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AUTHOR Jacobson, Jodi L.
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ABSTRACT

Locating the issue of abortion in a global public policy context, with the array of public health, human rights, and social questions that are implicated, is the aim of this paper. Abortion laws around the world have been liberalized since the 1950s, with a resultant decrease in abortion-related mortality among women. The proportion of the world's population, governed by laws that permit abortion on medical or broader social and economic grounds, is 75 percent (nearly 4 billion people). In addition to women living in those countries that have resisted liberalization of their abortion laws, many women have restricted access to abortion, even those in countries in which abortion is technically legal. There are a number of reasons for this, including a lack of government or public commitment to provide or fund services, lack of trained specialists, administrative roadblocks, a woman's ability to pay, and a lack of truthful information about legal rights and services. Abortion rates from countries around the world are examined and discussed in terms of the varying demographic and social realities. The large number of maternal deaths due to abortion that still occur is not due to a deficiency in technology, but a deficiency in the value placed on women's lives. The numerous roadblocks to safe abortion services drive women to seek illegal or clandestine abortions that greatly endanger their lives. The debate surrounding abortion has been too often portrayed as a conflict between black and white hues. The debate needs to take place in a larger context, complete with public health, family planning, and human rights concerns. Equality of political rights for women, and likely the lives of many, hinges on political decisions regarding abortion. (DB)

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The Global Politics of Abortion

Jodi L. Jacobson

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Introduction

Among the first actions taken by Romania's provisional government following the execution of dictator Nicolae Ceausescu in December 1989 was the repeal of a ban on abortion. The 14-year-old edict, created by Ceausescu in a fruitless attempt to raise the nation's birth rate, outlawed contraceptives and made abortion a criminal offense punishable in some instances by death. Despite the harsh law, data show that in the eighties the country outranked virtually all other European nations in rates of abortion and abortion-related maternal mortality.[1]

In legalizing abortion, Romania joined 35 other countries that have made similar changes since the late seventies. In fact, a 30-year tide of liberalization in laws governing access to family planning—contraceptives and abortion—reduced the relative number of unintended pregnancies and deaths due to illegal abortion in many countries, leading to vast improvements in public health and lower fertility worldwide. Today, however, abortion is at the center of an intense public controversy over religious and moral beliefs about the status of the fetus and a woman's right to make choices about pregnancy and motherhood.[2]

From the standpoint of public policy, few would disagree that reducing the number of unintended pregnancies and abortions worldwide is a desirable goal. A growing body of evidence suggests that dealing with abortion as part of a comprehensive strategy of public health and family planning, rather than making it illegal, is the most direct route to this end. Yet groups vociferously opposed to abortion—and in many cases

Special thanks for help with this paper go to Anne Marie B. Amantia, Mary Ann Castle, Henry David, Tomas Frejka, Stanley Henshaw, Renee Holt, Craig Lasher, The Population Council, and The International Women's Health Coalition. I am very grateful to Meri McCoy-Thompson and Ann Misch for research assistance, and to Denise Byers for production assistance.

to family planning altogether—have renewed their efforts to reinstate or maintain laws against it.

As a result, abortion politics has become deadlocked in a no-win dispute over the ideology and criminality of various procedures, yielding a tug-of-war over laws that do not even begin to address the complexity of this social phenomenon. This stalemate postpones the day when the energies spent fighting over reproductive freedom can be directed fully toward improving the health and welfare of women and children worldwide.

A dispassionate debate on abortion seems a remote possibility. But the current polemic reflects scant understanding of abortion's real place in demographic and public health trends, or of the social forces that influence abortion rates. Important questions go unasked: How many abortions are there and how many are legal? Where are the rates climbing, where falling? Who has abortions and why? What role does abortion play in social change? What are the costs to society of illegal abortion? How can the number of abortions be reduced without forcing women to carry unwanted pregnancies to term?

Irrefutable evidence remains unconsidered. Abortions are carried out in every country, no matter the law. History has shown that women determined to exercise control over the number of children they bear will do so, even if it means having dangerous illegal abortions. Worldwide, perhaps 50 million abortions are performed each year, nearly half of them illegal. Romania's experience is only one illustration that, irrespective of restrictive laws and religious doctrines and in spite of financial, logistical, and social obstacles, women everywhere continue to have abortions.[3]

Underneath the rhetoric are buried the real fissures of the abortion controversy: the changing role of women in society and the perceived challenges this presents to men, the ensuing declines in fertility, and the effects of these trends on access to the resources that determine political and economic power. In essence, the right to obtain and control power is the elemental rift of the abortion rights struggle.

"It is the number of maternal deaths, not abortions, that is most affected by legal codes."

A moral smokescreen effectively obscures the huge public health, human rights, and social costs of restrictive abortion policies. Although abortion politics is everywhere dominated by men, women bear the burden of restricted access. It is the number of maternal deaths, not abortions, that is most affected by legal codes. Criminalizing abortion makes one of the safest of all surgical procedures highly dangerous by driving it underground into the hands of unskilled and often unscrupulous practitioners. High rates of maternal death and even higher rates of permanent physical impairment, along with exorbitant fees, fear of discovery, ostracism, and loss of vital income due to illness, are only a few of the realities of life for women who seek to end unwanted pregnancies in societies with restricted access to abortion.

The more diffuse social costs are staggering and also remain largely unrecognized. Experience shows that leaving women no choice but to carry unwanted pregnancies to term results in higher rates of infanticide, greater numbers of abandoned and neglected children, and, particularly in the Third World, a decline in nutrition and health. Where the incidence of illegal abortion is high, a disproportionate share of scarce medical resources goes to treating complications. Moreover, because abortion, whether legal or illegal, plays a significant role in the move from high to low fertility, policies that restrict access actually delay the demographic transition.

Looking beyond the rhetoric to the reality of abortion—its incidence, its social and health costs when illegal, its place in the fertility transition, the way it fits in with the broader struggle for human equity and equality—makes crystal clear the urgency of moving the abortion debate from the realm of crime to common sense.

The Pace of Liberalization

Liberalization of abortion laws began full force in the fifties, as recognition of the need to reduce maternal mortality and increase reproductive choices became widespread. Social justice was also an issue. Bringing abortion into the public domain reduced the disparity between those

who could afford adequate medical care and those forced to resort to unsafe practitioners.

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The strategy worked. France, Poland, Tunisia, the United Kingdom, and the United States are a few examples of countries where the relative number of births due to unintended pregnancies and deaths due to illegal procedures fell following liberalization. Between 1970 and 1976, for instance, abortion-related mortality among U.S. women fell from 30 per 100,000 live births to 5. And in Poland, an analysis by the Commission on Health and Physical Culture concluded that legalization had, among other things, contributed to the elimination of infanticide and of suicides by pregnant women, and had initiated a fall in abortion-related deaths.[4]

The term "liberal" is generally applied to policies that recognize the rights of a pregnant woman to terminate an unwanted pregnancy under various conditions to be greater than those of a developing embryo or fetus...up to a point. In countries with the most liberal laws, that point is legally set at "viability," the gestational age at which a fetus can reasonably be expected to live outside the womb, albeit with intensive medical assistance.

The most significant prenatal development of brain, heart, and lungs—the organs central to life, and hence to the question of viability--begins around the 20th week of pregnancy and proceeds rapidly through birth. In medical circles, viability is generally recognized to occur at between 24 and 28 weeks of pregnancy. For this reason, most countries that use the viability framework severely circumscribe abortion rights after the 24th week, the end of the second trimester. The United Kingdom passed a law in the first half of 1990 reducing the legal limit on abortion from 28 to 24 weeks.[5]

Abortion laws are usually grouped according to "indications," the traditional justification of circumstances under which abortions can be performed. These categories are broad, representing a diverse set of statutes. (See Table 1 for examples of countries in each category.) Countries with the narrowest laws either completely ban abortions or

"In Poland, legalization contributed to the elimination of infanticide and of suicides by pregnant women."

Table 1: Conditions Under Which Abortions Are Allowed, Selected Countries

Life Endangerment[1]	Other Maternal Health Reasons[2]	Social and Socio-Medical Reasons[3]	No Mandated Conditions[4]
Bangladesh	Costa Rica	Argentina	Canada
Brazil	Egypt	India	China
Chile	Ghana	Peru	Czechoslovakia
Colombia	Israel	Poland	Italy
Indonesia	Kenya	United Kingdom	France
Ireland	Morocco	West Germany	Netherlands
Lebanon	Zimbabwe		Soviet Union
Mexico			Sweden
Nigeria			Tunisia
Pakistan			United States
Philippines			
Sudan			

[1]When a woman's life would be endangered by carrying the child to term; some countries in this category prohibit abortion without exception.
[2]Such as a threat to the woman's overall health, and sometimes in the case of a genetic abnormality, rape, or incest.
[3]Social factors, such as insufficient income, poor housing, or being single, may be considered in evaluating a "threat" to the woman's health, or may be deemed sufficient conditions in and of themselves to warrant termination of a pregnancy.
[4]Countries in this category have liberal abortion laws, commonly known as "on request," which indicates the lack of legal obstacles to abortion, but not necessarily the lack of social or administrative ones.

Source: Rebecca J. Cook, "Abortion Laws and Policies: Challenges and Opportunities," *International Journal of Gynecology and Obstetrics*, Supplement 3, 1989.

restrict them to cases where pregnancy poses a risk to the woman's life; some allow the operation in the case of rape and incest.[6]

Other laws consider risks to physical and mental health; still others, the case of a severely impaired fetus. Some societies allow abortion for what are known as "social" reasons, as in the case where an additional child will bring undue burdens to an existing family. The broadest category is that recognizing contraceptive failure as a sound basis for abortion, or allowing procedures on request (usually within the first trimester).

Most governments leave specific interpretations to the discretion of the medical community. The definition of "health," for example, is flexible. In some countries, doctors follow the broad definition of the World Health Organization (WHO): "a state of complete physical, mental, and social well being and not merely the absence of disease or infirmity."[7]

According to Rebecca Cook, professor of law at the University of Toronto, several of the 35 countries that liberalized their laws since 1977 created new categories, such as adolescence, advanced maternal age, or infection with the AIDS virus, as a basis for legal abortion. Cyprus, Italy, and Taiwan, for instance, all broadened their regulations to consider "family welfare," while Hong Kong included adolescence as a valid consideration.[8]

France and the Netherlands added clauses pertaining to pregnancy-related distress. In Hungary, one of the first East European countries to liberalize their laws, in 1956, abortion rights have been extended to pregnant women who are single or who have been separated from their husbands for up to six months, to women over 35 who have had at least three previous deliveries, and to women caught in economic hardship, such as the lack of appropriate housing.[9]

The majority of the world's people now live in countries that have moved from blanket prohibition of abortion to a more reasoned acceptance of its role as a backup to contraceptive failure and unwanted pregnancy. The Alan Guttmacher Institute indicates that about 40 percent of the world's population in theory has access to induced abortion on request. (See Table 2.)

