the health indication are more indistinct. The provisions do not reveal whether health includes mental as well as physical health nor how grave the threat to health must be before an abortion will be authorized. However, in response to a United Nations inquiry on population policies, the Government did indicate that both mental and physical health were grounds for legal abortion.

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

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

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

* The law does not specify whether health includes physical and mental health.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Too high
Government intervention concerning fertility level:	To lower
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49, 1987):	9
Total fertility rate (1995-2000):	6.3
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	55
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of childbearing and childbirth	Yes
Maternal mortality ratio (per 100,000 live births; 1990):	
National	1 300
Eastern Africa	1 060
Female life expectancy at birth (1995-2000):	44

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

Burundi

BACKGROUND

Decree-Law No. 1/6 of 4 April 1981, setting forth the amended Penal Code (Sections 353-357) prohibits abortion except to avert a risk that cannot otherwise be avoided and that threatens the life of the mother or may cause serious and permanent injury to her health. A person who performs an illegal abortion, including a woman who performs an abortion on herself, is subject to imprisonment for a period from six months to two years and a fine of 1,000 to 5,000 Burundi francs (FBUs). If the person performing the abortion is a medical or paramedical professional or a person studying for such a profession, the punishment is one to five years' imprisonment and a fine of FBU 1,000 to 10,000. If the death of the woman results, the punishment is imprisonment for twenty years. The Decree-Law also stipulates that, in any sentence resulting from prosecution for performing an illegal abortion, "account shall be taken of the social exigencies of the environment in which the act was committed". An explanatory clause to the law clarifies that, although the Government did not intend to liberalize abortion, it believes it would be wrong to "ignore certain social necessities, such as the situation of distress of the pregnant woman".

Burundi has relatively high fertility and low contraceptive prevalence. Despite the suspension of the country's official population policy in 1993, the Government has started to build a foundation for family planning, implementing a nationwide maternal/child health and family planning project and including population education in school curricula.

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

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

Only medical doctors and medical assistants or secondary midwives are authorized to perform abortions, which must be carried out in hospitals, health centres, clinics, and public or private obstetric centres authorized by the Ministry of Health.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Too high
Government intervention concerning fertility level:	To lower
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49, 1988):	33
Total fertility rate (1995-2000):	4.6
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	14
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of childbearing and childbirth	..
Maternal mortality ratio (per 100,000 live births; 1990):	
National	900
South-eastern Asia	440
Female life expectancy at birth (1995-2000):	56

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

Cambodia

BACKGROUND

Cambodia experienced a period of extended turmoil from the 1970s to the 1990s, and until recently, the exact status of the country's abortion law was somewhat unclear. At the time of independence, Cambodia inherited much of its law from the former French colonial Government. Under the Penal Code, which was based on the Penal Code of France, there were no explicit exceptions to a total prohibition on the performance of abortions, although under the general criminal law principles of necessity an abortion could be performed to save the life of the pregnant woman.

However, abortion was widely accepted as a medical procedure, despite the absence of formal guidelines on techniques, indications and consent, and those performing abortions, even when the abortions were unsafe, were not subject to prosecution. Most abortions were reportedly performed in secret by health workers who were untrained for this purpose and who charged high amounts of money for the procedure. Maternal mortality ratios were high, and the Ministry of Health estimated that one third of maternal mortality resulted from unsafe abortions performed by unskilled practitioners.

Concerned with the high maternal mortality ratios brought about by the unsafe conditions in which illegal abortions were generally being performed, in 1997 the Government decided to introduce abortion legislation to regulate the procedure formally. It hoped that the legislation would reduce the maternal mortality ratio by one half by 2010. Moreover, it depicted its proposed legislation as a measure designed to improve the social welfare of the population. In its "statement of reason" for proposing the legislation, it noted that the purpose of the legislation was to enhance and develop family welfare and referred to Article 52 of the Constitution which provides that "the State pays priority attention to the living situation and welfare of the people." Despite some opposition from those who argued that the country's Buddhist traditions do not allow the legalization of abortion, the proposed legislation was enacted in early October 1997.

Under the new law a woman may obtain an abortion on request during the first twelve weeks of pregnancy. After this point in the pregnancy, abortions are allowed only under the following circumstances: (a) if there is a probability of the pregnancy developing abnormally or if the pregnancy poses a danger to the mother's life; (b) if the baby who will be born "can get an incurable disease"; or (c) if the pregnancy is caused by rape. In these cases, the abortion must be approved by a group of "2 or 3 medical personnel." Only medical doctors and medical assistants or secondary midwives are authorized to perform abortions, and they must obtain the consent of the pregnant woman after explaining to her the possible complications from the abortion and the advantages of birth spacing. Abortions must be performed in hospitals, health centres, clinics, and public or private obstetric centres authorized by the Ministry of Health. These facilities must have the technical ability to manage emergencies due to the complications of abortions and must be able to transfer patients to a hospital if necessary. Persons who violate the provisions of the law are subject to warnings, fines or imprisonment depending on the violation, with the most severe fines imposed when an illegally performed abortion causes chronic illness, disability or death (Cambodia, 1997a).

Because the law was enacted so recently, it is unclear what effect it will have on maternal mortality in Cambodia. Health services in Cambodia are not highly developed and much of the population lacks adequate access to health services, particularly at the in-patient level. Additional health personnel who have the proper training to perform abortions safely are also needed. With such obstacles to overcome, it is likely that at least in the short run many abortions will still be performed in unsafe conditions by unskilled persons. The law's effect on abortion rates is equally unclear. A survey has indicated that the unmet need for contraception in Cambodia is high, but that only 13 per cent of the population is using contraception, with some 7 per cent employing modern methods.

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

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

An abortion must be performed by a qualified person. In the case of rape, the prosecution or the public prosecutor's office must certify a "good case" or the materiality of the facts before the abortion can lawfully be performed.

* The law does not specify whether health includes physical and mental health.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Too high
Government intervention concerning fertility level:	To lower
Government policy on contraceptive use:	Indirect support
Percentage of currently married women using modern contraception (aged 15-49, 1991):	16
Total fertility rate (1995-2000):	5.3
Age-specific fertility rate (per 1,000 women aged 15-19; 1995-2000):	140
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	Yes
Complications of childbearing and childbirth	Yes
Maternal mortality ratio (per 100,000 live births; 1990):	
National	550
Middle Africa	950
Female life expectancy at birth (1995-2000):	56

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

Cameroon

BACKGROUND

Cameroon has, in effect, two official versions of its Penal Code, one in French and one in English. Although the major provisions of the two versions are identical, they differ in certain details. Under the Penal Code (sections 337-339), the performance of abortions is illegal except if proven necessary to save the mother from grave danger to her health or when the pregnancy is the result of rape. According to the French version of the Code, the abortion must be performed by a qualified person. The English version stipulates that, in the case of a threat to health, the abortion must be performed by a qualified person, and in the case of rape, by a qualified medical practitioner. In the case of rape, the French version provides that the public prosecutor's office must certify the materiality of the facts, and the English version, that the prosecution must certify a "good case." Anyone performing an illegal abortion is subject to one to five years' imprisonment and a fine of 100,000 to 2 million CFA francs. A woman who procures or consents to her own abortion is subject to imprisonment for fifteen days to one year and/or a fine of 5,000 to 200,000 CFA francs. Penalties applied to medical professionals who perform illegal abortions shall be doubled and they may be prohibited from carrying out their obligations or be subject to having their professional premises closed.

Law No. 80-10 of 14 July 1980 to regulate the practice of pharmacy proscribes a number of abortion-related activities. It provides that no person shall indulge in acts capable of provoking or facilitating abortion, including (a) displaying, offering, causing to be offered, selling, putting up for sale, causing to be sold, distributing or causing to be distributed in any manner whatever, any medicines and substances, intrauterine catheters and similar articles; (b) making speeches in public places or meetings; (c) selling, putting up for sale or offering even in private, displaying, posting up or distributing on highways or in public places, or distributing at home, mailing under wrapper or in an envelope whether or not sealed, or surrendering to any distribution or transport agent, books, scripts, printed matter, advertisements or notices, posters, drawings, pictures or symbols; or (d) advertising doctors' offices or so-called offices. Violation of the Law is punishable by three months to two years' imprisonment and a fine of 150,000 to 500,000 CFA francs.

Induced abortion and its complications constitute a serious problem in Cameroon. Induced abortion is a particularly serious problem among adolescents. A national population policy was adopted by the Government in 1992 and an information and education programme on the benefits of responsible parenthood is being implemented. However, obstacles to an increase in contraceptive prevalence include pronatalist attitudes, poor communication infrastructure in some areas of the country and insufficient family planning facilities.

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

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

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

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Satisfactory
Government intervention concerning fertility level:	No intervention
Government policy on contraceptive use:	Indirect support provided
Percentage of currently married women using modern contraception (aged 15-49, 1995):	75
Total fertility rate (1995-2000):	1.6
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	23
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	No
Complications of childbearing and childbirth	No
Maternal mortality ratio (per 100,000 live births; 1990):	
National	6
Northern America	11
Female life expectancy at birth (1995-2000):	82

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

Canada

BACKGROUND

Canadian abortion laws have undergone significant changes in the past two decades. Prior to 1969, abortion was governed by the provisions of the Criminal Code of 1892, as amended (Sections 272-274). Under these, no exception was expressed to a general prohibition of abortion, although it was understood that one could be performed on the criminal law principle of necessity to save the life of the pregnant woman. In response to the mounting public debate, the Government of Canada instituted a review of its abortion law in 1967 and, in 1969, amended the Criminal Code to liberalize the law. Under the amended and recodified provisions of the Code (Section 251), abortion was permitted if the continuation of the pregnancy would or would be likely to endanger the woman's life or health. Although the new provisions broadened the grounds under which abortion was permitted, they also imposed some restrictions. An abortion was required to be carried out by a qualified medical practitioner in an accredited or approved hospital that had a therapeutic abortion committee comprised of no fewer than three qualified medical practitioners (not including the one performing the abortion). The Committee was responsible for determining whether a specific abortion could be performed legally, how long into a pregnancy it could be performed, and whether a married woman had to obtain the consent of her husband, or a minor, the consent of her parents. A physician who performed an abortion in violation of the law could be sentenced to life imprisonment, and a woman who consented to an abortion to two years' imprisonment.

One consequence of the law was a major disparity in the availability of legally performed abortions in the various parts of the country. By the mid-1980s, 75 per cent of all abortions were performed in 15 per cent of the hospitals, and in certain provinces such as Prince Edward Island and Newfoundland and Labrador it was almost impossible to obtain an abortion. Moreover, only 43 per cent of the hospitals in the country were accredited hospitals and only 52 per cent of these had decided to establish abortion committees. The law rendered generally impossible the performance of abortions in free-standing clinics, although the Government of Quebec in the early 1970s took the step of deciding not to prosecute safely performed abortions, no matter where performed.

In 1988, the Supreme Court of Canada ruled that Section 251 was unconstitutional because it violated Section 7 of the Canadian Charter of Rights and Freedoms, which guarantees the right to "life, liberty, and security of the person" (*R. v. Morgentaler*, 1988). The Court objected to the provisions of Section 251 governing the procedures of therapeutic abortion committees and the requirement that all abortions be performed in approved or accredited hospitals. It concluded that these features of the law were manifestly unfair, caused unnecessary delays, prevented access to abortion clinics, and subjected women to additional health risk and increased uncertainty and emotional distress. Although the Government of Canada tried to introduce new legislation to replace Section 251, it was unable to achieve a majority of Parliament members' approval for its proposal. In 1991, the Government abandoned these efforts, leaving the country without a federal criminal abortion law or any restrictions on the performance of abortions.

Despite the absence of a federal abortion law, a number of provinces have tried to step into the void left by the Supreme Court's ruling that Section 251 was unconstitutional and put into place their own restrictions on the performance of abortions. One area targeted by some provinces has been the practice of performing abortions in free-standing clinics. In 1989, for example, the Province of Nova Scotia enacted legislation having the effect of prohibiting the performance of abortions outside hospitals, thus precluding

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

their performance in free-standing clinics. The Province claimed that this legislation was enacted for the purpose of protecting health, rather than restricting access to abortions. In 1993, however, the Supreme Court of Canada held that this legislation was unconstitutional because it was essentially criminal law and thus outside the jurisdiction of provincial legislation (*R. v. Morgentaler,* 1993). Under Canadian law, criminal legislation is under the exclusive jurisdiction of the federal Government, while health legislation is partly under provincial jurisdiction. To support its decision, the Court pointed to legislative debates demonstrating that the major purpose of the legislation was to prevent the performance of abortions—a criminal matter—not to protect health, as the Province argued.

Another area targeted by provinces has been the funding of abortions under government-mandated health insurance. In 1988, for example, the Province of Prince Edward Island enacted legislation denying payment for abortions unless performed in a hospital and certified to be necessary by a panel of physicians. In 1995, the Supreme Court of the Province ruled that these restrictions were invalid because they were designed to prevent the performance of legal abortions for reasons considered undesirable, and thus were outside the powers given to health officials to regulate health under the provincial Health Services Payment Act (*Morgentaler v. Prince Edward Island,* 1995). It rejected the Province's argument that the restrictions were based on health considerations or intended to contain costs rather than restrict abortion. Similar decisions have been reached by courts in other Canadian Provinces, although the Supreme Court of Canada has yet to rule on this issue or on the question of the denial of funding for all abortions under provincial legislation. Consequently, the provinces still do not provide complete funding of all abortions.

In the wake of the Supreme Court's ruling that Canada's criminal abortion law was unconstitutional, the number of abortions performed on Canadian women increased from 70,000 in 1987 to 106,000 in 1995, with a trend toward stabilization at this level; the number performed in 1995 was only 0.4 per cent greater than in the previous year. Of these abortions, approximately one third are performed in clinics and two thirds in hospitals. Access to abortion is still limited, despite the Supreme Court's decision. No abortions are performed in the Province of Prince Edward Island, and no free-standing clinics have been established in Saskatchewan, the Northwest Territories or the Yukon Territory.

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

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

An abortion can be performed on any grounds if gestation is within 12 weeks. Thereafter, it can be performed only if continuance of the pregnancy poses a risk of death or of serious and permanent injury to the woman's health, both physical and mental; to prevent the probable transmission to the foetus of a serious hereditary or contagious illness; or to prevent the newborn from suffering from serious physical defects or mental disturbances. An abortion requires the woman's consent and must be performed in a hospital, with "medical assistance".

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Too high
Government intervention concerning fertility level:	To lower
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49; 1998):	53
Total fertility rate (1995-2000):	3.6
Age-specific fertility rate (per 1,000 women aged 15-19):	79
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	Yes
Complications of childbearing and childbirth	..
Maternal mortality ratio (per 100,000 live births; 1990):	
National (1980)	107
Western Africa (1990)	1 020
Female life expectancy at birth (1995-2000):	71

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

BACKGROUND

In the late 1970s and early 1980s, the Government of Cape Verde became concerned about the increase in the number of abortions performed and the considerable impact they were having on women's health. The number of abortions performed in the maternal and child health programme increased eightfold between 1978 and 1984. The Government subsequently enacted abortion legislation on 31 December 1986, which allows abortion on request during the first 12 weeks of pregnancy. The only prerequisites are the woman's consent to the abortion and the performance of the abortion in a hospital, with "medical assistance". After the first trimester, abortion is permitted only if continuance of the pregnancy poses a risk of death or of serious and permanent injury to her health, both physical and mental; to prevent the probable transmission to the foetus of a serious hereditary or contagious illness; or in order to prevent the newborn from suffering from serious physical defects or mental disturbances.

Compared with other countries in the region, health services in Cape Verde have greater coverage and are of higher quality. Family planning is provided as part of the Government's maternal and child health programme. Although services have been provided in some government centres since 1978 and are offered free of charge, not all islands have access to the services.

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

Central African Republic

ABORTION POLICY

Grounds on which abortion is permitted

To save the life of the woman	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

Not applicable.

* The law does not expressly allow abortions to be performed to save the life of the woman, but general principles of criminal legislation allow abortions to be performed for this reason on grounds of necessity.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Too high
Government intervention concerning fertility level:	No intervention
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49; 1994/95):	15
Total fertility rate (1995-2000):	4.9
Age-specific fertility rate (per 1,000 women aged 15-19; 1995-2000):	81
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of childbearing and childbirth	Yes
Maternal mortality ratio (per 100,000 live births; 1990):	
National	700
Middle Africa	950
Female life expectancy at birth (1995-2000):	47

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

BACKGROUND

Although the Penal Code, Law No. 61-239 of 18 July 1961 (Article 190), contains no explicit exceptions to the general prohibition of abortion, under the criminal law principles of necessity an abortion can be performed to save the life of the pregnant woman. Anyone performing, or attempting to perform, an illegal abortion, with or without the woman's consent, is subject to a sentence of one to five years' imprisonment and a fine of 200,000 to 2 million CFA francs. Physicians and paramedical practitioners face the same sentences and are also subject to being prohibited from practicing their profession for at least five years.

Since 1987, the Government has endorsed family planning as a measure to improve women's health. At that time, it formulated a national maternal and child health and family planning programme and officially recognized the Central African Association for Family Well-being (Association Centrafricaine pour le Bien-Etre Familial/ACABEF), which had been operating for some time. Constraints on family planning include the still widespread perception in traditional communities that large families are associated with prestige. Moreover, women's access to contraceptives is still subject to their husbands' authorization.

Despite restrictive legislation, illegal abortions continue to be performed in the Central African Republic. As is the case in several African countries, adolescent pregnancy rates are high, as are abortion rates for that age group.

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

Chad

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

The pregnant woman must consent to the procedure unless she is not in a position to consent and there is grave danger to her life. In addition, the physician performing the abortion must obtain the written approval of two other physicians, one of whom must be an expert on the list of the civil court.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Satisfactory
Government intervention concerning fertility level:	No intervention
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49):	..
Total fertility rate (1995-2000):	6.1
Age-specific fertility rate (per 1,000 women aged 15-19; 1995-2000):	185
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of childbearing and childbirth	..
Maternal mortality ratio (per 100,000 live births; 1990):	
National	1 500
Middle Africa	950
Female life expectancy at birth (1995-2000):	49

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

BACKGROUND

Abortion in Chad is governed by the Penal Code (Law No. 12-67 of 9 June 1967). Article 296 of the Code prohibits the performance of all abortions, although under the general criminal law principles of necessity, an abortion can be performed to save the life of the pregnant woman. Any person performing an illegal abortion is subject to one to five years' imprisonment and/or a fine of 50,000 to 500,000 CFA francs. If the person regularly performs abortions, the punishment is 5 to 10 years' imprisonment and a fine of 100,000 to 1,000,000 CFA francs. If the person is a medical professional, he or she is liable to suspension from professional practice for five years to life. A woman who induces her own abortion is subject to imprisonment for two months to two years and a fine of 5,000 to 50,000 francs. Law No. 28 of 29 December 1965 which regulates the exercise of pharmacy prohibits the importation, sale and advertisement of abortifacients, as well as contraceptives.

Conditions for the performance of legal abortions are set forth in article 38 of the Code of Medical Deontology. The pregnant woman must consent to the procedure unless she is not in a position to consent and there is grave danger to her life. In addition, the physician performing the abortion must obtain the written approval of two other physicians, one of whom must be an expert on the list of the civil court.

Illegal abortion is common in Chad; although some cases of illegal abortion have been tried in the Chadian courts, the majority of cases have been ignored by the judicial system. The 1920 French anti-contraception law was rescinded in Chad in 1993. A national maternal and child health/family well-being programme was established in 1992.

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

Chile

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

Not applicable.

*Abortion law in Chile has been amended to remove all indications for the legal performance of abortions; however, it is a matter of dispute whether a defense of necessity might be allowed to justify an abortion performed to save the life of the woman.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	No official position
Government intervention concerning fertility level:	No intervention
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception:	..
Total fertility rate (1995-2000):	2.4
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	49
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of childbearing and childbirth	Yes
Maternal mortality ratio (per 100,000 live births; 1990):	
National	65
South America	200
Female life expectancy at birth (1995-2000):	78

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

BACKGROUND

Abortion in Chile is governed by the Chilean Penal Code (12 November 1874, sections 342-345). Although the Code prohibits all abortions that are performed with malice (*maliciosamente*), historically it was understood that an abortion could be performed to save the life of the pregnant woman. Moreover, the Health Code (Decree No. 725 of 11 December 1967, section 119) expressly permitted a therapeutic abortion to save the life of the woman. The performing physician was required to obtain the written consent of two physicians.

On 15 September 1989, however, the Government of Chile amended section 119 of the Health Code to provide that "No action may be executed that has as its goal the inducement of abortion" (Law No. 18,826). The justification provided for the new restrictions was that, given the advances in modern medicine, an abortion was no longer needed to save the life of a pregnant woman. Owing to this amendment, it is generally, although not unanimously, believed that no abortions can now be legally performed in Chile.

Under the Penal Code, anyone who performs an abortion with the woman's consent is subject to the normal length of short-term imprisonment. If the abortion is performed without the woman's consent, the penalty is the maximum length of short-term imprisonment. A woman inducing her own abortion or consenting to it is subject to the maximum length of short-term imprisonment. Harsher penalties are imposed on physicians. Despite these penalties, few convictions are made for performing abortions because physical proof of abortion, such as traumatic injury to internal organs, is necessary to obtain a conviction.

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

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

Family planning services in Chile are provided mostly to married women. In 1996, the Ministry of Education created and implemented a sex education programme, despite opposition from conservative groups. In the same year, the Ministry of Health started a programme for adolescent health that does not, however, include reproductive health services. The on-going privatization of the health care system in Chile is having an impact on the availability of family planning services for the poorest sectors of society.

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

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Satisfactory
Government intervention concerning fertility level:	To maintain
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49, 1992):	83
Total fertility rate (1995-2000):	1.8
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	5
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of childbearing and childbirth	..
Maternal mortality ratio (per 100,000 live births, 1990):	
National	95
Eastern Asia (around 1983)	95
Female life expectancy at birth (1995-2000):	72

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

BACKGROUND

The Criminal Code of China (enacted by the National People's Congress on 1 July 1979) does not contain any provisions under which abortion, performed with the consent of the pregnant woman, constitutes an offence. Early abortions are performed in a clinic by medical personnel using the vacuum aspiration technique; second-trimester abortions are performed in a hospital by a physician. Abortion services are provided by the Government of China as a public service. A woman receives 14 days of paid sick leave for a first-trimester abortion or 30 days if the pregnancy is terminated after the first trimester. In some parts of the country, paid sick leave is extended if a woman who has an abortion has an intrauterine device (IUD) inserted or is sterilized after the abortion is performed. Although most abortions are performed in the early months of pregnancy, the Government permits abortions to be performed up to six months of gestation.

In the early 1950s, an abortion was permitted only under certain conditions. At that time, official statements of the central Government indicated that abortion was allowed when continuation of the pregnancy was medically undesirable, when the spacing of children was too close or when a mother with a child under four months of age had again become pregnant and experienced difficulties in breastfeeding. In such cases, a joint application of the couple and certification of a physician were required before the abortion could be performed. Under certain circumstances, special work or work (or study) that was too heavy could also be used as a legitimate reason for an abortion, but any request for the operation had to first be certified by the key personnel of the responsible organization and also approved by a medical organization. Abortions were to be performed as early as possible, preferably within the first month of pregnancy and at the latest not beyond the second month.

The results of data from the 1953 census contributed to the government decision to introduce and support the use of contraception and abortion to reduce the rate of population growth. On 12 April 1957, the Public Health Ministry announced that, from that date, all applications for abortion or sterilization would be free of restrictions concerning age, number of children and approval procedures. However, an abortion could only be performed once a year and was permitted only within the first 10 weeks of the gestation period. The Government stressed the promotion of contraception as a preventive measure, with abortion to be used mainly as a backup measure in cases of contraceptive failure.

In the early 1970s, the Government of China began to incorporate population activities into the planning of its national economy. The planned birth model was introduced, national goals were set and an education model of communication was developed. The "Later-Longer-Fewer" (*Wan-Xi-Shao*) campaign was followed in 1979 by the one-child-per-couple policy. An article of the Chinese Constitution provided that individual couples were required to practise and the Government to support family planning. Since then, family planning policy has been implemented primarily through a nationwide family planning programme that includes a strong information and education component, free contraceptive services and a system of economic and social incentives and disincentives, which vary by province and between rural and urban areas.

