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ENTRE NOUS 26-27, December 1994
EDITORIAL

The media and family planning

By Anver Versi

For years, family planning issues lay on the groaning Development Media table like a neglected little side-dish into which journalists only dipped in occasionally before moving to more “substantial” repasts.

The ICPD changed all that. Suddenly, for about a month before the Conference and a month during and after, the European mass media could not get enough about population. It gobbled up everything that came its way and kept begging for more.

Initially however, the main ingredient which attracted mass media attention was the potential for conflict that the ICPD in Cairo represented. There were several mouth-watering scenarios which even the tabloid newspapers could not resist: Islamic Fundamentalism running riot and perhaps massacring large segments of delegates; the Pope and the Vatican locked in mortal combat against family planning institutions; Jane Fonda stealing the show and bringing down the wrath of Christian, Muslim and “pro-life” fundamentalists on her head etc. etc.

Spice-laden articles

In between these spice-laden articles, however, virtually all the quality newspapers published some excellent, well-thought articles. Britain’s The Independent on Sunday, for example, published a perfectly balanced piece by Geoffrey Lean, entitled “Too Small a World”? in which he argued that, for a global sustainable future, the equitable sharing of the world’s resources was as crucial as reducing the population growth rate.

However, Lean was one of the few mass-media journalists to outline the full gamut of the family planning philosophy which included empowering women to take charge of their reproductive capacity and the vital need to educate women, especially in the Developing World.

However, most papers and journalists appeared to see family planning needs more in terms of Developing World demographics than as a system designed to promote the health and well-being of the family. If population growth rate in Western Europe is discussed at all, it is to point to a possibly alarming decline in replacement in some countries.

When some newspapers do take a stand on family planning matters, it is usually over the question of abortion.

This is an emotive subject and the mass media tends to deal with it in a fairly emotive manner. These are of course, broad generalizations and the manner in which the mass media deals with various sexuality and family health matters varies from country to country. In this issue, for example, we publish an article by a Swedish journalist who believes that a new conservative attitude towards abortion is slowly gaining ground in her country and that attempts are being made to harness the media towards that cause.

Different situation in the East

The situation is very different in the former Eastern block. In many of these countries, governments often pursued a determined pronomal policy, imposing harsh punishment for abortion and actively discouraging the use of contraceptives. The press, almost inevitably employed as an extension of the state’s propaganda machinery, was used quite effectively to propagate these views.

In the new, liberal climate, the mass media has been generally sympathetic to family planning campaigns, particularly the popularizing of contraceptive methods and the dissemination of sex education. However, as an interview with two leading officers of the Bulgarian Family Planning Association in this issue of Entre Nous reveals, a large segment of journalists appear to have only rudimentary knowledge of the basics of family planning.

To illustrate the cumulative effects of “working on the media”, we publish an article by the American-based Population Reference Bureau’s Winthrop Carthy who recounts the variety of devices he has had to use to place population and FP issues on the front pages of newspapers in the Developing World.

We also publish an article that shows how the media, properly sensitized to the subject, can bring about spectacular reforms in legislation- as happened in Ireland not so long ago.

From the huge number of journalists who attended the ICPD (some estimates put the number at around 3,000), there is little doubt that FP and population has now moved away from the area of specialist publications and is now firmly establishing itself within mainstream media outlets.

However, the number of trained journalists who can discuss these issues in a style that is inviting, exciting and at the same time informative, is still small. This area of journalism has not as yet acquired the sort of glamour that, say, environmental journalism has.

Yet there are a number of very excellent journalists and editors who have kept the flag flying for several decades, usually in specialized publications, and unless these very able pioneers can be encouraged, even funded, to pass on their knowledge and expertise to young, trainee journalists in Europe and the rest of the world, the public momentum that FP has gained as a result of the ICPD might be lost.

Perhaps an anecdote concerning Mahbub ul Haq, a Pakistani Minister of Finance and Planning in the 1980s and now a senior official with UNDP, will underline the point. Mr Haq recounts how he was so convinced that his country’s rapid population growth has to be checked that he set out to “saturate villages with condoms”. He mounted spectacular and ingenious campaigns to convince the people to use the condoms but, while the campaigns attracted large crowds of curious onlookers, the population growth rate actually went up!

In hindsight, it is easy to see why. The people’s attention had successfully been caught, but their hearts had not been won over. The campaign had failed to involve and mobilize the mass media and without a core of dedicated journalists and editors to spread the word, it had fallen on stony ground.

RU 486

Few modern inventions in fertility control have generated as much controversy as that of RU 486. Our parallel theme in this issue sets out to clarify the method, its uses and drawbacks.

We lead the section with an excerpt from the speech given by Professor Etienne-Emile Baulieu, the inventor of RU 486, following his elevation to the Chair, Foundations and Principals of Human Reproduction, Collège de France. Professor Baulieu talks about the role and responsibility of the scientist in society. We feel that his words will strike a responsive chord in the breasts of many researchers in the Sexuality and Family Planning field and perhaps afford them some inspiration during those long, lonely, thankless hours spent bent over test-tubes or poring over statistics and other data.
Grabbing the headlines

By Winthrop P. Carty

The Press worldwide doesn’t cover population issues very well or very often. On the face of it, this seems strange. Demography, after all, is really the story of people framed in numbers.

My job has taught me some of the reasons many journalists would rather not write about population. I am a journalist who works for a well-established U.S. non-governmental organization, the Population Reference Bureau (PRB). My task is to get journalists, particularly in less developed countries (LDCs), to give population issues good coverage. PRB is a nonadvocacy organization whose mission is to make demographic research accessible to reasonably well informed persons and let them draw their own conclusions.

