USSR: Ten million abortions?
In this issue

It is already nearly a year since the astonishing events of autumn and winter 1989 in eastern Europe, but the newly transparent affairs of this once most secretive half-continent still exert their grip on public attention.

For the second part of our eastern and central Europe survey, we have invited French demographer Dr Chantal Blayo to write a guest editorial. Analysing fertility trends, Dr Blayo finds that changes in abortion law have had no controlling influence on the number of children born to eastern European women. But they do have a very marked influence on the women's health.

If modern contraception is available, large numbers of women will use it. If it is not — often the case in eastern Europe — the pregnant woman may or may not abort. Should she decide not to have the child, the consequences for her health will be better if abortion is legal. Where it is not legal, her health will probably suffer, she may well die, and the overall maternal mortality rate will be high.

This is also true when abortion takes the place of contraception, as in the Soviet Union and to a lesser extent in other eastern countries. Dr A.A. Popov of the Soviet Academy of Sciences uses Health Ministry and United Nations statistics to show that Soviet women have between twice and 10 times as many abortions as women elsewhere in Europe. One rural area actually has over seven abortions for every birth.

This issue also contains the first outspoken statement on demographic policy in Albania, by Professor Lutfi Alia, Secretary-General of Health (page 10).

Our new Technology section announces large-scale trials of the hormone-releasing WHO vaginal ring (page 19) and a new barrier method that not only protects both partners against AIDS and other STDs but also, like the ring, is entirely under the woman's control.

On the world scene Drs M. Sabwa, P. Severyns and A. Keller report on UNFPA survey of three continents (page 16). This has pointed to ways in which family planning and maternal and child care programmes can, for a relatively modest investment, be made considerably more effective.

Diana Gibson

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Cover photo: Krass Clement & Billedhuset
Fertility in the east

by Chantal Blayo

At the end of the 1980s, the fertility level was lower in eastern Europe and the USSR than at the beginning of the 1960s, but the fluctuations over that period were more chaotic than in western Europe and the overall size of the reduction was smaller. The exception was Albania, where fertility was still very high in 1960 (averaging nearly 7.0 children per woman) but had fallen to less than 4.0 by about 1988.

As a consequence of these movements, changes have come about in the pattern of European fertility. There were many countries with relatively low fertility in the eastern part of Europe in 1960 — less than 2.0 children per woman in Latvia and Estonia, about 2.0 in Hungary and less than 2.4 in the other eastern European countries and other European republics of the Soviet Union — whereas most of the western European countries had higher levels. In 1988, on the other hand, the levels were least low in eastern Europe, although no country (again leaving aside Albania) attained a level of more than 2.2 children per woman (Poland), and in most cases it was less than 2.0. But there were also no countries showing fertility rates of 1.5 children per woman as in many western European countries, and still less 1.3, as in Italy.

The fertility levels of the various European republics of the USSR are now becoming more homogeneous (about 2.1 children per woman), although Moldavia, with 2.5, is an exception.

The timing of the sharp variations in the fertility levels observed during this period is connected with the dates of the legislative changes introduced in the various socialist countries. Generally speaking, however, restrictions on abortion in those countries where effective female contraceptive methods were not widely available have had much more spectacular effects on fertility than have family support policies, though these effects have often been only temporary.

In fact, one of the most surprising features of these countries is that they should have, given women the possibility of having legal abortions before modern contraceptive methods were available, in the 1950s in eastern Europe and in 1920 — even before there was any birth control by traditional methods — in the Soviet Union.

As a result, recourse to abortion has been much more common in these countries than in western Europe. The recent spread of the pill and intrauterine devices to some of them, such as Hungary, has made it less common, but abortion is still, in eastern Europe, much more widespread than it is in the west.

The German Democratic Republic is the only eastern European country recording less than 1.0 abortion per woman, a rate comparable to that of Italy, the western European country where abortion is most frequent (0.8 per woman). Hungarian, Polish and Czechoslovak women have an average of 1.0 to 1.5 abortions, while Bulgarian and Yugoslavian women have about 2.0. But the record is held by the women of the Soviet Union: seven million abortions a year are reported in the USSR and the unreported number is estimated at about three million. This gives an average number of abortions higher than 4.0 per woman if the under-reporting is taken into account, and an average number of pregnancies per woman in the region of 7.0, suggesting that little use is made of contraception, as A.A. Popov points out (page 5).

Abortion, liberalized in 1920 at a time when even traditional methods were still little used (the birth rate was then higher than 40%), was the first means of birth control used by couples in the USSR, which accounts for its very wide expansion in the absence of any competition. One result of these repeated abortions, which are not always carried out in the best possible conditions, is the proportion of maternal deaths due to abortion. For the USSR the figure is between 0.5 and 1.0 death for every 10,000 abortions, or 10 times more than the figure recorded in France (0.5 or 1.0 death per 100,000 abortions, depending on the year).

Disparities between different regions of the same country are sometimes as great as between countries. Yugoslavia holds the record, with an average of 4.0 abortions per women in Serbia compared with less than 1.0 in Kosovo.

There have been only slight variations in the average number of abortions in western Europe over the past 10 years or so. The movements recorded in eastern Europe are far greater: examples are the extremes recorded in Hungary (2.73 and 1.05) and in Czechoslovakia (0.75 and 1.42). Not only is there no negative correlation to be observed between abortion and fertility, but on the contrary it seems more likely that the correlation is positive: the most fertile eastern countries are also those in which abortion is most frequent. On the other hand, in Yugoslavia the most fertile republics

Not much room for a cat to get a nap: families are still larger in the eastern part of Europe. WHO photo
Brazilian women’s health group wins Dutch prize

The Coletivo Feminista, a women’s health collective in Brazil, has this year won the biennial Stimezo prize of 2,000 florins, awarded to organizations that have made an outstanding contribution to helping in abortion cases.

Stimezo, a Dutch association of abortion clinics, uses the prize to express its appreciation of women’s groups in developing countries which deal with family planning matters.

Coletivo Feminista has run a health Centre in Sao Paulo since 1986. The members provide information to parents on birth spacing, sexuality and contraceptive methods.

Women seeking an abortion are referred to trustworthy doctors who guarantee that the operation is performed under the best possible medical conditions.

In 1987 Coletivo Feminista organized a national congress on contraception, the latest reproductive techniques, research and legislation.

Condoms off the shelf

Yugoslavia’s modern RIS factory in Zagreb is now turning out 30 million condoms a year, reports Dr Fina Docevar, Assistant Federal Secretary for Labour, Health, Veteran Affairs and Social Policy.

Most of this production (25 million units) is for domestic consumption. Condoms can be bought from supermarkets, drug stores, pharmacies and newstands, and in some towns also from vending machines.

Poland, meanwhile, produced 75 million condoms in 1989, according to Ms Margaret Morrow, Vice-President and Director of Technology Management at PATH (Programme for Appropriate Technology in Health, USA), returning from a mission to evaluate Polish contraceptive production.

However, of this total, only 43 million condoms were actually used, which would be enough for no more than 300,000 women, or 3% of those in the reproductive age group.

Ms Morrow also found that Poles include condoms and spermicides under the heading “natural methods”, and have little access to oral contraceptives or IUDs.

The Ministry of Industry wants to produce 90 million condoms in 1990 in order to export the surplus.

In Turkey, 20 million units are supplied every year to the Ministry of Health by PIACT (Program for the Introduction and Adaptation of Contraceptive Technology). A feasibility study carried out in April 1988 by PATH estimated the potential annual market for condoms at between 50 and 80 million units.

Czechoslovakia’s average yearly production is 35-40 million units. In 1990, 25 million units will be used locally and the rest are expected to be exported.

Letters

Abortion in Denmark — correction

Thank you very much for sending me the issues of Entre Nous. I have read the latest issue with great interest, especially the articles about the situation in Eastern Europe.

But I have one remark about your short article on the meeting of 3 March on abortion in Denmark. When you refer to my lecture you state that I described the tendency in recent years as “worrying”.

My purpose was the opposite. The absolute numbers have been increasing slightly since 1985, but the rate did not increase until 1987. The large birth cohorts from the 1960s are beginning to count: that is the reason for the increase in numbers.

And when the birth rate is increasing as rapidly as it is — 14% since 1983 — the proportion of abortions is declining. So my purpose was to urge people to be careful when they discuss abortions, and especially not to point this out as being worrying.

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Competition

Still time for you to win $200!

Readers have asked us to extend the deadline for our logo competition, announced in Entre Nous No. 14/15, June 1990. It must have been harder than we thought.

So now you have until end December 1990 to send in your entry. Here’s what you have to do. Design a logo for the Sexuality and Family Planning Unit (SFP). You can refer back to the first article on page 4 of Entre Nous No. 14/15 to see what the SFP programme is all about. Don’t forget, your logo should be simple, easily understood, good to look at, and above all acceptable to all the Member States of WHO. The winner will receive a prize of US $200.

All our readers and their families can enter — why not ask your children to help?

Send your sketch to:

Entre Nous
Sexuality and Family Planning Unit
WHO Regional Office for Europe
Scherfigsvej 8
2100 Copenhagen Ø, Denmark.

Dominique Dalgaard

Continued from page 3

have far fewer abortions than those where contraception is commonly used (such as Serbia). There is therefore no systematic connection between the two phenomena, the form of contraception used being the most important factor.

The lack and inefficiency of contraception may lead to high fertility and few abortions or to high fertility and many abortions, or again to low fertility and many abortions, according to whether women choose, after conception, either to continue or to terminate their pregnancies.

The choice of abortion when conception has occurred is more frequent in Hungary than in Poland, but contraception is more widely practised there, so there are fewer pregnancies, fewer deliveries and fewer abortions. Contraception is still less common in Yugoslavia than in Poland, but in the event of pregnancy abortion is less often chosen in Poland than in Yugoslavia.

There are fewer pregnancies in Poland and fewer abortions (including clandestine abortions), but more deliveries.

