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Abortion: Facts & Figures

Introduction

Abortion is a sensitive and contentious issue with religious, moral, cultural, and political dimensions. It is also a public health concern in many parts of the world. More than one-quarter of the world's people live in countries where the procedure is prohibited or permitted only to save the woman's life. Yet, regardless of legal status, abortions still occur, and nearly half of them are performed by an unskilled practitioner or in less than sanitary conditions, or both.

Abortions performed under unsafe conditions claim the lives of tens of thousands of women around the world every year, leave many times that number with chronic and often irreversible health problems, and drain the resources of public health systems. Often, however, controversy overshadows the public health impact.

This guide provides data and other information to help shed light on the public health aspects of unsafe abortion.

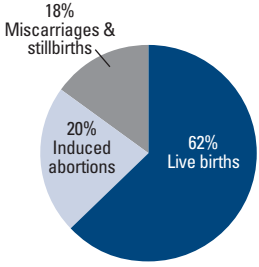
Overview

The World Health Organization (WHO) estimates that worldwide 210 million women become pregnant each year and that about two-thirds of them, or approximately 130 million, deliver live infants.[1] The remaining one-third of pregnancies end in miscarriage, stillbirth, or induced abortion.[2]

Of the estimated 42 million induced abortions each year, nearly 20 million are performed in unsafe conditions and/or by unskilled providers and result in the deaths of an estimated 47,000 girls and women.[3] This represents about 13 percent of all pregnancy-related deaths.[4] Almost all unsafe abortions take place in developing countries, and this is where 98 percent of abortion-related deaths occur.[5]

Unsafe abortion

WHO defines an unsafe abortion as a procedure for terminating an unintended pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both. When abortion is performed by qualified people using correct techniques in sanitary conditions, it is very safe. The death rate from legal induced abortion in the United States, for example, is less than one per 100,000 procedures.[6]



Worldwide, nearly one in 10 pregnancies ends in unsafe abortion.[7] But this is a global estimate, combining countries where abortion is safe and legal with those where it is restricted and often unsafe. In low-income countries, women have an average of one unsafe abortion during their reproductive lives.[8]

References

1-4 World Health Organization (WHO), *Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2003*, 5th ed. (2007).

5 Iqbal Shah and Elisabeth Ahman, "Unsafe Abortion in 2008: Global and Regional Levels and Trends," *Reproductive Health Matters* 18, no. 35 (2010).

6-7 WHO, *Unsafe Abortion*.

8 Iqbal Shah and Elisabeth Ahman, "Age Patterns of Unsafe Abortion in Developing Country Regions," *Reproductive Health Matters* 12, no. 24 (supplement, 2004).

Incidence of Unsafe Abortion

- Worldwide, one in five pregnancies (20 percent) ends in abortion, and one in 10 pregnancies ends in unsafe abortion.[1] (See Appendix II on how unsafe abortions are counted.)
- An estimated 42 million abortions are performed each year; 20 million of them are outside the legal system and considered unsafe because they are performed by people who lack the necessary skills or in places that do not meet minimal medical standards, or both.[2]
- An estimated 358,000 girls and women die from pregnancy-related causes each year, almost all of them in the developing world.[3] About 47,000 of these deaths are due to unsafe abortion.[4]
- Globally, abortion-related deaths account for 13 percent of all pregnancy-related deaths, but the percentage can be much higher at country levels.[5] A 2000 study estimated that unsafe abortions were responsible for nearly one-third of maternal deaths in West Africa, and WHO reports that in the countries of sub-Saharan Africa unsafe abortions are responsible for as much as 50 percent of maternal deaths.[6]
- Women in developed and developing regions of the world turn to abortion at similar rates; annually, 29 abortions are performed per 1,000 women in developing countries, compared with 26 per 1,000 women in developed countries.[7]
- In developing countries, two in five unsafe abortions occur among women under age 25, and about one in seven women who have unsafe abortions is under 20.[8]
- In Africa, about one-quarter of the unsafe abortions are among teenagers (ages 15 to 19), a higher proportion than in any other world region.[9]

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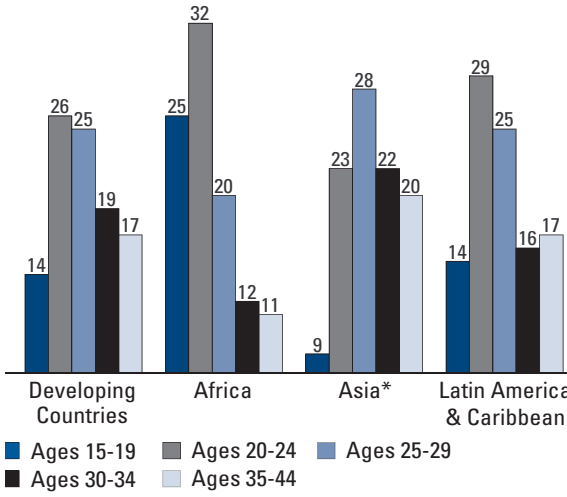
Estimates of Annual Incidence of Unsafe Abortions and Unsafe Abortion Rates, 2008

	Number of unsafe abortions	Unsafe abortion rate (per 1,000 women ages 15-44)
World	22 million	14
Developed countries	360,000	1
Developing countries	21.2 million	16
Sub-Saharan Africa	5.5 million	31
Africa	6.2 million	28
Eastern Africa	2.4 million	36
Middle Africa	930,000	36
Northern Africa	900,000	18
Southern Africa	120,000	9
Western Africa	1.8 million	28
Asia	10.8 million	11
Eastern Asia (excluding Japan)	negligible	negligible
South Central Asia	6.8 million	17
Southeastern Asia	3.1 million	22
Western Asia	830,000	16
Europe	360,000	2
Eastern Europe	360,000	5
Northern Europe	negligible	negligible
Southern Europe	negligible	negligible
Western Europe	negligible	negligible
Latin America/ Caribbean	4.2 million	31
Caribbean	170,000	18
Central America	900,000	29
South America	3 million	32
North America	negligible	negligible
Oceania (excluding Australia and New Zealand)	18,000	8

Source: Iqbal Shah and Elisabeth Ahman, "Unsafe Abortion in 2008: Global and Regional Levels and Trends," *Reproductive Health Matters* 18, no. 35 (2010).

Percent of Unsafe Abortions by Age Group, Around Year 2000



* Excludes Eastern Asia (China, North Korea, South Korea, and Mongolia).

Note: Figures may not add to 100 due to rounding.

Source: Iqbal Shah and Elisabeth Ahman, "Age Patterns of Unsafe Abortion in Developing Country Regions," *Reproductive Health Matters* 12, no. 24 (supplement, 2004).

The ages at which women have unsafe abortions differ markedly across regions.

- Nearly 60 percent of women in sub-Saharan Africa who have unsafe abortions are younger than 25, and 25 percent are still in their teens.[10]
- In Asia, 70 percent of unsafe abortions are among women 25 and older; many of them already have children and want to limit family size.[11]
- In Latin America and the Caribbean, more than half of unsafe abortions occur among women who are in their 20s, suggesting that women in this region use unsafe abortion to space births and limit family size.[12]

Trends in unsafe abortions

The annual number of unsafe abortions is increasing due to the growing number of women of reproductive age globally, according to the World Health Organization. The WHO estimated 19.7 million unsafe abortions in 2003 and 21.6 million in 2008.

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However, the rates of unsafe abortions (the number per 1,000 women of reproductive age) remained largely unchanged during the period.

