THE ALAN GUTTMACHER INSTITUTE

SHARING RESPONSIBILITY

WOMEN SOCIETY & ABORTION WORLDWIDE

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Contents

Preface

Two recent United Nations meetings—the 1994 International Conference on Population and Development, in Cairo, and the 1995 Fourth World Conference on Women, in Beijing—devoted an unprecedented, perhaps even disproportionate, amount of time to discussion about abortion. The topic dominated the news and media coverage of both events, dwarfing their considerable achievements in gaining consensus on other important aspects of reproductive health and the advancement of women. Why did this occur?

A partial answer, surely, can be found in the media's natural affinity for controversy. The confrontation over abortion had the singular attraction, in media terms, of pitting a powerful all-male entity—the Holy See, the only religious body with formal representation at the United Nations—against women and their right to self-determination.

It would be absurd to downplay the Vatican's influence over the governments of many countries, or its ability at these and other international conferences (those on human rights and war crimes, for example) to form alliances with other religious and conservative forces. Nevertheless, these political realities are not sufficient to explain the intense level of interest in abortion demonstrated at the Cairo and Beijing conferences. After all, abortion has been with us from time immemorial.

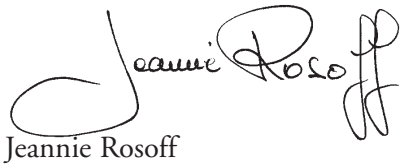
Another possible factor is the remarkably high level of participation at these meetings by nongovernmental organizations and the presence of thousands of women at huge meetings running parallel to the official conferences. Unprecedented, as well, was the level of representation of civic groups, private individuals and, again, women in the ranks of the official delegations.

This is not to imply that participation by nongovernmental organizations—or, for that matter, by women—necessarily ensured a consistently sympathetic approach to abortion or unanimity of views among the participants. Indeed, some of these representatives' vociferous opposition to abortion may have indirectly contributed to its inclusion on the agendas of these two meetings.

Given the wide differences separating the opposing viewpoints, it would have been surprising if a firm consensus on abortion had been achieved. Indeed, the final statement of the Cairo conference is somewhat ambiguous in its recommendations, probably satisfying no one. But for the first time at an international gathering of this size and scope, the subject was broached openly and in all of its complexity. No one came forward to claim that abortion does not occur in his or her country or community, and this tacit acknowledgment of the situation alone was a revolutionary accomplishment.

For centuries, abortion has been kept, literally and figuratively, in the back alleys of society, considered unfit for public discussion or mention. For years, women undergoing clandestine abortions have had to suffer their pain in silence, and many have died or been maimed as a result. Their anguish, loneliness and enforced shame were finally recognized and given a public hearing at the Cairo and Beijing conferences. Since then, abortion has no longer been a topic that is only "for women," as if men played no role in the dilemma of unwanted pregnancy that millions of women around the world face every year.

Talk and conference recommendations, of course, are not enough. Every country and community must find a way to deal with what is now an acknowledged reality. We hope that by documenting that reality and presenting a compilation of what is known about abortion worldwide, this report will lead to greater understanding of, and more informed action on, a social and health issue of urgency to all—women, families and nations.



Jeannie Rosoff
President, The Alan Guttmacher Institute

Section 1

Introduction

CHAPTER 1

Induced Abortion: An Individual Decision, a Shared Responsibility

Whether and in what circumstances abortion should be legal is highly debated in many parts of the world, with arguments based on religious, moral, political, human rights and public health grounds. Given the emotionality of the debate, it is crucial to shed light on why, how many and under what conditions women around the world have abortions. With the best available information, individual countries and the international community can engage in a balanced discussion of how to both reduce the levels of unintended pregnancy that lead to abortion and deal with the sometimes deadly consequences of unsafe abortion for women in many of the world's poorest countries.

Abortion may arouse more mixed feelings and generate more fundamental disagreement than almost any other social or public health issue. The reasons are not hard to understand. Abortion is an issue subject to conflicting ethical views, sensitive to varying interpretations, and related to a large number of important and often divisive public policy concerns.

The idea that a woman might voluntarily choose to end a pregnancy makes many people uncomfortable and provokes outright hostility in some parts of the world. At the same time, health and human rights advocates argue that laws criminalizing abortion not only ignore the sometimes dire consequences of unwanted pregnancies but display a profound disregard for women's ability to make autonomous and moral decisions.

The broad profiles and positions of the major groups in the abortion debate are generally familiar. Religious affiliation is one of the most influential factors fueling the debate around the world. Indeed, some major religions condemn the practice. But in the United States, for example, abortion has become a divisive issue on political as well as religious grounds, as the contrasting positions of the major political parties demonstrate.

Furthermore, religious views and considerations of reproductive rights and health are not the only bases for either individual attitudes toward abortion or government policies and regulations concerning the procedure. In a few countries with highly centralized and usually authoritarian governments, abortion policy has sometimes been used to advance overall cultural, eugenic or demographic aims and imperatives.

In recent years, abortion policies have been applied to control population growth (in China) and to halt population decline (in Romania under the communist ruler Ceausescu). Currently, there is concern that abortion is being misused in some parts of Asia to prevent the birth of girl babies.

The freedom of individuals to make informed and voluntary decisions regarding childbearing must always be protected from coercive policies and unethical practices—regardless of their emphasis, origins or motivation. While condemning all extreme practices, this report focuses on more general situations facing women seeking abortion, and aims to move the debate toward a greater understanding of why so many women around the world have abortions and what societies can do about it.

By providing the most reliable facts available to describe and explain the determinants, levels and consequences of abortion in many parts of the world, The Alan Guttmacher Institute hopes to create a frame of reference for future discussion and action regarding this issue.

Pregnancy Is Not Always Planned or Welcomed

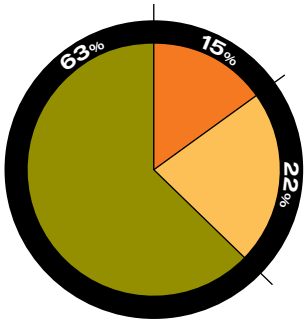
Some of the difficulty people have in dealing with abortion is related to their feelings and beliefs about the meaning of human life. On a simpler level, abortion troubles people who view most pregnancies and births as desirable events. Unfortunately, however, some women conceive when they do not wish to, and pregnancy is not always trouble-free.

It is instructive to consider the number of women who become pregnant each year and the outcome of these preg-

nancies. Every year, about 210 million women throughout the world discover that they are pregnant when they miss a menstrual period or have a positive pregnancy test (Chart 1.1).[1] Additionally, an unknown number become pregnant but are not aware of it because the pregnancy is lost in the first month or so of gestation.

By no means do all recognized pregnancies result in a live birth. Natural biological protections seem to ensure that pregnancies not likely to produce a viable life are interrupted early on. Worldwide, 15% of pregnant women spontaneously miscarry (largely within the second and third months of pregnancy, but some later) or experience a stillbirth. Another 22% end their pregnancy by abortion. Thus, only about two-thirds of known pregnancies each year—133 million—result in the birth of a baby.

Chart 1.1 **Worldwide, more than a third of pregnancies do not end in the birth of a baby.**



210 MILLION PREGNANCIES, 1999 (PROJECTED)

- Miscarriages and stillbirths
- Induced abortions
- Live births

SOURCE: reference 1.

Abortion Is a Response to Unplanned Pregnancy

While a pregnant woman has virtually no control over whether or not she experiences a miscarriage or stillbirth, an induced abortion is almost always the result of her decision that she is in no position to bring a child into the world. Her decision might be in response to any of a number of circumstances.

For some women, the choice to terminate an unwanted pregnancy may be shaped by broad social influences: the value placed on premarital chastity or marital fidelity, the unacceptability of childbearing outside marriage, or disapproval of having children late in life or too close together.

Induced abortion also touches upon some even more far-reaching aspects of community life: religious and cultural values, the law, the status of women and patterns of demographic change.

What is more, the conditions under which a woman obtains an abortion are often influenced by a country's abortion laws, the role of advocacy groups in influencing the formation and enforcement of those laws, and the availability and adequacy of health services.

Until quite recently, however, public discussion about induced abortion was largely off-limits in many countries and often avoided at the international level. But debate about abortion and its broad ramifications for women and for society has become both more common and more open.

This increased openness is due to a number of factors: the publication and dissemination of hundreds of mostly small, often hospital-based studies describing the health and financial toll of unsafe abortion in many parts of the world; the work of international agencies like the World Health Organization in documenting the impact of unsafe abortion on women's health and on maternal mortality; and the efforts of women's and human rights groups all over the world in bringing attention to inequities between countries and social classes in women's access to safe abortion.

Nevertheless, because much important information about abortion is still lacking or insufficient, one crucial aspect of the debate that often gets lost from view is the event that most commonly precedes it: an unplanned pregnancy. This report, therefore, begins by placing abortion in the broader context of factors that lead to unplanned pregnancy and a woman's decision to have an abortion. By documenting various aspects of abortion—laws, incidence and practice—it will argue that while unplanned pregnancy and unsafe abortion affect mainly women's lives, the responsibility for finding solutions must be shared by men, political leaders, health planners and professionals, communities and society at large.

Overall, the report addresses the following topics and questions (see also the box on page 8):

Unplanned Pregnancy

- What factors lead to unplanned pregnancy in both developing and developed countries?
- How common is unplanned pregnancy?
- What social, economic, health and personal considerations lead women to decide to end a pregnancy?

Induced Abortion

- What laws and administrative regulations pertaining to abortion are in force in various countries?
- How many induced abortions are performed around the world each year, what proportion of women in various countries are having abortions, and who are these women likely to be?
- What is the relationship between the legality and the safety of abortion?
- What are the quality and the availability of abortion services in settings where the procedure is legal?
- What are the quality and the availability of abortion services in settings where the procedure is severely restricted or prohibited by law?

■ What kinds of practitioners are involved in performing abortions in developing countries, and what methods do they—and women themselves—use?
■ How safe are modern abortion techniques, and what risks to women's life and health are posed by abortions performed outside medical settings?

Societal Responses and Responsibilities

■ What can countries do to reduce levels of unplanned pregnancy and to lessen the human toll from unsafe abortion?

About This Report

Unplanned pregnancy. The tables and charts on some of the major factors associated with unplanned pregnancy are based largely on available quantitative and qualitative information from three or four selected countries in each major world region. The focus is on 15 developing countries (Bangladesh, India, Indonesia and the Philippines in Asia; Egypt, Morocco and Tunisia in North Africa and the Middle East; Côte d'Ivoire, Kenya, Nigeria and Zimbabwe in Sub-Saharan Africa; and Brazil, Colombia, Mexico and Peru in Latin America) and three countries in the developed world (France, Japan and the United States). However, Appendix Table 1 contains information for an additional 31 developing countries.

Comparable measures are not always available for all 18 focal countries. In some cases, examples from other countries are added if they are the only data available, or if they illustrate or highlight important aspects of the analysis.

Induced abortion. Laws governing the official availability of abortion are documented for countries having populations of a million or more. The incidence of abortion–whether provided under legal, quasi-legal or clandestine conditions–is presented largely for countries in which abortion is legally permitted with few restrictions and the number of procedures is counted each year by an official government department; regional incidence is estimated, as is the incidence of abortion in some countries where the procedure is restricted or prohibited by law. Safe and unsafe abortion practices are described on the basis of existing research, which does not cover all parts of the world in the same depth.

Abortion practice is addressed primarily with illustrations from countries demonstrating general patterns. In some cases, however, countries are selected because they reveal particularly interesting or atypical conditions.

(See pages 12, 31 and 39 for more detailed information about the measures and data sources used.)

Section 2

Unplanned Pregnancy

CHAPTER 2

Sexual Intercourse and Reproductive Intentions: A Delicate Balance

Although women in much of the world commonly have sexual intercourse at very early ages and before or outside marriage, childbearing is often considered undesirable in these circumstances. Moreover, married couples almost everywhere increasingly want small families. Yet, for many reasons—inadequate access to contraceptive services, the poor quality of existing services, fear or distrust of methods, or conflict between partners about childbearing goals—many women who do not wish to become pregnant are not using an effective contraceptive, are not using a method correctly or are not using any method. And all contraceptive methods, even when used regularly and correctly, sometimes fail. Consequently, unplanned pregnancies occur in every society, and some proportion of women faced with an unplanned pregnancy decide to have an abortion. The reasons they give—primarily health, economic and relationship problems—are similar around the world.

At its most basic level, unplanned pregnancy results from a failure of the complex, often tricky, balancing act engaged in by most women (and men) to reconcile two aspects of their lives: sexual intercourse and the wish—or reluctance—to have children. Contraceptive use can mediate the tension between the two, but contraception is not always available, and all methods can fail.

However, people's attempts to reconcile sexual intercourse and the desire for children do not take place in a vacuum. The degree of control that a woman has over whether she has sexual intercourse and over when and how many children she has is often affected by her age, cultural and religious background, and social and economic position in society.

In addition to persistent and long-standing social and economic disparities between women and men, and between and within countries, and a highly inequitable distribution of the world's resources, some newer and perhaps even more destabilizing social forces have entered the picture. Civil wars, the resurgence of suppressed ethnic rivalries, organized genocide, famine, the virtual collapse of civil societies and the devastation wrought by AIDS in some countries—all are likely to disrupt and undermine the ability of men and women to control their own and their family's lives, including their reproductive lives.

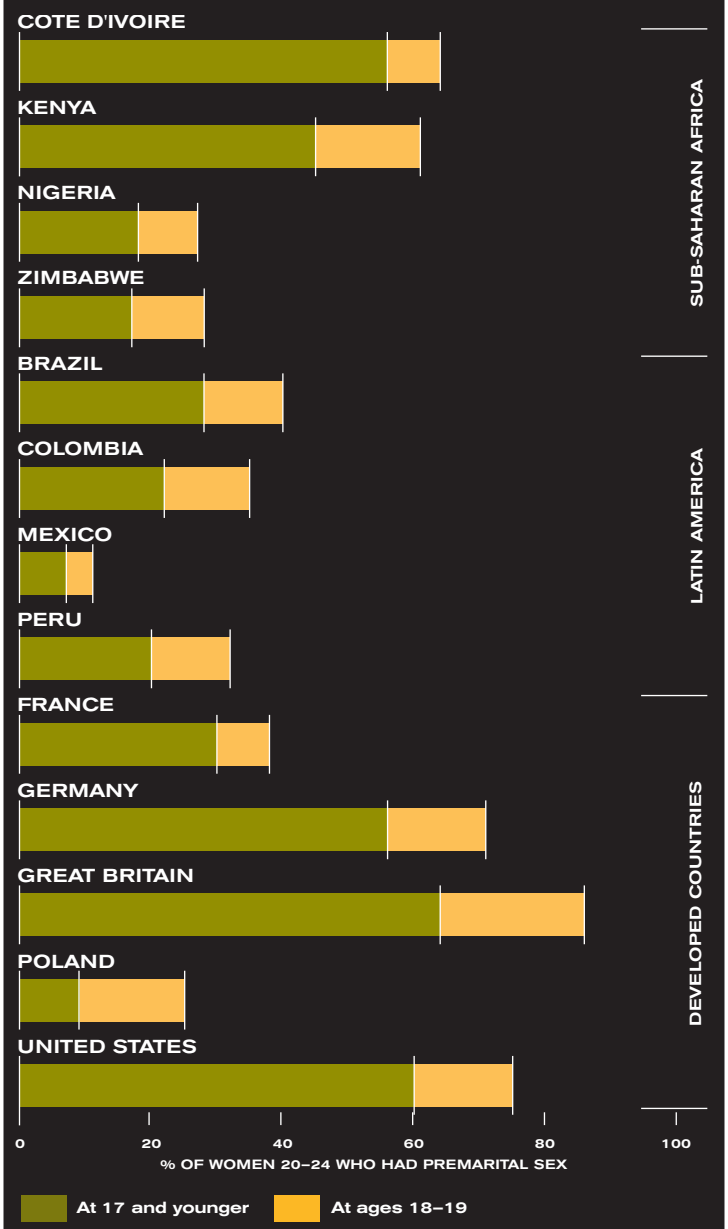
The reproductive consequences of sexual intercourse are more lasting and often far more serious for women than for men. In this section, therefore, we look at sexual intercourse, the desire for children and contraceptive use among women only (see box on page 12), to see what these measures can tell us about the probability—some might argue, the inevitability—that a certain level of unplanned pregnancy will always exist.

Pregnancies Resulting from Some Sexual Unions Are Likely to Be Unwanted

The physical expression of sexuality is fundamental and universal. What differs is how cultures, religions and societies construe and influence both the setting in which sexual intercourse between men and women occurs and the types of relationships in which pregnancy is encouraged or discouraged.

Most societies and most religions approve of sexual intercourse and childbearing only within marriage (defined here to include formal and consensual, or cohabiting, unions), and tend to discourage people from having sexual partners outside marriage. The stated ideal for most of the world is that a woman marries or starts to live with a man, they have children together, and the two do their best to stay in this union for the rest of their lives.

Chart 2.1 **Substantial proportions of adolescent women in some countries begin having sex before they marry.**



NOTES: In this and all subsequent charts, world regions are ordered as they appear in Appendix Table 1: Sub-Saharan Africa; North Africa and the Middle East; Asia; Latin America and the Caribbean; and developed countries. Within regions, countries are listed alphabetically. For this chart, data are not available for countries in North Africa, the Middle East and Asia. SOURCE: reference 2.

Yet in all societies, women and men have sexual intercourse before marriage and between marriages, as well as with partners other than their spouse. The extent to which they do so, however, varies among and within countries.

■ *Sexual intercourse before marriage.* Because of enormous variation in the social, cultural and economic factors determining when sexual intercourse and marriage are considered desirable or necessary for women, there are broad regional differences in the age at which girls start having intercourse and in the likelihood that their sexual lives will begin before or within marriage.

Sexual intercourse at quite young ages—as part of or apart from marriage—is common in many countries, developed and developing alike. In Bangladesh and India, for example, many girls are married before their 18th birthday.[1] In other developing countries, many women are younger than 18 and not married when they first have sexual intercourse—for instance, 56% in Côte d'Ivoire, 45% in Kenya and 22–28% in Brazil and Colombia (Chart 2.1).[2]

The premarital sexual behavior of Asian, Middle Eastern and North African women is largely undocumented. In these regions, a young woman having sexual intercourse before marriage would challenge strongly held social and religious values, and national surveys typically do not ask questions on this topic. However, this makes it all the more likely that a woman who breaks the taboo against premarital sexual intercourse will feel compelled to seek an abortion if she becomes pregnant.

In most developed countries, where early premarital intercourse is widespread, childbearing before marriage is likely to be considered unacceptable and undesirable—for the young woman herself and for society in general. Yet sexual intercourse at an early age and before marriage is much more prevalent now than it was a generation ago.[3] In many European countries and in the United States, the vast majority of young women first have sexual intercourse as adolescents (Table 2a), and mostly before marriage.[4]

Table 2a. **It is common in many developed countries for adolescents to begin having sex before age 18.**

Country	% of women 20–24, by age at first sex		
	Before 18	At ages 18–19	Before 20
BELGIUM	36	33	69
DENMARK	71	19	90
FINLAND	50	34	84
FRANCE	53	20	73
GERMANY	58	23	81
GREAT BRITAIN	64	23	87
ICELAND	72	16	88
NORWAY	59	25	84
POLAND	12	28	40
PORTUGAL	26	25	51
SWITZERLAND	40	36	76
UNITED STATES	63	18	81

Source: reference 4.

■ *Sexual intercourse outside marriage.* There are few, if any, societies in which extramarital relationships are unknown, even if this behavior goes mostly unmeasured. In recent years, because of growing concern about the heterosexual spread of HIV, some information has become available from special surveys carried out in a handful of countries. Concurrent sexual relationships with partners other than one's spouse or one's regular partner are common, especially in urban areas (Table 2b).[5]

Dissatisfaction with a marriage can lead to separation and divorce, which are common in the developed world and becoming increasingly so in developing countries, especially in Latin America and the Caribbean. Marriages also come to an end when a partner dies, and increasing numbers of young women are losing their husbands for this reason in areas where war or the AIDS epidemic is raging. However, the end of a marriage is not the end of the desire for intimacy, and separated, divorced and widowed women may become involved in nonmarital relationships.

In some parts of the world, the proportions of previously married women having sexual intercourse are surprisingly high—for instance, roughly one in seven in the Philippines, one in four in Mexico and Peru, and one in two or more in Brazil and the United States.[6] Even though societal disapproval of these relationships is probably eroding, few women in them are likely to want a child, given the difficulties of raising a child alone.

■ *Involuntary sexual intercourse.* Women are sometimes coerced into having sexual intercourse, especially if they are young, poor, uneducated or of low social status.[7] Even in the absence of physical force, women with no social or economic power often are unable to refuse the sexual advances of men who have power over them—employers, landlords, creditors, men of higher status or much older men, for example. And among women of all social classes, sexual coercion within marriage has begun to receive increased attention.

In parts of Africa, some adolescent women who want to

Table 2b. **In some areas, extramarital intercourse is quite common.**

Country	% with a recent extramarital relationship			
	Male		Female	
	Urban	Rural	Urban	Rural
SUB-SAHARAN AFRICA				
BURUNDI	10	4	3	1
CENTRAL AFRICAN REP.	23	10	7	3
COTE D'IVOIRE	51	41	16	9
GUINEA-BISSAU	42	35	27	14
KENYA	32	26	17	11
LESOTHO	45	40	20	19
TANZANIA	37	26	16	11
TOGO	22	17	1	1
ZAMBIA (LUSAKA)	33	u	10	u
ASIA				
PHILIPPINES (MANILA)	14	u	1	u
SINGAPORE	10	u	1	u
SRI LANKA	7	3	3	2
THAILAND	40	23	2	2
LATIN AMERICA				
BRAZIL (RIO DE JANEIRO)	44	u	11	u

Notes: Based on reports by men and women aged 15–49 of their experiences in the past year; includes unmarried men and women in sexual relationships that have lasted at least one year (or that are expected to last at least one year) who reported having intercourse with someone other than their regular partner. u=unavailable. *Source:* reference 5.

Data Sources on Reproductive Behavior

Over the past decade, nationally representative sample surveys of women of reproductive age were conducted in more than 50 developing countries by Macro International, in cooperation with national governments and organizations, and with funding from the U.S. Agency for International Development. All of these surveys questioned women about a wide range of issues, including marriage and sexual activity, childbearing, contraceptive use, unintended pregnancy and family-size preferences. Special tabulations from this set of surveys are presented in Appendix Table 1. Country reports on each survey and comparative reports published by Macro International are also an important source.

Similar surveys have been conducted by national governments in some developed countries, including the following, which are the basis for information in this report:

■ for France, the 1994 Survey on Families and Employment, carried out among a representative sample of women aged 20–49;[1]

■ for Japan, the 1992 National Fertility Survey, a study of couples in their first marriage, supplemented by data from the 1992 Mainichi Survey on Family Planning;[2] and

■ for the United States, the 1995 National Survey of Family Growth, conducted among a representative sample of women aged 15–44.[3]

More focused sets of surveys, covering fewer countries, were also utilized: the World Health Organization surveys of sexual behavior,[4] a series of surveys in Europe on sexual behavior,[5] and the International Health Foundation surveys on contraception in Western Europe.[6]

complete their schooling develop relationships with "sugar daddies"—older (often married) men who help with school fees and other expenses in return for sexual favors. Some young women are driven by poverty, family breakdown and homelessness to become commercial sex workers.

Incest and rape occur in all societies, even though, for understandable reasons, their incidence is seriously underreported. In recent years, rape committed as a tool of war or genocide has gained increasing international attention.