These two examples show clearly enough that the choice is not between abortion and fertility, but between abortion and contraception. Women’s fertility is not controlled by means of changes in the law concerning the possibility of abortion: their health status, however, is directly related to such changes. The health of women has improved in those countries where contraception was already very widespread and where the legalization of abortion has been accompanied by the practice of abortion in better sanitary conditions as has been the case in the eastern European countries. It has deteriorated in countries where the law has become more repressive in this respect, Romania being a tragic case in point. And finally, women’s health is still unsatisfactory in all the countries where abortion too often takes the place of contraception, as can be seen in the Soviet Union and to a lesser degree in other eastern European countries. Fertility, however, is governed by other factors.

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See Europe Diary, page 24.
Sky-high abortion rates reflect dire lack of choice

The Soviet Union is unique in the world, says A.A. Popov of the Academy of Sciences, in having undergone a demographic transition in fertility rates exclusively as a result of the widest possible use of induced abortion

Family planning is a demographic instrument available to the individual, the family, society and the State. Family planning care consists, and should consist, of actions directed at the free and responsible choice of reproduction and parenthood, this being a basic human right. This concept of family planning corresponds entirely both to the WHO definition and the position of the United Nations.

However, when family planning is included in the national demographic, family and social policy, it becomes subordinate to the objectives of that policy. Family planning is then transformed into a tool for the reproductive manipulation of the individual — in other words, it becomes the most inexpensive solution to the economic problems of the State.

This relationship and interdependence between the social objectives of the State and family planning can clearly be observed in the USSR, giving family planning in the Soviet Union the following main characteristics:

- In formal terms, the right to family planning has been endorsed by commitment to international agreements. But in fact this right has not been realized and family planning has remained out of reach.

- Information and specialized, qualified medical care in the area of family planning and modern contraception are still not available.

- Reproductive behaviour has been imposed, all the way from the motivation, through the choice of contraceptive method, to the outcomes of reproduction.

- The only accessible method of family planning was and continues to be induced abortion for "social" indications.

- There is a very wide range of regional variation in all the parameters of family planning; this depends on the variation in ethnographic and socioeconomic factors in the region concerned.

- The level of abortions in the USSR (Table 1) indicates that it is probably the only country which has passed through demographic transition in the area of fertility exclusively by means of the widest possible use of induced abortions. In Italy in 1979-1988, on the other hand, a transition in fertility took place against a background of accessible family planning services and therefore did not cause growing levels of induced abortions (Fig. 1).

Furthermore, the low level of fertility in the USSR continues to be kept stable by

<table>
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* Health services of some specialized administrations not included
* Vacuum extractions in early pregnancy not included
* Vacuum extractions included

induced abortions. This characteristic of family planning in the USSR really has no match in any of the economically developed countries.

A certain decline in induced abortions in the 1980s cannot be explained entirely by decreasing abortion rates. Standardization (indirect method) shows that the decrease in induced abortions in the Russian Federation in 1970-1980 can be explained entirely by the changing age structure of women of fertile age, both in urban and rural areas. Furthermore, vacuum extraction was introduced in USSR in the 1980s, but the official statistics did not include abortions performed by this method until 1988, when it accounted for nearly 10% of all induced abortions.

Ten million abortions?
The level of induced abortions in the Soviet Union of 6.5 million per year is so high that it accounts for about 10%-20% of the estimated yearly figure of 30-50 million worldwide. If abortions outside hospitals are also included, the total will be increased by 13% according to official estimates, or by as much as 50%-70% according to independent sources, in which case it will amount to 10-11 million. However, even the level of registered abortions exceeds that in

Pretty lucky: their mothers and grandmothers had to rely on abortions. Viggo Riva©/Billedhuset
western or eastern European countries by a factor of 2-10 (Fig. 1).

Furthermore, significant regional differences in abortion rates can be observed. They depend entirely on the stage of transition of a given republic from high to low fertility levels. This clearly supports the importance of induced abortions as the main instrument of the demographic transition in the USSR (Table 2).

The wide spread in regional differences in fact makes the USSR look like a demographic model of the world.

Within every single region or republic also one can observe a great variation in induced abortions, the degree of variation being the highest in the Russian Federation. There the abortion rate ranges from 45.6 per 100 births in the Dagestani ASSR to 245.8 in the Kamchatka region. In the Russian Federation as a whole it is 182.2.

The variation between urban and rural rates in each region can also be by a factor of three or four, reflecting differences in income, lifestyles, and so on (Table 3).

**Highest world rate**

It should be pointed out that the ratio of 770 abortions per 100 births in the rural areas of the Central Economic Region of the Russian Federation is statistically valid and has no parallel worldwide. This figure is 30 times as high as in the United Kingdom, and 12 times as high as in Hungary. The area of the Central Economic Region is slightly less than that of France, at 485,000 km².

These differences in the use of induced abortions are due to differences in the structure of family planning method use.

Different proportions of induced abortions and of contraceptives use in the USSR and Hungary reflect difference in the accessibility of proper information, health services and contraceptive to the populations of the two countries.

Closely related to this, there are also fundamental differences between Hungary and Moscow in the type of contraception practised — Hungarians using mainly modern methods (IUDs and pills) and Muscovites predominantly traditional contraceptive methods (rhythm, condoms, douche and withdrawal).

**Few services available**

The structure of contraceptive method use in the USSR is attributable to a considerable lack of information, health services and contraceptives. Up to 70% of patients in maternity clinics, for instance, are not informed about contraception. Some 99% of the reasons given for non-use of contraceptives are related to their lack of availability. The availability of contraceptives in 1989 was only 10-30%, if presented as contraceptives supplied to pharmacies for sale as a proportion of estimated need.

Earlier estimates demonstrated enormous geographical differences in the availability of contraceptives in the Russian Federation, varying between 70% availability in Moscow and only 4% in the Krasnoyarsk region in 1980.

The lack of availability of contraceptives plays a significant role in the adoption of abortion-oriented attitudes and behaviour by 25% of the female population of Moscow, in the high levels of abortions performed outside hospitals, and in abortions among teenagers and primiparae. This can be demonstrated even by the underreported figures of the official statistics.

The officially registered number of abortions outside hospitals is also quite high. Geographical variation is in the range of a factor of three to four. The most tragic consequence of the lack of family planning services in the Soviet Union is the maternal mortality rate, which is extraordinarily high for economically developed countries (Table 4).

In conclusion it should be mentioned that apart from the general inadequacy of family planning services, there is also considerable inequity between the republics, reflected in the variations in maternal mortality rates throughout the country (Table 5).
Sexuality and glasnost: better than in 1930

This letter, from an American doctor who worked in Moscow with Margaret Sanger in the 1930s, first appeared in the New York Times of February 13, 1990

Glasnost Only Brought Soviet Sex Into the Light
Dmitri N. Shalin’s “Glasnost and Sex” (Jan 24) merits clarification about sexual conduct in the Soviet Union. Certain suggestions in the article deserve support — there and in the United States.

With Margaret Sanger, founder of Planned Parenthood, I went to the Soviet Union in the early 1930s to help teach birth control methods. After graduating from New York University in gynecology, I had worked at the West 16th Street Planned Parenthood headquarters (and later founded a birth-control clinic in Port Chester, N.Y., supported by a number of Republican women in Greenwich, Conn., just across the state line — Connecticut had outlawed birth control).

In the Soviet Union, Mrs Sanger lectured. I visited Moscow hospitals for a number of days. What I saw was not particularly pretty, what I learned not especially edifying.

Mrs Sanger had been invited by VOKS, the organization that dealt with foreign guests. I remember attending a party in the VOKS gardens where caviar and vodka and other delicacies were abundantly available — to us, but not to the Russian people just emerging from a major famine.

To read the New York Communist press back then, one would have concluded that birth control was alive and well in every Soviet clinic and family planning part of the diet. The contrary was true. Neither material nor instruction was available. I had brought with me a very large carton of diaphragms and spermicidal jelly provided by the Holland Rants Company of New York (carefully noted on my passport and requiring an official hospital signout that Continued overleaf
Family planning's first birthday

Lyn Thomas, IPPF's Europe Regional Director, reports from Moscow

The Soviet Family and Health Association celebrated its first birthday in January and has already begun setting up branches in six republics, including Turkmenistan. At the end of 1989 IPPF donated 15 million condoms and 3,000 cycles of low-dose oral contraceptives, but the USSR probably needs 300 million condoms and more than 20 million cycles of pills each year just to provide a minimum service.

The Association was recently confirmed as an associate member of IPPF, a tribute to the determination of a group of people who recognized the urgent need for family planning services in the USSR.

Access to good contraceptive services is extremely limited in the Soviet Union, and although abortion is freely available, and an often-used method of fertility regulation, even anesthetics are in short supply.

The Soviet Union was the first country in the world to legalize abortion, in 1920. However, in 1936 abortion again became illegal, except in cases where the woman's life was threatened, and stipends were introduced for women with large families. In 1955, once again recognizing the increasing number of cases of death and infection, the law was repealed and abortion remains legal today.

It is under the auspices of the Lenin Children's Fund that the Soviet Family and Health Association operates. Branches have been established in Riga, Frunze, Ivanova, Ashabad and Moscow. Other SFHA activities mean that family planning is being integrated into existing health clinics in five industrial enterprises, while SFHA has recently conducted a survey among 1,000 adolescents in Moscow and Frunze investigating attitudes to sexuality and contraception.

Dr Alexander Baranov, Deputy Minister of Health, recently restated the Government's commitment to improving services, through the provision of family planning at its women's counselling centres. In addition the 154 marriage counselling centres will be providing health education. Since 1987 the Government has recognized family planning as a major issue, but — once awareness of contraception has increased — the problem will be meeting demand.

There are some 70 million women in the fertile age group. Currently women in the western republics use abortion as a main method of fertility regulation. It is estimated that some 10 million to 13 million abortions take place each year; this implies a lifetime abortion average per woman of six, compared with 0.5 in the UK and 1.5 in the United States.

