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Brief Survey of Abortion Laws of Five Largest Countries

by Luke T. Lee

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PREGNANCY TERMINATION

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Five Largest Countries Allow Legal Abortion On Broad Grounds

by
Luke T. Lee, J.D., Ph.D.

Five of the six most populous countries in the world—China, India, the Soviet Union, the United States, and Japan—now permit legal abortion in early pregnancy. Although different laws, policies, and judicial decisions have evolved from each country's unique political processes, the official justification in each case is identical—the physical, mental, social, and economic well-being of the woman concerned. The January 1973 decision of the U. S. Supreme Court, for example, which overturned restrictive abortion laws in most of the fifty states, noted specifically that “the right of privacy . . . is broad enough to encompass a woman's decision whether or not to terminate her pregnancy.”

The Japanese Eugenic Protection Law of 1948 as amended allows abortions at the doctor's discretion for “a mother whose health may be affected seriously by the continuation of pregnancy or by delivery, from the physical or economic viewpoint.” Soviet and Indian law essentially permits abortion by removing criminal penalties against physicians (or “registered medical practitioners”) performing the procedure up to 12 weeks gestation (or with additional consultation or approval after 12 weeks). The Indian Medical Termination Bill of 1971 explicitly states that in the case of rape or of a married couple's contraceptive failure “the anguish caused by such unwanted pregnancy may be presumed to constitute grave injury to the mental health of the pregnant woman.”

In the People's Republic of China, restrictions on abortion were relaxed by the Ministry of Health in 1957 “for the purpose of ensuring the health of mothers . . . because some women have given too frequent childbirth at too close a spacing.” Subsequently, abortion has not only become widely available but also medical costs and sick leave are subsidized by the state.

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China, India, the U.S.S.R., the United States, and Japan together contain more than half of the world's population. They include developed and developing, Asian, American, and European, Communist and non-Communist countries. The United Kingdom, the Scandinavian countries, and several Eastern European countries also permit abortion in early pregnancy on various grounds of health and individual or social welfare. Therefore a total of nearly 2.2 billion persons out of a world total of about 3.8 billion now live in countries where abortion is legal—a majority of 58 percent.

Despite the growing pressure of population growth, which adds about 75 million people to the world each year, none of these laws or policies is explicitly based on demographic factors. None are designed to restrict individual freedom or enforce compulsory or eugenic abortions. None seek to

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promote abortion instead of contraception and most emphasize strongly the advantages of preventive contraception. But each state tacitly recognizes in its laws that without broad access to legal abortion—for the poor as well as the rich—maternal health and family well-being will suffer.

A more detailed commentary on the legal situation in these five countries follows.

CHINA

The People's Republic of China now not only permits abortion on request, but also provides abortion as a free public service, thus implementing in full the 1969 United Nations Declaration on Social Progress and Development calling on U.N. members to provide families with not only the knowledge, but also the "means necessary to enable them to exercise their right to determine freely and responsibly the number and spacing of their children" (10).

The texts of Chinese laws or regulations on abortion are not available. The major official central government statements were made in 1954 when abortion was first permitted under restrictive conditions and in 1957 when many of these restrictions were lifted (4,8). Recent visitors report that abortion is common, often encouraged after the first birth, and readily available in both urban or rural areas. In the traditional Chinese legal system, a dichotomy exists between *li* (Confucian ethics) and *fa* (written code) in which *li* invariably prevails over *fa* in the event of a conflict (6). The integration of abortion into free family planning services was undoubtedly a decision made by the Communist Party based on its perception of what the *li* in the new society ought to be rather than upon any judicial decision or published legislation. The negative tone of earlier press and official comments therefore does not seem to reflect current practice.

Excerpts from Chinese statements, press accounts, or foreign visitors' reports follow:

Statement of Shao Li-tzu at the First National Peoples Congress, Peking *Kuang Ming Jih Pao*, December 19, 1954:

I consider that the stipulations made by the Ministry of Health of the Central People's Government governing the practice of artificial abortion are quite adequate. The stipulations are: "Abortion is allowed in cases where continued pregnancy is medically considered undesirable, where the spacing of childbirth is already too close and where a mother with her baby only 4 months old had become pregnant again and experiences difficulty of breast-feeding. The operation may be done upon the joint application of the couple, the certification of a doctor and the approval of the responsible organization to which they belong. If the reason is special work or too heavy work (or study), any request for operation must first be certified and endorsed by the key personnel of the responsible organization and also approved by a medical organization." However, it must be noted that artificial abortion must be done as early as possible, the best within one

month of pregnancy and at the latest not over two months. But if we have the necessary knowledge of contraception and take the necessary preventive steps, the practice of artificial abortion will not be necessary.