Again, laws in countries grouped in the same category vary widely. In Tunisia—one of the few Muslim countries with liberalized laws—abortion is legally available on request until viability, while in France abortions on request are sanctioned only through the first trimester. Other countries with similar on-request status through varying stages of gestation are Canada, China, the Soviet Union, the United States, and virtually all of Eastern and Western Europe.[10]

Table 2: Abortion Laws Worldwide, by Number of Countries and Share of World Population

Legal Conditions	Countries[1]	Share of World Population
	(number)	(percent)
Life endangerment[2]	53	25
Other maternal health reasons	42	12
Social and socio-medical reasons	14	23
No mandated conditions[3]	23	40

[1]Countries with populations of at least 1 million.
[2]Technically, in some countries in this category abortion is prohibited without exception.
[3]Includes some of the world's most populous countries (China, the Soviet Union, and the United States).

Source: Stanley K. Henshaw, "Induced Abortion: A World Review, 1990," *Family Planning Perspectives*, March/April 1990.

Adding the share of the world covered by social or maternal health indications—including India with its 835 million people—brings the total to 75 percent (nearly 4 billion people) who are governed by laws that permit abortion on medical or broader social and economic grounds. Included in this second group, it should be noted, are countries like Ethiopia and Costa Rica, where abortion is legal only in cases of risk to the woman's health.[11]

Another 20 percent of the world live in 49 countries that have resisted liberalization and still totally prohibit abortion, except in some cases to save the woman's life, while 4 other countries (the remaining 5 percent of the world) are governed by laws that add rape and incest to this

restrictive set of conditions. One in four women in the world, therefore, has little access to abortion—and she is likely to live in Africa, Latin America, or Muslim Asia, where she also has the least access to safe, affordable means of contraception to prevent unwanted pregnancy.[12]

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Roadblocks to Access

Changes in laws are a necessary but not sufficient condition for widespread access to safe abortion services. Because many nations' legal codes reflect social ambivalence about abortion, what happens in practice often does not reflect the law on the books. As a result, access—the most critical factor in successful reproductive and primary health care initiatives—is limited.

Access to abortion and other family planning services, like health care in general, is determined by four variables: laws, policies and the way they are interpreted, the commitment of public funds to provide services, and personal resources, particularly money. Control over many of these factors—from the enforced shortage of available facilities to the personal antipathy of physicians—is used by opponents of abortion rights to limit access to services.

Interpretations of laws are often as important as the statutes themselves in determining the availability of abortions. Stanley K. Henshaw, deputy director of research at the Guttmacher Institute, finds that "in most Muslim countries, and in Latin America and Africa, few legal abortions are performed under the health exception, while in Israel, New Zealand and South Korea, the legal abortion rates [under the health indication] are comparable to those in countries that allow abortion on request."[13]

Hungary's social justifications are interpreted with sufficient flexibility to afford virtually all women access to abortion on request, even though the law does not explicitly guarantee this. Yet elsewhere, national laws are undermined or interpreted differently in different regions. In the West German state of Bavaria, for instance, national laws guaranteeing

"Many women who should be able to get an abortion on demand find it difficult to exercise their legal rights."

access to abortion are circumvented by regulations imposed by local and municipal governments. In Switzerland, the exception for medical reasons is interpreted liberally in some cantons and narrowly in others.[14]

In many countries where women should be able to get an abortion on demand, they find it difficult to exercise their legal rights for a variety of reasons, including stricter-than-usual medical regulations, burdensome administrative requirements, lack of public funds for services, lack of information or referral networks, lack of trained providers, extreme centralization of services, and local opposition or reluctance to enforce national laws.

Access is determined in part by medical regulations governing how, where, and by whom abortion services can be provided. In most countries with liberal laws, abortions must generally be performed by licensed providers (though not necessarily physicians), a regulation both the intent and effect of which is to protect public health. Some countries take this one step further, however, by requiring that abortions be carried out only in designated hospitals or centers, or by highly trained specialists.

These and other laws often work against the goal of ensuring that when abortions do occur they are carried out at the earliest possible point. New laws in Bermuda, Kuwait, the Seychelles, and Qatar, while more liberal than their former ones, include hospital committee authorization requirements before an abortion can be performed. In most cases, these regulations, strongly supported by opponents of abortion rights, act only to delay abortion until later stages of pregnancy—when procedures are riskier and the fetus more developed. Nevertheless, several American states are considering such restrictions.[15]

Such institutional and third-party authorization requirements have come under legal attack in many countries and been overturned in the courts or defeated in legislatures in several, including Canada and Czechoslovakia. In 1988, the Canadian Supreme Court struck down Canada's standing abortion law, which required that abortions be performed only in hospitals and that women receive the permission of a

hospital authorization committee to obtain one. Among other findings, the Court stated that the delays in procuring abortions resulting from these administrative requirements interfered with "a woman's right to physical and bodily integrity."[16]

The lack of a government or public commitment to provide or fund services can severely undermine legal rights. Abortion became legal on broad grounds in India in 1971. But because registered practitioners are clustered in urban areas, rural women have little access to services. Survey data from 1984 showed that only about 1,000 out of a total of 15,000 physicians trained to perform abortions were living in rural areas, although 78 percent of the country's population falls in this category.[17]

Not surprisingly, just 388,000 of the estimated 4 million to 6 million abortions in India were carried out legally in government-regulated facilities. Were the Indian government to commit funds to expanding the number of outlets for reproductive health care, literally millions of women could avoid the dangers of illegal abortions.[18]

In Turkey, abortion is in theory available on request through the 10th week of pregnancy. Even so, a rural Turkish woman seeking an abortion within the gestational limit may not be able to procure one. Turkish law states that an abortion may be carried out only by or under the supervision of a gynecological specialist trained in such procedures, as opposed to, say, a general practitioner or a trained paramedic.[19]

The scarcity of trained specialists even in urban areas limits access, but such services are virtually nonexistent in rural Turkey, where medical services of any kind are generally hard to come by. Many potential outlets—health clinics staffed by medical personnel but without a trained specialist—are excluded from delivering services. Rural women without the information and financial resources to reach a doctor in a city are left with two choices: procure an illegal abortion or carry an unwanted pregnancy to term.

The many roadblocks to access are illustrated by the situation in Zambia, a country with one of the most liberal abortion laws in Africa.

Abortions are legal through the 12th week of pregnancy on broad grounds, but they may only be performed in a hospital setting. What is more, to get permission for a legal abortion a woman must obtain the signatures of three physicians (one of them a specialist) on a form that lists her previous births and abortions. The physicians must agree on one of three grounds for termination of the pregnancy—a medical condition of either the woman or the fetus or a non-medical condition that justifies termination.[20]

Despite the relatively liberal law, illegal abortions far outnumber legal ones in Zambia. First, the administrative requirements are neither widely known nor understood, especially among rural women. In fact, several Zambian doctors interviewed by Renee Holt, a nurse and lawyer who studies abortion trends, believe that "many Zambian women are not [even] aware of their right to an abortion and visit backstreet abortionists rather than a hospital."[21]

Second, the requirements themselves are virtually impossible to fulfill: Only three specialists in the entire country—one of whom now lives in Kenya—are legally empowered to sign the forms. Only one hospital in Lusaka performs the operation; sanctioned facilities—and hence legal abortions—are virtually nonexistent anywhere else. Holt reports that "obstetricians and gynecologists at the University Teaching Hospital (UTH) did not have enough operating time to perform all abortions requested. They were turning away half of the requests each day, and these were returning to UTH as incomplete or septic [infected] abortions, which then demanded their time [to save the woman's life], setting up a vicious cycle."[22]

Third, even if a woman clears these hurdles, she faces additional obstacles when she reaches the hospital. The situation there is nothing short of appalling. On one recent visit, Mary Ann Castle, an anthropologist at the City University of New York and a public health research consultant for the Population Council, made these observations:

> The proper way to secure a legal abortion begins at the hospital intake unit, where women are screened and many "filtered out."

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> A woman goes to the hospital to get an appointment...[which] hopefully, will be soon enough for a [legal] termination [usually within two weeks], and [will be held with] a "favorable" consultant physician....If she is sent to the "wrong" consultant (one who is against abortion), the doctor may refer her to another outpatient clinic, requiring...another appointment....When she returns for the appointment day...she...waits up to 3 hours for the appointment and is usually seen by a junior physician. The physician can agree to an abortion but must get further approval [to give] the woman a...booking date....A woman who has successfully negotiated this system then checks in the night before the operation [bringing her own] anesthetic for the operation.... If she is not operated on because of too many other cases, she needs to acquire another booking date for the operation.[23]

Small wonder, then, that even Zambian women aware of their legal rights resort to illegal practitioners.

Conversely, in some countries where abortion is illegal in principle it is carried out quite freely in practice. Such "lapsed law" countries include Brazil, Egypt, Indonesia, Mexico, Nigeria, and Thailand. In Colombia, abortions are technically legal only in cases where the woman's life is in danger. Observers note, however, that safe, dependable, and affordable services are available in most urban areas, and are freely advertised in local newspapers and on billboards. In Bogotá, private clinics provide comprehensive reproductive health services, including prenatal care, contraceptive counseling, and abortion. In fact, in at least one area local policewomen are on hand to escort neighborhood clients to a clinic. In this case, the highly restrictive law, which serves to placate opponents of legal abortion, is quietly overlooked by the authorities.[24]

Bangladesh is another country where a very restrictive law is softened by efforts to improve access (at least for a few women), in this case with government-funded abortion services. The law prohibits termination of a pregnancy except to save the life of the mother, but as part of a family planning program begun in the early seventies the government began supporting training in and provision of "menstrual regulation" services. Menstrual regulation, commonly known as MR, is performed using vacuum aspiration, the earliest and safest possible form of

"In some countries where abortion is illegal in principle it is carried out quite freely in practice."

mechanical abortion. Because it can be carried out soon after a woman misses her menstrual period, it may be done under the suspicion of pregnancy without an actual test result. The Bangladeshi government was able to circumvent its own law—thereby avoiding the controversy that would arise from an attempted legal reform—by supporting MR services in cases where a pregnancy was not clinically confirmed.[25]

In these two cases, access to abortion is enhanced by the tacit or active willingness of a government to overlook restrictive legislation. It is essential to note that in both these countries, however, as in the many others where similar acceptance exists, there are extreme inequalities in who has access to safe services, and the incidence of illegal abortion remains high. Low-income rural women are particularly disadvantaged in not having the resources—connections, education, money—to gain access to or information about safe abortions. The valuable but limited initiative to provide MR services has certainly not solved the problem of illegal abortion in Bangladesh; maternal deaths there due to complications of abortion remain among the highest in the world. Unfortunately, expansion of the program is in doubt. Government funding of MR services has come under political attack recently and been reduced.[26]

Money is among the most critical factors in securing safe abortion procedures, especially where laws are prohibitive. In Mexico, for example, access to safe abortions is restricted even when legally indicated under the country's narrow but ambiguous law. Safe services can be obtained in urban areas—for a price. The cost for medical abortions ranges from $215 to $644. Even the lower estimate is more than twice the monthly minimum wage of $103. According to one report, "many experts believe that safe medical abortion is now beyond the reach of the middle class."[27]

Even in the wealthiest of countries, the right to abortion on request may be compromised by an individual's ability to pay. Differences in the enforcement of European laws have affected access among women within those countries. The governments of Denmark, East Germany, France, and Sweden, which offer national health insurance to cover the

costs of abortion, have also had to take steps to ensure that sufficient abortion facilities exist in every region of the country.[28]