Many women prefer the perceived convenience of abortion to the insecurity of condoms, which have a reputation for being like "galoshes" and are in short supply, and irregular supplies of oral contraceptives, which are mostly imported from East Germany and Hungary. Pills are not well received since many women have gained a bad impression of them following publicity about their side-effects. IUDs, mostly imported from Finland although national commercial production has doubled in the past two years, are the favoured method in Asian republics, used by some 15% of women. To meet the needs of roughly 20% of women aged between 15 and 44, it is estimated that more than 1,000 million condoms a year are required. Joint ventures are being set up for contraceptive manufacture, but it will be some time before the needs of this large country with its diverse cultural mix can be met.

There is as yet no family planning information network in the USSR, and health personnel will need to be educated as well as the population. Existing health structures need to be reorganized and new ones established, while family planning training will be introduced into medical school curricula.
Background

A journey to Armenia

France Donnay is a gynaecologist/obstetrician working in Brussels

Leninakan, 7 December 1988. At 11.57 a terrible earthquake destroys the greater part of the city in a few seconds. Armenia's second city, Leninakan, has 210,000 inhabitants: there will be 50,000 dead, among them 25,000 children. The United Nations and numerous NGOs bring assistance to the Soviet Union and Armenia. They discover that, apart from emergency aid, the needs are enormous.

Leninakan, 7 September 1989. Nine months later, I am working at the Maternity Hospital in Leninakan, a gynaecological-obstetric mission for Médecins Sans Frontières (Doctors Without Borders).

With Armenian doctors and nurses, themselves survivors from the total destruction of their hospital, we help the women to bring into the world the children of the catastrophe, the children of hope.

However, in the surgery, I meet other women.

Women in black, seated and silent, who wait for us to tell them why they are not pregnant, and whether they can replace the children they have lost.

They are often adolescents. For others, at the age of 35, at 40, after five or six abortions, pregnancy becomes well-nigh impossible. A tragic example which illustrates what we all know: repeated abortions, used here as a means of birth control, seriously jeopardize fertility.

Whether legal or clandestine, the abortions most often take place in deplorably unsterile conditions, without any anaesthetic, by curettage and not by vacuum extraction. The only pills available have a strong dosage (0.05 mg ethinylestradiol), IUDs are not well tolerated. Contraceptive equipment is inadequate. Training of health workers is not up to scratch.

Like others before me, I had long discussions with my colleagues and patients about modern methods of family planning.

As I was leaving, Dr Mary Khachikian, a gynaecologist at the Krupskaya Institute of Yerevan, told me of her projects: a fertility survey in Yerevan and Leninakan, the setting up of pilot family planning centres until a real family planning programme can be established in Armenia. And after that, no news.

It's winter. Life is difficult. Perestroika gets bogged down in ethnic conflicts and economic difficulties. Romania explodes. People forget about Armenia. And, down there, the telephone never works. Where are the priorities?

Brussels, 7 March 1990. Through MSF I receive a telegram from Yerevan. At the request of the Armenian authorities, with the agreement of the Soviet Ministry of Health, I am to be responsible for an exploratory mission in April 1990. In the present phase WHO and MSF are equally involved in the answering the appeal. Contacts have been made with Professor Akundts, head of the gynaecological-obstetric services for the whole country, and with Dr Khachikian.

Armenia wounded is also Armenia enlightened. It wants to give itself the means of survival, and the right to choose.

Postscript

Brussels, July 1990. It was realized later that many women were unable to get pregnant again because of their previous abortions.

The effect of a dramatic event like an earthquake on people's fertility and sexuality ought to be investigated. Dr Mary Khachikian is now conducting a survey in Yerevan. The first results show a higher percentage of secondary infertility than usual (21%) and a primary infertility of 3%.

Contraceptive use among the 4,500 people interviewed is: IUD 8.1%, pills 1.79%, condoms 16%, natural methods 7.2%, coitus interruptus 19.1%, sterilization 0.18%.

During my visit in April 1990 I met the Armenian Health Minister, Professor Aznar, and the Chief of Obstetrics and Gynaecology, Professor Akundts. They want the international organizations to consider the family planning and infertility problems in their country and help the professionals improve women's health by reducing abortions and spreading adequate and safe contraceptive methods.

In January 1991 a multi-agency team is expected to assess the situation.

Professors Khachikian and Akundts and three other gynaecologists will visit Belgium and England in October 1990 to talk about family planning services, infertility consultations and family planning associations. At a later stage, western experts will go to Armenia to train the doctors and nurses and to set up pilot family planning programmes in some regions.

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Aftermath of catastrophe: the hospital is now a tent (above). Most of Leninakan lies in ruins

France Donnay
Albania

Pronatalist policy maintains 2% growth rate

Birth spacing and the avoidance of unwanted pregnancies in Albania are achieved entirely by natural methods and condoms. Lutfi Alia, one of the country’s top health officials, wrote this first public statement of Albania’s demographic and family planning policy especially for Entre Nous

Albania is undergoing a dynamic population increase. The average age is low and the younger generation make up the major part of the population. In 1989 Albania had 3.2 million inhabitants, twice as many as in 1960 and four times as many as in 1929.

The State implements a pronatalist demographic policy. Support for population increase has ensured a high rate of population growth, which has stood at 2% for the past five years. Meanwhile the annual rate of economic development planned for the same period was 5-7%, or two to three times higher than the rate of population increase. This means that family planning in Albania is supported by the demographic, political, economic and health situation of the country. Concentration on the family planning and health education policy is convincing people to increase the number of children they have, improve birth-spacing, and prevent undesired pregnancies by adopting natural methods and freely using condoms, which are sold in pharmacies.

Women are only allowed to use hormonal and mechanical contraceptives when there are medical indications. Legal abortion is permitted only for medical reasons and must always be approved by the medical commission of each district.

This family planning policy, which is linked to demographic trends and to the rate of socioeconomic development, has proved to be effective for Albania.

First WHO/UNFPA comprehensive population programme

One of the least known European countries, Albania is now cautiously opening up to the outside world.

Since 1987 the WHO Sexuality and Family Planning Unit has been helping the Albanian authorities with a major US$ 900,000 project, financed by UNFPA for three years, to strengthen the national reference centre for paediatrics. The project consists mainly of short-term international fellowships for specialization in paediatrics and obstetrics/gynaecology, and the supply of medical and surgical equipment.

In December 1989 a joint multidisciplinary UNFPA/WHO team was invited to Albania by the authorities to explore the possibility of funding a new phase to complete the previous project. The team made the following recommendations:

• The "maternal" component in the government’s MCH programme should be strengthened through a specific programme for each of the three levels: national, regional and local. The aim will be to improve diagnosis and treatment, update training, increase motivation and improve equipment.

• Birth spacing policy should be structured by means of specific activities in the framework of the family planning methods agreed and recommended by the government.

Two WHO consultants from the Regional Office for Europe and from Headquarters will visit Tirana at the end of September 1990 to prepare a project document along these lines, to be submitted to UNFPA for approval and funding.

At the moment, apart from traditional methods of birth spacing such as withdrawal (known to our Albanian colleagues as "changing down"!), access to modern contraception is very limited and seems to be available only on purely medical grounds.

For example, in 1988 some 300,000 condoms were imported, only about enough to cover the needs of 2,000 women for one year.

There are 30 medical indications for legal abortion, but the woman is obliged to appear before a committee whose decision is final. Illegal induced abortion is believed to occur, but it is difficult to estimate how many such abortions there are.

One of the aims of the new project will be to try to respond adequately to the needs of the Albanian people for modern contraceptives. It will be one of the components in UNFPA’s programme of assistance to Albania for the period 1991-1995.

Associate Professor Lutfi Alia
Secretary-General
Ministry of Health
Tirana, Albania

Early years: most Albanians today belong to the younger generation. Heine Pedersen/Billedhuset

D. Piorotti
WHO Regional Office for Sexuality and Family Planning

ENTRE NOUS 16, September 1990
Yugoslavia

Too many abortions

The mass use of abortion — legally available on request up to the end of the 10th week of pregnancy — is described by the Federal Assembly as an acute problem in Yugoslavia today. These extracts are from a new report by demographer Mirjana Rasevic

Why do Yugoslav women rely on abortion and not use modern contraception? The most frequent research findings point to insufficient knowledge about modern contraception and difficult access to it, distrust and fear of modern devices and methods, ineffectiveness of the devices used and lack of reasoning about preventive means.

The fact that abortions rose to 400,000 in the 1980s confirms that a large share of the population controls fertility with this method. In 1969 there were 66.2 abortions per 100 live births; in 1986, 108.1. Today, with 74.5 abortions per 1,000 women aged 15-44, Yugoslavia can be classified as one of the European countries with the highest rates. Only the USSR’s rate is higher (see page 5). Everywhere except in Kosovo, almost half of all pregnancies end in an abortion.

In most recent years, the share of illegally induced abortions in the total number of abortions has been negligible (0.1). This represents an achievement as an outcome of liberal legal regulation of abortion, the increased number of medical institutions, a higher level of education and better access to information about abortion possibilities.

The marked increase between 1969 and 1986 in the number of abortions per 1,000 women — from 14.0 to 50.4 — occurred in the 15-19 age group, and almost 11% of those who had an abortion in 1986 belonged to this group. Such an increase of abortion among adolescents reflects changes in their behavior, early maturing, earlier initiation of sexual intercourse, weakening of traditional norms and a preference for abortion over early marriage. Changes in the underlying causes of early sex activity are not accompanied by an appropriate knowledge of contraception. Sex education in schools and family planning counseling have been neither systematically developed nor widespread.

The extremely high abortion rates among adolescents in Bosnia and Herzegovina, a less developed republic, show that adolescents there are faced with a stronger controversy between modern and traditional than in other developing regions. They accept new patterns of sexual behavior without accepting other modern values to the same degree.

