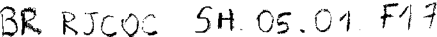
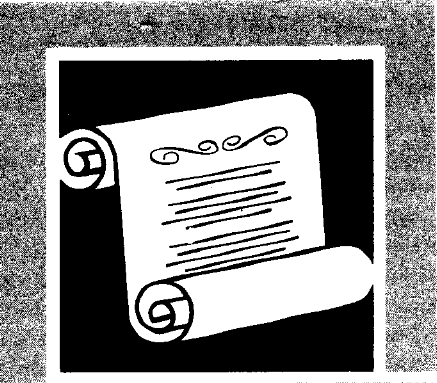

BR RJCOC SH.05.01 F17



Population Reports

SERIES E
NUMBER 3
MARCH 1976

LAW AND POLICY

Department of Medical and Public Affairs, The George Washington University Medical Center, 2001 S Street, N.W., Washington, D.C. 20009

Abortion Law and Practice — A Status Report —

SUMMARY

During the last 25 years there has been a gradual liberalization of abortion laws throughout the world. Today, 60 percent of the world's population live in countries where abortion during the first trimester is legal either for social and economic reasons or "on request" without any specific indication. Another 16 percent live in countries where abortion is permitted on extended medical grounds, for eugenic indications, and/or for humanitarian reasons such as those associated with rape or incest.

In some countries where abortion laws are technically illegal or very restrictive, legislation is not strictly enforced and, in practice, medically safe abortions are often available. In other countries where restrictions are still in effect, abortion reform is being discussed and more moderate legislation can be anticipated.

Most liberal legislation of the 1970s stresses a preference for first trimester abortions. Studies confirm that abortion performed during the early stages of pregnancy, using menstrual regulation and/or vacuum aspiration techniques is a much safer procedure than childbirth (97, 106, 137).

New technological advances, such as menstrual regulation—a safe, relatively simple, and inexpensive procedure—and the use of prostaglandin suppositories or injections, challenge the traditional interpretation of existing restrictive abortion laws. In countries, for example, where the law now makes it a crime to terminate a pregnancy whether or not it is known if the woman is pregnant, menstrual regulation cannot be performed without risking criminal prosecution. But since menstrual regulation should be performed within 6 to 14 days following a missed period, it is often not possible to know if the woman is pregnant prior to examining the aspirated uterine contents (61,83). The same is true of prostaglandins which are being used experimentally to induce bleeding at a time when pregnancy may be suspected but cannot be verified.

In most countries the current liberalization of abortion laws is apparently intended to improve maternal health by reducing the widespread incidence of illegal abortion (10,86,147). Aware that self-induced abortions or those performed by untrained persons in unsanitary facilities are still a leading cause of female mortality in countries with restrictive legislation, a country may decide to pass liberal legislation to assure medically adequate conditions under which abortions may be performed (37). To date, the desire to stem population growth has not been a significant motivation for abortion reform (99,108 126,147).

This Report on worldwide abortion laws and policies was prepared by Margot Zimmerman on the basis of published reports and articles, unpublished papers, personal interviews and correspondence.

The assistance of the following contributors and reviewers is appreciated: Elizabeth Connell, Rebecca Cook, Henry David, Stephen Isaacs, Edmund Kellogg, Luke Lee, E. Keys MacManus, Emily Moore-Čavar, Karen Mulhauser, Harriet Pilpel, Malcolm Potts, R. T. Ravenholt, J. Joseph Speidel, Christopher Tietze, Jean van der Tak, and Jorge Villareal.

Frances G. Conn is Executive Editor. Comments and additional updated material are welcome.

CONTENTS

Background E-26
Hazards of Illegal Abortions E-26
Early Abortion: A Safe Procedure E-27
Classification of Abortion Law E-28
Current Global Overview E-29
Recent Changes E-32
De Jure vs. De Facto E-32
Emerging Trends E-34
Implications of Liberalizing Abortion Laws E-36
Issues Affecting Liberalization E-38
Bibliography E-39

BR RJCOC SH.05.01. F17V

Population Reports is published bi-monthly at 2001 S Street N.W., Washington, D.C. 20009, USA, by the Population Information Program, Science Communication Division, Department of Medical and Public Affairs of the George Washington University Medical Center and is supported by the United States Agency for International Development. Helen K. Kolbe, Project Director. Second class postage paid at Washington, D.C.

If the recent trend toward liberalizing abortion legislation continues, the incidence of illegal abortions should lessen. Hazardous abortions will then increasingly be replaced by safe abortions performed by trained personnel during the first trimester of pregnancy (43).

However, a liberal law does not guarantee that safe abortions will be available to those in need. The following prerequisites are essential to assure the availability and utilization of abortion services:

- sufficient numbers of medically trained personnel who are willing to perform abortions even when there is no medical emergency;
- medical facilities that are geographically accessible;
- a rate schedule that excludes no one;
- a widespread communications network to inform all people, including those in rural and/or isolated areas, that these services are available.

To date, in many parts of the world the availability of abortion services has not kept pace with liberal legislation (151). Despite legal authorization, most women lack easy access to medically safe and adequate abortion services (133,151).

Given a choice, most couples prefer to limit their family size by contraception rather than abortion (15,25,78). Studies indicate that increasing reliance on contraception has decreased the number of abortions performed in many countries (81,109). However, the changes in fertility rates, the limitations of available contraceptives, and the time necessary for contraceptive practice to diffuse through a society all combine to make it likely that abortion will continue to be one of the major means of fertility regulation for years to come (15,108,131).

BACKGROUND

Abortion has been, and continues to be, one of the most widely employed methods of fertility control in the world (126,148). In the developing countries, according to IPPF Secretary-General Julia Henderson, it is the "major birth control method" (138) and the 1972 UN report calls abortion the "most important single means" of fertility control (140). It is common knowledge that women who terminate unwanted pregnancies often resort to abortion whether or not they break the law, and, as a result, jeopardize their well-being. Women will do anything to abort themselves, says Dr. Paul Belfort, president of the Brazilian Federation of Gynecological and Obstetrical Societies. Some Brazilian women "use knives, knitting needles, caustic soda, permanganate, iodine. It's horrible" (6).

More than 4 abortions were performed for every 10 live births, according to data collected in 1971 by IPPF from 87 countries. Put another way, allowing for spontaneous abortions and stillbirths, nearly 1 in every 4 pregnancies is terminated by either legal or illegal abortion (130). In some areas of the world, for example, the Western Pacific, the figure is even higher—2 abortions for every 3 pregnancies (63). However, in many countries this data is not reliable (63,134).

The influence of such data on the world's law and policy makers has undoubtedly contributed to the gradual liberalization of abortion laws—a trend that began after World War II and gained momentum during the last decade.

Today, 6 in 10 of the world's people live in countries where abortion is either available "on request" during the first trimester or where the language of the law encourages broad and liberal interpretation.

Not only do laws differ from one country to another, but even the definition of the term "abortion" varies. The most widely accepted meaning of "abortion" is the one likely to be used by physicians: termination of pregnancy before the fetus becomes viable (capable of living independently). This is usually defined as the 28th week of gestation when the fetus weighs approximately 1,000 grams (153).

Also, two types of abortion are distinguished: induced and spontaneous. "Induced abortions are those initiated by deliberate action undertaken with the intention of terminating pregnancy; all other abortions are considered to be spontaneous even if an external cause is involved, such as trauma or communicable disease" (153). Abortion in this report refers only to induced abortion.

Induced abortion can be either legal or illegal depending upon the law of a given country; this distinction has important medical as well as legal implications (87,94, 153). Initially, in the 19th century, laws restricted the practice of abortion to protect women from what was, at that time, a dangerous operation associated with high mortality and morbidity (52,87,103,145). Today, however, legal abortion, when done under proper medical supervision, involves less risk than continuing pregnancy to term (81,134).

HAZARDS OF ILLEGAL ABORTIONS

Improvement of maternal health by reducing the number of illegal abortions is, in many countries, the most compelling reason for liberalizing abortion (10,86,147). Illegal abortions performed by untrained personnel in unsanitary and ill-equipped facilities cause many women to experience complications such as perforation of the uterus, hemorrhaging, infection, and future sterility. As a result, they often require special gynecological care and hospitalization.

Such complications from illegal abortions continue to be the leading cause of death associated with pregnancy and childbearing in some countries with restrictive legislation (43). In Venezuela, for example, 1973 statistics

BR RJCOC SH. 05. 01. F18

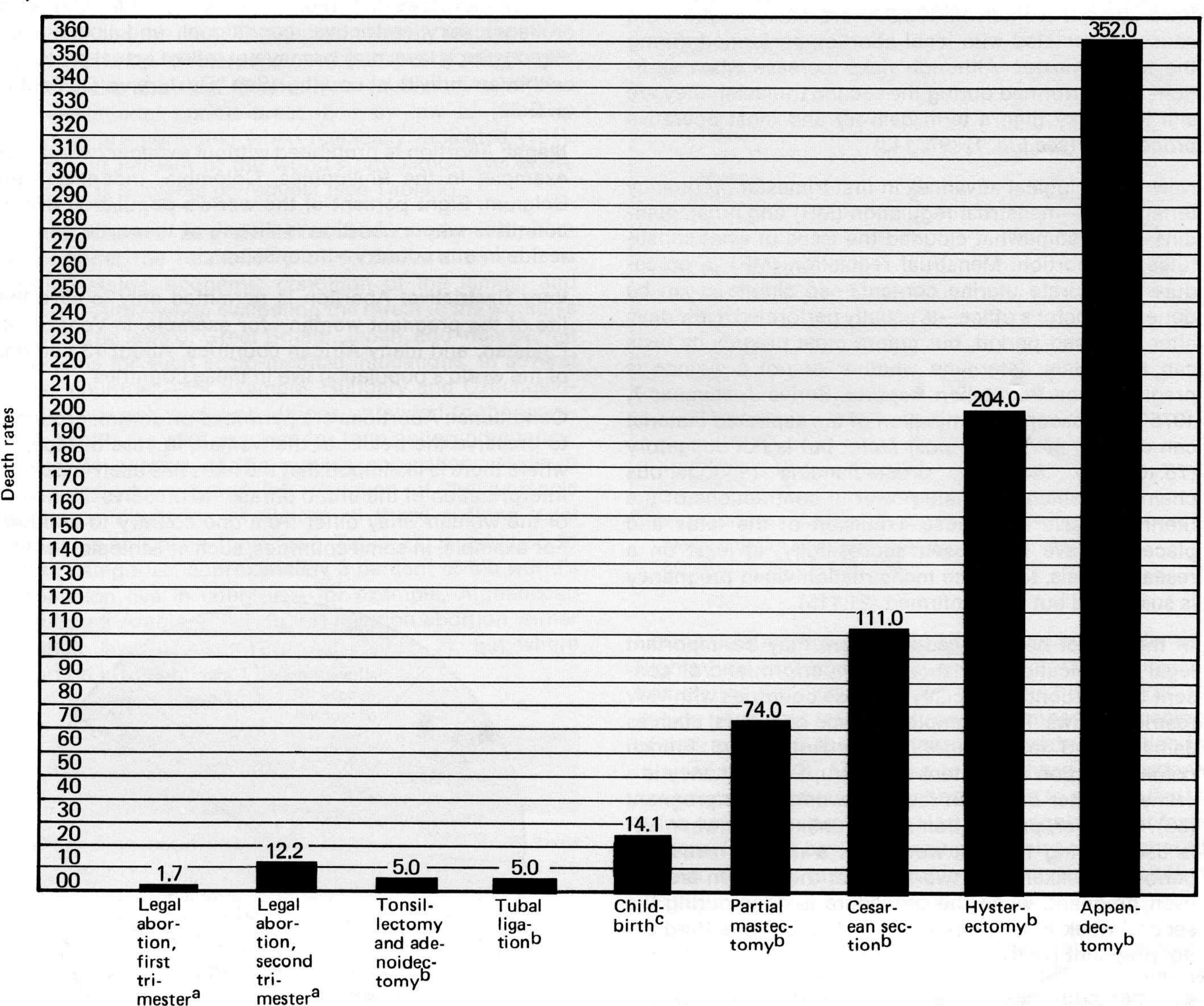
from the world's largest maternity hospital show that septic abortion, often due to illegal abortion, was responsible for 70 percent of the high maternal mortality rate (14). Also, in Nigeria's urban centers, illegal abortion remains the leading cause of maternal mortality and morbidity (16). In Chile, 40 percent of all maternal mortality is attributed to illegal induced abortion (24). Worldwide, 150,000 women die annually as a result of illegal abortion (88). This represents 30 to 50 percent of all maternal deaths associated with pregnancy and childbirth each year (88).