In 1990, contraceptive use by women of reproductive age was reportedly above 85 per cent, a rate that is close to the level in most developed countries and well above the rates in other Asian countries. A majority of contraceptive users in China rely upon one of three methods, the IUD, female sterilization or male sterilization, although many other methods, such as the pill and condoms, are also available and widely used. However, the contraceptive failure rate is relatively high in China.

Studies have shown that following an IUD expulsion, in many cases, no other method was substituted to prevent pregnancy. Therefore, owing to contraceptive non-use and to contraceptive failure, abortion has

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

assumed a greater role in controlling fertility. Government officials have estimated that 70 per cent of the abortions in China follow contraceptive failure. The number of abortions ranged from about 4 million to 5 million per annum between 1971 and 1978. In 1979, after the one-child policy went into effect, the incidence of abortion was about 7.9 million. The number reached an all-time high around 1983, with 14.4 million abortions recorded, and then gradually declined to about 10.6 million in 1989.

According to statistics released by the State Family Planning Commission at the end of 1990, the incidence of abortion was not uniform across the country. In general, ratios of abortions to births were lower in the inland provinces than in the coastal provinces. The populations of some inland provinces included large numbers of minorities that were exempt from some of the population policy measures. With a few exceptions, abortion ratios were higher in cities and towns than in rural areas. This rural/urban differential was attributed to behavioural factors, but it is also possible that many rural women seeking a late-trimester abortion had the procedure performed in a large hospital in a city.

According to some studies undertaken in the late 1980s, abortion rates, in general, increase sharply the higher the number of pregnancies. A clinical study on abortion conducted in 1990, covering certain regions and cities in provinces, such as Jiangsu, Shanghai and Sichuan municipality, reported an average of 1.08 children for the urban respondents versus 1.60 children for the rural respondents.

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

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

An abortion requires the woman's consent.

* The abortion law does not expressly allow abortions to be performed to save the life of the woman, but the general principles of criminal legislation allow abortions to be performed for this reason on grounds of necessity.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Too high
Government intervention concerning fertility level:	To lower
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49, 1995):	72
Total fertility rate (1995-2000):	2.8
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	88
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	Yes
Complications of childbearing and childbirth	Yes
Maternal mortality ratio (per 100,000 live births; 1990):	
National	100
South America	200
Female life expectancy at birth (1995-2000):	74

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

Colombia

BACKGROUND

Abortion in Colombia is governed by provisions of the Penal Code of 1980. Under Articles 343-345 of the Code, no exceptions are stated to the general prohibition against abortion. Nonetheless, under general principles of criminal law, an abortion can be performed to save the life of the pregnant woman. Penalties for illegal abortions vary according to the circumstances in which the abortion is performed. A woman who causes her own abortion or allows another person to cause it, as well as a person performing an abortion with the consent of the woman, is subject to one to three years' imprisonment. The punishment is greater when the abortion is performed without the consent of the woman or when the woman is under 14 years of age. In these cases, the person performing the abortion is subject to three to ten years' imprisonment.

The language of the Penal Code of 1980 follows closely that of the Penal Code of 1936; the 1936 Code had eliminated a previously expressed exception to the general prohibition of abortion when this procedure was absolutely necessary to save the pregnant woman's life. The major change introduced by the 1980 Code was the removal of reduced penalties, including pardon, when the abortion was performed to save the honour of the woman. In their place, the 1980 Code inserted provisions allowing for reduced penalties to be imposed on a woman who caused her own abortion or allowed it be caused when she had became pregnant as a result of violent or abusive sexual relations or through artificial insemination performed on her without her consent. In these cases, she is subject to four months' to one year's imprisonment.

Since the enactment of the 1980 Code, a number of attempts have been made to liberalize its provisions on abortion, the most recent of them in 1997 as part of a larger law on sexual and reproductive health proposed by a Colombian legislator. At the same time, those opposed to the performance of abortions have introduced legislation to increase the penalties for illegal abortions. None of the proposed legislation has achieved any success.

Two individuals have also attempted to change the abortion provisions of the Penal Code of Colombia through the medium of the courts. Their actions were made possible by the 1991 Constitution, which significantly expanded the opportunities for court challenges to existing legislation. One sought to have the provisions of the Code prohibiting abortions declared unconstitutional for violating the constitutional rights of couples to freely and responsibly determine the number of their children and the rights to freedom of conscience and religion. The other sought to have provisions of the Code authorizing reduced penalties for abortion in cases of rape, abusive sexual relations, or forced artificial insemination declared unconstitutional as violating the constitutional right to life. The Constitutional Court denied relief in both suits, and in the process forcefully rejected the idea of legalized abortion in Colombia.

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

Although the National Constitution of 1991 includes an article about the human right to family planning, services provided by the Government were marginal until recent years. However, the Colombian Basic Health Care Plan, compulsory until 2000, contains reproductive health services such as

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

maternal/perinatal care and family planning, including a wide range of contraceptive methods. To complement this plan, a new sexual and reproductive health policy was approved in 1998 which aims, among other things, at reducing maternal mortality as well as the number of deaths due to illegal abortions. To achieve this goal, the plan intends to regulate emergency care services, improve the capacity to respond in case of complications and ensure timely hospitalization and care. Sex education for adolescents was made compulsory in 1993. However, no regulations or reproductive health care programmes specifically target adolescents. The Colombian Association for Family Well-being (Asociación Pro-Bienestar de la Familia Colombiana/PROFAMILIA) is an important provider of family planning services, accounting for some 70 percent of family planning services nationwide as of 1995.

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

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

Two physicians must certify in writing that serious medical reasons exist to interrupt the pregnancy.

* Abortions can be performed for "serious medical reasons." The Penal Code does not indicate whether these reasons include reasons of both physical and mental health.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Too high
Government intervention concerning fertility level:	To lower
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49; 1996):	21
Total fertility rate (1995-2000):	4.8
Age-specific fertility rate (per 1,000 women aged 15-19; 1995-2000):	83
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of childbearing and childbirth	Yes
Maternal mortality ratio (per 100,000 live births; 1990):	
National	950
Eastern Africa	1 060
Female life expectancy at birth (1995-2000):	60

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

Comoros

BACKGROUND

The Penal Code of Comoros (Act No. 82-03P/AF of 19 November 1982) prohibits the performance of abortions except for serious medical reasons attested to by at least two physicians. Anyone performing or attempting to perform an illegal abortion, with or without the consent of the woman, and regardless of whether she is pregnant or not, is subject to one to five years' imprisonment and to a fine of 15,000 to 100,000 Comorian francs (CF). If the person regularly performs abortions, he or she is subject to five years' imprisonment and a fine of CF 30,000 to 400,000. A woman who procures or attempts to procure her own abortion or consents to the performance of one, is subject to six months' to two years' imprisonment and a fine of CF15,000 to 100,000. Physicians, pharmacists, medical and paramedical professionals, and other health-related personnel assisting in or performing an abortion are subject to suspension from practising their profession for five years to life.

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

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

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

An abortion reportedly requires authorization by a committee of physicians.

* The abortion law does not expressly allow abortions to be performed to save the life of the woman, but the general principles of criminal legislation allow abortions to be performed for this reason on grounds of necessity. In addition, reports suggest that abortion is permitted to protect the health of the pregnant woman.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Too high
Government intervention concerning fertility level:	To lower
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49):	..
Total fertility rate (1995-2000):	6.1
Age-specific fertility rate (per 1,000 women aged 15-19; 1995-2000):	141
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	Yes
Complications of childbearing and childbirth	Yes
Maternal mortality ratio (per 100,000 live births; 1990):	
National	890
Middle Africa	950
Female life expectancy at birth (1995-2000):	51

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

Congo

BACKGROUND

Under the Congolese abortion law, which is based on the French Penal Code of 1810 (section 317), no exceptions are stated to a general prohibition on the performance of abortions. Nonetheless, under the general principles of criminal law, an abortion can be performed to save the life of the pregnant woman, and reports indicate that abortions are also permitted to protect the health of the pregnant woman.

Clandestine abortion is widely practiced in the Congo. Several studies have documented the high incidence of abortion in various areas of the country. Many of the women obtaining abortions are young and unmarried. According to the Government's 1992-1996 Action Plan for National Health Development, induced abortion is the leading cause of maternal death in the Congo. In response to the high rates of maternal mortality and infertility caused by complications of induced abortion, the Government requested international assistance in 1979 to integrate family planning services into its maternal and child health programme. In 1988 the Government officially recognized the Congolese Association for Family Well-being (Association Congolaise pour le Bien-Etre Familial/ACBEF), an affiliate of the International Planned Parenthood Federation. Although the French anticontraception laws of 1920 are still in effect, the Government permits access to contraception by prescription. Contraceptives are available in government and private clinics, as well as in pharmacies. However, pronatalist attitudes, poor communication infrastructure, male resistance and poor understanding of family planning messages are some of the factors that have impeded the use of modern family planning methods.

Since the early 1980s, the reform of current abortion laws has been under consideration in the Congo. The Government is aware that the law is becoming increasingly unenforceable, given the large number of abortions that are currently performed; however, legal restrictions have not been eased, even though abortions are performed in some government hospitals.

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

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Too low
Government intervention concerning fertility level:	To raise
Government policy on contraceptive use:	Indirect support provided
Percentage of currently married women using modern contraception (aged 15-49):	..
Total fertility rate (1995-2000):	..
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	..
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of childbearing and childbirth	..
Maternal mortality ratio (per 100,000 live births; 1990):	
National	..
Oceania	..
Female life expectancy at birth (1995-2000):	..

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

Cook Islands

BACKGROUND

The Cook Islands are a self-governing country in free association with New Zealand. Abortion is governed by the Crimes Act 1969, which is based on New Zealand and, ultimately, British common law. Under the Act, anyone who unlawfully and intentionally procures or attempts to procure a miscarriage by drug or instrument is liable to up to seven years' imprisonment. If any other means is used unlawfully and intentionally to procure or attempt to procure the miscarriage the penalty is up to five years' imprisonment. A woman who unlawfully and intentionally procures or attempts to procure her own miscarriage, is liable to up to three years' imprisonment. The Act, however, allows an abortion to be performed to save the life of a pregnant woman, stipulating that a person is not guilty of a crime if, before or during the birth of any child, he or she causes the death of the child by means employed in good faith for the preservation of the life of the mother.

Most countries whose legal systems are based on the common law of the United Kingdom follow the 1938 English *Rex v. Bourne* decision in determining whether an abortion performed for health reasons is lawful. In the *Bourne* decision, a physician was acquitted of the offence of performing an abortion in the case of a woman who had been raped. The court ruled that the abortion was lawful because it had been performed to prevent the woman from becoming "a physical and mental wreck", thus setting a precedent for future abortion cases performed on the grounds of preserving the pregnant woman's physical and mental health. It is unclear whether the *Bourne* decision would be applicable in the Cook Islands.

Although family planning services have been available at health service outlets since the early 1980s, in the context of religious beliefs family planning remains a somewhat controversial issue. The Government is also concerned about possible depopulation of some of the islands resulting from high levels of emigration. Another constraint in the implementation of the family planning programme is the distribution of the country's 15 islands over wide areas of ocean.

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

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

The pregnant woman must consent to the abortion, which must be performed by a physician, or if no physician is available, by an authorized midwife.

*The Law does not specify whether preservation of health includes both physical and mental health.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Satisfactory
Government intervention concerning fertility level:	To lower
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49; 1992/93):	75
Total fertility rate (1995-2000):	2.8
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	85
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	Yes
Complications of childbearing and childbirth	..
Maternal mortality ratio (per 100,000 live births; 1990):	
National	55
Central America	140
Female life expectancy at birth (1995-2000):	79

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

Costa Rica

BACKGROUND

The Costa Rican Penal Code of 4 May 1970 (sections 118-122) permits an abortion to be performed in order to prevent danger to the life or health of the pregnant woman when this danger cannot be averted by any other means. The consent of the pregnant woman must be obtained, and the abortion must be performed by a physician or, if a physician is not available, by a midwife.

A person who performs an illegal abortion is subject to imprisonment for a period of one to three years if the abortion is performed with the woman's consent. The same punishment is applicable to a woman who induces her own abortion or consents to it. If the abortion is performed before the end of the second trimester of gestation, the punishment is reduced to six months' to two years' imprisonment. A person who performs an abortion without the woman's consent or when she is under fifteen years of age is subject to three to ten years' imprisonment. In the above cases, the punishment is increased if the woman dies as a result of the abortion. Section 120 of the Penal Code provides for a reduced sentence of three months' to two years' imprisonment in cases where the abortion has been performed with the woman's consent to hide her dishonour.

Reproductive health services are included as part of the primary health care services provided by all public institutions in Costa Rica since the late 1980s. Access to these services, which include family planning, prenatal and postnatal care and assistance to delivery, is easy and quality is high. Three quarters of the women are users of modern contraceptive methods, which are provided nearly free of charge by public services. In 1989, the Government approved a programme of comprehensive care to adolescents, which includes information, communication and sex education campaigns as well as care for adolescent mothers, provided in two public hospitals.

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

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

An abortion must be performed by a physician or surgeon, after consulting with two additional physicians, who must certify that the life of the mother can only be saved by the surgical or therapeutic operation employed.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Satisfactory
Government intervention concerning fertility level:	To raise
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49, 1994):	11
Total fertility rate (1995-2000):	5.0
Age-specific fertility rate (per 1,000 women aged 15-19; 1995-2000):	133
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of childbearing and childbirth	..
Maternal mortality ratio (per 100,000 live births; 1990):	
National	810
Western Africa	1 020
Female life expectancy at birth (1995-2000):	47

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

Côte d'Ivoire

BACKGROUND

Under the Penal Code of Côte d'Ivoire, Law No. 81-640 of 31 July 1981, abortion is prohibited except to save the seriously endangered life of the pregnant woman. The attending physician must consult with two additional physicians, who must certify that the life of the mother can only be saved by the surgical or therapeutic operation employed. If only one other physician resides in the place where the intervention is carried out, the attending physician need only consult with this physician. If the treating physician is the only physician residing in the place where the intervention is carried out, he must certify on his honour that the life of the mother can only be saved by the surgical or therapeutic operation employed. Although the Penal Code also prohibits incitement to abortion by means of public discussion or advertisement or by distribution or sale of substances or objects, it no longer contains the related restrictions on contraception that were enacted by the French colonial Government in 1920.

Anyone who procures or attempts to procure an abortion, with or without the consent of the woman, is subject to one to five years' imprisonment and a fine of 150,000 to 1.5 million CFA francs. A person regularly performing abortions is subject to 5-10 years' imprisonment and a fine of 1 million to 10 million CFA francs. A woman who procures or attempts to procure or consents to an abortion is subject to six months' to two years' imprisonment and a fine of 30,000 to 300,000 CFA francs. Health professionals who encourage or perform an abortion are subject to the same penalties as those performing them. Persons convicted of performing an illegal abortion are prohibited from carrying out any function or employment in childbirth clinics and other establishments that regularly take in women who are pregnant or presumed to be pregnant.

Illegal abortion is considered a growing problem in Côte d'Ivoire, particularly among the young. Up to 1981, when Côte d'Ivoire's anticontraception law was repealed, contraceptives were illegal. The Government now supports family planning. The Ministry of Public Health and Social Affairs, in collaboration with the Association Ivoirienne pour le Bien-Etre Familial (AIBEF), an IPPF affiliate, has drafted a National Family Planning Programme whose major objective is to increase contraceptive prevalence from 10 per cent in 1996 to 15 per cent in 2000 and to 30 per cent in 2010.

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

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

The woman must certify in writing that she is determined to have an abortion and the physician must be convinced of her determination. The woman must receive counselling at least six days prior to the procedure. The procedure must be performed by a physician under good medical conditions in a health care establishment with a proper information department.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Too low
Government intervention concerning fertility level:	To raise
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49):	..
Total fertility rate (1995-2000):	1.6
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	19
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of childbearing and childbirth	..
Maternal mortality ratio (per 100,000 live births; 1990):	
National	..
Southern Europe	14
Female life expectancy at birth (1995-2000):	77

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

Croatia

BACKGROUND

Beginning in 1952, abortion legislation in Yugoslavia went through a process of liberalization in response to a significant increase in illegal abortions associated with high levels of maternal morbidity and mortality. The subsequent changes in the abortion laws were expressly intended to facilitate access to legal abortion in order to discourage illegal practices. A significant decline in the number of illegal abortions was attributed to the decision in 1969 to eliminate the need for a commission's approval for termination of pregnancies of less than 10 weeks, a requirement that had served as a practical and psychological obstacle to abortion. 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.

In order to implement article 191 of the Federal Constitution of Yugoslavia of 21 February 1974, which proclaimed that it was a human right to decide on the birth of children, the former socialist republic passed a comprehensive law on 21 April 1978 concerning all aspects of fertility regulation, including contraception, sterilization, abortion and the treatment of infertility. It also amended the Criminal Code, with respect to sanctions for unlawful abortion.

When Croatia achieved independence from the former Socialist Federal Republic of Yugoslavia in 1991 and adopted a new Constitution, the law regulating abortion was not changed. Under the 1978 law, abortion is allowed on request during the first 10 weeks of pregnancy. The intervention must be performed by a physician in a hospital with a department of gynaecology or obstetrics or in another authorized health-care facility. If the woman is under age 16, the authorization of her parents or guardian and the guardianship authority is required. After the first 10 weeks of pregnancy, the performance of an abortion must be approved by a commission of experts, composed of two physicians, one of whom is a gynaecologist, and a social worker or registered nurse. The commission may consent to an abortion when it is medically established that it would otherwise be impossible to save the woman's life or prevent damage to her health, whether it should be during pregnancy, delivery or post-partum; when the probability that the child would be born with a serious congenital physical or mental defect is medically established; or when the conception is a consequence of a criminal act of rape, criminal act of sexual intercourse with an incompetent person, criminal act of sexual intercourse in consequence of abuse of authority, criminal act of sexual intercourse with a child or criminal act of incest. The woman can appeal to a commission of second instance if the commission of first instance rejects her request. An abortion can always be performed if the life or health of the pregnant woman is immediately endangered or if an abortion has already been initiated.

Medical organizations that perform abortions when not authorized to do so, as well as medical organizations that perform abortions after 10 weeks of pregnancy without the approval of a commission, are subject to a fine of 2,000 to 10,000 Croatian dinars (HrD). The individual medical workers involved in performing such abortions are subject to a fine of HrD 500 to 3,000. Further provisions in the Criminal Code of Croatia set penalties for persons performing abortions in violation of other provisions of the 1978 Law. They are subject to three months' to three years' imprisonment if the pregnant woman consents, and to one to eight years' imprisonment if she does not. If the person performing the abortion earns his living by such an activity or if the abortion results in serious injury to the pregnant woman and she has consented to its performance, the penalty is six months' to five years' imprisonment. If she has not consented and serious injury results from the abortion, the penalty is three years to 15 years' imprisonment. The Code sets forth various circumstances under which a court can increase or decrease the penalty.

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

Croatia

Family planning services were a part of the regular medical services in Yugoslavia, beginning in the mid-1950s. A family planning institution was established in 1963 at the national and local levels, and the Family Planning Association has existed since 1966. However, sex education in the schools and counselling on family planning have not been systematically developed; family planning has encountered continuing resistance throughout the country. Although Croatia has a higher contraceptive prevalence rate than the other republics of the former Socialist Federal Republic of Yugoslavia and is one of the few republics where contraceptive use has increased since the 1970s, use of modern contraceptive methods is still very limited and abortion remains a basic means of birth control.

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

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

An abortion requires the consent of the pregnant woman.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Satisfactory
Government intervention concerning fertility level:	No intervention
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49, 1987):	70
Total fertility rate (1995-2000):	1.5
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	65
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	No
Complications of childbearing and childbirth	..
Maternal mortality ratio (per 100,000 live births; 1990):	
National	95
Caribbean	400
Female life expectancy at birth (1985-1990):	78

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

Cuba

BACKGROUND

In pre-revolutionary Cuba, abortion laws were modelled after the 1870 Penal Code of Spain and were very restrictive. Some restrictions were removed in 1936 with the introduction of the new penal code, named the Social Defense Code, which permitted abortion when necessary to save the life of a pregnant woman or prevent serious injury to her health; in cases of rape, abduction not followed by marriage or statutory rape; or in order to prevent the transmission to the foetus of a serious hereditary or contagious disease. Authorization by two physicians was reportedly required for abortions performed in cases of risk to health. However, abortion was easily available in private clinics at a reasonable cost.

In the early years after the revolution (1959-1964), enforcement of abortion laws was somewhat stricter. Stricter enforcement, combined with the emigration of a substantial proportion of the physicians from Cuba, contributed to an increase in the number of abortions performed by unqualified personnel. The resulting rise in maternal mortality led the Cuban Government to adopt the World Health Organization definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity", which permitted a more liberal interpretation of the abortion law and led to the institutionalization of induced abortion by the national health system. Thus, since 1965, abortion has been available on request up to the tenth week of gestation through the national health system.

The new Penal Code adopted in 1979 to replace the Social Defense Code defines the conditions under which abortion would be considered illegal and establishes punishments for those performing an illegal abortion. An abortion is considered "illegal" if performed in disregard of health regulations established for the performance of abortion, and the person performing such an abortion is subject to imprisonment for a period of three months to one year. If the abortion is performed for profit or outside of official institutions or not performed by a physician, the possible punishment is increased to imprisonment for two to five years. An abortion is also considered "illegal" when performed without the consent of the pregnant woman. A person who performs such an abortion is subject to two to five years' imprisonment, if the abortion is performed without force or violence, and to three to eight years' imprisonment if force or violence is employed.

If gestation is 5 weeks or less, menstrual regulation is employed. Women require no confirmation of pregnancy and minors do not require parental consent for menstrual regulation to be performed. For abortions, gestation of 10-12 weeks requires confirmation of pregnancy. The pregnant woman must be examined by a gynaecologist and must receive counselling from a social worker. Women under 18 years of age must have parental consent. Women under 16 require authorization by a medical committee. For an abortion performed in the second trimester, in addition to meeting the conditions for abortion in the first trimester, the case must be authorized by a committee of obstetricians, psychologists and social workers.

Between 1968 and 1974, the rate of legal abortion quadrupled, increasing from 16.7 to 69.5 legal abortions performed per 1,000 women of reproductive age. Since then, abortion rates have fluctuated between 47 and 62 abortions per 1,000 women. Although an increase in contraceptive use in Cuba has reduced abortion rates in the past 15 years, levels remain fairly high.

Contraception is widely available in Cuba in all government health centres and through one private agency, Sociedad Científica Cubana para el Desarrollo de la Familia (SOCUDEF), which receives the full support of the Government. It is estimated that approximately 70 per cent of Cuban women of reproductive age are currently using a contraceptive method. However, supplies of some contraceptives are still insufficient and contraceptive choice is limited.

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

Cyprus

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

Certification by two physicians is required for all grounds except rape. In the case of rape, certification by a police authority is necessary, confirmed by medical certification, whenever possible. An abortion can be performed only by a registered medical practitioner.

* Legal interpretation generally permits these grounds.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Too low
Government intervention concerning fertility level:	To raise
Government policy on contraceptive use:	Indirect support provided
Percentage of currently married women using modern contraception (aged 15-49):	..
Total fertility rate (1995-2000):	2.0
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	17
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	No
Complications of childbearing and childbirth	..
Maternal mortality ratio (per 100,000 live births; 1990):	
National	5
Western Asia	320
Female life expectancy at birth (1995-2000):	80

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

BACKGROUND

The Criminal Code of Cyprus (sections 167-169 and 169A), as amended in 1986 (Law No. 186), permits abortion if two medical practitioners are of the good faith opinion that continuance of the pregnancy would endanger the life of the pregnant woman, or that physical, mental or psychological injury would be suffered by her or by any existing child she may have, greater than if the pregnancy were terminated, or that there is a substantial risk that if the child were born it would suffer from such serious physical or psychological abnormalities as to be seriously handicapped. The Criminal Code also permits abortion following certification by the competent police authority, confirmed by medical certification whenever possible, that the pregnancy resulted from rape and under circumstances in which the pregnancy, if not terminated would seriously jeopardize the social status of the woman or of her family. Although the Code does not specifically address socio-economic grounds other than as a factor in the criminal indication for abortion, in practice, "mental and psychological injury" is generally interpreted as including socio-economic grounds. The Code was first liberalized in 1974, when provisions permitting abortions only on therapeutic grounds were replaced.