"Special Report from Peking" as reported in *Wen-hui Pao*, Shanghai, April 12, 1957:

The Public Health Ministry today announced that from this day on all applications for abortion or sterilization will be free of restrictions of age, number of children, and approval procedures.

The notice also stated that abortion is a comparatively dangerous surgery. It can only be performed once a year. It may be performed if the (duration) of pregnancy is less than 10 weeks and if the person is healthy. Sterilization must be agreed upon by both husband and wife. The tying up of the spermatic duct or the Fallopian tube will not affect sexual function and health.

"Planning Childbirth and Promoting Late Marriage" *Medical and Health Data*, No. 5, July 1970, Shanghai:

Induced abortion is a passive method of birth control. It may be performed when contraceptive measures have failed or when the woman is pregnant without taking these measures but is unfit to give birth (for various reasons, such as too frequent intervals between births, multiple pregnancies, economic conditions and relationships of work). Generally it should not be carried out if the pregnancy exceeds two months. Although the operation is simple, it will affect the health of the woman to some extent. Therefore, prevention is the best, i.e., taking successful contraceptive measures.

Anibal Faundes and Tapani Luukkainen, "Health and Family Planning Services in the Chinese People's Republic," *Studies in Family Planning*, July, 1972 (2):

As soon as a woman realizes that she is missing a period, she attends the clinic. . . . If a positive diagnosis is made on the first visit and the patient declares that she does not want to have the baby, she is immediately taken to the appropriate ward where she waits for her turn to have an abortion. . . . [S]he will have 15 days of paid vacation and 18 days if an IUD was inserted postabortion.

Early abortions are usually performed by nurses and, in the communes, by trained barefoot doctors or midwives. . . . The complication rate seems to be very low because of the good aseptic procedures used. . . .

Mortality resulting from abortion seems to be nonexistent or extremely low. . . .

INDIA

Until 1972, the Indian Criminal law permitted abortion only on extremely narrow grounds—to save the life of the mother. Nevertheless, an official report in 1967 estimated the number of abortions each year was perhaps as high as 6.5 million—2.6 million natural and 3.9 million induced (5,9).

The Medical Termination of Pregnancy Bill of 1971 essentially nullified Section 312 of the Indian Penal code which had previously provided fines and jail sentences for persons

unauthorized institutions, in unsanitary conditions, or by unauthorized persons (13).

The decree of November 23, 1955, reads as follows:

1. Article I of the Decree of the Central Executive Committee and of the Council of Peoples' Commissars of the USSR, dated June 27, 1936 is abrogated.
2. Performing operations for the artificial termination of pregnancy is permitted only in hospitals and other medical institutions in accordance with an instruction of the Minister of Health of the USSR.
3. It remains a criminal offense both for doctors and for persons without special medical qualifications to perform abortions outside hospitals or other medical institutions.

UNITED STATES

In a landmark decision *Roe v. Wade* involving an unmarried Texas woman, the United States Supreme Court on January 22, 1973, ruled that:

- a) For the first three months of pregnancy, the decision to have an abortion lies with the woman and her doctor;
- b) For the next six months of pregnancy, State laws may regulate the abortion procedure in ways that are reasonably related to maternal health;
- c) For the last weeks of pregnancy, when the fetus is judged capable of surviving if born, any State may regulate or even prohibit abortion except where abortion is necessary to preserve the life or health of the mother (11).

In a separate decision *Doe v. Bolton*, involving a challenge to the Georgia abortion law, the Supreme Court declared unconstitutional any residency requirement. The Court also struck down the Georgia requirement that abortions be performed in private accredited hospitals, that applicants be screened by hospital committees, and that there be certification by two independent doctors that continued pregnancy is potentially dangerous to the woman's health (12).

