Joint Committee on the Eighth Amendment of the Constitution

(Meeting of 22nd November 2017)

Presentation

Abortion in the Netherlands: law and practice.

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1. Introduction.

In this paper, prepared as evidence for the Oireachtas Committee on the Eight Amendment of the Irish Constitution, we will first of all give a description of the Dutch abortion law (the Termination of Pregnancy Act) as it was adopted in 1981 (Section 2). Subsequently we will describe the legal developments after its introduction in 1984 (Section 3), and discuss how the Dutch law can be positioned in the European context (Section 4). Finally, we will provide information of how the law works in practice (Section 5), with particular reference to the Annual Report of the Health Inspectorate on the application of the Termination of Pregnancy Act (Section 6), followed in Section 7 with some final observations.

2. The Termination of Pregnancy Act (1981)

Terminating a pregnancy is a crime under Article 296 of the Dutch Penal Code. According to the fifth par. of that article, however, abortion will not be punished if carried out by a doctor in a hospital or abortion clinic with a license in accordance with the Termination of Pregnancy Act (in common lay terms: the Abortion Act). That act was adopted in 1981 (and came into force in 1984), after a long history and more than 10 years of public and political debate. The two conflicting values that had to be accommodated in it were clearly expressed by the government during parliamentary proceedings: “The bill is based on the view that women, who are in a situation of emergency due to an unwanted pregnancy, should receive help. But we consider the termination of unborn human life as such a serious act, that it is only acceptable if unavoidable because of that emergency. This means that the physician, the woman and others that may be involved before the decision to terminate, need to act with utmost care and in awareness of their responsibility towards unborn human life and of the consequences for the woman.”

At the moment 93 hospitals and 15 clinics do have a license to terminate pregnancies, which means that they are allowed to induce abortions provided that the provisions of the Abortion Act are complied with.¹ Such licences are granted by the Minister of Health to establishments that satisfy statutory requirements relating to the quality of treatment in terms of medical competence and facilities as well as psychological care. The directors of these establishments must submit periodical reports to the Health Care Inspectorate about the number and some characteristics of patients they have treated (the figures are published in the Inspectorate’s annual report).

Abortion is not seen as a routine medical procedure but as one that may be carried out on request of the woman if her circumstances leave her no other alternative. Basically, the Act does not provide substantive reasons or criteria for terminating a pregnancy. Instead, it sets standards in the form of a set of requirements designed to guarantee that the decision to terminate is taken with all due care.

¹ In 2015 91% of abortions was carried out in clinics, 9% in hospitals (Annual Report Health Care Inspectorate, 2015)
In 2015, about 30,000 abortions were carried out in the Netherlands. This results in an abortion rate (i.e. the number of abortions per 1000 women in the age of 15-44) of 8.6, which is relatively low if compared to several other European countries. The total number of 30,000 includes almost 4,000 abortions for non-residents (mostly from France and Germany; in 2015 34 women from Ireland).

The key provisions of the Abortion Act are those on careful decision-making. According to Article 5, termination may only take place if a situation of emergency of the woman makes that inevitable. ‘Emergency’ refers to the psychological state of mind of the woman due to the unwanted pregnancy; it does not require (the risk of) physical or mental injury. The Act does not provide substantive, general criteria for assessing whether or not the situation of the woman amounts to an emergency. The legislator has adopted this approach because the decision to terminate a pregnancy must be taken with due regard for the individual circumstances of each case. In establishing the existence of an emergency, the opinion of the pregnant woman is decisive, although the physician always retains a responsibility of his/her own for an abortion. In other words: both the woman and the doctor are responsible for the process of reaching a decision, although the decision as such is ultimately made by the woman. The physician shall assist the woman requesting an abortion in making up her mind. For that purpose, he/she must provide her with appropriate information about other solutions to her situation. Furthermore, the physician must see to it that her request is made and maintained freely and without undue pressure from other persons, and that she insists on that request only after careful consideration. A woman is not required to reach agreement with her partner or parents; the decision is hers alone. Like some other abortion laws, in order to ensure sufficient reflection, the Dutch law requires a waiting period between the first request of the woman and the eventual termination of her pregnancy; according to Article 3, termination may not take place before the 6th day after the initial request (which amounts to a lapse of 5 full days). An exception is possible when the health or life of the woman is at risk.