Many victims of rape or incest are desperate to end any pregnancy resulting from their violation, and even countries with some of the most restrictive abortion laws sometimes permit pregnancy termination on these grounds. In Bangladesh, sympathy for the large numbers of women raped during the 1971 war with West Pakistan led to the legalization of menstrual regulation, which differs legally from abortion because it is done without a test to confirm pregnancy.[8]

Women in Most Parts of the World Want Small Families

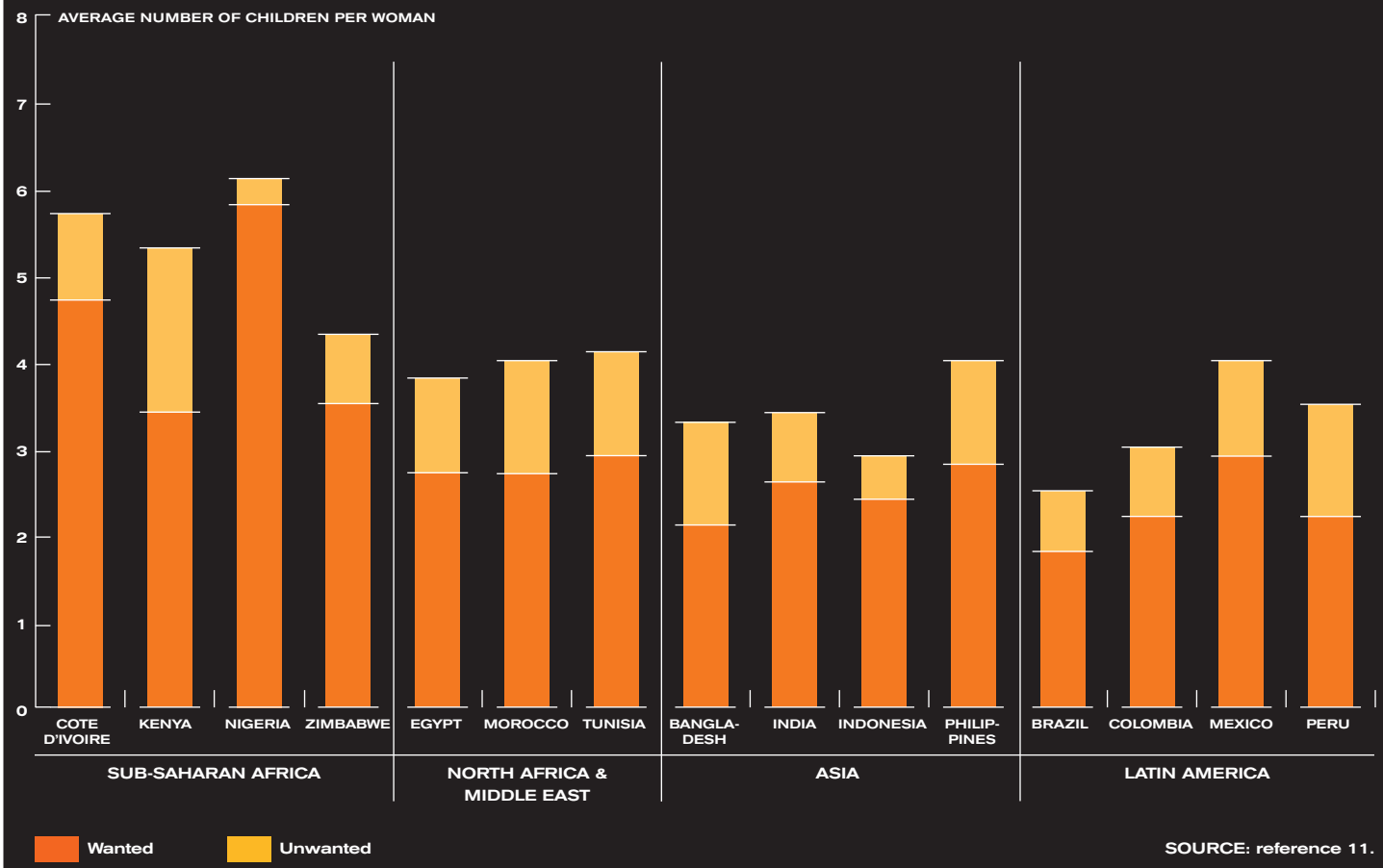
Like the sexual impulse, the desire to have children is fundamental and almost universal. Most people think about having a family at some point in their lives. But attitudes about ideal family size and the best time to have children are often the product of social expectations, cultural values and economic circumstances.

■ *Family size.* Except in much of Sub-Saharan Africa and a few Asian and Latin American countries (Pakistan and Guatemala, for example), women throughout the world increasingly want small families—often two or three children.[9]

The desire for small families has intensified in much of the developing world since the mid-1970s (Table 2c, page 14).[10] And in most developed countries, ideal family size has been around two children since the early 1960s. As nations have modernized and become more urbanized, and—perhaps most importantly—as women have achieved higher levels of education and have begun to work outside the home, smaller families have increasingly become the norm.

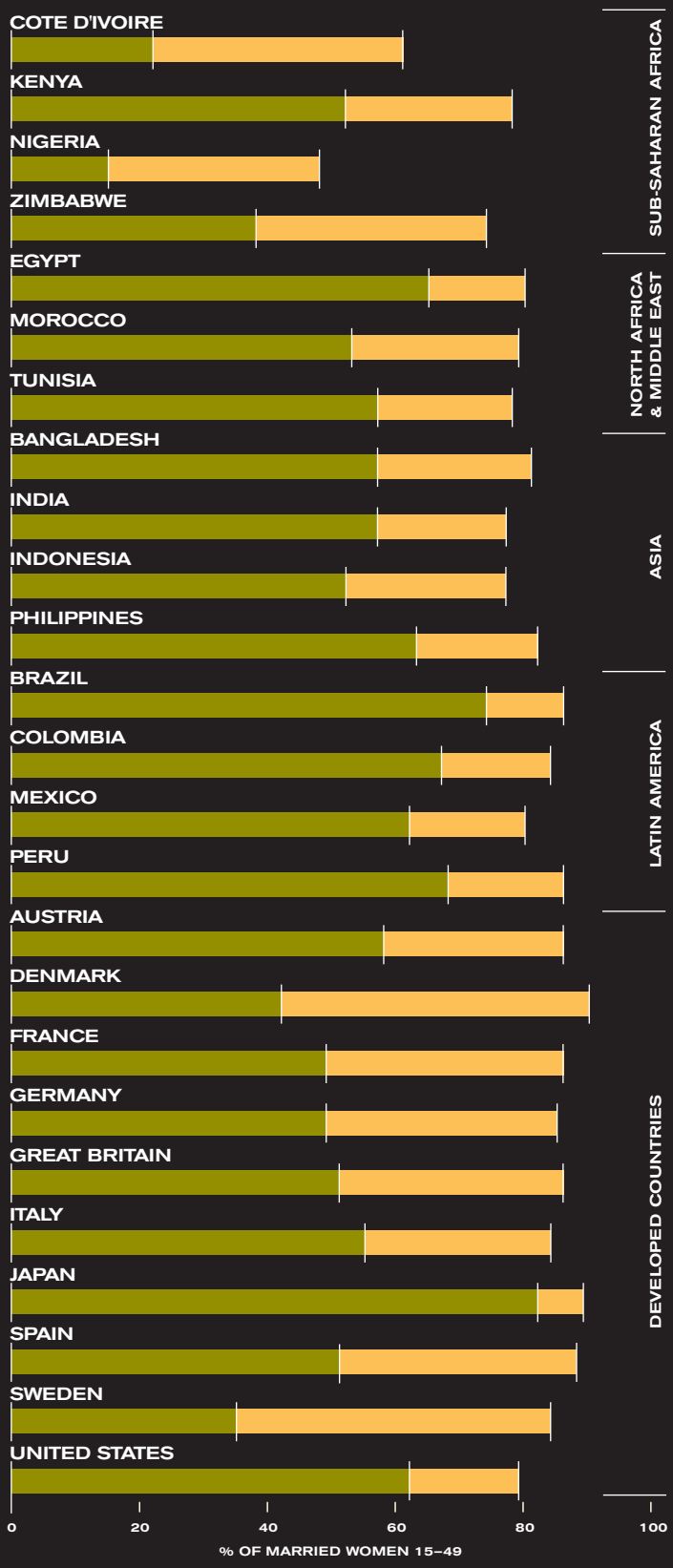
Yet in some countries, the number of children women have is still larger than the number they would ideally like (Chart 2.2).[11] In Bangladesh, for example, women have 3.3 children, on average—about one child more than they say they would prefer.

Chart 2.2 **Women in many developing countries often have more children than they want.**



SOURCE: reference 11.

Chart 2.3 **The vast majority of married women everywhere want no more children or do not want a child for the time being.**



NOTE: Data for Brazil and for developed countries are for married women 15–44. SOURCE: reference 12.

■ *Timing of births.* In countries where childbearing starts early, most women have had the number of children they want and feel they can care for by an early age, especially if ideal family size is no more than two or three children. Consequently, the vast majority of married women of childbearing age say that they want no more children, or that they want to delay their next birth for at least two years. Except in Nigeria, at least six in 10 women wish to stop having children or to delay their next birth. In most countries, more than eight in 10 women do so (Chart 2.3).[12]

Contraceptive Use Is Critical to Planning Pregnancy

All over the world, as a result of the growing desire for no more than two or three children, women want more, and more precise, control over not only the number of children they have, but when they have them. The role of contraception to help women and men reconcile their sexual lives and their desire for children is, therefore, crucial.

Most women are exposed to the risk of becoming pregnant from adolescence, when they become sexually active, to menopause. Yet if they want small families, they must spend a substantial part of their childbearing years trying to avoid conceiving. To achieve this, many couples, married and unmarried, practice contraception.

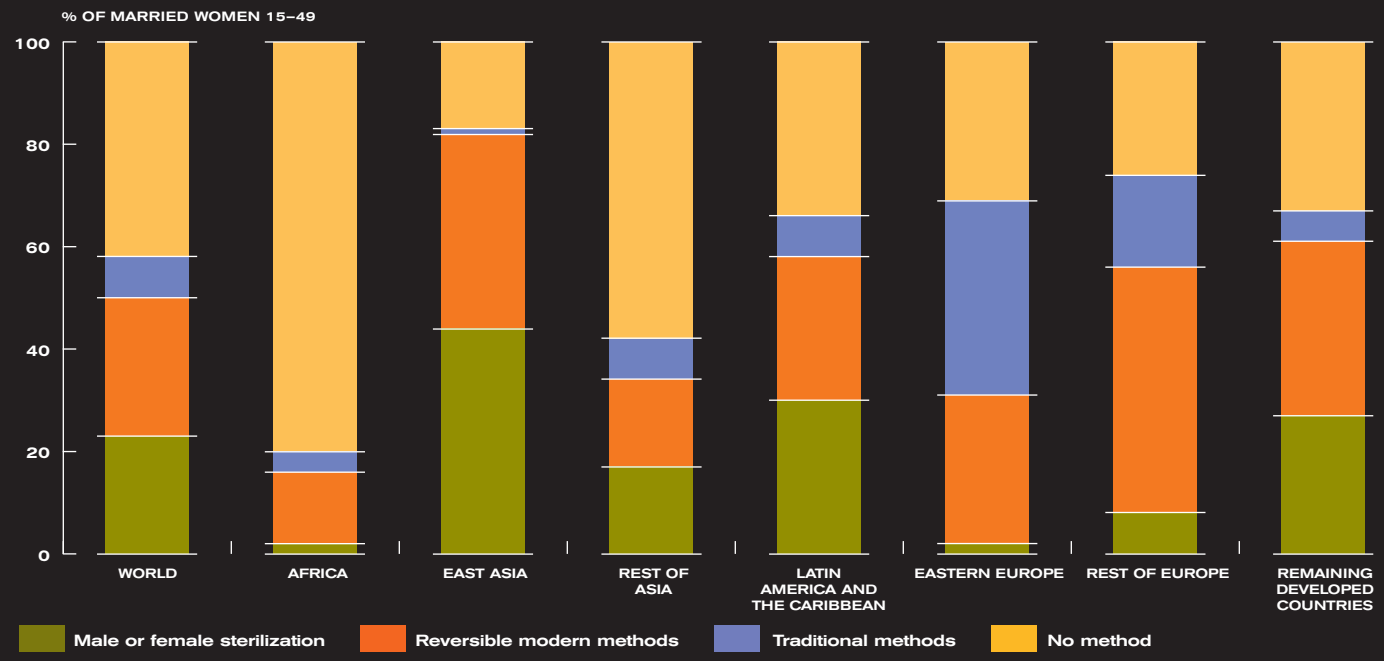
A variety of contraceptive options are available. Couples

Table 2c. **Increasingly, women in developing countries want fewer children than they did in the past.**

Country	Desired number of children		
	1970s	1980s	1990s
SUB-SAHARAN AFRICA			
KENYA	7.2	4.7	3.9
NIGERIA	8.3	u	6.2
ZIMBABWE	u	5.3	4.7
NORTH AFRICA & MIDDLE EAST			
EGYPT	4.1	2.9	2.9
MOROCCO	4.9	3.7	3.8
TUNISIA	4.1	3.5	u
ASIA			
BANGLADESH	4.1	u	2.5
INDONESIA	4.1	3.2	2.9
PHILIPPINES	4.4	u	3.5
LATIN AMERICA			
BRAZIL	u	3.0	2.5
COLOMBIA	4.1	3.0	2.5
MEXICO	4.4	3.3	3.3
PERU	3.8	2.9	2.6

Notes: Based on ever-married women 15–49. u=unavailable. *Source:* reference 10.

Chart 2.4 **Contraception is a part of women's lives around the world, but levels of use and choice of methods vary a great deal.**



NOTES: In this and subsequent charts containing data on world regions, the following definitions apply: East Asia consists of China, Hong Kong, Macao, Mongolia, North Korea and South Korea; Eastern Europe consists of Belarus, Bulgaria, Czech Republic, Hungary, Moldova, Poland, Romania, Russian Federation, Slovak Republic and Ukraine; remaining developed countries are Australia, Canada, Japan, New Zealand and the United States. Reversible modern methods are the pill, IUD, implant, injectable, condom, diaphragm and spermicides. Traditional methods are periodic abstinence, withdrawal, douche and folk methods. The category "no method" includes women who are currently pregnant, trying to become pregnant, postpartum or infertile. SOURCE: reference 13.

can use a "traditional" method: complete avoidance of sexual intercourse (sexual abstinence), avoidance during the fertile days of the menstrual cycle (periodic abstinence) or coitus interruptus (withdrawal).

Alternatively, couples can adopt modern contraception. They may choose a short-term, reversible method, which can be started and stopped relatively easily (the pill, condom, hormonal injectable, diaphragm or spermicides). Or they may select a longer acting method (an IUD or hormonal implant), which can be effective for up to five or even 10 years, but can be removed at any time. Or, for permanent contraception, one partner can become sterilized.

Globally, 58% of married women are practicing contraception. But use is even higher—about 65–80%—in developed regions, Latin America and the Caribbean, and East Asia. It is somewhat lower—42%—in the rest of Asia and is quite low—only 20%—in Africa, where large families are still considered the ideal and access to birth control services is generally poor or nonexistent (Chart 2.4.)[13]

Some married women who are not using contraceptives are trying to become pregnant, and some believe themselves to be infertile. Still others have recently had a child and are abstaining from intercourse after the delivery or are breastfeeding and therefore believe that they cannot conceive. However, many are in none of these situations and still have no protection against an unwanted pregnancy.

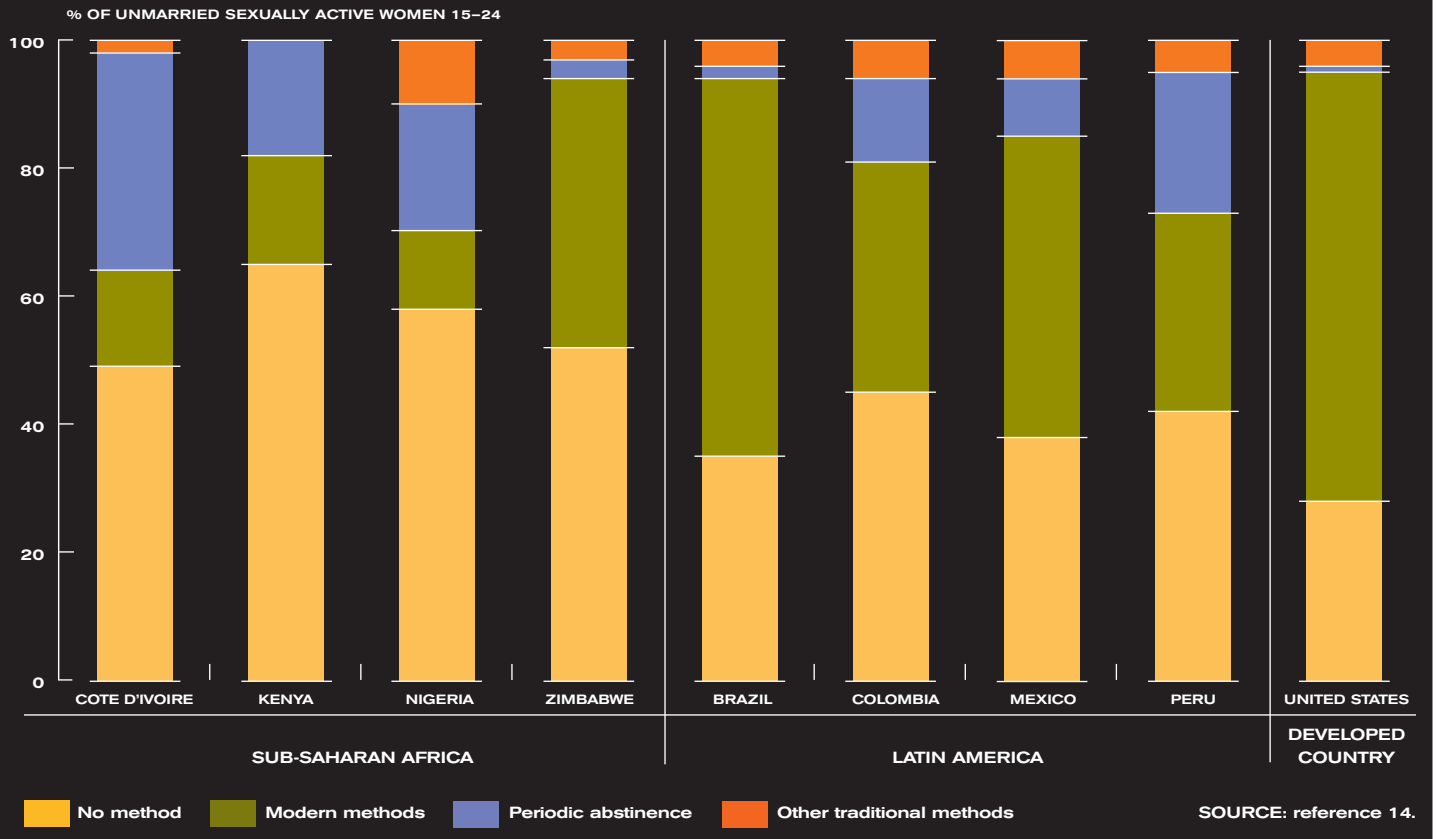
On the assumption that avoiding an unwanted pregnancy is even more important for unmarried women who are having sexual intercourse than for their married counterparts, one might expect contraceptive use among this group to be higher. However, in eight developing countries that have this information, between one-third and two-thirds of single, sexually active women are not using any contraceptive method; a further 10–40% are using a traditional method, predominantly periodic abstinence (Chart 2.5, page 16).[14]

All Contraceptives Can Fail, but Some Are More Dependable Than Others

Whether couples will be successful in preventing unplanned pregnancies is to a large extent determined by the effectiveness of their contraceptive use. The chance of an unexpected pregnancy is almost nonexistent for couples who rely on sterilization and very low for users of the IUD, injectable or implant. It is moderate for pill and condom users, and very high if couples rely upon periodic abstinence, withdrawal or spermicides (Table 2d, page 16).[15]

Since all methods may fail, many millions of couples

Chart 2.5 **Some young single women in a sexual relationship, especially those living in developing countries, do not use any method of birth control.**



SOURCE: reference 14.

around the world who are using contraceptives still face some risk of an unplanned pregnancy.

Many Women Are Not Using Effective Methods of Birth Control

Many married women do not want to be pregnant but are not using contraceptives, or are using methods with relatively high failure rates.[16] A number of reasons may explain this.

The decision to use permanent contraception requires a woman to be absolutely certain that she will not want any more children. And reversible modern methods all have certain drawbacks. For instance, some women fear having an IUD inserted. And many women find it difficult to remember to take the pill every day, year after year.

In a number of countries, condom use is associated with sex with prostitutes or with disease prevention rather than contraception. In addition, many men say it diminishes their sexual pleasure. Although the condom is the only available method that can protect men and women against the spread of HIV, it is not the most commonly used method in any country except Japan.[17]

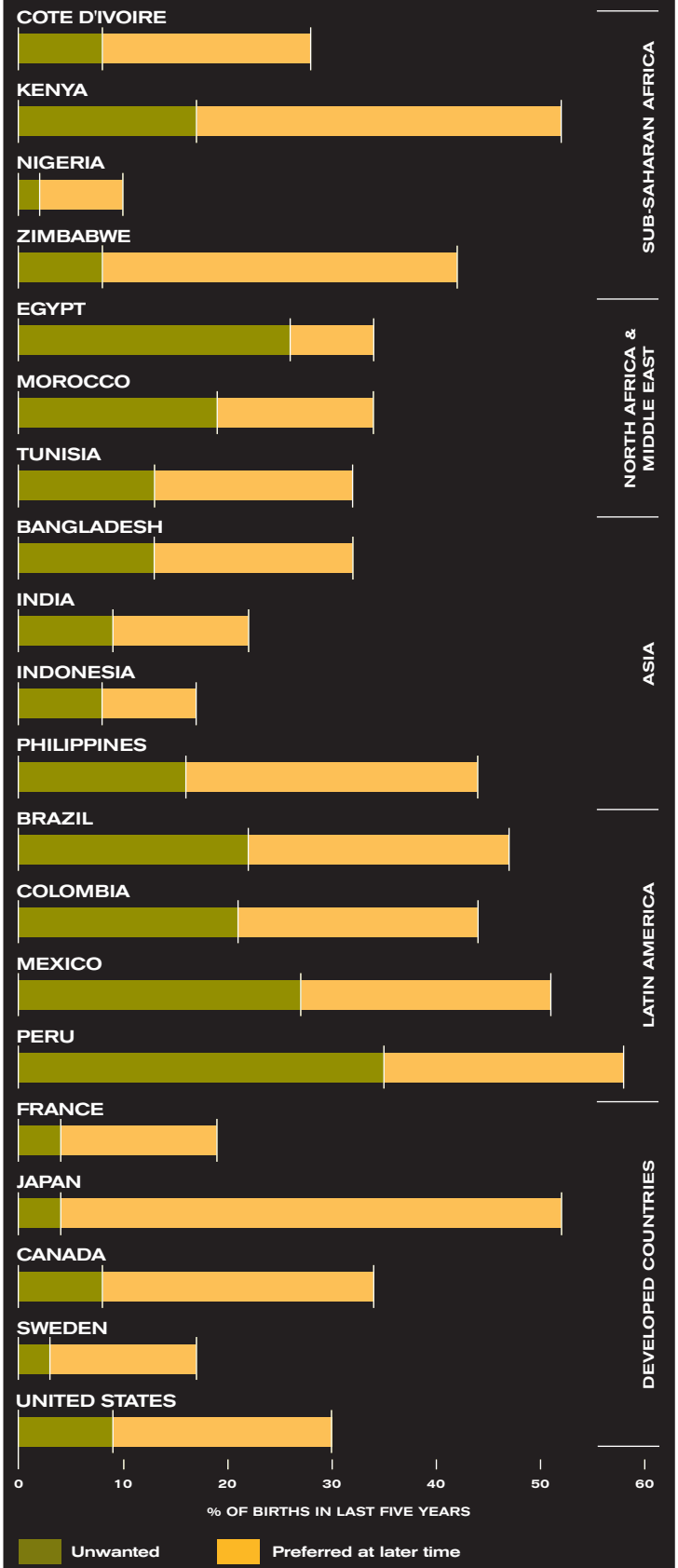
The use of traditional methods of contraception may not be much more desirable for some couples. Because the length of a woman's menstrual cycles can vary, and because refraining from sexual intercourse places some couples under strain, periodic abstinence is not always effective or easy to practice.