Any person performing an unlawful abortion is liable to seven years' imprisonment. A woman inducing her own abortion is liable to the same punishment. Any person unlawfully supplying or procuring anything knowing that it is unlawfully intended to be used to procure an abortion is subject to three years in prison. An abortion must be performed by a registered medical practitioner. Although not specified by law, in practice abortion is performed within 28 weeks of gestation.

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

The Government of Cyprus pursues a pronatalist policy and does not provide family planning services in its clinics. It has, however, officially recognized the private Family Planning Association of Cyprus (FPAC) and subsidizes its family planning services. The Association runs workshops on sex education and sexuality awareness for high school and college students; moreover, in an effort to maintain high quality services in the area of sexual and reproductive health, the FPAC has organized educational workshops for doctors and nurses.

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

Czech Republic

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

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

REPRODUCTIVE HEALTH CONTEXT

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

*Women in first marriage.

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

BACKGROUND

Since the end of the Second World War, the abortion law of the Czech Republic (until 1 January 1993, part of Czechoslovakia) has been amended a number of times, with the general trend being towards liberalization. Law No. 86/1950 (the Penal Code, sections 227-229), effective August 1950, permitted abortion when the pregnant woman's life or health was endangered and in cases of genetic defect. A woman who violated the law was subject to imprisonment for one year and the person performing the abortion to imprisonment for ten years. In 1957, owing to concern over the negative effects of clandestine abortions on women's health, the Government enacted new legislation broadening the circumstances under which abortions could be legally performed. Law No. 68 of 19 December 1957 specified that abortions could be legally performed on the basis of medical or "other important reasons." A commission was required to approve the abortion and the abortion had to be performed in a health establishment. A woman who obtained an illegal abortion would no longer be punished, and the sentence for the person performing the abortion was reduced to a maximum of five years.

Following the enactment of Law No. 68 in 1957, a series of ordinances and instructions were issued that specified in greater detail the nature of these "other important reasons" and the procedures that had to be followed to obtain the approval of the commission. By 1983, a woman was allowed to obtain an abortion if she was over 40, if she had at least three living children, if the pregnancy was the result of rape or another crime, if she was in a difficult situation due to an extramarital relationship, if she had lost a husband or her husband was in bad health, if she had difficult housing or material conditions that endangered the standard of living of her family (particularly minor children), or if a documented disintegration of the family had taken place. Authorization would not be granted if the pregnancy was of more than 12 weeks' duration, if it was found that the woman had a condition that would increase the risks of the abortion or if she had undergone an abortion in the past year. Exceptions to these rules were possible. An abortion could be performed despite a risk to her health if continuing the pregnancy would endanger the woman's life. An abortion could be terminated through the sixteenth week of pregnancy if the woman had contracted rubella and through the 26th week of pregnancy if genetic problems were present. Abortion could be performed up to the twelfth week of gestation, except to save the life of the pregnant woman or in the case of known foetal impairment. In the latter case, up to 24 weeks and exceptionally up to 26 weeks of gestation were allowed.

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

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

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

Czech Republic

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

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

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

Democratic People's Republic of Korea

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

Information not readily available.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Too high
Government intervention concerning fertility level:	To lower
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49, 1990/92):	62
Total fertility rate (1995-2000):	2
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	1.6
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of childbearing and childbirth	..
Maternal mortality ratio (per 100,000 live births; 1990):	
National	70
Eastern Asia	95
Female life expectancy at birth (1995-2000):	75

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

BACKGROUND

The Criminal Code of March 1950 states that abortion is allowed in the Democratic People's Republic of Korea "for important reasons". The particulars of these reasons are not specified in the Code. A person who performs an abortion in the absence of an "important reason" is subject to up to three years' imprisonment. However, a woman who consents to the performance of an abortion or who induces her own abortion is not held criminally responsible.

Although information on the application of the abortion provisions of the Criminal Code in the Democratic People's Republic of Korea is difficult to obtain, reports suggest that abortion is permitted virtually on request, up to the seventh month of pregnancy, owing to the broad interpretation of the phrase "important reasons". It has been reported that abortion is performed at provincial maternity hospitals free of charge.

Family planning programmes have been operative in the Democratic People's Republic of Korea since the early 1970s. Such programmes are integrated into maternal and child health services and are administered by the Ministry of Public Health. Information, education and communication activities are important elements of the programme. The Ministry of Public Health provides contraceptives and consultations in the obstetrics/gynaecology departments of all hospitals and clinics. These services are also provided through the "section doctor system", whereby one physician is responsible for the health of a group of neighbourhood families. The intrauterine device is the method used by 80-90 per cent of all contraceptive users in the Democratic People's Republic of Korea. However, locally produced IUDs supplied by the country's family planning programme had high failure rates and caused serious side effects; consequently, international assistance was provided for the importation of IUDs.

Source: Population Policy Data Bank maintained by the Population Division of the Department of Economic and Social Affairs of the 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	No
To preserve mental health	No
Rape or incest	No
Foetal impairment	No
Economic or social reasons	No
Available on request	No

Additional requirements

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Satisfactory
Government intervention concerning fertility level:	No intervention
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49, 1991):	8
Total fertility rate (1995-2000):	6.43
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	217.1
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of childbearing and childbirth	..
Maternal mortality ratio (per 100,000 live births; 1990):	
National	870
Middle Africa	950
Female life expectancy at birth (1995-2000):	52.3

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

Democratic Republic of the Congo

BACKGROUND

The general prohibition of abortion contained in the 1867 Penal Code of Belgium was incorporated into the Penal Code of the Democratic Republic of the Congo in the late 19th century. 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 articles 165 and 166 of the Penal Code, in its most recent version of 31 May 1982, a person who performs an abortion is subject to 5 to 15 years' imprisonment. A woman who voluntarily has an abortion is subject to 5 to 10 years' imprisonment.

Although the Code contains no expressed exceptions to the prohibition of abortion, under general criminal law principles of necessity, an abortion can be performed to save the life of the pregnant woman. In addition, it is reported that abortions are legally performed on therapeutic grounds not only to save the life of the pregnant woman, but also when serious danger exists to her physical or mental health and when it is likely 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 the Democratic Republic of the Congo. 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 1972 and was expanded in 1982 with the Desirable Births Services Programme. One of the aims of the Desirable Births Services Programme is to reduce, through the greater use of contraception, the incidence of induced abortion, infanticide, child abandonment and malnutrition resulting from numerous and closely spaced pregnancies. 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 a widespread lack of information concerning both contraception and legal abortion.

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

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

An abortion must be performed by a physician in a State or communal hospital or in a clinic attached to a hospital. If gestation is over 12 weeks and the pregnancy does not pose a risk to the woman's life or of serious deterioration to her physical or mental health, the abortion must be approved by a committee.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Too low
Government intervention concerning fertility level:	To raise
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-44, 1988*):	78
Total fertility rate (1995-2000):	1.7
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	8.5
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	No
Complications of childbearing and childbirth	No
Maternal mortality ratio (per 100,000 live births; 1990):	
National	9
Northern Europe	11
Female life expectancy at birth (1995-2000):	78

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

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

Denmark

BACKGROUND

Until 1937, abortion was illegal in Denmark except when necessary to avert a serious danger to the pregnant woman's life or health. In that year, the Parliament enacted legislation allowing abortions to be performed in cases of a threat to life or health, rape or incest, and foetal impairment. The law was further liberalized in 1956 and 1970 to allow abortions for various social reasons, such as having four or more children or being over thirty-eight years of age. The abortion had to be approved by a committee consisting of two physicians and a psychiatrist. Owing in part to the large number of requests for abortion being approved by committees (over 90 per cent), in 1973 the law was again liberalized to allow abortions to be performed on request during the first twelve weeks of pregnancy

Law No. 350 of 13 June 1973 entitles women domiciled in Denmark to undergo an abortion during the first 12 weeks of pregnancy, after the submission of an application for abortion. In addition, the woman is to be informed of the nature and risks of the procedure and of the possibilities for assistance if the pregnancy should continue to term. After the twelfth week of pregnancy, abortion is available without special authorization only when "necessary to avert a risk to her life or of serious deterioration to her physical or mental health, and this risk is based solely or principally on circumstances of a medical character". Abortion is also available after the twelfth week of pregnancy when authorized by a committee, consisting of the director of the institution where the abortion is to be performed and two physicians, one a specialist in gynaecology or surgery and the other in psychiatry or with special knowledge of social medicine. The committee may grant authorization when pregnancy, childbirth or child care entails a risk of deterioration of the woman's health on account of an existing or potential physical or mental illness or infirmity, or as a consequence of the conditions under which she is living; when the pregnancy resulted from a criminal act; when there is a danger that, on account of a hereditary condition or of an injury or disease during embryonic or foetal life, the child will be affected by a serious physical or mental disorder; if, due to physical or mental disorder, feeble-mindedness, or youth or immaturity, the woman is incapable of giving proper care to the child; or if "it can be assumed that pregnancy, childbirth, or care of a child constitute a serious burden to the woman, which cannot otherwise be averted," taking into account a number of socio-economic circumstances.

An abortion must be performed by a physician in a State or communal hospital or in a clinic attached to a hospital. Performing an abortion beyond the twelfth week of gestation without prior committee authorization, when required, is punishable by up to two years' imprisonment, or in the case of mitigating circumstances, by a fine. If the person performing an abortion is not a physician, he or she is subject to up to four years' imprisonment. Failure to comply with the other procedural requirements set by the Law is punishable by a fine.

Responsibility for family planning services, which is an integral part of the national health service, is in the hands of county clinics. The Government works in close collaboration with the Family Planning Association on a variety of domestic issues, and the Ministry of Health distributes information on contraception through the Family Planning Association and the Health Information Committee. Schools have been required to provide sex education since 1970, and since 1991, accompanied by official guidelines for teachers, sex education has been an integral part of the health education curriculum. The Family Planning Association, which is a longstanding proponent of quality sex education for all, promotes family planning, sexual well-being and reproductive health and views sexual knowledge as a human right, vital to personal and social life.

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

Djibouti

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

An abortion must be performed by a physician, in conformity with the Public Health Law.

* The Code permits abortions to be legally performed for therapeutic purposes, but does not specify what those purposes are.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Too high
Government intervention concerning fertility level:	..
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49):	..
Total fertility rate (1995-2000):	5.3
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	30
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of childbearing and childbirth	..
Maternal mortality ratio (per 100,000 live births; 1990):	
National	570
Eastern Africa	1 060
Female life expectancy at birth (1995-2000)	52

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

BACKGROUND

Until recently, only limited information was available on the status of abortion law in Djibouti. Before independence in 1977, Djibouti was a French colony and later became a protectorate governed by the provisions of criminal legislation imposed by the French. As in other countries ruled by the French, no exceptions were expressed to the general prohibition on the performance of abortions, although under the general criminal law principles of necessity, an abortion could be performed to save the life of the pregnant woman.

After independence, the provisions of this criminal legislation were presumably still in effect, although it is possible that, as an Islamic country, Djibouti may apply the provisions of Islamic Law relating to abortion. Under all Islamic law, abortion is permitted when the pregnant woman's life is threatened, regardless of the length of gestation.

In 1994, Djibouti enacted a new Penal Code containing provisions on abortion. Under these provisions, abortion is generally illegal. A person who performs an abortion or attempts to do so is liable to two years' imprisonment and payment of a fine of 500,000 Djibouti francs (DF) whether the pregnant woman consented or not. A woman who attempts to procure her own abortion or consents to an abortion is liable to six months' imprisonment and payment of a fine of DF 100,000. If the person performing the abortion regularly performs abortions, the punishment is five years' imprisonment and payment of a fine of DF 2,000,000. A physician or health professional who promotes or performs abortion is subject to the same penalty.

Nonetheless, the Penal Code provides that a pregnancy may be legally interrupted by a physician for therapeutic purposes, in conformity with the Public Health Law. The Code, however, does not specify which abortions will be considered therapeutic. Therapeutic abortions may be restricted to those performed to save the life of the pregnant woman, or they may be performed to preserve her physical and/or mental health as well.

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

Dominica

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

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

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	No official position
Government intervention concerning fertility level:	No intervention
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-44, 1987):	50
Total fertility rate (1988):	2.0
Age-specific fertility rate (per 1,000 women aged 15-19; 1995):	13
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of childbearing and childbirth	..
Maternal mortality ratio (per 100,000 live births):	
National (1987)	62
Caribbean	400
Female life expectancy at birth:	..

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

BACKGROUND

Abortion law in Dominica is based on the English common law system introduced during colonial rule. Under the Offences Against the Person Act of 1873 (sections 56-57), abortion is considered an offence in all cases. General criminal law principles of necessity, however, allow an abortion to be performed to save the life of the pregnant woman. Moreover, under section 8 of the Act, no person shall be found guilty of the offence of destroying a child capable of being born alive if the act was done in good faith for preserving the life of the mother. This Act is generally understood as applying to an unborn child of at least 28 weeks' gestation.

Most Commonwealth countries with legal systems based on British common law follow the 1938 English *Rex v. Bourne* decision in determining whether an abortion performed for health reasons is lawful. In the *Bourne* decision, a physician was acquitted of the offence of performing an abortion in the case of a woman who had been raped. The court ruled that the abortion was lawful because it had been performed to prevent the woman from becoming "a physical and mental wreck", thus setting a precedent for future abortion cases performed on the grounds of preserving the pregnant woman's physical and mental health. However, in Dominica, the *Bourne* decision is not applicable.

Family planning services are available through Government maternal and child health clinics and the Dominica Planned Parenthood Association (DPPA). Up to 1989, DPPA provided only information and education on family planning; in 1989, however, it introduced clinical services and a community-based distribution programme that complements the services provided by the Government. A high incidence of teenage pregnancy in recent years has led both the public and private sectors to place major emphasis on family planning education and services for adolescents.

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

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

* The abortion law does not expressly allow abortions to be performed to save the life of the woman, but the general principles of criminal legislation allow abortions to be performed for this reason on the grounds of necessity.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Too high
Government intervention concerning fertility level:	To lower
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49, 1996):	64
Total fertility rate (1995-2000):	2.8
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	89
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of childbearing and childbirth	Yes
Maternal mortality ratio (per 100,000 live births; 1990):	
National	110
Caribbean	400
Female life expectancy at birth (1995-2000):	73

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

Dominican Republic

BACKGROUND

The Penal Code of 1948 (section 317), which is based on the French Napoleonic Code of 1832, prohibits the performance of all abortions. Under the general principles of criminal legislation, however, abortion is permitted to save the life of the pregnant woman on grounds of necessity. Thus, in practice, both the legal and medical professions consider abortion performed to save the life of the woman to be legal in the Dominican Republic.

Persons who perform an illegal abortion are subject to imprisonment for an unspecified term, as are women who cause their own abortions or consent to an abortion. Any person who puts a pregnant woman in contact with another person for the purpose of abortion is subject to six months to two years in prison, so long as the abortion is performed. If the person performing the abortion belongs to the medical or paramedical profession, he or she is subject to 5 to 20 years of hard labour (*trabajos publicos*).

Family planning and maternal-child health services are provided in the Dominican Republic in more than 700 public institutions located throughout the country. The State provides a wide range of contraceptive methods, with assistance from several non-governmental organizations, such as the Dominican Family Welfare Association (Asociación Dominicano Pro-Bienestar de la Familia/PROFAMILIA). In addition to supplying contraceptives and providing training and technical assistance to more than 100 private clinics, PROFAMILIA also sells low-priced contraceptives through a large network of distributors in communities around the country and subsidizes contraceptives marketed in pharmacies and stores. This assistance is complemented with information, education and services that target adolescents in particular, given the high rate of adolescent pregnancies (22.7 percent of adolescents 15-19 were mothers or pregnant in 1996). Sterilization is also provided through the public sector, and the incidence of female sterilization is high, with more than 40 per cent of women of reproductive age choosing sterilization.

The incidence of induced abortion is also high in the Dominican Republic. The number of induced abortions was estimated to be about 65,000 per year, or one abortion for every three births, by the end of the 1980s and about 82,000 in the beginning of the 1990s.

Despite its illegality, abortion is performed with impunity in private hospitals and clinics, as well as in more clandestine and unsafe circumstances by the pregnant woman herself or by a midwife. In private hospitals and clinics, physicians generally classify an abortion as therapeutic when it is performed to save the life of the woman, but many are performed on eugenic and health grounds. So widespread is this practice that many physicians believe that abortion is legal on therapeutic grounds, and some public hospitals have gone so far as to develop procedures and regulations to consider and authorize the abortion. Generally, the procedure entails obtaining the written authorization of another medical colleague and/or placing the decision in the hands of a panel of physicians. Once an abortion is authorized, the legal authorities are notified that the abortion will be performed. In private clinic settings, a medical colleague is consulted. Sometimes, the abortion is performed only with the consent of the pregnant woman's spouse.

Although illegal abortions are reported to be widely performed, few cases are brought to the attention of the courts. Those which have been tried have generally been cases where the woman died from the procedure.

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

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

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

* The Penal Code does not specify whether health encompasses both physical and mental health.

** An abortion may be performed on these grounds only when the pregnant woman is an idiot or insane.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Too high
Government intervention concerning fertility level:	To lower
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49, 1994):	57
Total fertility rate (1995-2000):	3.0
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	72
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	Yes
Complications of childbearing and childbirth	Yes
Maternal mortality ratio (per 100,000 live births; 1990):	
National	150
South America	200
Female life expectancy at birth (1985-1990):	70

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

Ecuador

BACKGROUND

Sections 441-447 of the 1971 Penal Code of Ecuador prohibit abortion except in the case of a threat to the life or health of a pregnant woman, when this danger cannot be averted by other means, or when the pregnancy is the result of a rape or statutory rape of a woman who is an idiot or insane. In the latter case, the legal representative of the pregnant woman must consent. Anyone performing an abortion without the consent of the pregnant woman is subject to imprisonment for three to six years. If the abortion is performed with the woman's consent, the person performing it is subject to imprisonment for two to five years. If the woman dies, the punishment is increased to three to six years in prison if the woman consented to the abortion and to eight to twelve years in prison if she did not. A woman who induces her own abortion or consents to its inducement is subject to one to five years in prison. If she does so to hide her dishonour, she is subject to six months to two years in prison. Medical and paramedical personnel performing an abortion are subject to harsher penalties.

Although abortion is only permitted on therapeutic and limited juridical grounds, it is widely practised in Ecuador. The few studies available examining the incidence and prevalence of abortion do not distinguish between spontaneous and induced abortion and do not employ representative samples of the population. The scanty information available, however, suggests that the actual levels of induced abortion are greatly underestimated. Nevertheless, despite this high incidence, mortality associated with abortion is slightly lower than in other countries in the region.

On 4 June 1984, Ecuador adopted a new Constitution that guarantees the protection of life from conception (article 25) and the right of parents to have the number of children that they can support and educate (article 24). The constitutional right to determine family size was first introduced in the Constitution of January 1978. The National Population Action Plan launched in 1994 re-emphasized the importance of providing universal access to health services, with particular attention to maternal and child health care and family planning. Family planning has been available in government clinics since 1968, as well as in the private sector, and in clinics of the Asociación Pro-Bienestar de la Familia Ecuatoriana (APROFE) since 1967. A number of other private organizations also provide family planning services. The most prevalent contraceptive method used by married women is female sterilization, which in 1989 accounted for 35 percent of all contraceptive use.

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

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

Three physicians must certify that an accepted indication for the performance of the abortion exists. The husband's consent is required unless the physician believes the operation is needed.

* The Penal Code does not expressly allow abortions to be performed to save the life of the woman, but the general principles of criminal legislation allow abortions to be performed for this reason on condition of necessity. In addition, the condition of necessity is sometimes interpreted in Egypt as encompassing cases where the pregnancy may cause serious risks to the health of the pregnant woman as well as cases of foetal impairment.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Too high
Government intervention regarding fertility level:	To lower
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49, 1995):	47
Total fertility rate (1995-2000):	3
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	65
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of childbearing and childbirth	Yes
Maternal mortality ratio (per 100,000 live births; 1990):	
National	170
Northern Africa	340
Female life expectancy at birth (1995-2000):	68

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

Egypt

BACKGROUND

The Egyptian Penal Code of 1937 (sections 260-264) prohibits abortion in all circumstances. Under the general principles of criminal law, however, an abortion may be performed to save the life of the pregnant woman, that is, on grounds of necessity. This condition is described in general terms in Article 61 of the Penal Code, which states that "a person who commits a crime in case of necessity to prevent a grave and imminent danger which threatens him or another person shall not be punished, on condition that he has not caused it on his own volition or prevented it by other means". Although most commonly such grounds justify the performance of an abortion only when the life of the pregnant woman is endangered, in Egypt it is sometimes interpreted as encompassing cases where the pregnancy may cause serious risks to the health of the pregnant woman or even cases of foetal impairment.

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

Egypt was the first Arab country to adopt a national population policy. The Government adopted a policy to reduce fertility in 1962 and established the Supreme Council for Population and Family Planning in 1965. In 1973, the responsibility for the delivery of family planning services was transferred to the Ministry of Health. Contraception is also available through a number of private sector agencies. The Egyptian Family Planning Association (EFPA), which developed from the National Population Commission, has been providing family planning services at a number of clinics since 1995. EFPA collaborates closely with the Ministry of Health and Ministry of Social Affairs and coordinates the family planning activities of other voluntary organizations. The National Population Commission enlists EFPA's assistance to reach its contraceptive prevalence target.

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

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

Not applicable.

*Abortion law in El Salvador has been amended to remove all indications for the legal performance of abortions; however, it is a matter of dispute whether a defense of necessity might be allowed to justify an abortion performed to save the life of the woman.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Too high
Government intervention concerning fertility level:	To lower
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-44, 1993):	53
Total fertility rate (1995-2000):	3.2
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	95
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of childbearing and childbirth	..
Maternal mortality ratio (per 100,000 live births; 1990):	
National	300
Central America	140
Female life expectancy at birth (1995-2000):	73

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

El Salvador

BACKGROUND

Until 1997, the performance of abortions in El Salvador was governed by the provisions of the 1973 Penal Code. Under the Code, an abortion could be legally performed under three major circumstances: when the abortion was the only means of saving the life of the mother; in cases of rape or statutory rape (consensual sex with a minor under the age of consent); and in cases of foreseeable serious foetal deformity. In addition, an abortion caused by the negligence of the pregnant woman was not punished. The Code also recognized the concept of *honoris causa* abortions and imposed reduced penalties if a woman of good conduct caused her own abortion or consented to one being performed in order to protect her reputation.

This Code replaced the 1956 Penal Code under which there were no stated exceptions to the prohibition against abortion, although under the general principles of criminal law, one could be performed on the grounds of necessity to save the life of the pregnant woman. However, because it was evident that abortion was widespread and that it contributed significantly to maternal mortality, the Government moved to liberalize abortion laws. The Contraceptive Prevalence Survey conducted in 1975 found that close to 20 per cent of all ever-married women surveyed had had at least one abortion (induced or spontaneous) in their lifetime. The proportion that had undergone an abortion was slightly higher in rural areas. The National Fertility Survey conducted in 1978 obtained similar results.

By 1997, however, the views of El Salvador's legislature on abortion had again shifted. It enacted a new Penal Code that removed all exceptions to the general prohibition against abortion, except that involving abortion resulting from the negligent action of the pregnant woman. The Code provides that a person who induces an abortion with the consent of the woman or a woman who induces her own abortion or consents to another person inducing it is subject to imprisonment for two to eight years. A person who induces an abortion without the woman's consent is subject to imprisonment for four to 10 years, and if the person is a physician, pharmacist or related health worker who devotes him or herself to such practices, he or she is subject to imprisonment for six to 12 years.

In addition, the Legislature adopted two other measures to demonstrate its opposition to abortion. It moved the abortion provisions of the Code from the section on offences against the human body to a new section of the Code concerning offences relating to human life in formation. It also amended the Constitution to provide that every human person is recognized as a human being from the moment of his or her conception. At the same time, it removed the *honoris causa* provisions from the Code.

The effect of these changes is not entirely clear. On the one hand, they could be interpreted as prohibiting abortions completely, even those performed when no other way can be found to save the life of the pregnant woman. Some have argued that this is their effect, particularly in the light of the absolutist position of those who supported the changes. On the other hand, like most Penal Codes, the Penal Code of El Salvador contains general provisions on necessity that allow acts that would otherwise be considered illegal to be carried out without punishment when they are necessary to preserve a good. It could be argued that abortion performed as the only means to save the life of a pregnant woman falls under these provisions.