EARLY ABORTION: A SAFE PROCEDURE

The risks associated with pregnancy termination performed during the first trimester are much fewer than those associated with most surgical procedures, carrying a pregnancy to term, or second trimester abortion (see Fig. 1) (97,143).

According to Potts, the longer a woman delays abortion, the greater her risk. Therefore, he advises that those who want to terminate pregnancy do it as soon as possible. Beyond the twelfth week, Potts recommends against abortion unless there is a cogent reason (106) such as medical confirmation of a deformed fetus. One 2-year study made in New York State after that state's abortion law was liberalized confirms the advisability of following Potts' advice: among 343,955 first trimester abortions performed between July 1, 1970 and June 30, 1972 there were 10 deaths, but among 89,975 abortions performed after the first trimester (less than a third the number of first trimester abortions), there were 19 deaths (29). This represents 2.9 deaths per 100,000 first-trimester abortions and 21.1 deaths per 100,000 abortions done after the first trimester, thus indicating that risk of death is 7

Fig. 1. Abortion-related death rates compared to death rates for selected operative procedures, USA, 1972-1973. (Death rate per 100,000 procedures)



[a]Based on 1972-1973 data from the Center for Disease Control (US Department of Health, Education and Welfare)
[b]1969 data from C. G. Child III, "Surgical intervention," in *Life and Death and Medicine*, W. H. Freeman, San Francisco, 1973, p. 65.
[c]National Center for Health Statistics, DHEW, "Summary report: Final mortality statistics, 1973," *Monthly Vital Statistics Report*, Vol. 23, No. 11, Supplement (2), 1975.

SOURCE: Adapted from Lincoln, R., "The Institute of Medicine reports on legalized abortion and the public health." Family Planning Perspectives 7(4): 186. July/August 1975.

BR RJCOC SH.05.01. F18V

times higher for women who wait until the second trimester to terminate a pregnancy (29).

Mortality rates associated with illegal abortion are many times greater than those for legal abortion. Basing his figures on data from studies done in Britain, the USA, and some Eastern European countries, Tietze was able to calculate approximate annual mortality rates for induced abortions among women of reproductive age in fertile unions. He reports 3 deaths per 100,000 legal abortions performed in a hospital at an early stage of gestation versus 100 deaths per 100,000 abortions induced out of hospital by persons without medical training (129).

There is some evidence to indicate that legal abortions performed during the first trimester are becoming safer (32,134). Tietze's study compared the risks associated with first trimester legal abortion among women of reproductive age in fertile unions to those reported for a year's use of oral contraception and found them equal (129). Similarly, a recent US-based comprehensive report of legalized abortion and public health by the National Academy of Sciences' Institute of Medicine shows that fewer than 2 women in 100,000 are likely to die from causes associated with legal abortion performed during the first trimester. Although risks increase when abortions are performed during the second trimester, they are still less risky than a term delivery and most operative procedures (see Fig. 1) (97, 143).

New technological advances in first trimester pregnancy termination—menstrual regulation (MR) and prostaglandins—have somewhat clouded the issue of what constitutes an abortion. Menstrual regulation (MR), a procedure to aspirate uterine contents—so simple it can be done in a doctor's office—is usually performed a few days after a missed period, but before most pregnancy tests can accurately determine whether or not a woman is pregnant (see **Population Reports**, Series J, Number 7, 1975). Microscopic examination of the aspirated material can confirm pregnancy *post facto*, but is not obligatory (76,108,122). Similarly, prostaglandins (endogenous chemicals which stimulate powerful contractions of the uterine muscle and cause expulsion of the fetus and placenta) have been used successfully, at least on a research basis, to induce menstruation when pregnancy is suspected but not confirmed (21,115).

In the use of both procedures there may be important legal complications for those who perform and/or consent to abortions, especially in those countries with very restrictive laws. For example, in some countries, such as Jamaica and many other former British and French colonies, action with intent to interrupt a pregnancy is a crime whether or not, in fact, the woman was pregnant (83). However, prosecution seems unlikely, for when MR is used during the first week after a missed menstrual period, it is likely that two-thirds of the women are not even pregnant; when the procedure is done during the second week after a missed period, about one-third are not pregnant (76,97).

In other countries with very restrictive laws, however, intent to interrupt a pregnancy is not an offense. Unless it can be established that the woman is indeed pregnant, there is no crime. In these countries, such as Libya, the Dominican Republic, Malaysia, and Spain, MR and prostaglandins can be used as abortifacients without violating existing criminal abortion statutes (83,149).

Whether or not MR and the administration of prostaglandins should be considered abortions within the meaning of the criminal law is at issue, since proof of pregnancy is lacking and these treatments are often performed on women who are not pregnant. Perhaps increased recognition of menstrual regulation as a safe effective method of pregnancy termination may influence countries with restrictive legislation to do one of the following:

- revise their criminal codes;
- redefine the meaning of "abortion";
- classify MR and prostaglandins as methods for pregnancy prevention and make no decision as to whether they are contraceptives or abortifacients;
- acknowledge that in certain respects the traditional concepts of contraception and abortion may overlap (83).

CLASSIFICATION OF ABORTION LAW

All abortion laws fall into one of four major categories —illegal, very restrictive, conditional, and liberal (see Fig. 2). Such laws may or may not reflect actual practices within an individual country (See "De Jure vs. De Facto" p. E-32).

Illegal: Abortion is prohibited without exceptions—as, for example, in the Philippines, Colombia, Indonesia and Belgium. Eight percent of the world's population live in countries where abortion is illegal; of these, 40 percent reside in one country—Indonesia.

Very Restrictive: Abortion is permitted only to save the life of the pregnant woman—for example, in Venezuela, Pakistan, and many African countries. About 13 percent of the world's population live in these countries.

Conditional: Abortions are permitted on several grounds: to preserve the health of the woman, in case of rape, or where there is likelihood that the fetus has been impaired. Interpretation of the broad phrase "to preserve the health of the woman" may differ from one country to another. For example, in some countries, such as Ethiopia, the law

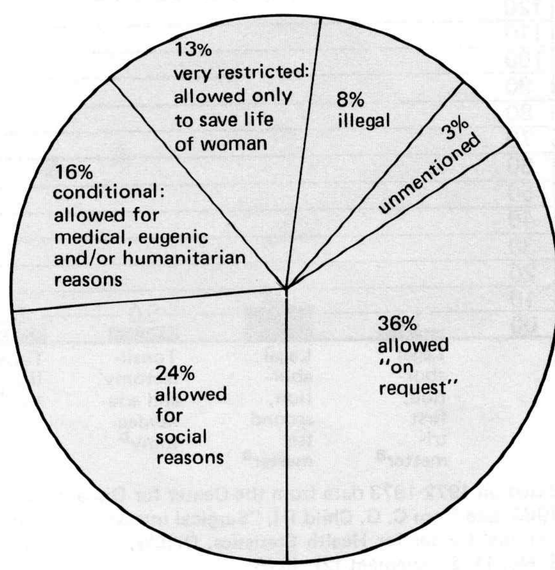


Fig. 2. Percentage of world population living in countries where abortion is illegal, very restricted, or unmentioned; or is available conditionally, for social reasons, or on request.

refers only to physical health, whereas in others such as Nigeria, a woman's mental health may also be a determining factor. In other countries, abortion is allowed on humanitarian grounds if the pregnancy resulted from rape or incest, or on eugenic grounds if it is believed the fetus has been impaired and/or the child would be born with serious physical or mental defects. In countries with conditional laws, the written consent of two physicians or an abortion board is usually required before any procedure is undertaken. Some countries—for example, the Republic of Korea—permit abortion on all of the above-mentioned grounds; others—for example, Lebanon—allow abortion only if the woman has been raped; and still others—for example, Turkey—permit abortion on medical and eugenic, but not humanitarian grounds (see Table 1). Sixteen percent of the world's population live in countries with such laws.

Liberal: This category has two subdivisions—"on request" with no restrictions and "for social reasons."

"On request" abortion is available during a defined period of time, usually the first trimester, in countries such as Tunisia, the People's Republic of China, Singapore, Sweden, and the USA. The decision usually rests with the woman and her doctor; she need not specify reasons for wanting the abortion. Generally, even abortions beyond the gestational period prescribed by law for elective abortion are permitted when medically indicated (134). Today, 36 percent of the world's population live where abortion is available on request (see Table 2).

"Social reasons" as grounds for abortion permit doctors to consider the relationship of social factors—such as marital status, economic condition of the family, and family health—when evaluating the threat to the woman's health. The laws of Great Britain, Japan, and India permit abortions for such socio-medical indications. In several other countries—for example, Hungary and Czechoslovakia—adverse social conditions unrelated to the woman's health are also grounds for terminating pregnancy. Some 24 percent of the world's population reside in countries where broad interpretation of the woman's social condition allows almost all those seeking legal abortions to obtain them (see Table 2). In addition to these categories, approximately 3 percent of the world's population live in countries—for example, Afghanistan and Saudi Arabia— that do not mention abortion, either in their laws or penal codes (see Fig. 2), but where abortion is presumed to be illegal.

BR RJCOC SH.05.01.F19

Table 1—Specific Grounds for Abortion in Countries where Laws are Conditional, 1975

Country	Grounds for Abortion		
	Medical	Eugenic	Humanitarian
EUROPE AND NORTH AMERICA			
Albania	X		
Canada	X		
Greece	X*		X
Italy	X*		
Switzerland	X		
AFRICA			
Cameroon	X		X
Ethiopia	X		
Ghana	X		
Kenya	X*		
Mauritius	X		
Morocco	X		
Nigeria	X*		
Sierre Leone	X*		
South Africa	X*	X	X
Sudan	X		
Swaziland	X		
Uganda	X*		
ASIA, MIDDLE EAST, OCEANIA			
Australia	X*		
Israel	X		
Jordan			X
Korea, Republic of	X*	X	X
Lebanon			X
Syria	X		
Thailand	X		X
Turkey	X	X	
LATIN AMERICA			
Argentina	X		X
Brazil			X
Chile	X		
Costa Rica	X		
Cuba	X	X	X
Ecuador	X		X
El Salvador		X	X
Guatemala	X		X
Honduras	X		
Mexico			X
Peru	X		

*Mental health specifically mentioned in the law.
SOURCES: 74, 92, 132, 134

CURRENT GLOBAL OVERVIEW

Twenty-nine countries have liberal abortion laws; over half passed in this decade. Another 34 have laws that are conditional, permitting abortion for specified reasons. Thirty-eight countries still have very restrictive laws, most dating back to the nineteenth or early twentieth century, with abortion permitted only to save a woman's life.