Nonadvocacy is no asset if an editor simply wants sensational stories based on “overpopulation,” AIDS, the immigrant invasion and the like.

While a balanced look at population issues appeals to repertorial specialists seeking nuanced information, it can confuse the story line for the uninformed.

Some veteran journalists, remembering past scare stories that didn’t pan out, are leery of population coverage. Twenty years ago it was fashionable to write about the “population bomb,” the “Malthusian squeeze,” “triage” and other doomsday scenarios. Since growth rates peaked in the late 1960s, the population bomb has now exploded, with an astonishing fallout that will double 1960’s global population of 3 billion by the year 2000. While the explosion is certainly traumatic, it is not quite the Apocalypse the alarmists predicted.

A majority of Third World nations, rhetorically at least, have adopted family planning. Why then are LDC editors so reluctant to run stories on the subject? The reasons are many and some are quite good.

Demographic issues are freighted with geopolitics, sex, race, religion, power, gender and personal rights. LDC editors—often working under the gun of government ownership or censorship, reader and advertiser sensitivities or nervous owners—must be careful what they put in their publications.

Even such basic facts as how many people live in the country and who they are can be contentious. Nigeria and other African nations, for example, are deeply divided along religious and ethnic lines. Relative numbers, therefore, represent claims on political power and central government funds.

Family planning directly raises all kinds of religious, ideological, and sexual issues that are taboo or highly controversial, running from the role of women in Saudi Arabia to Catholic Church opposition to family planning in the Philippines.

Such controversies, let me add, aren’t just Third World idiosyncrasies, as the abortion issue in the United States attests.

But LDC publications, operating without the independence that non-governmental advertising often brings and circulating in countries without a long tradition of press freedom, cannot stray too far from the conventional wisdom of God, country and government on family planning matters.

Further, Third World journalists have the practical problem of limited news space, due in large measure to the high cost of newsprint. And while Western reporters are swamped by the “information revolution,” most LDC journalists lack easy access to demographic data. Finally, the demographer’s raw information—with its jargon about the “completed fertility rate,” “population momentum,” “period analysis” and “population pyramids”—can be a crushing bore.

Given the controversies, complications and space limitations, most LDC editors prefer to run human interest or political stories with an assured readership. If they do run population piece, it is apt to focus on conflicting north-south views, global population growth or some other theme that is distant from the controversial complexities of a strictly national story.

With a Western reporter, especially one who covers population issues regularly, a good press release with new data will receive reasonable pick-up. But dealing with Third World journalists takes an extra effort. I deal with LDC senior editors as a fellow journalist. These men and women, who decide what goes into their respective publications, are the vital gatekeepers. I must convince them that demographic data can be translated into good, readable stories.

The first step is an invitation to a senior editor of a major publication to attend a journalist’s seminar co-sponsored by an international organization. With the International Planned Parenthood Federation, United Nations Environment Programme, Food and Agriculture organization and United Nations Population Fund, I have arranged population/environmental seminars in London, Mexico, Nairobi, Rome, and Rio. King Hussein invited 11 of my collaborating editors to hold a seminar in Jordan this year, and I took 20 editors to the ICPD in Cairo in September. Funding for the seminars has come from a variety of sources—private foundations and agencies, the U.S. Agency for International Development and various United Nations organizations. I know full well that some editors accept the invitation principally to get a trip to an interesting city.

But if the seminar is done properly, journalists out for a free ride will quickly become engaged in the process. I must also convince the co-sponsoring international organization that journalists don’t wish to hear about the great works of the international institution and its leader, but are looking for good stories—the essence of their job. Success for all lies in presenting information that is tailored for accessibility and newsworthiness.

Further, seminar time should be set aside for the journalists to discuss among themselves what makes a good population or environmental story, how the story should be played, what the editorial problems are and what they should look for in the future. In many ways the editors are more influenced by their colleagues than by seminar presenters. If a senior editor, through a process of self-enlightenment, adopts an issue, it will receive ongoing, sophisticated coverage.

Winthrop P. Carty

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ENREF NOUS 26-27, December 1994
The Irish experience

By Tony O’Brien and Jon O’Brien

The major battle on family planning issues in Ireland has been between the Irish Anti-choice Movement and advocates of reproductive freedom. With the addition to the Irish constitution in 1983 of a so called “Pro-Life” amendment, the battleground had been set on abortion. In effect the amendment sought to eliminate the right of Irish citizens to have abortions not just in Ireland, but elsewhere too.

Following the defeat of the Pro-choice Movement in the 1983 referendum the Anti-choice organizations had things very much their own way for almost ten years. The media accepted their “Pro-Life” language and rhetoric. Many involved in the media were afraid of the power of the Anti-choice Movement which had dubbed those who had supported the Pro-choice cause as murderers.

Images of Holocaust

An internal memo in the national television and radio network sent to producers from Management suggested that abortion should not even be discussed on live programmes for fear of retribution. Images of dismembered foetuses, comparisons between the Nazi Holocaust and abortion and a vocal and political church were all part of the Anti-choice propaganda machine. All this made it very difficult for ordinary citizens to express dissent.

The tide however began to turn when on the 12th February 1992, Ireland woke to the news that a 14 year-old school girl who was pregnant following rape, had been served an injunction compelling her to return to Ireland (and stay there) thus preventing her from aborting her unwanted pregnancy.

This had been decided despite the risk to her health and despite the very real risk of her taking her own life if she was compelled to carry her pregnancy to full term.