Incidence of Unsafe Abortion per 1,000 Women Ages 15-44, 2003 and 2008

	2003	2008
Africa	**29**	**28**
Eastern Africa	39	36
Western Africa	28	28
Middle Africa	26	36
Northern Africa	22	18
Southern Africa	18	9
Asia	**11**	**11**
Southeastern Asia	23	22
South Central Asia	18	17
Western Asia	8	16
Latin America/ Caribbean	**29**	**31**
South America	33	32
Central America	25	29
Caribbean	16	18

Sources: World Health Organization (WHO), *Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2003,* 5th ed. (2007); and Iqbal Shah and Elisabeth Ahman, "Unsafe Abortion in 2008: Global and Regional Levels and Trends," *Reproductive Health Matters* 18, no. 35 (2010).

The WHO estimates that 47,000 women died due to complications of unsafe abortion in 2008, down from 66,500 in 2003. Some of the decline, according to the WHO, appears to be from more women using medical abortion pills to terminate pregnancy on their own.[13]

References

1-2 World Health Organization (WHO), *Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2003,* 5th ed. (2007).
3 WHO, UNICEF, UNFPA, The World Bank, *Trends in Maternal Mortality: 1990 to 2008* (2010).
4 Iqbal Shah and Elisabeth Ahman, "Unsafe Abortion in 2008: Global and Regional Levels and Trends," *Reproductive Health Matters* 18, no. 35 (2010).
5 WHO, *Unsafe Abortion.*
6 WHO, *Communicating Family Planning in Reproductive Health* (1997).
7 Susheela Singh et al., *Abortion Worldwide: A Decade of Uneven Progress* (Guttmacher Institute, 2009).
8-12 WHO, *Unsafe Abortion.*
13 Shah and Ahman, "Unsafe Abortion in 2008."

Maternal Health

- An estimated 358,000 girls and women die of pregnancy-related causes each year, about 1,000 every day, and many times that number suffer long-term injuries and disabilities.[1]
- 99 percent of all maternal deaths occur in the developing world.[2]
- Of the 358,000 maternal deaths in 2008, most of them occured in Africa (207,000) and Asia (139,000). About 3 percent of maternal deaths were in Latin America and the Caribbean (9,200), and less than 1 percent (1,700) were in the developed countries.[3]
- Pregnancy-related deaths are often expressed as a ratio of deaths per 100,000 live births, allowing for comparison among countries and regions. The global ratio is 260 maternal deaths per 100,000 live births, but regional ratios range from 640 per 100,000 live births in sub-Saharan Africa to 23 per 100,000 live births in North America.[4]
- Direct causes of pregnancy-related deaths worldwide are:[5]

Severe bleeding	25%
Infection	15%
Unsafe abortion	13%
Hypertensive disorders	12%
Obstructed labor	8%
Other	8%

- 20 percent of pregnancy-related deaths are due to indirect causes, including diseases such as malaria, anemia, HIV/AIDS, and cardiovascular disease.[6]
- A woman in sub-Saharan Africa has a 1 in 31 chance of dying from a pregnancy-related cause, compared with a woman in North America, whose risk is 1 in 2,200.[7]
- Complications of pregnancy and childbirth are a leading cause of death and disability among women of reproductive age in most developing countries. For teenagers, these are the leading cause of death.[8]

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- Teenage girls are twice as likely as women over 20 to die of complications from pregnancy and childbirth. Girls under the age of 15 are five times as likely as women in their twenties to die of these complications.[9]

Maternal Mortality

	Maternal mortality ratio, 2008*	Lifetime chance of dying from maternal causes**
World	260	1 in 140
Developed countries	17	1 in 3,600
Developing countries	290	1 in 120
Africa	590	1 in 36
Northern Africa (including Sudan)	270	1 in 120
Sub-Saharan Africa	640	1 in 31
Latin America/ Caribbean	85	1 in 490
North America	23	1 in 2,200
Europe	16	1 in 4,200
Asia	180	1 in 230
Eastern Asia	39	1 in 1,400
South Central Asia	270	1 in 120
Southeastern Asia	170	1 in 260
Western Asia	66	1 in 460
Oceania	100	1 in 410

* Maternal deaths per 100,000 live births.

** Lifetime risk reflects a country or region's maternal mortality as well as its fertility rate. Risk is greater for women in areas of high fertility because they are pregnant more often and therefore face the risks of pregnancy more often than women in areas of low fertility.

Sources: WHO, UNICEF, UNFPA, The World Bank, *Trends in Maternal Mortality: 1990 to 2008* (2010); and Population Reference Bureau, *The World's Women and Girls 2011 Data Sheet*.

References
1-4 WHO, UNICEF, UNFPA, The World Bank, *Trends in Maternal Mortality: 1990 to 2008* (2010).
5 WHO, *World Health Report 2005*.
6 WHO, *Maternal Mortality*, Fact Sheet No. 348 (November 2010).
7 WHO, *Trends in Maternal Mortality*.
8-9 UNFPA, *Giving Birth Should Not Be a Matter of Life and Death* (2010).

Safe Abortion

Abortion is safest when performed early in a pregnancy. Safe methods of abortion used during the **first trimester (12 weeks)** of pregnancy are vacuum aspiration, dilation and curettage, and medication abortion. (The length of a pregnancy is measured from the first day of a woman's last menstrual period.) In some countries, women within a few weeks of a missed menstrual period can undergo a procedure called menstrual regulation, which uses vacuum aspiration or medication to induce menstruation; the procedure is often performed without testing for pregnancy.

Vacuum aspiration

- The procedure removes the contents of the uterus by applying suction through a tube, called a cannula, inserted through the cervix into the uterus.
- Either an electric pump or a manual aspirator is used to suction the uterine contents; with either method it is usually performed on an outpatient basis.
- The procedure is widely used through 12 weeks of pregnancy, and the more-experienced providers can use it safely through 15 weeks.
- As with any abortion procedure, side effects include abdominal cramping or pain and bleeding.
- The procedure is also known as suction abortion, vacuum curettage, suction curettage, and mini-suction.

Dilation and curettage (D&C)

- This method uses mechanical dilators to open the cervix and metal instruments called curettes to scrape the uterine walls.
- The procedure is typically performed under heavy sedation or general anesthesia and has a higher risk of complications (bleeding, infection, and perforation) than other methods.
- WHO advises that this method be used only when vacuum aspiration or medical methods of abortion are not available.
- It is also known as sharp curettage and surgical abortion.

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Medication abortion

- This method uses one or more drugs, most commonly mifepristone (known as RU486) and misoprostol (also known as Cytotec), to expel the contents of the uterus.
- The procedure usually requires at least two outpatient visits, and the abortion is almost always complete within a week. In 2 percent to 5 percent of cases, the abortion is incomplete and vacuum aspiration or D&C is required.
- Mifepristone with misoprostol is used through nine weeks of pregnancy, and its safety and effectiveness between nine and 12 weeks is being studied.
- Most women experience abdominal cramping and bleeding. Side effects include vomiting, nausea, diarrhea, chills, and fever.
- Misoprostol is sometimes used alone, usually where mifepristone is not available, but it appears to be less effective than the combination.
- Other terms for this procedure are medical, pharmaceutical, or pharmacological abortion; RU486; and the abortion pill.

For pregnancies of **more than 12 completed weeks** since the woman's last menstrual period, the two most widely used abortion methods are dilation and evacuation (D&E) and medication abortion.

Dilation and evacuation (D&E) involves dilating the cervix and using a combination of suction and instruments to remove contents of the uterus.

Reference

WHO, *Safe Abortion: Technical and Policy Guidance for Health Systems* (2003).

Unsafe Abortion

The World Health Organization defines an unsafe abortion as a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards, or both.[1]

Where abortion is restricted by law, girls and women who can afford to pay often can find a private physician, or sometimes a nurse or midwife, willing to perform a safe abortion. Women who cannot afford or cannot access these services may try to abort the pregnancy themselves, or they may turn to unskilled practitioners (including traditional or religious healers, homeopaths, and herbalists) who use a variety of methods.