Other countries' practices are not so true to the intent of their laws. Although abortion in England is, in principle, available free of charge from the government health program, the National Health Service is unwilling or unable to provide abortions to all who request them. Most are performed privately, therefore, and are paid for by the women themselves.[29]

Lack of access, whether because laws are restrictive or services not available, can create "abortion migration" within a country or from one country to another. Fully 82 percent of U.S. counties have no known abortion providers, forcing many rural women to seek care far from home. More than 5,000 Irish women and 3,000 French women were among the 31,000 nonresidents who terminated their pregnancies in the United Kingdom in 1988. Abortion is constitutionally forbidden in Ireland, while the 12-week limit on abortions in France drives some French women abroad.[30]

In every industrial country except the United States, some form of nationally funded insurance at least technically covers abortions needed to preserve the health of the pregnant woman. U.S. law, however, prohibits federal assistance for abortions even in the case of rape or incest, allowing it only if the woman's life is in danger. Regulations now under review by the U.S. Supreme Court, in a case brought by Planned Parenthood, would further limit access by circumscribing the type of information that medical personnel in federally funded clinics could offer patients.[31]

Under Title X, the U.S. Family Planning Act passed in 1970, some 3,900 U.S. clinics serving nearly 5 million low-income women received $136 million in 1989. Originally, Title X clinics were allowed to provide "nondirective counseling" to inform women about all pregnancy options, including abortion, and, if asked, to refer them to providers. In 1988, the Reagan administration sought to further restrict access to services by ruling that doctors and counselors could not give women any infor-

"Fully 82 percent of U.S. counties have no known abortion providers, forcing many rural women to seek care far from home."

mation on abortion, even if asked. In fact, these regulations would compel doctors to inform patients inquiring about abortion that it "is not a method of family planning," and instead provide them with information on childbirth. The Court is likely to decide this issue in early 1991.[32]

The resolution of other issues now under debate throughout the world could have a negative effect on abortion rights by restricting access. Those being considered are when and to what extent government health care programs should cover the costs of legal abortion, whether a husband's consent or notification should be required before a married woman can obtain an abortion, and whether laws should require parental notification or consent for adolescent abortions. Placing limits on access is only one part of a broader attack on legalized abortion. A glance beneath the surface waters of liberalization reveals a strong undertow tugging at recently codified reproductive rights.

Opponents of abortion rights, dismayed at the extent of legalization, have devised a three-pronged strategy. First, they seek to reinstate restrictive abortion policies in countries where they've been liberalized—Canada, France, Italy, Poland, Spain, the United States, and West Germany, to name a few. Second, they aim to maintain or reinstate restrictions in the Third World by supporting the growth of parallel movements there. Third, they are using legal and economic stoppers to plug every hole in the dam restricting access to services. This movement has scored some significant successes since 1977, most notably in countries where laws have been made considerably more restrictive.

Bucking the liberalization trend are Finland, Honduras, Iran, Ireland, Israel, and, most recently, the United States. Finland and Israel made their liberal laws more restrictive, while Iran and Ireland forbade abortions altogether. A Honduran law permitting abortions in cases where they would protect the life and health of the mother and in cases of rape and fetal deformity was rejected because it was perceived to conflict with constitutional provisions stating that the "right to life is inviolable."[33]

Changes in the constitutions of Ecuador (1978) and the Philippines

(1986) incorporated provisions giving the right to life "from the moment of conception." Some of these changes have ambiguous implications for abortion rights. Chile's constitution, for instance, protects the right to life and to physical and psychic integrity not only of individuals, but also of those "about to be born." Whether or not an embryo or a 10-week-old fetus is "about to be born" remains unclear. Chile recently added to its penal code a law making the act of abortion a homicide.[34]

In July 1989, the United States—a country with one of the world's most liberal abortion policies—took a step backward on reproductive rights. The U.S. Supreme Court's ruling in *Webster v. Reproductive Services* in effect gave the green light to those states seeking to regulate abortion procedures strictly. In *Webster*, the court threw out the trimester framework of viability established in the landmark 1973 *Roe v. Wade* decision, which permitted states to regulate abortions only after the first trimester and to ban them only in the last.[35]

The case upheld the State of Missouri's law that physicians must carry out extensive tests for viability before performing abortions after 20 weeks. Furthermore, *Webster* severely curtailed access to services in that state by upholding Missouri's ban on the use of public facilities for the operation. Since then, restrictive laws of various shades have been introduced in a number of state legislatures, although only a few have been passed. (See Table 3.)

Global trends in abortion politics are both reflected in and fueled by events in the United States. The U.S. decision in *Webster*, a major success of the so-called pro-life movement, sent shock waves through ranks of activists in Western Europe. The abortion debate there has been far less emotional than in the United States but is becoming more polarized. Europeans from both camps have described the decision as a "wind from the west."[36]

The struggle over abortion rights is now a cross-border affair, with money and anti-abortion protestors crossing the Atlantic from the United States. Moreover, a broader global effort to repeal or restrict abortion rights is being coordinated by the U.S.-based umbrella group

Table 3: U.S. Legislative Actions Post–*Webster*, Selected States, 1989–90

State	Legislative Action and Status
Pennsylvania	Law prohibits abortions at publicly funded hospitals, and requires spousal notification, mandated waiting periods, and anti-abortion counseling; most restrictions enjoined and under court review.
Idaho	Bill passed by Idaho legislature banning virtually all abortions within the state; vetoed by Governor Cecil Andrus.
South Carolina	Law limits teenagers' access to abortion. (Similar laws being considered in 27 other states.)
Territory of Guam	Guam's Governor signed law containing severe and far-reaching abortion restrictions; essentially bans abortion; currently enjoined by courts.
New Hampshire	Bill passed by legislature allowing abortion on request through viability; vetoed by Governor Judd Gregg.
Connecticut	Law ensures women's right to obtain an abortion on request through viability, irrespective of future Supreme Court decisions on *Roe v. Wade*.

Sources: National Abortion Rights Action League, "Post-*Webster* Anti-Choice Legislative Activity," Washington, D.C., memorandum, March 29, 1990; Kirk Johnson, "Connecticut Acts to Make Abortion a Statutory Right," *New York Times*, April 28, 1990.

Human Life International (HLI), which has set up branch offices in 18 countries. Their agenda in developing countries focuses on restricting abortion rather than providing couples with the means to prevent unintended pregnancies. Yet studies show that millions of Third World couples still lack access to contraceptives. Not surprisingly, poor women in these countries already suffer the highest rates of death due to complications of pregnancy and illegal abortion.

The first international meeting of HLI was held in Zambia in 1989. Representatives of this group are believed by Zambian health officials to be responsible for a widespread disinformation campaign, coincident with the conference, about side effects of locally available contraceptives. The Zambian Ministry of Health subsequently spent several months dispelling the considerable anguish and confusion that ensued.[37]

A Sense of Scale

Few people would claim to be indifferent on the subject of abortion. The emotions driving the politics on this issue are so intense, however, that little or no attention is paid to its demographic and social realities.

Broadly speaking, abortion rates are governed by the cultural and economic pressures on family size in a given society in concert with the mix of laws and policies that determine access to family planning. The numbers of illegal versus legal procedures in a given country, the degree to which pregnancy termination is used to regulate fertility, and the demographic makeup of the groups relying most heavily on this method are all shaped by social and economic pressures to limit or delay childbearing, by the availability and reliability of contraceptives, and by the legal, cultural, and political climate that surrounds abortion services.[38]

Abortion rates tend to be low where desired family size is large and fertility rates are limited only by traditional practices such as heavy reliance on breastfeeding and postpartum abstinence. In rapidly mod-

ernizing societies, however, changes in the status of women, in levels of education and income, and in the makeup of the work force, among other things, lead to equally rapid changes in desired family size.

As the number of children that they prefer falls, couples look for ways to avoid or terminate unwanted pregnancies. Abortion rates then tend to rise rapidly (irrespective of its legal status), especially if there is no strong tradition of contraceptive use or if contraceptives are not widely available. It is at this point in the transition that abortion's effect on birth rates is highest.

Although rates of contraceptive use and abortion may rise together for a while, eventually the latter peak and begin to decline. In South Korea, for instance, both rates rose rapidly from the late sixties throughout the seventies, reflecting an increasing desire for smaller families. But between 1979 and 1985, the rate of adoption of contraceptives continued to climb, while the abortion rate fell back to the level of 1973. Induced abortion clearly played a major role in South Korea's fertility transition: without it birth rates would have been some 22 percent higher in that period.[39]

Similarly, Japan is often touted as a country that quickly underwent the transition to low fertility rates, but the important role of induced abortion in achieving this is less widely recognized. Strict government control over importation of modern contraceptive methods has kept their use among Japanese women low. Still, the average number of children per family fell precipitously through the fifties due to several factors, including the trend toward later marriage and the liberalization of abortion laws in 1948. The number of abortions performed annually more than quadrupled, to 1.2 million, between 1949 and 1955—the years when fertility fell most quickly. Abortions have since fallen to about half that level due in large part to increasing contraceptive use.[40]

In this way, abortion has played an integral though varied role in the transition from high to low fertility in virtually every country that has to date achieved replacement-level fertility (approximately two children per family). The transition in terms of the decline in both abortion rates

and birth rates is slowed wherever access to family planning information and supplies is limited.

True to the pattern, the incidence of abortion has declined most rapidly in those countries where legalized abortion has been included as part of truly comprehensive voluntary family planning services—among the few to note are Denmark, France, Iceland, Italy, and the Netherlands. Likewise, in societies on the cusp or in the process of this transition throughout Africa, Asia, and Latin America, illegal abortion is now widely relied upon to limit family size, though at a tremendous price in women's lives and health.[41]

Based on available data about legal procedures, abortion appears to rank fourth in terms of birth control methods used, behind female sterilization, intrauterine devices (IUDs), and oral contraceptives. Use of these other methods, however, is heavily concentrated in China, India, and the industrial nations, whereas induced abortion is practiced in every country of the world.[42]

Estimates of the number of illegal abortions and maternal deaths for individual developing countries are generally drawn from hospital- or community-based studies that offer but a fragmented picture of the real situation. In both Bangladesh and Brazil, for example, demographic studies indicate that 20–35 percent of all pregnancies are aborted. Yet because of legal restrictions, bureaucratic indifference, and social disapproval, abortion in these countries is a largely undocumented and clandestine activity.[43]

In fact, so few countries keep accurate statistics on abortion that the omission itself has political implications of tremendous import. If society remains ignorant of the number of legal versus illegal procedures, if the number of women who die or are physically impaired due to illegal abortions remains unknown, if the costs in terms of health and productivity (not to mention individual freedom) remain untallied, then there is no empirical basis on which to challenge opponents of abortion rights. In effect, the pathetically poor quality of data narrows the debate on which set of social and individual priorities should prevail.

"The pathetically poor quality of data narrows the debate on which social and individual priorities should prevail."

Despite the lack of hard numbers, several researchers have made estimates based on available evidence, from which a number of conclusions about trends at the global and regional level can be drawn. Demographers calculate that from a third to half of all women of reproductive age undergo at le: st one induced abortion in their lifetimes. According to calculations by Stanley Henshaw of the Guttmacher Institute, some 36–51 million abortions were performed worldwide in 1987. He estimates the annual number of illegal procedures at 10–20 million annually, leaving from 26–31 million legal ones. Other estimates put the total number at between 40 million and 60 million. Using either set of figures implies close to one induced abortion for every two to three births worldwide.[44]

Comparisons of abortion trends within and between countries are made using abortion rates, the number of abortions per 1,000 women of reproductive age. Again, lack of data for many countries makes true comparisons difficult. But by using figures from countries with reliable statistics as well as figures adjusted for illegal abortions in those without data, a sketch can be drawn of regional and national abortion trends.