The loose network of Pro-choice groups decided to act. They came together frequently and decided that the emphasis of their campaign in the media had to be first and foremost to lift the injunction on the girl’s movement.

The Irish Family Planning Association (IFPA), one of the strongest organization within the network, decided that this issue was one which required a hard-hitting response. It decided to take on the Anti-choice Movement in a pro-active way and use their own tactics against them.

The first tactic was to demonize the “Pro-Life” amendment as a “Rapist’s Charter” more concerned with protecting the rapist’s progeny than his “victim”.

Anti-choice Movement even had the effect of distancing the church from their cause. In the main however, the church hierarchy remained silent in the early and crucial stages of the campaign.

The third arm of the strategy was to challenge the characteristic language used in the debate which included terms like “Pro-Life” to describe our opposition and “Pro-Abortion” to describe the Pro-choice Movement. We systematically challenged every incorrect usage and this did have an impact on the media’s and the public’s perception of the debate.

The net effect of media action by a range of Pro-choice groups was to bring tens of thousands of people onto the streets to demand that the girl be allowed to exercise her right to choose.

The Supreme Court lifted the injunction in a move widely believed to be a direct response to public opinion. The girl was free.

Our next objective was to seek positive action from the Government on the abortion question in Ireland. The case of the girl had highlighted the question of women’s rights to travel freely outside Ireland and their right to information on abortion which had hitherto been denied. The Government’s silence on the issue was intended to minimize public debate.

To broaden the debate, the Family Planning Association decided to concentrate on informing the world’s media about the situation in Ireland.

The international media had played a vital role in prompting the government to change the law when, during a previous campaign to change the law relating to the sale of condoms, the Association had been convicted by an Irish Court.

Being a small island in the European Union Irish politicians are acutely sensitive to international public opinion.

For the Association the issue of choice was a human rights issue that had to be brought to the attention of our partners in the European Union. This was crucial because the Anti-choice Movement had sought successfully to insert an opt-out clause for Ireland on the issue of abortion in the Maastricht Treaty.

Outrage and surprise

Use of international television, radio and the print media were most successful in not only raising political awareness but also in having a profound effect on the people in Ireland.

Through the media, Irish people could see that the rest of the world was outraged and surprised that the Irish would support a situation that denied the human rights of women.

While the majority of international
Journalists were excellent and professional, a small number who lacked any understanding of the situation in Ireland were a constant cause of frustration. Just as journalists had once asked "Is there anyone here who has been raped and speaks English?" some journalists sought to interview the 14 year-old girl who were critical of the Pro-choice Movement for not "providing" full face interviews with Irish women who had obtained abortions.

This insensitive request was made in a country were abortion remained illegal and the social consequences of a woman being exposed for having an abortion were horrific.

The Pro-choice Movement stood firm, however, and only facilitated interviews which guaranteed protection for the interviewees. These included TV interviews in silhouette. Only those journalists who were aware and sensitive to the situation of individual women were given access.

Having said that, it must be appreciated that the media do have a need to illustrate the problem first-hand and that can best be achieved through interviews with those who have experienced the issues concerned.

The Government finally sought to calm public opinion by promising a referendum to address the issues raised.

Misleading headlines

In the event the Government held three different votes. They switched the order of the ballots, used misleading headlines and a variety of tricks to make it difficult to conduct a campaign.

The first proposed amendment sought to draw back from the Supreme Court judgment. If this had been passed another case like that of the 14 year-old girl would have resulted in her not being allowed to have an abortion.

The second and third amendments were designed to guarantee the right to travel and the right to information. (There had been a number of actions against clinics and student groups providing information, and magazines coming into the country had been censored.

This situation left the Pro-choice Movement with a difficult, tactical problem, faced with having to campaign for a NO, YES, YES vote in the referendums.

Pro-choice groups agreed to run a hard hitting campaign which evoked direct memories of the case of the 14 year-old girl whilst providing simple codified voting information.

The theme of the campaign was crystallized in a hand bill bearing the slogan: "She is fourteen, raped and pregnant. Go on, tell her to kill herself!". This was backed by a series of street bill-board adverts which developed various Pro-choice themes.

A referendum campaign claimed for itself the moral high-ground. A vote for the campaign was projected as a real Pro-life vote, one which defended the life and health of thousands of individual Irish women. The campaign painted the opposition as extremists seeking to interfere with the basic human rights of other people. They were "busy bodies" and "self-appointed moral police".

The Pro-choice messages were simple, graphic and startling.

The secret weapon in the Pro-choice campaign was that of unity. In the run up to the referendum the Pro-choice groups carefully constructed coalitions of organizations that could work together without stifling the voices of member groups. The final umbrella group, the ALLIANCE FOR CHOICE brought together diverse resources and facilities.

But most importantly, the Alliance for Choice ensured that the press and public relations were centrally co-ordinated. This added clarity to our messages and provided the Alliance with a common voice.

Dramatic shift of focus

As it happened, a general election was held at the same time that the vote on abortion was to be held. National media attention, which had been focussed on the abortion issue for most of 1992, now shifted dramatically to the election. This made any exposure on radio, television or press most difficult. Despite this considerable obstacle, the Alliance still managed to communicate its message to the Irish people and urged them to vote NO, YES, YES.

For once, it was a united campaign. All too often, the Pro-choice Move-
Q: Professor Chernev, Dr Stamencova, you have been working with the media regularly and extensively during the past two years - can you tell us a bit about your experience?
A: First of all, we encountered great interest from all the media: television, radio, and press. After we announced the opening of the first Bulgarian Family Planning Association (BFPA) clinic in Sofia, so many journalists came that we could hardly see patients! There is also a good deal of interest from the specialized medical and health press. Radio stations have become heavily involved in FP. We have regular programmes on some stations, in such slots as Hours for the Family and Hours for young people.