Table 2d. **Some contraceptive methods are more difficult to use successfully than others.**

	Users who become pregnant:	
Method	Low %	High %
WITHDRAWAL	15	28
PERIODIC ABSTINENCE	14	57
SPERMICIDES	13	55
DIAPHRAGM	9	42
CONDOM	6	51
PILL	3	27
IUD	3	5
FEMALE STERILIZATION	0.5	0.5
INJECTABLE	0.3	0.3
IMPLANT	0.1	0.1
MALE STERILIZATION	0.1	0.2

Notes: Based on U.S. women, during the first year of contraceptive use. The low percentage reflects consistent and correct use; the high, less consistent and correct use.
Source: reference 15.

Chart 2.6 **Unplanned births are common events for women around the world.**



NOTE: In Asian and North African countries, data apply to births among married women only; in all other countries, they apply to births among all women. SOURCE: reference 18.

Yet, this method and withdrawal are still popular in many countries.

Many of the reasons that women do not, or are unable to, protect themselves against unplanned pregnancy are not so much personal as social, cultural or economic. In some traditional agrarian societies, the concept of planning for or preventing pregnancy is not yet widely accepted, although attitudes are steadily changing. In other settings, women who would like to achieve control over their childbearing do not have access to the contraceptive supplies or family planning services they need, because contraceptives are too expensive, supplies are erratic, or services are difficult or impossible to get to.

Why Women Choose Abortion

In every part of the world, women who have had an abortion give broadly similar reasons for their decision:[1]

To stop childbearing

I have already had as many children as I want.
I do not want any children.
My contraceptive method failed.

To postpone childbearing

My most recent child is still very young.
I want to delay having another child.

Socioeconomic conditions

I cannot afford a baby now.
I want to finish my education.
I need to work full-time to support [myself or] my children.

Relationship problems

I am having problems with my husband [or partner].
I do not want to raise a child alone.
I want my child to grow up with a father.
I should be married before I have a child.

Age

I think I am too young to be a good mother.
My parents do not want me to have a child.
I do not want my parents to know I am pregnant.
I am too old to have another child.

Health

The pregnancy will affect my health.
I have a chronic illness.
The fetus may be deformed.
I am infected with HIV.

Coercion

I have been raped.
My father [or other male relative] made me pregnant.
My husband [or partner or parent] insists that I have an abortion.

In many countries, some doctors or family planning clinics refuse to provide contraceptives to unmarried women or teenagers, or require that young people obtain a parent's permission. And in other countries, male partners or mothers-in-law with a great deal of power in the extended family discourage or forbid women from obtaining and using birth control methods. This is particularly true when very young brides have not yet had a child.

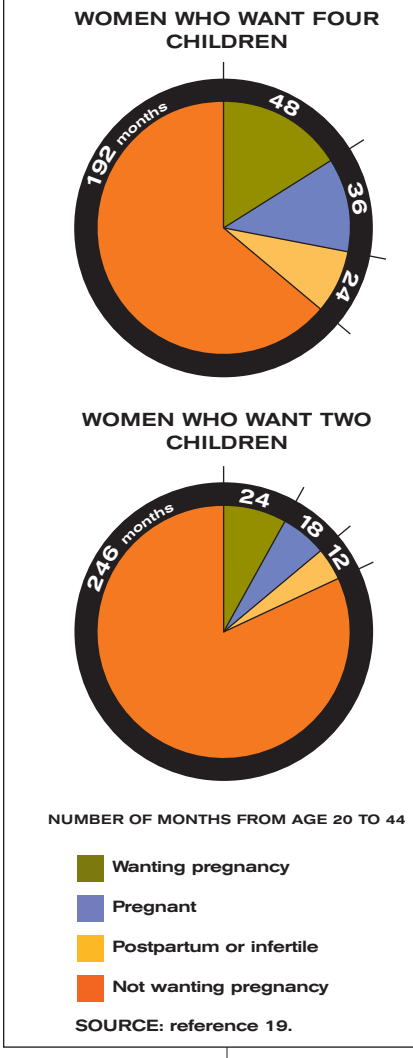
Some women's failure or inability to practice birth control is a function of perceptions related to their age or health. Some older women might think that because they do not have intercourse very frequently, they do not need to use a contraceptive method. And others might believe that they are no longer capable of becoming pregnant. Many women cannot tolerate the side effects they experience when using the pill, injectable or IUD. Others hear unfounded or exaggerated rumors about such side effects and are deterred from even trying these methods. Some women adopt a birth control method but become discouraged by side effects and stop using it.

Many Women in All Parts of the World Have Had an Unplanned Birth

With family-size desires shrinking and contraceptive methods and their use far from infallible, inevitably, many women become pregnant even though this is not what they had planned or wanted. Large proportions of married women all around the world report that in the past five years, they had a birth sooner than they had wished to (a mistimed birth) or at a time when they had wanted no more children (an unwanted birth).

The proportion of women who describe a recent birth as mistimed or unwanted is striking everywhere, but it is particularly high in Kenya and Zimbabwe, in the Philippines, in the four representative Latin American countries and in Japan (Chart 2.6, page 17).[18]

Chart 2.7 **To avoid unintended pregnancies, women must use birth control effectively for most of their childbearing years.**



SOURCE: reference 19.

Avoiding Unplanned Pregnancy Requires Years of Careful Contraceptive Use

Between the ages of 20 and 44, a fertile, sexually active woman is potentially capable of giving birth about 12 times, even if she breastfeeds each baby for one year. So if the average woman is to have a small family and avoid any unplanned pregnancies, she will have to practice contraception effectively for many years. For example, if she aims to limit her family to between two and four children and is to avoid the need for an abortion, she has to successfully practice birth control for 16–20 of her roughly 25 childbearing years (Chart 2.7)[19]

Faced with this reality, some women decide to bear all the children they want in quick succession and then become sterilized. Others prefer to maintain the option of becoming pregnant until they reach menopause; but as long as they remain sexually active and capable of conceiving, in no case can they stop or interrupt the use (or their partner's use) of an effective family planning method.

Women Turn to Abortion for Many Reasons

Throughout the world, the reasons women give for deciding to end an unplanned pregnancy are similar. Basically, women decide to have an abortion because they are too young or too poor to raise a child, they are estranged from or on uneasy terms with their sexual partner, they are unemployed, they do not want a child while they are trying to finish school, they want to be able to work or they must work to help support their family (see box on page 17).

These reasons are not frivolous or unconsidered. Rather, they demonstrate many of the difficulties that beset women in all walks of life who are trying to juggle competing roles and competing responsibilities and trying to adapt to changing societal expectations.

Section 3

Induced Abortion

CHAPTER 3

Abortion in Law: Legality and Actuality

The legal environment surrounding abortion is a significant factor affecting women's ability to end an unwanted pregnancy. One in four of the world's women—most of them in the developing world—live in countries that ban abortion or permit it only to save a woman's life. More than two in four women live under laws that permit abortion on broad grounds, but even these laws impose certain limitations on the procedure. Since the 1950s, many developed and some developing countries have liberalized their abortion laws, usually to minimize morbidity and mortality from clandestine procedures, but this trend has been slow in Africa and has hardly touched Latin America. Where abortion is severely restricted by law, prosecution of women for obtaining abortion is rare but persists in a few countries. While most well-off women everywhere can obtain a safe abortion—either in their own country or abroad—poor women often lack access to safe services, even when legally entitled.

Once a woman decides to have an abortion, the conditions she will face are likely to differ enormously from one part of the world to another. One of the most significant considerations affecting the circumstances she encounters will be whether the law permits or prohibits abortion where she lives.[1]

According to legislation currently in force, 25% of the world's women live in parts of the world where abortion is permitted only to save a woman's life or is prohibited altogether. Some 10% reside in countries where abortion is allowed when it is necessary to protect a woman's physical health or her life, and another 4% where it is permitted for these reasons or to protect a woman's mental health. The remaining 61% of women live under more liberal laws: 20% in countries that permit abortion for socioeconomic reasons, as well as for the narrower grounds described above, and 41% in countries where women may obtain the procedure without being required to give a specific reason (Chart 3.1).[2]

However, the proportion of people who live in settings where abortion is broadly permitted varies sharply between the developed and developing worlds (Chart 3.2, page 22).[3] In the developing world, slightly more than half of women (55%) live in countries that permit abortion on general grounds or for socioeconomic reasons, and the rest in settings with more restrictive laws. By contrast, the vast majority of women in the developed world (86%) live in countries with liberal abortion laws.

Nevertheless, the number of people in the developing world who are living under liberal laws (2.5 billion) is more than twice that in developed countries (1.1 billion). This is because three of the world's most populous countries—China, India and Vietnam—are in the developing world and have laws that permit abortion on broad grounds.

Even in Countries with Liberal Laws, There Are Usually Some Restrictions

In the 55 countries where abortion is permitted on general grounds or for socioeconomic reasons, the law usually stipulates some conditions. These restrictions, whose impact on a woman's ability to obtain an abortion varies from country to country, generally fall into certain categories.

- *Gestational limits.* Of the countries with liberal laws, all but five (Canada, China, North Korea, Vietnam and Zambia) specify some limitation on how late in the pregnancy a termination may be performed. The limit is 12 weeks in 36 countries, 14–22 weeks in eight and 24 weeks or fetal viability (generally considered to be 23–24 weeks of pregnancy) in six.

Most countries whose laws include gestational limits usually permit abortion later in pregnancy in some circumstances, or with additional requirements (such as approval by two physicians, rather than one). For example, Belgium,

France and Great Britain have gestational limits on most abortions but permit the procedure at any time to protect a woman's life or health or because of fetal impairment.

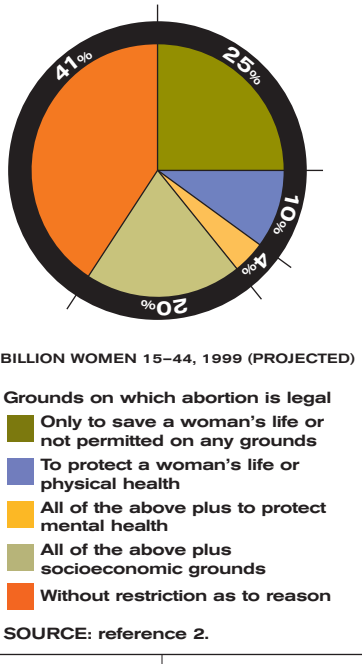
■ *Facilities and practitioners.* Many laws specify both the type of medical facility in which abortions must be performed and the type of health professional permitted to perform them. In Great Britain, India and South Africa, for example, abortions must take place in a government hospital or an authorized health care facility. Most countries require abortions to be performed by qualified physicians, but where physicians are not available, midwives or other registered practitioners may substitute in a few countries.

■ *Consent requirements.* In some countries, a woman may not have an abortion without the permission of other family members. Cuba, Denmark, France, Italy, Norway, Turkey and most countries in Eastern Europe, for example, require minors to obtain written parental consent. And in Turkey, an adult woman must have permission from her husband.

However, in France, if a minor wishes to have an abortion without the knowledge or consent of a parent or guardian, the hospital will go to court on her behalf to obtain permission from a judge. In the United States, some states require minors to have parental consent, and a similar type of override by a judge is possible; but the young girl herself must testify before a judge.

■ *Counseling and waiting period requirements.* Some countries have laws aimed at ensuring that women fully understand the procedure and its ramifications, and sometimes at discouraging her from following through on her decision to obtain an abortion. In Belgium, for example, a woman must receive counseling from a physician about the risks associated with the procedure and possible alternatives to abortion; she must then wait six days before having the abortion. In Germany, a woman is required to have counseling that has the stated aim of dissuading her from ending her pregnancy.

Chart 3.1 **One in four of the world's women live under laws that severely restrict their ability to obtain an abortion.**



SOURCE: reference 2.

Some Requirements Can Be Broadly Interpreted

In countries that permit abortion on particular grounds, the definition of these grounds may be wide-ranging. For example, a woman seeking an abortion on socioeconomic grounds must assert or demonstrate that her financial situation, marital status, age or family size makes it difficult or impossible for her to contemplate having a child or another child. Countries that permit abortion on socioeconomic grounds usually interpret these laws quite liberally. In Great Britain, Taiwan and Zambia, for instance, the law takes into consideration the effect that a continued pregnancy might have on the children a woman already has.

Women seeking an abortion to safeguard their physical health generally must show that their life would be threatened or that they would sustain serious or permanent damage to their health if forced to carry a pregnancy to term. Peru's penal code states that a therapeutic abortion performed by a physician and with the woman's consent "is not punishable" when it is the "sole means of saving the life of the pregnant woman or of avoiding grave and permanent harm to her health."

The circumstances that allow women to obtain abortions on mental health grounds are wide-ranging. Depending on the country, these might include psychological distress as a result of rape, mental stress caused by poverty or anguish at the prospect of having an infant with a severe handicap. In India, where abortion is permitted on socioeconomic grounds, it is also allowed after a contraceptive failure, on the assumption that an unintended pregnancy from this cause could constitute a "grave injury to the mental health of the pregnant woman."

Countries with Restrictive Laws May Allow Exceptions

Some countries permitting abortion only to safeguard a woman's life or protect her physical or mental health nevertheless allow a few exceptions. For example, pregnancy termination may be permitted in these countries if the woman has been a victim of rape or incest, or if it can be shown that her child will be born with serious defects. Brazil, Mexico, Panama and Sudan, which have highly restrictive laws, allow abortions following a rape. And the Democratic Republic of Congo and Panama permit the procedure when the fetus is impaired (Table 3a, page 23).[4]

In developing countries with restrictive laws, very few abortions are performed or reported under the exception for fetal impairment. In most of these countries, the diag-

nostic tools that can tell women they are carrying an impaired fetus are not available or are used too late in pregnancy for abortion to be an option.

Women May Need Help Navigating Complex Legal Systems

In countries where the grounds for abortion are restricted, women trying to avail themselves of their right to a legal abortion—for example, because of rape or incest—must know and understand the terms of the existing law and must find a health professional willing to perform the procedure. Cautious medical attitudes toward abortion, combined with often daunting procedural requirements, are likely to make the approval process complicated and intimidating. Even if women know that the law makes an exception in the case of rape or incest, those who live in remote rural areas, are very young or are unable to read or write will probably find the logistical obstacles insurmountable.

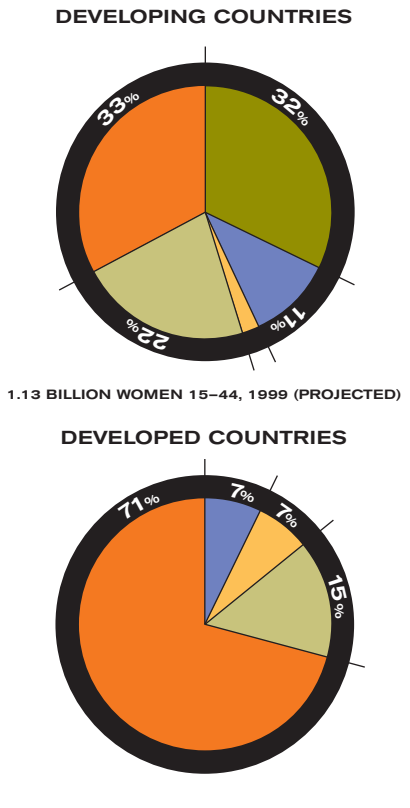
For women of any age or social background, the psychological obstacles are also likely to be formidable. A woman seeking a legal abortion after she has been raped is forced to relive the horror of her experience with family members or friends, possibly with a social worker, often with a lawyer and invariably with a doctor or nurse.

In Brazil, a serious effort has been mounted to offer legal abortion services to women who have been raped. The city of São Paulo was the first in the country to establish an official hospital service to provide this option. The hospital developed a program in which its medical and legal staff work together to help women through the demanding and time-consuming administrative and judicial processes required under the law.

During its first three years of operation, the program served about 200 women. (A limited budget and lack of staff skilled in developing a public information strategy probably prevented the program from reaching more women.) Unfortunately, by the time the legal paperwork is completed, the pregnancies of many eligible women exceed the gestational limit for rape victims (12 weeks).[5]

Nevertheless, public health advocates believe the São Paulo initiative has created a valuable precedent for the country. Seven other hospitals in Brazil now offer similar services to rape victims.[6]

Chart 3.2 **Women in developing countries are much more likely than those in developed countries to live under restrictive abortion laws.**



NOTES: In this and subsequent charts, developed countries are defined as all of Europe, Australia, Canada, Japan, New Zealand and the United States; developing countries are all the rest.
SOURCE: reference 3.

The Enforcement of Abortion Laws Is Uneven and Sometimes Nonexistent

The criminal prosecution of a woman or doctor for having or performing an abortion is not easy to pursue. Restrictive abortion laws are difficult to enforce because in the absence of a complaint, police and judicial authorities do not easily learn of violations. Even if they do, they often have difficulty locating witnesses willing to testify. And in many countries, the general public and even law enforcement agencies are not likely to favor punishing a woman who has already undergone the ordeal of a clandestine abortion.

Furthermore, sometimes the ambiguity in the language of an abortion law can work in a woman's favor. For example, not all laws prohibiting abortion after a particular point in gestation specify how to determine the length of gestation. It can be calculated from the first day of a woman's last menstrual period or from the estimated day of conception, which is about two weeks later.

The fluidity or vagueness of some legislation helps explain why, even in countries with the most restrictive abortion laws, there are few documented prosecutions of women or abortion practitioners.

A Few Countries Prosecute Quite Zealously

In a small number of countries, however, large numbers of people have been imprisoned for having or inducing abortions. During the 1980s, under the Pinochet regime, Chile's abortion laws were enforced with some vigor, even though fewer than one in six prosecutions led to conviction and imprisonment. More recently, the number of prosecu-

Table 3a. **Some countries that usually permit abortion only on narrow grounds also allow it in instances of rape, incest or fetal impairment.**

Country	Usual grounds	Also permitted for: Rape	Incest	Fetal impairment
SUB-SAHARAN AFRICA				
BOTSWANA	LIFE, MENTAL, PHYS. HEALTH	X	X	X
BURKINA FASO	LIFE, PHYS. HEALTH	X		
CAMEROON	LIFE, PHYS. HEALTH	X		
CONGO, DEM. REP.	LIFE			X
GHANA	LIFE, MENTAL, PHYS. HEALTH	X	X	X
LIBERIA	LIFE, MENTAL, PHYS. HEALTH	X	X	X
NAMIBIA	LIFE, MENTAL, PHYS. HEALTH	X	X	X
ZIMBABWE	LIFE, PHYS. HEALTH	X	X	X
MIDDLE EAST				
ISRAEL	LIFE, MENTAL, PHYS. HEALTH	X	X	X
KUWAIT	LIFE, PHYS. HEALTH			X
SUDAN	LIFE	X		
ASIA				
HONG KONG	LIFE, MENTAL, PHYS. HEALTH	X	X	X
IRAQ	LIFE, MENTAL, PHYS. HEALTH	X	X	X
SOUTH KOREA	LIFE, PHYS. HEALTH	X	X	X
THAILAND	LIFE, PHYS. HEALTH	X		
LATIN AMERICA				
ARGENTINA	LIFE, PHYS. HEALTH	X		
BRAZIL	LIFE	X		
BOLIVIA	LIFE, PHYS. HEALTH	X	X	
ECUADOR	LIFE, PHYS. HEALTH	X	X	
MEXICO	LIFE	X		
PANAMA	LIFE	X		X
URUGUAY	LIFE, PHYS. HEALTH		X	
DEVELOPED COUNTRIES				
NEW ZEALAND	LIFE, MENTAL, PHYS. HEALTH		X	X
POLAND	LIFE, PHYS. HEALTH	X	X	X
PORTUGAL	LIFE, MENTAL, PHYS. HEALTH	X		X
SPAIN	LIFE, MENTAL, PHYS. HEALTH	X		X

Note: Table includes only countries with population of one million or more. *Source:* reference 4.

tions for abortion in Chile (mostly self-induced abortions[7]) has dropped dramatically. In 1993, there were 245 prosecutions, about half the number in 1980. Following the pattern of earlier years, only a small proportion of these ended in acquittal, one in seven resulted in a conviction and the great majority were suspended with no decision reached (Table 3b).[8]

Abortion is considered homicide in Nepal. While the exact number of Nepalese women who have served prison terms for having an abortion is unknown, one study concluded that one-fifth of women now in jail in Nepal are there because they have been convicted of having an illegal abortion (Table 3c, page 24).[9] Not surprisingly, as in Chile, those who are sent to prison in Nepal are predominantly poor, since wealthy women can either obtain safe abortions in private clinics or go abroad to have an abortion in a country where the procedure is legal—for example, India.[10]

In many places, the main effect of rigorous enforcement of restrictive abortion laws cannot be measured in terms of the numbers of women or abortion providers being prosecuted or imprisoned. Rather, strict implementation of harsh laws is likely to reduce physicians' willingness to perform abortions, increase the amount that women have to pay, cause delays in the stage of pregnancy at which women seek and obtain an abortion, eliminate the possibility of legal recourse in the case of medical incompetence and diminish access to safe abortion procedures, particularly for women with limited financial resources.

Abortion Laws Are Changing, Although at Varying Rates

Until the second half of this century, induced abortion was illegal in almost every part of the world. Then, primarily in response to growing concern about the dangers to women's health and risks to their life posed by unsafe back-room and back-alley abortions, a rapid process of liberalization occurred between 1950 and 1985 in most countries of the developed world—and a handful of developing countries.[11]

The trend toward an easing of abortion laws has continued since the mid-1980s, but it has not gathered the same momentum in developing regions that it did in the developed world. Between 1985 and 1997, 10 developed and nine developing countries with populations of more than one million reduced restrictions on abortion. Of these, 12—including Cambodia, Mongolia and South Africa in the developing world—made first-trimester abortion available without restriction as to reason.

Efforts are under way in some developing countries with

Table 3b. **In Chile, hundreds of women are prosecuted for abortion each year.**

Year	Number of prosecutions	% by outcome: Conviction	Acquittal	No decision	Total
1993	245	15	3	82	100
1992	219	18	5	77	100
1991	218	11	4	85	100
1985	396	17	2	81	100
1980	550	12	1	87	100

Note: In some instances, women are tried in groups of up to six; therefore, a single prosecution may involve several women. *Source:* reference 8.

very restrictive abortion laws (Mexico[12] and Brazil,[13] for example) to encourage political and public debate about the possibility of legal reform. As in other parts of the world, arguments in favor of reform in these countries are often based on the need to improve women's reproductive health and to reduce maternal deaths from unsafe abortion. In fact, advocates of abortion law reform in Latin America urge removing the matter from the jurisdiction of national penal codes and making it a public health issue.[14]

Arguments in favor of reform are also advanced as part of basic human rights, as these have been formalized in a growing body of international law.[15] The classification of reproductive rights as an element of human rights was delineated and accepted by most nations at the 1994 International Conference on Population and Development in Cairo.[16]

In the end, the political situation in individual countries probably has the greatest influence on the likelihood of change in abortion laws. Movements supporting or opposing abortion law reform can come to the fore and then recede again quite rapidly, depending on local events (such as a visit by the Pope, publicity given to a sudden rash of abortion-related deaths or police raids on clandestine abortion clinics) and on the relative importance attached to other pressing social issues. And success in changing the law can hinge on the determination and energy of a few individuals or a single advocacy group.[17]

Abortion Law in South Africa

South Africa's 1996 abortion law includes the following provisions:[1]

"**2.** (1) A pregnancy may be terminated

(a) upon request of a woman during the first 12 weeks of the gestation period of pregnancy.

