ภาคผนวก

United State of America

ABORTION POLICY

Grounds on which abortion is permitted:

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

Additional requirements:

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

REPRODUCTIVE HEALTH CONTEXT

Government view on fertility level:	Satisfactory
Government intervention concerning fertility level:	No intervention
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-44, 1990):	67
Total fertility rate (1995-2000):	2.0
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	59
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of childbearing and childbirth	Yes
Maternal mortality ratio (per 100,000 live births, 1990):	
National	12
Developed countries	27
Female life expectancy at birth (1995-2000):	80.1

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United State of America

BACKGROUND

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Court decision of January 1973, which legalized abortion throughout the United States, 18 states had reformed or repealed their anti-abortion legislation.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

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

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

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

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

By upholding the Missouri law requiring physicians to conduct extensive viability tests on women at least 20 weeks pregnant before performing an abortion, the Webster decision weakened the trimester framework established in *Roe v. Wade*. Furthermore, the Court signalled its willingness to give individual

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United State of America

states far greater latitude in placing restrictions on a woman's right to have an abortion. Following the *Webster* decision, restrictive statutes were introduced in a number of state legislatures. For example, within five months of the decision, Pennsylvania enacted a law requiring a woman to notify her husband, receive state-prepared information concerning adoption and child-support alternatives from her physician and delay the procedure for a minimum of 24 hours before obtaining an abortion. Kansas, Mississippi, North Dakota and Ohio likewise imposed similar restrictions requiring anti-abortion information to be provided and imposing mandatory delays. Louisiana, Utah and the territory of Guam went even further and enacted sweeping criminal abortion bans with exceedingly narrow exceptions. Other states, such as Connecticut, moved in the opposite direction by enacting legislation guaranteeing a woman the right to an abortion under the state law.

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

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

Following the *Casey* decision, abortion restrictions in the United States continue to vary by state. As of October 1999, forty states have laws that prevent a minor from obtaining an abortion without parental consent or notice. Thirty-six of these states provide for a judicial bypass procedure as an alternative to parental consent or notification, and eleven provide some alternative to both parental involvement and judicial bypass. In 11 of these states, these laws have been enjoined by courts from enforcement. Of the remaining states, one requires that minors receive counselling that includes discussion of the possibility of consulting her parents before obtaining an abortion and the other allows a minor to receive counselling in place of obtaining parental consent for an abortion.

Twenty-nine states have abortion-specific informed consent laws, many of which require that women be given anti-abortion information and state-prepared materials intended to discourage them from obtaining an abortion. Seventeen states have specific mandatory waiting periods of at least 24 hours between the time at which information is provided and the time at which an abortion may be performed. In five of these states, these laws have been enjoined by courts from enforcement.

Under federal law, states that accept federal Medicaid funds (matching funds provided to the states for health insurance for the poor) are required to pay for abortions sought by Medicaid recipients in cases of pregnancy that is life-endangering or the result of rape or incest. Thirty-two states have declined to use their own funds to pay for abortions for Medicaid recipients other than in these circumstances, and two states (Mississippi and South Dakota) are in violation of federal law by refusing to fund abortions except in case of pregnancy that is life-threatening. Sixteen states use their own funds to pay for medically necessary abortions sought by Medicaid recipients.

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United State of America

The presidential administration that came into office in January 1993 took early action on the issue of federal limitations on abortions. On 22 January 1993, the policies of the previous administrations that were intended to discourage women from obtaining abortions were rescinded. First, the President of the United States lifted restrictions on abortion counselling at federally financed family planning clinics that had been in effect since 1988, as well as the ban on federal research using foetal tissue from aborted foetuses that was imposed in 1989. Another presidential order allowed physicians at United States military hospitals to resume performing abortions for armed services personnel and for their dependants who paid the cost. Federally financed abortions for military personnel have been barred since 1979 except in cases where the life of a pregnant woman is in danger. A fourth order cleared the way for United States funds to flow to international efforts providing abortions and other family planning services. Previously, the 1984 "Mexico City Policy" stipulated that the United States Government would not support international programmes that offered abortion services. Lastly, the President directed the Department of Health and Human Services to review the import ban on the French-made abortion pill, RU-486, and to rescind it if there were grounds for doing so.

However, congressional efforts continued to be directed at restricting the legality of abortion in the United States. One was the reinstatement of the prohibition against physicians at United States military hospitals performing abortions for armed services personnel and their dependants who paid for such abortions. Another was the enactment of legislation prohibiting federal employees' health insurance from including abortion coverage except in the case of life endangerment, rape or incest.

Perhaps the most visible area of congressional activity, though, was reflected in its efforts to restrict the performance of the dilation and extraction procedure for the performance of late-term abortions. Most recent estimates indicate that there were probably some 650 such procedures performed in 1996, accounting for about 0.03-0.05 per cent of all abortions. Legislation was introduced to prohibit the procedure entirely except when necessary to save the life of the pregnant woman. Proponents of the ban characterized the procedure as a brutal act that inflicted unnecessary suffering on the foetus and argued that there were alternative methods that could be used. Opponents of the ban contended that in a small number of cases, the procedure was both necessary to protect the health of the woman and safer than any other procedure employed to induce an abortion. Some, although opposed to the procedures, sought to include within the proposed legislation an additional exception to the ban when necessary to protect the health of the pregnant woman. The legislation was approved by Congress without this health exception by wide margins twice between 1996-1998, but the President of the United States vetoed the legislation, and Congress was unable to override the veto.

A number of states' efforts designed to prohibit the procedure were more successful. By October 1999, thirty states had enacted various versions of legislation to ban the procedure, most of them facing an immediate challenge in court. In twelve states the bans are partially or fully in effect, while in eighteen states, they have been enjoined from enforcement by courts. The great majority of the courts that have considered the validity of such laws have ruled that the laws are deficient in one of three ways: they define the procedure in terms that have no clear medical meaning; the procedures that they do define are so vague as to encompass the performance of abortions before foetal viability, which a woman has a constitutional right to have performed, and thus constitute an "undue burden" on woman's ability to obtain such a pre-viability abortion; and, even if precise in definition, the laws

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do not provide for a health exception to the prohibition as required by *Roe*, *Casey*, and other Supreme Court decisions.

On the other hand, in one area, Congress acted to protect the right of access to abortion services. In 1994, it enacted the Freedom of Access to Clinics Act (FACE) in order to counteract the more extreme activities of pro-life advocates picketing clinics where abortions are performed. The express purpose of the Act is to protect and promote public safety and health by establishing federal criminal penalties and civil remedies for certain violent, threatening, obstructive and destructive conduct that is intended to injure, intimidate or interfere with persons seeking to obtain or provide reproductive health services. To this end, the Act imposes fines and/or imprisonment on persons who contravene its provisions and authorizes persons who are "aggrieved" by conduct prohibited by the Act to sue those engaging in the conduct to obtain injunctions and compensatory and punitive damages. The Act also authorizes the federal Attorney General and states' attorneys general to institute suits on behalf of individuals and groups.