In many countries, abortion has become the primary metho[illegible] family planning as a direct result of government policies (or lack o[illegible]) that result in limited access to contraception. The connection is m[illegible] plain by the situation in Eastern Europe and the Soviet Union, whe[illegible] "contraceptive iron curtain" has hung for decades.[45]

With the exceptions of Albania (which retains restrictive policies) and of East Germany and Yugoslavia (which liberalized their laws in the seventies), abortion laws were changed in most of Eastern Europe in the fifties, making legal a practice that was already widespread. Few of these governments, however, concurrently made the availability of contraceptive information or supplies a priority; consequently, couples continued to rely on less effective methods, such as withdrawal, using abortion as a backup.[46]

This pattern held as social ills, economic hardship—evident in housing

shortages and long lines for basic rations—and environmental deterioration reinforced the strong desire of East Europeans to limit the size of their families. With virtually only one way to achieve this goal, throughout the sixties and seventies rates of induced abortion in the region were the highest recorded in the world. Even today, abortion rates in most of Eastern Europe are high for women in all stages of their reproductive years. (See Table 4.)[47]

Table 4: Legal Abortion Rates, Selected East European Countries, 1987

Country	Abortions (per thousand women aged 15-44)
Bulgaria	65
Czechoslovakia	47
East Germany[1]	27
Hungary	38
Romania[2]	91
Yugoslavia[1]	71

[1] 1984 data.

[2] Includes official estimates of illegal abortion.

Source: Stanley K. Henshaw, "Induced Abortion: A World Review, 1990," *Family Planning Perspectives*, March/April 1990.

In Poland, for example, a 1956 act legalizing abortion also committed public funds to establishing a network of family planning clinics. Although the government's initial efforts increased the availability and use of contraceptives, successive waves of opposition to both abortion and family planning have severely weakened the government's commitment to providing supplies and services.[48]

Since the early seventies, the desire of Polish couples to use contraceptives has consistently been thwarted by inadequate supplies and the low quality of available goods produced within the centrally planned economy. (One gynecologist described domestically produced birth

control pills as being "good for mares, not for people.") In a 1983 study, economist Marek Okolski of the University of Warsaw claimed "the evolution of government information and educational efforts regarding family planning and birth control over the last 15 years can be viewed as a trend toward ignorance....The supply of contraceptives on the Polish market has never met the demand and the gap has tended to widen over time."[49]

The dwindling commitment to family planning in general quickly showed up in abortion trends. Forced to rely on traditional but relatively ineffective forms of birth control, such as withdrawal and rhythm, Polish women experience high rates of unintended pregnancies. Okolski calls Poland's situation "enforced contraceptive recklessness...[one] result of the government's failure to provide modern contraceptives and family planning services [is that] women are forced to resort to abortion."[50]

Doctors, clergy, and government health officials agree that the rate of induced abortion in Poland is significantly higher than the officially reported 15 per 1,000 women of reproductive age. Some figures imply that in 1982, half of all pregnancies ended in abortion. And while abortions can be obtained free of charge at state hospitals, many women turn to private practitioners, desiring privacy and being unwilling to risk their health in the deteriorating environment of state-run facilities. A large number of abortions performed outside the system are not reported; one theory is that because physicians in private practice take in large amounts of money doing abortions on the side, they benefit by not reporting them, in part by evading taxes. If successful, ongoing attempts by the Catholic church and by certain factions in Solidarity to recriminalize abortion promise to drive the practice further underground.[51]

A lack of effective contraceptives in the Soviet Union has led to similar reliance on abortion there. The nation has some 70 million women of childbearing age yet not a single factory producing modern contraceptives, except the poor-quality condoms widely disparaged as "galoshes." Writing in the Soviet magazine *Ogonyok*, medical researcher

Andrei Popov states that "the way out [of unwanted pregnancies] is well-known—abortions...child abandonment [and] infanticide."[52]

Abortions are available throughout the Soviet Union on demand and at low cost. And the average Soviet woman, who terminates between five and seven pregnancies during her reproductive years, will likely take advantage of the system at some time. Still, administrative and technological barriers combined with public disapproval of abortion drive the majority of women to obtain what are essentially illegal procedures that they must pay for out of pocket. Many are reluctant to request state-funded abortions because, by law, the procedure must be recorded in work and health documents.[53]

It is clear the Soviet Union's share of total abortions worldwide is large; what is less clear is just what that share is. Official statistics put the number of abortions in 1987 at nearly 7 million, well in excess of the 6 million recorded live births; official rates were 100 per 1,000 women of reproductive age in 1985. Estimates made by independent researchers imply the true numbers are far higher. Henshaw calculates that possibly 11 million abortions are performed annually. Demographer Tomas Frejka, citing estimates of 13 million unauthorized procedures, claims the number could approach 20 million, a figure close to one put forward by Murray Feshbach, a U.S. researcher on Soviet health at Georgetown University.[54]

Three East European countries—Czechoslovakia, East Germany, and Hungary—have apparently kept their abortion rates relatively low by encouraging widespread contraceptive practice. Hungary, for example, relied on a campaign that included dissemination and education on the use of modern contraceptives. Between 1966 and the late seventies, the share of Hungarian women using modern contraceptives increased dramatically, leading to a substantial decline in abortion. In the words of Henry David, Director of the Transnational Family Research Institute, Hungary went from being "an abortion culture" to one relying on education and modern contraception.[55]

In Latin America, abortion rates have been consistently high for over

two decades, despite quite restrictive laws and the firm opposition of the Catholic church to any kind of modern family planning. Indeed, there is evidence of a long tradition of induced abortion in the region. In 1551, the King of Spain was notified that the indigenous population in his Venezuelan colony practiced induced abortion, through the use of medicinal herbs, to prevent their children from being born into slavery.[56]

During the seventies, the International Planned Parenthood Federation (IPPF) estimated that abortion rates in Latin America and the Caribbean were higher than in any other developing region: an estimated one-fourth of all pregnancies in Latin America were intentionally aborted in that period, compared with estimates of less than 10 percent in Africa and 15–20 percent in South and Southeast Asia.[57]

Fertility rates have fallen since the sixties, but the desire for even smaller families is strong throughout the region. Data from the World Fertility Survey in the seventies showed that while the average family contained at least four children, over half the women interviewed wanted to have only two to four. Over half the women with three children in all Latin American countries except Paraguay wanted no more children.[58]

Because political and religious opposition has kept contraceptive outlets to a minimum, the number of illegal abortions is high and shows no signs of falling off in the near future. Experts put the total number well in excess of 5 million, but some claim the number in Brazil alone may surpass 4 million.[59]

Tracking illegal abortions in Latin America is difficult at best. Frejka reports that "a large proportion of the induced abortions are performed in violation of existing laws and [providers] have a vested interest not to report them. Even after the fact, women tend to deny having had an abortion, and health personnel who treat abortion complications will under-report cases...to avoid involvement with the law." A hospital study in Campinas, Brazil, for instance, found maternal deaths due to abortion were underreported by 40 percent.[60]

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Today, induced abortion continues to account for about one-fourth of total fertility control in Latin America. Although use of contraceptives has been increasing steadily since the sixties, it is still relatively low and supplies remain unevenly distributed throughout the region. Access to services is unequal: those most at risk of unwanted pregnancy—teens, single women, and low-income women—are those for whom contraceptives and safe abortion services are most out of reach. Rates of contraceptive failure are still high, too. Frejka claims that "the incidence of induced abortion in Latin America will remain high, at least through the 1990s, even if its legislation continues to be restrictive. [This] situation implies serious reproductive health, and economic as well as social, problems for a large number of women and their families."[61]

A similar picture is developing in Africa, where the number of induced abortions and the related health and social costs of illegal or clandestine procedures are likely to continue rising for at least the next decade. The predominantly young population is characterised by high fertility and low rates of contraceptive use. Access to both contraceptives and safe abortion services is limited geographically and by income. Although fertility rates in Africa are among the highest in the world, the desire to limit family size is growing.

Yet laws circumscribing reproductive rights in Africa, inherited from colonial governments, remain largely intact. Among the former British colonies, for instance, only Zambia has liberalized its abortion law. Francophone Africa lags even further behind in this regard. In addition to criminalizing abortion, the French law of 1920 outlawed the sale, distribution, and advertisement of all contraceptives. Only Burundi, Togo, and the Seychelles among the Francophone countries have liberalized their laws enough to allow the operation for social indications.[62]

Social and cultural limitations on women in Africa are an equally important factor in the abortion equation, and may be much harder to change than laws. Nolwandle Nozipo Mashalaba, a private family practitioner in Botswana, sees the lack of communication between African couples on matters of sexuality and the desire to maintain male dominance within the household as the primary roadblocks to reducing

"The incidence of induced abortion in most Asian countries is high regardless of legal status."

pregnancies that women themselves may not want. He notes that where "men migrate...for work, they keep the wife in a continuous state of pregnancy and lactation as a way to keep her (possible) infidelity to a minimum."[63]

Studies show that these and other constraints can hamper contraceptive use even where knowledge of modern methods is high. A 1984 survey in Botswana found that more than 70 percent of women in both rural and urban areas knew at least one modern method of family planning; a more recent survey in Zimbabwe indicated that 9 out of 10 knew at least one method and the majority were familiar with five or more. But a number of factors—including the inaccessiblity of clinics, fear and anxiety over side effects, ineffective counseling, and the lack of programs for men—keep rates of contraceptive use well under 15 percent throughout most of Africa. Illegal abortion, in Mashalaba's words, is "the only solution."[64]

Abortion rates may be rising in many Asian countries as well. According to Erica Royston, a medical researcher in WHO's Division of Family Health, the incidence of induced abortion in most Asian countries is high regardless of legal status.[65]

Indonesia provides a classic example of the inevitable clash between rapidly changing social values and restrictive legal codes. According to Indonesian physicians Ninuk Widyantoro and Sarsanto W. Sarwono, rates of both abortion and contraceptive use in the country are climbing rapidly, indicating that "couples desire much smaller families than traditionally prevailed." They estimate that between 750,000 and 1 million abortions are performed annually.[66]

The legal status of the procedure has long been cloudy in Indonesia. A profusion of laws and morals concerning abortion and family planning reflects the country's diverse national heritage, drawn from the traditions of indigenous ethnic groups melded together with the mores and practices of Buddhism, Christianity, Hinduism, Islam, and former Dutch colonizers. In the seventies, high rates of maternal illness and death from unsafe abortion prompted the members of the medical com-

munity to seek clarification of the welter of statutes from the Indonesian High Court.[67]

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Although abortion was not then technically liberalized, nor has its status changed since, the court's decision that "procedures could not be regarded as illegal if they were carried out within the framework of normal medical practice by specialists and doctors" paved the way for an increase in trained providers. Since then, access to safe services has spread. Many doctors, although mainly in urban areas, have been trained in the use of and provided with vacuum aspiration equipment. Moreover, the Indonesian government has made a major commitment to increasing access to contraceptive information and supplies. Still, Widyantoro and Sarwono estimate that due to unequal access, social ambivalence about abortion, and lack of information on services, perhaps as many as 800,000 illegal abortions are carried out each year, "with many more unsuccessful attempted terminations going unnoticed." As a result, complication and fatality rates remain high.[68]

It appears that abortion rates are high and rising throughout the Philippines as well, despite the strict censure of the practice by the Catholic church. It may even be said that the church's opposition to contraceptive use in the Philippines has contributed to growing reliance on illegal abortion. Strong religious influences within the society and the government have kept efforts to promote family planning to a minimum. Sample surveys indicate complications of illegal abortion are rising as a result.[69]

Looking at the pattern of induced abortions in various nations according to age, marital status, educational level, and current family size provides an indication of which demographic groups have the greatest numbers of unwanted pregnancies, and even suggests who has least access t. effective, affordable, and acceptable contraceptives. In most industrial countries, for example, as in Canada and the United States, abortion rates tend to be highest among teenagers and women aged 20–24, groups that seek to delay childbearing either because of their marital status (single) or for other reasons, such as the desire to complete their education. (See Table 5.)