Q: Why has there been so much interest from the media?
A: The interest came about because there is a general lack of information from government health authorities. In addition, many people now realize that there is a demographic crisis in Bulgaria. In 1993, we had 90,000 births and 140,000 abortions!

One of the consequences of the frequent abortions is a higher rate of infertility when children are desired. Sexuality transmitted diseases are also increasing. Young people are neither informed nor prepared for sexual life. So the media has a very important role to play. Yesterday, for example, there was a small article about family planning in the paper, and today many people have called in, asking for information.

The media is the best vehicle in our country to popularize knowledge and to improve the reproductive health of the nation.

Q: How did you get the media involved?
A: We used some personal contacts at first, and searched among our friends for journalists interested in these problems, then they created networks of other interested colleagues.

Last year, we presented our ideas and activities at two press conferences. The first one was national and widely published. Later we gave a second press conference in our clinic for those journalist who were particularly interested. Since then, journalists have come to us on an individual basis.

We have also worked with the international media. For instance, when Dr Stanislava Popova, the Director of the Bulgarian National AIDS Prevention Programme was in London, she was interviewed on STD and AIDS in Bulby the Bulgarian section of the BBC World Service. The programme was transmitted to Bulgaria. On our return, we received lots of phone calls and questions from the public. In December last year, I was interviewed by the Bulgarian service of the Voice of America. Both interviews had been arranged by the press department of IPPF. The interviews in turn generated more interest in the Bulgarian press and gave weight to the issues of family planning, as well as improving the image of our association.

Q: In general, do you think that journalists have sufficient background information to cover these issues well?
A: In the national press, there are specialized medical and social issues journalists. Often they are the editors of health sections or have similar positions. They are usually well prepared and familiar with the issues they are talking about.

The same applies to radio and television journalists. But sometimes it happens that when we speak to journalists, we have to explain even simple expressions such as “contraceptives” and “reproductive health”. This ignorance is a reflection of the level of sex education in the nation.

Q: Which mass media have been most supportive of your work?
A: They all are, especially the press and radio. Unfortunately, we only have two TV channels, and it is difficult to get time on television.

But the two programmes we had during prime viewing time were probably the most effective in terms of providing information to the public. If we had more TV time, that would be very useful indeed, but everyone is trying to get on TV, so we’re relying more on the radio and on the press.

Q: I have heard that many of the BFPA branches have also used the local media.
A: Yes, for instance in Plovdiv - they started by inviting the press for the opening of their clinic and the local press then showed an ongoing interest. There is also some healthy competition between the local and national journalists. All journalists want to be up-to-date and to provide new information, even in the smaller towns.

Q: Are there any negative effects of all this publicity?
A: One of the dangers is not to be understood correctly - that is why we ask to see the articles before they are printed, but its not always possible, and sometimes incorrect information appears due to misunderstanding.

But, on the whole, this is rare, and we can try to correct mistakes through letters to the editors and the like.

Q: Before the political changes in Bulgaria, were the media promoting a different line?
A: Before the political changes in 1989/90 there were not so many newspapers, and there were no private radio stations or newspapers at all. The national papers only reported the government line.
With regard to family planning, they didn’t report much at all. There was officially a pronatalist policy, though contraception was available and not forbidden like in Romania, and abortion was legal. However, the use of family planning methods was not encouraged by the State.

Q: Did you see an increase of media interest in the preparation to the IPCD conference?
A: Not really, our journalists don’t have much information on this. But since 1994 is the “Year of the Family”, many journalists are asking us what we are doing for this occasion. We really want to keep our work continuous and not just do something because of the year of the family, or the 13th Party congress, or other such occasions.

Q: What are the most important problems that the media should touch upon in the future?
A: Reduction of abortions, prevention of STDs, sex education. Also, the prevention of sterility, pre-menopausal problems in women, early detection of breast cancer as well as early detection of congenital diseases, and general maternal and child health care.

Q: Finally, which recommendations would you give to others who would like to start this kind of work?
A: The easiest way to promote an idea is by giving it to many people. The media may be the only way to reach such large groups. When working with the media, it is important to be open, but also to have something to demonstrate. If you only hold press conferences, but have no programmes or results, you will not have much success with the media.

The media want to see activities. If you are doing good work and are appreciated by your community, the media will come along.

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**Sweden: Rise of the regressive right?**

**By Louise Boije af Gennaes**

Sweden’s liberal abortion legislation has been in effect since 1975. Abortion is legal until week 12, legal after consultation with a counsellor until week 18, and allowed under special permission until week 22. The vast majority of the public, as well as the media, are comfortable with this legislation and do not really wish to see it changed.

However, a very small group of anti-abortion activists are trying to change it, and they fall into two categories: those within Parliament (and within a specific political party) and those outside Parliament.

Since the change of government from a socialist to a conservative coalition in 1991, when the Christian party, KDS were included in the government, there have been propositions within Parliament to change the abortion legislation.

The neutral view on this is that the other conservative parties are “throwing a bone” to the KDS party by supporting their efforts to change the abortion legislation. This is seen as a ploy to pacify the KDS and also win their cooperation on more important issues.

The proposals include making abortion legal only until week 12, mandatory post-abortion counselling, and the suggestion that the phrase “life begins at conception” be included in the Swedish Constitution. This amendment of the Constitution would make abortion equivalent to murder.