Family planning services have been available through the Ministry of Health and the Social Security Institute of El Salvador (ISSS) since the late 1960s, and through the Asociación Demográfica Salvadoreña (ADS), a private affiliate of the International Planned Parenthood Federation, since 1966. However, whereas more than 95 per cent of women of fertile age and in union know a method of family planning, only a little more than half of them use a contraceptive method. Sterilization accounted for 63 per cent of contraceptive use in 1988.

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

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

The determination that grounds for a legal abortion are present must be made by a health professional, and the abortion must be performed in a health centre by a physician authorized to perform abortions.

* The Law does not specify whether preservation of health includes both physical and mental health.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Satisfactory
Government intervention concerning fertility level:	To maintain
Government policy on contraceptive use:	No support provided
Percentage of currently married women using modern contraception (aged 15-49):	..
Total fertility rate (1995-2000):	5.6
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	178
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of childbearing and childbirth	Yes
Maternal mortality ratio (per 100,000 live births; 1990):	
National	820
Middle Africa	950
Female life expectancy at birth (1995-2000):	52

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

Equatorial Guinea

BACKGROUND

Until 1991, abortion in Equatorial Guinea was governed by the provisions of legislation imposed by Spain, which dated back to the Spanish Penal Code of 1845 and remained in effect after independence. This legislation contained no explicit exceptions to the general prohibition on the performance of abortions, although under the general principles of criminal law an abortion could be performed when necessary to save the life of the pregnant woman.

In 1991, the Government adopted new abortion legislation to replace the provisions of the Penal Code. The motives for enactment of the new legislation were varied and somewhat contradictory. First, the Government was concerned with the loss of human life brought about by illegal abortions, as well as the effect of illegal abortions on the health of women. In publishing the law, it referred to the situation of students and single women who, owing to such factors as their inability to face the responsibility of being mothers, their abandonment by lovers or the reproaches of their parents, resorted to illegal methods to rid themselves of their unborn children.

At the same time, the Government voiced its concern over the "ethical scandals of society" caused by abortion and the abuses created by those whose ethics were supposed to be impeccable. In the preamble to the law, the Government noted that the new law derived from provisions of the national Constitution that established the responsibility of the State to protect children from conception until birth, and that the law was being enacted in order to protect the human foetus by punishing those responsible for abortions.

In keeping with the Government's punitive motives, the law maintains a general prohibition on the performance of abortions and imposes severe penalties on those who carry out abortions as well as on women who consent to abortions. The former are liable to imprisonment for six to 12 years if the pregnant woman consents and to imprisonment for 12 to 20 years if she does not. A woman who consents to an abortion is liable to imprisonment for a period of 6 to 12 years. Health professionals are singled out for particularly harsh sanctions. They are to be punished with the maximum of the above penalties and are liable as well for payment of a fine of 100,000 to 200,000 CFA francs. If they assist in an abortion, they are also required to make this fact known to the health authorities within 48 hours, on pain of special fines.

At the same time, the new law sets out for the first time in Equatorial Guinea specific circumstances under which abortions can be legally performed. When continuance of the pregnancy would result in serious consequences to the health or life of the pregnant woman, an abortion is permitted so long as certain requirements are met. The determination of the state of necessity must be made by a health professional, and the abortion must be performed in a health centre by a physician authorized to perform abortions. If the pregnant woman's husband or guardian expresses opposition, the physicians must make this fact known to the judicial authorities for a final determination.

While the law emphasizes that these circumstances are to be viewed as exceptions to the general rule, it nonetheless constitutes a major liberalization of preceding legal provisions. It is not known how in fact the law is being applied and whether legal abortions have become more common in Equatorial Guinea since its enactment.

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

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

Except when impossible, the danger to the pregnant woman's life or health must be certified in writing by a registered medical practitioner. A second doctor must provide a concurrent opinion. The pregnant woman, or, if she is incapable, her next of kin or legal representative, is required to give consent to the intervention.

*The Penal Code does not specify whether a threat to health includes both physical and mental health.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Too high
Government intervention concerning fertility level:	..
Government policy on contraceptive use:	No support provided
Percentage of currently married women using modern contraception (aged 15-49; 1995):	15.2
Total fertility rate (1995-2000):	5.6
Age-specific fertility rate (per 1,000 women aged 15-19; 1995-2000):	178
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of childbearing and childbirth	Yes
Maternal mortality ratio (per 100,000 live births; 1990):	
National	820
Eastern Africa	1 060
Female life expectancy at birth (1995-2000):	52

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

Eritrea

BACKGROUND

According to the most recent information available, abortion practices in Eritrea are still governed by the abortion law of Ethiopia. Since gaining its independence from Ethiopia in April 1993, Eritrea has sought to progressively adopt 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 that cannot be averted in any other way. A person who performs an illegal abortion is subject to "rigourous" imprisonment for up to five years. If the person has acted for gain or habitually made a profession of abortion, the punishment is increased to three to 10 years' rigourous imprisonment and payment of a fine. Such a person may also be prohibited from practising his or her profession. A woman who procures her own abortion is subject to three months to five years in prison. If the pregnancy has been terminated as a result of a grave state of physical or mental distress, especially following rape or incest, or if caused by extreme poverty, a court may consider these conditions as extenuating factors at the time of sentencing.

Except when impossible, the danger to the pregnant woman's life or health must be certified in writing by a registered medical practitioner. A second doctor must provide a concurrent opinion. The pregnant woman or, if she is incapable, her next of kin or legal representative, is required to give consent to the intervention. In the case of grave and immediate danger that can be averted only by an immediate intervention, these procedural requirements need not be met.

Although the Government of Eritrea has affirmed its interest in population matters and is in favour of family planning, its efforts have been concentrated on the reorganization of the country after independence. The formulation of population policies in Eritrea is still at an early stage. The Family Planning Association was established in 1992. However, the Association's limited human and financial resources are a major constraint in the expansion and promotion of family planning education and services. Currently, family planning methods are little known among the population of Eritrea. Unwanted pregnancies, including among adolescents, and unsafe abortions are becoming increasingly serious public health and social problems.

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

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

A pregnant woman must consent to an abortion and the abortion must be performed in a hospital by a physician. An abortion is available on request through the twelfth week of pregnancy. Thereafter, a pregnant woman must undergo a consultation with doctors.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Too low
Government intervention concerning fertility level:	No intervention
Government policy on contraceptive use:	Indirect support
Percentage of currently married women using modern contraception (aged 20-49; 1994):	70
Total fertility rate (1995-2000):	1.3
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	38
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of childbearing and childbirth	..
Maternal mortality ratio (per 100,000 live births; 1990):	
National	41
Eastern Europe	62
Female life expectancy at birth (1995-2000):	75

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

Estonia

BACKGROUND

Prior to September 1991, the abortion laws of Estonia were those of the USSR. The Soviet Decree of 27 June 1936 prohibited the performance of abortions except in the case of a danger to life, a serious threat to health, or the existence of a serious disease that could be inherited from the parents. The abortion had to be performed in a hospital or maternity home. Physicians who performed abortions outside a hospital or without the presence of one of these indications were subject to one to two years in prison. If the abortion was performed under unsanitary conditions or by a person with no special medical training, the penalty was no less than three years' imprisonment. A person who induced a woman to have an abortion was subject to two years' imprisonment. A pregnant woman who underwent an abortion was subject to a reprimand and the payment of a fine of up to 300 roubles in the case of a repeat offence.

In an edict of 23 November 1955, the Government of the former USSR repealed the general prohibition on the performance of abortions contained in the 1936 Decree. Other regulations, also issued in 1955, specified that abortions could be performed freely during the first twelve weeks of pregnancy if no contraindication existed and after that point when the continuance of the pregnancy and the birth would harm the mother (interpreted to include foetal handicap). The abortion had to be performed in a hospital by a physician and, unless the mother's health was threatened, a fee was charged. Persons who performed an abortion illegally were subject to criminal penalties established by criminal laws such as the Criminal Code. For example, if the abortion was not performed in a hospital, a penalty of up to one year's imprisonment could be imposed, and if it was performed by a person without an advanced medical degree, a penalty of up to two years' imprisonment was possible. In the case of repeat offences or the death or serious injury of the pregnant woman, a higher penalty of up to eight years' imprisonment could be imposed. A woman who underwent an illegal abortion was not penalized.

Despite the approval of the 1955 edict and regulations, the problem of illegal abortions did not entirely disappear in the former USSR. This situation resulted in part from the Government's conflicted attitude towards contraception. Although at times it manifested support for contraception, it did little to make contraception available, and in 1974 it effectively banned the widespread use of oral contraceptives. The situation also arose from a revived pronatalist approach to childbearing adopted at times by the Government, which looked unfavourably on abortion. The result was a reliance on abortion as the primary method of family planning.

Concerned with the high rate of illegal abortions, in 1982 the Government issued a decree allowing abortions for health reasons to be performed through the twenty-eighth week of pregnancy. The Government continued to amplify the conditions under which legal abortions were available, and on 31 December 1987 it issued another decree establishing a broad range of non-medical indications for abortions performed on request through the twenty-eighth week of pregnancy. These included the death of the husband during pregnancy; imprisonment of the pregnant woman or her husband; deprivation of maternity rights; multi parity (the number of children exceeds five); divorce during pregnancy; pregnancy following rape; and child disability in the family. Moreover, the order provided that, with the approval of a commission, an abortion could performed on any other ground.

Since independence, several minor changes have been made in the abortion law of Estonia. The Government has issued a decree shortening the period within which abortions can be performed for health and certain other reasons (from 28 to 20 weeks), including pregnancy at a very young age (under sixteen) or over forty-five years of age. Before the abortion can be performed, the woman must undergo a consultation with doctors. In addition, she must pay a larger cost of the abortion than she would if it should be performed on medical grounds.

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

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

Except when impossible, the danger to the pregnant woman's life or health must be certified in writing by a registered medical practitioner. A second doctor must provide a concurrent opinion. The pregnant woman, or, if she is incapable, her next of kin or legal representative, is required to give consent to the intervention.

* The Penal Code does not specify whether a threat to health includes both physical and mental health.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Too high
Government intervention concerning fertility level:	To lower
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49; 1990):	4
Total fertility rate (1995-2000):	6.3
Age-specific fertility rate (per 1,000 women aged 15-19; 1995-2000):	152
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of childbearing and childbirth	Yes
Maternal mortality ratio (per 100,000 live births; 1990):	
National	1 400
Eastern Africa	1 060
Female life expectancy at birth (1995-2000):	44

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

Ethiopia

BACKGROUND

The Ethiopian Penal Code of 1957 (sections 528-535) permits abortion only when necessary to "save the pregnant woman from grave and permanent danger to life or health that is impossible to avert in any other way". Although the Code permits neither broad health grounds nor juridical or socio-economic grounds, it does consider a "grave state of physical or mental distress, especially following rape or incest, or because of extreme poverty" to constitute extenuating circumstances in sentencing. Anyone performing an unlawful abortion is subject to "rigourous" imprisonment for up to five years. If the person has acted for gain or habitually made a profession of abortion, the punishment is increased to three to 10 years' rigourous imprisonment and payment of a fine. Such a person is also subject to prohibition of practising his or her profession. A woman who procures her own abortion is subject to three months to five years in prison.

Except when impossible, the danger to the pregnant woman's life or health must be certified in writing by a registered medical practitioner. A second doctor must provide a concurrent opinion. The pregnant woman or, if she is incapable, her next of kin or legal representative, is required to give consent to the intervention. In the case of grave and immediate danger that can be averted only by an immediate intervention, these procedural requirements need not be met.

Despite the fact that therapeutic abortion is permitted, cumbersome administrative restrictions limit the number of abortions performed legally on those grounds. Thus, many women resort to illegal abortion. Studies on levels and causes of maternal mortality carried out in the mid-1980s reported abortion to be the major cause of maternal death.

Although family planning services are available in Ethiopia, contraceptive prevalence is low. According to the Penal Code of 1957, contraceptives are available only on prescription. However, they can be bought without prescription in pharmacies, and some street vendors sell condoms. The Family Guidance Association of Ethiopia, which has been providing services since 1966, received official recognition in 1974 and has since been providing services in government clinics. The Government has been providing family planning services in its own clinics since 1988 as part of a national comprehensive health programme initiative. Currently, family planning services are integrated with maternal and child health services in more than 1,600 health institutions run by the Ministry of Health and other public entities.

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

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

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

*Legal interpretation generally permits these grounds. In addition, abortions performed in cases of foetal impairment and rape or incest are often permitted under the mental health indication.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Satisfactory
Government intervention concerning fertility level:	To lower
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49, 1974):	41
Total fertility rate (1995-2000):	2.7
Age-specific fertility rate (per 1,000 women aged 15-19; 1995-2000):	48
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of childbearing and childbirth	No
Maternal mortality ratio (per 100,000 live births; 1990):	
National	90
Oceania	680
Female life expectancy at birth (1995-2000):	75

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

BACKGROUND

Sections 172-174 of the Penal Code of Fiji (cap. 17) prohibit entirely the unlawful performance of abortions. Section 234 of the Code, however, makes an exception in the case of a threat to the life of the pregnant woman. It states that a person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation, upon any person for his benefit, or upon an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable with regard to the patient's state at the time and to all circumstances of the case.

In addition, in a decision of the Supreme Court of Fiji (*Emberson* v. *Emberson)*, Criminal Case No. 16 of 1976, the Court further clarified the law by specifying that abortion was permitted when the performing physician had formed an opinion "in good faith" that the abortion was necessary to preserve the pregnant woman's mental and physical health, "*taking into account the social circumstances of the patient*". Thus, in practice the law is interpreted very liberally. An abortion may be performed on the grounds of foetal deformity, rape or incest as they may be interpreted as producing a risk to the woman's mental health; it may also be performed in cases of economic duress.

Those performing an illegal abortion are subject to imprisonment for up to 14 years. The same punishment may be applied to someone unlawfully supplying instruments to perform the abortion. A woman attempting unlawfully to induce her own abortion or consenting to its being induced, is subject to imprisonment for up to seven years.

Family planning services, integrated with maternal and child health services, are available free through the national health infrastructure. However, providing family planning services to the widely dispersed land areas of Fiji is sometimes difficult. Services could also be improved by increasing the number of trained personnel, providing transport for outreach services and coordinating activities between the various family planning organizations.

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

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

An abortion must be authorized by one physician, two physicians, or the State Medical Board, depending on the grounds, and must be performed by a licensed physician in a hospital.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Satisfactory
Government intervention concerning fertility level:	No intervention
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women* using modern contraception (less than 45, 1977):	80
Total fertility rate (1995-2000):	1.7
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	10
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	No
Complications of childbearing and childbirth	No
Maternal mortality ratio (per 100,000 live births; 1990):	
National	11
Northern Europe	11
Female life expectancy at birth (1995-2000):	81

*Women in first marriage.

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

Finland

BACKGROUND

Prior to 1970, abortion was permitted on broad health grounds (to preserve the physical and mental health of the pregnant woman), on eugenic grounds and in the event of a pregnancy resulting from an act against the woman's will. It was also permitted if the pregnant woman was under 16 years of age at the time of conception (Law of 1 June 1950). Dissatisfaction with the 1950s laws, fuelled in part by the rise of the women's liberation movement and other liberal political trends, led to the enactment of the Abortion Act of 1970, which liberalized the grounds on which abortions could be legally performed.

The 1970 Abortion Act (Law No. 239 of 24 March 1970) permits abortion at the request of the pregnant woman in the following circumstances: (a) if the pregnancy or delivery would "endanger her life or health on account of a disease, physical defect or weakness in the woman"; (b) if delivery and care of the child would place a strain on her, given the living conditions of the woman or her family; (c) if the pregnancy was the result of a sexual offence; (d) if the woman is under 17 years of age or if she is over 40 or already has four children; (e) if there are grounds for presuming that the child will be mentally retarded or will have, or will later develop, a serious disease or a serious physical defect; or (f) if, owing to disease or mental disturbance, one or both parents are unable to care for the child. In the cases of (a), (b), (c) and (f), the written recommendation of two physicians is required. In the case of (d), the decision of the physician performing the operation is required. In the case of (e), the State Medical Board must give authorization. In addition, when the pregnancy is the result of a sexual offence, the abortion can be performed only if legal action in respect to the crime has been taken, a complaint has been lodged, or clear evidence of the crime has been obtained by police inquiry.

An abortion must generally be performed within the first 12 weeks of pregnancy. However, in cases of "disease or physical defect in the woman" (Law No. 564 of 19 July 1978 amending section 5 of Law of 1970), an abortion may be performed after this point in pregnancy. In addition, an abortion may be performed up to the twentieth week if the woman is under 17 years of age or there are "other special reasons", and up to the twenty-fourth week of pregnancy if amniocentesis or ultrasonic examination has established that the embryo is seriously impaired (Law No. 572 of 12 July 1985). In both cases, the State Medical Board must give approval.

An abortion must be performed by a licensed physician in a hospital approved by the State Medical Board. However, if the life or health of the pregnant woman would be seriously endangered owing to the delay involved, or for other reasons, the abortion need not be performed in a hospital and the required authorization need not be obtained. The woman herself should apply for the procedure, unless she is incapable of making a valid application. Women requesting an abortion are to be given information on the significance and effects of the operation prior to the termination of pregnancy and are to receive information on contraception after the procedure has taken place.

Anyone performing an illegal abortion is subject to a fine or up to one year's imprisonment. Anyone making a false statement or notification concerning an abortion shall be liable to the same penalties.

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

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

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

An abortion must be performed before the end of the tenth week of pregnancy by a physician in an approved hospital. Beyond the tenth week of pregnancy, it may be performed only if the pregnancy poses a grave danger to the woman's health or there is a strong probability that the expected child will suffer from a particularly severe illness recognized as incurable. In this case, two physicians must attest to the risk to the health of the woman or foetus.

* The Law requires a woman seeking an abortion to state that she is in a state of distress as a result of her situation; the decision to have an abortion, however, is entirely the decision of the woman.

REPRODUCTIVE HEALTH CONTEXT

Government view of fertility level:	Too low
Government intervention concerning fertility level:	No intervention
Government policy on contraceptive use:	Indirect support provided
Percentage of currently married women using modern contraception (aged 20-49, 1990/94):	79
Total fertility rate (1995-2000):	1.7
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	8.5
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	No
Complications of childbearing and childbirth	..
Maternal mortality ratio (per 100,000 live births, 1990):	
National	15
Developed countries	17
Female life expectancy at birth (1995-2000):	82

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

France

BACKGROUND

Law No. 75-17 of 18 January 1975 liberalized the abortion law of France. Prior to 1975, the performance of abortions was governed by legislation that prohibited abortion except to save the life of a pregnant woman when it was seriously endangered. Law 75-17 was introduced for a five-year trial period and was adopted as a permanent law by the Parliament in December 1979, with some amendments.

Although the law begins by providing that "the law guarantees the respect of every human being from the commencement of life", it nonetheless allows an abortion to be performed before the end of the tenth week of pregnancy by a physician in an approved hospital when a woman who is "in a situation of distress" because of her pregnancy requests the abortion. The physician must inform the woman about the risks involved and provide her with a guide to the rights and assistance provided by law to families, mothers and their children, as well as inform her of the possibilities for adoption should she decide not to terminate the pregnancy. The woman must consult an appropriate social worker or family counsellor about the interruption of the pregnancy, and if she still desires to terminate the pregnancy, she should renew her request in writing, no earlier than one week from the time of the first request. If the woman is an unmarried minor, consent of one of the persons who exercises parental authority over her or, if this is not possible, the consent of her legal representative is required. The abortion may be performed by the physician whom the woman first consulted or by another physician.

If the pregnancy poses a grave danger to the woman's health or if a strong probability exists that the expected child will suffer from a particularly severe illness recognized as incurable, an abortion may be performed at any time during pregnancy provided that two physicians certify, after an examination, that the health of the mother or foetus is at risk.

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

The 1979 law also amended section 317 of the Penal Code, under which a person performing or attempting to perform an illegal abortion on a pregnant or supposedly pregnant woman, with or without her consent, is subject to one to five years' imprisonment and payment of a fine of 1,800-100,000 French francs. If this person habitually performs such acts, he or she is subject to five to 10 years' imprisonment and payment of a fine of 18,000-250,000 francs. The 1979 law also made a woman who performed or attempted to perform an abortion on herself subject to six months to two years in prison and payment of a fine of 360-20,000 francs.

After 1979, further legislation relating to abortion was approved. Decree No. 80-285 of 17 April 1980 required regional hospital centres and general hospital centres to have facilities to perform abortion and to provide information and medical procedures related to birth control. Decree No. 88-59 of 18 January 1988 added public hospital establishments with surgical or obstetric units to this list. Law No. 82-1172 of 31 December 1982 extended social security coverage to 70 per cent of the costs of care and hospitalization associated with lawful termination of pregnancy.

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

Perhaps the most significant legal development since the passage of the 1975 abortion legislation, has been the approval by the French Government in late 1988 of RU-486, the so-called "abortion pill", manufactured by Roussel-UCLAF. The use of the drug is closely regulated. On 29 December 1988 the Government issued an order setting forth strict requirements on the purchase, storage, dispensing, and recording of use of RU-486. On 22 February 1990 it issued Circular 90-06, which outlines the procedures to be followed with regard to the use of RU-486. The drug can be used no later than the forty-ninth day of amenorrhoea and it must be taken in the presence of a physician. The patient must be examined by a physician 48 hours afterwards to be administered a prostaglandin, and one week later to verify the termination of pregnancy. Currently, RU-486 is used to induce 19 per cent of all abortions and 46 percent of all abortions performed in the first seven weeks of pregnancy.

The most recent development in French abortion law was occasioned by the activities of a small number of anti-abortion protesters. In the early 1990s, they began a campaign of harassment of clinics where abortions were performed and of persons performing abortions. They blockaded and invaded a number of hospitals and tried to discourage individual physicians from performing abortions. To respond to such attacks, the Government in late 1992 enacted legislation establishing new criminal penalties in the Penal Code to combat disruptive activities. Under these provisions, persons who prevent or attempt to prevent a voluntary termination of pregnancy by disrupting access to or the free movement of persons into and out of clinics or hospitals by threatening or engaging in any act of intimidation against medical and non-medical personnel are subject to fines and imprisonment. The provisions also apply to acts directed towards abortion counselling and requests for abortion and allow organizations established to protect the right to contraception and abortion to join as a party in suits brought against such obstruction.

In addition, the law introduced one substantive amendment into the abortion laws dating from the 1970s. It repealed provisions of the Penal Code that criminalized a woman's performing or attempting to perform an abortion on herself. The rationale of the sponsors for this provision was that women who resorted to self-abortion through despair or ignorance or because they lacked resources should not be further penalized.

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

REFERENCES

The references for this volume are divided into two sections: the first contains the general references used for the introductory chapters as well as for background information throughout the volume; the second contains the references used in the individual country profiles. The latter references are presented by country. Unless otherwise indicated, data used in the country profiles were taken from replies to the Seventh and Eighth United Nations Population Inquiry among Governments; *World Population Prospects: The 1998 Revision; World Contraceptive Use 1998* (see complete references below); and from other materials in the Population Policy Data Bank and the Population Projections Database (Demobase) maintained by the Population Division, Department of Economic and Social Affairs, United Nations Secretariat. Data on maternal mortality come from the World Health Organization, 1990 (revised) estimates.

A. FOR THE INTRODUCTION AND BACKGROUND TEXT

Boland, Reed (1992). Selected legal developments in reproductive health in 1991. *Family Planning Perspectives* (New York), vol. 24, No. 4 (July/August), pp. 178-185.

Boland, Reed (1993). The current status of abortion laws in Latin America: prospects and strategies for change. *The Journal of Law, Medicine and Ethics,* vol. 21, No.1, pp. 66-70.

Boland, Reed (1995). Population policies, human rights and legal change. *The American University Law Review*, vol. 44, No. 4 (April), pp. 1257-1278.

Boland, Reed (1997). The environment, population and women's human rights. *Environmental Law*, vol. 27, No. 4 (Winter), pp. 1137-1167.

Cairns, Gail (1984). Law and the status of women in Latin America: a survey. Development Law and Policy Program Working Paper, No. 13. New York: Columbia University, Center for Population and Family Health.