"The church's opposition to contraceptive use in the Philippines has contributed to growing reliance on illegal abortion."

Table 5: Legal Abortion Rates by Age of Woman, Selected Countries, Most Recent Year

Country	19 and younger	20-24	25-29	30-34	35-39	40 and older
	(legal abortions per thousand women in age group)					
Canada	15	19	12	8	5	2
East Germany	17	26	31	31	24	11
England/Wales	21	24	16	11	7	3
Hungary	26	45	47	46	41	22
Tunisia	1	13	27	36	31	16
United States	46	52	31	18	10	3

Source: Stanley K. Henshaw, "Induced Abortion: A World Review, 1990," *Family Planning Perspectives*, March/April 1990.

Making sex education and contraceptives more available to these groups lowers their abortion rates. The Transnational Family Research Institute compared approaches to family planning in Denmark and the United States to see how different strategies can result in different rates of unintended pregnancy and abortion among particular demographic groups.[70]

The Institute found that inability to pay limits access to contraceptives more often in the United States than in Denmark, especially among those groups most at risk of unwanted pregnancy. In the absence of national health insurance, women rely largely on private physicians to obtain contraceptives, and many are disadvantaged by cost constraints, their ineligiblity for public assistance, or their place of residence.[71]

Data show that 17 percent of U.S. women with low incomes lack health insurance of any kind; this group includes one-fourth of women under 25, one-fourth of unmarried women, and one-third of women whose incomes fell below 150 percent of the federal poverty level—all groups with the highest rates of unwanted pregnancy and abortion. Many of

these women cannot afford to purchase contraceptives. In Denmark, by contrast, national health insurance provides contraceptives, counseling, and pre- and postpregnancy health care for everyone, regardless of income.[72]

Federally funded family planning clinics do exist in the United States, but a lack of political commitment has kept their budgets spare. leading to limited hours, long waits for appointments, and a narrower menu of services offered. Moreover, services have been declining in the wake of recent budget cuts: less than half as much funding was made available to Title X clinics in fiscal year 1989 than in 1981.[73]

Danish family planning programs focus on preventing unwanted pregnancies to the greatest extent possible by making contraceptive services universally available, even to teenagers. The results have been clear. Today, conception rates among Danish teens are less than half those in the United States. Abortion rates among women age 15–19 fell by nearly half between 1977 and 1985. (See Table 6.)

The situation regarding teen access to contraceptives in the United States is vastly different. Proposals for starting U.S. programs similar to those in Denmark are hotly contested. As a result, rates of teenage pregnancy and of abortion in the United States well exceed those of other industrial countries, even though the ages at which teens first experience sex are comparable.[74]

The growing disparity between low rates of contraceptive use and increasing desires to limit family size—the unmet need for family planning that is evident throughout the Third World—is a sure prescription for even higher rates of illegal abortion. Regional surveys suggest that 50–60 percent of couples in Latin America, 60–80 percent in low-income Asian countries (except China), 75 percent in the Middle East and North Africa, and 90 percent of sub-Saharan Africa do not use any form of modern contraception. On the other hand, the same studies show that a majority of couples in Latin America and Asia—and a growing percentage throughout the Middle East and Africa—wish to space the timing or limit the number of their children.[75]

Table 6: Teen Abortion Rates, United States and Denmark, 1977–85

Year	United States	Denmark
	(abortions per thousand women aged 15–19)	
1977	37	25
1978	40	24
1979	42	22
1980	43	23
1981	43	20
1982	43	18
1983	43	18
1984	43	17
1985	44	16

Source: Henry P. David et al., "United States and Denmark: Different Approaches to Health Care and Family Planning," *Studies in Family Planning*, January/February 1990.

In most developing countries, abortion rates are highest among married women with several children who have no means of preventing additional, unwanted pregnancies. In Latin America, abortion rates among women over 35 are twice those for women age 20–34; the rate among women with five or more children is more than twice that for women with only one. A clinic-based study from Allahabad, India, showed that a large majority of women seeking abortions were married, between 20 and 29, and that most had several children already. Case studies in Indonesia documented almost identical results—the majority of abortion clients were married, had two to three children, and were over 25.[76]

It is commonly believed that abortion in Africa is used primarily by women in their teens and early twenties who want to delay childbearing. This fits with the social and demographic makeup of urban areas, for example, where higher levels of education and broader opportunities for women encourage a desire to delay marriage and childbearing.

Data from Nairobi bear this out: 79 percent of the induced abortion patients in one hospital study were young, single women.[77]

But additional data point to the growing reliance on abortion here too of older women with several children, especially in rural areas. In Tunisia, for instance, rates are highest among women age 25–39. A sample in Nigeria showed that 30 percent of complications from abortion in one hospital were reported in women over 25; of all the women, 52 percent had two or more children.[78]

Likewise, a Kenyan study found that 46 percent of abortion patients had one to three children, 22 percent had four to six, and 7 percent had seven or more. Under increasing social and economic stress, more married women are turning to abortion as their primary means of birth control. The striking implication of this finding is that the unmet need for family planning in Africa may be far higher than is currently assumed. If this is true, then the need to improve access to contraceptives, the safety of abortion services, and general reproductive health care throughout Africa—especially to stave off a precipitous rise in illegal abortions, not to mention to reduce fertility—is far more urgent than the spending and policy priorities of most African governments indicate.[79]

Abortion trends throughout the developing world could be predicted from what is known about the downward pressure on birth rates created by economic change. But evidence is mounting that quite a different process is at work. A growing share of the world's population lives in poverty, and inequalities in income, housing, and access to social services are increasing. These trends have been exacerbated by consistently high levels of international debt, widespread environmental degradation, and a pattern of development that has relentlessly ignored the needs and priorities of women.

Most poor women, therefore, would plainly understand the sentiments of Eudora Coma, a resident of Bucharest during the Ceausescu regime, who explained her decision to risk abortion thus: "My husband and I used to cry in the evenings because we had nothing to give our children to eat....It is better to have three healthy children than five unhealthy

"The unmet need for family planning in Africa may be far higher than is currently assumed."

ones." More and more, it seems, sheer desperation rather than the desire to delay childbearing in the hope of a more secure future is driving women to choose abortion. A growing number of women are likely to pay for this choice with their lives.[80]

The Invisible Plague

> 10:30 am, September 5, 1988: Ten women were lying, sitting and leaning on nine beds in three rooms...five others were sprawled on the concrete floors of the hallway connecting these rooms. A few more were lying or seated on the floor outside the entrance to the Gynecology Admissions Ward....Although the temperature was warm, the dark, concrete environment and the condition of the women required blankets or covers....There were none....Many of these women came to the hospital for medical treatment of complications of incomplete, induced abortion....Most wait 12 hours for treatment from a physician....The nurses are often alone with women who are aborting on the floors or on their way to the single toilet at the end of the long hall. "All we can do is clean it up." Each day three out of ten illegally induced abortion patients complete their abortions on the concrete floor with no medical care. Nurses are not permitted to give medications or analgesics without a doctor's prescription.
>
> According to the nurse-in-charge, the "average" woman ends up overnight on the floor. She receives no food or water because of the anticipated curettage procedure (surgical scraping of the uterus). [Consequently,] many women are dehydrated...increasing the need for intravenous fluids once treatment begins....Many...are in need of transfusions by the time they are taken into the operating room. Some refuse because of fear of HIV infection. Most who need blood, usually do not receive any because of shortages.[81]

This scene, a snapshot of what occurs daily on the wards of University Teaching Hospital in Lusaka, Zambia, where abortion is technically legal, might aptly describe conditions in any number of large-city hospitals in countries where illegal or clandestine abortion is widespread.

Though it might not be apparent, the women described here are lucky; they are among the minuscule percentage of women who have even a chance of receiving health care after their lives or health have been threatened by complications of illegal abortion. Millions of others do not.

Throughout the Third World, the lifetime risk of maternal death is between 80 and 600 times higher than it is in industrial countries. Each year, according to WHO, at least a half-million women worldwide die from pregnancy-related causes. Of these, WHO attributes the loss of roughly 200,000 women's lives annually to illegal abortion, most of which are performed by unskilled attendants under unsanitary conditions or are self-inflicted with hangers, knitting needles, toxic herbal teas, and the like. In terms of sheer numbers, more than half the abortion-related deaths worldwide occur in South and Southeast Asia, followed by sub-Saharan Africa, and then Latin America and the Caribbean.[82]

Here again, simple public recognition of problems related to women's health is stymied by lack of accurate data to assess and publicize the true extent of the problem. Reliable statistics on the incidence of induced abortion and related maternal mortality rates are available from only a handful of countries—the United States and most European countries are among those keeping accurate statistics. Even data from WHO are incomplete.

Evaluation of trends within individual countries imply that maternal deaths could be far higher than is commonly believed. One study in India, for example, estimated that a half-million women die annually in that country alone due to complications of illegal abortion. And for every woman who dies, 30–40 more suffer serious, often lifelong health problems—among them hemorrhaging, infection, abdominal or intestinal perforations, kidney failure, and permanent infertility—that affect their ability to provide for themselves and for any children they already have.[83]

The methods of illegal or clandestine induced abortion are as varied as

"Throughout the Third World, the lifetime risk of maternal death is between 80 and 600 times higher than in industrial countries."

the cultures they evolved in. According to Mary Ann Castle of the Population Council, Zambian women may use twigs or other solid objects; others, the more desperate and isolated, drink detergents or gasoline or take large overdoses of aspirin or chloroquine to bring on violent contractions. Elsewhere in Africa, women may seek abortions from midwives or traditional healers who insert the roots of cassava or other plants into the cervix, hoping to induce uterine contractions. In rural Indonesia and Thailand, intensive abdominal massage is the method of choice. Observers of abortion trends in Brazil note an increase among women there in the use of over-the-counter and prescription drugs found to have an abortion-inducing effect.[84]

Perhaps the most distressing fact about abortion-related deaths and illnesses is that the vast majority of complications that lead to these outcomes are totally preventable. What consigns so many women around the world to death or physical impairment is not a deficiency in technology, but a deficiency in the value placed on women's lives. Technologically simple, inexpensive, easy-to-use tools for safe early abortion are well known, and widely used in some countries. But social intransigence, religious intolerance, economic self-interest, and political apathy all narrow the options for millions of women. Society's message to these women is, in effect, "carry this unwanted pregnancy or risk your life to end it."