The Abortion Act has several other provisions. It states for instance that health professionals (also if working in a hospital with a licence) cannot be obliged to carry out an abortion and that conscientious objections must always be respected. Furthermore, physicians carrying out abortions must keep medical records on why in each case he/she decided to terminate a pregnancy. If required so, he/she must give the inspectorate access to these data (in a form which cannot be related to individual patients). Finally mention should be made of the obligation to provide adequate care after the termination has been performed. This includes not only a medical check and psycho-social assistance if needed, but – even more important maybe – an obligation of the establishment where the abortion takes place, to provide for responsible information and education concerning the prevention of undesired pregnancies.

The Dutch law is different from many other countries in Europe in that it makes no further distinction between the first and second trimester of pregnancy. There is only one exception to this: abortion clinics need special licence to perform an abortion after the 12th week of pregnancy (i.e. in the second trimester). This provision is not based on the (normative) view that in that stage of development the foetus deserves more legal protection than in the previous stage, but on the (factual) observation that after 12 weeks gestation an abortion is more invasive, both psychologically

\[\text{See for instance the abortion rate in the UK, which amounts to 16 (Abortion Statistics England and Wales, 1916)}\]

\[\text{According to the Annual Report of the Health Inspectorate 2015, in more than 90% of cases the time lapse was 6 or more days.}\]

\[\text{In a letter to Parliament of 24 January 2017 on ways to reduce the abortion rate, the Minister of Health states that she will also look how the re-imbursement of contraceptive care can be further improved.}\]
and medically, and that special skills and methods may be required to perform it safely. If this requirement is fulfilled, abortion can take place on the same basis during the first as well as the second trimester, as long as one remains within the 24 weeks limit.  

There are 3 interventions that do not fall under the Abortion Act. First of all, morning after methods, such as use of a “morning after pill” are not considered as a way to induce an abortion and are therefore not covered by the Act; the reason is of course that these methods prevent conception, which means that will be no pregnancy. The second situation is when abortion takes place as an unavoidable side effect of a necessary medical intervention or if continuation of the pregnancy would endanger the life of the mother. Although formally such an abortion still comes under the Penal Code, no prosecution or conviction will take place because the doctor is considered to have acted in a situation of ‘force majeure’ and he can invoke the defence of ‘necessity’, resulting from a conflict of duties. In the third place, inducing an abortion within the first month after conception does not come under the Abortion Act. This means that – although it still must be performed in a hospital or abortion clinic with a license (Article 296 Penal Code) – formally the provisions of the Abortion Act (including the statutory waiting period) do not apply. This interpretation of the Act goes back to the time (in the beginning of the 80ties) when it was not yet possible to confirm the existence of an early pregnancy beyond doubt. Although this situation belongs to the past now, this restrictive interpretation of the scope of the Act has survived until today (see further under Section 3 below).

The Abortion Act itself does not set a time limit for abortion, but the Penal Code does so. According to Article 82a, abortion amounts to a crime against human life if the unborn child has developed to the point where it is able to survive outside the mother’s womb (foetal viability). On the basis of present medical opinion, this is after 24 weeks gestation (in practice a period of 22 weeks is used). After that time period, the doctor involved can only defend himself by invoking a situation of necessity/conflict of duties (see further under Section 3 below).

3. Legal developments after introduction of the Act

After it came into force in 1984, the Abortion Act has not been modified. Nevertheless, some developments since the introduction of the Act deserve to be mentioned:

- the evaluation of the Act in 2004-2005;
- the establishment of an Advisory Committee in relation to late (third trimester) abortion in 2007;
- the introduction of a bill to enable general practitioners to induce medical abortion (by means of the ‘abortion pill’) in the first month after conception (in 2016 submitted to Parliament).

Unlike many more recent health laws in the Netherlands, the Abortion Act does not provide for an evaluation after 4 or 5 years after its introduction. However, its implementation is monitored by the Health Inspectorate. Anti-abortion groups and some political parties frequently raise issues with the government about abortion. Mainly in response to claims by these groups that the legislation is

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5 According to the Annual Report, more than 80% of terminations take place in the first trimester.
6 More exactly, this period (in which a termination is not considered an abortion in the meaning of the Abortion Act) is 44 days after the first day of the last menstruation (16 days overdue).
7 In practice, however, in almost 65% of these cases a waiting period ranging from 1 to more than 10 days is observed.
applied too liberally, it was agreed during the political negotiations for the new government coalition in 2002 that the application of the Abortion Act would be the subject of a nation-wide study.