Cook, Rebecca J. (1989). Abortion laws and policies: challenges and opportunities. In "Women's health in the third world: the impact of unwanted pregnancy", A. Rosenfield and others, eds. *International Journal of Gynecology and Obstetrics* (Limerick, Ireland), Supplement No. 3, pp. 61-87.

Cook, Rebecca J. and Bernard M. Dickens (1979). Abortion laws in Commonwealth countries. *International Digest of Health Legislation* (Geneva), vol. 30, No. 3, pp. 395-502.

_________ (1982). *Emerging Issues in Commonwealth Abortion Laws, 1982.* London: Commonwealth Secretariat.

_________ (1986). *Issues in Reproductive Health Law in the Commonwealth.* London: Commonwealth Secretariat.

David, Henry P. (1983). Abortion: its prevalence, correlates, and costs. In *Determinants of Fertility in Developing Countries,* Rodolfo A. Bulatao and Ronald D. Lee, eds., with Paula E. Hollerbach and John Bongaarts, vol. 2. New York: Academic Press.

David, René, and John E. C. Brierley (1978). *Major Legal Systems in the World Today.* London: Stevens & Sons.

El-Kammash, Magdi M. (1971). Islamic countries. In *Population and Law*, Luke T. Lee and Arthur Larson, eds. Leiden, Netherlands: A. W. Sijthoff; and Durham, North Carolina: Rule of Law Press.

El-Moiz Nigm, Abd (1986). *Human rights and health care.* Cairo, Egypt: Assiut University, Faculty of Law.

Eser, A., and H.-G. Koch (1988). *Schwangerschaftsabbrunch im internationalem Vergleich* (Abortion in International Comparison). Baden-Baden, Germany: Nomos Verlagsgesellschaft, 1988.

Francome, Colin (1988). United Kingdom. In *International Handbook on Abortion*, Paul Sachdev, ed. New York: Westport, Connecticut; and London: Greenwood Press.

Glendon, Mary Ann (1987). *Abortion and Divorce in Western Law.* Cambridge, Massachusetts: Harvard University Press.

Guilbert, Edith (1991). *Les femmes et l'avortement: revue de littérature.* Les Cahiers de recherche du Groupe de recherché multidisciplinaire féministe, cahier 44. Québec, Canada: Université de Laval.

Hecht, Jacqueline (1987). La législation de l'avortement en Europe de l'Est et en Union Soviétique. *Politiques de population: études et documents* (Louvain-la-Neuve, Belgium), vol. III, No. 1 (juin), pp. 89-105.

Henshaw, Stanley K. (1993). Recent trends in the legal status of induced abortion. Paper prepared for the Annual Meeting of the Population Association of America, Cincinnati, Ohio, 1-3 May 1993.

Henshaw, Stanley K. and Evelyn Morrow (1990). *Induced Abortion: A World Review, 1990 Supplement.* New York: The Alan Guttmacher Institute.

International Planned Parenthood Federation (1986). *Family Planning in Five Continents,* London.

________ (1993). *Unsafe Abortion: Dialogue, Overview, Responses, Action.* Planned Parenthood Challenges, No. 1993/1. London.

________ (1999). Country Profiles (various) (http://www.ippf.org/regions/countries/alb/index.htm). Accessed between 1and 15 October 1999.

Ketting, Evert (1993). Abortion in Europe: current status and major issues. *Planned Parenthood in Europe* (London), vol. 22, No. 3 (October), pp. 4-7.

Kloss, Diana M., and Bertram L. Raisbeck (1973). *Law and Population Growth in the United Kingdom.* Law and Population Monograph Series, No. 11. Medford, Massachusetts: Tufts University, The Fletcher School of Law and Diplomacy.

Knoppers, Bartha Maria, and Isabel Brault (1989). *La loi et l'avortement dans les pays francophones.* Montreal, Canada: Les Editions Thémis.

Lee, Luke T., and Arthur Larson, eds. (1971). *Population and Law.* Leiden, Netherlands: A. W. Sijthoff; and Durham, North Carolina: Rule of Law Press.

Liskin, Laurie S. (1980). *Complications of Abortion in Developing Countries.* Population Reports, Series F, No. 7. Baltimore, Maryland: Johns Hopkins University, Population Information Program.

Mohammad, N. (1990). An introduction to Islamic Law. In *Modern Legal Systems Encyclopedia*, K.R. Redden, ed., vol. 5A, Section 5A.100.3. Buffalo, New York: W.S.Hein.

Moore-Čavar, Emily Campbell (1974). *International Inventory on Information on Induced Abortion.* New York: Columbia University, International Institute for the Study of Human Reproduction.

Newman, Karen (1993). *Progress Postponed: Abortion in Europe in the 1990s.* London: International Planned Parenthood Federation, Europe Region.

Omran, Abdel R., and others, eds. (1992). *Reproductive Health in the Americas.* Washington, D.C.: Pan American Health Organization.

Pan American Health Organization (1990). *Health Conditions in the Americas: 1990 Edition,* vol. I. Scientific Publication, No. 524, Washington, D.C.

Paxman, J.M, et al. (1993). The clandestine epidemic: the unsafe practice of abortion in Latin America. *Studies in Family Planning*, vol. 24, No. 4 (July-August), pp. 205-226.

Royston, Erica, and Sue Armstrong, eds. (1989). *Preventing Maternal Deaths.* Geneva: World Health Organization.

Sachdev, Paul, ed. (1988). *International Handbook on Abortion.* New York; Westport, Connecticut; and London: Greenwood Press.

Tietze, Christopher, and Stanley K. Henshaw (1986). *Induced Abortion: A World Review, 1986.* New York: The Alan Guttmacher Institute.

United Nations (1987). *World Population Policies*, vol. I, *Afghanistan to France*. Population Studies, No. 102. Sales No. E.87.XIII.4.

________ (1989a). *Adolescent Reproductive Behaviour*, vol. II, *Evidence from Developing Countries*. Population Studies, No. 109A. Sales No. E.89.XIII.10.

________ (1989b). *World Population Policies*, vol. II, *Gabon to Norway*. Population Studies, No. 102/Add.1. Sales No. E.89.XIII.3.

________ (1990). *World Population Policies*, vol. III, *Oman to Zimbabwe*. Population Studies, No. 102/Add.2. Sales No. E.90.XIII.2.

________ (1992). *Abortion Policies: A Global Review*, vol. I, *Afghanistan to France*. Sales No. E.92.XIII.8.

________ (1998a). *World Population Monitoring 1996: Selected Aspects of Reproductive Rights and Reproductive Health*. Sales No. E.97.XIII.5

________ (1998b). *National Population Policies*. Sales No. E.99.XIII.3.

________ (1998c). *Global Population Policy Database. 1997*. Sales No. E.98.XIII.11.

________ (1999a). *World Population Prospects: The 1998 Revision*. Vol. I: *Comprehensive Tables*. Sales No. E.99.XIII.9.

________ (1999b). *World Contraceptive Use 1998*. Sales No. E.99.XIII.4.

United Nations Children's Fund (1999). *The State of the World's Children, 1999*. Oxford, United Kingdom: Oxford University Press.

United Nations Fund for Population Activities (1979). *Survey of Laws on Fertility Control*. New York.

________ (various years). Country reports of the Mission on Needs Assessment for Population Assistance. New York.

________ (various years). *Annual Review of Population Law*. New York: UNFPA; Boston, Massachusetts: Harvard Law School Library.

World Health Organization (1975). *International Classification of Diseases*, vol. 1, 9th rev. Geneva: WHO.

________ (1991a). *Maternal Mortality: A Global Factbook*. Compiled by Carla Abou Zahr and Erica Royston. Geneva: WHO.

________ (1991b). *Maternal Mortality Ratios and Rates: A Tabulation of Available Information*. 3rd ed. Geneva: WHO.

________ (1992). *International Classification of Diseases*, vol. I, 10th revision. Geneva: WHO.

________ (various years). *International Digest of Health Legislation*.. Geneva: WHO.

________ (1994a). *Abortion: a Tabulation of Available Data on the Frequency and Mortality of Unsafe Abortion*. Geneva: World Health Organization.

________ (1994b). *Constitution of the World Health Organization*. In *Basic Documents* (World Health Organization), vol. 7. Geneva: World Health Organization.

B. FOR COUNTRY PROFILES[1]

Afghanistan

El-Kammash, Magdi M. (1971). Islamic Countries. In *Population and Law*, L. T. Lee and A. Larson, eds. Leiden, Netherlands: A. W. Sijthoff; and Durham, North Carolina: Rule of Law Press.

Hunte, P. A. (1985). Indigenous methods of fertility regulation in Afghanistan. In *Women's Medicine: a Crosscultural Study of Indigenous Fertility Regulation*, Lucille F. Newman and James M. Nyce, eds. New Brunswick, New Jersey: Rutgers University Press.

Mohammad, N. (1990). An Introduction to Islamic Law. In *Modern Legal Systems Encyclopedia*, K.R.Redden, ed., vol. 5A, Section 5A.100.3. Buffalo, New York: W.S.Hein.

Nazer, Isam R., Hasan S. Karmi and Mahmud Y. Zayid, eds. (1974). *Islam and Family Planning*. Beirut, Lebanon: International Planned Parenthood Federation.

Sachedina, Z. (1990). Islam, procreation and the law. *International Family Planning Perspectives*, vol.16, No.3 (September), pp.107-111.

United Nations Fund for Population Activities (1979). *Survey of Laws on Fertility Control*. New York.

United Nations Population Fund (2000). Inventory of population projects in developing countries around the world, 1997: multilateral organization assistance, bilateral agency assistance, and non-governmental or other organizational assistance. Unpublished document.

Albania

Albania. Ministry of Health. Addition to Order No. 3, Dt. 17.6.89, "On permission Of prevention and eventual interruption of pregnancy (8 June, 1991).

Corrin, C. (1993). Is liberalisation damaging Albanian women's health? Focus on Gender (October, 1993) Vol. 1, No. 3, pp.35-37.

David, Henry P. (1970). *Family Planning and Abortion in the Socialist Countries of Central and Eastern Europe*. New York: The Population Council.

International Planned Parenthood Federation (1999). Country Profile: Albania. (http://www.ippf.org/regions/countries/alb /index.htm). Accessed on 15 October 1999.

International Reference Centre for Abortion Research (1989). Country notes. *Abortion Research Notes*, vol. 18, Nos. 1-2 and 3-4. Bethesda, Maryland: Transnational Family Research Institute.

Roudi, N. (1988). The demography of Islam. *Population Today* (Washington, D.C.), vol. 16, No. 3 (March), pp. 6-9.

Sahatci, E. (1995). The fight for reproductive rights in Central and Eastern Europe: Albania: discovering the human right to family planning. *Planned Parenthood Challenges*, No. 2 pp. 25-26.

Sahatci, E. (1993). Legal Abortion improved women's health in Albania. Women's Global Network for Reproductive Rights Newsletter (July-Sept., 1993), No. 44, p. 10.

United Nations Fund for Population Activities (1978). *Annual Review of Population Law, 1978*. New York: UNFPA; Boston, Massachusetts: Harvard Law School Library.

United Nations Population Fund (1979). *Survey of Laws on Fertility Control*. New York.

[1] All countries covered in chapter III are listed alphabetically in the reference list.

United Nations Population Fund (1988). *Annual Review of Population Law, 1988,* vol. 15. New York: UNFPA; Boston, Massachusetts: Harvard Law School Library.

World Health Organization (1990).. Albania: pronatalist policy maintains 2 per cent growth rate. *Entre nous* (Geneva), No. 16 (September).

Algeria

Armitage, A. (1993).Family planning in Maghreb: redefining responsibility. Entre Nous, (Oct., 1993), pp. 10-14.

Belkhodja, N. J., and others (1985). Evolution de la mortalité maternelle dans le secteur sanitaire et universitaire de Bab el Oued de 1977 à 1984. Paper presented at the lst Maghrebin Congress of Family Planning, Fertility and Contraception, Tunis, 18-20 October 1985, sponsored by the National Office for the Family and Population. Unpublished.

Brisset, Claire (1987). Algeria acts to curb growth. *People* (London), vol. 14, No. 2.

Chelala, C. (1998). Algerian abortion controversy highlights rape of war victims. *Lancet* (May 9, 1998) p. 351.

International Planned Parenthood Federation (1984). Algerian family health legislation. IPPF Open File: news digest of the world's largest voluntary family planning organization (two weeks ending 29 June). London. Mimeographed.

__________ (1986). *Family Planning in Five Continents.* London.

__________ (1987) FPA formed in Algeria. IPPF Open File: news digest of the world's largest voluntary family planning organization (two weeks ending 11 June). London. Mimeographed.

Ladjali, M. (1991). *Conception, contraception: do Algerian women really have a choice*? In Women and health in Africa, edited by Meredeth Turshen. Trenton, New Jersey: Africa World Press, pp. 125-141.

United Nations Fund for Population Activities (1978). *Annual Review of Population Law, 1978.* New York: UNFPA; Boston Massachusetts: Harvard Law School Library.

__________ (1979). *Survey of Laws on Fertility Control.* New York.

__________ (1988). *Annual Review of Population Law, 1985,* vol. 12. New York: UNFPA; Boston, Massachusetts: Harvard Law School Library, pp. 312-315.

World Health Organization (1978). *International Digest of Health Legislation* (Geneva), vol. 29, No. 2, pp. 267 and 315.

Andorra

David, Henry P. (1992). Abortion in Europe, 1920-91: a public health perspective. *Studies in Family Planning* (New York), vol. 23, No. 1 (January/February), pp. 1-22.

United Nations Population Fund (1993). *Annual Review of Population Law, 1990*, vol. 17. New York: UNFPA; Boston, Massachusetts: Harvard Law School Library.

World Health Organization (1991). *International Digest of Health Legislation* (Geneva), vol. 42, No. 3, p. 501.

Angola

Angola. Lei No. 18/90 de 27 de Outubro. Diario da Republica, Orgao Oficial da Republica Popular de Angola. Serie 1, 1990, October 27, pp. 441-51. (Family Planning Program).

United Nations Fund for Population Activities (1979). *Survey of Laws on Fertility Control.* New York.

United Nations Population Fund (1989). *Annual Review of Population Law, 1986*, vol. 13. New York: UNFPA; Boston Massachusetts: Harvard Law School Library.

Antigua and Barbuda

Cook, Rebecca J., and Bernard M. Dickens (1986). *Issues in Reproductive Health Law in the Commonwealth*. London: Commonwealth Secretariat.

Economic Commission for Latin America and the Caribbean (1998). *Caribbean Subregional Review and Appraisal Report on the Implementation of the ICPD Programme of Action (ICPD+5),* Caribbean Subregional Meeting for the Mid-term Review of the ICPD Programme of Action, 17-18 November 1998, Port of Spain, Trinidad and Tobago.

International Planned Parenthood Federation (1984). High teenage birth rate in Antigua. IPPF Open File: news digest of the world's largest voluntary family planning organization (two weeks ending 1 March). London. Mimeographed.

__________ (1999). Country Profile- Antigua and Barbuda. (http://www.ippf.org/regions/countries/alb /index.htm). Accessed on 1 October 1999.

United Nations Population Fund (1989). *Inventory of Population Projects in Developing Countries Around the World 1988/1989*. Sales No. E.90.III.H.1.

Argentina

Belluci, M. (1997). *Women's struggle to decide about their own bodies: Abortion and sexual rights in Argentina*. Reproductive Health Matters, vol. 5, No. 10 November, pp. 99-106.

Birgin, Haydee B. (1990). Los derechos reproductivos en la reforma constitucional. Paper presented at the Seminario Reforma Constitucional y Ordenamiento Legislativo en Materia de Población, Buenos Aires, Argentina, 29 May - 1 June.

Doro, R. E. (1988). Exito reproductivo y anticoncepción. *Contribuciones*, vol. 11, No. 37 (febrero-abril), pp. 20-28.

International Planned Parenthood Federation (1989). In brief: Argentina. *People* (London), vol. 16, No. 2, p. 30.

__________ (1999). Country Profile: Argentina. (http://www.ippf.org/regions/countries/alb /index.htm). Accessed on 1 October 1999.

López, E. and A.Masautis (1994). Aborto en el concurbano de Buenos Aires: opiniones, evidencias e interrogantes. Santa Fé de Bogotá, D.C. Colombia, Universidad Externado de Colombia.

Rogers, A. (1994). Abortion rights campaign in Argentina. Lancet (August 20), pp. 532-33.

United Nations Fund for Population Activities (1979). *Survey of Laws on Fertility Control*. New York.

__________ (1989). *Annual Review of Population Law, 1986*, vol. 13. New York: UNFPA; Boston, Massachusetts: Harvard Law School Library.

__________. *Annual Review of Population Law, 1988*, vol. 15. New York: UNFPA; Boston, Massachusetts: Harvard Law School Library.

Viel, Benjamin (1988). Latin America. In *International Handbook on Abortion*, Paul Sachdev, ed. New York: Greenwood Press.

World Health Organization (1988). *International Digest of Health Legislation* (Geneva), vol. 39, No. 2, pp. 385-386.

Armenia

Borisov, V.A., compiler (1989). *Naselenie Mira: Demographychesky Spravochnik* (World population: demographic reference book). Moscow: Mysl'.

David, Henry P., and Robert I. McIntyre (1981). *Reproductive Behavior: Central and Eastern European Experience*. New York: Springer Publishing Company.

Markarian, L. P., and others (1988), Sotsial'no-psikhologicheskie aspeckty iskusstvennogo preryvaniia nezhelatel'noi beremennosti (Social and psychological aspects of artificial interruption of unwanted pregnancy). In *Tezisy dokladov Vsesoiuznoi Naucho prakticheskoi Konferentsii Planirovanie Sem'i i Natsinal'nye Traditsii* (Abstracts of reports of the Scientific-practical Conference on Family Planning and National Traditions).

Popov, Andrej A. (1991). Family planning and induced abortion in the USSR: basic health and demographic characteristics. *Studies in Family Planning* (New York), vol. 22, No. 6 (November/December), pp. 368-377.

Union of Soviet Socialist Republics, Ministry of Public Health (1982). *O Poryadke Provedeniya Operatsii Iskusstvennogo Preryvaniya Beremennosti* (On the artificial interruption of pregnancies). Decree No. 234, 16 March.

_________ (1987). *O Poryadke Provedeniya Operatsii Iskusstvennogo Preryvaniya Beremennosti Rannikh Srokov Metodom Vacuum-aspiratsii* (On the artificial interruption of early-stage pregnancies by vacuum aspiration). Decree No. 757, 5 June.

_________ (1987). *O Poryadke Provedeniya Operatsii Iskusstvennogo Preryvaniya Beremennosti Po Nemeditsinskim Pokazaniyam* (On the artificial interruption of pregnancies for non-medical reasons). Decree No. 1342, 31 December.

_________ (1989). *Zdorov'e Naseleniya SSSR i Deyatelnost' Uchrezhdenii Zdravookhraneniya v 1988* (Health of the population of the USSR and activities of public health services in 1988). Moscow.

_________ (1990). *Zdravookhraneniye v SSSR v 1989: Statisticheskie Materialy* (Public health in the USSR in 1989: statistical data). Moscow.

Union of Soviet Socialist Republics, Moscow State University (1985). *Demografichesky Entsiclopedichesky Slovar'* (Demographic encyclopedic dictionary). Moscow: Sovetskaya entsiclopediya.

Union of Soviet Socialist Republics, Presidium of the Supreme Soviet (1958). Ob otmene zapreshcheniya abortov (On the repeal of the prohibition of abortions). Decree of 23 November 1955. In *Postanovleniya KPSS i Sovetskogo Pravitel'stva ob Okhrane Zdorov'ya Naroda* (Decrees of CPSU and the Soviet Government on public-health care). Moscow: Medgiz.

Union of Soviet Socialist Republics, State Committee on Statistics (1988, 1989). *Naselenie SSSR, 1987 and 1988.* Moscow: Finance and Statistics.

_________ (1990). *Demografichesky Ezhegodnik SSSR, 1990* (Demographic yearbook of the USSR, 1990). Moscow: Finance and Statistics.

_________ (1991). Problemy sem'i, okhrany materinstva i detstva. (Problems of family, maternal and child care). *Vestnik Statistiki* (Moscow), No. 8, pp. 55-64.

United Nations Children's Fund/World Health Organization (1992). The looming crisis in health and the need for international support: overview of the reports on the Commonwealth of Independent States and the Baltic countries. Prepared by the UNICEF/WHO Collaborative Missions with the participation of UNFPA, WFP AND UNDP, 17 February - 2 March 1992. Unpublished.

Australia

Cook, Rebecca J. (1989). Abortion laws and policies: challenges and opportunities. In "Women' health in the third world: the impact of unwanted pregnancy", A. Rosenfield and others, eds. *International Journal of Gynecology and Obstetrics* (Limerick, Ireland), Special supplement No. 3, pp. 61-87.

Cook, Rebecca J. and Bernard M. Dickens (1979). Abortion laws in Commonwealth countries. *International Digest of Health Legislation* (Geneva), vol. 30, No. 2, pp. 395-502.

_________ (1986). *Issues in Reproductive Health Law in the Commonwealth.* London: Commonwealth Secretariat.

Hart, Gavin, and Tony Macharper (1987). Induced abortion trends in South Australia, 1970-84. *American Journal of Public Health* (Washington, D.C.), vol. 77, No. 2 (February), pp. 200-202.

Henshaw, Stanley K. and Evelyn Morrow (1990). *Induced abortion: a world review, 1990 Supplement.* New York: The Alan Guttmacher Institute.

International Planned Parenthood Federation (1984). Teenagers and fertility control: Australia. IPPF Open File: news digest of the world' largest voluntary family planning organization (two weeks ending 18 May). London. Mimeographed.

Libesman, Teresa and Stripathy, Vani, eds. (1996). Your body your baby: women's legal rights from conception to birth. Redfern, N.S.W.: Redfern Legal Centre Publishing with assistance from the Office of the Status of Women and the Law Foundation of New South Wales.

Loff, B., and Cordner, S. (1998). Western Australia passes liberal abortion law. *The Lancet*, vol. 351, No. 9117 (June 6, 1998), p. 1714.

Quiggin, P. (1990). Personal communication. Canberra: The Australian University, Department of Demography.

Petersen, K. (1996). Procreative freedom: a legal and moral challenge. Medicine and Law, Vol. 15, No. 3, pp. 433-40.

Scutt, Jocelynne A. (1989). Australien. In Schwangerschaftsabbruch im internationalen Vergleich: Rechtliche Regelungen-Soziale Rahmenbedingungen-Empirische Grunddaten,Albin Eser and Hans-Georg Koch, eds. Baden-Baden, Germany: Nomos Verlagsgesellschaft. Teil 2. Ausereuropa.

Siedlecky, Stefania (1988). Australia. In *International Handbook on Abortion,* Paul Sachdev, ed. New York: Greenwood Press.

Tietze, Christopher, and Stanley K. Henshaw (1986). *Induced Abortion: A World Review, 1986.* New York: The Alan Guttmacher Institute.

Skene, L. (1995). *Prenatal diagnosis and later termination: a legal perspective.* Australia and New Zealand Journal of Obstetrics and Gynaecology, Vol. 35, No. 1, pp.3-6.

United Nations Fund for Population Activities (1979). *Survey of Laws on Fertility Control.* New York.

__________ (1989). *Annual Review of Population Law, 1986,* vol. 13. New York: UNFPA; Boston, Massachusetts: Harvard Law School Library.

World Health Organization (1972). *International Digest of Health Legislation* (Geneva), vol. 23, No. 1, pp. 13-14.

__________ (1977). *International Digest of Health Legislation* (Geneva), vol. 28, No. 3, pp. 427-429.

__________ (1979). *International Digest of Health Legislation* (Geneva), vol. 30, No. 4, pp. 718-719.

Austria

Anonymous (1978). Legal abortion in Europe. *Planned Parenthood in Europe* (London), vol. 7, No. 1, pp. 1-8.

Enigli, M. and Perthold, S. (1993). Der weibliche Korper als Schlachtfeld: neue Beitrage zur Abtreibungsdiskussion. (The female body as a battlefield: new contributions to the abortion discussion). Vienna, Austria: Promedia, 208 p.

Glendon, Mary Ann (1987). *Abortion and Divorce in Western Law.* Cambridge, Massachusetts and London: Harvard University Press.

Jones, M. (1980). Widening women's choice: Austria. *People* (London), vol. 7, No. 1, pp. 18-19.