The Act was immediately criticized by some pro-choice individuals and groups as a violation of their constitutional first amendment right to freedom of speech and a violation of the Commerce Clause of the Constitution which restricts the authority of the federal Government to enact legislation unless such legislation regulates interstate activity that has a substantial effect on interstate commerce. As yet the Supreme Court has not ruled on any challenge to the Act, although lower courts have generally upheld its provisions as constitutional. In addition, courts have generally upheld the validity of similar laws enacted by thirteen individuals states to protect access to clinics.

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

The United States Centres for Disease Control and Prevention reported 1,184,758 legal induced abortions in 1997, a 3 per cent decrease from 1996. These figures translate into an abortion rate of 20 abortions per 1,000 women aged 15-44. The abortion rate rose from 13 to 25 abortions per 1,000 women aged 15-44 between 1972 and 1980, and remained stable during much of the 1980s before declining in the 1990s. The 1997 rate of 20 is the lowest since 1975. In 1997, 20 per cent of women obtaining abortions were aged 19 or under, and 32 per cent were aged 20-24. In terms of gestation, 55 per cent of the 1997 abortions were performed within the first 8 weeks, and by 12 weeks that number had increased to 88 per cent. The Alan Guttmacher Institute reports that 49 per cent of pregnancies among American women are unintended and of that number, half are terminated by abortion. African-American women remain three times as likely as white women to have an abortion, and Hispanic women are roughly twice as likely. An estimated 14,000 abortions are obtained each year for rape or incest.

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FRANCE

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

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

REPRODUCTIVE HEALTH CONTEXT

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

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FRANCE

BACKGROUND

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

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

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

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

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

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

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FRANCE

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

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

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

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Germany

ABORTION POLICY

Grounds on which abortion is permitted:

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

Additional requirements:

Except for abortion on medical grounds, the woman must attend a pre-abortion social counselling session with a physician. The intervention must be performed in a hospital or other authorized facility.

REPRODUCTIVE HEALTH CONTEXT

Government view on fertility level:	Too low
Government intervention concerning fertility level:	No intervention
Government policy on contraceptive use:	Indirect support provided
Percentage of currently married women using modern contraception (aged 20-39, 1992):	72
Total fertility rate (1995-2000):	1.3
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	1.1
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	No
Complications of childbearing and childbirth	No
Maternal mortality ratio (per 100,000 live births, 1990):	
National	22
Developed countries	27
Female life expectancy at birth (1995-2000):	80.2

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Germany

BACKGROUND

Before the unification of the Federal Republic of Germany and the German Democratic Republic, the two countries operated under greatly differing abortion laws. In the Federal Republic of Germany, the law was based primarily on principles enunciated by the German Federal Constitutional Court in a ruling dating from 1975, shortly after the German Parliament voted to liberalize the country's abortion law to permit abortions on request during the first 12 weeks of pregnancy. In this ruling the Court held that the performance of abortions on request was unconstitutional, since it violated constitutional provisions protecting the right to life, including the right to life of the unborn.

In response to this decision, Parliament adopted legislation allowing abortion to be legally performed according to the following indications: if there was a serious threat to the health or life of the pregnant woman; if it could be presumed that a resulting child's health would be irremediably harmed; if the pregnancy was the result of a crime (e.g., rape or incest); or if the pregnant woman was in a state of intolerable distress (i.e., socioeconomic grounds). The state of intolerable distress was to be determined by a physician other than the one performing the abortion and not by the pregnant woman herself. Abortions were allowed in the case of the latter two indications only during the first 12 weeks of pregnancy. In the case of the first two indications, they were authorized later in pregnancy as well.

As a result of the requirement that a physician approve a request for an abortion (and, in the case of abortions performed on socioeconomic grounds, substantiate that the woman was in a state of intolerable distress), access to abortion, as well as abortion rates, differed substantially in various parts of the Federal Republic. In the North, physicians routinely approved and performed abortions on socioeconomic grounds, while in the South, in states such as Bavaria, the performance of abortions was less frequent. In addition, because of the procedural requirements imposed by the law, many German women chose to travel to the Netherlands, where abortions could be obtained quickly and easily.

In contrast, before unification, abortion policy in the German Democratic Republic was based on socialist principles. The communist Government fully supported the cause of women's rights and viewed easy access to abortion as one way of upholding those rights. Because of this attitude, abortions could be obtained upon request during the first 12 weeks of pregnancy and thereafter for serious reasons, including a threat to the pregnant woman's life. Unlike the law of the Federal Republic of Germany, there was no requirement that a woman experience difficult living conditions or be subject to the judgement of a physician in order to obtain an abortion. As in other Eastern European countries, abortion was used as an important means of controlling births.

Events leading up to the unification of Germany, however, forced a change in these diverging legal regimes. In preparation for unification, the Federal Republic of Germany and the German Democratic Republic entered into negotiations on a formal treaty of unification. A major part of these negotiations consisted of discussions on harmonizing the law of the two States, which also differed greatly in areas other than abortion. Although agreement was reached on almost all other issues, abortion law remained a sticking point. The German Democratic Republic was adamant in its refusal to adopt the law of the Federal Republic of Germany, in spite of its position on most of the other differences, and the Federal Republic of Germany was equally adamant about the German Democratic Republic's law. Because negotiators from the two countries did not want to delay the date of unification, they agreed to postpone final resolution of this issue until two years after the treaty was signed. In the meantime, the abortion law of each part of Germany would apply to that part of the country only.

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Germany

Agreement on a new law was not a simple task. However, a compromise was finally reached in June 1992 under which an abortion was legal if performed during the first 12 weeks of pregnancy and the pregnant woman found herself in a "situation of distress and conflict." Although required to undergo counselling by someone other than the physician performing the abortion as well as wait three days until the abortion was performed, the pregnant woman was allowed to make the final decision (rather than a physician, as under the previous law in effect in the Federal Republic of Germany). The counselling mandated by the law was specifically designed to protect life "in acknowledgment of its great value before birth." Abortions were also legal up to 22 weeks of pregnancy if it was believed that a child would be born with serious defects, and at any time during pregnancy to prevent a threat to the pregnant woman's life or a serious threat to her physical or mental health. The criminal indication was dropped from the law since an abortion would be available only in the first 12 weeks of pregnancy and hence would fall under the indication for abortion in situations of distress and conflict.