In 2005, the evaluation report was published. On the whole, the conclusion of the report is that the compliance (both by clinics and hospitals, and by individual professionals) with the Abortion Act was satisfactory and that – apart from some points that could be improved – health professionals did what the law required from them to ensure that decisions concerning abortion were taken in a careful way. As to the objectives of the Act, the report concludes that abortion services are available and accessible where needed and that, in general, they are of good quality. At the same time the Act contributes to the protection of unborn life, inter alia in that it restricts abortion to licensed institutions and promotes careful decision making.

As to the question how the concept of ‘emergency’ is applied, according to the women who answered the questionnaire, usually the reasons to request abortion are discussed with the physician. Those reasons are quite diverse (ranging from financial and housing constraints, to age, the fact that the family is already ‘complete’, a broken or fragile relationship lack, lack of possibilities to raise a child etc.). Most often, there is more than one reason to request abortion. This picture is confirmed by a later study commissioned by the Ministry of Health and conducted in 2012: most women that were interviewed said that their final decision was the result of a number of reasons/factors and should be seen against the background of their present situation in life. All of them experienced the decision to terminate their pregnancy as a hard one, however, and some of them as the most difficult decision they had to make in their life.

One of the most important recommendations of the report relates to the fact (see Section 2) that the Abortion Act does not apply to an abortion within the first month after conception (16 days overdue). According to the report, this remainder from a time when it was not yet possible to confirm the existence of an early pregnancy beyond doubt, should be removed and also this situation should be brought under the scope of the Abortion Act.

During the last years, a new evaluation of the Abortion Act has been planned. It should have been carried out in 2017, but has been postponed in order to allow the new government (in office since end October this year) to give the ‘green light’ for it.

As mentioned before, terminating a pregnancy after 24 weeks of gestation is prohibited (and a crime against life under Article 82a Penal Code). Nevertheless, in medical practice the need for third trimester abortion has made itself felt, at least in exceptional circumstances. In order to provide guidance with regard to good medical practice, in 1994 the Netherlands Association for Obstetrics and Gynaecology published a report which lays down certain criteria. According to that report, such a late term abortion may only be considered if a fetal abnormality is diagnosed which either excludes the possibility of survival after birth, or is so serious that postnatal life prolonging procedures will be considered futile. After setting up a multidisciplinary committee to advise them on how the criminal law system should deal with these cases, in 2007 the Ministers of Health and Justice established a Central Expert Committee. Cases of late abortion for very severe foetal abnormalities have to be notified to it so that – after reviewing them along the lines already set out in the 1994 report – it can offer its advice to the public attorney as to whether or not prosecution should take place. After an

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evaluation in 2013, this arrangement was slightly modified in the beginning of 2016, but the basic rules have remained the same.

In 2015, the Minister of Health announced that she would like to make it possible that also general practitioners could induce abortion, at least in the very first period of pregnancy (within 16 days overdue). The method of medical abortion had developed sufficiently to perform such an abortion safely outside hospitals and clinics, and – according to the Minister – it would be important to involve general practitioners since they knew their patients well and would be in the best position to talk with them and advise them in case a termination of a pregnancy was considered. This idea met with resistance from several sides (not only from the anti-abortion side, but also from others who felt that the delicate balance in the Abortion Act should not be disturbed), but nevertheless (in the beginning of 2017) the government (then a coalition of liberals and social democrats) submitted a bill to Parliament that was to enable general practitioners to induce medical abortion (by means of the ‘abortion pill’) within that very first period of gestation. General practitioners who wanted to do so, would need a license and basically, they would have to comply also with the other rules laid down in the Abortion Act. Another important element of the bill was that abortion within the first month after conception (16 days overdue) which until then did still not fall under the Abortion Act (in spite of the recommendation resulting from the evaluation of the Act, see above), would be brought under the scope of the Act (also if taking place in a hospital or clinic). The only ‘concession’ to the procedural requirements of the Abortion Act, was that, instead of the statutory waiting time of 5 days, a flexible time lapse could be observed (as is already current practice in this situation).

In the autumn of 2017 a new government coalition was formed (consisting of liberal and christian parties); in its first meeting with parliament, the new government announced that it would not proceed with the bill. So, inducing abortion (also by means of medicines) will remain limited to licensed hospitals and clinics; furthermore, the present legal situation is not likely to change in the years to come.