(b) from the 13th week up to and including the 20th week of the gestation period if a medical practitioner, after consultation with the pregnant women, is of the opinion that–

(i) the continued pregnancy would pose a risk of injury to the woman's physical or mental health; or

(ii) there exists a substantial risk that the fetus would suffer from a severe physical or mental disability; or

(iii) the pregnancy resulted from rape or incest; or

(iv) the continued pregnancy would significantly affect the social or economic circumstances of the woman.

(2) The termination of a pregnancy may only be carried out by a medical practitioner, except for a pregnancy referred to in subsection (1)(a), which may also be carried out by a registered midwife who has completed the prescribed training course.

"**3.** (1) The surgical termination of a pregnancy may take place only at a facility designated by the Ministry [of Health] by notice in the *Gazette* for the purpose under subsection (2).

(2) The Minister may designate any facility for the purpose contemplated in subsection (1) subject to such conditions and requirements as he or she may consider necessary or expedient for achieving the objects of this Act."

Table 3c. **In Nepal, about 80 women are sent to jail each year for having an abortion.**

Year	Number jailed for abortion	% of all women jailed
1997[1]	80	20
1995–1996	76	18
1994–1995	89	21
1993–1994	73	18
1992–1993	82	20

1. Includes women convicted for infanticide. *Source:* reference 9.

Simply Relaxing Restrictions Does Not Remove All Obstacles to Abortion Services

Even when abortion laws are liberalized, important nonlegal issues may continue to hinder some women's access to services. For example, many abortion laws do not stipulate where and by whom induced abortions may be performed. If, after legalization, services are provided primarily by the for-profit sector or public-sector services are inadequate, most poor women may be unable to afford to exercise their legal right to obtain an abortion.

South Africa's 1996 act making abortion legal addresses just these problems by specifying that all abortions must be performed in facilities designated by the Ministry of Health (see box). The law also allows that during the first trimester, the procedure may be performed by a registered midwife.

Ultimately, both the pace and the direction of reforms that countries adopt in addressing the many complex problems leading to and created by unsafe abortion are likely to vary as much as the countries themselves.

CHAPTER 4

Abortion in Fact: Levels, Trends and Patterns

An estimated 46 million women around the world have abortions each year—26 million in countries with liberal abortion laws and 20 million where abortion is restricted or prohibited by law. Worldwide, an average of 35 of every 1,000 women of childbearing age have an abortion each year, but this rate ranges from about 10 in some countries to around 80 in others. Despite variations in the legal status of abortion in developed and developing regions, overall rates are quite similar for both—39 and 34 abortions per 1,000 women, respectively. Eastern Europe has the highest abortion rate of any region, and Western Europe has the lowest; the disparity exists despite little difference in the legal status of abortion throughout Europe, and may be attributable to differences in availability and use of effective contraceptives. Evidence from a limited number of countries indicates that soon after the easing of a restrictive law, resort to abortion is likely to increase somewhat, but levels typically decline in the long term.

Various measures provide somewhat different perspectives of the incidence and impact of abortion. Numbers of abortions, by country or world region, tell us how many women seek services. Rates indicate how big a factor abortion is in women's reproductive lives and its role in preventing unplanned births. Measures that describe the characteristics of women having abortions shed light on the reasons why some women turn to this solution for an unplanned pregnancy. Estimates of safe and unsafe abortion suggest the possible impact of abortion on women's overall reproductive health.

The availability and quality of data on abortion depend to a great extent on the legal status of the procedure (see box on page 31). In most countries where abortion is permitted under broad grounds, official statistics are more or less dependable. Because official statistics on illegal abortions do not exist and the numbers of such procedures must be estimated, information for countries or regions in which abortion is highly restricted is necessarily much less reliable. Thus, while the data presented here are the best available estimates, they are not definitive.

Women in All Parts of the World Obtain Abortions

An estimated 46 million women throughout the world have induced abortions each year.[1] Of these women, 36 million (or 78%) live in developing countries, and 10 million (22%) in developed countries.[2]

Worldwide, about 11% of all women having abortions live in Africa, 58% in Asia and 9% in Latin America and the Caribbean (Chart 4.1, page 26).[3] The remainder live in Europe (17%) and elsewhere in the developed world—Australia, Canada, Japan, New Zealand and the United States (5%).

For the most part, the proportion of all abortions that are obtained by women in a given world region is very similar to the proportion of the world's women who live in that region. However, Eastern European women obtain a high proportion of abortions (14%) relative to their share of the world's population of women (5%).

Global estimates suggest that women having legal abortions (an estimated 26 million) outnumber those having illegal abortions (almost 20 million).[4] This is mainly because in two areas of the world in which extremely high numbers of women have abortions—China and Eastern Europe—the procedure is legal.

Given that abortion is basically prohibited in Africa and Latin America, negligible numbers of women in these regions obtain legal abortions. Almost half of legal abortions occur in East Asia (mostly in China, but also in Hong Kong and South Korea), 17% in the rest of Asia, 21% in Eastern Europe, 6% in the rest of Europe and 9% in the

rest of the developed world (Chart 4.2).[5]

Almost no women in East Asia, Europe (excluding Eastern Europe) or elsewhere in the developed world have illegal abortions, because pregnancy termination is permitted on broad grounds and is accessible in these regions. Half of women having illegal abortions live in Asia, 25% in Africa, 20% in Latin America, and the remaining 5% mainly in Eastern Europe.

Average Levels of Abortion Are Similar in Many Regions

Annual abortion rates (which measure the number of induced abortions each year per 1,000 women aged 15–44) make it possible to compare levels between one country or region and another, regardless of their relative population size.

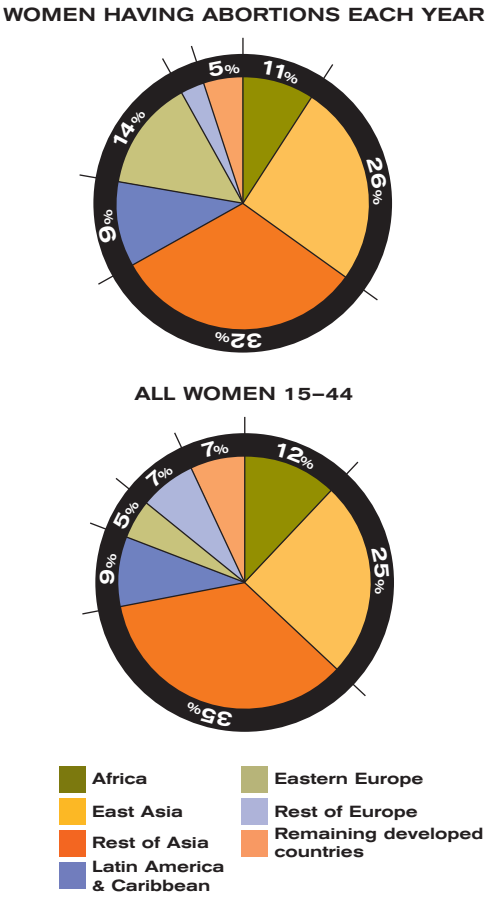
Worldwide, for every 1,000 women of childbearing age, 35 are estimated to have an induced abortion each year—20 have legal abortions, and 15 illegal abortions (Chart 4.3).[6]

If women living in developed and developing regions are compared, their overall abortion levels are strikingly similar (39 per 1,000 and 34 per 1,000, respectively). The slightly higher level in the developed world is a result of the upward pressure on average rates exerted by Eastern Europe, the region with the highest level of abortion.

Excluding Eastern Europe, the range in regional abortion rates is narrower than might be expected (Chart 4.4).[7] In Africa, Asia, Latin America and the Caribbean, abortion rates are estimated to be very similar: 31–37 per 1,000 women of childbearing age. However, in Latin America and Africa, almost all abortions are illegal; in East Asia, virtually all are legal; and in the rest of Asia, slightly more than one-third are legal.

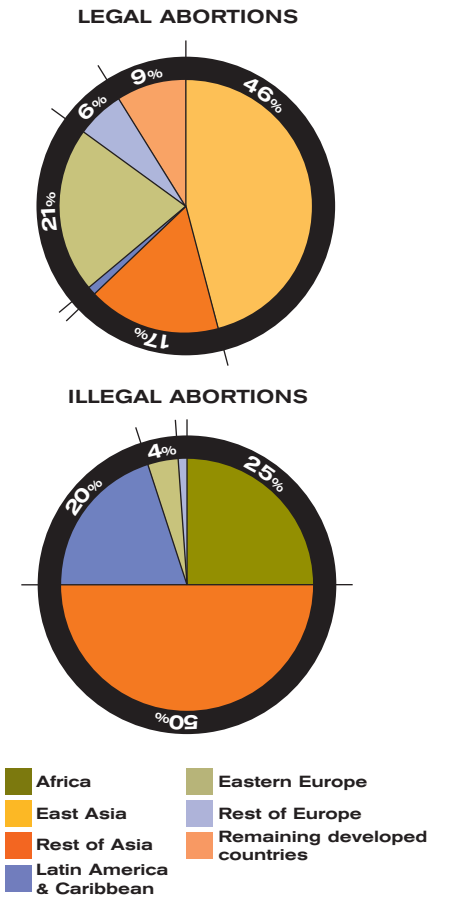
In the developed world, abortion rates are substantially lower than the world average: 17 per 1,000 in Europe

Chart 4.1 **Asian women represent more than half of both women having abortions and all women of childbearing age.**



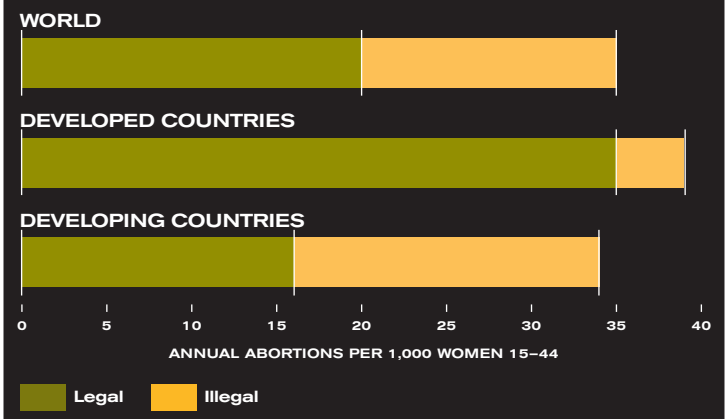
NOTE: For definition of world regions, see Chart 2.4.
SOURCE: reference 3.

Chart 4.2 **Legal abortions and illegal abortions are concentrated in different parts of the world.**



NOTE: For definition of world regions, see Chart 2.4.
SOURCE: reference 5.

Chart 4.3 **Whether a woman lives in a developed or a developing country, her average chance of having an abortion is much the same.**



NOTE: For definitions of developed and developing countries, see Chart 3.2. SOURCE: reference 6.

(excluding Eastern Europe) and 23 per 1,000 in all other developed countries together. All but a small number of these procedures are legal abortions.

Europe is notable because it includes the subregions with the highest and lowest abortion rates. In Eastern Europe, for every 1,000 women of reproductive age, 90 have an abortion each year; in the rest of Europe as a whole, the rate is 17 per 1,000, and in Western Europe, it is 11 per 1,000.[8] Yet abortion is legal throughout Europe.

Given the current worldwide abortion rate of 35 abortions annually per 1,000 women 15–44, over the course of 30 years (roughly the span of a woman's childbearing years), about 1,050 abortions will occur per 1,000 women. This implies a lifetime average of about one abortion per woman. A lower annual abortion rate implies a proportionally reduced average; so, for instance, where 22 of every 1,000 women of childbearing age have an abortion each year, the lifetime average would be 0.67 abortions per woman. And where the annual rate is in the 70s or 80s, the average woman is likely to have two or more abortions during her reproductive years.[9]

Abortion Levels Vary Much More Among Countries Than Among Regions

In the 65 countries for which data could be obtained or reasonably estimated, abortion rates during the early 1990s varied greatly (Chart 4.5, page 28).[10]

In 28 of these countries (the bars in the chart are green), the procedure is legal and the collection of abortion statistics is believed to be nearly complete. In 27 others (indicated by yellow bars), abortion is also legal, but national statistics are incomplete and, therefore, rates are underestimated.

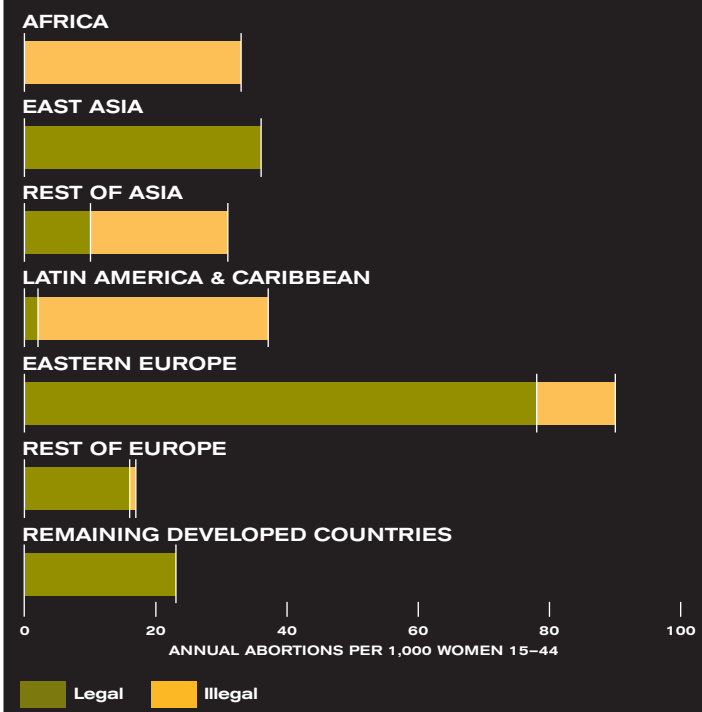
In 10 countries (indicated by orange bars), abortion is highly restricted and the rates are estimated from the number of women hospitalized each year for the treatment of abortion-related complications. These rates, somewhat less reliable than the others, are approximate levels.

The United States, Canada and most Western European countries have abortion rates of 10–23 procedures per 1,000 women of reproductive age, but the rate is even lower in Belgium, the Netherlands, Germany and Switzerland. Rates are above 50 per 1,000 in Latin America (Chile and Peru) and in countries formerly or currently under communist rule; Cuba, Romania and Vietnam have the highest reported abortion rates in the world (78–83 per 1,000).

Several factors may explain the pattern of high abortion rates seen in countries with a communist history. The most plausible is that during the Cold War—and even currently in some of these countries—women had great difficulty obtaining effective contraceptives.[11] At the same time, abortion services were usually easily available at no charge. And since these populations experienced the same increased pressure to have small families as the rest of the world, a dependence on abortion to regulate births prevailed.

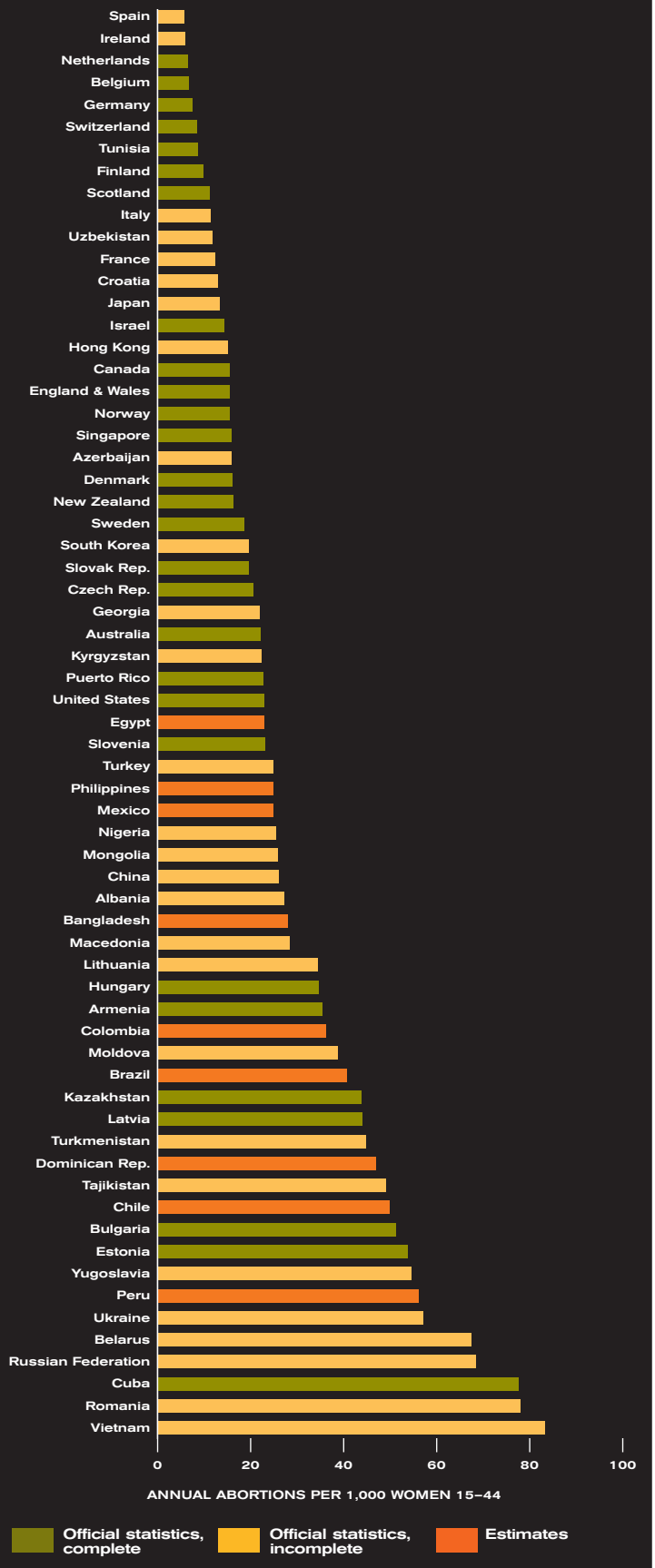
The situation in some Eastern European countries and some Central Asian former Soviet republics is changing rapidly, however, as contraceptives become easier to obtain from government and private sources.[12] In some of these countries, rates fell by as much as 50% between 1990 and 1996.[13]

Chart 4.4 **Eastern Europe is the region with by far the highest annual abortion rate.**



NOTE: For definition of world regions, see Chart 2.4. SOURCE: reference 7.

Chart 4.5 **Abortion rates vary enormously by country.**



SOURCE: reference 10.

Legalization and Rising Contraceptive Use May Affect Abortion Levels

In considering whether and why a country's abortion level might change over time, several questions often arise: How closely is the legalization of abortion linked to the incidence of abortion? Do abortion levels always decline once contraceptive use reaches appreciable levels? And is abortion sometimes necessary to achieve a small family?

•*Effects of legalization.* The evidence suggests that legal status makes little difference to overall abortion levels. Levels are very high in Eastern Europe and low in Western Europe, yet abortion is broadly legal in both. And levels are far lower in Western Europe than in Latin America, where abortion is highly restricted (except in Cuba and Guyana).

Because statistics are not collected where abortion is prohibited, few countries that have reformed their laws know how frequently the procedure was performed before legalization. Therefore, assessing the immediate and subsequent impacts of legalization in any specific setting is extremely difficult. Some evidence is available, however, on the trend in abortion levels after legalization; changing levels of abortion between 1975 and 1996 can be examined in 25 coun-

Table 4a. **Women increasingly use contraception to have small families but still rely on abortion.**

Country and measure	1970s	1990s	% change
TUNISIA			
AVERAGE NUMBER OF CHILDREN	5.9	2.9	–51
CONTRACEPTIVE USERS PER 100 MARRIED WOMEN	31	60	+94
ABORTIONS PER 1,000 WOMEN	14	14	0
SOUTH KOREA			
AVERAGE NUMBER OF CHILDREN	3.6	1.7	–53
CONTRACEPTIVE USERS PER 100 MARRIED WOMEN	44	79	+80
ABORTIONS PER 1,000 WOMEN	64	34	–47
BRAZIL			
AVERAGE NUMBER OF CHILDREN	4.5	2.5	–44
CONTRACEPTIVE USERS PER 100 MARRIED WOMEN	46	77	+67
ABORTIONS PER 1,000 WOMEN	22	39	+77
HUNGARY[1]			
AVERAGE NUMBER OF CHILDREN	1.9	1.6	–16
CONTRACEPTIVE USERS PER 100 MARRIED WOMEN	58	73	+26
ABORTIONS PER 1,000 WOMEN	83	35	–58
UNITED STATES			
AVERAGE NUMBER OF CHILDREN	1.8	2.0	+11
CONTRACEPTIVE USERS PER 100 MARRIED WOMEN	68	76	+12
ABORTIONS PER 1,000 WOMEN	22	23	+5

1. Data for the earlier period are for the 1960s. *Note:* Rates are based on women 15–44. *Source:* reference 17.

tries for which statistics are believed to be more or less complete, and another 29 for which reporting is incomplete.[14]

In most of these countries, the abortion rate rose immediately following legalization. This occurred partly because of the shift from unreported illegal abortions to reported legal abortions. But there was probably also a real increase in abortion rates in response to the demand for services, which can be more readily and more safely met following legalization.

The experiences of a few countries are illustrative. In Tunisia and the United States, abortion levels increased for some years following legalization in the early 1970s, then began to come down in the late 1980s or early 1990s.

In Eastern Europe, including the former Soviet republics, abortion was made legal much earlier—in the 1950s—and levels of abortion at that time were very high. They did not begin to decline until the 1980s.[15]

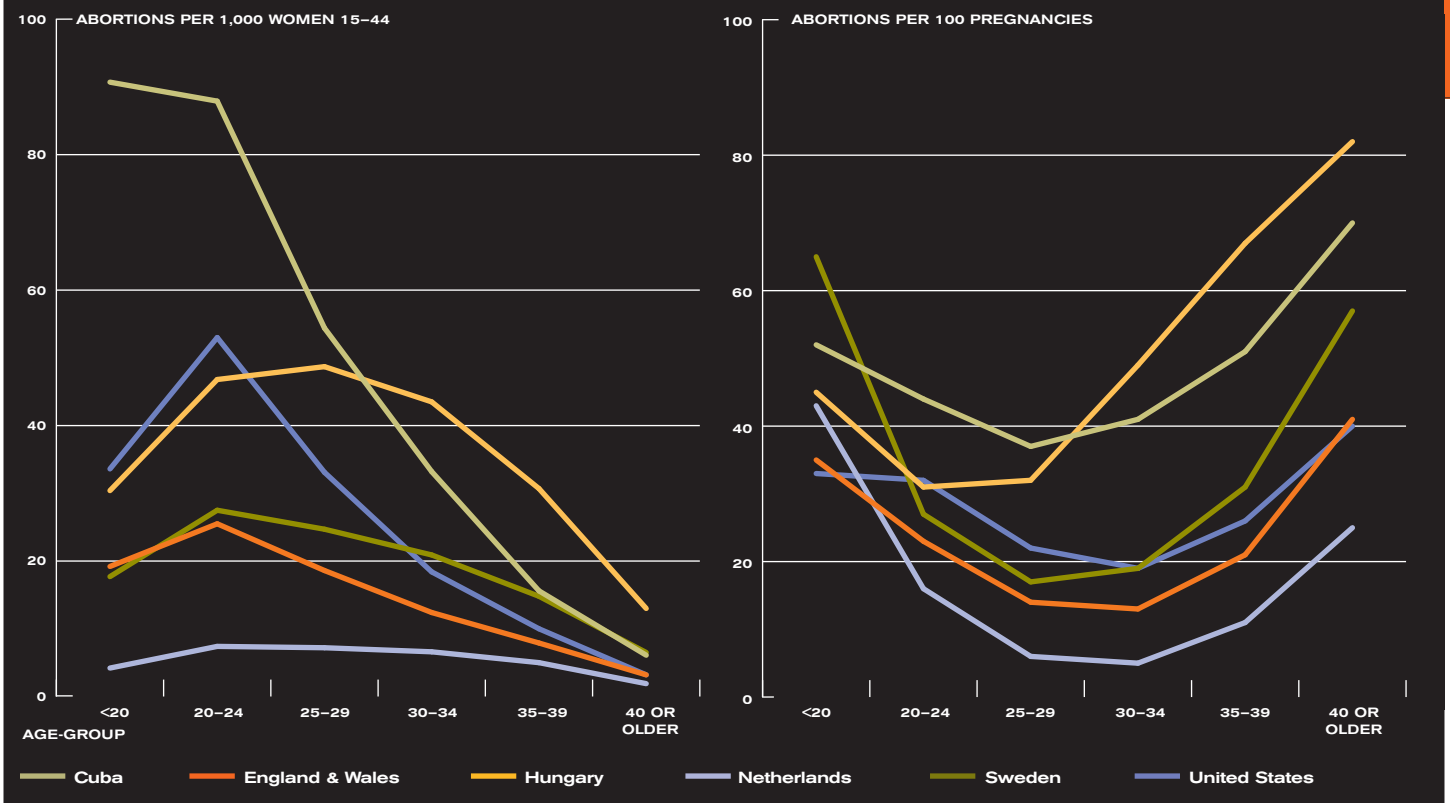
In Vietnam the level of abortion has risen consistently since legalization in 1975. This is probably because a national population policy made abortion services widely available; but until very recently, contraceptive services were inadequate in many rural areas, and women were given a limited choice of methods—either the IUD or sterilization.[16]

• *Contraception, family size and abortion.* Some participants in the abortion debate express concern that if abortion is legitimized and made easier to obtain, it could discourage contraceptive use or come to replace contraception as a means of spacing births and regulating family size.