Unsafe methods include:

- Swallowing large doses of drugs, such as antimalarials or oral contraceptives (birth control pills).
- Inserting a sharp object into the uterus.
- Drinking or flushing the vagina with caustic liquids such as bleach.
- Physical abuse such as jumping or falling from high places, vigorous dancing, or sustained and vigorous sexual intercourse over long periods.
- Prolonged and hard massage to manipulate the uterus, or repeated blows to the stomach.[2]

Not all illegal abortions are unsafe. For example, in some unsanctioned clinics in India, trained professionals perform abortions that may be medically safe but are technically illegal due to the unregistered status of the clinic.

Increasingly, women around the world can purchase medications, including misoprostol, on the black market and from other insecure and unreliable sources to induce abortions. Sometimes, these medications are unregulated and may be labeled incorrectly. Without the benefit of medical advice or attention, women may be unaware of how far along their pregnancies are and may ingest these medications well after it is safe to induce an abortion or in incorrect dosages.

An estimated 25 percent of the girls and women who have unsafe abortions suffer complications that

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need medical attention.[3] If left untreated, these complications can be fatal. Spontaneous abortion or miscarriage can result in the same serious complications.

Here are some of the serious conditions that require prompt medical attention:

Incomplete abortion occurs when some tissue remains in the uterus.

- Symptoms include abdominal pain; vaginal bleeding; and a soft, enlarged uterus.
- Treatment involves removing the remaining tissue in the uterus with vacuum aspiration or, if that is not available, with dilation and curettage. (See Safe Abortion.)

Infection of uterine tissue can result from use of contaminated instruments or when tissue remains in the uterus.

- Symptoms include those of incomplete abortion as well as fever, chills, foul-smelling vaginal discharge, and uterine tenderness. Most often, symptoms appear two to three days after the abortion.
- Treatment involves antibiotics and vacuum aspiration if needed to remove the remaining tissue in the uterus.

Heavy bleeding results when an incomplete abortion is not treated or from some abortion techniques such as dilation and curettage (see Safe Abortion) or insertion of sticks or other objects into the cervix.

- Heavy bleeding also can be triggered by toxic reactions caused by herbs, drugs, or chemicals that are swallowed or placed in the vagina.
- Treatment may require removing remaining tissue in the uterus and administration of drugs to stop the bleeding, intravenous fluid replacement, and, in severe cases, blood transfusion or surgery.

Uterine perforation can occur when a sharp object or instrument is inserted into the uterus.

- Other organs also can be injured, including the cervix, ovaries, bowel, bladder, and rectum.

- Observation and antibiotics may be all that is needed as treatment, but in more severe cases, surgery may be needed to repair damage to bowel, blood vessels, or other organs.

Untreated, these complications can cause disabilities and chronic conditions that include: chronic pelvic pain; pelvic inflammatory disease, an infection of the reproductive organs (see Glossary); and infertility.[4]

References

1 Iqbal Shah and Elisabeth Ahman, "Unsafe Abortion in 2008: Global and Regional Levels and Trends," *Reproductive Health Matters* 18, no. 35 (2010).
2 Susheela Singh et al., *Abortion Worldwide: A Decade of Uneven Progress* (Guttmacher Institute, 2009).
3 Shah and Ahman, "Unsafe Abortion in 2008."
4 WHO, *Safe Abortion: Technical and Policy Guidance for Health Systems* (2003).

Post-Abortion Care

- In some areas of the developing world, as many as half of the admissions to hospital gynecological wards are women needing treatment after unsafe abortions.[1]
- Women who seek medical treatment after an unsafe abortion may require extended hospital stays, ranging from several days to several weeks. This consumes hospital resources, including personnel time, bed space, medications, and blood supply.
- Studies show that hospitals in some developing countries spend as much as 50 percent of their budgets to treat complications of unsafe abortion.[2]

International health organizations generally recognize post-abortion care to include:

- **Emergency treatment** for complications of abortion or miscarriage.
- **Counseling** to identify and respond to women's emotional and physical health needs and other concerns.
- **Contraceptive and family planning services** to help women prevent an unwanted pregnancy or unsafe abortion or to practice birth spacing.
- **Management** of sexually transmitted infections.
- **Reproductive and other health services** that are provided on-site or through referrals to other accessible facilities.[3]

The 1994 International Conference on Population and Development, in its consensus Programme of Action, called for all women to have access to treatment for abortion-related complications and post-abortion counseling, education, and family planning services, regardless of the legal status of abortion. (See Appendix I.)

References
1 Center for Reproductive Rights, *Breaking the Silence: The Global Gag Rule's Impact on Unsafe Abortion* (2003).
2 WHO, *Communicating Family Planning in Reproductive Health* (1997).
3 Postabortion Care Consortium Community Task Force, *Essential Elements of Postabortion Care: An Expanded and Updated Model* (July 2002).

Unintended Pregnancies

- Around 80 million pregnancies each year are unintended and more than one-half result in induced abortion.[1]
- About one-third (26.5 million) of unintended pregnancies each year result from incorrect use or failure of contraceptives.[2]

Unintended Pregnancies by Region, 2008

Region	% of unintended pregnancies
Africa	39
Latin America/Caribbean	58
North America	48
Europe	44
Asia (excluding Japan)	38
Oceania	37

Note: Percentage of women answering "no" to a Demographic and Health Survey question asking whether their last birth was wanted; it does not include mistimed births. (See Appendix III.)

Source: Guttmacher Institute, *Abortion Worldwide: A Decade of Uneven Progress* (2009).

- No contraceptive method is 100 percent effective. Even with perfect use, some contraceptives fail. According to research based on U.S. women using a single contraceptive method for one year, male condoms used correctly and consistently will fail 2 percent of the time; with more typical use, which is not always correct or consistent, the failure rate of male condoms rises to 15 percent.[3]
- The failure rate of oral contraceptives is less than 1 percent with perfect use, but the rate rises to 8 percent with less-than-perfect use.[4]
- 62 percent of the world's women who are married or are in an informal union use some form of contraception.[5]
- Contraceptive use is lowest in sub-Saharan Africa, where 23 percent use some form of contraception and 17 percent use modern methods.[6]

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- **Modern methods** include hormonal methods such as birth control pills, implants like Norplant, and injectables like Depo-Provera; female and male sterilization; intrauterine device (IUD); barrier methods such as male or female condom, diaphragm, cervical cap, and contraceptive sponge; and chemical spermicides in the form of jelly or foam.
- **Traditional methods** include periodic abstinence (also known as rhythm or calendar method) and withdrawal.

Contraceptive Efficacy Rates

Percent of women experiencing an unintended pregnancy within the first year of use (United States)*

Method	Typical use	Perfect use**
No method	85	85
Spermicides	29	18
Withdrawal	27	4
Periodic abstinence	25	3 to 5***
Diaphragm	16	6
Female condom	21	5
Male condom	15	2
Pill	8	<1
Injectables	3	<1
IUD	<1	<1
Implants	<1	<1
Female sterilization	<1	<1
Male sterilization	<1	<1

* Most contraceptive effectiveness data come from studies in developed countries.

** Perfect use is defined as consistent and correct use of a family planning method.

*** Effectiveness varies with technique used.

Source: *Contraceptive Technology: 19th Revised Edition* (2007).

Emergency contraception

- Emergency contraceptives (EC) are back-up methods of preventing pregnancy after unprotected sexual intercourse. They do not terminate existing pregnancies, and they do not protect against sexually transmitted diseases.