Kopl, R. (1984). Austrian Socialist Party women's policy and the decriminalization of abortion. *Osterreichische Zeitschrift fur Politikwissenschaft* (Vienna), vol. 13, No. 4, pp. 457-463.

Lehner, O. (1994). Austria. In *Abortion in the New Europe: A Comparative Handbook.* Bill Rolsten and Anna Eggert, eds. Westport, Connecticut: Greenwood Press, pp. 1-17.

Stepan, J. (1985). How Europe changed the rules: abortion. *People* (London), vol. 12, No. 2, pp. 28-29.

United Nations Fund for Population Activities (1979). *Survey of Laws on Fertility Control.* New York.

United Nations Population Fund (1990). *Annual Review of Population Law, 1987,* vol. 14. New York: UNFPA; Boston, Massachusetts: Harvard Law School Library.

World Health Organization (1975). *International Digest of Health Legislation* (Geneva), vol. 26, No. 2, pp. 226-228.

Azerbaijan

Borisov, V., A., Compiler (1989). *Naselenie Mira: Demographychesky Spravochnik* (World population: demographic reference book). Moscow: Mysl'.

David, Henry P., and Robert I. McIntyre (1981). *Reproductive Behavior: Central and Eastern European Experience.* New York: Springer Publishing.

Popov, Andrej A. (1991). Family planning and induced abortion in the USSR: basic health and demographic characteristics. *Studies in Family Planning* (New York), vol. 22, No. 6 (November/December), pp. 368-377.

United Nations High Commissioner for Refugees/United Nations Children's Fund (1992). Fact-finding mission to Azerbaijan. Interim report of a joint UNHCR/UNICEF mission to Azerbaijan, 3-13 February 1992. Unpublished.

Bahamas

Cook, Rebeca J., and Bernard M. Dickens (1979). Abortion laws in Commonwealth countries, *International Digest of Health Legislation* (Geneva), vol. 30, pp. 395-502.

__________ (1986). *Issues in Reproductive Health Law in the Commonwealth.* London: Commonwealth Secretariat.

United Nations Economic Commission for Latin America and the Caribbean (1998). *Caribbean Subregional Review and Appraisal Report on the Implementation of the ICPD Programme of Action (ICPD+5),* Caribbean Subregional Meeting for the Mid-Term Review of the ICPD Programme of Action, 17-18 November 1998, Port of Spain, Trinidad and Tobago.

Government of the Bahamas (1924). Penal Code of the Bahamas 1924. Statute Law of the Bahamas, vi.II, chap. 77, section 316.

United Nations Fund for Population Activities (1979). *Survey of Laws on Fertility Control.* New York.

United Nations Population Fund (2000). Inventory of population projects in developing countries around the world, 1997: multilateral organization assistance, bilateral agency assistance, and non-governmental or other organizational assistance. Unpublished document.

Bahrain

Tellenbach, Silvia (1989). Übersichtsbericht Arabische Staaten . In Schwangerschaftsabbruch im internationalen Vergleich: Rechtliche Regelungen-Soziale Rahmenbedingungen-Empirische Grunddaten, Albin Eser and Hans-Georg Koch, eds. Baden-Baden, Germany:

United Nations Fund for Population Activities (1979). *Survey of Laws on Fertility Control.* New York.

__________ (1979). Report of Mission on Needs Assessment for Population Assistance: Bahrain. Report No. 14. New York.

United Nations Population Fund (1990). *Annual Review of Population Law, 1987*, vol. 14. New York: UNFPA; Boston, Massachusetts: Harvard Law School Library.

Bangladesh

Akhter, Halida (1988). Bangladesh. In *International Handbook on Abortion,* Paul Sachdev, ed. New York: Greenwood Press.

Cook, Rebecca J., and Bernard M. Dickens (1979). Abortion laws in Commonwealth countries, *International Digest of Health Legislation* (Geneva), vol. 30, pp. 395-502.

__________ (1986). *Issues in Reproductive Health Law in the Commonwealth.* London: Commonwealth Secretariat.

Dixon-Mueller, Ruth (1988). Innovations in reproductive health care: menstrual regulation policies and programs in Bangladesh. *Studies in Family Planning* (New York), vol. 19, No. 3, pp. 129-140.

Henshaw, Stanley K. (1990). "Induced abortion: a world review, 1990". In *Induced Abortion: A World Review, 1990 Supplement,* by Stanley K. Henshaw and Evelyn Morrow. New York: The Alan Guttmacher Institute.

Huda, S. (1992). The legal implications of the use of antiprogestin drugs. In Proceedings of the International Symposium on Antiprogestins, edited by Ghulam Mustafa, Kamal. Dhaka, Bangladesh: Bangladesh Association for the Prevention of Septic Abortion.

Kay, Bonnie J., and Ssnadra M. Kabir (1988). A study of costs and behavioral outcomes of menstrual regulation services in Bangladesh. *Social Science and Medicine* (Elmsford, New York), vol. 26, No. 6, pp. 597-604.

Khan, Atiqur Rahman, and others (1986). Induced abortion in a rural area of Bangladesh. *Studies in Family Planning* (New York), vol. 17, No. 2 (March/April), pp. 95-99.

Koenig, Michael A., and others (1988). Maternal mortality in Matlab, Bangladesh: 1976-85. *Studies in Family Planning* (New York), vol. 19, No. 2 (March-April), pp. 69-80.

Tellenbach, Silvia (1989). Übersichtsbericht Arabische Staaten . In Schwangerschaftsabbruch im internationalen Vergleich: Rechtliche Regelungen-Soziale Rahmenbedingungen-Empirische Grunddaten, Albin Eser and Hans-Georg Koch, eds. Baden-Baden, Germany:

Tietze, Christopher, and Stanley K. Henshaw (1986). *Induced Abortion: A World Review, 1986.* New York: The Alan Guttmacher Institute.

United Nations Fund for Population Activities (1979). *Survey of Laws on Fertility Control.* New York.

_________ (1980). *Annual Review of Population Law, 1980.* New York.

Whittaker, Maxine, and Sandra Mostafa Kabir (1990). Induced abortion: the Bangladesh perspective. Paper prepared for the Annual Meeting of the Population Association of America, Toronto, Canada, 3-5 May.

Barbados

Cook, Rebecca J., and Bernard M. Dickens (1979). Abortion laws in Commonwealth countries. *International Digest of Health Legislation* (Geneva), vol. 30, pp. 395-502.

__________ (1986). *Issues in Reproductive Health Law in the Commonwealth*. London: Commonwealth Secretariat.

International Planned Parenthood Federation (1990). Caribbean Contraceptive Prevalence Surveys. No. 6: Barbados: IPPF/Western Hemisphere Region. New York.

__________ (1999). Country Profile: Barbados. (http://www.ippf.org/regions/countries/alb /index.htm). Accessed on 1 October 1999.

Miller, B. A. (1981). The roots of population policy in Barbados. In *Health Needs of the World's Poor Women,* P. W. Blair, ed. Washington, D.C.: Equity Policy Center.

__________ (1990). Barbados Ministry of Health. Personal communication.

United Nations Fund for Population Activities (1979). *Survey of Laws on Fertility Control.* New York.

__________ (1985). *Annual Review of Population Law, 1983*, vol. 10. New York: UNFPA; Boston, Massachusetts: Harvard Law School Library.

World Health Organization (1983). *International Digest of Health Legislation* (Geneva), vol. 34, No. 3, pp. 514-517.

__________ (1984). *International Digest of Health Legislation* (Geneva), vol. 35, No. 3, pp. 612-613.

Belarus

Blayo, C. (1993). Access to abortion: The legal context, practice and frequency of recourse. Entre Nous (June, 1993), pp. 22-23.

Hecht, Jacqueline (1987). La législation de l'vortement en Europe de l'Est et en Union Soviétique. *Politiques de Population, Etudes et Documents* (Louvain la Neuve, Belgium), vol. III, No. 1 (juin), pp. 89-105.

United Nations (1998c). *Global Population Policy Database, 1997.* Sales No. E.98.XIII.11.

United Nations Fund for Population Activities (1979). *Survey of Laws on Fertility Control.* New York.

World Health Organization (1990). Family planning in the USSR. *Entre Nous* (Geneva), No. 16 (September).

Belgium

Bodifée, Gerard (1995). Abortus na de wet. Mensen en feiten, No. 19. Leuven: Davidsfonds.

Claeys, V. (1994). Belgium. In *Abortion in the New Europe: A Comparative Handbook.* Bill Rolston and Anna Eggert, eds. Westport, Connecticut: Greenwood Press.

Glendon, Mary Ann (1987). *Abortion and Divorce in Western Law.* Cambridge, Massachusetts: Harvard University Press.

Henshaw, Stanley K. (1990). "Induced abortion: a world review, 1990". In *Induced Abortion: A World Review, 1990 Supplement,* by Stanley K. Henshaw and Evelyn Morrow. New York: The Alan Guttmacher Institute.

Humblet, P.C., Vekemans, M. and Buekens, P. (1996). Developments in abortion policy in a context of illegality. The Belgian case from 1971 until 1990. European Journal of Public Health, Vol. 6, No. 4, pp. 288-93.

International Planned Parenthood Federation (1987). IPPF Open File: news digest of the world's largest voluntary family planning organization (two weeks ending 25 September). London. Mimeographed.

__________ (1989). Abortion laws in Europe. *Planned Parenthood in Europe* (London), vol. 18, No. 1 (Spring), supplement.

Jorda, K., and F. Deven (1985). Abortion in Belgium: historical and political aspects. *Pro Familia Magasin*, vol. 13, No. 2 (March/April) pp. 6-9.

Montgomery, Paul L. (1990). Belgium eases its abortion law. *The New York Times* (30 March 1990), p. A12.

Temmerman, Marleen, Jean-Jacques Amy, and Michael Thiery (1988). Belgium. In *International Handbook on Abortion*, Paul Sachdev, ed. New York: Greenwood Press.

United Nations Fund for Population Activities (1979). *Survey of Laws on Fertility Control.* New York.

__________ (1988). *Annual Review of Population Law, 1985*, vol. 12. New York: UNFPA; Boston, Massachusetts: Harvard Law School Library.

United Nations Population Fund. *Annual Review of Population Law, 1988*, vol. 15. New York: UNFPA; Boston, Massachusetts: Harvard Law School Library.

Vekemans, Marcel, and B. Verhaegem (1987). Enquête sur le nombre d'interruptions volontaires de grossesses pratiquées en Belgique en 1985. *Revue médicale de Bruxelles*, vol. 8, No. 1 (janvier), pp. 21-25.

Belize

Belize, Ministry of Finance; Belize Family Life Association; Belize Ministry of Health, and CDC (1991). *1991 Belize Family Health Survey: Preliminary Report.* Atlanta, Georgia: United States Department of Health and Human Services.

Cook, Rebecca J., and Bernard M. Dickens (1986). *Issues in Reproductive Health Law in the Commonwealth.* London: Commonwealth Secretariat.

Pan American Health Organization (1990). *Health Conditions in the Americas: 1990 Edition*, vols. I and II. Scientific Publication, No. 524, Washington, D.C.

United Nations Fund for Population Activities (1979). *Survey of Laws on Fertility Control.* New York.

__________ (1982). *Annual Review of Population Law, 1982*, vol. 9. New York: UNFPA; Boston, Massachusetts: Harvard Law School Library.

United Nations Population Fund (2000). Inventory of population projects in developing countries around the world, 1997: multilateral organization assistance, bilateral agency assistance, and non-governmental or other organizational assistance. Unpublished document.

World Health Organization (1983). *International Digest of Health Legislation* (Geneva), vol. 34, No. 1, pp. 73-74.

Benin

Kodja, A. (1978). Contribution to the study of induced abortion in the People's Republic of Benin. Doctoral dissertation, Université nationale du Benin.

International Planned Parenthood Federation (1984). Spreading the birth spacing message: Benin annual report. IPPF Open File: news digest of the world's largest voluntary family planning organization (two weeks ending 3 September). London. Mimeographed.

United Nations Development Programme (1988). UNFPA proposed projects and programmes. Recommendation by the Executive Director: assistance to Benin; support for a comprehensive population programme. DP/FPA/CP/32.

United Nations Fund for Population Activities (1979). *Survey of Laws on Fertility Control.* New York: UNFPA.

United Nations Population Fund (2000). Inventory of population projects in developing countries around the world, 1997: multilateral organization assistance, bilateral agency assistance, and non-governmental or other organizational assistance. Unpublished document.

World Health Organization (1974). *International Digest of Health Legislation* (Geneva), vol. 25, No. 1, p. 91.

Bhutan

United Nations Fund for Population Activities (1981). *Kingdom of Bhutan: Report of Mission on Needs Assessment for Population Assistance.* Report No. 42. New York.

__________ (1989). *Inventory of Population Projects in Developing Countries around the World 1987/1988.* Sales No. E.89.III.H.1.

World Health Organization (1990). Maternal health and safe motherhood programme: progress report, 1987-1990. Geneva.

Bolivia

Berer, M. (1997). Abortion: unfinished business. *Reproductive Health Matters*, vol. 5, No. 9 (May 1997), pp. 6-9.

Cisneros, A. J., G. La Fuente and C. Koch (1984). *Percepciones comparativas sobre la vida familiar de la mujer trabajadora.* Estudios de Sociología de la Familia (La Paz, Bolivia), No. 4.

Hardon, A. (1997). A review of national family planning policies. In *Reproductive Rights in Practice: A Feminist Report on Quality of Care*, pp 15-21. London, England: Zed Books.

Pommier, M. (1991). Abortion and contraception. *Jornadas multidisciplinarias sobre el aborto,* 25 de febrero al 10 de marzo, 1991. La Paz, Bolivia: Sociedad Boliviana de Ciencias Penales, pp. 99-106.

Soliz Pereyra, G. (1991). Medical aspects of induced abortion. *Jornadas multidisciplinarias sobre el aborto*, 25 de febrero al 10 de marzo, 1991. La Paz, Bolivia: Sociedad Boliviana de Ciencias Penales.

United Nations (1988). Case study on Bolivia. By L. B. Barragan. EGM/SSMAW/1988/CS.5.

United Nations Population Fund (1977). *Annual Review of Population Law, 1977,* New York.

United Nations Population Fund (1998). *Reply of the Bolivian Government to UNFPA's Inquiry of Country level Experience since ICPD.*

__________ (1979). *Survey of Laws on Fertility Control.* New York.

__________ (1987). *Annual Review of Population Law, 1984,* vol. 11, New York: UNFPA; Boston, Massachusetts: Harvard Law School Library.

Viel, Benjamin (1988). Latin America. In *International Handbook on Abortion,* Paul Sachdev, ed. New York: Greenwood Press.

Weisner, M. (1990). Induced abortion in Chile with references to Latin American and Caribbean countries. Paper prepared for the Annual Meeting of the Population Association of America, Toronto, Canada, 3-5 May.

World Health Organization (1983). *International Digest of Health Legislation* (Geneva), vol. 34, No. 2, pp. 226-227.

__________ (1996). *Coverage of Maternity Care: A Listing of Available Data* (WHO/RHT/MSM/96.28), Geneva.

Bosnia and Herzegovina

Andolšek, Lidija (1988). Yugoslavia. In *International Handbook on Abortion*, Paul Sachdev, ed. New York; Westport, Connecticut; and London: Greenwood Press.

Cook, Rebecca J. (1989). Abortion laws and policies: challenges and opportunities. In "Women's health in the third world: the impact of unwanted pregnancy", A. Rosenfield and others, eds. *International Journal of Gynecology and Obstetrics* (Limerick, Ireland), Supplement No. 3, pp. 61-87.

__________, and Bernard M. Dickens (1988). International developments in abortion laws: 1977-88. *American Journal of Public Health* (Washington, D.C.), vol. 78, No. 10 (October), pp. 1305-1311.

David, Henry P. and Robert J. McIntyre (1981). *Reproductive Behavior: Central and Eastern European Experience.* New York: Springer Publishing Company.

Kapor-Stanulovic, Nila (1989). Liberal approach for a patchwork population. *People* (London), vol. 16, No. 3, pp. 16-18.

Malacic, Janez (1989). Family planning, population policy and declining birth rates in Yugoslavia. *Planned Parenthood in Europe* (London), vol. 18, No. 2 (September).

__________ (1990). Political changes in Yugoslavia and family planning. *Planned Parenthood in Europe* (London), vol. 19, No. 2 (September).

Royston, Erica, and Sue Armstrong, eds. (1989). *Preventing Maternal Deaths.* Geneva: World Health Organization.

United Nations Fund for Population Activities (1979a). *Annual Review of Population Law, 1978.* New York: UNFPA; Boston, Massachusetts: Harvard Law School Library.

__________, (1979b). *Survey of Laws on Fertility Control.* New York.

World Health Organization (1970). Comparative health legislation: abortion laws. *International Digest of Health Legislation* (Geneva), vol. 21, No. 3, pp. 437-512.

World Health Organization, Regional Office for Europe (1990). Yugoslavia. *Entre nous: The European Family Planning Magazine* (Copenhagen, Denmark), No. 16 (September), pp. 11-12.

Botswana

Anonymous. Legislation on abortion in Africa (1995). *African Population Newsletter*, vol. 67 (January-June), pp. 5-6.

Botswana (1991). Penal Code (Amendment) Act, 1991 (11 October, 1991). *Government Gazette*, 1991; (Suppl A): A55-6.

Commonwealth Medical Association and Medical and Dental Association of Botswana (1996). *Report of a workshop held in Gaborone in January 1996 on women's health in Botswana.* London, England: British Medical Association.

Cook, Rebecca J., and Bernard M. Dickens (1979). Abortion laws in Commonwealth countries. *International Digest of Health Legislation* (Geneva), vol. 30, pp. 395-502.

__________ (1986). *Issues in Reproductive Health Law in the Commonwealth.* London: the Commonwealth Secretariat.

Mashalaba, Nolwandle Nozipo (1989). Commentary on the causes and consequences of unwanted pregnancy from an African perspective. In Women's health in the third world: the impact of unwanted pregnancy, A. Rosenfield and others, eds. *International Journal of Gynecology and Obstetrics* (Limerick, Ireland), Special supplement, No. 3, pp. 15-19.

Onyango, C. (1997). Sub-Saharan African women benefit from new programs. *Forum for Applied Research and Public Policy*, vol. 12, No. 2, Summer, pp 51-57.

Owout-Ormondi, L., and others (1993). *Determinants of Maternal Mortality in Botswana: An Institutional, Community and Household Perspective.* Gaborone: Ministry of Health, Health Education Unit.

United Nations Fund for Population Activities (1979). *Survey of Laws on Fertility Control.* New York.

Newsletter (1991). *Women and Law in Southern Africa Research Project.* Harare, Zimbabwe.

Brazil

Ashford, Lory, and Carolyn Makinson (1999). *Reproductive Health Policies and Practices: Case Studies from Brazil, India, Morocco and Uganda.* Washington, D.C.: Population Reference Bureau.

Barbosa, R. M., and M. Arilha (1993). The Brazilian experience with Cycotec. *Studies in Family Planning,* vol. 24, No.4 (July/August), pp. 236-240.

Brazil (1992). *Colecao das Leis*, Jul; 184(7):1901-45.

Centre for Reproductive Law and Policy, International Programme (1995). Women of the World. *Formal Laws and Policies Affecting Their Reproductive Lives*: Brazil, China Germany, India, Nigeria, United States. New York: Centre for Reproductive Law and Policy.

Cook, Rebecca J. (1989). Abortion laws and policies: challenges and opportunities. In "Women's health in the third world: the impact of unwanted pregnancy", A. Rosenfield and others, eds. *International Journal of Gynecology and Obstetrics* (Limerick, Ireland), Special supplement No. 3, pp. 61-87.

Correa, S. (1999). Cairo in action: the case of Brazil. *Development,* vol. 42, No. 1 (March), pp. 29-32.

Correa, S. (1998). *Reproductive health in policy and practice: Brazil.* Washington, D.C.: Population Reference Bureau.

Germain, A. (1999). Reproductive health: the continuing challenge. *Development*, vol. 42, No. 1, pp. 38-40.

International Planned Parenthood Federation (1988). Brazilian abortion exceed births. IPPF Open File: news digest of the world's largest voluntary family planning organization (two weeks ending 25 March). London. Mimeographed.

Latin American and Caribbean Women's Health Network (1999). *The Cairo Consensus: Women Exercising Citizenship Through Monitoring: Review of Five Latin American Countries,* Santiago: LACWHN.

Linhares Barsted, Leila (1990). La situación de los derechos reproductivos en Brasil. Paper presented at the Seminario Reforma Constitucional y Ordenamiento Legislativo en Materia de Población, Buenos Aires, Argentina, 29 May - 1 June 1990.

Merrick, T. W. (1983). La fecundidad y la planificación familiar en el Brasil. *Perspectivas Internacionales en Planificación Familiar* (New York), Special Issue for 1983. New York: The Alan Guttmacher Institute.

Papaleo, Celso Cezar (1993). Aborto e Contracepcão: Actualidade e Complexidade da Questão. Rio de Janeiro, Brazil: Renovar.

Pinotti, José Aristodemo, and Anibal Faúndes (1989). Unwanted pregnancy: challenges for health policy. In Women's health in the third world: the impact of unwanted pregnancy, A. Rosenfield and others, eds. *International Journal of Gynecology and Obstetrics.* (Limerick, Ireland), Special supplement No. 3, pp. 97-102.

Pitanguy, J. (1999). Reproductive rights are human rights. *Development,* vol. 42, No. 1 (March), pp. 11-14.

Rodrigues, Walter, and others. (1975). *Law and Population in Brazil.* Law and Population Monograph Series, No. 34. Medford, Massachusetts: Tufts University, The Fletcher School of Law and Diplomacy.

United Nations Fund for Population Activities (1979). *Annual Review of Population Law, 1979.* New York: UNFPA; Boston Massachusetts: Harvard Law School Library.

__________ (1979). *Survey of Laws on Fertility Control.* New York.

Viel, Benjamin (1988). Latin America. In *International Handbook on Abortion,* Paul Sachdev, ed. New York: Greenwood Press.

World Health Organization (1975). *International Digest of Health Legislation,* vol. 26, No. 2, Geneva, p. 266.

__________ (1976). *International Digest of Health Legislation*, vol. 27, No. 3, Geneva, p. 530.

__________ (1981). *International Digest of Health Legislation,* vol. 32, No. 1, Geneva, p. 76.

__________ (1986). *International Digest of Health Legislation* , vol. 37, No. 2, Geneva, pp. 270-271.

__________ (1996). *Coverage of Maternity Care: A Tabulation of Available Information.* WHO/RHT/MSM/96.28.

Brunei Darussalam

Laws of Brunei (1984). Criminal Procedure Code. Cap. 22, sections 312-314.

Hj Lawie, Datin H. J. (1986). Status of women's right and reproductive health in Brunei Darussalam. In *Proceedings of the ESEAOR Seminar on Women's Rights and Reproductive Health,* Singapore, 12-15 August 1985.

United Nations/United Nations Fund for Population Activities (1985). Population Policy Compendium: Brunei Darussalam.

Bulgaria

David, Henry P. (1970). *Family Planning and Abortion in the Socialist Countries of Central and Eastern Europe.* New York: The Population Council.

Frejka, Tomas (1984). Induced abortion and fertility: a quarter century of experience in Eastern Europe. *Population and Development Review* (New York), vol. 9, No. 3 (September), pp. 494-920.

Githens, M. (1996). Reproductive rights and the struggle with change in Eastern Europe. In *Abortion Politics: Public Policy in Cross-cultural Perspective.* M. Githens and D. Stetson, eds. New York, New York: Routledge, pp. 55-68.

Hecht, Jacqueline (1987). La législation de l'avortement en Europe de l'st et en Union Soviétique. *Politiques de population: études et documents* (Louvain-la-Neuve, Belgium), vol. III. No. 1 (juin), pp. 89-105.

Henshaw, Stanley K. (1990). Induced abortion: a world review, 1990. In *Induced Abortion: A World Review, 1990 Supplement,* by Stanley K. Henshaw and Evelyn Morrow. New York: The Alan Guttmacher Institute.

International Planned Parenthood Federation (1999). Country Profile: Bulgaria. (http://www.ippf.org/regions/countries/alb/index.htm). Accessed on 15 October 1999.