This proposition is difficult to test, because it is hard to find countries in which the trend in abortion can be tracked over a similar period as trends in contraceptive use and family size. These strands of information are available, however, for five countries: two developing countries in which abortion is legal (South Korea and Tunisia), one developing country in which it is not (Brazil) and two developed countries (Hungary and the United States).

In the three developing countries, average family size dropped rapidly between 1970 and 1990. During the same period, the practice of contraception rose rapidly, and there was no consistent trend in the abortion rate; it declined substantially in Korea, increased dramatically in Brazil and registered little change in Tunisia (Table 4a).[17] In Hungary and the United States, couples had already attained a small average family size of close to two children in the 1970s. The practice of contraception rose markedly in Hungary (with the level of modern method use more than tripling) and more slowly in the United States during the 20-year period. At the same time, the abortion rate declined substantially in Hungary and registered little change in the United States.

Chart 4.6 **Women in their early 20s have the highest level of abortion in most countries, but adolescents and women aged 40 or older are the most likely to obtain an abortion if they become pregnant.**



SOURCE: reference 21.

These data are indicative that abortions will not replace contraceptive use as a means of regulating family size. They also tell us that abortion should decline as contraceptive use rises, although it has not yet done so in Brazil, where estimates suggest that until 1991, the abortion rate continued to rise, even as contraceptive use increased.[18]

A possible explanation is that Brazil has no organized family planning program and the quality of contraceptive services is still quite poor. The vast majority of Brazilian women of childbearing age who have not turned to sterilization use the pill. But many women buy their supplies from pharmacies or other outlets that provide no advice or counseling on the best use of the method. Contraceptive failure rates appear to be very high.

In 1992, some 345,000 Brazilian women were hospitalized for the treatment of abortion-related complications. By 1997, the number had fallen nearly 30%.[19] This may signal the start of a drop in the abortion rate. It may also partly reflect that more Brazilian women are obtaining safe abortions that do not cause complications requiring hospitalization.

A general conclusion from these examples is that in countries where couples practice contraception effectively to limit or space births, abortion declines to moderate levels. Where contraceptive use remains low or ineffective and the motivation for small families and properly timed births is strong or increasing, abortion levels may increase and take some time to moderate.[20]

Table 4b. **Whereas most women having abortions in developing countries are married, many in the developed world are single.**

Country	% married	% single	Total
ASIA			
BANGLADESH	96	4	100
MALAYSIA	91	9	100
NEPAL	88	12	100
SINGAPORE	68	32	100
SRI LANKA	98	2	100
TURKEY	98	2	100
VIETNAM	96	4	100
LATIN AMERICA			
BRAZIL	39	61	100
COLOMBIA	72	28	100
DOMINICAN REPUBLIC	88	12	100
PERU	88	12	100
EUROPE			
ALBANIA	97	3	100
BELGIUM	34	66	100
CZECH REPUBLIC	61	39	100
ENGLAND & WALES	21	79	100
FINLAND	27	73	100
GERMANY	53	47	100
HUNGARY	52	48	100
ITALY	57	43	100
NETHERLANDS	50	50	100
SPAIN	33	67	100

Notes: Data for Bangladesh, Nepal, Sri Lanka and all four Latin American countries are based on nonrepresentative samples of women hospitalized for abortion complications. In the remaining countries, data are based on national statistics covering all women reported as having had a legal abortion in a given year. *Source:* reference 22.

Young Women and Old, Married and Unmarried Have Abortions

Abortion rates are typically highest among women 20–24 and lowest among those younger than 20 and those in their 40s (Chart 4.6, page 29).[21] This pattern simply confirms that women in their early 20s are the most likely to be sexually active, the most fecund and the most likely to become pregnant.

However, although abortion rates are lowest among women at the very beginning and at the end of their reproductive careers, when these women become pregnant, they are much more likely than those aged 20–34 to have an abortion. In other words, the proportion of pregnancies ended by abortion is greatest at the beginning and at the end of women's childbearing lives.

This pattern reflects some of the most common reasons women give for their decision to have an abortion. Very young women often are single or want to postpone starting a family, and many older women have already had as many children as they had planned, or even more.

Another characteristic likely to affect whether a woman has an abortion is her marital status (Table 4b).[22] In regions where sexual activity tends to be limited to married women, as in Asia, most women having abortions are married. In contrast, in Europe, North America and Latin America, where sexual intercourse frequently occurs before or outside marriage, many women having abortions are unmarried.

Abortion Statistics and Their Limitations

Countries where abortion is legal under broad conditions. Abortions generally are officially recorded in these countries, even though the completeness of reporting varies greatly. The Alan Guttmacher Institute requested and collated available data from all such countries with a population of one million or more.[1] National statistical offices and local experts were the principal sources, providing both unpublished and published information. Of the 55 countries with more than one million population that allow abortion under broad grounds, we obtained some information on 49. Some data exist for Austria, Greece and Taiwan; however, we excluded them from presentation because the data cover only services provided in public facilities and thus represent a small, atypical fraction of women who have abortions. We were unable to obtain official statistics for Bosnia, Cambodia, North Korea or Turkey. For Turkey, however, we used the results of a survey of ever-married women aged 15–49 that asked respondents about their abortion experience in the previous year; since unmarried women were not included, the number of abortions for Turkey is underestimated. Because reporting is incomplete and potentially misleading in many countries, we asked local experts to assess the completeness of the data; we set apart results for countries where fewer than 80% of abortions are thought to be reported or whose completeness of reporting is unknown.

Countries where abortion is more restricted or virtually prohibited. We obtained official data for eight countries with more restrictive laws. Data for South Korea are from a survey including only married women aged 20–44 and therefore probably underestimate the number of abortions. In addition, estimates are available for 10 countries.[2] These estimates are based on data on women hospitalized for abortion complications and make adjustments for undercoverage and underreporting; spontaneous abortions; women who have a complication but are not hospitalized; and those who have an illegal abortion under safe conditions.

Regional and worldwide estimates of illegal abortions. We used estimates made by the World Health Organization (WHO) of the numbers of abortions occurring in regions where abortion is highly restricted and in regions where abortion is legally permitted but where significant numbers are performed under illegal conditions.[3] These estimates take into account all relevant information, including the numbers of women treated for abortion complications, the extent of access to safe illegal abortion and to hospital treatment, and the level of urbanization.

Regional and worldwide estimates of total abortions. We estimated the number of abortions at the subregional, regional and world levels by combining WHO estimates of illegal abortions; the number of abortions in countries with complete official statistics; and adjusted counts of legal abortions in countries where the procedure is broadly legal but statistics are incomplete or nonexistent. These adjustments were based on experts' judgment of the likely level of underreporting and on the level of abortion in countries with a similar profile of service provision, and similar legal and social conditions.

CHAPTER 5

Abortion in Practice: Safe and Unsafe Conditions for Women

In countries where abortion is broadly legal, services are usually accessible, and the procedure is performed early in pregnancy by skilled practitioners; in these circumstances, abortion-related deaths are rare. Where abortion is generally against the law, well-off women in cities are frequently able to obtain safe abortions, but many of their poor and rural counterparts try to end their own pregnancies or turn to unskilled practitioners. Of the 600,000 women who die each year from pregnancy-related causes, an estimated one in eight die of complications from abortion. Abortion-related deaths are hundreds of times more common in Latin America and Africa than in developed countries. Furthermore, experts believe that about one-third of women undergoing unsafe abortions experience serious complications, yet fewer than half of these women receive hospital treatment. Levels of maternal death and illness due to abortion have fallen dramatically in countries that have liberalized their abortion laws.

Raw numbers reveal little about the general conditions in which women have abortions. A good deal of information is available about the provision of abortion in countries with liberal abortion laws, but for obvious reasons, conditions are far less well documented in countries where the procedure is prohibited or severely restricted (see box on page 39).

Legality and safety usually coincide. But in some countries where abortion is legal, not all procedures are safe, and in many countries where abortion is not legally permitted, it is possible for some women to obtain "safe" services.

In India, for example, where abortion has been allowed for socioeconomic reasons since 1971, around 600,000 legal procedures a year are reported. But many Indian women, especially in rural areas, do not even know that abortion is legal. Furthermore, authorized abortion facilities are inadequate in number, and some health professionals in government facilities treat patients badly, even going so far as to insist that a woman undergoing a legal abortion also have an IUD inserted or be sterilized. As a result, women frequently go outside the authorized system and obtain extralegal abortions, many of which are unsafe.[1]

Making abortion legal, therefore, does not guarantee that services will be easily accessible, of good quality or safe. But neither is it the case that under conditions of illegality, all abortions will be of poor quality and unsafe. Even where abortion is illegal, some physicians offer safe medical pregnancy terminations. Consequently, as the World Health Organization (WHO) notes, "the legality or illegality of...services may not be the defining factor of their safety."[2]

The WHO defines an unsafe abortion as a "procedure for terminating an unwanted pregnancy [carried out] either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both."[3] Furthermore, the agency points out that even if performed by physicians, abortions carried out in unauthorized facilities or in a country where abortion is illegal place women's health and lives at risk.[4] Thus, the WHO's estimate of almost 20 million unsafe abortions each year—19 million in developing countries, and the remainder mostly in Eastern Europe—includes some procedures performed by trained physicians, even though most of these are technically safe.

When Abortion Is Provided in Safe Conditions, It Poses Little Risk to Women's Health

The safest abortions are those performed early in pregnancy by well-trained practitioners using medical or surgical methods. These practitioners work in hygienic conditions in a setting in which the procedure is legal and the appropriate legal protections are enforced.

Where abortions are performed in safe conditions, mor-

Table 5a. **Where abortion is legal, safe and available, mortality rates from the procedure are very low.**

Country	Deaths per 100,000 legal abortions
BULGARIA, 1980–1988	1.2
CANADA, 1976–1994	0.1
DENMARK, 1976–1995	0.5
ENGLAND & WALES, 1989–1993	0.4
FINLAND, 1976–1995	0.7
HUNGARY, 1979–1987	0.7
NETHERLANDS, 1976–1983	0.2
SCOTLAND, 1976–1996	1.0
UNITED STATES, 1987–1991	0.6

Source: reference 5.

tality and morbidity rates are generally very low. In some representative developed countries, a woman's likelihood of dying as a result of a safe abortion performed with modern methods is no more than one per 100,000 procedures (Table 5a); this is lower than the risk of dying as a result of pregnancy or childbirth, which is between six and 25 per 100,000 live births in most developed countries.[5]

The probability of complications and death increases with gestation, however. For example, in the United States, abortions at 16–20 weeks have a fatality rate of 6.9 deaths per 100,000 procedures, whereas those performed at gestations of eight weeks or less have a fatality rate of only 0.4 per 100,000.[6]

A Variety of Techniques May Be Used to Induce Abortion Safely

The choice of an appropriate abortion method will depend largely on the length of time a woman has been pregnant (see box page on 34). Within the first 12 weeks of gestation, when most terminations are carried out (Chart 5.1),[7] vacuum aspiration has replaced dilation and curettage as the most commonly used method in the developed world.

Vacuum aspiration equipment, whether electric or manual, is relatively inexpensive and is easy to operate and maintain. Moreover, this method, which can be performed under local anesthesia, is easier, less likely to involve complications and more cost-effective than dilation and surgical curettage under general anesthesia.[8] The rate of medical complications with vacuum aspiration (about one in 200 procedures) is half that for surgical curettage (almost one in 100).[9]

In some areas of North America and Europe, pharmacological methods to induce abortion early in pregnancy are changing the picture of abortion practice. Antiprogestins (mifepristone, for example) to halt the growth of the fetus, in combination with prostaglandins (such as misoprostol) to stimulate contractions of the uterus, can be safely used before nine weeks of gestation. Although the use of these methods is still very limited, they are becoming more widely known and tested, and their use may well increase.[10]

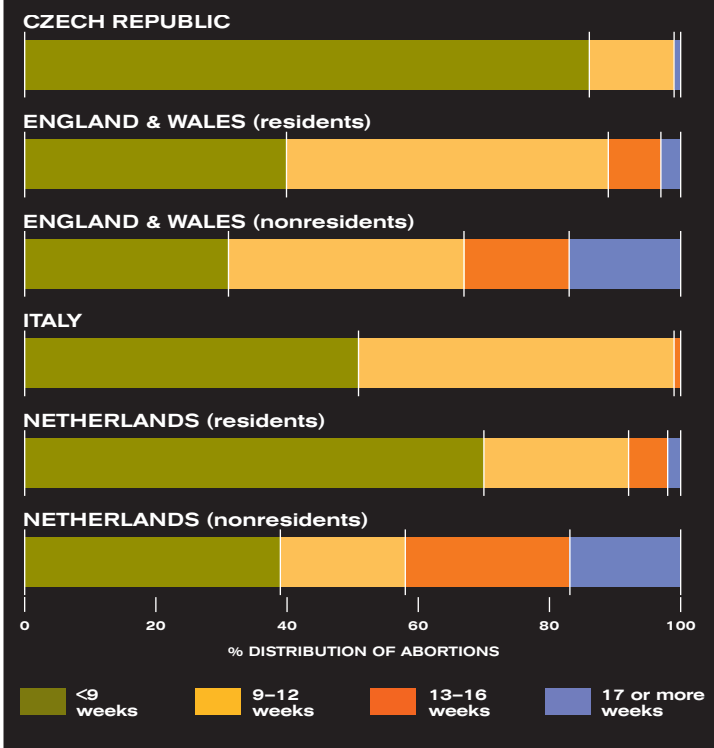
At later stages of pregnancy (13 weeks or more), dilation and evacuation is commonly used. Medical induction of labor is also frequently used for second-trimester abortions in most developing and some developed countries. Instillation methods and hysterotomy are rarely chosen in most developed countries, except for the small number of abortions performed very late in pregnancy.

Nonmedical Considerations Also Influence Safety

In countries in which abortion is permitted under broad conditions, legal requirements may create barriers that could cause a woman to delay obtaining an abortion and therefore increase the chance of adverse health consequences. For example, the need for permission from a husband or parent, counseling requirements, mandatory waiting periods, approval procedures and the need to locate and travel to an authorized provider are likely to mean that abortions are performed later in gestation than they otherwise would be.

Another factor that may cause women to delay obtain-

Chart 5.1 **An overwhelming majority of women having legal abortions obtain them within the first 12 weeks of pregnancy.**



SOURCE: reference 7.

ing an abortion is the need for those who live under a restrictive law to travel to a country where the procedure is legal. This is part of the reason why nonresidents obtaining abortions in England, Wales and the Netherlands are more likely than resident women undergoing the procedure to have it in the second trimester (Chart 5.1).

A few countries permit menstrual regulation—the practice of manual vacuum aspiration at an early gestation without a test to confirm that the woman is pregnant. However, the availability of manual vacuum aspiration in these countries is often uneven, especially in rural areas. Also, women may not know that the procedure is legal and may not understand how to comply with the legal requirements. For example, about one-third of Bangladeshi women seeking legal manual vacuum aspiration are turned away from clinics because their pregnancy has exceeded the legal requirement of 10 weeks' gestation.[11] As a result, even though menstrual regulation is allowed, many unsafe abortions may still occur.

The Cost of Services Can Be an Obstacle to Safety

A high cost of abortion relative to average family income can increase the health risks associated with the procedure. A poor woman who wishes to obtain an abortion from a private practitioner might need so much time to secure the necessary funds that the procedure has to be delayed into

Medical and Surgical Abortion Technologies

Pregnancy stage	Method	What is it?	How does it work?
Up to 7–9 weeks	Mifepristone and misoprostol	An antiprogestin and a prostaglandin	Mifepristone prevents progesterone from supporting the pregnancy, and misoprostol causes contractions, leading to expulsion of products of conception.
Up to 7–9 weeks	Methotrexate and misoprostol (used only in United States and Canada)	An antimetabolite and a prostaglandin	Methotrexate stops growth, and misoprostol causes contractions, leading to expulsion of products of conception.
Up to 12 weeks	Manual vacuum aspiration	Uterine evacuation procedure using a hand-held vacuum syringe	Uterine contents are evacuated through a cannula into a syringe; local anesthesia is commonly used.
Up to 13–14 weeks	Electric vacuum aspiration	Uterine evacuation procedure using a cannula attached to an aspirator	Suction action of machine empties the uterus; local or general anesthesia may be used.
Up to 13–14 weeks	Dilation and curettage	Uterine evacuation procedure using small forceps and curette	The cervix is dilated using laminaria or a prostaglandin, and the uterine contents are removed with forceps and curette; in most situations, general anesthesia is used.
13 or more weeks	Dilation and evacuation	Uterine evacuation procedure using small forceps, curette and suction cannula	The cervix is dilated using laminaria or a prostaglandin; forceps and curette are used to remove the fetus; a suction cannula is used to evacuate amniotic fluid and remaining tissue; general anesthesia is often used.
13 or more weeks	Medical induction or instillation	Procedure to induce contractions to expel the fetus	Contractions are induced by prostaglandin or by injection of saline or urea solution into the amniotic fluid; the woman experiences labor and delivery, as in a miscarriage. The procedure is usually done in a hospital with general anesthesia.
13 or more weeks	Hysterotomy	Mini–cesarean section	A surgical procedure is performed, commonly under general anesthesia, to remove the fetus.

Table 5b. **The death rate from abortion is hundreds of times higher in developing than in developed regions of the world.**

Region	Deaths per 100,000 abortions
DEVELOPING[1]	**330**
AFRICA	680
SOUTH & SOUTHEAST ASIA	283
LATIN AMERICA	119
DEVELOPED	**0.2–1.2**

1. Excluding China. *Source:* reference 17.

the more dangerous later months of pregnancy.

In most developed countries, cost is not likely to deter many women from obtaining a safe abortion, because the procedure is generally available under private or government health insurance systems. Furthermore, in most developed countries, abortion services are publicly financed.[12]

Yet even in developed countries, financial considerations may hamper some women's ability to obtain an abortion. In the United States, which has no universal national health care coverage, one in four women have no health insurance, and some private health insurance plans do not pay for abortions.[13] Thus, many women—including some covered by Medicaid, a joint federal-state program for indigent mothers of small children—must pay for an abortion out of their own pockets. Under federal law, Medicaid pays for abortions only if the pregnancy endangers the woman's life or resulted from rape or incest. However, 16 of the 50 states use their own funds to subsidize abortions for women enrolled in Medicaid.

The health systems of Austria and Lithuania pay only for abortions performed for medical reasons. Bulgaria's health service covers medically necessary abortions, as well as abortions for minors, women older than 35, women with an income below a specified level and women whose pregnancy is a result of rape.[14] In Israel, abortions are subsidized under the national health insurance program for medical reasons, as well as for any reason if the woman is younger than 18.[15] And as a number of Central and Eastern European countries have begun to turn to a market economy, some of their national health systems have begun to institute fees for abortion (which may make services more difficult for poor women to obtain), and the private sector is becoming more involved in the provision of services.[16]

Many Women Die as a Result of Unsafe Abortions

Each year, millions of women living in countries that place severe restrictions on abortion ignore the law and attempt to end their pregnancies by unauthorized means. Many unauthorized (or clandestine) abortions are unsafe.

In developing regions (excluding China), 330 deaths occur per 100,000 abortions, a mortality rate that is hundreds of times higher than the rate in developed countries. The rate is highest—an estimated 680 deaths per 100,000 procedures—in Africa (Table 5b).[17]

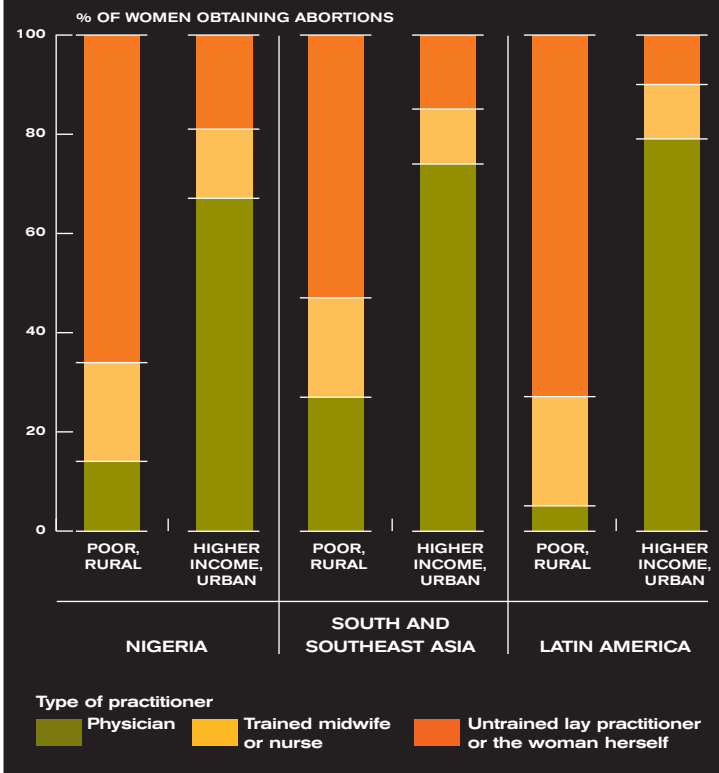
The WHO estimates that of the approximately 600,000 pregnancy-related deaths occurring each year around the world, 13% (or 78,000) are related to complications resulting from unsafe abortion. In Latin America, as many as 21% of maternal deaths are estimated to be associated with unsafe abortion.[18]

The abortifacient methods most likely to be life-threatening are those that involve penetration with sharp objects (which can perforate the uterus), the insertion into the cervix of contaminated materials and the use of unclean instruments. Unsterilized catheters, for example, are a common source of infection.

Income and Residence Influence Women's Choice of an Abortion Practitioner

A series of surveys of health professionals carried out by The Alan Guttmacher Institute (AGI) found that in parts of the

Chart 5.2 **Even where abortion is illegal, some women can obtain one from a physician far more readily than other women.**



SOURCE: reference 20.