The law also contained a wide variety of other provisions designed to prevent the need for abortions, including provision of free counselling and information on reproductive health matters and help for pregnant woman, provision of free treatment and contraceptives for persons under the age of 20, provision of improved benefits for pregnant women and children, and the guarantee of the right for all children to attend nursery school. Those drafting the compromise believed that these provisions would demonstrate that they were as interested in addressing high abortion rates from a social viewpoint as they were in making abortions easier to obtain.

As a result of the depth of controversy over the legislation, a group of legislators and the state of Bavaria challenged it before the Constitutional Court of Germany, arguing that the law violated right-to-life provisions contained in the German Constitution. In 1993, the Court rendered its decision. It ruled that the provisions of the law permitting lawful abortions to be performed when a pregnant woman was in a situation of distress and conflict violated the right to life explicitly guaranteed by the German Constitution. It declared that all abortions except those performed for therapeutic reasons were unlawful. It also ruled that the provisions of the law dealing with mandated counselling were unconstitutional because they were not sufficiently designed to protect life. It stated that the provisions of a future law on counselling would have to be more specifically crafted so as to preserve the life of the unborn child and to convince the pregnant woman not to have an abortion, and it set out detailed guidelines on such counselling.

At the same time, however, the Court ruled that although abortions performed on the grounds of a woman's situation of distress and conflict were unlawful, they could be performed in Germany without the participants being prosecuted. As long as the pregnant woman obtained the required counselling and waited three days before the abortion was performed, neither she nor the physician could be punished. Because such abortions would be unlawful, they could not be paid for by State health insurance, as was the case under the previous laws of both parts of Germany, except in cases in which the women seeking abortions were too poor to pay for their own abortion. The practical effect of the decision was that Parliament once again would have to enact abortion legislation.

After almost a year of disagreement over what the outlines of the new law should be, Parliament in 1995 enacted new legislation. On all major points, the legislation adhered to the Court's decision. In the first 12 weeks of pregnancy, a woman could obtain an abortion if she was in a state of distress and conflict and received proper counselling three days before the abortion was performed. Such an abortion was illegal but not punishable. Because the point of counselling was to protect unborn life, the counsellor was required to inform the pregnant woman that the unborn have a right to life and to try to convince her to continue her pregnancy. At the same time, however, counselling was not designed to force this choice on a pregnant

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woman, but to bring about increased awareness. If the woman agreed, other persons with an interest were to be brought into counselling, including the father of the unborn child. The law also introduced penalties for persons who forced a pregnant woman to obtain an abortion or who induced a pregnant woman to have an abortion by maliciously withholding support payments. It also provided that abortions performed when a woman was in a situation of distress and conflict would not be paid from health insurance funds except when a woman's income fell below a certain threshold. In deference to concerns over Germany's national socialist past, the law removed the existence of congenital abnormalities as an explicit ground for abortion later in pregnancy. It also reinstated separately the criminal indication for abortion, available during the first 12 weeks of pregnancy.

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Slovakia

ABORTION POLICY

Grounds on which abortion is permitted:

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

Additional requirements:

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

REPRODUCTIVE HEALTH CONTEXT

Government view on fertility level:	Too low
Government intervention concerning fertility level:	To raise
Government policy on contraceptive use:	Indirect support provided
Percentage of currently married women using modern contraception (aged 15-44, 1991):	41
Total fertility rate (1995-2000):	1.4
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	32
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	..
Complications of childbearing and childbirth	No
Maternal mortality ratio (per 100,000 live births, 1990):	
National	..
Developed countries	27
Female life expectancy at birth (1995-2000):	76.7

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

Slovakia

BACKGROUND

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

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

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

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

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

Slovakia

If the woman is under 16 years of age, consent of her legal representative is required. If the woman is between 16 and 18 years of age, her legal representative must be notified. An abortion must be performed in a hospital.
Through the years, abortion has remained the preferred method of birth control in Slovakia. Part of the reason was that abortion was free but contraceptives were not and were also difficult to obtain. The new 1986 law attempted to reduce the use of abortion by providing contraception (excluding condoms) free of charge and discouraging abortion by charging a fee for abortions performed after eight weeks of gestation. The fee was waived only if the abortion was medically indicated.

The abortion rate in Slovakia rose from 30.5 per cent in 1984 to a high of 43.1 in 1988. However, the abortion rate declined substantially in the course of the 1990s. It was estimated at 19.7 abortions per 1,000 women aged 15-44 in 1996. The Government reported a gross abortion rate of 4.9 per cent in 1999.

Slovakia's rate of modern contraceptive usage was 41 per cent in 1991. That rate is thought to have increased after 1991. For example, the International Planned Parenthood Federation reported a five-fold increase in the use of oral contraceptives after 1990. The total fertility rate for 1995-2000 was 1.4 children per woman, and the population growth rate was 0.1 per cent.

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

Republic of Korea

ABORTION POLICY

Grounds on which abortion is permitted:

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

Additional requirements:

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

REPRODUCTIVE HEALTH CONTEXT

Government view on fertility level:	Satisfactory
Government intervention concerning fertility level:	No intervention
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-44, 1991):	70
Total fertility rate (1995-2000):	1.7
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	4
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	Yes
Complications of childbearing and childbirth	Yes
Maternal mortality ratio (per 100,000 live births, 1990):	
National	70
Eastern Asia	95
Female life expectancy at birth (1995-2000):	76.0

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

Republic of Korea

BACKGROUND

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

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

The passage of the 1973 law had only a limited effect because prior to its enactment, most women in the Republic of Korea did not realize that abortion was illegal and abortions were widely performed. The estimated abortion rate (based on surveys of ever-married women aged 20-44) rose as high as 64 abortions per 1,000 women but has declined to 36 in 1990 and 20 in 1996. However, statistics on the actual number of abortions performed may be underestimated, as reporting is not mandatory, and most abortions are performed in private clinics. The recent trend towards a decline in the incidence of abortion is counterbalanced by an increase in the age-specific abortion rate for women in their twenties; most of these women use abortion as a means of contraception.

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

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

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

Republic of Korea

The total fertility rate in the Republic of Korea has declined over the period 1970-2000 from 4.3 children per woman to 1.7, while the population growth rate has similarly fallen from 2.0 to 0.8 per cent over the same period, well below replacement level. As a result, the population programme shifted emphasis from a policy of modifying fertility levels to maintaining the level and improving the quality of family planning programmes, improving maternal and child health care through prevention of unwanted pregnancies and induced abortions, and sex education for adolescents. The Republic of Korea recorded a modern contraceptive prevalence rate of 70 per cent in 1991. Female sterilization accounted for almost half of the total. Until recently, the Government offered family planning services free of charge. The Government has now decided to impose user fees for family planning services, to eliminate the incentive schemes for the one-child family and to support instead a two-child policy.

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

Mongolia

ABORTION POLICY

Grounds on which abortion is permitted:

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

Additional requirements:

An abortion can be performed during the first three months of pregnancy and later if the pregnant woman suffers from an illness seriously threatening her health. Approval of the family or of the spouse is required.