Tietze, Christohper, and Stanley K. Henshaw (1986). *Induced Abortion: A World Review, 1986.* New York: The Alan Guttmacher Institute.

United Nations Fund for Population Activities (1979). *Survey of Laws on Fertility Control.* New York.

Vasilev, D. (1988). Tridset godini legalno izkustveno prekusvane na bremennostta v Bulgariia: izuvdi i problemi (Thirty years of legal induced abortion in Bulgaria: conclusions and problems. *Akushestvo I Ginekologiya*, vol. 27, No. 1, pp. 1-10. In Bulgarian with English summary.

Vassilev, D. (1994). Bulgaria. In *Abortion in the New Europe: A Comparative Handbook.* B. Roylsten, and A. Eggert, eds. (Westport, Connecticut: Greenwood Press), pp. 43-54.

World Health Organization (1973). *International Digest of Health Legislation* (Geneva), vol. 24, No. 4, pp. 731-738.

__________ (1974). *International Digest of Health Legislation* (Geneva), vol. 25, No. 3, pp. 541-548.

Burkina Faso

Burkina Faso (1984). Code pénal. Première partie, section 317.

Burkina Faso (1994). Loi No. 23/94/ADP, 19 May 1994, portant Code de la Santé Publique.

Burkina Faso (1996). Loi No. 043/96/ADP, 13 November 1996, portant Code Pénal.

International Planned Parenthood Federation (1999). Country Profile: Burkina Faso. (http://www.ippf.org/regions/countries/alb/index.htm). Accessed on 15 October 1999.

Komy' Sambo, Antoine. (1984). *Lois et règlements concernant la population au Burkina Faso.* Ministère de la planification et du développement populaire, Burkina Faso.

United Nations Fund for Population Activities (1979). *Survey of Laws on Fertility Control.* New York.

__________ (1988). *Annual Review of Population Law, 1985,* vol. 12, New York: UNFPA; Boston, Massachusetts: Harvard Law School Library.

World Health Organization (1973). *International Digest of Health Legislation* (Geneva), vol. 24, No. 3, pp. 642-663.

__________ (1990). *International Digest of Health Legislation* (Geneva), vol. 41, No. 2, p. 270.

Burundi

International Planned Parenthood Federation (1989). Burundi survey highlights better health picture. IPPF Open File: news digest of the International Planned Parenthood Federation (London), (August/September). Mimeographed.

__________ (1999). Country Profile: Burundi. (http://www.ippf.org/regions/countries /alb/index.htm). Accessed on 15 October 1999.

Paxman, John M., and Ruth Jane Zuckerman (1987). *Laws and Policies Affecting Adolescent Health.* Geneva: World Health Organization.

United Nations Development Programme (1987). UNFPA proposed projects and programmes. Recommendation by the Executive Director: assistance to the Government of Burundi; support for a comprehensive population programme. DP/FPA/CP/24.

United Nations Fund for Population Activities (1979). *Survey of Laws on Fertility Control.* New York.

_________ (1985). *Annual Review of Population Law*, vol. 12. New York: UNFPA; Boston, Massachusetts: Harvard Law School Library.

World Bank (1983). Republic of Burundi: population and health sector review. Population, Health and Nutrition Department, Report No. 4500-BU. Mimeographed.

World Health Organization (1986). *International Digest of Health Legislation* (Geneva), vol. 37, No. 2, pp. 271-272.

Cambodia

Anonymous (1997). Cambodia passes new limits on abortion. *Reproductive Freedom News*, vol. VI, No. 17 (October), p. 7.

Goodburn, E.A., S .Sprechmann and S.C. Soeung (1997). The role of abortion in meeting the unmet need for contraception in Cambodia. Unpublished paper presented at the IUSSP XXIIIrd General Population Conference, Beijing, China, 11-17 October 1997.

Government of Cambodia (1995). *Birth Spacing Policy for Cambodia.* Phnom Penh: Ministry of Health.

Government of Cambodia (1996). *Ministry of Health Policy and Strategies* 1996-2000. Phnom Penh: Ministry of Health.

Government of Cambodia (1997). Law on Abortion, 12 November 1997.

International Planned Parenthood Federation (1999). Country Profile: Cambodia. (http://www.ippf.org/regions/countries /alb/index.htm). Accessed on 15 October 1999.

Tek-To (1974). Family planning situation in Khmer Republic. In *Report on the Regional Workshop on Coordinating Education and Family Planning, Singapore, 17-21 December 1973.* Kuala Lumpur, Malaysia: Intergovernmental Coordinating Committee.

United Nations Children's Fund (1988). Country programme recommendation: Kampuchea. E/ICEF/1988/P/L.19.

United States of America, Central Intelligence Agency (1980). Kampuchea: a demographic catastrophe. A report of the National Foreign Assessment Center. McLean, Virginia.

Cameroon

Anonymous (1995). Legislation on abortion in Africa. *African Population Newsletter*, vol. 67 (January-June), pp. 5-6.

Cameroon (1975). Penal Code. Law No. 65-LF-24 of 12 November 1965 and Law No. 67-LF-1 of 12 June 1967, sections 337-339.

Gubry, P., and M. Sala-Diakanda (1988). Cameroon: from a moderate pronatalist policy to a moderate antinatalist policy? *Les Dossiers du CEPED* (Paris), No. 2 (September), pp. 23-48. Centre français sur la population et le développement.

International Planned Parenthood Federation (1994). Assessment of unsafe abortion in Africa. Summary of six country profiles: Kenya, Zambia, Ghana, Nigeria, Senegal, Cameroon. Unpublished.

_________ (1999). Country Profile: Cameroon. (http://www.ippf.org/regions/countries /alb/index.htm). Accessed on 15 October 1999.

Leke, Robert J. (1989). Commentary on unwanted pregnancy and abortion complications in Cameroun. In Women's health in the third world: the impact of unwanted pregnancy, A. Rosenfield and others, eds. *International Journal of Gynecology and Obstetrics* (Limerick, Ireland), Special supplement No. 3, pp. 33-35.

United Nations Fund for Population Activities (1979). *Survey of Laws on Fertility Control.* New York.

World Health Organization (1969). *International Digest of Health Legislation* (Geneva), vol. 20, No. 3, pp. 397-398.

Canada

Bindman, Stephen (1989). Split decision on whether bill survives. *The Ottawa Citizen*, 4 November.

Githens, M., and D. Stetson (1996). *Abortion politics: public policy in cross-cultural perspective.* New York, New York: Routledge, 234p.

Henshaw, Stanley K. (1990). Induced abortion: a world review, 1990. In *Induced Abortion: A World Review, 1990 Supplement*, by Stanley K. Henshaw and Evelyn Morrow. New York: The Alan Guttmacher Institute.

International Advisory Committee on Population and Law (1976). *Annual Review of Population Law, 1975.* Law and Population Monograph Series, No. 39. Medford, Massachusetts: Tufts University, The Fletcher School of Law and Diplomacy.

International Planned Parenthood Federation (1987). Access to abortion services in Canada inadequate. IPPF Open File: news digest of the world's largest voluntary family planning organization (two weeks ending 25 September). London. Mimeographed.

__________ (1991). Canadian abortion bill defeat. IPPF Open File: news digest of the world's largest voluntary family planning organization (two weeks ending 22 February). London. Mimeographed.

Mason, J.K. (1990). *Medico-legal aspects of reproduction and parenthood.* Aldershot, England: Dartmouth.

Morgentaler, H. (1998). Roe v. Wade: Canada's example. *Conscience*, vol. 18, No. 4 (Winter), p. 31.

Perrault, M. (1996). The right to choose and the choice of law: the experience of the Ontario Coalition for Abortion Clinics and the Morgentaler decision. *Canadian Journal of Political Science/Revue Canadienne de Science Politique.* Jun: 29 (2): 243-67.

Sachdev, Paul (1988). Canada. In *International Handbook on Abortion*, Paul Sachdev, ed. New York: Greenwood Press.

Tietze, Christopher, and Stanley K. Henshaw (1986). *Induced Abortion: A World Review, 1986.* New York: The Alan Guttmacher Institute.

United Nations Fund for Population Activities (1979). *Survey of Laws on Fertility Control.* New York.

__________ (1987). *Annual Review of Population Law, 1984.* vol. 11, New York: UNFPA; Boston, Massachusetts: Harvard Law School Library.

World Health Organization (1970). *International Digest of Health Legislation* (Geneva), vol. 21, No. 4, pp. 678.

__________ (1976). *International Digest of Health Legislation* (Geneva), vol. 27, No. 2, p. 295.

Yaffe, B. (1987). The abortion issue in Newfoundland: a province divided. *Canadian Medical Association Journal*, No. 136 (April), pp. 865-866.

Cape Verde

United Nations. Economic Commission for Africa (1993). Population policies and programmes in the member States of the Economic Commission for Africa. In *Population Policies and Programmes. Proceedings of the United Nations Expert Group Meeting on Population Policies and Programmes*, Cairo, Egypt, 12-16 April 1992. ST/ESA/ SER.R/128.

United Nations Development Programme (1988). UNFPA proposed projects and programmes. Recommendation by the Executive Director: assistance to the Government of Cape Verde; support of a population programme. DP/FPA/CP/34.

United Nations Fund for Population Activities (1988). *Cap-Vert: rapport de mission sur l'evaluation des besoins d'aide en matière de population.* Rapport No. 93 (May). New York.

__________ (1990). *Annual Review of Population Law, 1987*, vol. 14. New York: UNFPA; Boston, Massachusetts: Harvard Law School Library.

Central African Republic

Anonymous (1995). Legislation on abortion in Africa. *African Population Newsletter*, vol. 67 (January-June), pp. 5-6.

International Planned Parenthood Federation (1999). Country Profile: Central African Republic. (http://www.ippf.org /regions/countries /alb/index.htm). Accessed on 15 October 1999.

Nyong'o, D. (1996). Generating public awareness in Africa. Advocacy for reproductive health: Africa. *Planned Parenthood Challenges*, No. 19, pp. 2-4.

United Nations, Economic Commission for Africa (1985). Le droit et la condition de la femme en République Centrafricaine. Série de recherche. E/ECA/ATRCW/85/09. Addis Ababa.

United Nations. Economic Commission for Africa (1993). Population policies and programmes in the member states of the Economic Commission for Africa. In *Population Policies and Programmes: Proceedings of the United Nations Expert Group Meeting on Population Policies and Programmes*, Cairo, 12-16 April 1992. ST/ESA/ SER.R/128.

United Nations Fund for Population Activities (1979). *Survey of Laws on Fertility Control.* New York.

Chad

International Planned Parenthood Federation (1999). Country Profile: Chad. (http://www.ippf.org /regions/countries /alb/index.htm). Accessed on 15 October 1999

Salmon, Y. M. (1988). Problèmes juridiques afferents à l'avortement an Tchad. In *Rapport final de la Conférence sur le bien-être familial au Tchad: N'Djamena 15-21 Octobre 1988*, Leslie Leila Brandon, ed. N'Djamena, Chad: Ministère de la santé publique.

United Nations Development Programme (1989). UNFPA proposed projects and programmes. Recommendation by the Executive Director: assistance to the Government of Chad: support for a comprehensive population programme. DP/FPA/CP/54.

United Nations Fund for Population Activities (1979). *Survey of Laws on Fertility Control.* New York.

United Nations Population Fund (1989). *Inventory of Population Projects in Developing Countries Around the World 1987/88.* Sales No. E.89.III.H.1.

Chile

Alexander L. (1995). Chile. In *The Right to Know: Human Rights and Access to Reproductive Health Information.* Sandra Coliver, ed. London: Article 19, pp. 142-58.

Anonymous (1987). Safe motherhood through family planning. *Network* (Durham, North Carolina), vol. 9, No. 1 (Fall), p. 8.

Casas Becerra, Lidia (1996). Mujeres procesadas por aborto. Santiago, Chile: *Foro Abierto de Salud y Derechos Reproductivos*; New York: Centre for Reproductive Law and Policy.

Casas-Becerra, L. (1997). Women prosecuted and imprisoned for abortion in Chile. *Reproductive Health Matters*, vol. 5, No. 9 (May), pp. 29-36.

Chile (1989). Ley No. 18.826 (15 de septiembre). *Diario oficial de la República de Chile.* Santiago: Ministerio de Justicia.

Espinoza, V., L. H. Mu oz and A. Nu ez (1985). Estudio clínico epidemiológico del aborto en mujeres chilenas. *Revista Chilena de Obstetricia y Ginecología* (Santiago), vol. 50, No. 4, pp. 278-285.

Government of Chile (1993). *Status of Health and Health Care Services in Chile.* Santiago: Ministry of Public Health.

Hablemos de Aborto Terapeutico (1993). Memoria, Simposio Nacioal Leyes para la Salud y la Vida de las Mujeres: Hablemos de Aborto Terapeutico. Santiago. Foro Abierto de Salud y Derechos Reproductivos.

Latin American and Caribbean Women's Health Network (1999). *The Cairo Consensus: Women Exercising Citizenship Through Monitoring: Review of Five Latin American Countries* (Santiago, LACWHN).

Liskin, Laurie S. (1980). *Complications of Abortion in Developing Countries.* Population Reports, Series F, No. 7. Baltimore, Maryland: The Johns Hopkins University, Population Information Program.

Population Council (1979). Chile adopts pronatalist policy. *Population and Development Review*, vol. 5, No. 3, New York.

Schreck, L. (1998). Chilean women prosecuted after clandestine abortion are often reported by the hospitals that treat them. *International Family Planning Perspectives*, vol. 24, No. 4 (December), pp. 200-201.

Sallat, L. (1994). Rites and rights: Catholicism and contraception in Chile. In *Private Decisions, Public Debate: Women, Reproduction and Population.* Judith Mirsky and Marty Radlett, eds. London: Panos Publications.

Taucher, Erica (1986). Fecundidad y salud materno infantil. *Boletin-Asociación Chilena de Protección de la Familia* (Santiago), vol. 22, No. 7-12 (julio-diciembre), pp. 26-46.

United Nations Fund for Population Activities (1979). *Survey of Laws on Fertility Control.* New York.

United Nations Population Fund (1988). *Annual Review of Population Law, 1988,* vol. 15. New York: UNFPA; Boston, Massachusetts: Harvard Law School Library.

Vandenberg, Bea J., and Chin Long Chiang (1986). Maternal mortality and differentiation by cause of death. In *New Developments in the Analysis of Mortality and Causes of Death,* Harold Hansluwka and others, eds. Bangkok: WHO; Mahidol University.

Viel, Benjamin (1988). Latin America. In *International Handbook on Abortion,* Paul Sachdev, ed. New York: Greenwood Press.

Weisner, M. (1990). Induced abortion in Chile, with reference to Latin American and Caribbean countries. Paper prepared for the Annual Meeting of the Population Association of America, Toronto, Canada, 3-5 May 1990.

World Health Organization (1998). *Unsafe Abortion. Global and Regional Estimates of Incidence and Mortality Due to Unsafe Abortion with a Listing of Available Country Data*, Third Edition, WHO/RHT/MSM/97.16.

China

Bittles, A.H. (1998). Eugenics and population policies. In *Human Biology and Social Inequality.* S.S. Strickland and P.S. Shetty, eds. New York, New York: Cambridge University Press.

Centre for Reproductive Law and Policy, International Program (1995). *Women of the World: Formal laws and policies affecting their reproductive lives: Brazil, China, Germany, India, Nigeria, United States.* New York: Center for Reproductive Law and Policy.

Greenhalgh, Susan (1986). Shifts in China's population policy, 1984-1986: views from the central, provincial and local levels. *Population and Development Review* (New York), vol. 12, No. 3 (September), pp. 491-515.

Gregory, L. B. (1992). Examining the economic component of China's one-child family policy under international law: your money or your life. *Journal of Chinese Law.* Spring; 6(1): 45-87.

Hardee-Cleaveland, Karen, and Judith Banister (1988). Fertility policy and implementation in China, 1968-88. *Population and Development Review* (New York), vol. 14, No. 2 (June), pp. 245-515.

Henshaw, Stanley K. (1990). Induced abortion: a world review, 1990. In *Induced Abortion: A World Review, 1990 Supplement,* by Stanley K. Henshaw and Evelyn Morrow. New York: The Alan Guttmacher Institute.

Jiang, Z. (1997). Recent developments in the family planning program in China. In *1992 National Fertility and Family Planning Survey, China: Selected Research Papers in English.* Compiled by the State Family Planning Commission of China and the United States Centres for Disease Control and Prevention. Atlanta, Georgia: CDC.

Kaufmann, Joan, and others (1989). Family planning policy and practice in China: a study of four rural counties. *Population and Development Review* (New York), vol. 15, No. 4 (December), pp. 707-729.

Rigdon, S. M. (1996). Abortion law and practice in China: an overview with comparisons to the United States. *Social Science and Medicine*, vol. 42, No. 4 (February), pp. 543-560.

Rylko-Bauer, B. (1996). Abortion from a cross-cultural perpsective: an introduction. *Social Science and Medicine*, (February), pp. 479-482.

Sichuan People's Congress (1988). Sichuan provincial birth planning rules. *Population and Development Review*. vol. 14, No. 2 (June), pp. 370-375.

Tietze, Christopher, and Stanley K. Henshaw (1986). *Induced Abortion: A World Review, 1986*. New York: The Alan Guttmacher Institute.

Tuan, Chi-hsieh (1988). China. In *International Handbook on Abortion*, Paul Sachdev, ed. New York: Greenwood Press.

United Nations Fund for Population Activities (1979). *Survey of Laws on Fertility Control*. New York.

_________ (1987). *Annual Review of Population Law, 1984*, vol. 11. New York: UNFPA; Boston, Massachusetts: Harvard Law School Library.

_________ (1989). *Annual Review of Population Law, 1986*, vol. 13. New York: UNFPA; Boston, Massachusetts: Harvard Law School Library.

United Nations Population Fund (1990). *Annual Review of Population Law, 1987*, vol. 14. New York: UNFPA; Boston, Massachusetts: Harvard Law School Library.

Colombia

Berer, M. (1993). Making abortion safe and legal: the ethics and dynamics of change. *Reproductive Health Matters* (November), vol. 2, No. 2.

Eschen, A. (1997). New laws limit access to family planning in Colombia. *AVSC News*, vol. 35, No. 2 (Summer), pp. 1, 8.

Government of Colombia, Constitutional Court (1994). Decision No. C-133/94, 17 March 1994. Jurisprudencia y Doctrina, vol. 23, No. 270 (June), pp.745-758.

Government of Colombia, Constitutional Court (1997). Decision No. C-013/97, 23 January 1997. Jurisprudencia y Doctrina, vol. 26, No. 304 (April), pp. 437-457.

International Planned Parenthood Federation (1982). Illegal Abortion in Latin America. *IPPF Medical Bulletin*, vol. 16, No. 4.

_________ (1999). Country Profile: Colombia . (http://www.ippf.org/regions/countries /alb/index.htm). Accessed on 1 October 1999.

Latin American and Caribbean Women's Health Network (1998). *The Cairo Consensus: Women Exercising Citizenship Through Monitoring: Review of Five Latin American Countries*. (Santiago: LACWHN).

Marthe Zapata, Leonello (1994). El aborto en Colomia y en otros paises: aspectos medico-juridicos. Santafe de Bogotá: Grijalbo.

Portugal, A. M., and Amparo Claro (1988). Latin America: virgin and martyr. In *Maternal Mortality: A Call to Action*, Marge Berer, ed. Special Issue. International Day of Action for Women's Health (28 May), Amsterdam: Women's Global Network on Reproductive Rights.

Posada, C. (1997). Abortion: a social, legal and juridical debate of the first order in Colombia. *Reproductive Health Matters* (May), vol. 5, No. 9, pp.147-148.

Remez, L.C. (1995). Confronting the reality of abortion in Latin America. *International Family Planning Perspectives*, vol. 21, No. 1, (March), pp. 32-36.

Singh, S. and G. Sedgh (1997). The relationship of abortion trends in contraception and fertility in Brazil, Colombia and Mexico. *International Family Planning Perspectives*, vol. 23, No. 1.

United Nations Fund for Population Activities (1979). *Survey of Laws on Fertility Control.* New York.

_________ (1980). *Annual Review of Population Law, 1980.* New York: UNFPA; Boston, Massachusetts: Harvard Law School Library.

Uriza Gutiérrez, G. (1982). *Manual de anticoncepcion.* Monografías de la Corporación Centro Regional de Población, vol. 17. Bogotá, Colombia: Corporación Centro Regional de Población.

Viel, Benjamin (1988). Latin America. In *International Handbook on Abortion*, Paul Sachdev, ed. New York: Greenwood Press.

Weisner, M. (1990). Induced abortion in Chile with references to Latin American and the Caribbean countries. Paper prepared for the Annual Meeting of the Population Association of America, Toronto, Canada, 3-5 May 1990.

Comoros

International Planned Parenthood Federation (1986). *Family Planning in Five Continents.* London.

United Nations Fund for Population Activities (1989). *Annual Review of Population Law, 1986*, vol. 13. New York: UNFPA; Boston Massachusetts: Harvard Law School Library.

Congo

Congo, Ministère de la santé et des affaires sociales (1984). Les avortements provoqués en Republique populaire du Congo. Direction de la santé maternelle et infante et de l'éducation pour la santé. Unpublished manuscript.

International Planned Parenthood Federation (1999). Country Profile: Congo. (http://www.ippf.org/regions/countries/alb/index.htm). Accessed on 15 October 1999.

Samba, J. (1982). Rapport d'enquête socio-demographique. Mission effectuée du 2 au 18 mai 1982 à Pointe-Noire. Project FNUAP CNG/MCH/001. Unpublished.

United Nations. Economic Commission for Africa (1993). Population policies and programmes in the member States of the Economic Commission for Africa. In *Population Policies and Programmes: Proceedings of the United Nations Expert Group Meeting on Population Policies and Programmes*, Cairo, 12-16 April 1992. ST/ESA/ SER.R/128.

United Nations Fund for Population Activities (1979). *Survey of Laws on Fertility Control.* New York.

United Nations Population Fund (2000). Inventory of population projects in developing countries around the world, 1997: multilateral organization assistance, bilateral agency assistance, and non-governmental or other organizational assistance. Unpublished document.

Costa Rica

Asociación Demográfica Costarricense (1987). *Encuesta Nacional de Fecundidad y Salud: Costa Rica, 1986.* San José, Costa Rica: Asociación Demográfica Costarricense; and Columbia, Maryland: Westinghouse Health Systems.

Low, S. M., and B. C. Newman (1985). Indigenous fertility regulating methods in Costa Rica. In *Women's Medicine: A Cross-Cultural Study of Indigenous Fertility Regulation*, Lucille F. Newman and James M. Nyce, eds. New Brunswick, New Jersey: Rutgers University Press.

Sosa, D. et al. (1987). *The Costa Rica Fertility and Health Survey, 1986.* Costa Rica: Asociación Demográfica Costarricense, and Atlanta, Georgia: CDC.

Viel, Benjamin (1988). Latin America. In *International Handbook on Abortion*, Paul Sachdev, ed. New York: Greenwood Press.

United Nations Fund for Population Activities (1979). *Survey of Laws on Fertility Control.* New York.

United Nations Population Fund (1990). *Annual Review of Population Law, 1987*, vol. 14. New York.

United Nations Population Fund (1998). *Reply of the Costa Rican Government to UNFPA's Inquiry of Country level Experience since ICPD.*

World Health Organization (1972). *International Digest of Health Legislation* (Geneva), vol. 23, No. 1, pp. 63.

_________ (1975). *International Digest of Health Legislation* (Geneva), vol. 26, No. 1, p. 61.

Côte d'Ivoire

International Planned Parenthood Federation (1999). Country Profile: Côte d'Ivoire. (http://www.ippf.org/regions /countries/alb/index.htm). Accessed on 15 October 1999.

United Nations Fund for Population Activities (1979). *Survey of Laws on Fertility Control.* New York.

_________ (1982). *Annual Review of Population Law, 1982*, vol. 9. New York: UNFPA; Boston, Massachusetts: Harvard Law School Library.

_________ (1989). *Annual Review of Population Law, 1986*, vol. 13. New York.

United Nations Population Fund (2000). Inventory of population projects in developing countries around the world, 1997: multilateral organization assistance, bilateral agency assistance, and non-governmental or other organizational assistance. Unpublished document.

World Health Organization (1983). *International Digest of Health Legislation* (Geneva), vol. 34, No. 1, pp. 75-76.