- EC in pill form—also called the "morning-after pill"—can reduce the risk of pregnancy by 75 percent or more if taken within 72 hours (three days) of unprotected sexual intercourse. It is more effective the sooner after sex it is taken.
- EC pills contain the same medicine used in birth control pills but in higher doses. They work by stopping or delaying the release of an egg from the ovary, and they also may prevent sperm from fertilizing an egg or a fertilized egg from attaching to the uterus.
- If a woman is pregnant (a fertilized egg is implanted in her uterus), EC pills will not cause an abortion and the pregnancy will continue.
- Insertion of an IUD within seven days after unprotected sex can reduce the risk of pregnancy by 99 percent.
- EC is intended to be used after sexual intercourse when no contraceptive has been used, a contraceptive method has failed or been used incorrectly, or sex was forced.
- EC is not intended to be used in place of regular, ongoing contraception.[7]

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Global and Regional Estimates of Contraception Rates

	% married women using *any* method of contraception	% married women using *modern* method of contraception	Lifetime births per woman (total fertility rate)
World	**62**	**55**	**2.5**
More developed	71	60	1.7
Less developed	60	54	2.7
Africa	**29**	**23**	**4.7**
Northern Africa	49	44	3.0
Sub-Saharan Africa	23	17	5.2
Western Africa	14	10	5.5
Eastern Africa	28	23	5.3
Middle Africa	19	7	5.9
Southern Africa	59	58	2.5
North America	**78**	**73**	**2.0**
Latin America/ Caribbean	**73**	**67**	**2.3**
Asia	**66**	**60**	**2.2**
Western Asia	52	35	3.1
South Central Asia	54	45	2.8
Southeastern Asia	60	53	2.4
Eastern Asia	84	82	1.5
Europe	**70**	**56**	**1.6**
Northern Europe	81	75	1.9
Western Europe	73	69	1.6
Eastern Europe	69	48	1.5
Southern Europe	62	46	1.4
Oceania	**82**	**63**	**2.5**

Source: Population Reference Bureau, *2010 World Population Data Sheet*.

References

1 WHO, *Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2003* (2007).
2 WHO, *Safe Abortion: Technical and Policy Guidance for Health Systems* (2003).
3-4 *Contraceptive Technology: 19th Revised Edition* (2007).
5-6 Population Reference Bureau, *2010 World Population Data Sheet*.
7 International Consortium for Emergency Contraception.

Unmet Need for Family Planning

In developing countries, about one in six married women faces an "unmet need" for family planning—they prefer not to become pregnant but are not using any form of contraception.[1]

Unmet need is measured with the Demographic and Health Survey (DHS) and other large, national household surveys, in which married women ages 15 to 49 are asked about their childbearing preferences and their use of contraceptives. (It should be noted that these surveys often do not measure the contraceptive needs of unmarried women or women who are not satisfied with the contraceptive method they are using.)

According to surveys in developing countries, women who said they did not want to become pregnant cited various reasons for not using contraception. The most common was that they didn't think they could get pregnant because they were having sex infrequently, were in menopause, or were breastfeeding. Other reasons were:

- Opposition to family planning by the woman, her husband, or others.
- Problems with contraceptive methods, including side effects and health concerns, and, to a lesser extent, cost and access.
- Lack of knowledge about methods or where they could get them.

Reducing unmet need can help to reduce unintended pregnancies, which lead to abortions and unwanted births. Ways in which unmet need can be addressed include:

- Informing women of the benefits and possible side effects of available contraceptive methods so they can choose the method most appropriate for them.
- Informing women of their chances of becoming pregnant after an abortion or childbirth, during breastfeeding, or when they are approaching menopause, and counseling them on family planning methods that might be appropriate for them.

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- Improving communication between health care providers and their clients.
- Providing periodic follow-up counseling to reduce the number of women who don't want to become pregnant but who stop using contraception.
- Encouraging men to discuss family planning with their wives.

Reference

1 Population Reference Bureau, *Family Planning Worldwide 2008 Data Sheet*.

Abortion Laws and Policies

The legal status of abortion is one factor that determines the extent to which the procedure is safe, affordable, and accessible. In countries where abortion is legal, abortions are more likely to be performed by trained health professionals, be more available, and cost less. In these countries, maternal deaths and injuries tend to be lower.

In some countries, written laws or policies on abortion do not necessarily reflect what is actually practiced. Some countries may have a specific law prohibiting abortion, but in practice government officials, the courts, and health care providers interpret the law more broadly, or interpretation can be unpredictable and enforcement of laws can vary.

Abortion laws generally fall into five categories, from most to least restrictive:

- To save the life of the pregnant woman.
- To preserve her physical health.
- To protect her mental health.
- On socioeconomic grounds.
- For any reason.

In addition, many countries allow abortion in cases of rape, incest, and fetal impairment.

Countries also may:

- Limit the length of a pregnancy during which an abortion can be performed.
- Require the husband's or parent's approval.
- Specify the types of medical facilities where abortions can be performed and health care personnel who can perform them.
- Require counseling before an abortion can be performed.

In many cases, requirements such as these are intended to raise the quality of care, but they also can serve as barriers to safe abortion.

Abortion is generally more restricted in developing countries than in developed countries.

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- Abortion is permitted in nearly every country at least to save the life of the pregnant woman. This exception is either stated explicitly or inferred from what is known as the "defense of necessity," which allows a doctor, for example, to justify breaking the law by performing an abortion because the action saved a woman's life. About 25 percent of the world's people live in countries with this restriction.
- A majority of countries also allow abortion to preserve the physical health of the pregnant woman, though countries may define "physical health" differently. Many countries also allow abortion to preserve the mental health of the woman, and the definition of this term may also vary.
- Nearly half of all countries permit abortion in cases of rape or incest, in addition to other grounds, though procedural requirements in these cases may vary. Some countries require the case to be reported to authorities or even investigated before an abortion can be performed, while others require no proof other than the statement of the woman to her physician that her pregnancy is the result of rape.
- Many of the same countries permit abortion in cases of fetal impairment, in addition to other grounds; some countries specify the extent of impairment necessary in these cases.
- More than one-third of all countries allow abortion on economic or social grounds, such as income level, age, marital status, and number of children.
- More than 50 countries, with nearly 40 percent of the world's population, permit abortion for any reason, though most limit the period during which women can readily access the procedure.[1]

Even in circumstances where abortion is legally permitted, a woman may be unable to get a safe abortion due to:

- Lack of trained providers.
- Lack of adequately equipped medical facilities.
- Providers unwilling to perform abortions because of extensive procedural requirements or social stigma.
- Government restrictions on the types of medical facilities that can carry out abortions and providers who can perform the procedure.
- Physicians lacking knowledge on what the law allows, sometimes because the laws are unclear.
- Lack of clear government guidelines on how to interpret and implement restrictive or vague laws.
- Lack of resources to pay for a safe abortion.
- Social stigma and spousal or family disapproval.

These factors also can prevent women from receiving medical treatment for complications from an unsafe abortion.[2]

References

1 Center for Reproductive Rights, *The World's Abortion Laws* (2009).
2 Susheela Singh et al., *Abortion Worldwide: A Decade of Uneven Progress* (Guttmacher Institute, 2009).

Glossary

Developed and developing countries. (Used interchangeably with more developed and less developed countries.) Following the United Nations classification, more developed countries comprise all of Europe and North America, plus Australia, Japan, and New Zealand. All other countries are classified as less developed.

Dilation and curettage (D&C). Uses suction to empty the uterus and a medical instrument (a curette) to clean the walls of the uterus; used for first trimester pregnancies. Also known as sharp curettage.

Dilation and evacuation (D&E). A surgical procedure in which the cervix is slowly opened and the uterus is emptied with medical instruments, suction, and curettage; generally used for pregnancies of more than 12 weeks since the last menstrual period.