REPRODUCTIVE HEALTH CONTEXT

Government view on fertility level:	No official position
Government intervention concerning fertility level:	No intervention
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (15-49*,1994):	25
Total fertility rate (1995-2000):	2.6
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	47
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	No
Complications of childbearing and childbirth	Yes
Maternal mortality ratio (per 100,000 live births, 1990):	
National	65
Eastern Asia	95
Female life expectancy at birth (1995-2000):	67.3

* For all women of ages specified.

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

Mongolia

BACKGROUND

Under the Mongolian Criminal Code of 6 July 1960, abortion was generally illegal. If it was performed by a physician, it was punishable by up to two years' imprisonment. If it was performed by a person lacking the highest medical qualifications, or if performed under unsanitary conditions, the punishment was increased to up to five years' imprisonment. Nonetheless, under general criminal law principles of necessity, an abortion could be performed to save the life of the pregnant woman.

In 1986, the abortion provisions of the Code were amended. Although abortion is in general still considered a serious offence, the Code authorized medical authorities to establish the conditions for the performance of legal abortions. Three years later in 1989, the health law was amended to reflect this change. Paragraph 56 of the Code was modified to provide that becoming a mother was a matter of a woman's own decision. During the first three months of pregnancy she could obtain an abortion on request and, later in pregnancy, when necessary due to illness. Abortions were to be performed by physicians under hospital conditions, and the Ministry of Health was to approve a list of illnesses justifying the performance of an abortion on medical grounds.

The health law was revised in 1998 but its provisions on abortion remained the same. The 1996 National Population Policy of Mongolia adopted by Parliament stated that abortion should not be promoted as a means of family planning. The Government considers the abortion rate to be too high. The Government also reiterated in 1999 that abortion is generally permitted if a pregnant woman requests it and that abortion is publicly subsidized.

Prior to these amendments to the law enacted in the late 1980s, legal provisions governing abortion in Mongolia echoed the pronatalist population policy of the Government. In responding to the Eighth United Nations Inquiry among Governments on Population and Development, the Government indicated no position on the fertility level and no policy to modify it. The Government remains seriously concerned over the high levels of infant, child and maternal mortality.

The Government has attributed the relatively high abortion rate, 25.9 abortions per 1,000 women aged 15-44, to shortages of modern contraceptives, as well as to a lack of knowledge concerning contraceptive use. Many women choose to have abortions carried out illegally by private physicians because of cheaper costs. Induced abortion accounts for a large percentage of maternal mortality in Mongolia, causing at least 850 maternal deaths each year.

The Government seeks to increase the contraceptive prevalence rate to more than 50 per cent by 2001. The National Reproductive Health Programme was adopted in 1997. The Government reports that, since the International Conference on Population and Development, held in Cairo in 1984, successful steps have been undertaken to ensure access of women to reproductive health-care services. Each provincial centre and some district cities have established reproductive health cabinets attached to the local public health centres. These cabinets provide services such as counselling, and pregnancy monitoring and evaluation. A National Adolescent Health Programme was adopted in 1997.

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

Luxembourg

ABORTION POLICY

Grounds on which abortion is permitted:

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

Additional requirements:

Certification by a physician other than the one performing the abortion is required for all grounds. The woman must give written agreement. A one-week reflection period is required and the pregnant woman must be given an information booklet in which options other than abortion are explained. An abortion must be performed in a hospital or other approved facility.

REPRODUCTIVE HEALTH CONTEXT

Government view on fertility level:	Too low
Government intervention concerning fertility level:	To raise
Government policy on contraceptive use:	No support provided
Percentage of currently married women using modern contraception (aged 15-49):	..
Total fertility rate (1995-2000):	1.7
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	12
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	Yes
Complications of childbearing and childbirth	Yes
Maternal mortality ratio (per 100,000 live births, 1990):	
National	-
Developed countries	27
Female life expectancy at birth (1995-2000):	79.9

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

Luxembourg

BACKGROUND

Abortion law was liberalized in Luxembourg in 1978, a few years later than similar liberalization occurred in other Western European countries. Owing to the overall conservatism in Luxembourg, the liberalized law was enacted by only a small margin in Parliament.

Prior legislation on the interruption of pregnancy in Luxembourg dated from 1879 and was based on the Napoleonic Penal Code of 1810, as adapted in the Belgian Penal Code of 1867. Both a person who performed an abortion and the woman consenting to the abortion were subject to severe penalties, including imprisonment. Although the legislation contained no exceptions to a general prohibition of abortion, under general criminal law principles of necessity, abortions could be performed to save the life of the pregnant woman and procedures were developed for notifying the Government of such abortions before they were performed.

Under the 1978 law, which repealed prior provisions, abortion is legal during the first 12 weeks of pregnancy in the following circumstances (section 353 of the Penal Code, as amended): when the continuation of the pregnancy or the living conditions that may result from the birth are likely to endanger the physical or mental health of the pregnant woman; when there is a serious risk that the child will be born with a serious disease, physical malformation or considerable mental defects; or when the pregnancy can be considered as resulting from rape.

The woman is required to consult a gynaecologist or an obstetrician who is to inform her of the medical risks involved in the operation and she must give her consent in writing to the abortion, except when her life is in danger, she is a minor, or she is not able to express her will. In these cases, an ad hoc legal representative is required to give consent.

Additional requirements are a one-week waiting period from the time of her consultation with a gynaecologist or obstetrician and a physician's certification concerning the existence of the circumstances listed above. The abortion must also be performed by a physician in a hospital or other establishment approved by order of the Minister of Health. The cost of the abortion is covered by government insurance plans.

Beyond the 12-week period, the law permits abortion only if there is a very serious threat to the life or health of the pregnant woman or of the child to be born. In such cases, two qualified physicians are required to attest in writing that a serious threat exists. A physician is not required to perform an abortion except when the life of the pregnant woman is in imminent danger.

A person who performs an illegal abortion without the consent of the woman is subject to solitary confinement. If the abortion is performed with the consent of the pregnant woman, the person is subject to imprisonment for two to five years and a fine of 2,501-250,000 Luxembourg francs (Lux F). A woman who consents to her own illegal abortion is subject to a fine of Lux F 2,501-20,000. A woman who acts under the influence of a situation of great distress is considered not to have committed an offence. Given that "distress" is not defined, the law has been liberally interpreted.

Despite the passage of a more liberal abortion law, there has been some reluctance on the part of physicians in Luxembourg to perform abortions, owing in part to the prevailing religious conservatism. Physicians generally perform an abortion only in special circumstances, such as when the woman is well known to them or when the woman's situation is particularly difficult. Given that most hospitals in the country are private and belong to religious orders, many physicians have preferred to send women to family planning centres where information on abortion services abroad can be obtained.