Because of the social stigma of abortion, the dispersion of medical technologies for safe procedures is held back even while progress is made on other forms of health care. According to Julie DeClerque of the International Projects Assistance Services (IPAS), "data on infant mortality and hospital admissions for abortion complications in Santiago, Chile over a 20-year period show that while infant mortality dropped by over half, hospitalization from abortion complications increased by over 60 percent."[85]

Equally disturbing is the resounding silence on the part of international bodies concerned with health and development—the World Bank, the World Health Organization, the U.S. Agency for International Development, to name a few—about the human and economic costs of

illegal abortion. Abortion-related deaths and illness are to them an invisible plague.

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WHO studies in various settings indicate that the share of maternal deaths caused by induced abortion ranges from 7 percent to more than 50 percent. On average, between 20 and 25 percent of maternal mortality is attributable to illegal or clandestine abortion. In Latin America, complications of illegal abortion are thought to be the main cause of death in women between the ages of 15 and 39.[86]

The number of abortion deaths is a direct reflection of access to safe services. Thus it is not difficult to understand the high rates of abortion-related maternal mortality in Ceausescu's Romania. (See Table 7.) Wherever illegal abortions are widespread—as they are in countries as disparate as Ethiopia, Argentina, and the Soviet Union—women's lives are at risk.

Abortion-related deaths are estimated to reach 1,000 per 100,000 illegal abortions in some parts of Africa, as opposed to less than 1 death per 100,000 legal procedures in the United States. Hospital admissions in African cities, virtually the only available indicator of abortion trends, are rising in tandem with reliance on abortion as a method of birth control. Khama Rogo, a medical doctor and faculty member at the University of Nairobi, indicates that admissions of women suffering from complications of illegal abortions have risen 600–800 percent at Nairobi's Kenyatta National Hospital over the past decade. He estimates that in 1990 more than 74,000 African women may die following an illegal abortion.[87]

Rogo notes that in East and Central Africa at least 20 percent of all maternal deaths are due to complications of induced abortion, and that the share has reached 54 percent in Ethiopia. He suspects that "gross underreporting" of abortion cases may be responsible for the fact that studies in several West African hospitals imply overall maternal death rates from abortion of only 10 percent.[88]

The problem is not limited to developing countries. It exists wherever

Table 7: Share of Maternal Deaths Due to Illegal or Clandestine Abortions, Selected Countries, Mid-Eighties

Country	Share
	(percent)
Romania	86
Ethiopia	54
Chile	36
Argentina	35
Jamaica	33
Costa Rica	30
Colombia	29
Soviet Union	29
Zimbabwe	28
Nigeria	25
Tanzania	21
Sri Lanka	13

Source: Based on Erica Royston and Sue Armstrong, eds., *Preventing Maternal Deaths* (Geneva: World Health Organization, 1989); Erica Royston, "Estimating the Number of Abortion Deaths," Seminar on Abortion Research Methodology, Population Council, New York, December 12–13, 1989.

access to safe abortion is blocked. Because doctors and other providers of abortion in the Soviet Union rely heavily on outdated techniques, the number of complications due to both legal (within the government system) and "illegal" abortions is high.

Neither authorized nor private service-providers offer contraceptive counseling in the Soviet Union. They are often unaware of technical advances and are seldom motivated to change their practices. In 1987, the overall maternal mortality rate was 46 deaths per 100,000 live births, compared with 9 in the United States. One recent estimate indicates that 29 percent of maternal deaths were abortion-related, yet only

recently did the Soviet press and medical community recognize this as a "serious and growing health crisis."[89]

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As the Zambian example shows graphically, hospitals in many developing countries are literally inundated with women seeking treatment for complications of illegal abortion. Over 30 percent of the beds in the gynecological and obstetric wards of most urban hospitals in Latin America are filled with women suffering abortion complications. At Mama Yemo hospital in Kinshasa, Zaire, and at the Kenyatta National Hospital in Nairobi, Kenya, some 60 percent of all gynecological cases fall in this same category. And at a hospital in Accra, Ghana, between 60 and 80 percent of all minor surgery performed relates to the after-effects of illegal abortions; in 1977, half that hospital's blood supply was allocated to related transfusions.[90]

From one-fifth to half of all maternal deaths worldwide could be prevented by providing access to safe abortion services. No international effort to accomplish this is on the horizon, but in a few countries individual groups are working to furnish the technical means and training to deal more efficiently, at least, with complications. IPAS, for one, has been working in sub-Saharan Africa to train clinicians in safe use of the manual vacuum aspiration technique. Use of this in the treatment of incomplete abortions has reduced the time needed to treat women suffering from poorly executed operations, and lowered their risk of hemorrhage and infection. Pilot projects at hospitals in both Kenya and Nigeria have yielded "a great savings in health resources," according to Ann Leonard of IPAS.[91]

Each roadblock to safe abortion raises the social costs of illegal procedures severalfold. Illegal abortions drain health resources. Complications from them require treatments that are in short supply. A study of 617 women suffering abortion complications who were admitted to 10 hospitals in Zaire found that 95 percent required antibiotics, 62 percent anesthetics, and 17 percent transfusions. Oftentimes, hospital supplies in Africa are so scarce that women must go to the local pharmacy and provide their own antibiotics—or not receive treatment. The increased competition for health resources posed by the growing num-

"One-fifth to half of all maternal deaths worldwide could be prevented by providing access to safe abortion services."

bers of illegal abortions in Africa will make coping with another health crisis there—AIDS—that much more difficult.[92]

In a study of the effects on the health system in Latin America, demographer Judith Fortney concluded that illegal abortions require, on average, "2 or 3 days in the hospital, 15 or 20 minutes in the operating room, antibiotics, anaesthesia, and quite often a blood transfusion. In many hospitals, each of these resources is relatively scarce and their use for abortion patients may mean that other patients are deprived." When multiplied by the share of illegal abortions worldwide resulting in complications, the enormity of the problem becomes obvious. The costs could be reduced greatly if safe, legal abortions were accessible to all.[93]

Strict laws and barriers to access keep the cost of illegal abortion high in Brazil. Legally, abortions are allowed only when a pregnancy threatens the life of the mother or results from rape or incest. In practice, administrative procedures, such as needing the signature of more than one doctor, keep even women in these categories from receiving adequate care. Illegal abortions are epidemic: reports indicate that nearly half the national health system's obstetrics budget goes to treating the complications.[94]

Hospital studies from Turkey, where abortion is technically legal, indicate that treating complications following an illegal operation costs four times as much as a safe medical procedure. And at the Bertha Calderon Hospital in Nicaragua, IPAS has found that the costs of treating illegal abortion are over 1,800 times those of providing a safe one.[95]

Restricting access to safe abortion services increases the financial burdens on low-income women and their families. Procuring a clandestine abortion can be expensive, but for those women who suffer complications, the costs are higher still. In Thailand's rural Chayapoom province, women suffering complications of illegal abortion severe enough to require hospitalization lost an average of 12 days of time from their normal activities; those whose complications did not require a hospital stay still lost 6 days.[96]

A recent accounting by the Alan Guttmacher Institute of U.S. national

and state expenditures on contraceptive counseling and supplies hints at the broader social costs of unwanted births. The research group estimated that every dollar spent to provide contraceptive services to women who might otherwise find it difficult or impossible to obtain them without help saved $4.40. In 1987, a total of $412 million was spent by federal and state governments for family planning. The study's authors calculated that without this funding about 1.2 million more unintended pregnancies would have occurred nationwide, leading to 509,000 mistimed or unwanted births and 516,000 abortions. Averting these unwanted pregnancies saved $1.8 billion that would otherwise have been spent on medical and nutritional services and on welfare payments.[97]

Children themselves are the other victims of restricted access. Studies indicate that the children born from an unwanted pregnancy are less likely to survive childhood and more likely than others their age to exhibit social and psychological problems. According to another study in rural Thailand, children wanted by one or neither parent were twice as likely to die before their first birthday as children wanted by both parents, even when accounting for other factors influencing child survival. Sociologist Ruth Dixon-Mueller suggests it "is possible that the widely noted higher mortality risks of infants born 'too early, too late, too many, or too close,' represent in some degree the disguised effects of the pregnancy having been unwanted."[98]

In *Born Unwanted: Developmental Effects of Denied Abortion*, Henry David assessed the psychological and social development of children in Czechoslovakia who were born to women denied abortions for that particular pregnancy. As opposed to children of planned and wanted pregnancies, these children had higher rates of behavioral and social adjustment problems and poorer performance in school.[99]

In the Third World, the lack of any kind of social support for the poor leaves women who carry unwanted pregnancies to term few options. Among them is the outright abandonment of children, which is increasing in developing and other countries. In Romania, for example, the number of abandoned and neglected children soared after abortion and

"In Romania, the number of abandoned and neglected children soared after abortion and contraception were outlawed."

contraception were outlawed. Foreign relief officials estimate that as many as 30,000 children were deposited in "human warehouses" by "thousands of families forced by the state to produce babies." According to Dr. Gheorghe Jipa, director of Bucharest's Victor Babes hospital, "even girls in the eighth grade were compelled to have a child when they became pregnant."[100]

Politics and the Mythology of Abortion

Voltaire once described history as a "set of fables agreed upon." Much the same can be said of the current public policy debate on abortion.[101]

The abortion controversy is often portrayed as a conflict between black and white views, with virtually every person firmly planted on one side or the other, either unswervingly against the right to choose abortion or unexceptionally for it. But the canvas of social morality is painted in every imaginable hue. Social discomfort with abortion often exists alongside the notion that abortion may best be viewed as a "lesser evil," and a necessary adjunct to public health and women's freedom of determination.

In most societies with liberal laws, public opinion polls bear this out. In the United States, for example, many surveys show that while the majority of people are to varying degrees uncomfortable with abortion, they are opposed to governmental interference in a woman's right to choose to end an unwanted pregnancy. Half the adults surveyed by the *New York Times* in 1989 supported the availability of abortion as specified by *Roe v. Wade*. Only 9 percent felt abortions should not be permitted at all. Likewise, four out of five Britons believe the decision on an individual's abortion should be a private matter between a woman and her physician. In developing countries where opinion surveys have been carried out, similar sentiments are evident, especially among urban dwellers and people with higher levels of income and education.[102]

Abortion politics, however, has been heavily influenced by those who

seek to completely ban abortions, except perhaps in cases where a woman's life is at stake. More and more, the public policy debate on abortion has been shaped by a series of myths, based on a kind of "moral absolutism" that is perpetuated by opponents of the right to choose abortion. This absolutist view is blind to the vast public health and social costs of restrictive abortion policies.

The first and most pervasive myth is that theological unanimity exists regarding a woman's right to end an unwanted pregnancy. In fact, religious doctrines have been interpreted differently at different periods in history and by different theologians.