Most of the women who had abortions in 1986 (90.8%) were married. Although considerable parts of Yugoslavia are developing regions, such a high share of married women controlling fertility by abortion makes Yugoslavia an exception in Europe and is another indicator of the prevalence of abortion as a means of fertility control.

Although there are limitations to the data, over 70% of women interrupting a pregnancy had already had an abortion. As the number of repeated abortions increases, the share of women with high abortion orders, among all women having an abortion, decreases. It seems that they only become aware of the negative implications and begin to use more effective contraception after having several abortions. Perhaps voluntary sterilization, only recently introduced, will be a solution.

The number of maternal deaths has gone down from 35.1 per 100,000 abortions in 1969 to 3.1 in 1986. This is still relatively high for a developed country but it does show that liberalization and legalization of abortion, as in other countries, have reduced the death rate from this method of birth control.

In the 1980s the fertility control methods still used by the Yugoslav population are far from satisfactory. Better results are not likely to be achieved quickly. The duration of the prevalence of induced abortions indicates that the underlying causes of the frequency of abortions are numerous and stable over time. A change will depend, to a large extent, on the ability and willingness of the State to cope with this issue.
New population law gives regions a choice

Population and family planning policy in Yugoslavia at last reflects the economic and demographic disparities in the country’s republics and autonomous regions. On 20 April 1989 the Federal Assembly passed a Resolution on population development and family planning which took special account of these regional differences. *Entre Nous* invited authors from two different disciplines to comment.

**Dubravka Stajpar** is Professor at the Zagreb Institute of Mother and Child Health in Croatia. After the Second World War, Yugoslavia developed a system of health care in which primary health care paediatricians and gynaecologists played a central role in providing services to mothers and children, including family planning. Abortion was legalized as a method of fertility regulation, and fertility has been continuously declining.

Family planning has not developed according to need: the number of registered family planning services has not corresponded to the number of practising gynaecologists in all regions.

The net reproduction rate has been lowest in Voivodina, Serbia proper and Croatia. It is under 1% in six of eight regions (a net reproduction rate of 1% means exact replacement). Life expectancy is higher in all parts of Yugoslavia for females, the differences between the sexes depending on the economic developments in the particular region. About 90% of the Yugoslav population have a fertility rate under replacement level. Abortion rates have been highest in Serbia proper and Voivodina.

Under the terms of the new Resolution the regions of Yugoslavia now develop their proposals for population policy according to their fertility levels and trends. The aim of the population policy is to encourage families to have two or three children.

The new laws on health and health insurance vary according to changes in the economic and social organization of the regions. Several articles in these laws provide for institutions to organize MCH and family planning.

For the first time the health care programme in Croatia for the 1986-1990 period included a primary health care system which covers the entire field of primary health, as can be seen from the programme for health education and services related to family planning. This trend is set to continue in the 1990s.

The continuation and development of sex education for adolescents of both sexes in cooperation with a variety of subject teachers will be particularly valuable. The aim is to teach adolescents about various aspects of sexual life, the risks in particular. The risks are pointed out of unwanted pregnancy and abortion associated with a too early sexual debut, and of STDs associated with too frequent changes of sexual partner. There is also emphasis on changing the previous attitude towards women.

Physicians working in school health care have been trained in a number of subjects, including public health and the clinical and organizational aspects of the health status of school-age children and adolescents.

We do not have recent data for all regions. At the MCH Institute in Zagreb we have done KAP studies on sexual life and family planning several times since 1971. The results of the most recent study will be published this year.

The abortion rate in Yugoslavia per 1,000 adolescents is lower than in the United States, Canada, Scandinavia and some central and eastern European countries. Registered family planning services in Yugoslavia exist only as part of primary health care for women, and are very few in number in relation to the needs of adolescents.

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**Nila Kapor-Stanulovic** is Professor of Psychology at the University of Novi-Sad, in the autonomous region of Voivodina, Serbia.

The Federal Assembly’s Resolution grew out of increasing concern over the demographic situation in Yugoslavia.

There are great regional differences in population growth, fertility is declining in many regions, and the population is aging. The natural increase of the population in Yugoslavia as a whole continues to decrease. In 1988 this overall natural rate of increase was 6.2 per 1,000. However, the individual rates range from 0.2 per 1,000 in the Autonomous Province of Voivodina to 24.0 per 1,000 in the Autonomous Province of Kosovo (data for 1988). The Resolution contains general principles and directions for population development.

No repressive measures will be undertaken. The right of each individual to decide freely on childbirth, proclaimed as a basic human right in the Yugoslav Constitution, is to be preserved. It is expected, however, that individuals should take into consideration the broader aims of society when deciding on the number of children to have.

Modest birth rates are being promoted (two to three children per couple), as is the idea of responsible parenthood. Plans are now being made for specific measures to disseminate contraceptive information and supplies more widely. At the same time, reliance on abortion (although there are no limitations on its use) is being discouraged. A number of provisions which already exist, but at present are perceived primarily as social welfare benefits, will be strengthened. These include maternity leave (to be prolonged), child allowances, and child care facilities, the number of which will increase.

A month earlier, on 15 March 1989, the Yugoslav Assembly passed another important document. This is called “Operative programme of social policy measures related to family planning in the autonomous province of Kosovo”. The main objective of this programme is to increase the acceptability of family planning in Kosovo (south-eastern Yugoslavia). The birth rates in Kosovo are the highest in the country. At the same time the level of general development and the standard of living are the lowest.

The programme consists of 27 measures. Each specifies its objective, the responsible body and a fixed deadline for implementation. The measures range from educational interventions to improvements in health services and social and legislative regulations related to family planning.

**Professor Nila Kapor-Stanulovic**
Department of Psychology
Faculty of Philosophy
University of Novi-Sad
21000 Novi Sad, Yugoslavia
Czechoslovakia

Time for more sex education and family planning?

Medical sexology is well established in the Czech and Slovak Federal Republic but full sex education and contraception are not. Jan Zbytovsky, psychiatrist and sexologist, hopes that changes are on the way.

The Institute of Sexology was founded in Prague in 1921, shortly after the First World War. Professor Josef Hynie, the founder of Czechoslovak sexology, established the principle of multidisciplinarity in this branch of medicine. Hynie was the inventor (in the 1930s) of andrography, which made it possible to simultaneously investigate the erectile and the secretory (and/or excretory) ability of male genital organs.

Since the early 1960s the Institute has been the educational base for psychiatrists, gynaecologists and dermatovenereologists interested in a postgraduate education in sexology.

Today, medical sexology is officially accepted as an independent medical speciality. It has its own postgraduate training programmes, board of specialists, and examinations. In 1974 Professor Raboch became Head of the Institute.

New sexology clinics

Outpatient clinics in the regions deal chiefly with the diagnosis and treatment of functional sexual disorders (about 70% of clients) followed by the examination and treatment of sexual deviants and, to a lesser degree, patients suffering from male infertility. Disorders of sexual identification are treated by multidisciplinary teams.

Sexological research laboratories are equipped with phalloplesymographic apparatus [for measuring blood pressure in the penis] built to Figar's original Czechoslovak-patented design.

Marital counselling is done mostly in cooperation with the special counselling centres.

Most sexologists are involved in sex education, which is part of the school curriculum for all levels but mostly given during the final years of primary and secondary school. Things are improving nowadays: there are better opportunities for publishing, and the mass media are more open, devoting considerable space to sexual questions. Cooperation with the schools and the educational institutions is also better.

Condoms exported

Sex education is strictly limited to discussion of contraceptive matters. Czechoslovakia is one of the main producers of condoms in eastern Europe (see Briefing, page 4), but much of this production is exported and one Czechoslovak man in the 15-60 age group uses only two to three condoms a year (in Poland the figure is only one condom a year).

Only 23.5% of our women aged 15-44 use hormonal contraceptives or IUDs in Prague, paradoxically, the figure is only 12.6%. In the German Democratic Republic, for comparison, hormonal contraceptives only are used by 60% of women.

Only 15% of young people use some form of contraceptive (mostly the condom) at first intercourse, whereas the figure in Sweden is 85%.

Nowadays, in the AIDS era, we have had about 150 HIV-positive persons registered by the State health services. About 15 were registered as sick people, and of this number five have died. In fact, we presume that we have many more HIV-positive persons (at least 10 times more) who have no confidence in the State health service. That is also the reason why, since the November revolution in 1989, homosexuals have started to become active and have founded voluntary associations which are organizing AIDS counselling services, with the possibility of anonymous HIV-testing. They plan to cooperate with specialists (sexologists, psychologists, social workers) and also volunteers.

Our society has recently undergone major and all-embracing structural changes, and we hope that this new, favourable reality will also be reflected in the field of sex education and family planning.

Dr Jan Zbytovsky
Head, Sexological Clinic
Department of Psychiatry
University Hospital
Hradec Králové, Czechoslovakia

Bulgaria

Male infertility surprisingly high

More than half of all cases of childlessness in Bulgaria are due to infertility in the man. Treatment is free, but many patients come too late. Dimitar Vassilev reports

Bulgaria's overall infertility incidence of 11.4% — assessed during a representative study of 28,652 Bulgarian families in 1982 — is similar to the average for European countries.

However, the male factor as a principal cause or component of the complex causes of childlessness in a couple was diagnosed in approximately 55% of cases.

Primary infertility prevails, due to the better results now obtained from the treatment of secondary infertility. There is an enormous regional variation, which cannot be explained on the basis of the date available.

Three main causes

In 38.6% of the cases of male infertility investigated, sperm-count disorders were found to be a leading symptom, while in 39.5% various degrees of sperm immobilization (asthenospermia) were detected. A large number of men — husbands, presumably from the oldest cohorts — had not come to the infertility clinics for spermogram evaluation (only 22.2% had been checked in this way). In almost one in five cases (18.4%) severe oligospermia or azoospermia was found.