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

Netherlands

ABORTION POLICY

Grounds on which abortion is permitted:

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

Additional requirements:

A five-day waiting period is required between the initial consultation and the performance of an induced abortion. An abortion must be performed in a licensed hospital or clinic. The cost of an induced abortion is subsidized by the Government.

REPRODUCTIVE HEALTH CONTEXT

Government view on fertility level:	Satisfactory
Government intervention concerning fertility level:	No intervention
Government policy on contraceptive use:	Indirect support provided
Percentage of currently married women using modern contraception (aged 18-42, 1993):	76
Total fertility rate (1995-2000):	1.5
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	4
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	No
Complications of childbearing and childbirth	No
Maternal mortality ratio (per 100,000 live births, 1990):	
National	12
Developed countries	27
Female life expectancy at birth (1995-2000):	80.7

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

Netherlands

BACKGROUND

Under the Penal Code of the Netherlands (1886), the performance of abortions was classified as an offence against life and persons convicted of the offence were subject to imprisonment. However, because proof that the foetus was alive at the time of the abortion was a requirement for conviction under the law and such proof was difficult to obtain, it was nearly impossible to convict anyone of performing an abortion. In 1911, the abortion law in the Netherlands was amended to overcome this obstacle to conviction by making it an offence to treat a woman, whether she was pregnant or not, so as to indicate to her or produce the expectation that an abortion would be performed. In practice, it was illegal in all circumstances except when performed to save the life of the pregnant woman. During the 1970s, several attempts were made to liberalize the abortion law, but they were not successful owing to strong opposition from various sources. However, the existing law was not strictly enforced and abortion services were readily available.

On 1 May 1981, a far-reaching abortion law was adopted in the Netherlands which repealed the restrictive abortion provisions. Under the law, abortion is permitted virtually on request at any time between implantation and viability if performed by a physician in a hospital or clinic licensed to perform abortions. Upon consulting a physician, a woman seeking an abortion must be counselled by the physician to ensure that the decision to terminate a pregnancy is taken carefully and reached only if the distress in which the pregnant woman finds herself leaves her no other choice. This counselling is to include the provision of sound information on ways other than abortion of dealing with her distressed condition. After receiving the counseling, the woman must wait six days before the abortion can be performed and, following the abortion, she must be given access to adequate after care, including information on methods of preventing unwanted pregnancies. The six-day waiting period may be waived if the woman's life is threatened. An abortion performed after 13 weeks of pregnancy can only be carried out in a hospital or clinic that meets special requirements and has received special approval.

Under article 20 of the law, a physician who has a conscientious objection to providing abortions or arranging for their provision shall immediately inform a woman seeking an abortion of this fact. He or she also has a duty to provide other physicians with information concerning the woman's condition if requested to do so, provided that the woman has given consent.

A physician who, knowing that a pregnancy is of more than 13 weeks' duration, performs an abortion in a clinic unlicensed to perform abortions of such duration is subject to one year's imprisonment or payment of a fine. The law also imposes penalties on a physician who performs an abortion before the end of the six-day waiting period, or who fails to inform a woman of his or her decision concerning whether to assist with the abortion within the stipulated period of time.

Although the abortion law was liberalized in 1981, the regulation governing its practice was not formally adopted until 1984. Prior to the liberalization of the law, abortion was widely available through private non-profit clinics and in some hospitals, mainly as a result of the widespread acceptance of family planning within the society.

In the Netherlands, family planning was traditionally discouraged because it was regarded as being contrary to the objectives of marriage and as promoting promiscuity. As a result, the practice did not receive the backing and support of the Government or a majority of the population, including health professionals. Contraceptives were not readily available and could not be advertised in the Netherlands until 1969.

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

Netherlands

Moreover, physicians were reluctant to provide family planning services for fear of having to share in the responsibility for an unwanted pregnancy which might occur from contraceptive failure and which might in turn necessitate an induced abortion. This situation contributed to keeping the crude birth rate at the relatively high level of 20.7 per 1,000 during the mid-1960s.

The introduction of the pill in 1964 and its proven high reliability led to the widespread acceptance and practice of family planning. Since about 1965, family planning services have routinely been offered as part of general health-care services.

Since November 1984, women in the Netherlands have been able to obtain abortions free of charge under the government-sponsored national health insurance system. The Exceptional Medical Expenses Fund covers the cost of abortions performed in clinics. Payment by this fund has not resulted in a rise in abortions, but rather has caused a shift in the balance of providers from hospitals to clinics. Although foreigners are not prohibited from having an abortion in the Netherlands, they are required to pay for it.

A sizeable proportion of women undergoing induced abortion in the Netherlands are foreign-born. In 1984, out of a total of 43,200 induced abortions performed in the Netherlands, 18,700 were for residents in the Netherlands, and the balance were for women from neighbouring countries. In 1990, the abortion rate for Netherlands nationals was 5.2 per 1,000 women aged 15-44, and the abortion rate per 100 live births was 9.6, an incidence that is one of the lowest in the world. The incidence of induced abortion has been relatively stable in the Netherlands, mainly due to the high contraceptive prevalence rate (over 75 per cent). However, the population most at risk for an unwanted pregnancy are women in the age group 20-30. More than one third are typically married and have mainly used condoms, rhythm or withdrawal as their preferred contraceptive methods. Following an induced abortion, most women choose the pill, intrauterine device or sterilization.

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

Cyprus

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

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

*Legal interpretation generally permits these grounds.

REPRODUCTIVE HEALTH CONTEXT

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

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

Cyprus

BACKGROUND

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

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

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

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

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

New Zealand

ABORTION POLICY

Grounds on which abortion is permitted:

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

Additional requirements:

The fact that the pregnant woman is mentally subnormal or that she is near the beginning or the end of the usual child-bearing age, while not being a ground "in itself", can also be taken into account under medical indications. In general, an abortion must be performed by a registered physician in a licensed institution. Termination of pregnancy beyond 12 weeks of gestation may only be performed in an institution with a "full licence". The woman must obtain the approval of two certifying consultants, one of which must be an obstetrician/gynaecologist.

*Rape in itself does provide grounds for abortion but may be taken into account under medical indications. A pregnancy occurring as a result of incest can be terminated on juridical grounds, while a pregnancy resulting from rape may be terminated under medical indications.

REPRODUCTIVE HEALTH CONTEXT

Government view on fertility level:	Satisfactory
Government intervention concerning fertility level:	No intervention
Government policy on contraceptive use:	Indirect support provided
Percentage of currently married women using modern contraception (aged 20-49, 1995):	72*
Total fertility rate (1995-2000):	2.0
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	34
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	No
Complications of childbearing and childbirth	No
Maternal mortality ratio (per 100,000 live births, 1990):	
National	25
Developed countries	27
Female life expectancy at birth (1995-2000):	79.7

* Preliminary or provisional.