Further proposed changes would demand that a woman give specific reasons for her decision, that aborted fetuses be given regular funerals, and that the government probe all research conducted on fetuses. The larger aim in this case is to minimize this type of research.

There is also a suggestion that a “conscience clause” be included in the educational legislation, whereby medical students unwilling to learn about contraceptives or abortion would have the right to abstain from such instruction.

The non-parliamentary pressure groups fall mainly in the Ja till Levet (Yes to Life), and the religious free church organizations such as Livets Ord (Word of Life).

The leader of Livets Ord, pastor Ulf Ekman is quite wealthy and plans to open his own university this autumn. Among other courses, a degree course in the media will be offered. This, it is believed, will enable Ekman to educate journalists for the press, television, and radio within the framework of his own dogma, thus gaining more power over how family planning issues are presented to the public.

Despite these developments and the growing influence of groups such as Ekman’s, the public in general tends to look on the growing anti-abortion movement with astonishment.

The conscience clause was debated in parliament, but defeated on the 26th of May 1994.

**Regressive forces?**

The major newspapers have all taken liberal views on these issues, and have objectively reported on the ongoing debate. In general, women journalists seem to cover the topics more frequently, but there is not a gender bias, and it is natural for women to show greater interest in this issue, since it affects them more directly.

Although the main conservative paper, Svenska Dagbladet, sometimes publishes anti-abortion editorials, the only real stronghold of the anti-abortionist movement is the Christian paper Dagen, which regularly attacks the abortion legislation.

The Swedish Family Planning Association, however, reports that it has observed an increase in editorial and readers’ letters criticizing the present abortion legislation. Sex Education has also come up for discussion in Parliament, and some groups want to see a more conservative legislation.

The possible repercussions of this debate don’t really seem to worry either the public or the press. The prevailing attitude is typically Swedish: “Oh no, they won’t touch our legislation or educational system. This is Sweden and we’ll remain liberal no matter what”.

To me the more conservative developments in Sweden are aimed at driving women back to the home, away from the workplace, and taking away their own choices in sexuality and reproduction.

A liberal abortion legislation is an extremely important foundation for equality between men and women, and this seems to be precisely what the fundamentalists object to.

I find it extremely important to fight for family planning, the free availability of contraceptives and liberal abortion legislations throughout the world.

It may seem futile to argue over a possible restriction in the abortion legislation in Sweden, given the problems that exist in other parts of the world, but Sweden has a crucial role to play as an example of a functioning, liberal society at a time when so many countries are going back to more restrictive policies.

I know that both my male and female journalist colleagues agree with me on this.

Unfortunately, there seems to be a widening gap between how the people of Sweden really feel about this issue, and the actual policy makers’ attempts to change conditions to fit some larger agenda without really consulting us openly.

Louise Boije af Gennaes is a journalist in Sweden.

ENTRE NOUS 26-27, December 1994
RU 486 - THE PROS AND THE CONS

We begin our discussion of RU 486 by publishing an extract from Professor Etienne-Emile Baulieu's inaugural lecture following his election to the Chair, Foundations and Principals of Human Reproduction, Collège de France. Professor Baulieu is the inventor of RU 486.

The development of an antiprogesterone was not easy. It was necessary to verify that the compound would interrupt the second part of the woman's cycle (during which progesterone is secreted) and compromise the installation or continuation of the pregnancy: this was established in Geneva, with Walter Herrmann.

On the other hand, it was necessary to show it was safe to use and this, highly remarkably, turned out to be certain for women. However, one cannot in principle ever be sure of the total innocuity for the embryo of a compound administered at the beginning of a pregnancy in the case where the interruption does not occur.

There may always be a risk, however minute, of provoking an anomaly at birth. In the case of RU 486 there is no known indication of teratological anomalies being provoked by this compound administered to a pregnant woman (1).

In any case, I am an advocate of not taking any risk and of carrying out an evacuation in all the cases (1 to 3%) where the hormonal method was insufficient.

I have also been confronted by another major question: should a scientist follow the applications of his research "personally", by participating in their development for different uses?

Thus should I, for RU 486, involve myself in its application to gynaecological and obstetrical pathology and to mammary, cerebral or adrenal tumours?

Should I myself explain to the doctors, to those who make the decisions in society, to a wide public? Should one morally and intellectually take charge of the "development risks", a phrase which is both juridical and entrepreneurial.

Such an activity takes a great deal of energy and time, at the expense of efforts consecrated to fundamental research.

The impact of RU 486 on society has given rise to important controversies. I was in the front line and I have remained there. The applications of science are not a simple modality of the work of a scientific research worker. They take him away from his test tubes to confront him with society and its evolution.

The parameters that are then brought into play cannot be learnt in scientific publications. As it happens, I have had more than my fair share of the violent reactions that the irruption of science in the social order is able to bring about.

Doubtless I have never imagined my life nor my work shielded from society. As a young man, in a country scarred by war, heir to a family whose religious and cultural traditions had just been shattered, I chose medicine because I have always believed in the beneficial use of science.

I have never aspired to clerical isolation: I like the open window in Carpaccio's painting of Saint Augustine at his work table. The books are in the background and, in the foreground, his gaze towards the open window seems to indicate his desire to serve other men; at his side is a small dog which, in my opinion, indicates a benevolent friendship with nature.

The influence of scientific activity on the life of women, the meeting of science and the feminine condition, without doubt determines one of the fundamental mutations of our epoch.

The discoveries of these last 200 years have freed women from their social enclaves in an irreversible way by largely liberating them from the material tasks of a subaltern household condition.