U.N. Involvement

Since 1966, when it issued its Declaration on Population which stated that "the size of the family should be the free choice of each individual family," the United Nations has heightened its involvement in population matters (43).

Delegates attending the 1968 UN Conference on Human Rights held in Teheran unanimously adopted a resolution stating that "couples have the basic human right to decide freely and responsibly on the number and spacing of their children—and the right to adequate education in this respect" (43). According to Lee, these declarations have encouraged many member nations to use the law to solve population problems. Having recognized that family planning is a basic human right, each country should reform existing laws to conform with the resolution (19,82).

At the World Population Conference, held in August 1974, representatives of 137 countries met in Bucharest to discuss worldwide population trends and future prospects related to social and economic development, the family, resources, and the environment (139). The result was the well-publicized World Plan of Action (for a summary see **Population Reports**, E-2, November 1974, page E-17). Similar to the statement issued at the 1968

BR RJCOC SH.05.01. F19V

Table 2—Countries with Liberal Abortion Laws, 1975

Countries	Estimated Population (millions)[a]	Liberal Legislation and Year Effective: For Social or Social-Medical Reasons	On Request
AFRICA			
Tunisia	5.7	1965	1973
Zambia	5.0	1972	
ASIA			
China, People's Republic of	822.8		1957
Hong Kong	4.2	1972	
India	613.2	1972	
Japan	111.1	1948, 1960	
Singapore	2.2	1969	1974
Vietnam, Dem. Rep. of	23.8		1971[b]
EUROPE (EASTERN)			
Bulgaria	8.8	1968, 1973, 1974	1956
Cyprus	.7	1974	
Czechoslovakia	14.8	1957, 1973	
Germany, Dem. Rep. of	17.2	1950, 1965	1972
Hungary	10.5	1973	1956
Poland	33.8	1956, 1961	
Romania	21.2	1966, 1971	1957
USSR	255.0		1920, 1955
Yugoslavia	21.3	1960, 1969	
EUROPE (WESTERN)			
Austria	7.5		1975
Denmark	5.0	1937, 1956, 1970	1973
Finland	4.7	1950, 1970	
France	52.9		1975
Germany, Fed. Rep. of	61.9	1975[c]	
Great Britain	54.7	1967	
Iceland	.2	1938	
Norway	4.0	1960, 1975	
Sweden	8.3	1938, 1946, 1964	1975
LATIN AMERICA			
Uruguay	3.1	1968	
NORTH AMERICA			
USA	213.9		1973
OCEANIA			
S. Australia & N. Territories	1.4	1969, 1974	

[a]Population Reference Bureau, 1975 World Population Data Sheet.
[b]Exact year never released.
[c]Court decision in force pending new legislation.
SOURCES: 74, 80, 92, 132, 134.

Conference on Human Rights, the Plan of Action reiterated agreement on "the fundamental rights of couples and individuals to decide freely and responsibly the number and spacing of their children" as well as "the obligation of states to provide guidance and means to allow the exercise of this right" (139). In addition to reaffirming a need for social and economic development, the Plan suggests that countries establish interdisciplinary population policy and planning units at a high administrative level (139,151).

Whether or not the World Population Conference contributed to liberalization of abortion law is not yet clear. The Conference Plan of Action makes no reference to abortion (139), but the subject was discussed and debated at the Population Tribune, the meeting of nongovernmental organizations and private individuals that was held simultaneously.

In the months following the Conference, consultations were held in the four UN Regional Commissions—Asia and the Pacific, Latin America, Middle East and North Africa, and Sub-Sahara Africa—to consider the implications of the World Plan of Action in the context of each region's developmental priorities and population problems. Delegates from the Asia and the Pacific region and some from the Sub-Saharan African region favored considering the legalization of abortion as a step toward reduction of female mortality. At meetings of the Latin America and Middle East/North African regions, legalization of abortion was not discussed (151).

Abortion was also debated at the 1975 International Women's Year Conference in Mexico City (7). Their World Plan of Action, although not advocating legal reform, does recognize the public health problems associated with illegal abortion (95,141).

Europe

Since 1973 abortion has been liberalized in Austria, France, Italy, and the Federal Republic of Germany, and further liberalized in Sweden, Norway, and Denmark. In Sweden, since January 1, 1975, a doctor may be fined or imprisoned for up to six months for refusing to comply with a woman's request for a first trimester abortion (123). The Netherlands and Switzerland have liberal abortion bills under consideration in their legislatures. But there are still some European countries—Belgium, Ireland, and Portugal—where abortion remains illegal with no exceptions.

In most of Eastern Europe, where abortion has been legal since the 1950s, a few countries such as Romania, Hungary and Czechoslovakia have, in recent years, passed more restrictive legislation, although in world perspective they remain liberal, taking into account both social and medical conditions. In so doing, they cited concern over falling birth rates and the potential long-term health impact of freely available abortion (62,86). Unlike her neighbors, Bulgaria in 1974 retracted some restrictions imposed the year before (31).

Asia and the Middle East

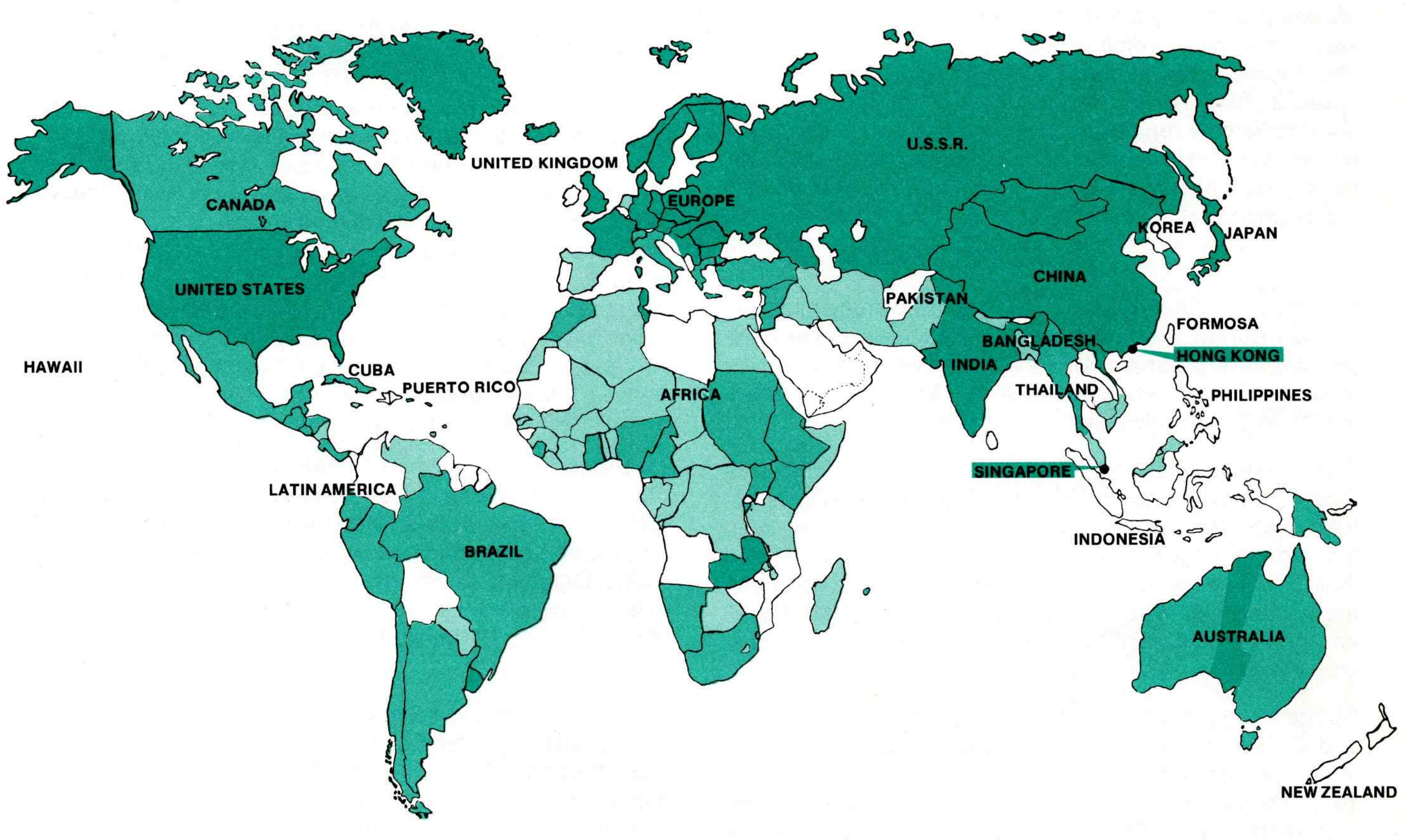
The legal status of abortion in Asia varies from liberal, as in Singapore, India and the People's Republic of China, to illegal under any circumstances as in the Philippines, Indonesia and Burma (67). Between these are countries like Sri Lanka and Iraq that allow abortion only to save the life of the woman, and other Middle Eastern countries such as Saudi Arabia, Afghanistan and Bahrain, that fail even to mention abortion in their statute books (63) and where the practice is presumed to be illegal or very restricted (134).

Latin America

In all Latin American countries today abortion is a major method of fertility control, even though in most of these countries it is either illegal or permitted only if necessary to save the life of the woman (69). Induced abortion is the most important single cause of maternal death in Latin America (2,69). Furthermore, in some countries, except

BR RJCOC SH. 05. 01. F20

Legal Status of Abortion*
1975



= liberal legislation—abortion legal on request or for socio-economic reasons with limits only on gestation period, place, and/or practitioner.

= conditional/legal—abortion legal on medical, eugenic and/or humanitarian grounds.

= very restrictive/legal—legal only to save life of mother.

= abortion illegal (or not mentioned and presumed illegal) by law with no exceptions.

*Abortion may, of course, be readily available and prevalent even where it is not legal.

BR RJ.OC 5H.05 01. FAD /

for childbirth, the most frequent cause of hospital admissions among women is complications from induced abortions (23).

Recognition of these factors has led to a reconsideration—and some action—on restrictive abortion laws. Within the last two years, El Salvador and Guatemala have passed conditional laws with more moderate restrictions (see Table 1). Earlier, abortion was prohibited in El Salvador, and only allowed in Guatemala if necessary to save a pregnant woman's life. Since 1968 Uruguay has had the most liberal abortion law in Latin America (see Table 2) (68). Recent reports from Cuba indicate that abortion is now readily available in government hospitals during the first trimester of pregnancy (10,72), but the penal code has not yet been amended to reflect this policy change (73).

Africa

In 1973 Tunisia passed a law permitting abortion on request during the first trimester. Zambia was the only country in Sub-Sahara Africa with liberal abortion legislation until 1975 when South Africa also liberalized an earlier very restrictive law.

Other African nations, such as Zaire, Tanzania and Ghana, are still bound by their traditional emphasis on high birth rates (to counteract high mortality rates) and the stringent laws inherited from colonial days (114). Most allow abortions only to protect the life and health of the woman (92). There is evidence, however, that illegal abortions are increasing (114,148), especially in urban areas.