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

New Zealand

BACKGROUND

Prior to 1977, abortion legislation in New Zealand was largely based on nineteenth-century English statutory law, which had remained virtually unchanged through various revisions of the criminal law, and on case law interpretations. Abortion was generally illegal except when performed "in good faith" for the preservation of the life of the pregnant woman or her physical or mental health. Because of the lack of clarity as to what constituted physical or mental health, variations occurred in interpretation and application. This situation fuelled arguments for the reform of abortion law in New Zealand, particularly after the liberalization of abortion laws in the United Kingdom and in South Australia in the late 1960s.

Legislation reforming existing abortion law was enacted in the 1970s. In 1977 and 1978 the Government amended the Crimes Act 1961 to provide a clearer definition of the grounds for legal abortion. Under sections 182-187A of the Act, an abortion is permitted during the first 20 weeks of pregnancy: (a) continuance of the pregnancy would result in serious danger (not that normally attendant upon childbirth) to the life or to the physical or mental health of the woman; (b) if there is a substantial risk that the child, if born, would be so seriously abnormal as to be handicapped mentally or physically; (c) if the pregnancy is the result of incest or of sexual intercourse with a girl under care or protection; or (d) if the pregnant woman is severely mentally "subnormal". In determining whether continuance of the pregnancy would result in serious danger to the life or physical or mental health of the pregnant woman, the following may be taken into consideration: that the woman is near the beginning or the end of the usual childbearing years and that reasonable grounds exist for believing that the pregnancy is the result of rape. After 20 weeks of pregnancy, an abortion is permitted only when it is necessary to save the life of the woman or to prevent serious permanent injury to her physical or mental health.

In 1977, the Government also enacted the Contraception, Sterilization, and Abortion Act of 1977 (No. 112) to establish the procedures under which a woman could obtain an abortion. The Act establishes a statutory body, the Abortion Supervisory Committee, to oversee the operation of abortion law. The Committee consists of three members, two of whom must be registered physicians. A woman seeking an abortion must obtain the approval of two consultants, one of whom is a practising obstetrician or gynaecologist, certifying that legal grounds for the performance of the abortion exist. If they approve the abortion, the two consultants must sign certificates to this effect to be sent to an institution where the abortion is to be performed and satisfy themselves that an operating surgeon is available to the woman. In general, an abortion can only be performed in an institution licensed under the Act. If the pregnancy is of more than 12 weeks' duration, an abortion can only be performed in an institution with a "full licence". A woman may request counselling from a trained counsellor before the abortion is performed. Some critics have argued that the above procedure is so cumbersome that the new legislation has in effect made abortion laws in New Zealand more restrictive than before.

Under the Crimes Act, as amended, a person performing an unlawful abortion is subject to imprisonment for up to 14 years. The woman upon whom the abortion is performed or a woman who performs her own abortion, however, is not considered to have committed an offence. Nonetheless, under the Contraception, Sterilization, and Abortion Act of 1977, if she procures her own abortion, she is subject to payment of a fine not to exceed 200 New Zealand dollars ($NZ).

Abortion does not appear to be a major method of fertility regulation in New Zealand and seems to have played a minor role in the fertility decline over the past several decades. During the 1980s, even though most women obtaining abortions were of European descent, Maori women and women of Pacific island descent

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were over-represented in the sample population when compared with their proportions in the total population. Other studies have shown that for the low-fertility population of European origin, induced abortion appears to be used primarily for timing purposes by young (under age 30) nulliparous women to delay their first birth; for the higher fertility minority populations, induced abortion is a backup method in cases of contraceptive failure for women that have achieved their desired family size. In addition, teenage pregnancy has increasingly become a public issue in New Zealand. A significant proportion of teenage pregnancies are terminated by abortion.

Abortions performed in New Zealand at a public hospital are normally free of charge. Unequal access to abortion services owing to geographical distribution is of concern to policy makers. The issue of contraception is of similar concern. More than one third of all women do not use any contraceptive method at all and most of the women seeking an abortion in New Zealand do so because of contraceptive failure.

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Bahrain

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

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

REPRODUCTIVE HEALTH CONTEXT

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

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Bahrain

BACKGROUND

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

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

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

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Poland

ABORTION POLICY

Grounds on which abortion is permitted:

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

Additional requirements:

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

REPRODUCTIVE HEALTH CONTEXT

Government view on fertility level:	Too low
Government intervention concerning fertility level:	To raise
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 20-49, 1991):	19[a,b]
Total fertility rate (1995-2000):	1.5
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	23
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	Yes
Complications of childbearing and childbirth	No
Maternal mortality ratio (per 100,000 live births, 1990):	
National	19
Developed countries	27
Female life expectancy at birth (1995-2000):	76.9

[a] Including consensual unions, where possible.
[b] Excluding sterilization.

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Poland

BACKGROUND

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

A law adopted by the Polish Parliament (Sejm) on 27 April 1956 (Law No. 61) further liberalized the abortion laws by permitting abortion on medical grounds, if the pregnancy resulted from a criminal act or because of "difficult living conditions". Although abortion was not explicitly permitted on grounds of foetal impairment, serious defects of the unborn child often constituted "difficult living conditions" for the pregnant woman. The great majority of abortions were performed on the ground of "difficult living conditions", which, under regulations issued subsequent to the law, left the decision essentially to the pregnant woman as long as she could find a physician willing to perform the operation.

Although the procedural requirements to be observed in order for a lawful abortion to be performed were amended repeatedly over the years (1956, 1959, 1969, 1981 and 1990), access to abortion after the passage of the 1956 legislation remained largely constant until 1990 with the election of the first non-Communist Government in Poland since the end of the Second World War. Under regulations issued by the Ministry of Health and Social Welfare (Ordinance of 30 April 1990), a request for an abortion on the grounds of difficult living conditions had to be approved by two gynecologists and a general practitioner. The pregnant woman was also required to obtain the counselling of a State-approved psychologist. The Ministry also set a fee for the performance of abortions on non-therapeutic grounds.

In 1993, Parliament enacted further restrictions on access to abortion by eliminating entirely "difficult living conditions" as a ground for the performance of legal abortions. Henceforth, abortions could be performed legally only in cases of serious threat to the life or health of the pregnant woman, as attested by two physicians, cases of rape or incest confirmed by a prosecutor, and cases in which prenatal tests, confirmed by two physicians, demonstrated that the foetus was seriously and irreversibly damaged. A ban was also placed on the performance of abortions in private clinics. A physician who performed an abortion in violation of the law was subject to up to two years' imprisonment, although the pregnant woman herself was exempt from punishment. The law also amended the abortion law to provide that "Every human being shall have a natural right to life from the time of his conception" and gave a person who was damaged before birth a right to seek compensation. The Law set no time limits on the performance of abortions.