Whether the religion in question is Catholicism, Islam, or Judaism, historical evidence indicates a diversity of opinion and practice regarding induced abortion. Early Christians condemned abortion, but did not view the termination of a pregnancy to be an abortion before "ensoulment," the definition of when life began in the womb. Ensoulment was then equated with "quickening," generally taken to mean the end of the first trimester. While the distinctions between "formed and unformed" fetuses were eliminated by Pope Pius IX in 1869, leading to "excommunication for abortion" even to save the life of the woman, therapeutic abortion on medical indications was not explicity or publicly condemned by any Roman Catholic authority before 1895. Today, Catholic canon law assigns embryonic life equal importance to that of the mother from the moment of conception.[103]

No other major religion has a consistent or unified position on this issue. Islamic law, for example, allows abortion through the fourth month of pregnancy, although few fundamentalist Muslim countries grant women this right. Within Judaism, the Orthodox and Hasidic sects prohibit abortion, while the Reform and Conservative branches do not.[104]

In spite of strict teachings, women of every faith have defied dogma in their reliance on abortion as a means of ending unwanted pregnancies. Illegal abortion is widespread throughout heavily Catholic Latin America, for example, and in the United States, 32 percent of all abortions are obtained by Catholic women.[105]

The second myth is that criminal laws will eliminate abortion, which provides the underlying justification for the modern-day crusade to ban this procedure. But why focus on banning on abortions when history has proved that laws cannot eliminate them, they can only make them more or less safe and costly?

Try as it might, no government has ever legislated abortion out of existence. Ceausescu's policies made preventing unwanted pregnancies virtually impossible. Contraceptives were outlawed. A special arm of the secret police force, Securitatae—dubbed the "Pregnancy Police"—oversaw monthly checkups of female workers. Pregnant women were monitored, married women who did not conceive were kept under surveillance, and a special tax was levied on unmarried people over 25 and on childless couples who could not give a medical reason for infertility. No Romanian woman under 45 with fewer than five children could obtain a legal abortion. Despite the law, both abortion and abortion-related mortality rates rose precipitously.[106]

Recent estimates indicate that more than 1.2 million clandestine abortions were performed each year in this country of 23 million, as compared with some 1.6 million legal procedures carried out annually in the United States, a country with 11 times as many people. One survey found that Bucharest Municipal Hospital alone dealt with 3,000 failed abortions in 1989; other sources indicate that well over 1,000 women died within that city each year due to complications of botched procedures. Legalization of abortion in Western Europe and the United States, by contrast, has produced the world's lowest abortion-related mortality rates. Moreover, in several European countries the widespread availability of family planning information and supplies has precipitated a fall in the number of abortions.[107]

Another myth holds that abortion is not a method of family planning, a notion that even abortion rights advocates have unwittingly helped to further. This myth serves a dual purpose. For one thing, it allows moral absolutists to perpetuate social discomfort about the practice of abortion. Second, it provides a convenient escape for politicians who want

to straddle both sides of the fence by supporting "family planning" but not abortion.

Ignoring abortion's critical role in the spectrum of family planning services is not only counterintuitive, it is counterproductive to the goal of reducing induced abortions.

Socially and ethically, abortion is generally recognized and used as a birth control method of last resort. From a purely medical standpoint, however, abortion is the most effective method of birth control. Measured against all methods of family planning except possibly sterilization, abortion has the lowest failure rate: a woman is assured of avoiding a birth after an induced abortion to an extent that no pill or barrier method of contraception offers.

Moreover, early abortion is one of the safest available methods of fertility control. Like any medication or medical intervention, birth control methods entail different risks of both side effects and method failure. Apart from personal preferences, differences in risks related to a woman's age and her medical and reproductive history, for example, may render a particular contraceptive method—the pill, IUD, Norplant—unsuitable for a given individual.

Properly performed, early abortions are among the safest of all surgical procedures. In the United States, for instance, an early abortion is 11 times safer than a tonsillectomy or than childbirth. Strict comparison of the risks shows that a woman who uses barrier methods backed up by early legal abortion faces the lowest risk to her health of any birth control strategy.[108]

Unfortunately, the "abortion is not an acceptable form of family planning" myth is so strong it has permeated every level of public policy. In the United States, it has been used as a justification for denying poor women federal funding of abortions, even in cases of rape and incest. The Reagan and Bush administrations have used this dubious reasoning as the basis for severing ties between publicly funded providers of contraceptives and providers of abortion.[109]

"Contraceptives reduce, but do not eliminate, the need for abortion as a backup to their own failure."

Without access to abortion, it is impossible for a woman to have total control over her own fertility. Demographers have calculated that in the absence of contraception, each woman would require an average of 9 or 10 abortions in her life to reduce the number of births from seven (the average number in sub-Saharan Africa, for example) to two (the industrial-country average). Contraceptives reduce, but do not eliminate, the need for abortion as a backup to their own failure: 7 out of 10 women using a 95-percent effective method of birth control would still require at least one abortion in their lifetimes to achieve a two-child family.[110]

This separation of abortion from family planning is a direct abrogation of basic human rights as recognized by the United Nations. The U.N. General Assembly declared in 1968 that it is the basic right of couples to "decide freely and responsibly on the number and spacing of their children." Quite plainly, without access to abortion as a backup to contraceptive failure or to end an unwanted pregnancy conceived in the absence of contraception, a woman cannot exercise this right.[111]

Nevertheless, opponents of abortion rights have successfully used this myth to undercut both access to and research on abortion at the international level over the past two decades. Despite the U.N. Declaration, neither the United Nations Population Fund (UNFPA) nor the World Health Organization—the U.N. agencies that deal, respectively, with family planning and public health—recognize abortion as a method of family planning. Indeed, the climate is such that representatives of these two organizations are reluctant to discuss abortion at all.

This myth was also exploited in the politicking by U.S. groups that led the Reagan administration to dramatically restructure its funding of international family planning. A turnabout in U.S. policy was announced at the 1984 International Conference on Population in Mexico City. Under the new policy, private voluntary groups providing abortion services or counseling as part of their programs were prohibited from receiving U.S. funds unless they signed a contract promising to end these activities. Although a few, such as the International Planned Parenthood Federation, could afford to refuse U.S. contributions, most smaller organizations were compelled by financial need to sign on.

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Apart from curtailing already limited access to safe abortion services throughout the Third World, the policy has other far-reaching and insidious effects on women's health. The interpretation of "abortion services" has been read by both the Reagan and Bush administrations to prohibit giving advice and information about medical indications for abortion and about where it can be legally obtained, as well as lawful lobbying to preserve, expand, or create the right to safe legal abortion. Furthermore, the policy enforces a "gag rule" forbidding even abortion research and data-gathering, further constraining efforts to combat illegal abortion.[112]

Similarly, abortion politics was responsible for the withdrawal of U.S. funds from UNFPA, ostensibly due to its links with China. For about a decade, the Chinese government employed a system of incentives and disincentives encouraging couples to limit themselves to one child. The voluntary nature of the program was severely compromised by the setting of regional population quotas. To meet their targets, some local officials employed coercion, forcing women to have abortions or accept IUDs, for example.[113]

Using UNFPA's monetary and technical contribution to China's censuses as a wedge, opponents of family planning assistance convinced the Reagan administration to end U.S. support of the agency. As with IPPF, the loss of U.S. funds has hampered UNFPA's programs. The Chinese government subsequently relaxed its one-child family policy. Yet President Bush has refused to rethink the Mexico City policy or to reverse the decision on UNFPA, a move that would have a beneficial impact on maternal and child health worldwide.[114]

But the concern with human rights abuses in China as justification for not funding UNFPA is belied by more recent events. Bush recently announced reinstatement of China's "most favored nation status"—granting the lowest possible tariffs on imports into the United States—which was originally suspended in the aftermath of China's brutal crackdown on prodemocracy demonstrators in June 1989.[115]

According to the *New York Times*, the White House, under intense pres-

sure from U.S. companies with interests in China, concluded that the "potential harm to American companies and to reform-minded Chinese outweighed a desire to register disapproval of Beijing's human rights." What about the potential harm to millions of women of limiting reproductive health care or making it completely unavailable? Don't their rights outweigh the benefits of politicizing family planning?[116]

Abortion myths allow politicians to avoid dealing with the effects on public health and reproductive freedom of limits on the access to safe procedures. Moreover, absolutist arguments against abortion rights provide cover to those groups opposed to or threatened by the empowerment of women in full possession of their reproductive rights. Looking behind the myths reveals the genuine tensions in the abortion debate.

The Power of Abortion Rights

What, then, is the abortion debate really about? In the words of abortion rights activist and medical doctor Warren Hern, it is a struggle over "who runs our society...self-determination...individual choice, personal freedom and responsibility." This is particularly and painfully true for women. The struggle for abortion rights cannot be separated from the broader struggles of women to gain equality in all facets of life, from family and domestic issues to parity in the workplace.[117]

In *Births and Power: Social Change and the Politics of Reproduction*, anthropologist W. Penn Handwerker observes that while individual births are important to particular families or communities, on the whole births are "significant within societies...insofar as they cement or change power relationships." In societies where women's access to resources is limited, childbearing is often their most secure investment activity. By proving her fertility, a woman may gain and keep a husband; by bearing many children, she simultaneously expands her family's economic power and guarantees economic support in retirement. In sum, fertility is one path to power.[118]

But as economies evolve, so do families. Educational attainment

becomes the criteria for advancement, and children become more expensive to raise. New opportunities for employment and new sources of empowerment open up for women. Changes in property rights and family laws favoring greater access to resources for women usually hasten this transition. Inevitably, women seek ways to limit their fertility, in part through contraception or abortion.

Increased competition for employment and income as well as changes in the structure of the work force alter the power relationships among various groups, an evolution that is well under way in the United States and throughout Western Europe. As roles change, tensions arise between the sexes, in much the same way as they develop between racial and ethnic groups competing in similar circumstances. But conflicts over the roles of men and women in society are complicated by religious and social proscriptions against expressions of sexuality outside its role in procreation.

Individuals or groups that feel threatened by these changes may and often do attempt to retain the status quo. This pits them directly against women who, in weighing childbearing against other opportunities, seek to exercise control over when and if to become a parent. As Handwerker notes, "The issue is not whether abortion is 'right' or 'wrong.' What is 'right' or 'wrong' varies with resource access...and power relations....Abortion may improve or optimize resource access....Thus, the issue is choice. The conflict...is intense because the issue is whether one group can deny to another the fundamental right to seek a better life."[119]

His assertions are borne out in an examination of how the "rights and wrongs" of abortion politics have changed over time. A late-nineteenth century abortion campaign in the United States, the initial attempt to regulate what was a widespread practice in that country, was led by doctors. They were concerned not about the moral or ethical implications of abortion, but about the extent to which it was being performed by practitioners not sanctioned by the medical community. Of no little import was the fact that these lay abortion providers also channeled income away from physicians. Although the public focus of

the campaign was on safeguarding m. .rnal health, the driving force was the desire of the medical community to retain power and income.[120]

In the postwar United States, sexuality was the "wrong." Rosalind Petchesky, director of women's studies at Hunter College in New York, recalls being a teenager in the fifties in Tulsa, Oklahoma, when "the abortion experience was of course steeped in shame, but it had little to do with harm to the fetus. My generation of [women] knew nothing about the fetus. Like the pregnancy scare and 'unwed motherhood,' abortion meant shame only because it connoted sex—you'd 'done it' without the sanctity of marriage."[121]

Today, women's reproductive rights are pitted against yet another icon, the fetus. That a pregnant woman has within her body an organism with the potential of achieving personhood, barring miscarriage, is not disputable. That a single-celled blastocyst, a 2-week-old embryo, a 10-week-old fetus, or a 20-week-old fetus all have "rights" equal to a child already born, and that these "rights" are preeminent over the reproductive decisions of the woman who carries that potential person, is very much in dispute. There is neither cultural nor theological unity on the issue of these rights.