Doctors, judges, and other influential persons in Nigeria and Ghana are beginning to speak out against abortion laws they call "discriminatory and repressive" (26,80, 151). The countries of Francophone Africa, where laws patterned after those that existed during the French colonial period remain in force, are likely to be influenced toward legal reform as a result of the 1975 liberalization of abortion laws in France (151).

North America

In Canada abortion is legal only when a special abortion committee certifies that the pregnancy may endanger the woman's life or health. But the law is not strictly enforced, and though technically illegal, medically performed abortions are common (37). Women wishing to terminate a pregnancy for nonmedical reasons often cross the border to have the operation done in the USA (130).

In the USA the woman and her doctor decide whether or not an abortion in the first trimester will be performed. This reflects 1973 Supreme Court rulings that individual states cannot, at least during the first trimester, interfere with a doctor-patient decision on abortion. Beyond that period, states can interfere only to set standards "reasonably related to maternal health" (103,145).

In 1971, the President of the USA banned abortion in military hospitals in states that did not permit abortion. Shortly thereafter, the US Public Health Service issued similar instructions to its hospitals (56). However, two recent administrative decisions by federal government agencies revoked these bans: the Department of Health, Education and Welfare announced that it has instructed Public Health Service hospitals to resume performing abortions, and the Defense Department directed military base commanders to heed the liberal Supreme Court decisions rather than the state laws that restrict abortion (11,40,85,144). Abortions will now be offered as part of a wide range of health services to families of American Indians, merchant seamen, and all military personnel (11,85).

RECENT CHANGES

New abortion laws generally reflect a gradual trend toward liberalization. In countries such as Norway, Singapore, and the Federal Republic of Germany, that have recently liberalized their laws, abortion was already legal on either medical, eugenic, and/or humanitarian grounds. An exception to this gradual evolution is France, where new "on request" abortion legislation replaces a very restrictive law permitting abortion only to save the life of the pregnant woman (50). Hong Kong, while not actually passing new liberal legislation, extended a liberal ordinance of 1972, due to expire in 1974, for another two years (57).

In Bulgaria the Ministry of Public Health issued instructions liberalizing the 1973 restrictions on the abortion law (31). For details on this 1973 law, as well as other 1973-74 legal changes in the abortion laws of Austria, Czechoslovakia, Denmark, El Salvador, Guatemala, Hungary, South Korea, Sweden, Tunisia and the USA, see **Population Reports**, E-1, Eighteen Months of Legal Change, July 1974).

In both Italy and the Federal Republic of Germany, federal courts have recently effected legal changes. Italy's Constitutional Court in February 1975 ruled that abortions performed to avoid endangering the woman's physical or psychological health were not illegal (17). Now Italy's several political parties are drafting new legislation to amend those sections of the Penal Code restricting abortions that were declared unconstitutional (67).

In the Federal Republic of Germany, Paragraph 218A of a June 1974 law allowing abortion on request during the first trimester was declared unconstitutional. However, the German constitutional court suggested circumstances under which abortions could be performed during the first trimester, including "when the birth could cause grave hardship" (67). These new regulations will have the force of law until the Bundestag passes new legislation. The remainder of the law was unchanged (75).

In Cyprus abortion change was a direct result of war. Following their civil war, Cyprus passed legislation permitting abortion if pregnancy resulted from rape (38,49).

Most of the recent liberalization of abortion legislation has occurred in European or Asian countries. In African countries the few legal changes made ranged from very restrictive to conditional. In Latin America, there are no legal changes to report (see Table 3 for details).

DE JURE VS. DE FACTO

Abortion law is not always an accurate guide to a country's *de facto* practices. For example, although abortion is

BR RJCOC 5H.05 U7 F47

Table 3—Recent Changes in Abortion Laws in Selected Countries, 1972-1975

Country	Ref. No.	Category of Abortion Legislation	Type of Government Action	Summary of Action	Effective Date
Bulgaria	31 49 75	liberal— 1973 restrictions liberalized	Amendments & additions to instruction of Ministry of Public Health	List of those eligible for abortion on request expanded to include women who are widowed, divorced, or re-married; are aliens; are over 40 with one living child; have 2 living children (including adopted children); have 2 children from previous marriage of husband now living with the family. At any stage of pregnancy, abortions may be performed on basis of medical, men-tal, & nervous indications, as listed in extensive "annex" to the instructions.	February 1974
Cyprus	5 38	liberal— social factors considered	Amend. to Criminal Code: now Sect. 169A of Chap. 154	Abortion permitted on grounds of detrimental socio-economic & psychological conditions, as well as rape.	1974
Dahomey[a]	42	very restrictive	Ordinance No. 73-14	Therapeutic abortion legal if attending physician and 2 consultant physicians have certified in writing that procedure is required to save life of mother.	February 1973
France	50	liberal— on request dur-ing first 10 weeks	Law No. 75-17	Termination of pregnancy by a physician in licensed hospital legal before the end of 10th week. Therapeu-tic abortion legal regardless of gestation if two doctors certify termination necessary to health of woman or for eugenic reasons.	January 1975
Germany, Fed-eral Republic of	5 51 67 75	liberal— "grave hardship"	Decision of Constitu-tional Court	Court refused to allow abortion on request during the first 3 months of pregnancy, but did allow first tri-mester abortion in cases of rape, danger to the wom-an's health, possibility of fetal deformity, or when the birth could cause "grave hardship." Court regula-tions have force of law until Bundestag passes new legislation.	February 1975
Hong Kong	57 64	conditional	Governmental decree ex-tending Sect. 47A of Or-dinance No. 15 for an-other 2 years	If pregnancy injurious to the physical or mental health of the woman, therapeutic abortion on advice of 2 physicians permitted. In reaching decision, account may be taken of "the pregnant woman's actual or reasonably foreseeable environment" (Terms similar to the Abortion Act of 1967 of Great Britain).	1974
Italy	17 67	conditional	Constitutional Court decision	Declared the penal code provision outlawing abor-tion "partly unconstitutional." Court ruled abortion legal if mother's physical or psychological health in danger.	February 1975
Norway	4 13	liberal— social factors considered	Liberalization of existing law	Abortion Panels, comprising 2 physicians, now able to permit abortions on social as well as medical grounds during first trimester. By providing a more uniform practice in considering applications, new law attempts to simplify procedure and speed up final de-cision. Woman has automatic appeal to a Board, which includes a social worker. Now extremely difficult to get an abortion after 12th week of pregnancy.	June 1975
Singapore	120 66 49	liberal—on re-quest in first 16 weeks of pregnancy	Act No. 24 of 1974— liberalization of existing law	Termination of Pregnancy Board abolished; abortion available on request until 16th week of pregnancy. Between 16th and 24th weeks, abortion must be per-formed by qualified specialist. After the 24th week, abortion only legal to save woman's life or to prevent "grave injury" to woman. There is a 4-month resi-dency requirement for other than Singapore citizens.	December 1974
South Africa	121	conditional	Abortion & Sterilization Act; Act No. 2, 1975	Abortion may be performed by a medical doctor in cases where continued pregnancy constitutes a threat to the woman's life or physical or mental health; and also on eugenic and humanitarian grounds (where "foetus conceived in consequence of unlawful carnal intercourse"). In each instance, 2 other physicians must concur, in writing, to the need for abortion. Same law governs territory of South West Africa.	March 1975

[a]In 1975 name changed to the People's Republic of Benin.

illegal or very restrictive in some countries such as Taiwan, Greece, and the Netherlands, it is being performed by physicians without interference from the authorities (147). Conversely, passing liberal abortion laws is no guarantee that abortion services actually will be available to all women who want their pregnancies terminated. Lack of proper facilities, a maldistribution of medical personnel, and/or conservative attitudes among doctors and hospital administrators may curtail access to abortion, especially among the poor, uneducated, and economically disadvantaged (55).

For example, despite the 1973 Supreme Court decision, at least one-third of the American women seeking abor-

BR RJCOL DH. 05-01 F31V

tions that year—mainly poor adults, unmarried teenagers, and residents of rural areas—were unable to get them (133); by the end of March 1974, only 15 percent of the country's public hospitals had performed even a single abortion (36,133,152). Similarly, the Lane Committee (Great Britain) reported in 1974 that about 30 percent of the women who applied each year to the National Health Service (NHS) for abortions were initially refused. Some persevered, however, and eventually obtained a free abortion through NHS; others who were able to pay had their abortions in private or nonprofit clinics; more than half continued with an unwanted pregnancy (18,53).

In India, where first trimester abortions are legal, the number performed was far less than the government foresaw (35). Despite a liberal law, regulations governing the certification of operating facilities and requiring doctors to personally prepare and file numerous forms virtually halted abortion services until 1975 when the regulations were altered (35,108). Many other countries continue abortion practices that are at variance with their legal position (see Table 4).

EMERGING TRENDS

Trends toward liberalizing existing restrictive legislation and increasing official interest in abortion are apparent in many countries where there have not yet been legal changes.

In part this may be due to the post-Bucharest concern with family planning and population growth or, perhaps, to an awareness on the part of government policy makers that regulation will help ensure a safe alternative to illegal abortion.

Europe

Belgium, one of the three remaining European countries which totally prohibits abortion, and Switzerland, where abortion is legal only to save or protect the health of the pregnant woman, are both considering legislative changes. A moderate abortion law was proposed several years ago in Belgium, but it encountered powerful political and religious opposition. In December 1974 the Government established a National Commission on Ethical Problems that is expected to develop an "adequate policy" on abortion (28). In October 1974, the Swiss Government suggested that its parliament consider a law favoring abortion for social reasons (75). A year later it was passed by the National Council (lower house), but the State Council (upper house) has yet to approve it (102). In the UK, it is expected that a bill allowing abortion "on request" will be introduced in parliament during 1976 (118).

Asia and the Middle East

Bangladesh, determined to take measures to slow down its population growth and eventually stabilize it, proposed in its First Five-Year Plan, released in October 1973, to consider further liberalization of restrictive abortion laws (151). Also, in Taiwan and Thailand there was talk of liberalization. In 1974 the Thai Minister of Health proposed a more liberal interpretation of, and some revisions in, existing laws; however, a subsequent government—recently dissolved—took no action (151). Last year the Ministry of Justice in Nepal released a draft proposal for "relaxing penal provisions for abortions" (66), and currently the Family Planning Association of Nepal is drafting a moderate abortion law (12,75). In 1974 Iran liberalized its abortion statutes (45), but the administrative codes to implement this parliamentary decree have not yet been promulgated (151). Indonesia, the world's largest country still prohibiting abortion, is working on a revision of its penal code and may re-examine those sections dealing with abortion (75). The Medico-Legal Society of the Law and Population Committee of the Family Planning Association of Sri Lanka, where abortion is currently permissible only to save the woman's life, has started a campaign to liberalize restrictive legislation (12).

Latin America

In Latin America several countries are discussing the possibility of legalizing abortion under certain conditions. For example, in Panama and Colombia, where abortion is prohibited under any circumstance, influential organizations, such as the College of Obstetrics and Gynecology, have begun to openly question this policy (151). The law in Barbados may be changed in the near future, as influential Barbadians now are concerned that their country is not moving along with the times (46,92). In 1975 the Government of Jamaica introduced legislation in the House which would amend the Offenses against the Person Act and allow abortion when necessary either to protect the life and health of the mother or in cases of rape, incest, and carnal abuse (39). In Cuba it is expected that a new abortion law stating the government's liberal attitude will soon be published (73).