As a young research worker I was fascinated by the work of Gregory Pincus on the contraceptive pill.

At the heart of our century, in 1960, for the first time science was intervening openly, deliberately and specifically in
the evolution of the feminine condition by allowing unwanted maternities to be avoided, an essential problem for all couples and a crucial one for the future of the planet. The event was as symbolic as it was concrete and I decided to participate after my own fashion, as a "doctor who does science". Thus I chose the study of sex hormones, hoping that sooner or later I would contribute to the mastery of reproduction; I believe that scientific activity is one of the essential motors for social change.

Doubtless, human nature evolves little or not at all through the centuries but modes of behaviour are transformed. One does not fight in the same way with a flintstone, a musket or an atomic bomb.

By modifying women's situation, science contributes to the determination of a different social order. As soon as men and women are made responsible for their reproduction, habits and even feelings can be transformed. In that way, for example, it is possible to wonder whether, with male contraception again on the agenda, it will open up new modes of behaviour.

Will women have confidence in men in this respect? Will men want to claim this new responsibility?

Am I, myself, able to avoid the debate between science and society? It is indissociable from my thought and my work. The evolution of mentalities may well be slower and more difficult than the discovery itself.

Nevertheless, once the latter has been accepted, one can count on the transmission of knowledge, a human property which is without a physical code, to perpetuate the benefits one hopes to gain from it. The flintstone was used for making fire and for hunting for food more than for killing fellow men. In the same way, Paul's and Lister's observations did not lead to bacteriological warfare but are still profitably used by billions of individuals.

Hiroshima and Chernobyl will seem far off when atomic energy has become indispensable for the survival of humanity.

I have confidence in an immanent human wisdom, which probably only reflects our species' instinct for self-preservation.

Despite the stockpiles of asphyxiating gases and atomic weapons in our troubled world, despite the warning shots which have been sufficiently horrific to be dissuasive, they have not been used. My pessimism is optimistic.

In the domain of reproduction, science offers men and women the very essence of its double role: on the one hand to enlighten knowledge by the description of biological mechanisms and, on the other hand, to develop means of intervention whose diversity must correspond to that of situations.

To give everyone the practical and psychological means to face up to nature and to the severity of the tests with which it confronts us, that must be the moral inspiration of research and action in the medical domain.

It is then a matter of creating the conditions for an informed and lucid choice and of offering it to everyone without ever imposing the supervision of individuals by the experts in scientific knowledge. When scientific, emotional and moral problems are interwoven to this extent, science cannot give instructions about the individual and collective behaviour. It is up to society to define the conditions for choice and up to each individual to exercise it personally.

If the 20th century has been able to preserve democracy in some countries, we must still go beyond this precious and fragile conquest by assimilating the consequences of scientific discoveries. Knowledge and responsibility will be the foundation for this new humanism in science.

Research must remain free and unpredictable, like the human mind. Its results must be registered in humanity's common patrimony.

RU 486 illustrates the stakes and the difficulties of putting these principles into operation. This new hormonal means of voluntary interruption of pregnancy avoids more or less traumatic instrumental interventions.

Abortion is a timeless practice and is still widespread: more than 50 million interruptions of pregnancy are practiced each year in the world and under precarious conditions.

Without counting the numerous and grave health problems, more than 150,000 women die annually because of rudimentary procedures and RU 486 can and should reduce if not eradicate this mortality.

In the controversial domain of abortion, contested in principle by some currents of thought, the reliability and safety of RU 486 have not been undermined sufficiently: however, more than 200,000 women have already used this compound in France, Great Britain and Sweden and, combined with an oral prostaglandin (2), its efficacy and innocuousness has been established.

Unfortunately, the difficulties in distributing the compound in the world have created a situation today whose danger must be underlined. The delays and the halt to the international distribution of RU 486 and its manufacture, without authorization or control, in China and true, in India and elsewhere, give rise to fears of finding counterfeiters of unguaranteed chemical quality on the market tomorrow.

Still worse, there is the threat of unauthorized use of RU 486 because its managed distribution threatens to lead to uncontrolled use, without a medical presence (3), especially in countries where contraceptive methods are not practiced much and where the recourse to abortion is, alas, very frequent.

Putting RU 486 at people's disposal must be carried out under strict conditions. The present circumstances carry the double danger of uncontrolled use on the one hand and the maintenance of a dramatic situation on the other.

This question will only be resolved by confining the product to an international group of scientists, doctors, jurists and wise men gathered in a foundation dated with the power and responsibility for taking the appropriate measures, as quickly as possible, for having RU 486 exploited in conformity with the deontological, medical and social rules of each country, while respecting each individual's freedom of choice.

The permanent evaluation of the results, with complete transparency, will be indispensable. By this public warning I would like to bear witness not only to the goodwill but also to the decided will of a society that wants to say out loud what it is in question when a new method is proposed following a biomedical discovery.

This will certainly occur again on numerous occasions with progress in medicine. Scientists must participate more in society's debates, which they themselves have provoked. This is the only way to prevent such dramatic situations as those recently seen with certain pharmaceutical compounds, glandular extracts or blood products.

High level research in genetics for example, has already demonstrated its spirit of responsibility.

Research must remain free and unpredictable, like the human mind. Its results must be registered in humanity's common patrimony. I think that the applications of research and of its discoveries belong to everyone, but that research workers have a duty of responsibility towards what their inventions become.

(1) The same is true with the non-human primate (research with Prof. Gary Hodgson at the John Foundation in Norfolk, Virginia).