The implication of these decisions are clear: the Texas decision invalidates strict anti-abortion laws in 31 states; the Georgia decision requires amendment of restrictive abortion statutes in 16 other states and further relaxation of restrictions in Alaska, Hawaii, and Washington where recently amended laws in effect allowed abortion on request but imposed a residency requirement. The Court noted that the qualifications of the person performing the procedure and some aspects of the facility where it is performed are permissible areas of state regulations.

The Court observed that the restrictive criminal abortion laws in effect in the majority of the States were of comparatively recent origin—dating, for the most part, from the latter half of the 19th century when the procedure was extremely hazardous for the woman. It took note of improved medical knowledge and "the now established medi-

cal fact . . . that until the end of the first trimester mortality in abortion is less than mortality in normal childbirth." Also the Court noted the detrimental social and psychological effects of denied abortions upon the woman, the unwanted child, the family and all concerned.

The U. S. Supreme Court considered and then rejected the argument that a fetus becomes a "person" upon conception and is thus fully entitled to due process and equal protection guarantees under the Constitution. In fact, the Court explicitly stated that the fetus is not a "person" within the meaning of the 14th Amendment.

Expounding on the right of privacy which it first invoked in 1965 to invalidate a Connecticut law prohibiting the use of contraceptives (*Griswold v. Connecticut*), the Court held that this right "is broad enough to encompass a woman's decision whether or not to terminate her pregnancy."

The total effect of these decisions is that the Court has required that there must be a compelling State interest to warrant interference with the woman's basic right to privacy by prohibiting abortion. No such legal interest exists in the first trimester of pregnancy. It develops, however, to a limited extent in the second trimester and becomes strong during the third. Although, as the Chief Justice stated, these decisions do not provide abortion on demand, they nevertheless allow the woman and her doctor to take whatever action seems appropriate during the first trimester without governmental interference.

Excerpts from the Supreme Court decision follow:

the Court has recognized that a right of personal privacy, or a guarantee of certain areas or zones of privacy, does exist under the Constitution. . . . this right of privacy, whether it be founded in the Fourteenth Amendment's concept of personal liberty and restrictions upon state action, as we feel it is, or, as the District Court determined, in the Ninth Amendment's reservation of rights to the people, is broad enough to encompass a woman's decision whether or not to terminate her pregnancy. The detriment that the State would impose upon the pregnant woman by denying this choice altogether is apparent. Specific and direct harm medically diagnosable even in early pregnancy may be involved. Maternity, or additional offspring, may force upon the woman a distressful life and future. Psychological harm may be imminent. Mental and physical health may be taxed by child care. There is also the distress, for all concerned, associated with the unwanted child, and there is the problem of bringing a child into a family already unable, psychologically and otherwise, to care for it. In other cases, as in this one, the additional difficulties and continuing stigma of unwed motherhood may be involved. All these are factors the woman and her responsible physician necessarily will consider in consultation.

In areas other than criminal abortion the law has been reluctant to endorse any theory that life, as we recognize it, begins before live birth or to accord legal rights to the unborn except in narrowly defined situations and except when the rights are contingent upon live birth. For example, the traditional rule of tort law had denied recovery for prenatal injuries even though the child was born alive. That rule has been changed in almost every jurisdiction. In most States recovery

is said to be permitted only if the fetus was viable, or at least quick, when the injuries were sustained, though few courts have squarely so held. In a recent development, generally opposed by the commentators, some States permit the parents of a stillborn child to maintain an action for wrongful death because of prenatal injuries. Such an action, however, would appear to be one to vindicate the parents' interest and is thus consistent with the view that the fetus, at most, represents only the potentiality of life. Similarly, unborn children have been recognized as acquiring rights or interests by way of inheritance or other devolution of property, and have been represented by guardians *ad litem*. Perfection of the interests involved, again, has generally been contingent upon live birth. In short, the unborn have never been recognized in the law as persons in the whole sense.

In view of all this, we do not agree that, by adopting one theory of life, Texas may override the rights of the pregnant woman that are at stake. We repeat, however, that the State does have an important and legitimate interest in preserving and protecting the health of the pregnant woman, whether she be a resident of the State or a nonresident who seeks medical consultation and treatment there, and that it has still another important and legitimate interest in protecting the potentiality of human life. These interests are separate and distinct. Each grows in substantiality as the woman approaches term and, at a point during pregnancy, each becomes "compelling."