Africa

Illegally induced abortion is perceived solely as a medical problem in several African countries. Three alternative draft proposals that would liberalize the current abortion law are now being circulated by the Law Reform Commission in Ghana (20). In Nigeria the Medical Society and the Society of Obstetricians and Gynecologists sent a strong memorandum to the government in 1974 arguing the case for abortion law repeal or reform (26,66). As a member of the High Court of Justice said, "the provision in the Criminal Code relating to abortion is inadequate to meet the present day needs of our society. There is a dire need for a new legislation or decree. . ." (80).

North America

In Canada there has been some discussion of liberalizing the abortion laws (37). However, in March 1975, in the Morgentaler case, the Canadian Supreme Court upheld a strict interpretation of the 1969 law which permits a doctor to perform abortion only in a licensed hospital after a special abortion committee agrees that to continue the pregnancy would endanger the woman's life or health (75).

Oceania

In 1974 the government of New Zealand and the Australian Parliament established commissions to inquire into the whole field of abortion, sterilization, and contraception. In Australia, at present, only the state of South Australia and the Northern Territories (49,75) have liberal abortion legislation. However, New South Wales, Victoria, and Western Australia, where de facto interpretations

BR RICOC 5H.05.01 fdk

are already liberal (108), may take similar legal action soon (136).

Countries with a Pronatalist Position

Not all countries are discussing new legislation to legalize abortion or liberalize existing legislation. Some countries, such as Greece, Argentina and many of those in Francophone Africa, take a pronatalist position, claiming future development requires increased population. Such countries generally have no government endorsed family planning programs and are opposed to any measures that might restrict population growth. Also, some of the

Table 4—Legal Position and De Facto Practices Related to Abortion in Selected Countries, 1975

Country	Ref. No.	De Jure vs De Facto: Legal Position on Abortion	De Facto Interpretation
Bangladesh	49 58 75 108 134	prohibited except to save woman's life	Government-provided MR services have become acceptable form of fertility regulation. Abortions being performed in district capital clinics and hospitals with knowledge of government personnel; no legal repercussions to date.
Belgium	60 86	prohibited	Extremely low incidence of court conviction. Accepted practice not to prosecute when abortion performed on medical or eugenic grounds.
Chile	68	permitted only on therapeutic grounds	Chilean abortion laws widely ignored. One well known doctor knew of only 2 prosecutions for abortion law violations. In both cases the woman had died, and the doctor was acquitted.
Colombia	68	prohibited	"... the crime of abortion is practically unknown by the authorities."
Cuba	10 72 73	permitted for medical, humanitarian, and/or eugenic reasons, but only if husband or other family member has no objections	Government hospitals provide free first trimester abortions on request with no restrictions.
Egypt	98	prohibited except to save woman's life	Gap exists between law and application; prestigious medical schools perform abortions.
Greece	92 146	permitted for medical and humanitarian reasons	Accepted as an important means of family limitation. Often performed on pretext of menstrual disorders.
Israel	22	permitted only on strict medical grounds. Otherwise, abortion punishable by 5 years in prison	For many years the law has been enforced only after an abortion-related death was publicized.
Jamaica	1 113 92	prohibited except to save woman's life	Government has neither necessary police force nor legal machinery to enforce abortion law. Annually 25,000 illegal abortions on request performed for modest fee.
Jordan	41 92	prohibited except in cases of rape or incest "to protect family honor."	In practice, abortion performed by doctors in private hospitals as therapeutic abortion.
Korea (South)	34 151	permitted on medical, eugenic, and humanitarian grounds	Before South Korea's restrictive abortion laws were reformed in 1973, safe medical abortions were widely available. In a survey taken before liberalization, 68% of women sampled either thought abortion was legal or were unsure of the law.
Lebanon	116	prohibited except in cases of rape or incest "to protect family honor"	Doctors perform abortions "to fill the gap when contraception has failed." (Also, contraception is illegal.)
Netherlands	86 147	prohibited except to save woman's life	More than a dozen abortion clinics provide first trimester terminations upon request.
Puerto Rico	117	permitted on demand in first trimester; US Supreme Court decision of 1973 binding on Commonwealth	Medical community opposes abortion. Requests for abortion often rejected. Hence, the poor usually cannot get abortions even on medical grounds.
Taiwan	92	prohibited—criminal code of 1935 provides severe punishments	Abortion is widely practiced; safe medical services available.
Thailand	92	permitted on medical and humanitarian grounds	Most doctors are reluctant to perform abortions even in those situations where it would be technically legal.

BR K3COC 3H 05 U7 F22V

Eastern European countries, for example Romania, Hungary and Czechoslovakia, are concerned about declining birth rates (148). Since 1973 they have passed legislation restricting earlier "on request" abortion laws, but in each case the new legislation allows the physician to base a decision on socio-economic conditions affecting the woman and her family (45).

Attempts to Restrict Liberal Laws

In some countries with liberal laws abortion still remains a controversial subject. In the USA, Japan and Great Britain there are vocal opponents to such legislation who wish to alter or restrict the current laws. For example, during the 1975 session of the US Congress, eight proposed constitutional amendments were brought before the Senate Judiciary Subcommittee on Constitutional Amendments. Although none of these proposals—which either forbade abortions except to save a woman's life or reserved to the states the power to decide if pregnancy might be terminated—was endorsed by the committee, the committee chairman remarked that he had "rarely encountered such an emotional issue in twenty years of political life" (27,70).

Federal laws have already limited the scope of the January 1973 US Supreme Court decision, *Roe v Wade,* which found that all the state laws limiting abortion were unconstitutional violations of a woman's right of privacy (103). An amendment to the Health Program Extension Act of 1973 provides that a hospital's receipt of federal funds shall not, of itself, be the basis for requiring it to perform abortions and sterilizations if that hospital's policy bars these procedures on religious or moral beliefs (150). (In the opinion of many lawyers, it would be unconstitutional for a public hospital to refuse to perform an abortion, but this amendment has yet to be tested in the courts (104).) A May 1974 addition to the Legal Services Bill prohibits federally funded legal services attorneys from bringing pro-abortion cases into the courts (103) or interfering in any way should an indigent client have difficulty obtaining an abortion (95).

Another piece of US legislation has ramifications in other countries. An amendment to the Foreign Assistance Act of 1973, referred to as the Helms' Amendment, prohibits the use of US foreign assistance funds to pay for abortion services or "to motivate or coerce any person to practice abortion" (142).

A proposed revision of the Eugenic Protection Law in Japan would have deleted "economic reasons," a phrase open to very broad interpretation, and substituted "mental health" as admissible grounds for abortion. The House of Representatives in May 1974 passed favorably on the change, but the bill was later shelved by Japan's upper house (64).

Early in 1975 a restrictive Abortion (amendment) Bill received a majority vote on a second reading in the British House of Commons (8,119), but subsequently lapsed before final voting (108,118). Had this bill become law, it would have severely restricted the scope of the 1967 Abortion Act. It would have made the grounds for legal abortion more exacting, excluded foreign patients, banned abortion after 20 weeks, placed the burden of proof on the doctor that regulations had been followed —thereby reversing the normal process of English legal tradition—and insisted that girls under 16 be interviewed only in the presence of their parents (119).

IMPLICATIONS OF LIBERALIZING ABORTION LAWS

Recent liberalization has swelled the numbers of legal abortions in the USA, Great Britain, Sweden, the German Democratic Republic, and Denmark (148). In Denmark, for example, there was a 38 percent upsurge in legal abortions during the first three-month period following the 1973 law permitting abortion on request up to the twelfth week of pregnancy (86). Paralleling this trend in these countries, the incidence of illegal abortion has greatly decreased (134,148).

Mortality Declines with Liberalized Laws

In nearly all countries with reliable data, the increase in the total number of abortions performed following liberalization has been associated with a decline in maternal mortality. This trend has been documented in the USA, Great Britain, Canada, Cuba, and most Eastern European countries which have liberalized legislation (147). Conversely, when "on request" liberal abortion practices are made more restrictive, an increase in maternal deaths due to illegal abortions is likely to occur. Evidence from Romania supports this view (44,90,97,105).

Table 5—Status and Grounds for Abortion in the World's 13 Most Populous Countries, 1975

Country	Population, Estimated mid-1975*	Is Abortion Legal?	Grounds
China, People's Republic of	822,800,000	yes	On request in first three months
India	613,200,000	yes	For medical, eugenic, humanitarian reasons and for pregnancy caused by contraception failure
USSR	255,000,000	yes	On request in first twelve weeks
USA	213,900,000	yes	On request in first trimester
Indonesia	136,000,000	no	
Japan	111,100,000	yes	Considers economic conditions of family
Brazil	109,700,000	yes	To save life of mother or in case of rape
Bangladesh	73,700,000	yes	Only in cases of rape
Pakistan	70,600,000	yes	Only to save life of mother
Nigeria	62,900,000	yes	For health reasons—both physical and mental health
Germany, Federal Republic of	61,900,000	yes	Medical, eugenic, humanitarian and "grave hardship"
Great Britain	56,400,000	yes	Socioeconomic factors considered

*Population Reference Bureau, 1975 World Population Data Sheet. Washington, D.C.

BR KJC02 3H.U3.07 F.23

In 1973 in the USA following the Supreme Court's rulings that restrictive abortion laws were unconstitutional, deaths related to abortion dropped by more than 40 percent (127,133,143). At the same time, there was a significant rise in the number of legal abortions performed, about 745,000 in 1973 compared to fewer than 23,000 in 1969, the year before the first four states passed nonrestrictive legislation (84).

The number of all known abortion-related deaths in the USA declined from 128 in 1970 to 79 in 1972 to 47 in 1973 (97,143). Twenty-two of these 1973 deaths were associated with legal abortion (84), resulting in a mortality rate of 3.0 per 100,000 legal procedures (133,152). (In the USA currently, when abortions are performed within the first trimester, a substantially lower death rate of 1.7 per 100,000 has been achieved (see Fig. 1).)

In New York City, in the four years prior to repeal of restrictive abortion legislation, 91 abortion-related deaths were reported. In the first four years after the law was liberalized, despite an annual increase of about 0.5 percent in New York City's female population of reproductive age (125), that figure dropped to 36 (97), a decline of more than 60 percent.

In Great Britain, too, while the number of legal abortions increased, the number of abortion-related deaths dropped. Between 1968 (the first year after passage of a liberal act) and 1971, the number of reported abortions —including those on foreign women—in England, Wales and Scotland increased from 25,000 to 133,000 a year (53). Prior to 1968, abortion deaths were as high as 60 a year; the first year after liberalization that figure fell to 35, and in 1971 there were only 27 abortion-related deaths. Abortion-related deaths dropped to 26 in 1972, then to 12 in 1973, and 11 in 1974 (53,96,134).

Canada's abortion law became somewhat less restrictive in 1969. Since then there has been a 100-fold increase in the abortion rate, while, concurrently, a significant decline in maternal mortality with a decrease in the number of criminal abortions (9).

In 1968 abortion was the leading cause of maternal death in Cuba. By 1974 it had fallen to third position (72). Legal abortion has contributed significantly to the reduction in the maternal mortality rate from 118 per 100,000 live births in 1962 to 63 in 1971. According to Kaiser, abortion-related deaths have dropped even further since then (72,73), but the government has not released the figures.

Unfortunately, in some countries inaccurate and incomplete statistics make comparisons of abortion-related mortality rates difficult or impossible. In Japan and many other Asian countries, although doctors are required to report all abortion procedures, record-keeping is lax and statistics are not always reliable (86). Figures released by the Japanese Health and Welfare Ministry indicated that the 1,471,700 abortions performed in 1970-1971 resulted in 28 deaths (134).