Croatia

Andolšek, Lidija (1988). Yugoslavia. In *International Handbook on Abortion*, Paul Sachdev, ed. New York: Greenwood Press.

Cook, Rebecca J. (1989). Abortion laws and policies: challenges and opportunities. In Women's health in the third world: the impact of unwanted pregnancy. A. Rosenfield and others, eds. *International Journal of Gynecology and Obstetrics*, Limerick, Ireland, Supplement No. 3, pp. 61-87.

Cook, Rebecca J., and Bernard M. Dickens (1988). International developments in abortion laws: 1977-88. *American Journal of Public Health* (Washington, D.C.), vol. 78, No. 10 (October), pp. 1305-1311.

David, Henry P., and Robert J. McIntyre (1981). *Reproductive Behavior: Central and Eastern European Experience.* New York: Springer Publishing Company.

Kapor-Stanulovic, Nila (1989). Liberal approach for a patchwork population. *People* (London), vol. 16, No. 3, pp. 16-18.

_________ (1990). Political changes in Yugoslavia and family planning, *Planned Parenthood in Europe* (London), vol. 19, No. 2 (September).

Malacic, Janez (1989). Family planning, population policy and declining birth rates in Yugoslavia. *Planned Parenthood in Europe* (London), vol. 18, No. 2 (September).

Royston, Erica, and Sue Armstrong, eds. (1989). *Preventing Maternal Deaths*. Geneva: World Health Organization.

United Nations Population Fund (1979a). *Annual Review of Population Law, 1978.* New York: UNFPA; Boston, Massachusetts: Harvard Law School Library.

_________ (1979b). *Survey of Laws on Fertility Control.* New York.

World Health Organization (1970). Comparative health legislation: abortion laws. In *International Digest of Health Legislation* (Geneva), vol. 21, No. 3, pp. 437-512.

________, Regional Office for Europe (1990). Yugoslavia. *Entre nous: The European Family Planning Magazine* (Copenhagen, Denmark), No. 16 (September), pp. 11-12.

Cuba

Alvarez-Lajonchere, Celestino (1989). Commentary on abortion law and practice in Cuba. In Women's health in the third world: the impact of unwanted pregnancy, A. Rosenfield and others, eds. *International Journal of Gynecology and Obstetrics* (Limerick, Ireland), Special supplement, No. 3, pp. 93-95.

Catasus. S., and others (1988). *Cuban women: changing roles and population trends.* Women, Work and Development, Monograph No. 17. Geneva: International Labour Office.

David, Henry P. (1983). Cuba: low fertility, relatively high abortion. *Intercom* Washington, D.C.(July/August).

Government of Cuba (1998). Estadísticas de Salud. Havana: Instituto Nacional de Estadística.

Hollerbach, Paula (1988). Cuba. In *International Handbook on Abortion,* Paul Sachdev, ed. New York: Greenwood Press.

Nebreda-Moreno, M., and O. Avalos-Triana (1986). El aborto como causa de mortalidad materna en 3 provincias seleccionadas, años 1979-1982. *Revista Cubana de Administración de Salud* (Havana), vol. 12, No. 3 (julio/septiembre), pp. 213-219.

Soza, Miguel, and others (1990). Abortion in Cuba, 1989. Paper prepared for the Annual Meeting of the Population Association of America, Toronto, Canada, 3-5 May.

United Nations Fund for Population Activities (1979). *Annual Review of Population Law, 1979.* New York: UNFPA, Boston, Massachusetts: Harvard Law School Library.

United Nations Population Fund (1998a). Inventory of population projects in developing countries around the world, 1997: multilateral organization assistance, bilateral agency assistance, and non-governmental or other organizational assistance. Unpublished document.

United Nations Population Fund (1998b). The State of the World Population – The New Generations, UNFPA: New York.

________ (1988). *Annual Review of Population Law,* vol. 15. New York.

Cyprus

Cook, Rebecca J., and Bernard M. Dickens (1986). *Issues in Reproductive Health Law in the Commonwealth.* London: Commonwealth Secretariat.

International Advisory Committee on Population and Law (1976). *Annual Review of Population Law, 1975.* Law and Population Monograph Series, No. 39. Medford, Massachusetts: Tufts University, The Fletcher School of Law and Diplomacy.

United Nations Fund for Population Activities (1979). *Survey of Laws on Fertility Control.* New York.

________ (1987) *Annual Review of Population Law, 1984,* vol. 11. New York.

United Nations Population Fund (2000). Inventory of population projects in developing countries around the world, 1997: multilateral organization assistance, bilateral agency assistance, and non-governmental or other organizational assistance. Unpublished document.

World Health Organization (1987). *International Digest of Health Legislation* (Geneva), vol. 38, No. 2, pp. 262-263.

Czech Republic

Hecht, Jacqueline (1987). La législation de l'avortement en Europe de l'Est et l'Unión Sovietique. *Politiques de population: études et documents* (Louvain-la-Neuve, Belgium), vol. III, No. 1 (juin), pp. 89-105.

Heddy, Julian (1989). Czechoslovakia: still not out of the closet. *People* (London), vol. 16, No. 3, pp. 19-20.

Henshaw, Stanley K. (1990). Induced abortion: a world review, 1990. In *Induced Abortion: A World Review, 1990 Supplement,* by Stanley K. Henshaw and Evelyn Morrow. New York: The Alan Guttmacher Institute.

International Planned Parenthood Federation (1999). Country Profile: Czech Republic. (http://www.ippf.org/regions/countries/alb/index.htm). Accessed on 15 October 1999.

Šrácek, Jii. (1988). Czechoslovakia. In *International Handbook on Abortion,* Paul Sachdev, ed. New York: Greenwood Press.

Tietze, Christopher, and Stanley K. Henshaw (1986). *Induced Abortion: A World Review, 1986.* New York: The Alan Guttmacher Institute.

United Nations Fund for Population Activities (1980). *Annual Review of Population Law, 1980.* New York: UNFPA, Boston, Massachusetts: Harvard Law School Library.

World Health Organization (1974). *International Digest of Health Legislation* (Geneva), vol. 25, No. 1, pp. 71-88.

__________ (1975). *International Digest of Health Legislation* (Geneva), vol. 26, No. 3, p. 511.

__________ (1982). *International Digest of Health Legislation* (Geneva), vol. 33, No. 3, p. 491-493.

__________ (1983). *International Digest of Health Legislation* (Geneva), vol. 34, No. 4, p. 757-758.

__________ (1988). *International Digest of Health Legislation* (Geneva), vol. 39, No. 3, p. 642-645.

Democratic Republic of Congo

Henshaw, Stanley K., and Evelyn Morrow (1990). *Induced Abortion: A World Review, 1990 Supplement.* New York: The Alan Guttmacher Institute.

Royston, Erica, and Sue Armstrong, eds. (1989). *Preventing Maternal Deaths.* Geneva: World Health Organization.

Tietze, Christopher, and Stanley K. Henshaw (1986). *Induced Abortion: A World Review, 1986.* New York: The Alan Guttmacher Institute.

United Nations, Economic Commission for Africa (1985). Le droit et la condition de la femme au Zaïre. Série de recherche. E/ECA/ATRCW/85/02.

United Nations Population Fund (1979). *Survey of Laws on Fertility Control.* New York: UNFPA, Boston, Massachusetts: Harvard Law School Library.

United Nations Population Fund (1986). *Annual Review of Population Law, 1986,* vol. 13. New York: UNFPA, Boston, Massachusetts: Harvard Law School Library.

__________ (1991). *Annual Review of Population Law, 1988,* vol. 15. New York: UNFPA, Boston, Massachusetts: Harvard Law School Library.

World Health Organization (1970). Comparative health legislation: abortion laws. *International Digest of Health Legislation* (Geneva), vol. 21, No. 3, pp. 437-512.

__________ (1977). *International Digest of Health Legislation* (Geneva), vol. 28, No. 3, p. 697.

__________ (1990). Safe motherhood: abortion. A tabulation of available data on the frequency and mortality of unsafe abortion. Geneva. Unpublished report.

Democratic People's Republic of Korea

United Nations (1982). *World Population Trends and Policies: Monitoring Report*, vol. II, *Population Policies*. Population Studies, No. 79. Sales No. E.82.XIII.3.

Yunde, Liu (1989). *Trip Report: Visit to Democratic People's Republic of Korea.* New York: United Nations Population Fund.

Denmark

Glendon, Mary Ann (1987). *Abortion and Divorce in Western Law.* Cambridge, Massachusetts: Harvard University Press.

Heisterberg, Lars (1988). Denmark. In *International Handbook on Abortion*, Paul Sachdev, ed. New York: Greenwood Press.

Henshaw, Stanley K. (1990). Induced abortion: a world review, 1990. In *Induced Abortion: A World Review, 1990 Supplement*, by Stanley K. Henshaw and Evelyn Morrow. New York: The Alan Guttmacher Institute.

Tietze, Christopher, and Stanley K. Henshaw (1986). *Induced Abortion: A World Review, 1986.* New York: The Alan Guttmacher Institute.

Knudsen, L. B., and I. Tanska (1988). Legalt prouskerede aboster 1987 (Legal induced abortions in 1987). *Ugeskrift for Laeger*, vol. 150, No. 40 (3 October), pp. 2406-2407.

World Health Organization (1970). *International Digest of Health Legislation* (Geneva), vol. 21, No. 3, pp. 572-576.

__________ (1973). *International Digest of Health Legislation* (Geneva), vol. 24, No. 4, pp. 773-777.

__________ (1975). *International Digest of Health Legislation* (Geneva), vol. 26, No. 1, pp. 95-97.

__________ (1976). *International Digest of Health Legislation* (Geneva), vol. 27, No. 1, p. 113.

__________ (1986). *International Digest of Health Legislation* (Geneva), vol. 37, No. 4, pp. 792.

Djibouti

International Planned Parenthood Federation (1986). *Family Planning in Five Continents*. London.

__________ (1999). Country Profile: Djibouti. (http://www.ippf.org/regions/countries /alb/index.htm). Accessed on 15 October 1999.

Jones, C., and M. Wilkenson (1986). *Population Policy Brief: Djibouti.* Demographic Data for Development. Columbia, Maryland: Institute for Resource Development.

United Nations Population Fund (2000). Inventory of population projects in developing countries around the world, 1997: multilateral organization assistance, bilateral agency assistance, and non-governmental or other organizational assistance. Unpublished document.

Dominica

Cook, Rebecca J., and Bernard M. Dickens (1979). Abortion laws in Commonwealth countries. *International Digest of Health Legislation* (Geneva), vol. 30, No. 2, p. 395-502.

__________ (1986). *Issues in Reproductive Health Law in the Commonwealth.* London: Commonwealth Secretariat.

Epps, Roselyn P., and others (1986). Family life education in the English-speaking Caribbean. *Journal of Community Health* (New York), vol. 11, No. 1 (Spring), pp. 70-74.

International Planned Parenthood Federation (1986). *Family Planning in Five Continents.* London.

________ (1990). *Caribbean Contraceptive Prevalence Surveys, No. 8: Dominica.* New York: IPPF/Western Hemisphere Region:

________ (1999). Country Profile: Dominica. (http://www.ippf.org/regions/countries /alb/index.htm). Accessed on 15 October 1999.

Dominican Republic

Centro de Estudios Demográficos y Sociales (CESDEM) (1997). *Encuesta Demográfica y de Salud 1996.* Santo Domingo: CESDEM, PROFAMILIA and Oficina Nacional de Planificación (ONAPLAN); Columbia, Maryland: Macro International, Inc.

International Planned Parenthood Federation (1999). Country Profile: Dominican Republic. (http://www.ippf.org /regions/countries /alb/index.htm). Accessed on 15 October 1999.

Paiewonsky, Denise (1988). *El Aborto en la Républica Dominicana.* Santo Domingo: Centro de Investigación para la Acción Femenina.

________ (1990). *Determinantes Sociales y Consecuencias del Aborto Inducido en la República Dominicana.* Santo Domingo: PROFAMILIA, Instituto de Estudios de Población y Desarrollo.

United Nations Fund for Population Activities (1979). *Survey of Laws on Fertility Control.* New York.

Ecuador

Ecuador (1971). Regimen Penal Ecuatoriano. Título VI, cap. I, De los delitos contra la vida, arts. 441-447.

International Planned Parenthood Federation (1999). Country Profile: Ecuador. (http://www.ippf.org/regions/countries /alb/index.htm). Accessed on 1 October 1999.

Monteith, Richard S., and others (1992). *Ecuador Family Planning and Child Survival Survey, 1989: Final English Language Report.* Atlanta, Georgia: CDC.

Pan American Health Organization (1990). *Health Conditions in the Americas: 1990 Edition*, vol. I. Scientific Publication No. 524. Washington, D.C.

United Nations Fund for Population Activities (1977). *Annual Review of Population Law, 1977.* New York: UNFPA; Boston, Massachusetts: Harvard Law School Library.

________ (1989). *Annual Review of Population Law, 1986*, vol. 13. New York.

United Nations Population Fund (2000). Inventory of population projects in developing countries around the world, 1997: multilateral organization assistance, bilateral agency assistance, and non-governmental or other organizational assistance. Unpublished document.

United Nations Population Fund (1998). *Resource Requirements for Population and Reproductive Health Programme:- Country Profiles for Population Assistance.* New York.

United States of America (1991). Ecuador contraceptive prevalence and health survey, 1989: preliminary tables. Atlanta, Georgia: CDC.

Viel, Benjamin (1988). Latin America. In *International Handbook on Abortion*, Paul Sachdev, ed. New York: Greenwood Press.

Weisner, Monica (1990). Induced abortion in Chile with reference to Latin American and the Caribbean countries. Paper prepared for the Annual Meeting of the Population Association of America, Toronto, Canada, 3-5 May.

World Health Organization (1990). Maternal health and safe motherhood programme: progress report, 1987-1990. Division of Family Health. WHO/MCH/90.11. Geneva.

Egypt

Al Dakkak, Mohamed S. (1987). The interaction between the legislative policy and the population problem in Egypt. *Population Bulletin of ESCWA*, No. 30 (June).

El-Ghamry, A., and S. Soliman (1987). Levels and differentials in pregnancy wastage. In *Maternal Health and Mortality in Egypt*. Egyptian Central Agency for Public Mobilization and Statistics, Population Studies and Research Centre.

El Moiz Nigm, Abd (1986). Human rights and health care. Cairo: Assuit University Faculty of Law.

International Planned Parenthood Federation (1999). Country Profile: Egypt. (http://www.ippf.org/regions/countries /alb/index.htm). Accessed on 15 October 1999.

Tellenbach, Silvia (1989). Ägypten. In Schwangerschaftsabbruch im internationalen Vergleich: Rechtliche Regelungen-Soziale Rahmenbedingungen-Empirische Grunddaten,Albin Eser and Hans-Georg Koch, eds. Baden-Baden, Germany: Nomos Verlagsgesellschaft. Teil 2. Außereuropa.

United Nations (1998). *World Population Monitoring 1996: Selected Aspects of Reproductive Rights and Reproductive Health.* Sales No. E.97.XIII.5

United Nations Fund for Population Activities (1979). *Survey of Laws on Fertility Control.* New York.

United Nations Population Fund (2000). Inventory of population projects in developing countries around the world, 1997: multilateral organization assistance, bilateral agency assistance, and non-governmental or other organizational assistance. Unpublished document.

El Salvador

Asociación Demográfica Salvadoreña, and Institute for Resource Development (1987). El Salvador: Encuesta Nacional de Salud Familiar: FESAL-1985. Columbia, Maryland: Institute for Resource Development/Westinghouse.

El Salvador (1997a). Código Penal, 1997. *Diario Oficial*, 10 June 1997.

El Salvador (1997b). Recopilación de Nuevas Leyes Penales. San Salvador: Ministry of Justice, 1997.

International Advisory Committee on Population and Law (1974). *Annual Review of Population Law, 1974.* Medford, Massachusetts: Tufts University, The Fletcher School of Law and Diplomacy.

International Planned Parenthood Federation (1999). Country Profile: El Salvador. (http://www.ippf.org/regions/countries /alb/index.htm). Accessed on 15 October 1999.

Monteith, Richard S. et al. (1992). *El Salvador: Family Planning and Child Survival Survey 1989: Final English Language Report.* Centres for Disease Control and Prevention, Atlanta, Georgia. CDC.

Morris, Leo, and others (1979). Contraceptive use and demographic trends in El Salvador. *Studies in Family Planning* (New York), vol. 10, No. 2 (February), pp. 43-49.

United Nations Fund for Population Activities (1979). *Survey of Laws on Fertility Control.* New York.

United Nations Population Fund (1998a). *Inventory of Population Projects in Developing Countries Around the World 1997.* Sales No. E.97.III.H.1.

United Nations Population Fund (1998b). *Resource Requirements for Population and Reproductive Health Programmes: Programme Country Profiles for Population Assistance.* New York: UNFPA.

Viel, Benjamin (1988). Latin America. In *International Handbook on Abortion,* Paul Sachdev, ed. New York: Greenwood Press.

World Health Organization (1972). *International Digest of Health Legislation* (Geneva), vol. 27, No. 3, pp. 535-536.

Equatorial Guinea

United Nations (1990). United Nations Population Fund: proposed projects and programmes: assistance to the Government of Equatorial Guinea: support for a comprehensive population programme/recommendation by the Executive Director. DP/FPA/CP/63.

United Nations Population Fund (2000). Inventory of population projects in developing countries around the world, 1997: multilateral organization assistance, bilateral agency assistance, and non-governmental or other organizational assistance. Unpublished document.

Eritrea

Haile, Daniel, and Erku Yimer (1976). *Law and Population Growth in Ethiopia*. Law and Population Monograph Series, No. 35. Medford, Massachusetts: Tufts University, The Fletcher School of Law and Diplomacy.

Henshaw, Stanley K., and Evelyn Morrow (1990). *Induced Abortion: A World Review, 1990 Supplement*. New York: The Alan Guttmacher Institute.

Tietze, Christopher, and Stanley K. Henshaw (1986). *Induced Abortion: A World Review, 1986*. New York: The Alan Guttmacher Institute.

United Nations Fund for Population Activities (1979). *Survey of Laws on Fertility Control*. New York.

Estonia

Hecht, Jacqueline (1987). La Législation de l'avortement en Europe de l'Est et en Union Soviétique. *Politiques de population: études et documents* (Louvain-la-Neuve, Belgium), vol. III, No. 1 (juin), pp. 89-105.

United Nations Fund for Population Activities (1979). *Survey of Laws on Fertility Control*. New York.

World Health Organization (1990). Family planning in the USSR. *Entre nous* (Geneva), No. 16 (September).

Ethiopia

Haile, Azbaha (1990). Fertility conditions in Gondar, northwestern Ethiopia: an appraisal of current status. *Studies in Family Planning* (New York), vol. 21, No. 2 (March/April), pp. 110-118.

Haile, Daniel, and Erku Yimer (1976). *Law and Population Growth in Ethiopia*. Law and Population Monograph Series, No. 35. Medford, Massachusetts: Tufts University, The Fletcher School of Law and Diplomacy.

Kwast, Barbara E., Roger W. Rochat and Widad Kidane-Mariam (1986). Maternal mortality in Addis Ababa, Ethiopia. *Studies in Family Planning* (New York), vol. 17, No. 3 (November/December), pp. 288-301.

International Federation of Women Lawyers of Kenya, and the Centre for Reproductive Law and Policy (1997). *Women of the World: Laws and Policies Affecting their Reproductive Lives*. New York: Centre for Reproductive Rights.

International Planned Parenthood Federation (1999). Country Profile: Ethiopia. (http://www.ippf.org/regions/countries/alb/index.htm). Accessed on 15 October 1999.

United Nations Fund for Population Activities (1979). *Survey of Laws on Fertility Control*. New York.

United Nations Population Fund (1998). *Inventory of Population Projects in Developing Countries Around the World 1997*. Sales No. E.97.III.H.1.

Yoseph, S., and G. Kifle (1988). A six-year review of maternal mortality in a teaching hospital in Addis Ababa. *Ethiopian Medical Journal* (Addis Ababa), vol. 26, No. 3 (July), pp. 115-120.

Fiji

Anonymous (1977). Law clarified. *People* (London), vol. 4, No. 1, p. 39.

Cook, Rebecca J., and Bernard M. Dickens (1979). Abortion laws in Commonwealth countries. *International Digest of Health Legislation* (Geneva), vol. 30, No. 2, pp. 395-502.

International Planned Parenthood Federation (1999). Country Profile: Fiji. (http://www.ippf.org/regions/countries/alb /index.htm). Accessed on 15 October 1999.

United Nations (1998). *World Population Monitoring 1996: Selected Aspects of Reproductive Rights and Reproductive Health.* Sales No. E.97.XIII.5

United Nations Fund for Population Activities (1979). *Survey of Laws on Fertility Control.* New York.

United Nations Population Fund (2000). Inventory of population projects in developing countries around the world, 1997: multilateral organization assistance, bilateral agency assistance, and non-governmental or other organizational assistance. Unpublished document.

________ (1990). *Annual Review of Population Law, 1987*, vol. 14. New York: UNFPA, Boston, Massachusetts: Harvard Law School Library.

Finland

Glendon, Mary Ann (1987). *Abortion and Divorce in Western Law.* Cambridge, Massachusetts: Harvard University Press

Henshaw, Stanley K. (1990). Induced abortion: a world review, 1990. In *Induced Abortion: A World Review, 1990 Supplement*, by Stanley K. Henshaw and Evelyn Morrow. New York: The Alan Guttmacher Institute.

International Planned Parenthood Federation (1999). Country Profile: Finland. (http://www.ippf.org/regions /countries/alb /index.htm). Accessed on 15 October 1999.

Niemelä, P. (1988). Finland. In *International Handbook on Abortion,* Paul Sachdev, ed. New York: Greenwood Press.

Ritamies, M. (1986). Legal abortions in Finland and some other selected countries. *Yearbook of Population Research in Finland*, vol. 24. Helsinki: The Population Research Institute.

World Health Organization (1970). *International Digest of Health Legislation* (Geneva), vol. 21, No. 4, pp. 700-701.

________ (1979). *International Digest of Health Legislation* (Geneva), vol. 30, No. 1, p. 31.

________ (1988). *International Digest of Health Legislation* (Geneva), vol. 39, No. 3, p. 645.

France

Enigli, M. and Perthold, S. (1993). Der weibliche Korper als Schlachtfeld: neue Beitrage zur Abtreibungsdiskussion. (The female body as a battlefield: new Contributions to the abortion discussion). Vienna, Austria: Promedia, 208 p. .

Glendon, Mary Ann (1987). *Abortion and Divorce in Western Law.* Cambridge, Massachusetts: Harvard University Press.

Henshaw, Stanley K. (1990). Induced abortion: a world review, 1990. In *Induced Abortion: A World Review, 1990 Supplement*, by Stanley K. Henshaw and Evelyn Morrow. New York: The Alan Guttmacher Institute.

International Advisory Committee on Population and Law (1974). *Annual Review of Population Law, 1974.* Medford, Massachusetts: Tufts University, The Fletcher School of Law and Diplomacy.

International Planned Parenthood Federation (1989). France: late abortion. *Planned Parenthood in Europe* (London), vol. 18, No. 1 (Spring), pp. 6-8.

International Planned Parenthood Federation (1999). Country Profile: France. (http://www.ippf.org/regions /countries/alb /index.htm). Accessed on 15 October 1999.

Klitsch, Michael (1989). RU486: The Science and the Politics. New York: The Alan Guttmacher Institute.

United Nations Fund for Population Activities (1979). *Annual Review of Population Law, 1979,* vol. 6. New York.

_________ (1982). *Annual Review of Population Law, 1982*, vol. 9. New York.

World Health Organization (1979). *International Digest of Health Legislation* (Geneva), vol. 30, No. 4, p. 803.

_________ (1980). *International Digest of Health Legislation* (Geneva), vol. 31, No. 3, pp. 505-507.

_________ (1989). *International Digest of Health Legislation* (Geneva), vol. 40, No. 1, pp. 79-80.

_________ (1990). *International Digest of Health Legislation* (Geneva), vol. 41, No. 3, p. 449.

Wolf, Bernard (1973). *Anticontraception Laws in Sub-Saharan Francophone Africa: Sources and Ramifications*. Law and Population Monograph Series, No. 15. Medford: Massachusetts: Tufts University, The Fletcher School of Law and Diplomacy.

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