Congenital defects were the most prominent: varicocele, cryptorchidism, cysts of the epididymis or ductus deferens, absence of some parts of the male reproductive organs, etc. Close to two thirds

Puzzling: no-one knows why the male infertility rate in Bulgaria varies so much. UN Photo
Continued from previous page
of the patients with varicocele (67.8%) had abnormal spermograms. More than eight out of ten had the abnormality on the left side.

As a second cause, chronic inflammation, presumed to be prostatitis, was found: this in up to 30-35% of the cases. It was very difficult to specify the microorganisms involved in each individual case, especially when microbial association was suspected. The fact that chlamydiosmosis was observed in one quarter of the males and mycoplasmas in 57.4% is significant. Unfortunately, no practical method for the easy paraclinical diagnosis of Chlamydia infection is yet available.

In third place (22-25% of cases) came idiopathic oligospermia. Cryptorchidism usually correlated with an azoospermia (61.5% of cases) or oligospermia. In one out of seven cases cryptorchidism is connected with other abnormalities such as hypospadias, phimosis, etc.

Artificial insemination
Male infertility has been recognized as a common cause of infertility in Bulgaria since the early 1960s, which is when research began. In 1968 artificial insemination by donor (AID) was confirmed as a legally accepted procedure under the Family Code. The estimated number of successful AIDs done annually is about 2,500-3,000 cases, with a positive result in approximately 27.2%. The results correlate negatively with the age of the women inseminated. After the age of 36, pregnancies as a result of AID are very rare.

In 1981 a national semen bank was created with the help of UNFPA and the WHO Regional Office for Europe. Sperm donation and AID were regulated by means of a special decree, which specified the procedures, payment and medical requirements. The donation of semen is government-financed.

Countrywide network
Since the 1960s the whole country has been covered by a network of infertility clinics. In the early 1970s a uro-andrological service was established. Treatment of the various types of male infertility is free of charge.

For the time being the basic problems facing public health infertility services are the screening system (59.7% of patients come too late) and the introduction of new technologies. Other important areas of need are the mobilization of resources, training, and the regular supply and importation diagnostic products (kits, other technology and instruments).

Spotlight
Hungary’s Mr IUD
In 1992 István Batár, Professor of Gynaecology at the University of Debrecen in Hungary, celebrates an important anniversary: 20 years of loyalty to his hospital, 20 years as head of the Family Planning Centre, 20 years of gynaecological consultations.

With 23,057 IUD insertions to his credit since 1972 — or six per day for 18 years — István Batár holds a record that is hard to match.

Entrez Nous has decided to award him the title of “Hungary’s Mr IUD”!

Doesn’t it get monotonous performing the same, repetitive surgical procedure — which after all is fairly simple for someone with experience — morning after morning? Not at all, says Mr IUD, with his usual benevolent smile.

He has in fact tested and used every IUD authorized for use in Hungary over the last 20 years — a total of 21 models.

The first was Szontagh’s loop, just a length of nylon fishing-line knotted into two interlinked circles. Now he is testing the new generation of active devices: the LNG, containing levonorgestrol, a long-acting progestogen, and the Flexigard®, consisting of six copper sleeves attached to a nylon body which is fixed to the top of the uterus by a small hook.

New devices mean new research. István Batár is currently supervising seven studies to compare the side-effects, tolerance and efficacy of the new IUDs. Since 1972 he has either directed or taken part in more than 30 international studies that have been written up in over 50 journal articles.

On top of this exceptional record, he has never had a fatality or a disabling accident among his clients.

For three women, each with a uterus bicornis, he has even inserted two IUDs per uterus, one in each "horn".

And finally, accepted wisdom notwithstanding, a handful of his clients have worn a Szontagh loop for 20 years without a break, and more than 3,000 have for 10 years worn copper IUDs, for which the period of use usually recommended is two, three or five years at the most.

As a method, the IUD takes second place in Hungary, with 15% of women of reproductive age using it — way behind the pill, used by 35%. In the year 2000, Mr IUD will celebrate 28 years in the service of contraception, with perhaps his thirty-five-thousandth insertion.

Entrez Nous wishes him good luck.

D. Pierotti

IUD record: Professor Batár’s clients have tested 21 different models. Sven Oredson/Billedhust

Professor Dimiter Vassilev
President of the Bulgarian Society of Planned Parenthood and Family Development
PO Box 5
Sofia 1199, Bulgaria
AIDS strategies in eastern Europe

The following are the results of an informal *Entre Nous* survey on the AIDS problems and priorities in various eastern European countries.

**Czechoslovakia.** The main risk groups for HIV infection are homosexuals and bisexuals. Several hundred intravenous drug users have been tested, but none was HIV-positive (March 1990). The health authorities' current programme includes: continuation of educational campaigns; testing, and counselling of HIV-positive people; and increasing the role and influence in AIDS prevention of NGOs such as the Lambda Union (of homosexuals) and SAP (AIDS Help).

**Poland.** Testing has identified intravenous drug users, homosexuals and prostitutes as the major population groups infected with HIV. The government is now concentrating on educating medical workers, providing better equipment to hospitals and seeking more money for health care generally.

**USSR.** All sexually active people are considered to be at risk. Information, education and testing for HIV-positivity are the present strategy.

Yugoslavia. The four main groups at risk are intravenous drug users, homosexuals, Yugoslav workers in the African AIDS belt, and Yugoslav "guest-workers" in various western countries. The government is engaged in anonymous, unlinked testing; voluntary testing of target groups; and education of medical personnel so that they can carry out counselling.

*Entre Nous* is grateful to all those in the ministries concerned who replied to its questionnaire.

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**Cumulative AIDS cases in selected countries (as of 1 March 1990)**

![Graph showing AIDS cases in selected countries as of 1 March 1990.]

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**Cumulative AIDS cases by percentage transmission group (selected countries as of 31 March 1990)**

![Graph showing AIDS cases by percentage transmission group.]

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**HIV-testing of the Soviet population as of 13 January 1990**

<table>
<thead>
<tr>
<th>Population tested</th>
<th>Number tested</th>
<th>HIV by western blot</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epidemiological investigation *</td>
<td>306</td>
<td>0.0009</td>
</tr>
<tr>
<td>Drug addicts</td>
<td>286,886</td>
<td>2</td>
</tr>
<tr>
<td>Homosexuals/bisexuals</td>
<td>48,326</td>
<td>2</td>
</tr>
<tr>
<td>SDT</td>
<td>1,026,857</td>
<td>28</td>
</tr>
<tr>
<td>Sexually promiscuous</td>
<td>449,493</td>
<td>5</td>
</tr>
<tr>
<td>From abroad</td>
<td>440,874</td>
<td>16</td>
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<tr>
<td>Blood donors</td>
<td>32,237,974</td>
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</tr>
<tr>
<td>Pregnant women</td>
<td>13,614,973</td>
<td>14</td>
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<tr>
<td>Blood recipients</td>
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<td>Military</td>
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<td>Prisoners</td>
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<td>Clinical reasons</td>
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<td>Anonymous</td>
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<td>Casual contact</td>
<td>99,810</td>
<td>0</td>
</tr>
<tr>
<td>Others</td>
<td>2,772,804</td>
<td>17</td>
</tr>
</tbody>
</table>

Total: USSR citizens | 47,172,882 | 429 | 0.0006 |

* Includes children infected through nosocomial transmission

*ENTRE NOUS* 16, September 1990
MCH/FP programmes weak on information management and logistics support

Poor collection, analysis and utilization of data in maternal and child health and family planning programmes around the world are hampering effectiveness in the daily management of programmes and supplies. M. Sabwa, P. Severyns and A. Keller of UNFPA report on a recent diagnostic survey and the remedies proposed.

Too many MCH and family planning programmes suffer from a lack of basic information, irregular collection of data and a lack of basic indicators, according to a diagnostic survey completed recently by UNFPA and other organizations in 40 countries of Africa, Asia, Latin America and the Caribbean.

Where data do exist, say the investigators, they are often useless for managing daily activities or making decisions on programme orientation and future activities.

Moreover, the logistics support systems of MCH/FP programmes studied in 18 African countries also proved to have serious deficiencies in needs assessment, dispatch, customs clearance procedures, warehousing, transport and statistical data collection.

Overhaul in view

Plans to strengthen the information management and planning base of MCH/FP programmes have emerged from the survey, in which bodies such as CELADE (Latin American Development Centre), ESCAP (United Nations Economic and Social Commission for Asia and the Pacific) and the Population Council collaborated with UNFPA.

The first part of the survey covered information management systems of programmes in 27 countries in Africa, 5 in Asia and 8 in Latin America and the Caribbean. The second covered logistics support systems in 18 sub-Saharan African countries, where MCH/FP needs are the most urgent.

Experienced consultants carrying out the diagnosis spent about three weeks in each of the countries participating in the survey, collecting the national and regional information needed.

The countries were chosen on the basis of a contraceptive prevalence of 30% or lower, and the fact that they neither had received, were receiving or had been promised assistance from any outside source.

Specially designed questionnaires were used to interview representatives of multilateral and bilateral agencies, NGOs, health professionals and staff of national authorities.

The weaknesses observed in the information management systems in the 40 countries can be summed up as:

- too many programmes functioning without access to basic information on infrastructures and human resources;
- too many functioning without regular collection of statistical data on programme activities; and
- too many functioning without indicators of quality.

The consultants concluded that to make information management systems an effective management and planning tool the most important needs were:

- the transfer of technical knowledge through consultancies and an adequate training programme;
- in certain countries additional trained staff although these can easily be kept to a minimum by the training and specialization of existing staff, with financial help from abroad; and
- the acquisition of data processing equipment and a very few vehicles.

The cost of applying these remedies is estimated at about US$300,000 per country per year for three years, and the same amount again for a follow-up survey.

Useful investment

However, this should be an excellent investment, in view of the enormous sums now being spent on MCH/FP programmes and services without the existence of a solid management and planning base. Better management will also bring many other benefits as the programmes' health and demographic objectives are achieved.