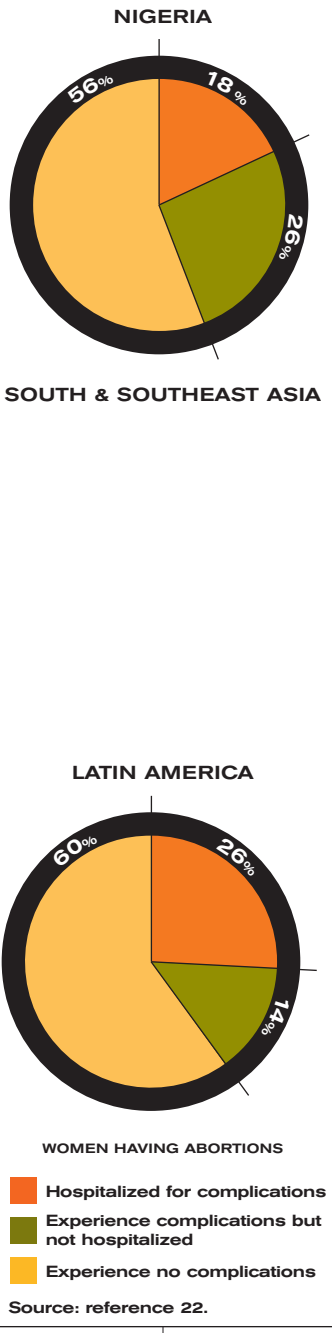
developing world, three broad types of practitioners typically are involved in performing or assisting in abortions: physicians, trained nurses and midwives, and traditional practitioners.[19] Information on Nigeria, South and Southeast Asia, and Latin America demonstrates that while wealthier, urban women go primarily to physicians, poor women in rural areas who wish to terminate a pregnancy predominantly go to traditional practitioners or induce their own abortion (Chart 5.2, page 35).[20] In Latin America, health professionals estimate that only one in 20 poor, rural women seeking an abortion obtain safe services from a physician.

■ *Physicians.* Especially in large metropolitan areas, women who can afford to pay can usually find a private doctor to perform safe pregnancy terminations using dilation and curettage or vacuum aspiration. Doctors usually perform these procedures in their private offices, in special clinics or in the hospitals with which they are professionally linked. Some physicians also provide misoprostol. Others are known to begin an abortion and then advise the patient to go to a hospital emergency room for the treatment of an incomplete abortion when bleeding starts.

■ *Trained midwives and nurses.* In many developing countries, particularly in rural areas, trained midwives and nurses provide most of the medical care available to women. In some countries, nurses learn how to carry out vacuum aspiration. Many nurses also know how to insert catheters to start an abortion, and they have access to the equipment and pharmacological products that are frequently used to interrupt pregnancies.

■ *Traditional or lay practitioners and women themselves.* All over the developing world, and particularly in areas where trained medical workers are scarce or nonexistent, certain women in the community act as lay health practitioners and traditional birth attendants. Some of these women also perform clandestine abortions.

Chart 5.3 **In countries where abortion is not generally legal, some women experience serious complications but do not receive care in a hospital.**



Source: reference 22.

The abortifacient techniques used by traditional practitioners (many of which are based on traditional folk medicine and are of little proven effectiveness) are extraordinarily diverse (see box).[21] For instance, some lay abortion practitioners use prolonged and hard massage to manipulate the pregnant woman's uterus. This method is common in some parts of Southeast Asia, especially in the rural areas of Cambodia, Indonesia, Laos, Myanmar, the Philippines and Thailand. The technique can bring about a complete abortion, but it can also lead to complications.

Women seeking the help of a lay practitioner may also undergo repeated blows to the stomach, or the insertion of rubber catheters, stones, twigs or sharp wire objects into the vagina and cervix. They drink concoctions of caustic substances or local bitter herbs. Many traditional methods seem to be based on the notion that treatment must involve shock to dislodge the fetus.

An astounding variety of local products—herbs, roots, tree bark, commercial cleansers and the dye extracted from blue jeans, for example—are used in traditional infusions to induce an abortion. Whether they are effective in terminating a pregnancy or not, the recipes for these remedies are frequently handed down from generation to generation.

In poor countries throughout the world, many women who decide to end an unwanted pregnancy first apply a homemade or locally purchased remedy. Women who try to terminate their own pregnancy use many of the same methods that traditional practitioners would administer: They insert hard objects into the vagina, drink or flush the vagina with caustic liquids or take large quantities of oral contraceptives, for example. Women also report jumping from high places, undertaking particularly arduous physical labor, dancing or even sustaining vigorous sexual intercourse over long periods in an effort to induce an abortion.

Traditional Methods Used to Induce Abortion

Herbal/natural
- Achampong leaf
- Ajvain (herbal potion)
- Algae
- Ants
- Apiol (oil from parsley seeds)
- Aralen
- Asawa cotton
- Avocado pear and rue steward
- Avocado seed (cooked)
- Bamboo sticks
- Barbados nut
- Betel nut paste
- Borage (herbal) water
- Brews, beverages and teas:
  - Marijuana or hemp
  - Oak and avocado
  - Parsley and coriander
  - Seeds from gourd
- Broom flower
- Cassava stem (fresh)
- Castor bean
- Celery cuttings and roots
- Commelina twig
- Dhutura seed and flower
- Dried or boiled dates
- Fetid passionflower
- Geranium stalk
- Germinated corn stalk
- Gladiolus sap
- Gloria de la Mañana
- Green sand
- Guava leaves
- Henna
- Herbal stalks
- Jaggary
- Jamu pelumtur
- Jamuzan
- Jathropha sap (mildly corrosive)
- Kapoktree
- Laminaria stem/rod/tent
- Leaves containing potassium chlorate
- Lemon
- Lime
- Mahogany leaves
- Mango
- Marjoram and lurica, rue or oregano
- Matico (aromatic wild pepper)
- Mullaca root
- Namba tree bark
- Nim tree
- Ogyamma leaves
- Onion
- Papaya (raw)
- Parsley leaves and roots
- Pepper
- Pineapple
- Potash
- Potato shoot or sprout
- Quick lime solution
- Radal
- Rue leaves
- Sabrabisie bark
- Sour fruits
- Stalks of castor-oil plant
- Starbellow
- Sterculia
- Stick or bulrush
- Sugarcane
- Tapioca
- Tigernuts
- Tobacco-based products

Manufactured
- Alcoholic beverages
- Astringent pastes
- Beer with aspirin
- Caustic substances:
  - Alum
  - Bleach
  - Copper sulfate
  - Detergent
  - Ether tablets with herbs
  - Formaldehyde
  - Gasoline
  - Hair dye
  - Laundry blue
  - Laundry blue with aspirin
  - Lead monoxide or litharge
  - Marine blue
  - Potassium permanganate
  - Silver nitrate
- Cantharides
- Clarified butter
- Cola
- Cortal
- Epsom salt
- Ergot
- Guinea pepper
- Gunpowder
- Herbs with warm beer, malt or red wine
- Jamaican rosewood soap
- Purgatives:
  - Alophin
  - Castor oil
  - Laxative
  - Magnesium sulfate
- Rice wine and gunpowder
- Soapy substances
- Sugar in high concentrations
- Tea of boiled coins
- Teas with hormonal injection
- Vaginal ointments
- Vapors
- Vinegar

Physical
- Catheter insertion
- Catheter insertion followed by infusion of:
  - Alcohol
  - Cumin-water mixture
  - Dettol
  - Distilled water
  - Duogynon-Forte
  - Gasoline
  - Glucose
  - Piton-S
  - Saline
- Douche
- Foreign object inserted into cervix:
  - Ballpoint pen
  - Bicycle spoke
  - Clothes hook
  - Cotton thread dipped in mustard oil
  - Crochet hook
  - Feather dipped in herbal medicines
  - Hairpin
  - Knitting needle/pins
  - Leaves/roots/stems
  - Pencil
  - Pouches filled with arsenic/caustic soda
  - Spoon
  - Stick/twig
  - Umbrella rod or rib
  - Wire
- Insertion of IUD
- Kovaks' technique (create distended balloon with condom in extra-amniotic space)
- Manipulation of cervix by fingering
- Manual disruption of uterus
- Massage of uterus
- Vaginal or uterine manipulation

Prayer/magic
- Amulets
- Fetishism
- Spiritual incantations with massage

Voluntary trauma
- Exhaustion by beating
- Frequent vigorous sexual intercourse
- Injury to abdomen:
  - Hot stone
- Intentional fall:
  - From roof
  - From staircase
  - From tree
- Intoxication
- Physical exhaustion:
  - Dance and liquor
  - Prolonged standing
- Voluntary blows to stomach:
  - By other
  - By self

Pharmeceutical techniques
- Contraceptive jelly diluted in hydrochloric and saline solution
- Oral:
  - Antibiotics/paraceformil
  - Antimalarial drugs
  - Aspirin
  - Cortal
  - Dyspirin
  - Hipofisinas
  - Mensicol with alcohol
  - Methylergometrin/maleate
  - Quinine/quinine sulfate/chloroquine
- High doses of any estrogen:
  - Oral contraceptives (an entire pack)
  - Gynavion pills
- Injection of:
  - Depot medroxyproges-terone acetate
  - Entocol
  - Ergometrine
  - Flavicorpin
  - Nupavin
  - Pitocin
  - Quinine
  - Syntocinon (oxytocin)
  - Tocofinal
- Oral or vaginal:
  - Misoprostol
  - Prostaglandin
  - Veterinary prostaglandin

Table 5c. **In countries where abortion is permitted only on narrow grounds, thousands of women are hospitalized each year with serious complications from unsafe procedures.**

Country	Abortion-related hospitalizations	Hospitalizations per 1,000 women 15–44
AFRICA		
EGYPT, 1996	216,000	15.3
NIGERIA, 1996	142,200[1]	6.1
ASIA		
BANGLADESH, 1995	71,800[2]	2.8
PHILIPPINES, 1994	80,100	5.1
LATIN AMERICA		
BRAZIL, 1991	288,700	8.1
CHILE, 1990	31,900	10.0
COLOMBIA, 1989	57,700	7.2
DOMINICAN REPUBLIC, 1990	16,500	9.8
MEXICO, 1990	106,500	5.4
PERU, 1989	54,200	10.9

1. Includes 21,500 women hospitalized for complications of an abortion performed by a physician. 2. Includes 19,400 women hospitalized for complications of menstrual regulation. *Source:* reference 26.

Women Suffering Complications from Unsafe Abortion Often Receive No Treatment

After having an unsafe abortion, some women experience no side effects or only mild complications. Others, however, experience severe trauma, such as tears in the cervix, perforation of the uterus, fever, infection (sepsis), septic shock and severe hemorrhaging. Women with these conditions require medical attention, but many are unable to obtain the care they need.

Generally, the more potentially dangerous the abortion method used, the higher the proportion of women who will have to be hospitalized for the treatment of complications. Also, the more accessible the hospital emergency services, the likelier it is that women with complications will be hospitalized for treatment.

In urban areas, women probably have fairly easy access both to safe abortion methods and practitioners and to emergency hospital care. In rural areas, by contrast, abortion techniques are likely to be less safe, and emergency care services less readily available. And whatever the seriousness of the complication or the availability of emergency services, some women will not seek treatment because of fear, embarrassment, shame or poverty.

Again, data from Nigeria, South and Southeast Asia, and Latin America suggest how these considerations might shape the outcome of unsafe abortions (Chart 5.3, page 36).[22] In Nigeria, where about half of illegal abortions are believed to be performed by doctors or nurses, many paramedics use prostaglandins and many women go to chemists (pharmacies) to obtain abortifacients,[23] experts believe that about four in 10 women having induced abortions experience severe complications and that the majority of these (about 60%) do not receive treatment.

Similarly, in Latin America, where abortion laws are highly restrictive but safe services are available in the major urban areas of some countries, four out of 10 women having abortions are estimated to experience complications.[24] However, of those who do, about two-thirds are believed to receive hospital treatment.

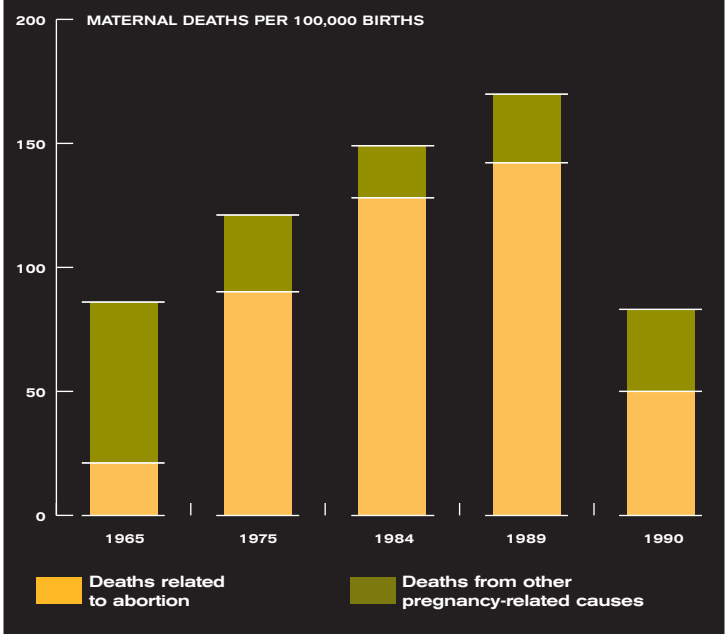
In South and Southeast Asia, one-third of women having abortions are believed to experience complications, and more than half of these women do not receive hospital treatment.[25]

These findings, which reflect the illegality of abortion, the unavailability of safe services and the absence of emergency health facilities in urban and rural areas, help explain the high levels of morbidity and mortality often associated with unsafe abortion in developing countries.

Each Year, Thousands of Women Are Hospitalized for Complications from Unsafe Abortion

Even though not all women suffering severe complications receive the treatment they need, the numbers who manage to get to a hospital are still large, as findings from 10 countries indicate (Table 5c).[26] In the illustrative countries, the annual

Chart 5.4 **When abortion was against the law in Romania, from 1975 to 1989, abortion-related deaths soared.**



SOURCE: reference 32.

Sources for Information on Conditions in Which Abortions Are Performed

Literature review: A wide-ranging review of research in this area was carried out, using the bibliographic indices to this field, Popline and Medline. In addition, requests for unpublished and hard-to-find research reports were sent to a large group of individuals and institutions around the world. The material thus obtained includes many small-scale studies, both community- and hospital-based.[1]

World Health Organization (WHO): The WHO is an important source of information on estimates of the number of deaths due to abortion, the proportion of maternal deaths due to abortion and the number of unsafe abortions occurring in each region of the world.[2]

Surveys of health professionals: In selected countries in three regions, The Alan Guttmacher Institute carried out surveys of small samples of professionals knowledgeable about abortion. In 1994, a total of 200 professionals were surveyed in six countries of Latin America. In 1996, surveys were fielded among 67 professionals in Nigeria and 232 professionals in 16 countries of South and Southeast Asia. Abortion is legal in only two of the surveyed countries–India and Vietnam. The surveys, which were all very similar in design, asked respondents about their perceptions of the characteristics of abortion provision, women's likelihood of suffering complications and being hospitalized, and how the situation differs depending on whether women are poor and whether they live in urban or rural areas.

hospitalization rate for the treatment of abortion-related complications ranges from around three per 1,000 women 15–44 in Bangladesh to around 15 per 1,000 in Egypt.

The costs of treating women for abortion-related complications can be substantial. In some developing countries in which abortion is illegal, as many as two out of every three maternity beds in large urban public hospitals are taken up by women hospitalized for the treatment of abortion complications,[27] and up to one-half of obstetrics and gynecology budgets are spent on this problem.[28] In Egypt, about one-fifth of all obstetric and gynecologic admissions are abortion-related.[29]

Some experts believe that the overall rate of complications resulting from unsafe abortion practices may be declining in some parts of the world as the result of increased use of noninvasive abortion techniques and growing use of antibiotics. According to the AGI surveys of health professionals, antibiotics are routinely prescribed prophylactically by many professional and lay practitioners who have come to recognize the role of infection in contributing to the likelihood of illness or death from unsafe abortion.[30]

Legalization Reduces the Adverse Consequences of Unsafe Abortion

By reducing or eliminating the need for unsafe procedures, the legalization of abortion increases women's chances of surviving the procedure and improves their subsequent health. It reduces the number of women likely to suffer complications from unsafe abortion, leads to a drop in abortion-related mortality and thereby substantially lowers overall maternal mortality rates.

For example, in Romania, abortion was legally available from 1957 to 1966, then was severely restricted as part of an overall pronatalist policy.[31] As illegal and unsafe abortions replaced legal procedures, abortion-related mortality rose steeply, reaching a record-high level of 142 deaths for every 100,000 live births in 1989; just one year later, when most restrictions were removed, the rate fell to about one third its peak level (Chart 5.4).[32]

In Guyana, where abortion was made legal in 1995, admissions for septic and incomplete abortions in the capital's largest maternity hospital declined by 41% within six months after the law went into effect. Before that, septic abortion had been the third largest, and incomplete abortion the eighth largest, cause of admissions to the country's public hospitals.[33] And in South Africa, six months after legal abortion became available in February 1997, the number of incomplete abortions at one large hospital in Port Elizabeth had declined from an average of 18 every week to approximately four.[34]

Postabortion Services Help Women Avoid Another Unplanned Pregnancy

Services to treat abortion complications are necessary to save women's lives and to help prevent the long-term health problems that can result from untreated complications. And by also offering family planning advice and referrals or actual services, hospitals can help women who have had an unsafe abortion avoid repeating the experience.

Most women hospitalized for abortion-related complications do not receive any counseling about the need to use contraceptives once they are discharged.[35] Therefore, while the period of hospitalization, when women are likely to be in weakened physical and emotional condition,[36] may be a difficult time to offer counseling, providers must also consider a woman's risk of pregnancy if she leaves the facility without contraceptive protection and the possibility that

she may not return for services. Most hospitalized women spend no more than a day or two in care, and once they leave the hospital or emergency facility, they may not go back for follow-up care.

The ideal would be to provide every woman treated for abortion-related complications with an effective contraceptive method of her choosing before she leaves the health facility. Currently, some hospitals are able to provide women only with condoms or spermicidal products. Others can only give a woman a referral slip to a family planning clinic in her neighborhood.

Pilot projects to introduce the use of manual vacuum aspiration, which can reduce the cost of postabortion care and free up resources for other obstetric and gynecologic services, are under way in Egypt, Ethiopia, Kenya, Mexico, Nepal, Nigeria, Zimbabwe and elsewhere. Limited attempts are also being made to expand and improve treatment protocols and contraceptive counseling for women who are hospitalized with complications from unsafe abortion.[37]

Section 4

Societal Responses and Responsibilities

CHAPTER 6

Unplanned Pregnancy and Abortion: Options for the Future

Globally, nearly four in 10 pregnancies are unplanned, and about two in 10 end in abortion. Given the many social and personal factors that hinder individuals' effective contraceptive use, and the risk that any contraceptive method may fail, some level of unplanned pregnancy will persist. Consequently, so will the need for abortion. Countries wishing to reduce levels of unplanned pregnancy and abortion and to help women avoid the adverse consequences of unsafe abortion have a number of choices, depending on their particular situation. One of the most promising is to provide good contraceptive services. But in countries where abortion is permitted only on the narrowest grounds, concerted action on several fronts may be needed, including expanded contraceptive services, educational interventions and legislative reform. In the absence of any action or change, millions of women in these settings will continue to be exposed to the risk of prosecution, disability and death.

This report has illustrated the many circumstances that lead to unplanned pregnancy and the varied situations that women face if they decide to seek an abortion. It emphasizes that to be effective in addressing the many health and legal issues related to abortion, societies and policymakers must place it in its proper context as a response to unplanned pregnancy.

What, specifically, have these data shown about the global and regional levels of unplanned pregnancy and abortion? How can societies reduce high levels of unplanned pregnancy and, thus, the need for abortion? And what part can governments and the international community play in reducing the suffering linked to unsafe abortion?

Unplanned Pregnancy and Abortion Are Remarkably Common

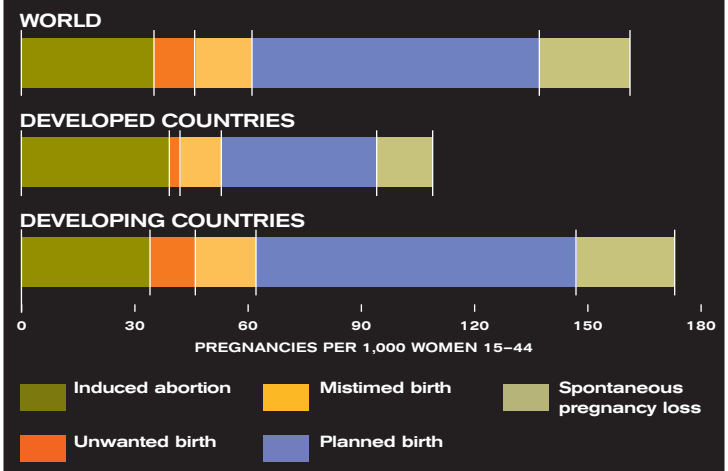
Despite the shortcomings of some relevant data, the overall picture of unplanned pregnancy and abortion is clear. In general, in countries where women desire small families but their contraceptive use is inadequate to meet their needs, levels of unplanned pregnancy (including mistimed and unwanted births, as well as pregnancies ending in abortion) and abortion may be high.

- Worldwide, of the approximately 210 million pregnancies occurring every year, an estimated 38% are unplanned, and 22% end in abortion (Chart 6.1).[1]
- In developed countries, of the 28 million pregnancies occurring every year, an estimated 49% are unplanned, and 36% end in abortion.
- In developing countries, of the 182 million pregnancies occurring every year, an estimated 36% are unplanned, and 20% end in abortion.

By geographic region, these estimates span an even wider range (Chart 6.2):[2]

- In Africa, 30% of the 40 million pregnancies occurring each year are unplanned, and 12% end in abortion.
- In East Asia, 39% of the 40 million pregnancies occurring each year are unplanned, and 30% end in abortion.
- In the rest of Asia, 34% of the 83 million pregnancies occurring each year are unplanned, and 17% end in abortion.
- In Latin America and the Caribbean, 52% of the 18 million pregnancies occurring each year are unplanned, and 23% end in abortion.
- In Eastern Europe, 63% of the 11 million pregnancies occurring each year are unplanned, and 57% end in abortion.
- In the rest of Europe, 33% of the seven million pregnancies occurring each year are unplanned, and 21% end in abortion.
- In the United States, Canada, Australia, New Zealand and Japan, 45% of the 10 million pregnancies occurring each year are unplanned, and 23% end in abortion.

Chart 6.1 **More than a quarter of women who become pregnant each year have either an abortion or an unwanted birth.**



NOTE: For definition of developed and developing countries, see Chart 3.2. SOURCE: reference 1.

Many of the Reasons for Unplanned Pregnancy and Abortion Transcend Geographic Boundaries

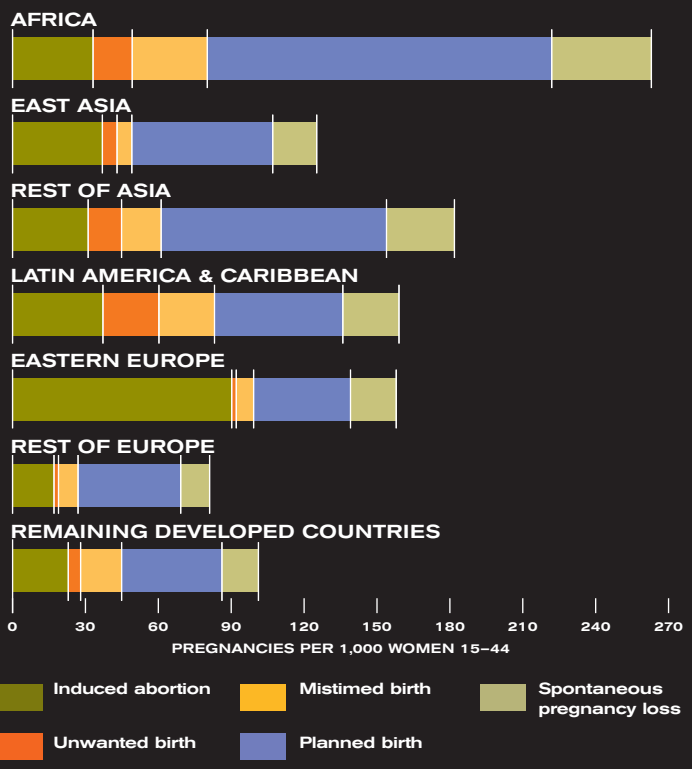
The underlying reasons for the existence of high levels of unplanned pregnancy and induced abortion are similar in many parts of the world:

- Many women, married and unmarried, who do not want to be pregnant are not using a contraceptive method or are using a method that provides insufficient protection against pregnancy. In some areas, women have poor access to modern contraceptives, do not know where to obtain them or cannot afford them. In others, they have not yet learned about modern methods or how to use them effectively.
- Some women who are using a contraceptive method nevertheless become pregnant. Accidental pregnancy may happen because the method fails or because couples sometimes use contraceptives inconsistently or incorrectly.
- Hundreds of millions of couples struggling to raise families on very meager resources recognize that an unplanned birth could threaten the well-being of every member of the family, including their children and dependent parents.
- In many parts of the world, it is considered unacceptable for an unmarried woman to have a baby.
- Many adolescents, and many societies, recognize that pregnancy and childbearing at a very early age are not desirable.
- In some parts of the world, men, other family members or the prevailing religious authorities may discourage or prevent women from wanting or trying to regulate their childbearing.
- Many women want and try to end pregnancies resulting from rape, incest or other kinds of sexual violence. In war-torn and refugee areas, international investigations are revealing increasing numbers of women who have been subjected to rape. And the problem of sexual violence of all kinds against women, sometimes perpetrated by their husbands and regular sexual partners, is coming to light in many parts of the world.