(2) Prostaglandins, discovered and used thanks to Sune Bergström, Bengt Samuelsson and Marc Bygdem, are "local hormones" which increase the contraction of the fibres of the uterus and open its cervix.

(3) The medicalization of the method is not due to RU 486, which is without danger by itself. Pregnancy is a risk for women, whether they wish to continue it or not. Neither RU 486 nor aspiration treat extra-uterine pregnancies, whose severe prognostics and growing frequency are known.

ENTRE NOUS 26-27, December 1994
Medical abortion - early reports

By Elisabeth Aubeny

Women have always preferred medical abortion to surgery. Since the discovery about a decade ago of an antiprogestrone, RU 486, the possibility of pharmaceutical abortion has become a reality.

At present it is authorized for use in France, England and Sweden. The RU 486 in combination with a minimal dosage of synthesized prostaglandin, a substance which causes the uterus to contract, induces pharmaceutical abortion.

In France, this pharmaceutical combination can be used up to 49 days after the last menstrual period (LMP) although, as a rule, it translates into three weeks after the missed period was due. In England and Sweden, RU 486 can be used up to 63 days after the LMP although, as a rule, five weeks after the missed period was due.

Only approved centres where abortion is performed are allowed to dispense RU 486. Its distribution is strictly controlled. It is not available from pharmacists.

APPLICATION METHOD

The method for the application of RU 486 is as follows (after the legal procedures required by each of these countries have been complied with):

Day 1: The patient takes 600 mg of RU 486 orally (three 200 mg tablets) at an approved private or public abortion centre, following which she returns home.

Day 3: 48 hours after taking the RU 486 the patient returns to the centre for the administration of prostaglandin in the form of tablets or suppositories. The patient remains under medical surveillance for four hours after receiving the tablets, and for six hours in the case of the suppositories. The majority of patients (approx. 61%) abort during this period. Others who abort successfully do so at home over the following 24 hours. Between day 10 and day 12 the patient returns to the approved centre for a check-up.

MEDICAL ABORTION IN FRANCE

Abortions induced through RU and prostaglandin have been legally permitted since 1987.

From 1987 to 1992 the prostaglandin used was in the form of an intramuscular injection. In 1992, this was replaced by an oral prostaglandin, Misoprostol, which is safer to use and less costly. The dose administered is 400 mg, in the form of two tablets.

Results of this technique: (figures are taken from a multicentre study conducted by the firm Roussel on 488 cases in France):

The success rate was 95.36%. The failures fell into the following classes: (1) pregnancy continued: 0.8%; (2) pregnancy terminated but not expelled within 10 days: 1.8%; (3) surgical intervention required due to hemorrhaging: 0.4%.

All pregnancies which were not expelled spontaneously were terminated with vacuum curettage.

The point at which expulsion occurred: 2.9% of women expelled after having taken RU 486 before taking Misoprostol; 60.9% of women expelled during the four hours of surveillance in hospital after the administration of prostaglandin.

Loss of blood: All the patients suffered from some blood. The average duration of bleeding was nine days, extending in extreme cases up to 32 days.

Action taken in cases of hemorrhage: The normal action was curettage but blood transfusion, was applied in extreme situations. During the study, blood transfusion was given in one case and there were four curettages.

In summary, the majority of women using the method appreciated the possibility of avoiding surgery and its traumas, both physical and psychological. All of them, however, emphasized the sense of responsibility which the method entailed.

Side effects: Pelvic pain: When Misoprostol is used, any pain is generally very moderate: 20% of the women felt no pain, 60% reported pains comparable to menstrual pains, beginning usually a quarter of an hour after taking Misoprostol and lasting for about three quarters of an hour. 20% of the patients had pains requiring mild painkillers. None of them were given morphinics drugs. Gastrointestinal Symptoms; nausea was relatively frequent (42.5%), but only 1.9% of cases required treatment. Vomiting and diarrhea were very rare. Acceptability of the method: There are some important constraints which could lead to the rejection of this method. In the first instance, the method implicates the patient to a large extent. It is she who must take the initiative to set the abortion process in motion; it is she who conducts the process of abortion in her own home and subsequently in the hospital after the administration of prostaglandin; it is she who decides whether or not she needs a painkiller; it is she who observes whether the abortion has or has not occurred and examines the discharge. The doctor and paramedical personnel only act in a surveillance role. In order to evaluate the acceptability of this method of abortion, patients at the Broussais hospital were asked to give their written impressions as to whether their experience in fact supported their reasons for choosing this method.

Out of 100 responses: 100 women reported that they had chosen this method because it did not involve surgery, did not require anesthesia and it seemed to them more natural. 92% were satisfied with their choice and did not experience the feeling of being physically violated as they would have, had they undergone surgery and anesthesia (some had previously undergone voluntary surgical abortions).

Many added that they had felt they were experiencing something natural. They described how they had felt a sense of responsibility during the 48 hours until the abortion took place and how they appreciated this.

Eight percent of the women however, said they regretted not having chosen surgery. They felt that the medical method took too long and was in some cases too difficult for them psychologically: "I would have preferred the doctor to take charge completely", said one respondent.

In summary, the majority of women using the method appreciated the possibility of avoiding surgery and its traumas, both physical and psychological. All of them, however, emphasized the sense of responsibility which the method entailed.

Since 1987, 100,000 women have availed themselves of the method using RU and prostaglandin, 10,000 using RU and Misoprostol.

In 1991, 86% of the women who were able to take advantage of this method (for pregnancies which had lasted for less than 49 days from the LMP) chose to do so. In other words, a method opted for by women). (Ref: New England Journal of Medicine, May 1993. No 2 Vol. 328.)