In addition, the law contained provisions obligating the Government to guarantee "free access to methods and means of birth control", to provide social, medical and legal assistance during pregnancy and after childbirth, including material support and information on the rights, benefits and services available to families and unmarried mothers; to allow pregnant students maternity leave; and to introduce into schools classes on human sexuality, including information on birth control, responsible procreation, and the value of the family and the life of the unborn child. The provisions were designed to address the problem of abortion in ways other than restricting the performance of the procedure.

These amendments to Poland's abortion law did not end the controversy. Because the Law had eliminated socio-economic grounds for abortion, woman's groups and left-leaning political parties, including the successor to the Communist party, began working to modify its effects. Conversely, some of the strongest opponents of the former law sought to restrict abortion even further, believing

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abortion to be immoral under all circumstances. The former groups were aided in their cause by the results of the next set of elections held in 1993. Owing in part to the hardships faced by much of the Polish population by the abrupt shift from a socialist economy to a capitalist one and the loss of many social benefits that had been taken for granted, a new Government made up of left-leaning parties, including the former Communists, gained control of Parliament.

One year after the elections, this Parliament, despite considerable opposition, approved a bill to allow abortions for socio-economic reasons. The bill, however never went into effect. To become law, it needed the approval of Poland's President who is separately elected from Parliament. Because the President was opposed to abortion, he refused to sign the law, thus leaving in place the 1993 restrictive legislation.

Two years later, however, after another election resulted in a new president who was favourable to abortion law reform, the Government again introduced liberalized legislation. Parliament voted to amend the recent law to allow abortions to be performed on the grounds of difficult living conditions or a precarious personal situation up until the twelfth week of pregnancy. The pregnant woman would be required to undergo counselling, give written consent to the operation, and wait three days after the counselling until the abortion took place. The law once again allowed abortions to be performed in private clinics. It also set a 12-week limit for abortions performed on the grounds of health, foetal impairment or as a result of a criminal act (rape or incest), and provided for sex education in schools and cheaper contraceptives.

Enactment of the new law heightened the hostility of pro-life groups to the performance of abortions. Many legislators, religious leaders and health personnel opposed to abortion pledged themselves to counter its effect. At the same time, growing numbers of physicians and hospitals refused to perform abortions, as they were allowed to do under a conscience clause contained in the law. In some cities, there were no public institutions willing to perform abortions, leaving private clinics with much higher fees as the only resort for women seeking abortions. Some estimates were that almost half of all public hospitals in Poland had adopted this approach to the issue.

In addition, shortly after the passage of the amendments, a number of legislators moved to challenge the law's constitutional validity before Poland's Constitutional Tribunal. They argued that, because the law allowed the performance of abortions, it violated provisions of the Constitution guaranteeing the rule of democratic law and social justice and the Constitution's implied guarantee of the right to life. In its ruling later in the case in mid 1997, the Court essentially agreed with this argument. It pointed specifically to the part of the Law that allowed abortions on socio-economic grounds. It found this to be defective because of a lack of precise justified criteria as to what constituted difficult living conditions or a precarious personal situation and to constitute abortion on request. It reasoned that, without such criteria, the law did not sufficiently protect human life from the moment at which it arises, which it stated was a value protected under the Constitution, even though not so expressed. It concluded that the law amounted to authorization of abortion on request.

The effect of the decision was to give the Government six months' time to enact new legislation conforming to the decision or to override it by a two thirds majority vote in Parliament. During this time, the provisions of the law were to remain in effect. The Government, however, was unable to override the Court's decision by the required majority, and after elections that brought a pro-life majority to Parliament, Parliament voted to endorse the court's decision and reinstate the former law of 1993.

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Poland

It is difficult to determine the number of abortions being carried out in Poland. Official abortion statistics are believed to underestimate the true extent of abortion because it is not known how many abortions are performed in private out-patient clinics. For example, although there were 123,000 officially reported abortions in 1987, some estimates suggest that the actual number of abortions performed may have been from three to four times the official number. Underground private abortion services are robust in Poland, as is "tourism" abortion by Polish women who travel to neighbouring countries including, Austria, Belarus, Belgium, the Czech Republic, Germany, Holland, Lithuania, the Russian Federation, Slovakia and Ukraine. Rough 1996 estimates suggest there may be 50,000 underground abortions a year.

The suspected high incidence of abortion is due to a number of factors, including shortages of low-cost, high-quality modern contraceptives, reliance upon less reliable natural methods of fertility control and a lack of comprehensive sex education programmes. The Polish Government is concerned about the high level of induced abortions and the lack of popularity of contraceptives. The modern contraceptive prevalence rate was estimated in 1991 to be 19 per cent.

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

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Belgium

ABORTION POLICY

Grounds on which abortion is permitted

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

Additional requirements

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

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

REPRODUCTIVE HEALTH CONTEXT

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

*Flemish population.

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Belgium

BACKGROUND

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

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

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

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

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

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

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

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

Greece

ABORTION POLICY

Grounds on which abortion is permitted:

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

Additional requirements:

The abortion must be performed by a practising physician in a private clinic or hospital. A physician other than the one performing the abortion must confirm the existence of valid grounds for the abortion. A minor must obtain the written consent of her parents or guardian.

REPRODUCTIVE HEALTH CONTEXT

Government view on fertility level:	Too low
Government intervention concerning fertility level:	No intervention
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 15-49):	..
Total fertility rate (1995-2000):	1.3
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	13
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	No
Complications of childbearing and childbirth	No
Maternal mortality ratio (per 100,000 live births, 1990):	
National	10
Developed countries	27
Female life expectancy at birth (1995-2000):	80.7

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

Greece

BACKGROUND

Until the Second World War, the Government of Greece was strictly opposed to induced abortion, except on medical grounds. The Greek Orthodox Church considers abortion to be a crime and has therefore strongly condemned the act. Religious tenets have inevitably influenced legislation and attitudes in Greece concerning abortion. Under the Greek Penal Code of 1950, heavy penalties were imposed on both the woman consenting to the abortion and the person performing it. Abortion was permitted only if it constituted the only means of saving the life of the pregnant woman or preventing a serious and lasting injury to her health; or if the pregnancy was the result of rape or incest, or of the seduction of a girl under age 15.

As a result of the efforts of various organizations, such as the Family Planning Association of Greece, the law on abortion in Greece was liberalized in 1978 (Law No. 821 of 14 October). Under the new law, abortion was thereafter permitted for reasons of serious foetal abnormalities during the first 20 weeks of pregnancy. It was also allowed in cases of a risk to the mental health of the mother, as determined by a psychiatrist on the staff of a public hospital, but only in the first 12 weeks of gestation.