Emergency contraception (EC). Back-up contraceptive methods that women can use within the first few days after unprotected intercourse to prevent an unwanted pregnancy. Methods include doses of birth control pills and insertion of an intrauterine device (IUD).

Induced abortion. The act of ending a pregnancy; it may be done with surgery or medicine.

Incomplete abortion. An abortion in which parts of the fetus or placental tissue are retained in the uterus and can result in hemorrhage, intense pain, uterine infection, and death if left untreated.

Maternal mortality. Death related to pregnancy or childbirth; usually expressed as a ratio of the number of deaths per 100,000 live births in a given year.

Maternal morbidity. Disease, disability, or injury related to pregnancy or childbirth.

Medication abortion. Nonsurgical abortion using medication to end pregnancy. For pregnancies of up to nine weeks (measured from the first day of the last menstrual period), WHO recommends a combination of mifepristone, known as RU486, and misoprostol, a prostaglandin that causes uterine contractions. This combination is being investi-

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gated for use between nine and 12 completed weeks of pregnancy. For pregnancies of more than 12 weeks, mifepristone is used with repeated doses of misoprostol or another prostaglandin. In many developing countries, mifepristone is not available and misoprostol is being used alone to induce abortion.

Menstrual regulation. Used to induce menstruation, usually done within a few weeks following a missed menstrual period; uses vacuum aspiration or medication, and proof of pregnancy often is not required.

Miscarriage. Spontaneous termination of a pregnancy before the fetus is viable.

Pelvic inflammatory disease (PID). An infection in the reproductive tract that can lead to chronic pelvic pain, damage to reproductive organs, and infertility.

Spontaneous abortion. Naturally occurring expulsion of a nonviable fetus; 10 percent to 15 percent of all pregnancies end in spontaneous abortion; also known as a miscarriage.

Surgical abortion. Most common types are dilation and curettage (D&C), and dilation and evacuation (D&E). The method used depends on the length of the pregnancy.

Total fertility rate. The average number of children born alive that a woman has during her lifetime.

Trimesters of pregnancy. Pregnancy is generally divided into three stages, each about three months long. First trimester is measured from the first day of the last menstrual period through about the 12th week of pregnancy. Second trimester is generally considered to be the 13th through the 27th week. Third trimester runs from around the 28th through the 40th week of pregnancy. A full-term pregnancy is usually 40 weeks.

Vacuum aspiration. Either manual (MVA) or electric (EVA), removes the uterine contents by applying suction through a tube called a cannula that has been inserted through the cervix into the uterus; typically used through the 12th to 15th week of pregnancy.

Appendix I: International Conventions

Several UN documents that recognize women's sexual and reproductive rights also address abortion. Here are relevant excerpts:

Programme of Action adopted at the International Conference on Population and Development, Cairo (1994)

"In no case should abortion be promoted as a method of family planning. All Governments and relevant intergovernmental and non-governmental organizations are urged to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services. Prevention of unwanted pregnancies must always be given the highest priority and every attempt should be made to eliminate the need for abortion. Women who have unwanted pregnancies should have ready access to reliable information and compassionate counseling. Any measures or changes related to abortion within the health system can only be determined at the national or local level according to the national legislative process. In circumstances where abortion is not against the law, such abortion should be safe. In all cases women should have access to quality services for the management of complications arising from abortion. Post-abortion counseling, education and family planning services should be offered promptly, which will also help to avoid repeat abortions." (Paragraph 8.25)

Fourth World Conference on Women, Beijing (1995)

"Governments, in collaboration with non-governmental organizations and employers' and workers' organizations and with the support of international institutions [should]:

j. Recognize and deal with the health impact of unsafe abortion as a major public health concern, as agreed in paragraph 8.25 of the Programme of Action of the International Conference on Population and Development;

continued...

k. In the light of paragraph 8.25 of the Programme of Action of the International Conference on Population and Development ... consider reviewing laws containing punitive measures against women who have undergone illegal abortions." (Paragraph 106)

Key Actions for the Further Implementation of the Programme of Action of the International Conference on Population and Development (1999)

(ii) Governments should take appropriate steps to help women avoid abortion, which in no case should be promoted as a method of family planning, and in all cases provide for the humane treatment and counseling of women who have had recourse to abortion.

(iii) In recognizing and implementing the above, and in circumstances where abortion is not against the law, health systems should train and equip health-service providers and should take other measures to ensure that such abortion is safe and accessible. Additional measures should be taken to safeguard women's health." (Paragraph 63)

Appendix II: How Unsafe Abortions Are Counted

Determining the incidence of abortion depends largely on whether the procedure is legal. Where abortions are legal, they generally are officially recorded; but where abortions are legally restricted, they are not easily counted.

Much of the data in this guide comes from the most up-to-date and comprehensive source of unsafe abortion statistics, which was published in 2007 by the World Health Organization: *Unsafe Abortion —Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2003* (5th ed.).

WHO says it derives data from published and unpublished reports, including national and community-based studies, where available, and hospital data. Its analysis takes into account such factors as abortion laws and their enforcement, information on providers of unsafe abortions, prevalent abortion methods, fertility rates, and contraceptive use. It also adjusts for cultural factors as well as urban and rural differences.

WHO also notes that because of the stigma attached to abortion, it is likely to be underreported even where it is legal.

Because the data are incomplete, WHO says that its estimates of the incidence of unsafe abortion and related deaths "should be considered only as best estimates given the information currently available."

Appendix III: About the Sources

The sources used for information in this guide:

Centers for Disease Control and Prevention (CDC) is a U.S. government agency whose mission is to promote health and quality of life by preventing and controlling disease, injury, and disability. It works throughout the United States and the world monitoring health, investigating health problems, conducting research, and implementing prevention strategies.
www.cdc.gov

Center for Reproductive Rights is a nonprofit legal advocacy organization dedicated to promoting and defending women's reproductive rights worldwide.
www.reproductiverights.org

Demographic and Health Surveys (DHS) project is a global data collection effort funded by the U.S. Agency for International Development and carried out by ICF Macro and in-country organizations. These nationally representative household surveys collect data on demographic patterns, fertility, health, and nutrition for policy and program planning.
www.measuredhs.com

Guttmacher Institute is a nonprofit organization focused on sexual and reproductive health research, policy analysis, and public education.
www.guttmacher.org

International Consortium for Emergency Contraception was founded by seven internationally known organizations working in the field of family planning with a mission to expand access to emergency contraception worldwide but especially in developing countries.
www.cecinfo.org

Ipas is an international nonprofit organization that has worked for three decades to increase women's ability to exercise their sexual and reproductive rights and to reduce deaths and injuries of women from unsafe abortion.
www.ipas.org

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Population Reference Bureau informs people around the world about population, health, and the environment, and empowers them to use that information to advance the well-being of current and future generations.
www.prb.org

Postabortion Care Consortium works to encourage international donors and agencies in the reproductive health and population field to address the issue of unsafe abortion in their policies and programs.
www.pac-consortium.org

Save the Children is an international nonprofit organization founded in the aftermath of World War I that works to improve the lives of children in need and mobilizes life-saving assistance to children in times of war, conflict, and natural disasters.
www.savethechildren.org

United Nations Population Fund (UNFPA) is the UN agency that is the largest international source of funding for population and reproductive health programs.
www.unfpa.org

World Health Organization is the UN's specialized agency for health. It was established in 1948. WHO's objective, as set out in its Constitution, is the attainment by all people of the highest possible level of health.
www.who.int

Regional Data for Africa

Incidence

- An estimated 6.2 million unsafe abortions are performed each year in Africa, and about 5.5 million of them are in the sub-Saharan countries.
- Africa's nearly 36,000 unsafe abortion deaths account for more than 50 percent of the worldwide total.
- About one-quarter of Africa's unsafe abortions occur among young women ages 15 to 19, higher than in any other region.
- Nearly 60 percent of unsafe abortions in Africa are among women under age 25, and nearly 80 percent are among women under 30.
- For every 1,000 women ages 15 to 44 in Eastern and Middle Africa, 36 have had an unsafe abortion — the highest rates on the continent. In other parts of Africa, the numbers of unsafe abortions per 1,000 women of reproductive age are 28 in Western Africa, 18 in Northern Africa, and 9 in Southern Africa.