Although women throughout the world have many of the same reasons for seeking abortion, some reasons may be more prevalent than others in certain parts of the world.

- In many parts of the developing world, unemployment, widespread poverty and growing economic hardship are among the most important reasons for couples to decide that they cannot afford another child. But poor access to a wide range of effective family planning methods and to good reproductive health services means that many couples are unable to prevent unwanted pregnancies.
- Economic considerations are important in highly modernized countries as well. As the cost of living, the need for extended education and consumption standards rise, in many families both husbands and wives work full-time to make ends meet. Children no longer contribute to a family's resources, as they did in an agrarian society, and many couples decide that they can manage to raise no more than two children.

Chart 6.2 **The regional pregnancy level varies widely, as does the proportion of pregnancies that women plan.**



NOTE: For definition of world regions, see Chart 2.4.
SOURCE: reference 2.

■ Women's low status and lack of autonomy, especially in developing regions, may impair their ability to avoid unplanned pregnancies by practicing contraception. However, the ability to assert some control over their reproductive lives becomes evident when these same women decide to seek an abortion.

■ In most developed and in some developing countries, early adolescent sexual activity accounts for much unplanned pregnancy. Yet, many young teenagers who become pregnant want to delay becoming mothers or avoid becoming single mothers and know that their chances of completing schooling are better if they do not have a child.

■ Easy access to and effective use of contraceptives remain problems in parts of Eastern Europe, including the former Soviet republics. In some countries in this region, family planning services are only now becoming available. Nevertheless, increases in contraceptive use are already having an effect in lowering levels of abortion.

Societies Can Do Much to Reduce Unplanned Pregnancy and Abortion

Even the best practice of contraception will not eliminate the need for abortion. In Western Europe, where couples want very small families and the use of both modern and traditional birth control methods is extremely high, the average annual abortion rate is 11 per 1,000 women of childbearing age, a low but by no means negligible level.[3]

One of the reasons why abortion has not disappeared in Western Europe is that all available contraceptive methods have some risk of failure, and all people are fallible, especially when it comes to sexual behavior.

Given these realities, it becomes apparent that countries must take certain crucial actions: They must give priority to introducing contraceptive services where these are nonexistent, and to expanding and improving them where they are inadequate. Where contraceptive and abortion services are of high quality and easily accessible, governments still need to give priority to maintaining them. And where unsafe abortion exists, governments must try to create a consensus in favor of addressing its harmful social and health consequences.

In some countries, increased political will is clearly needed if the many existing barriers to continuous and effective contraceptive use are to be lowered or removed. But if the availability of contraception is to be expanded, help is needed from both the private and the public health sectors.

A Country's Assessment of Its Situation Is the First Step Toward Taking Action

The threats to women's health and well-being associated with unplanned pregnancy and unsafe abortion are less severe in some places than in others. Nevertheless, most countries have unfinished business of some kind if they are to reduce the level of unplanned pregnancy and the need for abortion. Table 6a presents a framework involving four scenarios—of increasing degrees of seriousness, going from A to D—to describe typical situations in differing parts of the world.

This framework addresses four considerations: How high are levels of unplanned pregnancy? How high are levels of induced abortion? What is the legal status of induced abortion? Are safe abortion services widely available to and accessible by most women?

Under the first scenario, unplanned pregnancy and abortion levels are both low, abortion is legal and high-quality services are within the reach of most women. This requires that all women of childbearing age—adolescents and the unmarried included—have access to effective methods of contraception. Very few countries fall into this category—for example, Belgium, Switzerland and the Netherlands.

At the other end of the spectrum, many women have abortions to resolve high levels of unwanted pregnancy, abortion is permitted only on the most narrow grounds, and clandestine services often are dangerous and expose women to the risk of possible death, disability and prosecution. Almost all countries in Africa, the Middle East, Latin America and Southeast Asia, as well as some in South Asia, fit into this scenario.

Policymakers, health planners, nongovernmental health and development organizations, professional bodies, international agencies and donors can decide roughly where individual countries might fit along this spectrum. They can then review possible policy responses to address reproductive health and broad social problems faced by individual countries or regions.

Policy and Program Responses Are Needed on a Range of Issues

Given the multiplicity of causes of unplanned pregnancy, solutions are likely to be wide-ranging. The scenarios presented in Table 6a suggest that countries in categories A and B have the fewest issues to address. Obviously, most of these countries would like to see further improvement in their levels of unwanted pregnancy and effective contraceptive use. By and large, therefore, their major needs are to make sexuality and family life education more universally available and effective, intensify and expand access to good contraceptive and abortion services, and address the needs of disadvantaged groups.

Countries in category C, where abortion is legal but access to safe services is poor, have an intermediate level of need for action. As exemplified by India, their most pressing needs are to continue to expand the range of contracep-

Table 6a. **Countries are in differing situations regarding abortion and face varied policy choices.**

SCENARIO	POLICY OPTIONS
A: Levels of unplanned pregnancy and abortion are low; abortion is legal; services are safe and generally accessible.	Provide comprehensive sexuality and family life education. Maintain access to high-quality contraceptive services. Maintain access to safe abortion services. Improve access to all reproductive health services (including contraception and abortion) for relatively disadvantaged groups (e.g., adolescents, poor and rural women, immigrants). Improve socioeconomic conditions of relatively disadvantaged groups.
B: Levels of unplanned pregnancy and abortion are moderate to high; abortion is legal; services are safe and generally accessible.	Provide comprehensive sexuality and family life education. Improve access to contraceptive services. Maintain access to safe abortion services. Improve access to all reproductive health services (including contraception and abortion) for relatively disadvantaged groups (e.g., adolescents, poor and rural women, immigrants). Improve socioeconomic conditions of relatively disadvantaged groups. Investigate factors that contribute to high levels of unplanned pregnancy.
C: Levels of unplanned pregnancy and abortion are moderate to high; abortion is legal; some abortions occur in unsafe conditions; access is poor.	Provide comprehensive sexuality and family life education. Improve access to contraceptive services. Improve availability of and access to safe abortion services. Encourage use of manual vacuum aspiration over dilation and curettage for treatment of complications. Improve access to all reproductive health services (including contraception and abortion) for relatively disadvantaged groups (e.g., adolescents, poor and rural women, immigrants). Improve socioeconomic conditions of relatively disadvantaged groups. Investigate factors that contribute to high levels of unplanned pregnancy.
D: Levels of unplanned pregnancy and abortion span the range of low to high; abortion is illegal or highly restricted; most abortions occur in unsafe conditions; access is poor.	Provide comprehensive sexuality and family life education. Improve access to contraceptive services. Improve access to all reproductive health services (including contraception and postabortion contraceptive counseling and services). Improve access to all reproductive health services (including contraception) for relatively disadvantaged groups (e.g., adolescents, poor and rural women, immigrants). Encourage use of manual vacuum aspiration and dilation and curettage for treatment of complications. Improve treatment of women with complications of abortion. Stop prosecution of women undergoing abortion and of abortion providers. Investigate approaches for making safe abortion services available under some existing legal circumstances or under new interpretations of current law. Document incidence of abortion and the impact of unsafe abortion on women, families and society. Educate the public about the consequences and costs of unsafe abortion. Encourage public debate on the legal status of abortion.

tive methods available and to improve the availability and accessibility of good-quality safe abortion services.

The countries with the greatest need fall into category D. For the most part, these countries are in the developing world and are extremely poor, which means that without international support, their program options are severely limited. They can ignore the problem altogether, as some now do. In that event, however, they will continue to suffer the consequences of crowded urban hospitals' being forced to use scarce health resources to treat thousands of women each year for serious complications resulting from unsafe abortion.

They can continue, as some also do, to tolerate a two-tier situation based on socioeconomic status. Better-off women—usually those living in large urban centers—can obtain safe abortions under clandestine circumstances (to which the authorities turn a blind eye). At the same time, adolescents, poor women and rural women usually must try to induce their own abortions or use the services of unskilled practitioners applying dubious and often highly dangerous traditional methods.

A more humane, as well as a more practical, approach from an economic standpoint would be for countries in this group to acknowledge the problem and to deal with it effectively. As first steps, they might consider introducing, or improving, services to treat women hospitalized for complications of unsafe abortion and improving access to contraception.

Where a more advanced level of awareness and political will to bring about change exists, countries might consider initiatives to introduce gradual or even total reforms in their abortion laws. However, it should be emphasized that chipping away at restrictive laws—for example, by expanding the grounds for legal abortion to include rape and incest—usually has mainly symbolic value (although symbols can be important). In general, the impact of such

reforms on women's health conditions and on equal access to reproductive rights is minimal, or even nonexistent.

Nevertheless, in countries where rape is being used as a tool of war or ethnic oppression, even this small reform might bring untold relief to many women. Moreover, small changes of all kinds often open the way for broader debate of the issues surrounding abortion practice and reform.

Reducing Unsafe Abortion Is Feasible

Some countries are afraid of the prospect of legal reform, not just because they fear pressure from powerful religious and political forces, but also because they believe that the demand for legal abortion services of good quality will impose a further burden on their already overtaxed health infrastructures. This is a burden they might feel unable to assume in the light of severe fiscal constraints and the pressure brought on health services by epidemics such as HIV.

However, these fears are unfounded. As this report has shown, a sustained rise in the level of abortion rarely follows the liberalization of abortion laws. The need and demand for abortion are likely to decline if liberalization is accompanied by a broad range of policies and programs to enhance reproductive health services, improve sexuality and contraceptive education, expand support services for women and families, offer contraceptive counseling and services to women who have had an abortion and encourage adolescents to delay sexual activity.

Additionally, in many developing countries, as is now the case in some wealthy developed countries, the private sector can become a substantial source of abortion services, thus alleviating the burden on overextended public health providers.

What is more, the demand for services to treat women who have had unsafe abortions would decline and eventually disappear under conditions of legality. The government resources now being spent on such services could then be directed elsewhere.

Reducing Unplanned Pregnancy Is a Global Responsibility

This report has documented that induced abortions occur everywhere, both in countries where the procedure is legal and in those where it is not. It has also shown that the vast majority of unsafe abortions occur in the developing world, mostly in countries where the procedure is illegal and often among the world's poorest women.

This last finding should generate the most concern. Where safe abortion services are not available or are difficult to obtain, women face severe risks of infection, illness, disability and death. And, as in every other aspect of reproductive health, the women most likely to die or suffer lifelong disability are the poor.

The Cairo Plan Addresses Unplanned Pregnancy and Abortion

"All Governments and relevant intergovernmental and non-governmental organizations are urged to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family-planning services. Prevention of unwanted pregnancies must always be given the highest priority and every attempt should be made to eliminate the need for abortion. Women who have unwanted pregnancies should have ready access to reliable information and compassionate counselling. Any measures or changes related to abortion within the health system can only be determined at the national or local level according to the national legislative process. In circumstances where abortion is not against the law, such abortion should be safe. In all cases, women should have access to quality services for the management of complications arising from abortion. Post-abortion counselling, education and family planning services should be offered promptly, which will also help to avoid repeat abortions."[1]

At the 1994 International Conference on Population and Development, held in Cairo, the world community agreed that unsafe abortions cause unacceptable levels of morbidity and mortality. It is up to the international community and to the governments of individual countries to decide whether the actions recommended in Cairo to reduce the toll of suffering exacted by unsafe abortion (see box) are being adequately implemented.

Ultimately, all governments must ask themselves whether they can afford to allow unsafe abortions to continue to threaten the health and survival of women and their families. And people everywhere must question whether it is morally acceptable for the world to continue to ignore the grave human rights abuses and the glaring health inequities inherent in the abortion policies and practices that prevail in many parts of the world.

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Box: Sources for Information on Conditions in Which Abortions Are Performed

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2. Division of Reproductive Health, WHO, Unsafe abortion: global and regional estimates of incidence of and mortality due to abortion, with a listing of available country data, third ed., Geneva: WHO, 1998.

Chapter 6: Unplanned Pregnancy and Abortion

1. The estimates combine the following measures: **Births:** United Nations (UN) medium projection for 1999 (source: UN, *World Population Prospects: The 1996 Revision—Annex II and III,* New York: UN, 1996). **Abortions:** The 1995 number is used, on the assumption that this number will not change in the short run (source: Appendix Table 3). **Miscarriages and stillbirths:** Bongaarts J and Potter RG, *Fertility, Biology and Behavior: An Analysis of the Proximate Determinants,* New York: Academic Press, 1983, p. 39. **Women aged 15–44:** UN, *The Sex and Age Distribution of the World Populations: The 1996 Revision,* New York: UN, 1997. **Planning status of births:** Averages of the proportion of recent births reported by women as unwanted or mistimed, based on countries within a region that have these data, are applied to the total number of births for that region. The averages unwanted and mistimed are 8% and 17%, respectively, for Africa (based on data for 26 countries); 8% and 9%, respectively, for East Asia (based on data for Indonesia); 11% and 13%, respectively, for the rest of Asia (based on data for eight countries); 23% and 24%, respectively, for Latin America (based on data for 11 countries); 4% and 15% for Europe (based on data for France and Sweden); and 8% and 27% for Canada, the United States, Oceania and Japan (based on data for all but Oceania). These regional averages were aggregated to create estimates for the world (10% unwanted and 15% mistimed), for developed countries (6% and 20%, respectively) and for developing countries (11% and 14%, respectively).

2. Ibid.

3. Appendix Table 3.

Box: The Cairo Plan

1. United Nations (UN), *Report of the International Conference on Population and Development, Cairo, 5–13, September 1994,* New York: UN, 1994, para. 8.25, pp. 58–59.

Appendix Table 1. **Measures of sexual activity, contraceptive use and fertility preferences related to the risk of unplanned pregnancy among women in 49 countries**

Country and survey year	% of never-married women 15–44 ever sexually active	% of formerly married women 15–49 sexually active[1]	% of married women 15–49 who do not want a child soon[2]			% of unmarried sexually active women 15–24			Mean desired family size[4]	% of unplanned births among women 15–49[5]		
			Using no method	Using periodic abstinence	Using other traditional methods[3]	Using no method	Using periodic abstinence	Using other traditional methods[3]		Total	Mistimed	Unwanted
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
SUB-SAHARAN AFRICA												
BOTSWANA, 1988	78	68	26	0	1	57	1	0	4	53	48	5
BURKINA FASO, 1992–1993	22	35	19	2	2	63	20	5	5	24	21	3
BURUNDI, 1987	4	19	54	4	2	[59]	[26]	[2]	5	24	19	5
CAMEROON, 1991	55	61	17	5	2	24	60	11	5	20	16	4
CENTRAL AFRICAN REP., 1994–1995	46	51	20	3	1	68	20	4	5	23	16	7
CÔTE D'IVOIRE, 1994	70	53	25	4	1	49	35	2	5	28	20	8
GHANA,1993	56	46	30	6	3	63	18	5	4	43	34	8
KENYA, 1993	46	55	37	4	1	65	18	0	4	51	35	17
LIBERIA, 1986	78	68	30	1	0	80	3	1	5	u	u	u
MADAGASCAR, 1992	45	44	39	7	2	75	21	2	5	23	9	14
MALAWI, 1992	u	u	48	2	3	u	u	u	5	41	27	14
MALI, 1987	7	29	39	1	1	u	u	u	5	14	10	4
NAMIBIA, 1992	53	55	29	0	1	60	2	1	4	34	21	12
NIGER, 1992	9	24	37	0	1	53	4	18	6	13	11	2
NIGERIA, 1990	37	33	26	1	1	58	21	10	5	11	8	2
RWANDA, 1992	9	26	48	4	3	61	13	2	4	49	24	25
SENEGAL, 1992–1993	15	30	39	1	1	63	8	4	5	28	23	4
TANZANIA, 1991–1992	40	55	32	1	2	84	9	1	5	22	14	7
TOGO, 1988	59	51	22	4	6	40	41	11	5	39	32	7
UGANDA, 1995	33	23	37	3	3	55	16	1	5	29	22	7
ZAMBIA, 1992	50	48	30	1	4	92	2	2	5	32	26	6
ZIMBABWE, 1994	18	55	16	0	5	52	3	3	4	42	34	8
NORTH AFRICA & MIDDLE EAST												
EGYPT, 1992	u	u	27	1	2	u	u	u	3	34	8	26
MOROCCO, 1992	u	u	27	3	3	u	u	u	3	33	15	19
SUDAN, 1989–1990	u	u	36	2	1	u	u	u	5	23	19	4
TUNISIA, 1988	u	u	26	6	3	u	u	u	3	32	19	13
YEMEN, 1991–1992	u	u	32	0	2	u	u	u	5	u	u	u
ASIA												
BANGLADESH, 1993–1994	u	7	29	5	3	u	u	u	3	32	19	13
INDIA, 1992–1993	u	u	27	2	1	u	u	u	3	21	13	9
INDONESIA, 1994	u	2	23	1	1	u	u	u	4	17	9	8
PAKISTAN, 1990–1991	u	u	43	1	1	u	u	u	4	21	8	13
PHILIPPINES, 1993	u	13	35	7	7	u	u	u	3	44	28	16
SRI LANKA, 1987	u	16	17	13	5	u	u	u	3	36	23	13
THAILAND, 1987	u	19	20	1	1	u	u	u	3	31	17	14
TURKEY, 1993	u	u	17	1	26	u	u	u	2	31	11	20
LATIN AMERICA & CARIBBEAN												
BOLIVIA, 1993–1994	15	22	30	20	5	49	29	3	3	54	18	36
BRAZIL, 1996	27	63	9	3	3	35	2	4	2	47	25	22
COLOMBIA, 1995	23	51	9	4	7	45	13	6	3	45	23	21
DOMINICAN REP., 1991	6	52	19	2	2	61	5	14	3	38	23	15
ECUADOR, 1987	8	20	32	5	2	[71]	[0]	[6]	3	35	21	14
EL SALVADOR, 1985	u	24	28	2	1	u	u	u	3	49	22	26
GUATEMALA, 1987	5	24	40	3	1	[93]	[7]	[0]	4	26	16	10
MEXICO, 1987	4	24	20	4	3	38	9	6	3	51	24	27
PARAGUAY, 1990	26	35	23	4	7	76	6	3	4	23	16	7
PERU, 1996	15	27	18	16	4	42	22	5	3	58	23	35
TRINIDAD & TOBAGO, 1987	3	29	26	2	5	[50]	[0]	[20]	3	35	19	16
DEVELOPED COUNTRIES												
FRANCE, 1994	u	u	9	u[6]	5	u	u	u	2	19	15	4
JAPAN, 1992	u	u	20	u[6]	8	u	u	u	3	52	48	4
UNITED STATES, 1995	59	67	5	2	2	28	1	4	2	30	21	9

FOR NOTES AND SOURCES, SEE PAGE 53.

Appendix Table 2. **Countries, by reasons for which abortion is legally permitted, according to region, 1997**

Reasons	The Americas and the Caribbean	Central Asia, the Middle East and North Africa	East and South Asia and Pacific	Europe	Sub-Saharan Africa	
To save the woman's life[1]	BRAZIL (R) CHILE COLOMBIA DOMINICAN REP. EL SALVADOR GUATEMALA HAITI HONDURAS MEXICO (R) NICARAGUA PANAMA (R,F) PARAGUAY VENEZUELA	AFGHANISTAN EGYPT IRAN LEBANON LIBYA OMAN SUDAN (R) SYRIA UNITED ARAB EMIRATES YEMEN	BANGLADESH INDONESIA LAOS MYANMAR NEPAL PAPUA NEW GUINEA PHILIPPINES SRI LANKA	IRELAND	ANGOLA BENIN CENTRAL AFR. REP. CHAD CONGO CÔTE D'IVOIRE DEM. REP. OF CONGO (F) GABON GUINEA-BISSAU KENYA LESOTHO	MADAGASCAR MALI MAURITANIA MAURITIUS NIGER NIGERIA SENEGAL SOMALIA TANZANIA TOGO UGANDA
To save the woman's life or protect her physical health	ARGENTINA (R) BOLIVIA (R,I) COSTA RICA ECUADOR (R,I) PERU URUGUAY (R)	KUWAIT (F) MOROCCO SAUDI ARABIA	PAKISTAN SOUTH KOREA (R,I,F) THAILAND (R)	POLAND (R,I,F)	BURKINA FASO (R) BURUNDI CAMEROON (R) ERITREA ETHIOPIA GUINEA	MALAWI MOZAMBIQUE RWANDA ZIMBABWE (R,I,F)
All of the above plus to protect mental health	JAMAICA TRINIDAD & TOBAGO	ALGERIA IRAQ (F,R,I) ISRAEL (F,R,I) JORDAN	AUSTRALIA HONG KONG (F,R,I) MALAYSIA NEW ZEALAND (F,I)	NORTHERN IRELAND PORTUGAL (F,R) SPAIN (F,R) SWITZERLAND	BOTSWANA (F,R,I) GAMBIA GHANA (F,R,I)	LIBERIA (F,R,I) NAMIBIA (F,R,I) SIERRA LEONE
All of the above plus socioeconomic grounds			INDIA (R,F) JAPAN TAIWAN (I,F)	FINLAND (R,F) GREAT BRITAIN (F)	ZAMBIA	
General, without restriction as to reason	CANADA CUBA UNITED STATES PUERTO RICO	ARMENIA AZERBAIJAN GEORGIA KAZAKHSTAN KYRGYZSTAN TAJIKISTAN TUNISIA TURKEY TURKMENISTAN UZBEKISTAN	CAMBODIA CHINA MONGOLIA NORTH KOREA SINGAPORE VIETNAM	ALBANIA AUSTRIA BELARUS BELGIUM BOSNIA-HERZEGOVINA BULGARIA CROATIA CZECH REPUBLIC DENMARK ESTONIA FRANCE GERMANY GREECE HUNGARY ITALY LATVIA LITHUANIA MACEDONIA MOLDOVA NETHERLANDS NORWAY ROMANIA RUSSIAN FEDERATION SLOVAK REPUBLIC SLOVENIA SWEDEN UKRAINE YUGOSLAVIA	SOUTH AFRICA	

1. This category includes a few countries where abortion is not allowed on any grounds, even to save a woman's life. However, in some of these countries, legal appeals on grounds of saving a woman's life may be successful. *Notes:* F= Abortion also allowed in cases of fetal impairment. I = Abortion also allowed in cases of incest. R=Abortion also allowed in cases of rape. *Source:* Rahman A, Katzive L and Henshaw SK, A global review of laws on induced abortion, 1985–1997, *International Family Planning Perspectives,* 1998, 24(2):56–64.