The German Democratic Republic passed liberal abortion legislation in March 1972 in an attempt to control the growing number of illegal abortions. In 1973 110,800 abortions were performed, but there are no reliable estimates of the mortality rate (86,134).

If a liberal abortion law results in lower overall maternal mortality, a policy change restricting such a law will, in all probability, cause an increase in abortion-related deaths. This is exactly what happened in Romania where, in October 1966, restrictive legislation replaced a 1957 "abortion on request" law. Data from Romania clearly show that when nonrestrictive abortion laws are tightened, deaths associated with illegal abortion increased significantly (97,105). In 1965, the last year abortion on request was permissible, there were 64 deaths attributed to illegal abortion. In 1967, the first year under restrictive legislation, that number has risen to 170, and by 1971 there were 364 deaths attributed to illegal abortions (see Table 6) (97). While the female population rose less than 10 percent during those years, the number of illegal abortion-related deaths increased by more than 500 percent.

Since 1973 a number of other Eastern European countries have restricted previously "on request" abortion laws, but data detailing how this has affected abortion-related mortality statistics are not yet available.

Morbidity Declines with Liberalized Laws

As medically safe abortions become available, women no longer have to resort to illegal abortion to terminate unwanted pregnancies. Complications such as infection, hemorrhage, or perforation are reduced when abortions are performed by doctors or other trained persons in a hospital, clinic, or office (154), as compared to the incidence of complications resulting from abortions which are self-induced or performed by untrained people in unsanitary facilities.

Data on hospital admissions resulting from abortion complications—some of which can be presumed to be due to illegal abortions—show a decline in the number of admissions following liberalization of the abortion laws (90). In Yugoslavia abortion-related hospital admissions declined by more than 50 percent in the five years following enactment of liberal legislation: from 3,745 in 1960, when the law was changed, to 1,468 in 1965. In England there was a 37 percent reduction in hospital admissions for abortion complications between 1966, the year prior to enactment of liberal legislation, and 1969 (90).

In San Francisco (USA) marked declines in the numbers of women admitted to hospitals for aftercare following

Table 6—Deaths Attributed to Illegal Abortion in Romania, 1965-1971

Year	Total Female Population	Number of Deaths
Abortion available on request:		
1965	9,712,000	64
1966	9,752,000	83
Restrictions imposed:		
1967	NA	170
1968	NA	221
1969	NA	258
1970	10,308,000	314
1971	10,413,000	364

NA = Not Available
SOURCE: World Health Organization. Statistics annual, selected years, 1966-1971.
Adapted from National Academy of Science. Institute of Medicine. Legalized abortion and the public health: report of a study. Washington, D.C., May 1975. p. 84.

BR RJCOC SH 05 01. F.3V

abortions done elsewhere were reported in the years after abortion laws were liberalized. In 1967, when abortion was illegal, San Francisco General Hospital reported 68 septic abortions per 1,000 live births. In 1968 after California reformed its abortion law, there were only 36 septic abortions per 1,000 live births, and by 1969 that figure dropped to 22 per 1,000 live births (105). This drop in hospital admissions following liberalization suggests a sharp reduction in unsafe, illegal procedures (105).

Conversely, in Romania, maternal health deteriorated after 1966 when the restrictive law replaced the liberal one. There was a huge increase in hospital admissions for septic or incomplete abortions, reflecting an increase in the incidence of illegal abortion (155). (Only 16,686 hospital admissions in 1959, but a jump to 104,351 in 1967, the year following imposed restrictions (90).) Similarly, preliminary reports from Hungary, following 1974 restrictions to a previously "on request" abortion law, indicate a slight rise in the number of women hospitalized for "spontaneous" abortions, suggesting an increase in illegal or self-induced procedures (67).

Legalizing abortion, however, does not necessarily result in an immediate improvement in maternal health statistics. A four-year study at a large city hospital in the state of Georgia (USA) showed that not only must legal abortion services be available, but also a widespread awareness of the services must exist before women will stop resorting to unsafe and illegal means of pregnancy termination. It was only after the number of legal abortions continued to rise for three consecutive years that a decline in the incidence of complications attributable to illegal abortions was discernible (71).

Equal Opportunity Enhanced by Abortion

When abortion services and adequate medical treatment are available to all who need them, then liberal legislation "may rank as one of the great equalizers of our time" (79). Where abortion is illegal, the poor often have no recourse except to terminate the pregnancy themselves or bear an unwanted child. In Italy and France, for example, prior to recent legal changes, clandestine abortions performed by reputable physicians were financially unfeasible for low-income women (48,81). Unable to afford an illegal abortion and often not even knowing where to turn for help, they are at a disadvantage (81). The rich can usually find someone willing to perform an abortion because they are able to pay and know where to seek help. If the laws in their country are too restrictive, the rich can afford to travel to another country where abortion is readily available.

However, in situations where abortion is legal, facilities accessible, and standards set by the government, it is the poor who benefit most (79). For example, between 1970 and 1971 in some New York City low-income areas, black women took advantage of a state law permitting municipal hospitals to perform abortions through the 24th week of pregnancy without the consent of either parents or husbands. As a result, their total fertility rate (average number of births per woman during her reproductive life) dropped from 2.85 to 2.11 just 18 months after the law's enactment (79). Blacks were able to avert a substantial number of unwanted births, allowing them to maintain whatever family size they deemed economically viable (79).

Potential for Decline in Population Growth

Often the outcome of abortion liberalization has been a reduction in fertility—and, concomitantly, population growth—especially in countries where the use of effective contraceptives has been low (91,147). Although only the abortion laws of Singapore and Tunisia were accompanied by a statement commenting on the need to control their population growth, liberal laws have had a considerable impact on fertility rates in many countries.

For example, fertility declined dramatically in Japan following liberalization of the abortion law. The crude birth rate was halved in the decade between 1947—when the Eugenic Protection Act was passed—and 1958 (89,132). Because there were economic reasons for limiting population growth, the Japanese were already motivated to limit family size and did not require additional incentives or media campaigns to persuade them to utilize the cheap, effective, and relatively safe abortion services that rapidly became widely available (89).

Eastern Europe has followed a similar pattern. Since the mid-1959s, when many countries liberalized their law, there has been a continuous decline in birth rates. Some governments now believe their birth rates have declined to a point where they may adversely affect the "national interest" (86). This is one reason why some—for example, Czechoslovakia and Hungary—recently instituted more restrictive abortion laws (86).

Technically, abortion in Taiwan is still prohibited by law. However, a recent study of the effect of abortion on fertility decline indicates that, if illegal but medically safe abortions had not been available, the total fertility rate for Taiwan in 1968 would have been 11.8 percent higher than it was (65).

Uruguay, the only country in South America with liberal abortion legislation, has the lowest crude birth rate in Latin America, 21.3. This can be attributed to the high incidence of induced abortion—both legal and illegal —approximately three abortions for every live birth (151).

However, liberal abortion laws alone will not have an impact on fertility. Abortion services, including trained personnel and hospital and/or clinical facilities, must be easily accessible to a very large proportion of the population before a decline in population growth attributable to abortion can be identified. In many places with liberal legislation, such as India, Zambia and rural Tunisia, the medical infrastructure is still not adequate to make safe, cheap abortions readily available (151). In contrast, in developing countries where safe, legal abortion services are readily available, legislation is having an impact on birth rates and population growth (126,147,151). This is happening in Uruguay, Singapore and apparently in the People's Republic of China—although no statistics have yet been released.

ISSUES AFFECTING LIBERALIZATION

Whenever governments consider changing prohibitive or very restrictive abortion laws, experience has indicated

that the following issues are among those most likely to arise:

- Can a country control the incidence of abortion by continuing to prohibit—or severely restrict—abortions?
- Will legalizing abortion lead to a relaxation in contraceptive use?
- If a country has an effective contraceptive program, does it still need to legalize abortion?
- Will legalizing abortion and assuring its availability lower a country's birth rate?
- Will legalizing abortion put too heavy a strain on a country's medical personnel?
- Will hospital operating rooms become over-crowded if abortion laws are liberalized?
- What are the effects of repeated abortions on a woman's health?
- What have been the effects of illegal abortion on a woman's health?

BIBLIOGRAPHY

1. ANONYMOUS. Abortion and sterilization. [Statement of Dr. J. Burrowes of Jamaica]. British Medical Journal 9(5194): 320. May 11, 1974.

2. ANONYMOUS. Abortion: changing attitudes in Latin America. People 1(2): 26. January 1974.

3. ANONYMOUS. Abortion conference held in Ghana: abortion conference speeches. Africa-Link. January 1974. p. 1-2.

4. ANONYMOUS. Abortion law reform adopted. Norway News Bulletin. May 23, 1975. p. 1.

5. ANONYMOUS. The abortion see-saw. People 2(2): 37. 1975.

6. ANONYMOUS. Brazilian tragedy. Parade Magazine, October 19, 1975. p. 7.

7. ANONYMOUS. Conference report 2. People 2(4): 30-31. 1975.

8. ANONYMOUS. A criminal approach to abortion. British Medical Journal 2(5967): 352-353. May 1975.

9. ANONYMOUS. Family planning. [Statement of Dr. Dickinson and Dr. Aldis of Vancouver]. Lancet 1(7853): 370. March 2, 1974.

10. ANONYMOUS. Family planning, part of maternal health, spurred record low infant, mother death rates in Cuba. International Family Planning Digest 1(3): 5. September 1975.

11. ANONYMOUS. HEW set to resume abortions. Washington Post, December 6, 1975. p. A11.

12. ANONYMOUS. Law and population. Future 2(3): 7-10. July-August 1975.

13. ANONYMOUS. Liberalized abortion law passed. News of Norway 32(12): 46. August 22, 1975.

14. ANONYMOUS. Nearly 50,000 deliveries a year. A close look at Caracas' Concepcion Palacios Maternity Hospital: the facts behind the figures. Contemporary OB/GYN 3(6): 68-91. June 1974.

15. ANONYMOUS. No substitute for contraception. People 2(4): 32. 1975.

16. ANONYMOUS. Population and family planning: the particulars of five nations. Equilibrium 2(2): 36-37. April 1974.

17. ANONYMOUS. Reform Italian style. People 2(3): 26. 1975.

18. ANONYMOUS. Report of working of British abortion law. IPPF Medical Bulletin 8(2): 3-4. April 1974.

19. ANONYMOUS. Symposium on law and population: text of recommendations, June 17-21, 1974, Tunis. Medford, Massachusetts, Tufts University, Fletcher School of Law and Diplomacy, 1974. (Law and Population Monograph Series No. 20). p. 21-27.

20. ANONYMOUS. Three proposals. IPPF News. August/September 1975. p. 6.

21. ABORTION LAW REFORM ASSOCIATION. Abortion act inquiry. Wheathamstead, United Kingdom, June 1974. 21 p.

22. AMIR, A. Israel: regulations tightened [abortion]. Atlas 21(10): 15. November 1974.

23. ARMIJO, R. Abortion in Latin America. In: Hankinson, R., Kleinman, R., Eckstein, P., eds. Proceedings of the 8th International Conference of IPPF, Santiago, Chile, April 9-15, 1967. London, International Planned Parenthood Federation, 1967. p. 143-147.

24. ARMIJO, R. and MOREAL, T. The problem of induced abortion in Chile. Milbank Memorial Fund Quarterly 43(4): 263-271. 1965.