Estimates of Annual Unsafe Abortions and Unsafe Abortion Rates, 2008

	Number of unsafe abortions	Unsafe abortion rate (per 1,000 women ages 15-44)
Africa	**6.2 million**	**28**
Eastern Africa	2.4 million	36
Middle Africa	930,000	36
Northern Africa	900,000	18
Southern Africa	120,000	9
Western Africa	1.8 million	28

Source: Iqbal Shah and Elisabeth Ahman, "Unsafe Abortion in 2008: Global and Regional Levels and Trends," *Reproductive Health Matters* 18, no. 35 (2010).

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Maternal Health

African countries have among the highest maternal death rates in the world. On average, a woman in sub-Saharan Africa has a 1 in 31 chance of dying from a complication related to pregnancy or childbirth.

Country Estimates of Maternal Mortality

	Maternal mortality ratio	Lifetime chance of dying from maternal causes*
Africa	**590**	**1 in 36**
Northern Africa	**270**	**1 in 120**
Algeria	120	1 in 340
Egypt	82	1 in 380
Libya	64	1 in 540
Morocco	110	1 in 360
Sudan	750	1 in 32
Tunisia	60	1 in 860
Sub-Saharan Region	**640**	**1 in 31**
Western Africa	**720**	**1 in 25**
Benin	410	1 in 43
Burkina Faso	560	1 in 28
Cape Verde	94	1 in 350
Côte d'Ivoire	470	1 in 44
Gambia	400	1 in 49
Ghana	350	1 in 66
Guinea	680	1 in 26
Guinea-Bissau	1,000	1 in 18
Liberia	990	1 in 20
Mali	830	1 in 22
Mauritania	550	1 in 41
Niger	820	1 in 16
Nigeria	840	1 in 23
Senegal	410	1 in 46
Sierra Leone	970	1 in 21
Togo	350	1 in 67
Eastern Africa	**570**	**1 in 32**
Burundi	970	1 in 25
Comoros	340	1 in 71
Djibouti	300	1 in 93
Eritrea	280	1 in 72
Ethiopia	470	1 in 40

	Maternal mortality ratio	Lifetime chance of dying from maternal causes*
Kenya	530	1 in 38
Madagascar	440	1 in 45
Malawi	510	1 in 36
Mauritius	36	1 in 1,600
Mozambique	550	1 in 37
Rwanda	540	1 in 35
Somalia	1,200	1 in 14
Tanzania	790	1 in 23
Uganda	430	1 in 35
Zambia	470	1 in 38
Zimbabwe	790	1 in 42
Middle Africa	**700**	**1 in 23**
Angola	610	1 in 29
Cameroon	600	1 in 35
Central African Rep.	850	1 in 27
Chad	1,200	1 in 14
Congo	580	1 in 39
Congo, Dem. Rep.	670	1 in 24
Equatorial Guinea	280	1 in 73
Gabon	260	1 in 110
Southern Africa	**400**	**1 in 90**
Botswana	190	1 in 180
Lesotho	530	1 in 62
Namibia	180	1 in 160
South Africa	410	1 in 100
Swaziland	420	1 in 75

* Lifetime risk reflects a country or region's maternal mortality as well as its fertility rate. Risk is greater for women in areas of high fertility because they are pregnant more often and therefore face the risks of pregnancy more often than women in areas of low fertility.

Sources: WHO, UNICEF, UNFPA, The World Bank, *Trends in Maternal Mortality: 1990 to 2008* (2010); and Population Reference Bureau, *The World's Women and Girls 2011 Data Sheet*.

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Contraception

- In sub-Saharan Africa, the lowest rates of contraceptive use are in Western Africa (14 percent for all methods and 10 percent for modern methods).
- In sub-Saharan Africa, the country of South Africa has the highest rate for modern methods (60 percent) and one of the lowest fertility rates.

Country Estimates of Contraception and Fertility Rates

	Any method	Modern method	Lifetime births per woman (total fertility rate)
Africa	**29**	**23**	**4.7**
Northern Africa	**49**	**44**	**3.0**
Algeria	61	52	2.3
Egypt	60	58	3.0
Libya	42	20	2.7
Morocco	63	55	2.4
Sudan	8	6	4.5
Tunisia	60	52	2.1
Sub-Saharan Africa	**23**	**17**	**5.2**
Western Africa	**14**	**10**	**5.5**
Benin	17	6	5.6
Burkina Faso	17	13	6.0
Cape Verde	61	57	2.9
Côte d'Ivoire	13	8	4.9
Gambia	10	9	5.3
Ghana	24	17	4.0
Guinea	9	6	5.7
Guinea-Bissau	10	6	5.8
Liberia	11	10	5.9
Mali	8	6	6.6
Mauritania	9	8	4.5
Niger	11	5	7.4
Nigeria	15	10	5.7
Senegal	12	10	4.9
Sierra Leone	8	7	5.1
Togo	17	11	4.8

	Any method	Modern method	Lifetime births per woman (total fertility rate)
Eastern Africa	**28**	**23**	**5.3**
Burundi	9	8	5.4
Comoros	26	19	4.1
Djibouti	18	17	4.0
Eritrea	8	5	4.7
Ethiopia	15	14	5.4
Kenya	46	39	4.6
Madagascar	40	29	4.8
Malawi	41	38	6.0
Mauritius	76	42	1.5
Mozambique	17	12	5.1
Rwanda	36	27	5.4
Somalia	15	1	6.5
Tanzania	26	20	5.6
Uganda	24	18	6.5
Zambia	41	33	6.2
Zimbabwe	60	58	3.7
Middle Africa	**19**	**7**	**5.9**
Angola	6	5	5.8
Cameroon	26	13	4.7
Central African Rep.	19	9	4.8
Chad	3	2	6.2
Congo	44	13	5.0
Congo, Dem. Rep.	21	6	6.4
Equatorial Guinea	—	—	5.5
Gabon	33	12	3.6
Southern Africa	**59**	**58**	**2.5**
Botswana	44	42	3.2
Lesotho	37	35	3.2
Namibia	55	53	3.4
South Africa	60	60	2.4
Swaziland	51	48	3.7

— Indicates data unavailable or inapplicable.

Source: Population Reference Bureau, *2010 World Population Data Sheet*.

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Abortion Laws

Abortion is restricted in most African countries. Some countries have written laws on abortion that are more restrictive than the practice observed or inferred. For example, some countries' written laws permit abortion only to save the life of the woman, but in practice they permit abortion to preserve the woman's physical and mental health as well. In some countries, abortion is prohibited without exception in the written law, but in practice it is permitted to save a woman's life. In some cases, abortion law is vague and subject to different interpretations.

In the lists below, some countries' laws may be interpreted more broadly or restrictively than the classification under which they appear. Countries have a gestational limit of 12 weeks unless otherwise noted.