4. Dutch law in the European context

In order to place the Dutch approach in a comparative perspective, a distinction between three models (a medical indication model, a time limitation model, and a counselling model), as elaborated by Eser and Koch in their standard work on abortion law) may be helpful. The more restrictive approach is reflected in the first model (in their words ‘the indication model on the basis of third party review’). In this approach, protection of the unborn life prevails and the exceptions to the prohibition of abortion are rather narrow. They are predominantly formulated in terms of medical indications (e.g. serious danger to the woman’s life or health); there is a reluctance to accept social ‘emergencies’ as a sufficient reason for abortion (except for exceptional ones, such as rape). What is typical for this approach is that the presence of an indication is to be established by persons other than the pregnant woman herself, usually one or more physicians. Although counselling of the woman may play a role, third party evaluation is decisive. The more permissive approach is represented by the ‘time limitation model’. Here, the woman’s right to self-determination equals, or even takes precedence over, the protection of unborn life, at least for a certain period (usually the first 12 weeks or first trimester of pregnancy). For that period, the decision on abortion is left to the pregnant woman, without further justification, let alone third party evaluation, being required. Any procedures provided for by the law, such as counselling, are rather

seen as a help to the pregnant woman to make up her mind, than as a duty imposed on her. Between these two classical position, there is the ‘counselling model’ or (in the words of Eser and Koch) the ‘emergency-oriented discourse model’. It is to be found in quite a few of the European countries that have reformed their abortion legislation in the past decades, such as France, Belgium and Germany. In this middle position, abortion is allowed if necessary to solve a situation of conflict or emergency in which there are no other remedies available to the pregnant woman. Whereas so far it has more in common with the indication model, it is more similar to the time limit model in that it leaves the final decision on whether abortion is the only solution, to the woman. At the same time, the process of decision making is not completely free, as – within a certain time-frame – the woman must submit to counselling and share her reasons to request abortion with the physician.

According to Eser and Koch, in abortion law reforms there is a tendency towards this third model. This is not only because it is trying to find the middle ground between a very restrictive and a very permissive approach. At a more practical level, taking into account that often an unwanted pregnancy will be terminated anyway, the best option may be to create a situation of trust in which the woman feels respected and so to provide optimal circumstances for careful decision making as well as for advice to prevent another unplanned/undesired pregnancy.

In terms of the three models described above, the Dutch legislation can be considered an example of the counselling model. Whereas protection of the unborn life has been an important concern for the legislator (abortion law continues to be linked to criminal law and abortion is considered a measure of the last resort), in the final analysis it is the pregnant woman who decides whether the emergency situation required by the law is there, be it in communication with the physician. The protection of unborn life is not aimed at by substantive exceptions to a general prohibition, but rather by procedural provisions intended to ensure sufficient time and counselling in order to make a careful decision. In contrast to some other countries that can be said to follow a counselling model in their legislation, however, counselling is not provided carried out by a third party to which the woman is referred (as in Germany), but by the physician who eventually performs the abortion and other health professionals (like nurses) who play a role at the intake and sometimes also in a further stage of the process preceding the termination of a pregnancy.

As mentioned in Section 3, research shows that women requesting abortion do so for many different reasons, and often for more than one reason at the same time. A medical indication model may not do sufficient justice to that situation, whereas the counselling model may be more responsive to the complex reality behind a request for abortion. It demands a weighing up process whose determining criterion is a conflict that the pregnant woman cannot avert in any way other than through termination. At the same time, in this model the competence of the professionals and the quality of counselling is crucial. This can be considered a weakness of the counselling model, in the sense that it makes the abortion practice less subject to direct control. On the other hand, competence and quality can be reviewed and improved, and in general professionals are willing to be accountable to these aspects of their work.

12 The Dutch Association of Abortion Specialists, for instance, has (in cooperation with other professional organisations) issued a number of guidelines relating to different aspects of their work, including the counselling process preceding the termination of a pregnancy.
5. Application of the law in practice

Cooperation agreement
Since 2016 there has been a national cooperation agreement between the Dutch Association of Abortion Specialists (NGvA), The Dutch psychosocial counselling service for questions of unintended pregnancy, adoption and abortion (FIOM), Dutch Society of Obstetrics and Gynaecology (NVOG) and the Royal Dutch association of Midwives (KNOV) on unplanned and unwanted pregnancy care.