With respect to the State's important and legitimate interest in the health of the mother, the "compelling" point, in the light of present medical knowledge, is at approximately the end of the first trimester. This is so because of the now established medical fact . . . that until the end of the first trimester mortality in abortion is less than mortality in normal childbirth. It follows that, from and after this point, a State may regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation and protection of maternal health. Examples of permissible state regulation in this area are requirements as to the qualifications of the person who is to perform the abortion; as to the licensure of that person; as to the facility in which the procedure is to be performed, that is, whether it must be a hospital or may be a clinic or some other place of less-than-hospital status; as to the licensing of the facility; and the like.

This means, on the other hand, that, for the period of pregnancy prior to this "compelling" point, the attending physician, in consultation with his patient, is free to determine, without regulation by the State, that in his medical judgment the patient's pregnancy should be terminated. If that decision is reached, the judgment may be effectuated by an abortion free of interference by the State.

With respect to the State's important and legitimate interest in potential life, the "compelling" point is at viability. This is so because the fetus then presumably has the capability of meaningful life outside the mother's womb. State regulation protective of fetal life after viability thus has both logical and biological justifications. If the State is interested in protecting fetal life after viability, it may go so far as to proscribe abortion during that period except when it is necessary to preserve the life or health of the mother.

To summarize and to repeat:

1. A state criminal abortion statute of the current Texas type, that excepts from criminality only a *life saving* procedure on behalf of the mother, without regard to pregnancy stage and without recognition of the other interests involved, is violative of the Due Process Clause of the Fourteenth Amendment.

(a) For the stage prior to approximately the end of the first trimester, the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician.

(b) For the stage subsequent to approximately the end of the first trimester, the State, in promoting its interest in the

health of the mother, may, if it chooses, regulate the abortion procedure in ways that are reasonably related to maternal health.

(c) For the stage subsequent to viability the State, in promoting its interest in the potentiality of human life, may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment for the preservation of the life or health of the mother.

2. The State may define the term "physician" as it has been employed in the preceding numbered paragraphs of this Part XI of this opinion, to mean only a physician currently licensed by the State, and may proscribe any abortion by a person who is not a physician as so defined.

This holding, we feel, is consistent with the relative weights of the respective interests involved, with the lessons and example of medical and legal history, with the lenity of the common law, and with the demands of the profound problems of the present day. The decision leaves the State free to place increasing restrictions on abortion as the period of pregnancy lengthens, so long as those restrictions are tailored to the recognized state interests. The decision vindicates the right of the physician to administer medical treatment according to his professional judgment up to the points where important state interests provide compelling justifications for intervention. Up to those points the abortion decision in all its aspects is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician.

JAPAN

In Japan, abortion was first legalized by the Eugenic Protection Law of 1948. That law authorized certain physicians to perform operations for induced abortion upon approval by the Eugenic Protection Committees established under the Law to investigate and determine the validity of applications for abortion. Originally, these physicians could, at their discretion, perform only operations for strictly "eugenic" reasons; in all other cases, they had first to obtain approval from the committees which had to be satisfied that the following conditions were fulfilled: (a) that a woman was afflicted with one or more specified diseases; (b) that the health of a mother might be seriously affected by the continuation of pregnancy or by delivery; or (c) that the pregnancy resulted from threat or act of violence (7).

In June 1949, the Eugenic Protection Law was revised to include economic factors as well as health and eugenics as legal justifications for induced abortion. A further amendment in April 1952 eliminated the need to apply for committee authorization to perform an induced abortion, the sole requirements being the physician's discretion and the consent of the person in question or the spouse. These statutes entirely superseded and nullified Article 212 of the Japanese Criminal Code which until 1948 had provided prison sentences under forced labor for anyone involved in causing "a miscarriage by the use of drugs or other means."

Under present Japanese law, no abortion may be performed

causing "a woman with child to miscarry." The new law, which came into effect in January 1972, reads as follows:

3. (1) Notwithstanding anything contained in the Indian Penal Code, a registered medical practitioner shall not be guilty of any offence under that Code or under any other law for the time being in force, if any pregnancy is terminated by him in accordance with the provisions of this Act.