The serious weaknesses found in the logistic support systems studied in the 18 sub-Saharan African countries had to do with needs assessment, dispatch, customs clearance, warehousing, transport and statistical data collection.

Surprisingly, unmet needs in buildings and transport were the least of the problems, according to governments and donors such as the World Bank, Unicef and USAID, which were operating in almost all the countries surveyed.

The most flagrant deficiencies, on the other hand — in 16 of the 18 countries — turned out to be in needs forecasting procedures, advance requisition of supplies, implementation and use of a data collection system, the definition of maximum and minimum stocks, and to some extent in the first-in/first-out system.

Skills to be upgraded

Here again the most important remedies were said to be technical assistance and staff training. As technical assistance costs consist essentially of salaries and subsistence for consultants, they could be reduced by building up regional expertise. The estimated cost would then be US$200,000 per country per year for three years. This investment will not only benefit other health services in the countries but also help encourage government and external investments, and help reduce the negative effects of poor management of contraceptive and essential drugs supply systems.
New MCH/FP director for Turkey

Professor Tomris Türmen has recently been appointed Director of the General Directorate of Maternal and Child Health and Family Planning in Ankara. A paediatrician and neonatologist by training, Professor Türmen will also continue with clinical work at Ankara University.

She is delighted with her new job and convinced that her team are highly qualified, highly motivated and well organized.

In family planning matters, Professor Türmen believes in methods of gentle persuasion. One of her Directorate's key tasks will be to inform every couple that they can have as many children as they want, so long as they have the psychological, environmental and material means of providing for them and giving them an education.

There will be a whole series of measures designed to bring down maternal morbidity and mortality. Young married couples, for example, will be asked to put off their first pregnancy until the woman's 18th birthday.

Some 23% of pregnancies are still attended by untrained traditional midwives, but in four years' time, when qualified midwives are assigned to all the rural areas and a public information campaign is completed, this should no longer happen.

Pregnant women will be encouraged to attend antenatal clinics at least four times, beginning as soon as the pregnancy is diagnosed.

Neonatal intensive care and treatment of paediatric disorders are both emphasized in Turkey's new MCH/FP programme.

At primary level the midwives will be given a manual on principles and care enabling them to identify cases needing referral to the secondary level for treatment.

The secondary level will be the cornerstone of the whole service. Gynaecologists and paediatricians working at this level will undergo specialized training and have the appropriate equipment. If necessary they will refer infants to the tertiary level.

The tertiary level will be reserved for serious cases needing paediatric intensive care and for training students.

For a programme of this kind, the training in neonatology needs to be fully recognized, easily accessible and widely accepted by doctors. It has always been considered a sub-section of paediatrics, coming after specialization as a paediatrician. But Professor Türmen has been the guiding hand behind a new training plan fought through with the support of the Health Minister over the past three years. A draft law is now ready, the plan has been finalized and the Directorate is waiting with bated breath for the signature recognizing the new specialty of "neonatal intensive care".

Where the status of women is concerned, Professor Türmen is determined that the law shall be applied. Turkey is relatively well off in that women have had the same rights as men since 1920, notably the right to go to the university and the right to work. Admittedly, there is still a marked preference for men in the rural areas, but this is gradually dying out, as shown by school attendance, obligatory for both boys and girls.

Discrimination does sometimes occur, of course, and Professor Türmen is determined to fight it. But she recognizes that modern Turkey is a country of young people and that time must sometimes be left to take its course.

D. Fierucci

Gentle persuasion: have as many children as you want, but make sure you can care for them. Jørgen Schytte/Billedhuset

AIDS: danger of complacency in Europe

A slowing of the incidence of new AIDS cases in some areas of Europe is leading to a sense of complacency about the disease, according to a preliminary review of prevention and control activities just issued by the WHO Global Programme on AIDS, Regional Office for Europe. Even in countries where there is a high level of knowledge about AIDS, writes Steven Wayling, author of the review, studies show that there are still conflicting attitudes and some people have not changed their sexual behaviour.

Nevertheless in Europe generally, he adds, strong programmes continue to be set up which reflect the latest realities of the AIDS situation.

Mr Wayling also observes that:
• the far-reaching social and political changes that have occurred in eastern and central Europe have increased the risk of HIV transmission in that area;
• while prevention of new HIV transmission continues to be a priority, a growing number of people are living with AIDS and HIV and require care; and
• policy-makers are increasingly demanding more concrete information on the impact of their programmes.

The WHO review charts the development of AIDS in various countries and risk groups; the approaches being taken to policies and programmes; funding; knowledge, attitudes and behaviour; and the expected directions of AIDS programmes during 1991 and 1992.

AIDS: 1990 Update (Current Status of HIV/AIDS Control Policies in the European Region) and also a Selected Bibliography of materials published by the AIDS programme are available (both in English only) from: Globe Programme on AIDS, WHO Regional Office for Europe, Scherfigsvej 8, DK-2100 Copenhagen 0, Denmark.

STOP PRESS

The irrefutable proof

In Romania, maternal deaths from abortion fell from 292 in the period January-June 1989 to 92 in the period January-June 1990 — a 317% decrease due to the introduction of a family planning programme and access to safe abortion.
Earth's future could be "a poisoned inheritance"

"The 1990s will be a critical decade. The choices of the next 10 years will decide the speed of population growth for much of the next century; they will decide whether world population trebles or merely doubles before it finally stops growing; they will decide whether the pace of damage to the environment speeds up or slows down."

So begins UNFPA's new report on The State of World Population 1990, published in May. In the next decade it points out, the world's population, already standing at 5.3 billion, will increase by another billion — or a whole new China.

Dr Nafis Sadik, UNFPA Executive Director, declares in the report: "The next 10 years will decide the shape of the 21st century. They may decide the future of the earth as a habitation for humans."

During the 1990s the number of human beings will grow faster than in any decade in history. But 90% of this growth will take place in developing regions. By far the biggest increases will be in the poorest countries — those which by definition are the least well prepared to satisfy the needs of these new arrivals and invest in the future.

At present the human race numbers "only" 5.3 billion, says the report, of which about a billion live in poverty. Can the earth meet even modest aspirations for the "bottom billion", let alone those of the better-off and their descendents, without irreparable damage to its life-support systems?

By far the largest share of resources used, and waste created, is currently the responsibility of the "top billion" people, those in industrialized countries.

However, in developing countries the combination of poverty and population growth among the "bottom billion" is damaging the environment in several of the most sensitive areas.

Developed or developing, the more people the more pollution: at any level of development, larger numbers consume more resources and produce more waste.

According to the report, redressing the balance demands action in three major areas: • a shift to cleaner technologies, energy efficiency and resource conservation by all countries, but especially by the richer quarter of the world's population; • a direct and all-out attack on poverty itself; and • reductions in overall rates of population growth: reducing population growth, especially in the countries with the highest rates of growth, will be a crucial part of any strategy of sustainable development.

"At the start of the 1990s", Dr Sadik warns, "the choice must be to act decisively to slow population growth, attack poverty and protect the environment. The alternative is to hand on to our children a poisoned inheritance."

Copies of The State of World Population 1990 can be obtained from: UNFPA, 220 East 42nd St, New York, N.Y. 10017, USA.

Swazi men say "yes" to Man Talk

Marie Stopes International, in the opening issue of its newsletter First People (Autumn 1989), reports that the British ODA is funding a three-year project in Swaziland aimed at increasing the involvement and awareness of men in family planning issues.

The project is being run by Occupational Health Services (OHS), a local NGO, under the direction of Dr Geoff Douglas and his enthusiastic team. From the very beginning it was felt that in order to have any impact on Swazi men a distinctive, eye-catching logo should be developed — this resulted in "Man Talk" being adopted as the project name and posters, car stickers and magazine advertisements now encourage men to call OHS for further information and become involved in the Man Talk campaign.

The project staff have developed a series of educational leaflets, ranging from advice regarding AIDS and sexually transmitted diseases to the use of condoms. These colourful leaflets are produced in both Siswati and English and are available for men and women.

The Ministry of Health sanctioned Man Talk to continue and consolidate male education in the country, as Government efforts continue to focus on female involvement.

A condom distribution and marketing campaign commenced with the selection and training of "depot holders" in places of work who will promote the use of condoms. Educational talks proved successful and negotiations were held with various bars and shops to ensure that condoms are widely available. The project also has a weekly column in a local magazine.
WHO vaginal ring — trials starting soon of new over-the-counter contraceptive

Supplies of a progestogen-releasing vaginal ring with several advantages over other forms of contraception will be available later this year and introductory trials are due to start in 1991.

Developed by the WHO Special Programme of Research, Development and Research Training in Human Reproduction, the ring releases levonorgestrel at a low rate of 20 micrograms per day. It exploits the fact that many hormones can be taken up directly through the lining of the vagina.

The Indian Government has expressed interest in starting a trial as soon as possible. WHO has also had requests from other countries such as China and plans a series of introductory trials in 1991 and 1992.

The WHO ring can be left in place for as long as three months, an advantage over rings releasing both an estrogen and a progestogen, which have to be removed once a month for withdrawal bleeding to occur. While the ring only inhibits ovulation in about half of users, it also works through local effects, including on the cervical mucus, which becomes thick and impermeable to sperm.

Another of the ring’s advantages is that the woman can insert and remove it herself, without the need for medical or paramedical personnel, and can easily check whether it is still in place (which is not always possible with an IUD, for instance).

The ring is designed to release the hormone at a constant rate, which pills and most intramuscular injections do not. Because the daily amount released is small, the level in the blood falls rapidly after the ring is removed, which may be important in the event of pregnancy.

Also, the ring does not need to be inserted just before intercourse, but can be worn throughout the day. And since the woman herself can insert or remove it, she need only visit the family planning clinic occasionally for follow-up visits. Replacement rings could be distributed, like condoms, diaphragms and spermicides, over the counter.