Women with an unplanned and/or undesirable pregnancy and doubts about continuation of the pregnancy will generally go to their general practitioner. Some may go to an abortion clinic, a midwife, a gynaecologist or another health care provider. To support those professional in their care and to provide for an adequate referral system, this agreement has been produced.

Cast: who does what?
General practitioner: may be the first contact. Counsels the woman about her options. May refer the woman to an abortion clinic, a gynaecologist or for further (psychological) counseling. There is a national ‘Guidance for general practitioners in case on unplanned pregnancy’.
Abortion clinic doctor: may be the first contact. Counsels the woman about her options. May perform the procedure or may refer the woman for further counseling.
Midwife: may be the first contact. Counsels the woman about her options. May refer the woman to an abortion clinic, a gynaecologist or for further (psychological) counseling. However, a midwife may never be the referring physician, since legally only doctors are allowed to refer a patient for an abortion. Considering the legal framework of abortion (5 day reflection period) this is important to note.
Gynaecologist: may be the first contact. Counsels the woman about her options. May perform the procedure or may refer the woman to an abortion clinic or for further counseling.
Other professional: may be the first contact. Counsels the woman about her options. May refer the woman to the general practitioner or abortion clinic, but is never the legal referring physician.

General considerations in case of unplanned and undesirable pregnancy:
- Ask if the pregnancy test has been performed and whether it would be necessary to repeat the test
- Ask if the pregnancy is planned or unplanned
- Ask about the circumstances leading to the pregnancy, contraceptive use
- Mention there is always a choice and a dilemma in case of unplanned pregnancy
- Ask if the pregnancy has been correctly dated with a scan, in case of doubt perform a scan (in early pregnancy preferably transvaginally. When referring for a scan, please mention whether it is an undesirable pregnancy
- Is the partner present at the consultation? Explore whether the request is voluntary.
- Explore whether there has been any sexual abuse resulting in this pregnancy
- Be aware of cultural and religious factors
- Ask whether there would be a risk of genital tract infections, always test for sexually transmitted diseases.
- Always discuss contraceptives
- Is the request consistent or does the woman seem to panic and potentially may benefit from more time to make a decision?
- When referring a woman for an abortion always document the first date of the abortion request
• Offer digital choice help: [www.zwangerwatnu.nl](http://www.zwangerwatnu.nl)

**General questions to be asked in case of an undesirable pregnancy:**

- Are you certain about your decision?
- How did you reach this decision?
- Is this your own choice?
- Have you considered other options?
- Would you like me to explain the options?
- Do you need help to make a proper decision?

If the partner is present:

- What is his vision?
- Have they considered other options?

In case of ambivalence:

- The woman is responsible for her own choice, ultimately she has to make the decision
- Do not force the woman into making a decision, try to help her making a choice
- Do not blame the woman for being ambivalent
- Consider the emergency situation of the woman
- If the woman remains ambivalent, refer the woman for further counseling and to the FIOM

**The importance of time**

Time is important in any case of unplanned pregnancy in view of the method of abortion. Once a woman is referred or seeks advice a quick appointment is mandatory.

From the moment the woman indicates she is considering an abortion and the actual treatment a reflection time of at least 5 completed days is mandatory. This reflection time is not mandatory until a gestational age of 6 weeks plus 2 days (44 days after the first day of the last menstrual period).

**Treatment options**

1. **Termination of pregnancy**

Which treatment option is possible is dependent on gestational age. Basically there are three main options: curettage and medical abortion with mifepristone (anti-progesterone) and misoprostol (Cytotec-prostaglandin), or a combined method with misoprostol and curettage.

Women may choose where to have an abortion, in an abortion clinic or in a hospital. Both need a license to operate, provide by the government.

Women >16 years do not need parental consent. Between 12- 16 years parental consent is required, but may be withheld in case of reasonable arguments by the woman.

With the increasing awareness of the potential risk of curettage such as adhesions and an increased risk of preterm birth in a subsequent pregnancy, more and more doctors are advising medical abortions over curettage.

2. **Carry to term**

In case the woman wishes to carry to term, or the pregnancy is too far progressed to allow abortion the baby can be given up for adoption or for foster care.
In case of adoption The Dutch psychosocial counselling service for questions of unintended pregnancy, adoption and abortion (FIOM), the Council for Child protection and Youth Service play an eminent role.