25. ASCADI, G., KLINGER, A., SZABADY, E. Family planning in Hungary. Main results of the 1966 fertility and family planning study. Budapest, Demographic Research Institute, 1970. p. 148.

26. BAKARE, C. Nigerian survey of medical and paramedical opinion on abortion, Ibadan, Nigeria. Univerity of Ibadan, Behavioral Sciences Research Unit, 1975. 23 p. (To be published in 1976 as a book chapter).

27. BAYH, B. Constitutional amendments relating to abortion. Congressional Record 121(136): S-16092. September 17, 1975.

28. BELGIUM, LAWS, STATUTES, ETC. Crown Order of 13 December 1974 concerning the establishment of a National Commission on Ethical Problems. International Digest of Health Legislation 26(3): 463. 1975.

29. BERGER, G., TIETZE, C., PAKTER, J., KATZ, S. Maternal mortality associated with legal abortion in New York State: July 1, 1970—June 30, 1972. Obstetrics & Gynecology 43(3): 315-326. March 1974.

30. BUCKHOUT, R. Toward a 2-child norm: changing family planning attitudes. American Psychologist 27: 16-26. January 1972.

31. BULGARIA. LAWS, STATUTES, ETC. Amendments and additions to Instruction No. 0-27 regulating the artificial interruption of pregnancy. International Digest of Health Legislation 25(3): 541-548. 1974.

32. BURHANUDDIN, A. Abortion as a measure of population planning and its relevance for Bangladesh. International Journal of Gynecology and Obstetrics 12(3): 93-100. May 1974.

33. BURNHILL, M. [Medical Director of Preterm, Washington, D.C.] Personal communication. November 19, 1975. 1 p.

34. CHANG, K. S., WORTH, G. C., MICHAEL, P. H. Korea (South). Studies in Family Planning 5(5): 152-156. May 1974.

35. CHHABRA, R. India: reluctant doctors [abortion]. Atlas 21(10): 16-18. November 1974.

36. COHN, V. Thirty-three percent wanting abortions can't get them. Washington Post, October 7, 1975. p. A1.

37. COLLINS, L. The legal aspects of abortion. Canadian Journal of Public Health 66(3): 234-236. 1975.

38. COOK, R. Liberalized abortion in four countries. IPPF Medical Bulletin 9(2): 4. April 1975.

39. COOK, R. Report on abortion law in Commonwealth Caribbean countries [draft]. London, International Planned Parenthood Federation, August 1975. 7 p.

40. COWAN, J. [Assistant Secretary, US Department of Defense] Memorandum for the assistant secretaries of the military departments: abortion policy. Washington, D.C., Office of the Assistant Secretary of Defense, September 17, 1975. 2 p.

41. DABBAS, H. Abortion in Jordan. In: Nazer, I., ed. Induced abortion: a hazard to public health? (Proceedings of the First Conference of the International Planned Parenthood Federation Middle East and North Africa Region, Beirut, Lebanon, 1971). Beirut, Lebanon, IPPF/MENAR, 1972. p. 202.

42. DAHOMEY. LAWS, STATUTES, ETC. Ordinance No. 73-14 of 8 February 1973, laying down of Code of Medical Deontology. International Digest of Health Legislation 25(1): 91. 1974.

43. DAVID, H. Abortion research in transnational perspective: an overview. In: David, H., ed. Abortion research: international experience. Lexington, Massachusetts, D.C. Heath, 1974. p. 3-11.

44. DAVID, H. and WRIGHT, N. Abortion legislation: the Romanian experience. Studies in Family Planning 2(10): 205-210.

45. DEAN, C. and PIOTROW, P. Eighteen months of legal change. Population Reports, Series E, No. 1. Washington, D.C., George Washington University Medical Center, Population Information Program, July 1974. 12 p.

46. EBANKS, G. and GILKES, L. Barbados. Country Profiles. December 1973. 8 p.

47. FIGA-TALAMANCA, I. Social and psychological aspects of abortion. Paper presented at World Population Conference, Bucharest, August 1974. 5 p.

48. FIGA-TALAMANCA, I. Social and psychological factors in the practice of induced abortion as a means of fertility control in an Italian population. Genus 27(1-4): 248-251. 1971.

49. FLETCHER SCHOOL OF LAW AND DIPLOMACY. LAW AND POPULATION PROGRAM. Legal handbook on contraception, voluntary sterilization and abortion: country profiles and checklist. Medford, Massachusetts, 436 p. (in press)

50. FRANCE. LAWS, STATUTES, ETC. Law No. 75-17 of 17 January 1975, concerning the voluntary termination of pregnancy. International Digest of Health Legislation 26(2): 351-357. 1975.

51. GERMANY, FEDERAL REPUBLIC OF. LAWS, STATUTES, ETC. Fifth Law of 18 June 1974, to reform the penal law. International Digest of Health Legislation 25(4): 779-783. 1974.

52. GOLDFINE, R. Right to safe abortion itself a "right to life." Ob. Gyn News 9(20): 79. October 15, 1974.

53. GREAT BRITAIN. COMMITTEE ON THE WORKING OF THE ABORTION ACT. Vol. I. Report. London, Her Majesty's Stationery Office, April 1974. (Cmnd. 5579). 271 p.

54. GRISEZ, G. Abortion: the myths, the realities and the arguments. New York, Corpus Books, 1970. p. 185-266.

55. HELLMAN, L. Fertility control at a crossroad. American Journal of Obstetrics and Gynecology 123(4): 331-337. October 15, 1975.

56. HELLMAN, L. Personal communication. January 14, 1975. 1 p.

57. HONG KONG. LAWS, STATUTES, ETC. An Ordinance (No. 15 of 1972) to amend the Offenses against the Person Ordinance. International Digest of Health Legislation 25(2): 322. 1974.

58. HUBER, S. C. Personal communication. December 3, 1975. 2 p.

59. HUBER, S. C. World survey of family planning services and practices. In: International Planned Parenthood Federation [IPPF]. Survey of world needs in family planning. London, IPPF, 1974. p. 27-72.

60. HUBINONT, P., BRAT, T., POLDERMAN, J., RAMDAYAL, R. Abortion in Western Europe. In: Hall, R., ed. Abortion in a changing world. Vol. I. New York, Columbia University Press, 1970. p. 325-331.

61. HUNT, W. B., 2nd. Pregnancy tests—the current status. Population Reports, Series J, No. 7. Washington, D.C., George Washington University Medical Center, Population Information Program, November 1975. 16 p.

62. IFFY, L. Abortion Laws in Hungary. Obstetrics & Gynecology 45(1): 115-116. January 1975.

63. INTERNATIONAL PLANNED PARENTHOOD FEDERATION [IPPF]. Survey of world needs in family planning. London, IPPF, 1974. 84 p.

64. INTERNATIONAL REFERENCE CENTER FOR ABORTION RESEARCH. Legislative trends. Abortion Research Notes 3(3): 26. October 1974.

65. INTERNATIONAL REFERENCE CENTER FOR ABORTION RESEARCH. Country notes. Abortion Research Notes 4(1): 29. February 1975.

66. INTERNATIONAL REFERENCE CENTER FOR ABORTION RESEARCH. Legislative trends. Abortion Research Notes 4(1): 30. February 1975.

67. INTERNATIONAL REFERENCE CENTER FOR ABORTION RESEARCH. Legislative trends. Abortion Research Notes 4(2): 37. May 1975.

68. ISAACS, S. and SANHUEZA, H. Abortion in Latin America: the legal perspective. In: Pan American Health Organization [PAHO]. Epidemiology of abortion and practices of fertility regulation in Latin America: selected studies. Washington, D.C., PAHO. (PAHO scientific publication 306) (in press)

69. ISAACS, S. and SANHUEZA, H. Law and the practice of abortion in Latin America. Paper presented at the Third World Congress on Medical Law, Ghent, August 19-23, 1973. 11 p.

70. JOHNSON, J. Panel denies backing to abortion curbs. Washington Post, September 18, 1975. p. C14.

71. KAHAN, R., BAKER, L., and FREEMAN, M. The effect of legalized abortion on morbidity resulting from criminal abortion. American Journal of Obstetrics and Gynecology 121(1): 114-116. January 1, 1975.

72. KAISER, I. Family planning in Cuba, 1974. Paper presented at the annual meeting of the Association of Planned Parenthood Physicians, Los Angeles, April 17-18, 1975. 15 p.

73. KAISER, I. Personal communication. December 8, 1975. 2 p.

74. KALIS, M. and DAVID, H. Abortion legislation: a summary international classification, 1974. In: David, H., ed. Abortion research: international experience. Lexington, Massachusetts, D.C. Health, 1974. p. 13-34.

75. KELLOGG, E. Personal communication. November 5, 1975. 3 p.

76. KESSEL, E. Estimated incidence of pregnancy by duration of amenorrhea. Advances in Planned Parenthood 9(3-4): 16-22. 1975.

77. KESSEL, E., LAUFE, L., HUSSMAN, C., and BRINTON, L. Menstrual regulation: a new family planning service. Abortion Research Notes 3(3): Supplement No. 10. October 1974. 1 p. insert.

78. KLINGER, A. Az újabb Magyar családtervezési vizsgálatok föbb eredményei. [Important results of the latest Hungarian family planning survey] [Table 15 only]. Statisztikai Szemle 53(2-3): 244. 1975.

79. KRAMER, M. Legal abortion among New York City residents: an analysis according to socioeconomic and demographic characteristics. Family Planning Perspectives 7(3): 128-137. May/June 1975.

80. LAKERU, A. Abortion in Lagos as seen at the Lagos Island Maternity Hospital. New York, Population Council Postpartum Program, May 1974. (Circular No. 72). 17 p.

81. LEE, L. International status of abortion legalization. In: Osofsky, H. and Osofsky, J. The abortion experience: psychological and medical impact. Hagerstown, Maryland, Harper and Row, 1975. p. 338-364.

82. LEE, L. The law: a tool of social change. People 1(3): 14-15. April 1974.

83. LEE, L. and PAXMAN, J. Legal aspects of menstrual regulation. Medford, Massachusetts, Tufts University, Fletcher School of Law and Diplomacy, 1974. (Law and Population Monograph Series No. 19). 49 p.

84. LINCOLN, R. The Institute of Medicine reports on legalized abortion and the public health. Family Planning Perspectives 7(4): 185-188. July/August 1975.

85. MATHEWS, D. [Secretary of US Department of Health, Education & Welfare]. Policy on abortion services provided by public health service direct medical care programs. [Washington, D.C. US Department of Health, Education & Welfare], November 19, 1975. 2 p. (unpublished)

86. McGRAW HILL WORLD NEWS CORRESPONDENTS. Abortion abroad. Contemporary OB/GYN 4(4): 70-72, 76-78, 81, 87-93, 97-99, 105-106. October 1974.

87. MEANS, C., Jr. The law of New York concerning abortion and the status of the foetus, 1664-1968: a case of cessation of constitutionality. New York Law Forum 14(3): 411-419. Fall 1968.

DK KJ.O. 3H.05.07 FdaTV

88. MEHLAN, K. Die Abortsituation im Weltmasstab. [Worldwide abortion situation]. In: Mehlan, K., ed. Arzt und Familienplanung. [The doctor and family planning]. Berlin, German Democratic Republic, VEB Verlag Volk und Gesundheit, 1968. p. 69-70.

89. MOORE-ČAVAR, E. Demographic aspects [of abortion]. In: Moore-Čavar, E. International inventory of information on induced abortion. New York, International Institute for the Study of Human Reproduction, 1974. p. 611-619.