Each year, millions of individual women around the world of all cultural, religious, economic, and educational backgrounds come to the conclusion that, for whatever personal reason or constellation of causes, they cannot carry a pregnancy to term. Where abortion services are safe and affordable, by far the largest share of women terminate their pregnancies within the first trimester. (See Table 8.) Where those services are scarce or too expensive, they may delay until later stages.

What a growing collection of social science studies from around the world makes clear, however, is that each woman weighs the decision in the context of her own sense of fairness, ability to care for a child, and personal circumstances and needs. Yet opponents of abortion rights seek to impose on all women their vision that a fertilized egg and a just-born child each have equal rights in the world.

Table 8: Legal Abortions by Weeks of Gestation, Selected Countries, Most Recent Year

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Country	8 weeks or less	9–12 weeks	13–16 weeks	17 weeks or more
		(percent distribution)		
Canada	33	55	8	3
Denmark	41	57	1	1
Japan	52	41	[illegible]	3
Sweden	41	55	[illegible]	1
United States	51	40	5	4

Distributions do not add to 100 due to rounding.

Source: Stanley K. Henshaw, "Induced Abortion: A World Review, 1990," *Family Planning Perspectives*, March/April 1990.

The biggest irony lies in the fact that groups opposed to abortion rights have consistently fought against the programs most likely to prevent the greatest number of abortions. The term "pro-life" translated plainly into "anti-family planning" in California, where groups pressured the state to slash funding from 500 family planning clinics that provide health care to the poor. According to one study, the funding cuts—the $24 million budget was originally slashed to zero and then restored to $20 million—would have led to nearly 86,000 more pregnancies in California, at least half of which would have been aborted. Clearly, abortion itself is not the only target of attack.[122]

It is not necessary to read between the lines of the magazines and newsletters of organizations working to ban abortions to know that these same groups also oppose modern methods of contraception that prevent unwanted pregnancy. In the words of Father Paul Marx, president of HLI, the use of contraceptive pills and IUDs simply represents a method of "silent abortion" and is a "chief cause of the present moral chaos." Judie Brown, president of the American Life Lobby, has stated that her organization opposes "use of the pill or IUD."[123]

"Organizations working to ban abortions also oppose modern methods of contraception that prevent unwanted pregnancy."

Curiously, once a child is born, he or she might not get so much attention from these crusaders. The commitment of the so-called pro-life movement to social services for disadvantaged children is hardly evident. Where, for example, is the international outcry over the thousands of children in Romanian warehouses? In the United States, there is no simultaneous push among opponents of abortion for adequate prenatal care, maternal and infant health care, day-care services, or increased access to contraceptives among groups most at risk of unwanted pregnancy. Opponents of abortion rights have been the most vociferous lobbyists against reauthorization of Title X, the U.S. Family Planning Act, even though studies show that some 5.3 million low-income women and 3.4 million teenage girls need medically supervised reproductive health care but cannot now attain it.[124]

In developing countries, the issue of "choice" is often not so much about a "better" life as it is about the fundamental right to life itself. In societies where cultural constraints on women are strong and they remain economically and politically subservient to men, reproduction is simply one among many aspects of their lives in which women lack self-determination.

From childhood well into their reproductive years the power of individual women—to determine at what stage they become sexually active, whom they are bonded to, when sex will take place, or when and how to bear children—is low, if it exists at all. Women may be forced into unwanted sexual contact and unwanted pregnancies through violent attack, sexual coercion, or the more socially acceptable arranged and often forced marriage. Once wed, the decision on the timing and number of births is more often the prerogative of a woman's husband and family members than her own. Even where the means to prevent pregnancy are available to women in the Third World (and this is relatively rare), lack of spousal support often leads to high rates of contraceptive failure.

Equally reprehensible is the subjugation of women's desires to those of state-enforced pronatalism. Nicolae Ceausescu is only one among many heads of state who have relegated women to reproduction in the

interest of "national security." As demographer Judith Bruce states quite plainly, for women who by no choice of their own face unwanted pregnancy, "abortion is the final exit from a series of enforced conditions." For a large share of the millions of women whose only option is illegal abortion, that final exit is death.[125]

From Crime to Common Sense

The impact of unwanted pregnancy embraces but extends beyond the individual to encompass broader objectives, including the struggle for women to become equal partners in society and efforts to improve health among women and children. Less well recognized but equally important is the role that abortion, whether legal or illegal, plays in the transition from high to low fertility.

An international consensus among a diverse body of policymakers already exists on the adverse effects of rapid population growth on economic performance, the environment, family welfare, health, and political stability. For reasons of politics many of these same leaders shy away from or ignore the role played by abortion in slowing birth rates. Yet as public health researchers Stephen Mumford and Elton Kessel note, "no nation wanting to reduce its growth to less than 1 percent can expect to do so without the widespread use of abortion." Policymakers who call for slower population growth while remaining silent on the issue of access to safe abortion are willing to achieve this goal at a high price in women's lives.[126]

The tremendous social gains to be reaped from eliminating illegal abortions cannot be ignored. First among them is a reduction in abortion-related maternal mortality of at least 25 percent and in related illnesses of far more. Reductions in illegal abortions and unwanted pregnancies would save billions in social and health care costs, freeing these resources for other uses.

Only by increasing access to family planning information and supplies, offering couples a wider and safer array of contraceptives, and improv-

ing the delivery of comprehensive reproductive health care services can the number of abortions be reduced. Some countries have already chosen this commonsense approach. Italy, for example, now requires local and regional health authorities to promote contraceptive services and other measures to reduce the demand for abortion, while Czech law aims to prevent abortion through sex education in schools and health facilities and through the provision of free contraceptives and associated care. Some countries now require postabortion contraceptive counseling and education; some mandate programs for men as well.[127]

Many of these efforts registered success quickly. On the Swedish Island of Gotland, for example, abortions were nearly halved in an intensive three-year program to provide information and improved family planning services. Similar results have been seen in France and elsewhere.[128]

The steps needed to make these gains universal are plain. Decriminalization and clarification of laws governing abortion would secure the rights of couples around the world to plan the size and spacing of their families safely. Policies that put abortion into the context of public health and family planning would immediately reduce the incidence of illegal operations. Removal of the administrative, financial, and geographic roadblocks to access not only to safe abortions but to family planning services in general would reduce overall abortion rates and further improve public health.

While the way is evident, the will is lacking. The missing ingredient is political commitment. Natural allies—representatives of groups concerned with women's rights, environmental degradation, family planning, health, and population growth—have failed to mount a concerted effort to dispel abortion myths. And despite the overwhelming evidence of the high human and social costs incurred by restrictive laws, abortion politics remains dominated by narrowly drawn priorities that reflect only one set of beliefs and attitudes. Respect for both ethical diversity and factual accuracy is a precondition for a truly "public" policy on the question of abortion.

Reforming restrictive laws may stir opposition. Failing to do so exacts an emotional and economic toll on society—and sentences countless women around the world to an early grave.

Notes

1. Henry David, Director, Transnational Family Research Institute, Bethesda, Md., private communication, February 28, 1990.

2. Since January 1990, several other countries have liberalized their abortion laws, including Belgium, Bulgaria (which made abortion available on request in the first trimester), and Malaysia; Stanley K. Henshaw, Deputy Director of Research, Alan Guttmacher Institute, New York, private communication, June 7, 1990.

3. Stanley K. Henshaw, "Induced Abortion: A World Review, 1990," *Family Planning Perspectives*, March/April 1990.

4. Abortion-related mortality rates in the United States from W. Cates et al., "Legalized Abortion: Effect on National Trends of Maternal and Abortion-Related Mortality," *American Journal of Obstetricians and Gynecologists*, Vol. 132, 1978; Marek Okolski, "Abortion and Contraception in Poland," *Studies in Family Planning*, November 1983.

5. Henshaw, private communication.

6. A comprehensive discussion of abortion laws and trends worldwide can be found in Henshaw, "Induced Abortion," and in Rebecca J. Cook, "Abortion Laws and Policies: Challenges and Opportunities," *International Journal of Gynecology and Obstetrics*, Supplement 3, 1989; see also Rebecca J. Cook and Bernard M. Dickens, "International Developments in Abortion Laws: 1977–88," *American Journal of Public Health*, October 1988.

7. Ruth Dixon-Mueller, "Abortion Policy and Women's Health in Developing Countries," *International Journal of Health Services*, Vol. 20, No. 2, 1990.

8. Cook, "Abortion Laws and Policies."

9. Ibid.; Henshaw, "Induced Abortion."

10. Cook, "Abortion Laws and Policies"; Henshaw, "Induced Abortion."

11. Cook, "Abortion Laws and Policies"; Henshaw, "Induced Abortion"; India's population from Population Reference Bureau, *1990 World Population Data Sheet* (Washington, D.C.: 1990).

12. Henshaw, "Induced Abortion."

13. Ibid.

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14. Tomas Frejka, *Induced Abortion and Fertility: A Quarter Century of Experience in Eastern Europe*, Center for Policy Studies, Working Paper No. 99 (New York: The Population Council, 1983); Tomas Frejka, "Induced Abortion and Fertility," *International Family Planning Perspectives*, December 1985; Cook, "Abortion Laws and Policies"; Henshaw, "Induced Abortion."

15. Cook, "Abortion Laws and Policies"; National Abortion Rights Action League, "Post-*Webster* Anti-Choice Legislative Activity," Washington, D.C., memorandum, March 29, 1990.

16. D.K. Piragoff, Canadian Department of Justice, Ottawa, Canada, private communication, June 7, 1990.

17. Dixon-Mueller, "Abortion Policy and Women's Health in Developing Countries"; "Deaths from Abortion," in Erica Royston and Sue Armstrong, eds., *Preventing Maternal Deaths* (Geneva: World Health Organization (WHO), 1989).

18. "Deaths from Abortion," in Royston and Armstrong, *Preventing Maternal Deaths.*

19. Katie McLaurin, "Issues of Access to Abortion: Policy, Law and Reality," presentation at the American Public Health Association Annual Meeting, Chicago, October 22–26, 1989.

20. Ibid.; Renee Holt, "Abortion: Law, Practice, and Project Possibilities in Zambia," prepared for Columbia University Center for Population and Family Health, New York, September 25, 1989.

21. Holt, "Abortion in Zambia."

22. Julie DeClerque, "Unsafe Abortion Practices in Subsaharan Africa and Latin America: A Call to Policymakers," presentation at Panel on Culture, Public Policy, and Reproductive Health, Association for Women in Development Conference, Washington, D.C., November 17–19, 1989; Holt, "Abortion in Zambia."

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JODI L. JACOBSON is a Senior Researcher at the Worldwatch Institute. She is the author of several Worldwatch Papers and coauthor, since 1987, of *State of the World*. Her research interests include the relationship between human population and the environment, reproductive health and family planning, and women and development issues. Ms. Jacobson is a graduate of the University of Wisconsin-Madison, where she studied economics and environmental science.

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