There is ‘Guideline for counselling women considering termination of pregnancy’ (also in English: https://www.ngva.net/public/dokter_info/?section=8&langId=en)

6. **Trends and numbers**

The Dutch Health Care Inspectorate (Inspectie voor Gezondheidszorg, IGZ) produces an annual report with statistical information about terminations performed in the Netherlands during the preceding year, specifically for those which take place during the first 24 weeks of pregnancy. Further to the provisions of the Termination of Pregnancy Act 1984, all licensed hospitals and abortion clinics are required to submit a quarterly report to the Inspectorate. Registration may therefore be assumed 100%. The last report is for 2015.

### Total number of abortions in the Netherlands

![Graph showing the total number of abortions in the Netherlands from 1990 to 2015. The graph indicates a slight decrease in the number of abortions since 2000, with a slight increase in 2015.]

In 2015 there was a total number of 30,803 of which 3,882 in women from a foreign country (13%). The majority of the foreign women are from France and Germany. Only a small fraction comes from Ireland. Since 2000 there has been a slight decrease in the number of abortion. Not so in 2015. One of the arguments that has been considered is the fact that since 2011 oral contraceptive pills are only reimbursed to women up to 21 years.

Of all the abortion 16,121 are performed before 7 weeks gestation (52%), while 8,943 are performed between 7 and 12 weeks gestation (29%). Thus 25,064 (81%) of all abortion are performed < 13 weeks gestation.
The majority of women undergoing an abortion are between 25 and 30. Only 83 pregnancies were terminated in women < 15 years of age in 2015, as opposed to 96 and 87 in 2014 and 2013 respectively. The total number of pregnancy terminations in teenagers (up to 19 years) was 3,079. This was 102 abortions less compared to 2014 (3,181 teenage abortions) and 564 less than in 2013 (3,643 abortions). In 2015 only 10% of all pregnancies was performed in teenagers, as compared to 16.8% in 2002. Since 2002 there has been a steady decrease in teenage pregnancies. This is also reflected in the number of live birth among teenagers (data from CBS). Compared to other European countries the teenage pregnancy rate is low.
Internationally the abortion number is defined the same way and calculated by the number of abortions per 1,000 women between 15-44 years. Variation between countries is large. However, in most countries the abortion number has been relatively stable (primarily > 2005).

**International abortion number per 1000 women 15-44 years**
The potential effect of prenatal screening

Since 2007 all pregnant women in the Netherlands may undergo prenatal screening. They are offered the combined test for screening for Down syndrome, Edward syndrome and Patau syndrome. As of 2017 NIPT has been added as a first trier test to screen for the above mentioned trisomies. Moreover every women is offered a 20 week structural anomaly scan.

The majority (80%) of second trimester abortion > 12 weeks gestation are still being performed in abortion clinics. However since the introduction of prenatal screening the number of second trimester abortion treated in hospital has been increasing. Since 2011 it is possible to address whether an abortion is the result of prenatal diagnosis. Due to the manner in which the abortion are gathered, it concerns aggregated data so no correlation between the different components of the abortion registration.

In 2015 only 1053 of all abortions (3.3%) were performed after prenatal diagnosis of which 931 had a treatment in a hospital and only 93 in an abortion clinic, thus reflecting the difference of the situation.
We do know from the aggregated data that > 32% of the abortions in hospitals is due to prenatal diagnosis compared to only 0.5% in abortion clinics. However, we do not have any knowledge on diagnosis, nor is it possible to correlate the date with gestational age.

Number of abortion because of prenatal diagnosis

<table>
<thead>
<tr>
<th>Year</th>
<th>Prenatal diagnosis</th>
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<tr>
<td>2011</td>
<td>800</td>
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<tr>
<td>2012</td>
<td>900</td>
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<td>2015</td>
<td>1000</td>
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Prenatal diagnosis
7. Other considerations

Since 2012 it is mandatory to provide sexual education to all school going children. This should start in Elementary school around the age of 10 years.

Till 2011 contraceptives have always been reimbursed for every woman with insurance. Since 2011 only women up to 21 years get reimbursement.

Abortion is free for everyone who is legal and insured in the Netherlands. It is subsidized care. The costs are not reimbursed by the insurance companies but paid for by the Ministry of Health.

For foreigners or people living illegally in the Netherlands cost vary between 380 and 940 euro.