Appendix Table 3. **Global and regional estimates of the number of legal and illegal abortions, abortion rate per 1,000 women 15–44 and abortion ratio per 100 pregnancies, 1995**

Region and subregion	Number of abortions (millions)			% illegal	Abortion rate	Abortion ratio
	Total	Legal	Illegal			
WORLD	**45.5**	**25.6**	**19.9**	**44**	**35**	**26**
DEVELOPED REGIONS	**10.0**	**9.1**	**0.9**	**9**	**39**	**41**
DEVELOPING REGIONS	**35.5**	**16.5**	**19.0**	**54**	**34**	**23**
AFRICA	**5.0**	[1]	**5.0**	**99**	**33**	**15**
EAST AFRICA	1.9	[1]	1.9	100	41	16
MIDDLE AFRICA	0.6	[1]	0.6	100	35	14
NORTH AFRICA	0.6	[1]	0.6	96	17	12
SOUTHERN AFRICA	0.2	[1]	0.2	100	19	12
WEST AFRICA	1.6	[1]	1.6	100	37	15
ASIA	**26.8**	**16.9**	**9.9**	**37**	**33**	**25**
EAST ASIA	12.5	12.5	[1]	[2]	36	34
SOUTH CENTRAL ASIA	8.4	1.9	6.5	78	28	18
SOUTHEAST ASIA	4.7	1.9	2.8	60	40	28
WEST ASIA	1.2	0.7	0.5	42	32	20
EUROPE	**7.7**	**6.8**	**0.9**	**12**	**48**	**48**
EASTERN EUROPE	6.2	5.4	0.8	13	90	65
NORTHERN EUROPE	0.4	0.3	[1]	8	18	23
SOUTHERN EUROPE	0.8	0.7	0.1	12	24	34
WESTERN EUROPE	0.4	0.4	[1]	[2]	11	17
LATIN AMERICA & CARIBBEAN	**4.2**	**0.2**	**4.0**	**95**	**37**	**27**
CARIBBEAN	0.4	0.2	0.2	47	50	35
CENTRAL AMERICA	0.9	[1]	0.9	100	30	21
SOUTH AMERICA	3.0	[1]	3.0	100	39	30
UNITED STATES & CANADA	**1.5**	**1.5**	[1]	[2]	**22**	**26**
OCEANIA	**0.1**	**0.1**	[1]	**22**	**21**	**20**

1. Fewer than 50,000 abortions. 2. Less than 0.5%. *Notes:* Numbers may not add to totals because of rounding; percentages presented in the text and in Chart 4.1 are based on unrounded numbers. Pregnancies are defined as abortions plus live births. Developed regions are defined as all of Europe, Australia, Canada, Japan, New Zealand and the United States; all other countries are defined as developing. Geographic regions are defined as by the United Nations: Eastern Europe consists of Belarus, Bulgaria, Czech Republic, Hungary, Moldova, Poland, Romania, Russian Federation, Slovak Republic and Ukraine; East Asia consists of China, Hong Kong, Japan, Macao, Mongolia, North Korea and South Korea. *Sources:* **Populations:** United Nations (UN), *The Sex and Age Distribution of the World Population: The 1996 Revision,* New York: UN, 1997. **Births:** UN, *World Population Prospects: The 1996 Revision, Annex II and III,* New York: UN, 1996. **Illegal abortions:** Division of Reproductive Health, World Health Organization (WHO), Unsafe abortion: global and regional estimates of incidence of and mortality due to abortion, with a listing of available country data, third ed., Geneva: WHO, 1998. **Legal abortions:** Estimates from local experts were used when available. In countries where abortion reporting is incomplete or nonexistent, estimates were based on local experts and abortion rates in countries with similar abortion service provision. See box on page 31 for more details on data quality and sources.

NOTES AND SOURCES FOR APPENDIX TABLE 1

1. Sexually active in the past three months. 2. In Brazil, Guatemala and the United States, women 15–44 were surveyed; in France, women 20–49 were surveyed. In all countries of Sub-Saharan Africa and Latin America, and in Morocco, the Philippines, France and the United States, all women were surveyed, regardless of their marital status. In the remaining countries of North Africa and the Middle East and Asia, only ever-married women were included; in Japan, only currently married women were surveyed. Marriage includes legal and consensual unions. 3. Withdrawal and folk methods. 4. Women who say their desired family size is "up to God" are assumed to want six children. 5. In North Africa, the Middle East and Asia, data are for ever-married women; in other regions, data are for all women. Percentages are based on births in the five years before the survey. Unplanned births are the total that the respondent reported as not wanted at the time she became pregnant (mistimed) and not wanted at any time (unwanted). 6. Included in column 5. *Notes:* u=unavailable. Percentages in brackets denote that the denominator was 10–19 cases. *Sources:* **Developing countries:** Demographic and Health Surveys. **Developed countries:** national fertility surveys (see box on page 12).

Appendix Table 4. **Measures of legal induced abortion, by country, and completeness of statistics**

Country, completeness of statistics and year	Number of abortions[1]	Abortion rate per 1,000 women 15–44	Abortion ratio per 100 pregnancies[2]	Total abortion rate[3]
	(1)	(2)	(3)	(4)
STATISTICS BELIEVED TO BE COMPLETE				
AUSTRALIA, 1995–1996	91,900	22.2	26.4	0.57
BELARUS, 1996	155,700	67.5	61.9	2.04
BELGIUM, 1996[4]	14,600	6.8	11.2	0.21
BULGARIA,1996	89,000	51.3	55.2	1.55
CANADA, 1995[5]	106,700	15.5	22.0	0.49
CUBA, 1996	209,900	77.7	58.6	2.33
CZECH REPUBLIC,1996	46,500	20.7	34.0	0.63
DENMARK, 1995	17,700	16.1	20.3	0.48
ENGLAND & WALES, 1996[6]	167,900	15.6	20.5	0.48
ESTONIA, 1996	16,900	53.8	56.0	1.63
FINLAND, 1996	10,400	10.0	14.7	0.31
GERMANY, 1996	130,900	7.6	14.1	0.23
HUNGARY, 1996	76,600	34.7	42.1	1.07
ISRAEL, 1995	17,600	14.3	13.1	0.43
KAZAKHSTAN, 1996	178,000	43.9	41.3	1.32
LATVIA, 1996	23,100	44.1	53.9	1.33
NETHERLANDS, 1996[6]	22,400	6.5	10.6	0.20
NEW ZEALAND, 1995	13,700	16.4	19.1	0.49
NORWAY, 1996	14,300	15.6	19.1	0.47
PUERTO RICO, 1991–1992	19,200	22.7	23.0	0.68
SCOTLAND, 1996[7]	12,300	11.2	17.2	0.34
SINGAPORE, 1996	14,400	15.9	22.8	0.48
SLOVAK REPUBLIC, 1996	24,300	19.7	28.8	0.59
SLOVENIA, 1996	10,400	23.2	35.7	0.70
SWEDEN, 1996	32,100	18.7	25.2	0.56
SWITZERLAND, 1996[8]	12,800	8.4	13.3	0.25
TUNISIA, 1996	19,000	8.6	7.8	0.26
UNITED STATES, 1996	1,365,700	22.9	25.9	0.69
STATISTICS INCOMPLETE OR OF UNKNOWN COMPLETENESS				
ALBANIA, 1996	21,200	27.2	23.7	0.82
ARMENIA, 1996	31,300	35.4	39.4	1.06
AZERBAIJAN,1996	28,400	16.0	18.0	0.49
BANGLADESH, 1995–1996[9]	100,300	3.8	3.1	0.11
CHINA, 1995	7,930,000	26.1	27.4	0.78
CROATIA, 1996	12,300	12.9	18.7	0.38
FRANCE, 1995	156,200	12.4	17.7	0.37
GEORGIA, 1996	26,600	21.9	33.2	0.66
HONG KONG, 1996	25,000	15.1	27.9	0.45
INDIA, 1995–1996	566,500	2.7	2.1	0.08
IRELAND, 1996[10]	4,900	5.9	8.9	0.18
ITALY, 1996	140,400	11.4	21.1	0.34
JAPAN, 1995	343,000	13.4	22.4	0.40
KOREA (SOUTH), 1996[11]	230,000	19.6	24.6	0.59
KYRGYZSTAN, 1996	24,600	22.4	17.5	0.67
LITHUANIA, 1996	27,800	34.4	41.5	1.03
MACEDONIA, 1996	14,200	28.5	31.1	0.86
MOLDOVA, 1996	38,900	38.8	42.7	0.83
MONGOLIA, 1996	15,600	25.9	18.2	0.78
ROMANIA, 1996	394,400	78.0	63.0	2.34
RUSSIAN FEDERATION, 1995	2,287,300	68.4	62.6	2.56
SOUTH AFRICA, 1997	26,400	2.7	2.4	0.08
SPAIN, 1996	51,000	5.7	12.6	0.17
TAJIKISTAN, 1990[12]	55,500	49.1	21.2	1.47
TURKEY, 1993[11]	351,300	25.0	20.5	0.75
TURKMENISTAN, 1990[12]	37,200	44.9	22.9	1.35
UKRAINE, 1996	635,600	57.2	57.6	1.72
UZBEKISTAN, 1996	63,200	11.8	9.5	0.35
VIETNAM, 1996[13]	1,520,000	83.3	43.7	2.50
YUGOSLAVIA, FR, 1993	119,300	54.6	45.8	1.64
ZAMBIA, 1983	1,200	0.4	0.4	0.01

FOR NOTES AND SOURCES, SEE PAGE 56.

Appendix Table 5. **Trends in the rate of legal induced abortion per 1,000 women 15–44, by country and completeness of statistics**

Country and completeness of statistics	1975	1980	1982	1984	1986	1988	1990	1991	1992	1993	1994	1995	1996
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
STATISTICS BELIEVED TO BE COMPLETE													
BELARUS	[92.4]	[93.7]	[92.2]	[98.4]	[79.2]	100.3	101.7	94.1	92.8	83.8	80.1	75.4	67.5
BELGIUM	u	u	u	u	7.0[1]	7.4[1]	u	u	u	6.1	6.2	6.2	6.8
BULGARIA	64.3	76.7	73.1	61.9	65.5	64.1	70.3	67.6	64.9	55.0	49.9	50.0	51.3
CANADA[2]	10.5	12.6	12.5	11.4	11.2	11.6	14.6	14.7	15.1	15.3	15.5	15.5	u
CUBA	65.3	47.1	55.3	58.9	62.6	58.0	87.2[3]	86.6[3]	85.3[3]	71.1[3]	75.3[3]	76.8[3]	77.7[3]
CZECH REPUBLIC	26.4	32.3	34.5	36.5	37.9	48.7	47.7	45.9	41.6	30.8	23.8	21.4	20.7
DENMARK	27.0	21.4	19.3	18.5	17.7	18.6	18.2	17.6	16.8	16.9	15.9	16.1	u
ENGLAND & WALES[4]	11.2	12.8	12.2	12.8	13.5	15.3	15.8	15.2	14.8	14.7	14.6	14.4	15.6
ESTONIA	[126.2]	[113.3]	[115.0]	[107.7]	[110.3]	[95.5]	[74.6]	79.0	78.2	72.0	61.9	55.8	53.8
FINLAND	20.4	13.9	12.6	12.3	12.0	11.5	11.1	10.7	10.2	9.6	9.4	9.3	10.0
HUNGARY	41.9	36.3	35.5	37.0	37.7	39.5	41.2	40.6	39.1	33.7	33.4	34.7	34.7
ISRAEL	u	17.9	19.8	21.4	18.4	16.5	15.8	15.5	15.5	14.2	13.7	14.3	u
KAZAKHSTAN	[124.0]	[108.3]	[103.3]	[98.1]	[91.5]	[97.1]	[92.4]	82.9	80.5	65.5	57.0	49.2	43.9
LATVIA	[107.1]	[107.0]	[106.4]	[106.2]	[98.5]	[90.2]	[76.9]	64.7	59.7	55.2	47.9	46.7	44.1
NETHERLANDS[4]	5.2	6.7	6.3	5.6	5.3	5.1	5.2	5.6	5.6	5.7	6.0	6.1	6.5
NEW ZEALAND	u	8.6	9.6	9.7	10.5	12.8	14.0	14.4	14.3	14.6	15.7	16.4	u
NORWAY	19.7	16.3	15.8	15.9	17.1	17.2	16.8	16.8	16.5	16.3	16.7	14.9	15.6
SCOTLAND	8.1	8.4	8.4	8.9	9.2	9.7	9.8	9.6	10.3	10.4	10.7	10.4	11.2
SINGAPORE[5]	23.5	28.4	28.6	32.2	32.9	28.0	22.5	21.0	20.0	19.2	18.2	16.4	15.9
SLOVAK REPUBLIC	24.8	28.7	29.9	30.5	35.6	43.1	40.5	37.8	35.2	31.9	28.1	23.4	19.7
SLOVENIA	u	u	u	u	40.3	37.0	32.5	30.9	29.3	26.9	25.1	24.8	23.2
SWEDEN	20.2	20.7	19.0	17.7	18.9	21.4	21.3	20.4	20.0	19.7	18.7	18.3	18.7
SWITZERLAND[6]	u	11.3	u	9.3	u	u	8.7	8.6	8.3	8.0	7.8	u	8.4
TUNISIA	13.7	15.1	14.7	13.7	13.6	13.6	11.0	10.8	10.0	9.5	9.6	9.4	8.6
UNITED STATES	21.7	29.3	28.8	28.1	27.4	27.3	27.4	26.3	25.9	25.4	24.1	22.9	22.9
STATISTICS INCOMPLETE OR OF UNKNOWN COMPLETENESS													
ALBANIA	u	u	u	u	u	7.4	7.3	15.9	23.1	33.1	30.4	29.3	27.2
ARMENIA	[69.1]	[43.2]	[42.0]	[43.3]	[48.4]	35.8	31.1	32.2	32.7	32.3	35.1	35.0	35.4
AZERBAIJAN	[48.7]	[43.3]	[43.1]	[37.7]	[32.4]	26.4	14.3	19.6	18.5	19.2	18.8	16.2	16.0
BANGLADESH[7, 8]	u	0.6	2.3	2.9	3.5	3.7	4.1	3.4	4.1	4.0	4.5	3.3	3.8
CHINA	27.5	44.8	54.9	36.6	44.4	46.2	u	40.0	35.6	27.9	24.5	26.1	u
CROATIA	41.6	50.3	u	u	52.6	44.8	40.1	34.6	27.2	26.2	20.5	14.9	12.9
FRANCE	u	15.3	15.8	15.4	13.9	13.4	13.5	13.6	13.2	13.2	12.9	12.4	u
GEORGIA	[85.7]	[76.4]	[71.6]	[60.3]	[64.0]	[66.0]	43.1	42.0	34.9	33.9	34.6	29.0	21.9
GERMANY[9]	na	na	na	na	na	na	8.5	7.1	6.9	6.5	6.0	5.7	7.6
HONG KONG	1.1	8.7	10.3	11.3	12.4	13.0	14.5	14.9	16.2	16.9	16.4	15.6	15.1
INDIA[8]	0.8	2.5	2.9	3.3	3.3	3.4	3.3	3.1	3.3	3.1	3.1	3.1	2.7
IRELAND[10]	2.6	4.8	5.2	5.3	5.2	5.0	5.4	5.4	5.6	5.6	5.8	5.7	5.9
ITALY	u	18.7	19.6	18.4	16.0	14.2	13.0	12.5	12.3	12.1	11.5	11.2	11.4
JAPAN	25.2	22.5	22.5	21.4	19.8	18.2	17.0	16.1	15.4	14.6	14.0	13.4	u
KOREA (SOUTH)[11]	63.9	64.0	u	50.2	u	u	36.5	u	u	33.7	u	u	19.6
KYRGYZSTAN	[96.0]	[84.0]	[83.9]	[79.0]	[84.2]	[87.6]	[82.3]	63.3	45.0	39.1	38.1	29.4	22.4
LITHUANIA	[61.7]	[59.0]	[58.4]	[54.3]	49.6	43.4	33.8	50.0	50.1	43.0	37.1	38.2	34.4
MACEDONIA	45.2	64.1	68.6	65.1	70.6	66.7	52.2	48.4	41.2	38.6	33.6	32.0	28.5
MOLDOVA	[102.7]	[101.2]	[98.8]	[94.1]	[113.5]	[104.7]	[82.7]	63.6	61.2	54.6	49.7	49.1	38.8
ROMANIA	u	u	u	u	u	u	181.7	158.7	123.6	102.4	91.6	86.6	78.0
RUSSIAN FEDERATION	[129.4]	[123.1]	[124.3]	[124.0]	[124.0]	[126.6]	[109.3]	93.6	88.7	80.5	75.3	68.4	u
SPAIN	u	u	u	u	u	3.1	4.3	4.8	5.1	5.1	5.4	5.5	5.7
TAJIKISTAN	[59.8]	[50.0]	[47.2]	[42.4]	[43.4]	[51.7]	[49.1]	u	u	u	u	u	u
TURKEY[12]	u	u	u	u	46.1	u	u	u	u	25.0	u	u	u
TURKMENISTAN	[68.4]	[55.6]	[53.9]	[42.7]	[38.1]	[60.9]	[44.9]	u	u	u	u	u	u
UKRAINE	[104.8]	[106.6]	[106.8]	[108.7]	[109.1]	93.1	86.3	80.9	76.5	70.2	66.9	61.4	57.2
UZBEKISTAN	[58.2]	[48.0]	[47.8]	[49.6]	[53.0]	[60.7]	[46.6]	u	23.0	19.3	14.6	12.0	11.8
VIETNAM	5.0	15.0	11.0	13.9	24.8	26.8	66.4	71.1	81.9	81.3	80.2	78.6	83.3
YUGOSLAVIA	88.2	101.4	u	106.6	104.7	94.3	90.0	72.3	65.2	54.6	u	u	u

FOR NOTES AND SOURCES, SEE PAGE 56.

Appendix Table 6. **Abortion rate per 1,000 women by age-group, according to country and completeness of statistics**

Country and year	Less than 20 (1)	20–24 (2)	25–29 (3)	30–34 (4)	35–39 (5)	40 or more (6)
COMPLETE NATIONAL STATISTICS						
AUSTRALIA, 1995–1996	23.9	36.9	29.3	21.9	15.2	6.2
BELGIUM, 1995	6.2	10.1	8.4	6.7	4.5	1.7
BULGARIA, 1995	32.7	85.4	84.1	60.1	30.8	10.9
CANADA, 1995	21.8	31.5	20.9	12.9	8.0	2.8
CUBA, 1990	90.7	87.9	54.4	33.2	15.6	6.1
CZECH REPUBLIC, 1996	12.4	26.7	30.8	28.0	18.9	9.5
DENMARK, 1995	14.8	22.5	21.4	19.1	12.5	5.4
ENGLAND & WALES, 1996	19.2	25.5	18.6	12.4	7.9	3.2
ESTONIA, 1996	33.1	85.3	80.5	62.1	44.2	21.6
FINLAND, 1996	9.6	15.6	13.8	11.2	7.5	3.9
GERMANY, 1995	3.1	7.5	7.6	7.1	5.3	2.6
HUNGARY, 1996	30.4	46.8	48.7	43.5	30.7	13.0
ISRAEL, 1996	10.2	16.3	16.8	17.0	15.9	9.9
KAZAKHSTAN, 1995[1]	14.4	72.3	106.8	76.6	50.8	19.9
NETHERLANDS, 1992	4.2	7.4	7.2	6.6	5.0	1.9
NEW ZEALAND, 1994	19.3	27.3	20.7	13.8	8.6	3.1
NORWAY, 1995	15.2	23.9	20.1	15.1	9.7	4.6
SCOTLAND, 1995[2]	16.6	19.5	12.4	8.0	4.8	2.0
SINGAPORE, 1983	12.0	36.4	40.3	33.7	24.0	10.2
SLOVAK REPUBLIC, 1995	11.1	31.5	38.8	32.7	21.3	8.9
SLOVENIA, 1996	10.9	26.3	27.7	32.1	27.3	14.8
SWEDEN, 1996	17.7	27.5	24.7	20.9	14.8	6.5
UNITED STATES, 1994	33.6	53.0	33.1	18.4	10.0	3.2
INCOMPLETE NATIONAL STATISTICS						
FRANCE, 1995[3]	8.9	18.2	16.6	14.4	10.8	5.3
ITALY, 1995	5.9	12.6	13.8	14.0	12.5	6.9
JAPAN, 1995	6.3	16.6	15.4	17.2	16.9	8.4
KOREA (SOUTH), 1996[4]	u	79.0	51.0	49.0	16.0	3.0
KYRGYZSTAN, 1997[1]	4.9	50.8	77.4	79.4	51.8	27.6
MOLDOVA, 1994–1997[5]	12.0	74.0	81.0	46.0	31.0	16.0
ROMANIA, 1990–1993[1,6]	32.0	153.0	209.0	167.0	79.0	40.0
SPAIN, 1994	4.3	8.0	6.6	5.5	4.5	2.3
TURKEY, 1993[1]	16.1	27.2	39.9	36.9	27.3	15.5
UZBEKISTAN, 1996[1]	1.4	18.2	31.5	34.7	22.0	17.4

1. Rates are based on average number of abortions for the three years preceding the survey. 2. Includes abortions performed in England and Wales. 3. Age is defined as the age attained during the year, rather than at the time of the abortion. 4. Rates are based on a survey of married women 20–44. 5. Rates are calculated for the three years preceding the survey, based on a survey of women, from published report. 6. Rates are calculated for the three years preceding the survey, based on a survey of women aged 15–44, from published report. *Note:* u=unavailable. *Source:* Bankole A, Singh S and Haas TA, Characteristics of women who obtain induced abortion: a worldwide review, *International Family Planning Perspectives,* 1999, 25(forthcoming).

NOTES AND SOURCES FOR APPENDIX TABLE 4

1. Rounded to the nearest 100. 2. Pregnancies are defined as legal abortions plus live births. 3. The number of abortions that would be experienced by the average woman during her reproductive lifetime, given present age-specific abortion rates; where age-specific rates are not available, the total abortion rate is calculated from the annual rate. 4. Including abortions obtained in the Netherlands. 5. Including abortions obtained in the United States. 6. Residents only. 7. Including abortions obtained in England and Wales. 8. Includes estimates for two of the 26 cantons. 9. Menstrual regulations. 10. Based on Irish residents who obtained abortions in England. 11. Based on surveys of ever-marrried women aged 20–44 (Korea) and 15–49 (Turkey). 12. Includes miscarriages. 13. Excludes an estimated 500,000 private-sector abortions. *Source:* Henshaw SK, Singh S and Haas TA, The incidence of abortion worldwide, *International Family Planning Perspectives,* 1999, 25(Supplement):S30–S38.

NOTES AND SOURCES FOR APPENDIX TABLE 5

1. Includes illegal abortions in Belgium in 1986 and 1988, and legal abortions obtained by Belgian residents in England, Wales and the Netherlands. 2. Includes abortions obtained in the United States. 3. Includes menstrual regulation. 4. Residents only. 5. Prior to 1990, rate is based on estimated number of citizens. From 1990 onward, rate is based on estimated resident population. This difference caused a two-point decrease in the abortion rate. 6. Official data for 24 of the 26 cantons; estimated data for the remaining two. 7. Based on menstrual regulations only. 8. Rate for fiscal year ending in indicated year. 9. Data are for unified Germany; reporting improved after 1995. 10. Based on women obtaining abortions in England. 11. Based on survey of ever-married women aged 20–44; the 1980 column presents the 1981 rate. 12. Based on survey of ever-married women aged 15–49; the 1986 column rate presents the 1987 rate. *Notes:* Rates in brackets include spontaneous abortions. u=unavailable. na=not applicable. *Source:* Henshaw SK and Morrow E, *Induced Abortion: A World Review, 1990, Supplement,* New York: The Alan Guttmacher Institute, (AGI), 1990; and AGI, unpublished data, 1998.

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