Until 1980, family planning was illegal in Greece. According to the Fertility Survey conducted in 1983, the general pattern in Greece was for children to be born early in the marriage and for family size to be carefully controlled by the use of withdrawal and condoms, backed up by abortion. The survey found that abortion was widespread despite its illegality and was used mainly as a form of birth control.

The performance of abortions was further liberalized by Law No. 1609 of 28 June 1986. Thereafter, abortion on request could legally be obtained in Greece during the first 12 weeks of pregnancy. Also, if the pregnancy was a result of rape, incest or seduction of a minor, abortion was permitted during the first 19 weeks of pregnancy. Lastly, in the case of serious foetal abnormalities, the legal limit was extended to 24 weeks.

It is widely believed that the liberalization of the abortion law in Greece has made little difference in the abortion rate because, prior to its liberalization, a person performing an abortion or a woman undergoing an illegal abortion was rarely prosecuted. Indeed, it is believed that one of the main motives for the liberalization of abortion law was to preserve the integrity of the legal system, which was threatened by the increasing incidence of illegally performed abortions that were not prosecuted.

Although many women in Greece use the National Health Care System for their abortion, the majority resort to private gynaecologists, primarily because private abortions are performed immediately. In contrast, the Government-run system is characterized by bureaucratic procedures and resultant delays. A large number of illegal abortions are still performed in Greece because the public is not yet fully aware of the new abortion law. Despite liberalization of the law on abortion, advertising of abortion services (excluding information supplied in family planning centres) remains a criminal offence.

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

Sweden

ABORTION POLICY

Grounds on which abortion is permitted:

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

Additional requirements:

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

REPRODUCTIVE HEALTH CONTEXT

Government view on fertility level:	Satisfactory
Government intervention concerning fertility level:	No intervention
Government policy on contraceptive use:	Direct support provided
Percentage of currently married women using modern contraception (aged 20-44* 1981):	71
Total fertility rate (1995-2000):	1.6
Age-specific fertility rate (per 1,000 women aged 15-19, 1995-2000):	7
Government has expressed particular concern about:	
Morbidity and mortality resulting from induced abortion	No
Complications of childbearing and childbirth	No
Maternal mortality ratio (per 100,000 live births, 1990):	
National	7
Developed countries	27
Female life expectancy at birth (1995-2000):	80.8

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

Sweden

* All sexually active women.

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Sweden

BACKGROUND

Performance of an abortion was considered a crime in Sweden at the beginning of the twentieth century except to save the life of a pregnant woman or protect her from serious health consequences. Both the sale of contraceptives and the dispensing of information on contraceptives were prohibited by law in 1910. In 1938, Sweden enacted legislation permitting the termination of pregnancy under broader circumstances. The 1938 Abortion Act, which remained in force until 1975, provided that abortion, although prohibited in principle, could be legally performed on a wide range of grounds. In addition to health indications, an abortion was permitted for eugenic reasons, in cases where the pregnancy was the result of a crime, and in cases of medical-social hardship, designated as "frailty of the mother". An abortion performed for medical reasons could be performed at any time during pregnancy, after the approval of two physicians. Abortions performed on other grounds required the approval of a health authorities board and had to be performed during the first 20 weeks of pregnancy. Women who did not meet the requirements and wished to terminate their pregnancies resorted to illegal abortions.

The 1938 Act was amended in 1946 to enlarge the definition of medical-social hardship so as to allow abortions to be performed when, taking into consideration the living conditions and other circumstances, the physical or mental strength of the mother would be seriously weakened by the birth or rearing of the child. The amendment stipulated that a woman seeking an abortion had to consult a social worker, who would investigate the woman's situation and help her prepare the application. Social workers were expected to offer social and economic assistance so that a woman could reconsider her decision or provide her with support if the application for abortion was refused. In addition, the period during which abortions could be legally performed on other than health indications was extended to 24 weeks of pregnancy. In 1963, the Abortion Act was amended again to include the existence of "prenatal injury in the foetus" as a ground for the termination of pregnancy.

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

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

An abortion performed after 18 weeks of pregnancy is legal only if the National Board of Health and Welfare authorizes the procedure based on special reasons. In general, such an abortion may not be performed if there is reason to suppose that the embryo is viable. However, if there is a serious

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threat to the life or health of the pregnant woman, an abortion may be authorized at any time during pregnancy. In cases of emergency, a person authorized to practise medicine may perform an abortion without authorization. The abortion law makes no specific provision for consent.

Non-physicians who perform an abortion are subject to a fine or imprisonment for a maximum of one year. This penalty does not apply to a woman who terminates her own pregnancy or cooperates in a illegal termination. In 1995, the Abortion Law was amended to remove the requirement that a woman desiring to obtain an abortion between 12 and 18 weeks of pregnancy should discuss the abortion with a social worker.

After the new Abortion Act went into effect in 1975, the procedure for having an abortion in Sweden was simplified, making it possible for more women to obtain an abortion early in their pregnancy. Ninety-five per cent of abortions are performed during the first 12 weeks of gestation. Since 1975, between 30,000 and 37,000 abortions have been performed annually in Sweden, constituting 18-21 abortions per 1,000 women aged 15-44 years, or 24-26 per cent of known pregnancies. In 1996, for example, there were 32,100 reported abortions, producing a rate of 18.7 abortions per 1,000 women aged 15-44. Illegal abortion is very rare in Sweden.

For the period 1995-2000, Sweden registered a total fertility rate of 1.6 children per woman and a population growth rate of 0.3 per cent. In its response to the *Eighth United Nations Inquiry among Governments on Population and Development*, the Government of Sweden said it had no official position on the fertility rate and no policy to influence the rate. Population is integrated within development planning, and various government agencies are responsible for taking population variables into account. The Swedish social welfare system lessens the financial burdens of childbearing and child-rearing. Maternity and paternity leave is available for up to 290 days, during which time 90 per cent of wages are paid. Sixty days of paid leave are also provided annually if a family is caring for a sick child. Until the child reaches the age of 16, a system of family allowances pays 750 Swedish kronor (SKr) a month for one child, SKr 1,500 for two children, SKr 2,625 for three children, SKr 4,125 for four children and SKr 6,000 for five children.

Family planning services, integrated within maternal and child health care, have been established throughout the country. The emphasis is on preventive measures and a reduction in the number of abortions. Sweden has a high rate of modern contraceptive use, estimated in 1981 at 71 per cent of all sexually active women aged 20-44. Sterilization is available upon request in Sweden to those 25 years of age or over and with medical approval to those under age 25. The combination of health education on sexuality and family planning, easy access to contraceptive services, and free abortion on request is thought to have helped reduce both teenage birth rates and abortion rates in Sweden.

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