The whole amount of the levonorgestrel in the ring reaches the target organs, as with injections and implants. With the pill, on the other hand, the hormone is first metabolised in the liver, after which much of it is lost from the body in bile or urine.

Together with PIACT (Programme for the Introduction and Adaptation of Contraceptive Technology), the WHO Programme has also developed IEC (information, education and communication) materials to go with the ring, including a counselling manual, a clinicians’ manual, and a booklet for users. These will be pretested during 1990 and used with the ring in the trials.

Vaginal sheath protects both partners against STDs

A new plastic vaginal sheath promises to fulfil the widely felt need for a barrier contraceptive that can be put on before intercourse and is controlled by the woman, according to the WHO Special Programme of Research, Development and Research Training in Human Reproduction.

The soft, loose-fitting polyurethane sheath, equipped with two flexible polyurethane rings, can be used in conjunction with spermicidal creams or gels.

One of the rings, lying inside the closed end of the sheath, is used to insert it and to hold it in place. The other ring at the outer end of the sheath remains outside the vagina, providing more physical coverage for both parties than the condom and so protecting the labia and the base of the penis from sexually transmitted diseases (STDs), including AIDS.

The sheath does not need to be positioned exactly over the cervix and its shape adapts naturally, lining the contours of the vagina. Polyurethane transmits body heat better than the latex used to make the condom, giving greater sensitivity.

The vaginal sheath is prelubricated and additional lubricant can be used. It is intended for one use only, is disposable, and can easily be removed by twisting the outer ring and pulling.

The manufacturer of this "female condom" conducted the initial clinical studies, which concentrated mainly on user-acceptability, in Scandinavia, the Federal Republic of Germany, the United Kingdom and the United States.

Women at high risk of contracting an STD saw the vaginal sheath as a valuable method for protecting themselves and one which, most importantly, was under their control. In in vitro studies, the sheath has been shown to be impermeable to both HIV and the cytomegalovirus.

The WHO Programme has completed a pilot acceptability study among family planning providers in Bangkok which suggested that the sheath was too large for Thai women, but there were almost no problems with insertion. A shorter sheath with softer rings will be tried in further studies.

In another WHO study in Thailand, in a group of couples attending or staffing a family planning clinic, many of the women who felt that they were not at risk of an STD said they would not use the sheath routinely, but did feel it would be ideal if infection were possible. Again using a shorter sheath, this study will be expanded to include more family planning clinic attenders and also women working in massage parlours.

Bonus point: neither HIV nor cytomegalovirus can get through. Charte International Plc

Easily inserted: the sheath need not sit exactly over the cervix. Charte International Plc
RESOURCES

Reports

Safe Motherhood Initiative
The target of this initiative is to reduce maternal deaths by at least half in the next 10 years and substantially reduce maternal morbidity. Various reports and a bibliography have been published recently. The Prevention and Treatment of Obstetric Fistulae (WHO/FHE/89.5) includes advice on setting up a fistula service and mobilizing resources. It says it is imperative for the problem of obstetric fistulas to be brought before the world, emphasizing social causes as well as deficiencies in care. Measuring Reproductive Morbidity (WHO/MCH/90.4) points to gaps in research, especially in obstetric morbidity, and describes how studies can best be done. The Risks to Women of Pregnancy and Childbearing in Adolescence (WHO/MCH/89.5) is an annotated bibliography with author, subject and country indexes. Iron Supplementation During Pregnancy: Why Aren’t Women Complying? (WHO/MCH/90.5) reviews factors affecting compliance, successful programmes and the literature, and makes recommendations for research. The Prevention and Management of Postpartum Haemorrhage (WHO/MCH/90.7) discusses epidemiology, how to reduce incidence and impact, management and research. Available from: Division of Family Health, WHO, CH-1211 Geneva 27, Switzerland.

Population and conservation
An IUCN study of small-scale projects has shown that it is feasible to protect and restore the environment while at the same time trying to reduce population pressure, and that if this is done conservation goals are more quickly achieved. Case Studies in Population and Natural Resources (1990) is a report on field investigations and workshop discussions. Available from IUCN (The World Conservation Union), Avenue du Mont-Blanc, CH-1196 Gland, Switzerland.

Adolescent health
Most of the population of the Pacific region is under age 25 and may need the help of youth counsellors on sex, reproduction, and emotional and development issues. Youth Counselling and Reproductive Health is the report of a Pacific Regional Workshop held in Fiji last year, organized by the World Association of Youth and the Fiji National Youth Council. For more information, write to: Dr Herbert L. Friedman, Maternal and Child Health, WHO, CII-1211 Geneva 27, Switzerland.

Magazines/newsletters

People, the population and development magazine, and its regular section Earthwatch are published quarterly in English and French by the: International Planned Parenthood Federation (IPPF), P.O. Box 759, Inner Circle, Regent’s Park, London NW1 4LQ, United Kingdom.

Progress is the quarterly newsletter in English issued by the: Special Programme for Research, Development and Research Training in Human Reproduction, WHO, CH-1211 Geneva 27, Switzerland. A Chinese translation is published in Shanghai.

Nursing/midwifery in Europe, a newsletter, appears three times a year in English, French, German and Russian. Free of charge on request from: Nursing Unit, WHO Regional Office for Europe, Scherfigsvej 8, DK-2100 Copenhagen O, Denmark.

First People, the newsletter of Marie Stopes International, is available in English from: Marie Stopes International, 129 Whitefield Street, London W1P 5RT, United Kingdom.

Safe Motherhood, the “newsletter of worldwide activity in maternal health”, is available free in English and French from: Division of Family Health, WHO, CH-1211 Geneva 27, Switzerland.

Maternal Mortality and Morbidity: A call to women to action was published on the occasion of the International Day of Action for Women’s Health, 28 May 1990. The magazine looks at political issues, the extent and causes of mortality and morbidity among mothers, and ways of making changes. Joint publishers are: Women’s Global Network for Reproductive Rights, NWZ Voorburgwal 32, 1012 RZ Amsterdam, Netherlands, and Latin American & Caribbean Women’s Health Network/Isis International, Casilla 2067, Correo Central, Santiago, Chile.

Planned Parenthood in Europe is published three times a year in English and is free of charge on request from IPPF, Europe Region, P.O.Box 759, Inner Circle, Regent’s Park, London, NW1 4NS, UK.

Keeping population growth down
The 1990 Report on Progress towards Population Stabilization is in fact a full-colour fold-out wallchart. In graphic form it gives figures on family size around the world, costs of family planning and numbers of couples using family planning. Also shows sources of population and family planning funds, and describes a plan for stabilizing population. Published by: Population Crisis Committee, 1120 19th St NW, Suite 550, Washington D.C. 20036-5609, USA.

Populi, the UNFPA magazine, appears four times a year in English. Details from: Populi, United Nations Population Fund, 220 East 42nd St., New York, N.Y. 10017.

More information on magazines and newsletters in our next issue
Books

Injectables
Currently licensed in over 100 countries, injectable hormonal contraceptives are among the most effective methods of contraception available. *Injectable Contraceptives: Their Role in Family Planning Care* (1990) is intended to help those in charge to introduce and increase the availability of this method. It includes technical information and guidance on managing a programme. For programme managers, administrators and service providers at all levels. Available from: Distribution and Sales, WHO, CH-1211 Geneva 27, Switzerland. Price: 21 Swiss francs. ISBN 92 4 154402 3

Maternal tragedies
The scale of the suffering associated with pregnancy and childbirth — much of it preventable — and the long-neglected needs of women are the subject of *Preventing Maternal Deaths* (1989), edited by Erica Royston and Sue Armstrong. The book aims to stimulate debate and promote the changes in public policy needed to make childbirth safer. Obtainable from: Distribution and Sales, WHO, CH-1211 Geneva 27, Switzerland. Price: 40 Swiss francs. ISBN 92 4 156128 9

WHO AIDS series
Seven booklets on aspects of AIDS prevention and control for use throughout the world are now available from WHO. They deal respectively with:

- National AIDS prevention and control programmes
- Sterilization and disinfection methods
- Nursing management of infected people (in collaboration with the International Council of Nurses)
- Monitoring of national programmes
- Planning of health promotion
- Prevention of sexual transmission
- AIDS and first aid in the workplace (in collaboration with the International Labour Office and the League of Red Cross and Red Crescent Societies).

At prices varying between 4 and 14 Swiss francs, the booklets are available from: Distribution and Sales, WHO, CH-1211 Geneva 27, Switzerland.

Working with the community
In a new WHO book for health planners, *Community Participation in Maternal and Child Health — Family Planning*, Susan B. Rifkin analyses a number of case studies and points to various management problems and behavioural factors that will inevitably affect programmes based on community participation. Available in English and French from: Distribution and Sales, WHO, CH-1211 Geneva 27, Switzerland. Price: 9.50 Swiss francs. ISBN 924 256135 5

Use of contraception
Studies of contraceptive behaviour in eight countries (Austria, Denmark, Federal Republic of Germany, France, Italy, Spain, Sweden and the United Kingdom) were presented together for the first time at an International Health Foundation Symposium held in 1988. They are now published in *Contraception in Western Europe: A Current Appraisal*, edited by A. Ketting (1990), which also discusses the common features in the development of FP in these countries as revealed by the studies. Published by: Parthenon Publishing Group, Casterton Hall, Carnforth, Lancs LA6 2LA, United Kingdom. ISBN 1 85070 290 X

Economic aspects of AIDS
*AIDS: The Challenge for Economic Analysis* (1990), edited by Michael F. Drummond and Linda M. Davies, is based on papers presented at a WHO meeting in 1989. It covers, among other subjects, the economic implications of AIDS, the economics of prevention, economic analysis in policy formulation and the impact of AIDS on other sectors of the economy. Published in collaboration with the WHO Regional Office for Europe by: Health Services Management Centre, University of Birmingham, Park House, 40 Edgbaston Road, Birmingham B15 2RT, United Kingdom. Prices including postage: £ 8.00 (UK), US$ 15 (elsewhere). ISBN 0 7044 1073 7

Human reproduction manual

Drugs in pregnancy
Cigarettes, caffeine, drugs of abuse, vaccines, the pill and even spermicides are all included in a new critical review of the literature on medicines and other substances likely to have adverse effects on the fetus or the pregnant woman, *Drug Safety in Pregnancy*, by P. J. Foul and M.N.G. Dukes (1990). The authors hope their book will help promote safer and more rational use of medicines by and on behalf of the pregnant woman. Drugs are presented by category, and a number of useful appendices include indexes of both drugs and side effects. Published by: Elsevier Science Publishers, P.O.Box 1527, NL-Amsterdam, Netherlands.