Permitted only to save the woman's life

Angola
Central African Rep.
Congo (Brazzaville)
Côte d'Ivoire
Dem. Rep. of Congo
Egypt
Gabon
Guinea-Bissau
Kenya
Lesotho
Libya – PA
Madagascar
Malawi – SA
Mali – R/I
Mauritania
Mauritius
Nigeria
Senegal
Somalia
Sudan – R
Tanzania
Uganda

Permitted to protect the woman's life and physical health

Benin – R/I/F
Burkina Faso – R/I/F
Burundi
Cameroon – R
Chad – F
Comoros
Djibouti
Equatorial Guinea – SA/PA
Eritrea – R/I
Ethiopia – R/I/F/+
Guinea – R/I/F
Morocco – SA
Mozambique
Niger – F
Rwanda
Togo – R/I/F
Zimbabwe – R/I/F

Permitted to protect the woman's mental health as well as her life and physical health

Algeria
Botswana – R/I/F
Gambia
Ghana – R/I/F
Liberia – R/I/F
Namibia – R/I/F
Sierra Leone
Swaziland – R/I/F

In addition to protecting the woman's life and physical and mental health, permitted on socio-economic grounds, such as a woman's economic resources, her age, marital status, and number of children

Zambia – F

Without restriction as to reason (during first trimester)

Cape Verde
South Africa
Tunisia

Note:

R – Abortion permitted in cases of rape

I – Abortion permitted in cases of incest

F – Abortion permitted in cases of fetal impairment

SA – Spousal authorization required

PA – Parental authorization/notification required

+ – Abortion permitted on additional enumerated grounds relating to such factors as the woman's age or capacity to care for a child

Source: Center for Reproductive Rights, *World's Abortion Laws* (2009).

Regional Data for Asia

Incidence

- In this region, unsafe abortion rates are highest in Southeast Asia.
- Unsafe abortion deaths are negligible in China and other East Asian countries, where abortion is legal and generally accessible.
- Abortion has been legal in India for more than 30 years, yet it has a high number of unsafe abortions. About two-thirds of all abortions in India take place outside the authorized health services.

Estimates of Annual Unsafe Abortions and Unsafe Abortion Rates, 2008

	Number of unsafe abortions	Unsafe abortion rate (per 1,000 women ages 15-44)
Asia	**10.8 million**	**11**
Eastern Asia	negligible	negligible
South Central Asia	6.8 million	17
Southeastern Asia	3.1 million	22
Western Asia	830,000	16

Source: Iqbal Shah and Elisabeth Ahman, "Unsafe Abortion in 2008: Global and Regional Levels and Trends," *Reproductive Health Matters* 18, no. 35 (2010).

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Maternal Health

About 139,000 of the estimated 358,000 pregnancy-related deaths worldwide each year are in Asia.

Country Estimates of Maternal Mortality

	Maternal mortality ratio	Lifetime chance of dying from maternal causes
Asia	**180**	**1 in 230**
Asia (Excl. China)	**220**	**1 in 150**
Western Asia	**66**	**1 in 460**
Armenia	29	1 in 1,900
Azerbaijan	38	1 in 1,200
Bahrain	19	1 in 2,200
Georgia	48	1 in 1,300
Iraq	75	1 in 300
Israel	7	1 in 5,100
Jordan	59	1 in 510
Kuwait	9	1 in 4,500
Lebanon	26	1 in 2,000
Oman	20	1 in 1,600
Palestinian Territory	—	—
Qatar	8	1 in 4,400
Saudi Arabia	24	1 in 1,300
Syria	46	1 in 610
Turkey	23	1 in 1,900
United Arab Emirates	10	1 in 4,200
Yemen	210	1 in 91
South Central Asia	**270**	**1 in 120**
Afghanistan	1,400	1 in 11
Bangladesh	340	1 in 110
Bhutan	200	1 in 170
India	230	1 in 140
Iran	30	1 in 1,500
Kazakhstan	45	1 in 950
Kyrgyzstan	81	1 in 450
Maldives	37	1 in 1,200
Nepal	380	1 in 80
Pakistan	260	1 in 93
Sri Lanka	39	1 in 1,100
Tajikistan	64	1 in 430

	Maternal mortality ratio	Lifetime chance of dying from maternal causes
Turkmenistan	77	1 in 500
Uzbekistan	30	1 in 1,400
Southeastern Asia	**170**	**1 in 260**
Cambodia	290	1 in 110
East Timor	370	1 in 44
Indonesia	240	1 in 190
Laos	580	1 in 49
Malaysia	31	1 in 1,200
Myanmar	240	1 in 180
Philippines	94	1 in 320
Singapore	9	1 in 10,000
Thailand	48	1 in 12,000
Vietnam	56	1 in 850
Eastern Asia	**39**	**1 in 1,400**
China	38	1 in 1,500
Japan	6	1 in 12,200
Korea, North	250	1 in 230
Korea, South	18	1 in 4,700
Mongolia	65	1 in 730

— Indicates data unavailable or inapplicable.

Sources: WHO, UNICEF, UNFPA, The World Bank, *Trends in Maternal Mortality: 1990 to 2008* (2010); and Population Reference Bureau, *The World's Women and Girls 2011 Data Sheet*.

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Contraception

East Asia has the highest level of contraceptive use in the region (84 percent for any method and 82 percent for any modern method of contraception).

Country Estimates of Contraception and Fertility Rates

	Any method	Modern method	Lifetime births per woman (total fertility rate)
Asia	**66**	**60**	**2.2**
Asia (Excl. China)	**56**	**47**	**2.6**
Western Asia	**52**	**35**	**3.1**
Armenia	53	20	1.7
Azerbaijan	51	14	2.2
Bahrain	—	—	1.9
Georgia	47	27	1.7
Iraq	50	33	4.1
Israel	—	—	3.0
Jordan	59	42	3.8
Kuwait	52	39	2.2
Lebanon	58	34	2.3
Oman	—	—	2.6
Palestinian Territory	50	39	4.6
Qatar	43	32	1.8
Saudi Arabia	24	—	3.8
Syria	58	43	3.3
Turkey	71	43	2.1
United Arab Emirates	—	—	2.0
Yemen	28	19	5.5
South Central Asia	**54**	**45**	**2.8**
Afghanistan	19	16	5.7
Bangladesh	56	48	2.4
Bhutan	31	31	3.1
India	56	49	2.6
Iran	74	56	1.8
Kazakhstan	51	49	2.7
Kyrgyzstan	48	46	2.8
Maldives	35	27	2.5
Nepal	48	44	3.0
Pakistan	30	22	4.0

	Any method	Modern method	Lifetime births per woman (total fertility rate)
Sri Lanka	68	53	2.4
Tajikistan	38	33	3.4
Turkmenistan	62	53	2.5
Uzbekistan	65	59	2.8
Southeastern Asia	**60**	**53**	**2.4**
Cambodia	40	27	3.3
East Timor	22	21	5.7
Indonesia	61	57	2.4
Laos	32	29	3.5
Malaysia	—	—	2.6
Myanmar	37	33	2.4
Philippines	51	34	3.2
Singapore	62	55	1.2
Thailand	72	70	1.8
Vietnam	80	69	2.1
Eastern Asia	**84**	**82**	**1.5**
China	87	86	1.5
Japan	54	44	1.4
Korea, North	69	58	2.0
Korea, South	81	67	1.2
Mongolia	66	61	2.7
Taiwan	71	—	1.0

— Indicates data unavailable or inapplicable.

Source: Population Reference Bureau, *2010 World Population Data Sheet*.

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Abortion Laws

Despite high rates of abortion throughout Asia, abortion laws and policies vary significantly across the region. While abortion is legal on fairly broad grounds in both India and Nepal, it is outlawed in the penal code and constitution of the Philippines. In Bangladesh, abortion is permitted only to save the life of the pregnant woman, while menstrual regulation is legal. Menstrual regulation, which requires no pregnancy testing, is a procedure similar to abortion that uses vacuum aspiration or medication to induce menstruation within a few weeks after a missed period. Menstrual regulation is also widely used in Vietnam, where abortion is legal.