(2) Subject to the provisions of sub-section (4), a pregnancy may be terminated by a registered medical practitioner,—

(a) where the length of the pregnancy does not exceed twelve weeks, if such medical practitioner is, or

(b) where the length of the pregnancy exceeds twelve weeks but does not exceed twenty weeks, if not less than two registered medical practitioners are,

of opinion, formed in good faith, that—

(i) the continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury to her physical or mental health; or

(ii) there is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities as to be seriously handicapped.

Explanation I.—Where any pregnancy is alleged by the pregnant woman to have been caused by rape, the anguish caused by such pregnancy shall be presumed to constitute a grave injury to the mental health of the pregnant woman.

Explanation II.—Where any pregnancy occurs as a result of failure of any device or method used by any married woman or her husband for the purpose of limiting the number of children, the anguish caused by such unwanted pregnancy may be presumed to constitute a grave injury to the mental health of the pregnant woman.

(3) In determining whether the continuance of a pregnancy would involve such risk or injury to the health as is mentioned in sub-section (2), account may be taken of the pregnant woman's actual or reasonably foreseeable environment.

(4) (a) No pregnancy of a woman, who has not attained the age of eighteen years, or, who, having attained the age of eighteen years, is a lunatic, shall be terminated except with the consent in writing of her guardian.

(b) Save as otherwise provided in clause (a), no pregnancy shall be terminated except with the consent of the pregnant woman.

4. No termination of pregnancy shall be made in accordance with this Act at any place other than—

(a) a hospital established or maintained by Government, or

(b) a place for the time being approved for the purpose of this Act by Government.

5. (1) The provisions of section 4, and so much of the provisions of sub-section (2) of section 3 as relate to the length of the pregnancy and the opinion of not less than two registered medical practitioners, shall not apply to the termination of a pregnancy by a registered medical practitioner in a case where he is of opinion, formed in good faith, that the termination of such pregnancy is immediately necessary to save the life of the pregnant woman.

(2) Notwithstanding anything contained in the Indian Penal Code, the termination of a pregnancy by a person who is not a registered medical practitioner shall be an offence punishable under that Code, and that Code shall, to this extent, stand modified.

It may be seen that this language virtually allows abortion on request in view of the difficulty, if not impossibility, of proving that a pregnancy was *not* caused by contraceptive failure.

UNION OF SOVIET SOCIALIST REPUBLICS

Russian and then Soviet abortion policy has shifted several times in the last two centuries. Before the nineteenth century, Russian law prohibited abortion absolutely—allowing for no exception even for medical reasons. Then a decree of November 18, 1920, legalized abortion if performed by doctors in hospitals, and the Criminal Code of 1920 (Art. 140 (1)) reflected this change of policy. In 1936, however, abortions were again prohibited except when continued pregnancy would pose a serious danger to the life or health of the mother or when the parents suffered from serious inheritable diseases, such as epilepsy, idiocy and progressive paralysis (3).

The abortion law was amended and relaxed on September 2, 1954, when a decree of the Presidium of the Supreme Court abolished criminal penalties for women who consented to the interruption of pregnancy. Under a further decree of November 23, 1955, abortions were permitted if done by qualified personnel in medical facilities. The commentary accompanying the decree notes "in order to give women the possibility of deciding by themselves the question of motherhood" the Praesidium of the Supreme Soviet "has decided to repeal the previous law on abortions." The commentary also points out that these measures will permit women to participate more actively in economic, social, and cultural life. "The repeal of the prohibition on abortions will permit the limitation of the harm caused to the health of women by abortions carried out outside of hospitals" (1).

A Ministry of Health instruction on December 28, 1955, provided a list of "Contraindications," under which no abortion may be performed, including

- a) acute or chronic gonorrhoea;
- b) acute or chronic inflammatory conditions of the sexual organs;
- c) purulent foci, irrespective of localization;
- d) acute infectious diseases; and
- e) a previous abortion within the preceding six months.