ENTRE NOUS 16, September 1990
**AIDS in simple language**

*Le SIDA (AIDS)* is a small booklet in French for health personnel that answers 85 commonly asked questions about HIV/AIDS in a clear, straightforward way. It covers the disease, diagnostic tests, transmission of the virus and prevention. Also contains hints on how to advise members of the public, a glossary and a list of useful addresses. 2nd edition, March 1990. Available from: ARCAT-SIDA, 57 rue St Louis en l’île, F-75004 Paris, France.

**Child abuse**

In France child abuse is the second leading cause of morbidity among children, a public health problem now being tackled by the Government in an extensive programme. Professor J.-F. d’Ivernois has produced *La Maltraitance des Enfants* (Child Abuse) as a manual for the training of trainers, with sections on definitions, epidemiology, the factors involved, how to recognize when a child is being abused, what to do, therapy, prevention and evaluation, and a bibliography. Available from: Comité français d’éducation pour la santé, 2 rue Auguste Comte, F-92310 Vanves, France.

**Population decline**

Ben Wattenberg, Senior Fellow at the Enterprise Institute in Washington DC. and syndicated journalist, believes that the low fertility rates in America (and in Europe and Japan) have now gone so low as to be harmful and that they will probably last — unless people understand the magnitude of the problem and respond by changing their reproductive behaviour. *The Birth Dearth* (1987) by Ben J. Wattenberg is published by Pharos Books, New York.

**Family and population**

The causes and consequences of the dramatic transitions taking place in the institution of the family in the western world and their demographic impact in Canada are the subject of *The Family in Crisis* (1989), proceedings of a colloquium organized by the Federation of Canadian Demographers and the Royal Society of Canada, P.O. Box 9734, Ottawa, Canada.

**Unwanted children**

The limited information available on the developmental effects on children and adolescents of the fact that their mothers were denied an abortion is the subject of *Born Unwanted* (1988), edited by Henry P. David, Zdeněk Matějček and Vratislav Schüller.

The studies used as a basis for the review come from Czechoslovakia, Finland and Sweden. Available from: Avicennum-/Czechoslovak Medical Press, Prague, Czechoslovakia or Springer Publishing Co., 536 Broadway, New York, N.Y. 10021, USA.

**Videos/films**

**Female sterilization**

The most frequently used techniques of female sterilization are the subject of a Portuguese PAL/VHS video produced by Socivideo and based on an idea by Professor Albino Aroso, Deputy Minister of Health and head of a project to strengthen family planning in general hospitals. Intended for medical and nursing schools, the video is simple, clear, uses a minimum of verbal explanations and has an unusual accompaniment of modern dance music. Duration: 19'20". In Portuguese only.

Enquiries to: Professor A. Aroso, Ministry of Health, Av. J. Crisostomo 9, Lisbon, Portugal.

**AIDS**

The IPPF AIDS Prevention Unit has produced a video called *Unmasking AIDS*, with a resource pack. It shows, through a drama-documentary, work with young adults from a deprived area of London who produced puppet and mask plays on AIDS for other young people. Activities building up to the performances are shown, two puppet plays on condom use, and a mask play on communication about sexual concerns between couples. The resource pack contains activities on sexual issues and drama which can be used on training courses for FPA staff and peer educators, and activities for community groups. Further information from: Ms Gill Gordon, IPPF AIDS Prevention Unit, Regent’s College, Inner Circle, Regent’s Park, London NW1 4NS, UK.

**Family planning**

Two African women tell their own story of life and death and how family planning has brought better health to them and their children in *Two Mothers*, produced for IPPF by North South Productions. An accompanying illustrated booklet tells the story in greater detail and answers general questions on birth spacing and child survival. In 16 mm and videocassette form. More details and prices from: IPPF Distribution Unit, Regent’s College, Inner Circle, Regent’s Park, London NW1 4NS, UK.

**Training opportunities**

**Contraceptive services: training and exchange projects**

Planned Parenthood of Northern New England (PPFNE) operates 22 clinics in Vermont and New Hampshire (USA) for women in small rural communities. PPFNE not only provides training and technical assistance for national family planning organizations, holding upwards of 40 workshops, seminars and conferences each year, but also trains and educates many international visitors and provides family planning training in developing countries. PPFNE is interested in overseas assign-
Tobacco or health

It Can Be Done: A Smoke-free Europe is a 70-page full-colour glossy report on the first European Conference on Tobacco Policy (Madrid, November 1988). Packed with facts, drawings, arguments and information, it also contains a Tobacco Charter and 10 Strategies for a Smoke-free Europe, covering legislation, advertising, financial disincentives, political alliances and so on.

 Obtainable in English only from:

 Distribution and Sales
 WHO, CH-1211 Geneva 27
 Switzerland

 Price: 18 Swiss francs. ISBN 92 890 1121 1
 The same report is also obtainable in document form, free of charge, in French, German and Russian, from:

 Tobacco or Health Unit
 WHO Regional Office for Europe
 Scherfigsvej 8
 DK-2100 Copenhagen O, Denmark

Family planning research and management
The Institute of Population Studies at the University of Exeter, UK, which specializes in family planning research and management, offers a variety of short courses and attachments, two MA programmes and a three-year PhD programme, between October and July. For information, please write to: Training Officer, Institute of Population Studies, University of Exeter, Hoopern House, 101 Pennsylvania Road, Exeter, Devon EX4 6DT, UK.

General

 Detecting ovulation
 Basal Body Temperature: Interpretation and Correlation is a wallchart designed for physicians and family planning counsellors.

 Available free to non-profit groups from:
 Mr J. Pulcrano, Biosel Distribution S.A.,
 Case postale 172, CH-1226 Thônex,
 Switzerland.

 Family welfare in Finland
 Väestöliitto, the Finnish Population and Family Welfare Federation, was founded in 1941. It aims for a demographically balanced society that is favourable to families and children. Its aims and activities are described in a folder obtainable from:
 Väestöliitto, Kalevankatu 16, 00100
 Helsinki, Finland.

See Europe Diary, Page 24

First European Conference on Food and Nutrition Policy
Budapest, 1–5 October 1990
Europe

From Abortion to Contraception: Public Health Approaches to Reducing Unwanted Pregnancy and Abortion through Improved Family Planning Services. This international meeting is being organized by the WHO Regional Office for Europe with the aims of reporting on the actual situation in Europe, identifying gaps in knowledge, exchanging information on practical experience and innovative programmes, and recommending ways of moving from abortion to contraception.

(Tbilisi, USSR, 10-13 October 1990)

First European Conference on Food and Nutrition Policy. The aim is to inspire policymakers to draw up food and nutrition policies that will benefit their nation’s health. The organizers will demonstrate how the planning of a population’s food supply and nutritional behaviour can be made compatible with nutritional recommendations and health goals. Details from: Nutrition Unit, WHO Regional Office for Europe, Scherfigsvej 8, 2100 Copenhagen O, Denmark.

(Budapest, 1-5 October 1990)

Seminar on Counselling Skills on Sexual and Reproductive Health for Adolescents. Details from: Sexuality and Family Planning Unit, WHO Regional Office for Europe, Scherfigsvej 8, DK-2100 Copenhagen O, Denmark.

(Dubrovnik, Yugoslavia, 5-9 November 1990)

International Conference on Sexual Aspects of Chronic Illness or Disability. Organized by the Israel Rehabilitation Society. Topics include sexual counselling for disabled adolescents and their parents, sexuality and mental retardation/mental illness/physical disability/cancer, training programmes for counsellors and role of surrogates. Information: Dr E. Chiegier, c/o Omega Conventions, P.O.B. 71102, Jerusalem 91079, Israel.

( Herzliya, Israel, 4-8 November 1990)

Promoting Sexual Health and Family Planning. UK/FPA conference focusing on health promotion, sexual health, young people and sexuality, and sexual behaviour and attitudes. Details from: Ms L. Earl or Ms J. West, UK Family Planning Association, Margaret Pyke House, 27-35 Montmore Street, London W1N 7RJ, UK.

(London, 22 November 1990)

International


(Manila, Philippines, 3-10 November 1990)


(Manila, Philippines, 3-7 February 1991)

At the second planning meeting held in Paris on 3 July 1990 it was decided that the International Symposium on Fertility and Insularity will be held in November 1991 in November 1991 in Saint-Denis, Reunion, and will be organized by the General Council of Reunion Island, and co-sponsored by WHO (Headquarters and European Region) and UNFPA.

Disability and the law

The disabled have the same rights as everyone else, but are they always encouraged and enabled to exercise them?

Is the Law Fair to the Disabled?, a survey of 25 European countries, explores the laws affecting the disabled and how they are implemented.

Each country profile looks at the measures aimed at eliminating discrimination against the disabled, facilitating their social reintegration and full participation, preventing disability and ensuring a system of income support.

This is a heartening review of the conditions disabled people now live under in Europe. It should be read with interest by the disabled themselves, by all those involved in their affairs, and by anyone concerned about the way society treats its minority groups.

Available from:
Distribution and Sales
WHO, CH-1211 Geneva 27, Switzerland.

Prize: 45 Swiss francs. ISBN 92 890 1120 3