Countries have a gestational limit of 12 weeks unless otherwise noted.

Permitted only to save the woman's life

Afghanistan
Bangladesh
Bhutan – R/I/+
Indonesia
Iran – F
Iraq
Laos
Lebanon
Myanmar
Oman
Philippines
Sri Lanka
Syria
United Arab Emirates – SA/PA
West Bank & Gaza Strip
Yemen

Permitted to protect the woman's life and physical health

Jordan
Kuwait – SA/PA/F
Maldives – SA
Pakistan
Qatar – F
South Korea – SA/R/I/F
Saudi Arabia – SA/PA

Permitted to protect the woman's mental health as well as her life and physical health

Israel – R/I/F/+
Malaysia
Thailand – R/F

In addition to protecting the woman's life and physical and mental health, permitted on socio-economic grounds, such as a woman's economic resources, her age, marital status, and number of children

India – PA/R/F
Japan – SA
Taiwan – SA/PA/I/F

Without restriction as to reason (during first trimester)

Armenia
Azerbaijan
Bahrain
Cambodia – GL 14 weeks
China – S/GL-none
North Korea – GL-none
Georgia – PA
Kazakhstan
Kyrgyzstan
Mongolia
Nepal – S
Singapore – GL 24 weeks
Tajikistan
Turkey – SA/PA/GL 10 weeks
Turkmenistan
Uzbekistan
Vietnam – GL-none

Note:

R – Abortion permitted in cases of rape

I – Abortion permitted in cases of incest

F – Abortion permitted in cases of fetal impairment

SA – Spousal authorization required

PA – Parental authorization/notification required

U – Law unclear

GL – Gestational limit

S – Sex-selective abortion prohibited

+ – Abortion permitted on additional enumerated grounds relating to such factors as the woman's age or capacity to care for a child

Source: Center for Reproductive Rights, *World's Abortion Laws* (2009).

Regional Data for Latin America and the Caribbean

Incidence

- 9,200 women die from pregnancy-related causes each year in Latin America and the Caribbean.
- About 4.2 million unsafe abortions are performed each year in the region.

Estimates of Annual Unsafe Abortions and Unsafe Abortion Rates, 2008

	Number of unsafe abortions	Unsafe abortion rate (per 1,000 women ages 15-44)
Latin America/ Caribbean	**4.2 million**	**31**
Caribbean	170,000	18
Central America	1 million	29
South America	3 million	32

Source: Iqbal Shah and Elisabeth Ahman, "Unsafe Abortion in 2008: Global and Regional Levels and Trends," *Reproductive Health Matters* 18, no. 35 (2010).

Maternal Health

The risk of dying as a result of a pregnancy-related cause varies widely across countries – from a 1 in 2,000 chance in Chile to a 1 in 93 chance in Haiti.

Country Estimates of Maternal Mortality

	Maternal mortality ratio	Lifetime chance of dying from maternal causes
Latin America/ Caribbean	**85**	**1 in 490**
Central America	**90**	**1 in 400**
Belize	94	1 in 330
Costa Rica	44	1 in 1,100
El Salvador	110	1 in 350
Guatemala	110	1 in 210
Honduras	110	1 in 240
Mexico	85	1 in 500
Nicaragua	100	1 in 300
Panama	71	1 in 520
Caribbean	**160**	**1 in 260**
Bahamas	49	1 in 1,000
Cuba	53	1 in 1,400
Dominican Republic	100	1 in 320
Haiti	300	1 in 93
Jamaica	89	1 in 450
Trinidad and Tobago	55	1 in 1,100
South America	**75**	**1 in 540**
Argentina	70	1 in 600
Bolivia	180	1 in 150
Brazil	58	1 in 860
Chile	26	1 in 2,000
Colombia	85	1 in 460
Ecuador	140	1 in 270
Guyana	270	1 in 150
Paraguay	95	1 in 310
Peru	98	1 in 370
Suriname	100	1 in 400
Uruguay	27	1 in 1,700
Venezuela	68	1 in 540

Sources: WHO, UNICEF, UNFPA, The World Bank, *Trends in Maternal Mortality: 1990 to 2008* (2010); and Population Reference Bureau, *The World's Women and Girls 2011 Data Sheet*.

Contraception

Overall, contraceptive use in Latin America is relatively high, with 73 percent of women using some method of contraception and 67 percent using a modern method. Rates for using any method range from 84 percent in Puerto Rico to 32 percent in Haiti.

Country Estimates of Contraception and Fertility Rates

	Any method	Modern method	Lifetime births per woman (total fertility rate)
Latin America/ Caribbean	**73**	**67**	**2.3**
Central America	**68**	**63**	**2.5**
Belize	34	31	3.1
Costa Rica	80	72	1.9
El Salvador	73	66	2.4
Guatemala	43	34	4.4
Honduras	65	56	3.3
Mexico	71	67	2.2
Nicaragua	72	70	2.5
Panama	—	—	2.7
Caribbean	**62**	**55**	**2.4**
Antigua and Barbuda	—	—	1.9
Bahamas	—	—	1.9
Barbados	—	—	1.7
Cuba	73	72	1.6
Dominican Republic	73	60	2.7
Grenada	—	—	2.2
Haiti	32	25	3.5
Jamaica	69	66	2.4
Puerto Rico	84	72	1.6
Trinidad and Tobago	43	38	1.6
South America	**76**	**69**	**2.2**
Argentina	65	64	2.3
Bolivia	61	35	3.5
Brazil	81	77	2.0
Chile	64	—	1.9
Colombia	78	68	2.4

continued...

	Any method	Modern method	Lifetime births per woman (total fertility rate)
Ecuador	73	59	2.6
Guyana	43	40	2.8
Paraguay	79	71	3.1
Peru	73	50	2.6
Suriname	42	41	2.4
Uruguay	77	75	2.0
Venezuela	70	62	2.6

— Indicates data unavailable or inapplicable.

Source: Population Reference Bureau, *2010 World Population Data Sheet*.

Abortion Laws

Abortion is highly restricted throughout Latin America and the Caribbean; it is not permitted for any reason in Chile, El Salvador, and Nicaragua. In 2006, Colombia eased its strict prohibition to allow abortion in cases of danger to the woman's life or health, rape, incest, and fetal impairment.

Not permitted for any reason

Chile
El Salvador
Nicaragua

Permitted only to save the woman's life

Antigua & Barbuda
Brazil – R
Dominica
Dominican Republic
Guatemala
Haiti
Honduras
Mexico – R/FS
Panama – PA/R/F
Paraguay
Suriname
Venezuela

Permitted to protect the woman's life and physical health

Argentina – R
(of a woman with a mental disability)
Bahamas
Bolivia – R/I
Costa Rica
Ecuador – R
(of a woman with a mental disability)
Grenada
Peru
Uruguay – R

Permitted to protect the woman's mental health as well as her life and physical health

Colombia – R/I/F
Jamaica – PA
Saint Kitts & Nevis
Saint Lucia – R/I
Trinidad & Tobago

In addition to protecting the woman's life and physical and mental health, permitted on socio-economic grounds, such as a woman's economic resources, her age, marital status, and number of children

Barbados – PA/R/F/I
Belize – F
Saint Vincent & Grenadines – R/F/I

Without restriction as to reason (during first trimester)

Cuba – PA
Guyana – GL 8 weeks
Puerto Rico

Note:

R – Abortion permitted in cases of rape

I – Abortion permitted in cases of incest

F – Abortion permitted in cases of fetal impairment

SA – Spousal authorization required

PA – Parental authorization/notification required

GL – Gestational limit

FS – Abortion law determined at state level; classification reflects legal status of abortion for largest number of people

Source: Center for Reproductive Rights, *World's Abortion Laws* (2009).

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