A gynecologist usually discusses with each woman the reason for her application for abortion and warns her of possible adverse effects. However, if the woman persists, her application must be granted (7). The cost for an induced abortion is 5 rubles (\$6.10 U.S.), although the therapeutic abortions are free (1). Special permissions are required if pregnancies are more than 12 weeks old. Abortions are now subject to penalties only when performed in

without the consent of the person in question or the spouse, but the sole consent of the person in question is sufficient if the spouse cannot be identified, or fails to declare his or her intention, or disappears after conception has occurred. If the person who is to undergo the abortion is insane or feeble-minded, the consent of her guardian given pursuant to Section 20 or 21 of the Mental Hygiene Law may be regarded as that of the person in question.

Although "economic" reasons alone would not, under the law, constitute a sufficient ground for abortion, the difficulty or impossibility of disproving their serious adverse effect upon health has resulted in such a liberal interpretation of the law in practice that every healthy woman—regardless of wealth or poverty—can obtain abortion. Most of the operations for induced abortion have indeed been performed on economic grounds (7).

Paragraph (1) of Article 14 of the Eugenic Protection Law of 1948, as amended, now reads as follows:

The physician designated by the Medical Association, which is a body corporate established in the prefectural district (hereinafter called the "designated physician"), may carry out the operation for interruption of pregnancy, at his discretion, in the case of persons subject to the provisions of any of the following items, with the consent of the person in question or the spouse:

(1) a person or his spouse, who suffers from psychosis, mental deficiency, psychopathy, hereditary bodily disease or hereditary malformation;

(2) a relative in blood within the 4th degree of consanguinity of a person or his spouse who suffers from hereditary psychosis, hereditary mental deficiency, hereditary psychopathy, hereditary bodily disease or hereditary malformation;

(3) a person or his spouse who is suffering from leprosy;

(4) a mother whose health may be affected seriously by the continuation of pregnancy or by delivery, from the physical or economic viewpoint;

(5) a person who has conceived as the result of an act of violence or a threat or while unable to resist or refuse.

Clearly there are many different roads leading to the legalization of abortion. Whether it be accomplished through judicial decisions (United States), liberal interpretation of existing law (Japan), new legislation (Soviet Union), official explanation incorporated in new legislation (India), or party action (China), depends on the unique features of each country's legal system. But the result in these five countries is to confirm the right of a woman or couple and medical advisor to make their own personal or professional judgment. Thus, despite some continuing opposition, the majority of the world's population now has legal access to abortion as a means of fertility control.

Table 1—Abortion Laws of the World's Twelve Most Populous States

Country	Population, 1972	Abortion Legal
China	786,000,000	Yes
India	585,000,000	Yes
USSR	248,000,000	Yes
USA	209,000,000	Yes
Indonesia	129,000,000	No
Japan	106,000,000	Yes
Brazil	98,000,000	No
Bangladesh	79,000,000	Legisl. pending
Pakistan	66,000,000	No
West Germany	59,000,000	No
Nigeria	58,000,000	No
United Kingdom	57,000,000	Yes

Source: Population Reference Bureau; International Reference Center for Abortion Research, Transnational Family Research Institute.

Table 2—Population of Countries with Legal Abortion 1972

Country	Population
Bulgaria	8,700,000
China (People's Republic)	786,100,000
Czechoslovakia	14,900,000
Cyprus	600,000
Denmark	5,000,000
Finland	4,800,000
Germany (East)	16,300,000
Hungary	10,400,000
Iceland	200,000
India	584,800,000
Japan	105,000,000
Norway	4,000,000
Poland	33,700,000
Romania	20,800,000
Sierra Leone	2,800,000
Singapore	2,200,000
Sweden	8,200,000
Tunisia	5,400,000
Uganda	9,100,000
USSR	248,000,000
United Kingdom	56,600,000
United States	209,200,000
Uruguay	3,000,000
Vietnam (North)	22,000,000
Yugoslavia	21,000,000
Zambia	4,600,000
Total Population with Legal Abortion	2,188,400,000
Total World Population	3,782,000,000
Percentage of World Population in Countries with Legal Abortion	58%

Source: Population Reference Bureau; International Reference Center for Abortion Research, Transnational Family Research Institute.

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 2. That the pregnant woman is declared by a medical doctor not to be affected by a disease which would rule out such an operation; and
 3. That no induced abortion has been performed within the last past 12 months.
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