90. MOORE-ČAVAR, E. Illegal and legal abortion. In: Moore-Čavar, E. International inventory of information on induced abortion. New York, International Institute for the Study of Human Reproduction, 1974. p. 593-609.

91. MOORE-ČAVAR, E. Induced abortion and contraception. In: Moore-Čavar, E. International inventory of information on induced abortion. New York, International Institute for the Study of Human Reproduction, 1974. p. 555-582.

92. MOORE-ČAVAR, E. Legal and administrative aspects [of abortion]. In: Moore-Čavar, E. International inventory of information on induced abortion. New York, International Institute for the Study of Human Reproduction. 1974, p. 39-99.

93. MOORE-ČAVAR, E. Medical aspects [of abortion]. In: Moore-Čavar, E. International inventory of information on induced abortion. New York, International Institute for the Study of Human Reproduction, 1974. p. 471-476.

94. MOORE-ČAVAR, E. Summary and conclusions. In: Moore-Čavar, E. International inventory of information on induced abortion. New York, International Institute for the Study of Human Reproduction, 1974. p. 635-641.

95. MULHAUSER, K. [Executive Director of National Abortion Rights Action League]. Personal communication. October-January 1975. 1 p.

96. MUNDAY, D. The abortion debate. Family Planning 24(1): 17-20. April 1975.

97. NATIONAL ACADEMY OF SCIENCE. INSTITUTE OF MEDICINE. Legalized abortion and the public health: report of a study. Washington, D.C., May 1975. 167 p.

98. NAZER, I. The Middle East and North Africa. In: David, H., ed. Abortion research: international experience. Lexington, Massachusetts, D.C. Heath, 1974. p. 237-241.

99. NORTMAN, D. The demographic impact of adding induced abortion to national family planning methods. Paper presented at Population Association of America Annual Meeting, Seattle, April 17-19, 1975. 15 p.

100. NOZUE, G. Abortion in the Far East. In: Hankinson, R., Kleinman, R., Eckstein, P., eds. Proceedings of the 8th International Conference of IPPF, Santiago, Chile, April 9-15, 1967. London, International Planned Parenthood Federation, 1967. p. 129-133.

101. OJO, S. L. Need for liberalization of laws dealing with abortion in Africa. Paper presented at the Inaugural Conference, Population Association of Africa, University of Ibadan, Nigeria, 1974. 16 p.

102. PAULI, S. [Embassy of Switzerland, Washington, D.C.] Personal communication. December 16, 1975. 1 p.

103. PILPEL, H. Abortion: USA style. Journal of Sex Research 2(2): 113-118. May 1975.

104. PILPEL, H. Personal communication. January 8, 1975. 1 p.

105. PLANNED PARENTHOOD FEDERATION OF AMERICA [PPFA]. Facts and figures on legal abortion of importance to all Americans. New York, PPFA, 1975. 8 p. (leaflet)

106. POTTS, D. M. Abortion: a personal testimony. Nursing Times 70: 314-316. February 28, 1974.

107. POTTS, D. M. Abortion and contraception. Medical Newsletter No. 45, September 1972, 8 p.

108. POTTS, D. M. Personal communication. December 29, 1975. 1 p.

109. POTTS, D. M. Postconceptive control of fertility. International Journal of Gynecology and Obstetrics 8: 957-970. 1970.

110. POTTS, D. M. World trends in induced abortion. London, International Planned Parenthood Federation, 1972. 22 p.

111. PUFFER, R., GRIFFITH, G. Patterns of urban mortality. Report of the Inter-American Investigation of Mortality. Washington, D.C., Pan American Health Organization, 1967. p. 169-182, 263-270.

112. RIAÑO-GAMBOA, G., FERGUSON, J., GOLDSMITH, A. Manejo clinico del aborto incompleto en los hospitales univeritarios de Colombia. [Clinical management of incomplete abortion in the university hospitals of Colombia]. Paper presented at the Eleventh Colombian Congress of Obstetrics and Gynecology, Barranquilla, Colombia, December 2-6, 1975. 25 p.

113. ROSEN, R. Law and population growth in Jamaica. Medford, Massachusetts, Tufts University, Fletcher School of Law and Diplomacy, 1973. (Law and Population Monograph Series No. 10). 44 p.

114. SAI, F. Sub-Saharan Black Africa. In: David, H., ed. Abortion research: international experience. Lexington, Massachusetts, D.C. Heath, 1974. p. 243-249.

115. SCHULMAN, H., SALDANA, L., TSAI, T., LEIBMAN, T., CUNNINGHAM, M., RANDOLPH, G. Prostaglandin E_2 induced abortion with vaginal suppositories in a contraceptive diaphragm. Prostaglandins 7(3): 195-200. August 10, 1974.

116. SHINER, G. Moslem nations: the Koran forgotten [abortion]. Atlas 21(10): 16. November 1974.

117. SILVA, A. [Deputy Secretary of Health for Family Planning, San Juan, Puerto Rico]. Personal communication. November 3, 1975. 2 p.

118. SIMMS, M. "On request" law for Britain? People 3(1): 29-30. January 1976.

119. SIMMS, M. The progress of the abortion (amendment) bill. Family Planning 24(2): 32-33. July 1975.

120. SINGAPORE. LAWS, STATUTES, ETC. Abortion Act: Act No. 24 of 1974. Sections 4-1a and 1b. Singapore, 1975.

121. SOUTH AFRICA. DEPARTMENT OF THE PRIME MINISTER. Abortion and Sterilization Act. 1975. Republic of South Africa Government Gazette 117(4608): 2-12. March 12, 1975.

122. STRINGER, J. Menstrual regulation conference in Hawaii. Medical Bulletin 8(2): 3. April 1974.

123. SWEDEN. LAWS, STATUTES, ETC. The Abortion Law (No. 595) of 14 June 1974. International Digest of Health Legislation 25(3): 618-619. 1974.

124. SWEDEN. NATIONAL BOARD OF HEALTH WELFARE. Table G—Number of induced abortions 1970-1974 by method of operation and by type of care (out-patient or in-patient care). Statistiska Meddelenden, No. 27, 1975. p. 13.

125. TIETZE, C. Contraceptive practice in the context of a nonrestrictive abortion law: age-specific pregnancy rates in New York City, 1971-1973. Family Planning Perspectives 7(5): 197-202. September/October 1975.

126. TIETZE, C. Demographic aspects of abortion. Paper presented at World Population Tribune, Bucharest, Romania, August 1974. 10 p.

127. TIETZE, C. The effect of legalization of abortion on population growth and public health. Family Planning Perspectives 7(3): 123-127. May/June 1975.

128. TIETZE, C. Mortality with contraception and induced abortion. In: David, H., ed. Abortion research international experience. Lexington, Massachusetts, D.C. Heath, 1974. p. 103-107.

129. TIETZE, C. Mortality with contraception and induced abortion. Studies in Family Planning 45: 6-8. September 1969.

130. TIETZE, C. Personal communication. January 6, 1976. 1 p.

131. TIETZE, C. and BONGAARTS, J. Fertility rates and abortion rates: simulations of family limitation. Studies in Family Planning 6(5): 114-120. May 1975.

132. TIETZE, C. and DAWSON, D. Induced abortion: a factbook. Reports on Population/Family Planning No. 14, December 1973. 56 p.

133. TIETZE, C., JAFFE, F., WEINSTOCK, E., and DRYFOOS, J. Provisional estimates of abortion need and services in the year following the 1973 Supreme Court decisions. New York, Alan Guttmacher Institute, 1975. 88 p.

134. TIETZE, C. and MURSTEIN, M. Induced abortion: 1975 factbook. Reports on Population/Family Planning No. 14, Second ed., December 1975. 75 p.

135. TIETZE, C., PAKTER, J., BERGER, G. Mortality with legal abortion in New York City, 1970-1972: a preliminary report. Journal of the American Medical Association 225(5): 507-509. July 30, 1973.

136. TRUSKETT, I. and PFANNER, D. Forum: abortion-community trends. Medical Journal of Australia 2(3): 288-291. August 1974.

137. TRUSSEL, J., Jr. and HATCHER, R. Women in need. New York, Macmillan, 1972. 177 p.

138. TUCKWELL, S. Abortion: the hidden plague. New Internationalist 14: 25-27. May 1974.

139. UNITED NATIONS. CENTRE FOR ECONOMIC AND SOCIAL INFORMATION. Action taken at Bucharest. New York, United Nations, 1974. 63 p.

140. UNITED NATIONS. DEPARTMENT OF ECONOMIC AND SOCIAL AFFAIRS. Measures, policies and programs affecting fertility, with particular reference to national family planning programmes. New York, United Nations, 1972. p. 101.

141. UNITED NATIONS. WORLD CONFERENCE OF THE INTERNATIONAL WOMEN'S YEAR. Text of World Plan of Action: G. Population. Department of State Bulletin, August 18, 1975. p. 20.

142. UNITED STATES. CONGRESS. Senate Amendment No. 566. [Helms Amendment to the Foreign Assistance Act of 1973] Congressional Record 119(146): S-18368. October 2, 1973.

143. UNITED STATES. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE. CENTER FOR DISEASE CONTROL. Surveillances summary: abortion-related mortality, 1972-1973—United States. Morbidity & Mortality Weekly Report 24(3): 22, 27-28. January 24, 1975.

144. UNITED STATES. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE. HEW News. Washington, D.C., December 6, 1975. 2 p.

145. UNITED STATES. SUPREME COURT. Roe v. Wade. 410 US 113. 1973.

146. VALAORAS, V. and TRICHOPOULOUS, D. Abortion in Greece. In: Hall, R., ed., Abortion in a changing world, Vol. I. New York, Columbia University Press, 1970. p. 284-288.

147. VAN DER TAK, J. Abortion, fertility and changing legislation: an international review. Lexington, Massachusetts, D.C. Heath, 1974. 141 p.

148. VAN DER TAK, J. Major trends in recent abortion research. Abortion Research Notes 4(2): 34-37. May 1975.

149. VAN DER VLUGT, T. and PIOTROW, P. T. Menstrual regulation update. Population Reports, Series F, No. 4. Washington, D.C., George Washington University Medical Center, Population Information Program, May 1974. 16 p.

150. WASSERMAN, R. The legal issues surrounding the continued refusal of hospitals to allow abortions. Family Planning/Population Reporter 4(3): 50-54. June 1975.

151. WATSON, W. and LAPHAM, R. Family planning programs: world review 1974. Studies in Family Planning 6(8): 205-234. August 1975.

152. WEINSTOCK, E., TIETZE, C., JAFFE, F., and DRYFOOS, J. Legal abortions in the U.S. since the 1973 Supreme Court decisions. Family Planning Perspectives 7(1): 23-31. January-February 1975.

153. WORLD HEALTH ORGANIZATION [WHO]. SCIENTIFIC GROUP. Spontaneous and induced abortion. Geneva, WHO, 1970. (WHO Technical Report Series No. 461). p. 5-10.

154. WORTMAN, J. Training nonphysicians in family planning services. Population Reports, Series J, No. 6. Washington, D.C., George Washington University Medical Center, Population Information Program, September 1975. 20 p.

154. WRIGHT, N. Restricting legal abortion: some maternal and child health effects in Romania. American Journal of Obstetrics and Gynecology 121(2): 246-255. January 1975.

GWU-SCD-76-2P

CHANGE OF ADDRESS FORM

In the future, please send *Population Reports* to my new address:

Name

Street

City, State, Zip Code

Country

(Attach old label here or write in old address.)