MEDICAL ABORTION IN ENGLAND AND SWEDEN

The use of 600 mg of RU plus prostaglandin vaginal suppositories has been authorized since 1991. It is per-
mitted up to 63 days from the LMP. The rate of success is 95%, comparable to that using oral prostaglandin. Pelvic pain, however, is notably more common, as 60% of women were given pain-killers. Use of the method is growing rapidly in the private sector. In public hospitals long waiting periods make it difficult to make use of this method.

In Sweden 600 mg of RU 486 has been used in combination with Gemeprost up to 63 days after the LMP since September 1992. No reports have yet been published on the practice.

RU 486 IN OTHER COUNTRIES

A number of countries are seeking to put the method into effect. These include both countries which have legalized voluntary induced abortion and countries which have not legalized voluntary abortion but wish to introduce the method at the same time as the regulations in question are adopted.

At present, however, the French pharmaceutical firm Roussel, a daughter company of the German Hoechst group which owns a 60% interest, is only authorized to sell RU 486 in those countries which have legislation permitting abortion, and which are capable of controlling the distribution of RU 486, administration through high quality medical methods, and where public opinion is in favour of the method.

Negotiations are going on in other countries where abortion is legal, especially in the Nordic countries and the USA and it seems that an agreement is on the point of being reached. No attempt to introduce the method has been made in countries which have not legalized abortion.

IN CONCLUSION

In those countries where it is used, the combination of RU and prostaglandin (Misoprostol up to 49 days after the LMP or Gemeprost up to 63 days after the LMP) has been shown to be an effective and safe combination. This pharmaceutical form of abortion has been selected by women where they have been offered the option of choosing it, as it appears to them more natural and less intrusive than the surgical method, despite the fact that it implicates them to a greater extent. It is desirable that, when undergoing as traumatic an event as abortion will always remain, women should have the possibility of this option.

Dr Elisabeth Aubeny, Head, Family Planning Center, Hopital Broussais, 96, rue Didot, 75014 Paris France.

Postinor:
The ultimum refugium?*

By István Batár

For millennia vaginal douching was a widely used and probably the only postcoital method of preventing unwanted pregnancy.

When hormonal contraception became available, both researchers and clinicians tried to find a new and more effective way of systemic administration of drugs in order to achieve a "post facto" approach of fertility control.

However, the "morning-after pill" - in reality - does not mean contraception, but rather interception, i.e. prevention of implantation after fertilization.

The first trials were done with different estrogens (diethylstilbestrol, ethinyl-estradiol, conjugated estrogens). The most frequent preparations were ethinyl-estradiol and diethylstilbestrol both of them given in different dosages for five days.

According to the limited literature available one has to conclude that postcoital estrogens could prevent pregnancy. The number and ratio of immediate side effects, however, was high.

Some long-term effects

The most frequent disturbances were nausea (50%), vomiting (20%), mastalgia (20%), menses delay (12%), menstruation (12%) and amenorrhea (less than 1%). Beside these risks, some possible long-term effects attributed to estrogens also have to be taken into consideration such as thrombosis, hypertension, liver disease, diabetes and increased risk of congenital malformation of the offspring if pregnancy occurs.

All these above-mentioned facts mean a real drawback in utilizing these drugs routinely for postcoital contraception.

Yuzpe and co-workers in the early 1980s proposed a combined pill regimen of 1mg dl-norgestrel + 100ug ethinyl-estradiol taken on two occasions 12 hours apart within 72 hours of a non-protected coitus.

Using levonorgestrel instead of the racemic mixture, 0.5mg is about equal in biological potency of 1mg dl-norgestrel. Two tablets of the Hungarian product, Ovidon (G. Richter) gives the identical dose of the above regimen.

More than a decade ago, a new approach to postcoital contraception was developed: the single high-dose oral norgestrel, a real "morning-after pill".

In Hungary, the first such pill was marketed also in the early 1980s and named Postinor (G. Richter). It contains 0.75mg levonorgestrel. The tablet is to be taken immediately (maximum within 1 hour) after unprotected coitus.

In case repeated sexual intercourse occurred after three or more hours, another pill should be taken.

Subsequent (accumulated) coituses need a pill taken immediately after the first intercourse and a second pill to be taken eight hours later.

Postinor is advised for those who have sexual intercourse occasionally or rarely.

The maximum number of pills that can be taken in one cycle (in the majority of cases less than 100 patients and only some hundreds of cycles). The other problem is that the life table calculation (suggested by Tietze) cannot be applied.

The Pearl-index, where published or computable, is between 0.0 and 10.7.

The table summarizes the available data on Postinor published by Hungarian authors. Although almost all of them calculated Pearl-index, they gave the failure rate as a percentage of the number of the sexual intercourse. Their figures of between 0.0% and 0.4% is unrealistically low.

This statistical method is very debatable since coitus occurring in the late
luteal phase of a normal cycle is safe without any protection.

As the amount of separate published data is small, it is better to pool the data and calculate the Pearl-index for a total of 11 pregnancies and 3135 cycles (duration of use by 559 patients). In this way the failure rate is 4.2 calculated for 100 women per one year - which is much closer to reality.

Breakthrough bleeding and spotting was the most frequent side effect (20-30%). This was unanimously stated by all authors. Other problems, such as headache, nausea, vomiting, breast tenderness; nervousness, hirsutism, weight gain, etc. also occurred but were usually not serious enough to discontinue the method.

In a prospective randomized study, Hok of Singapore compared the effectiveness and the over-all performance of the Yuzpe regimen and the Postinor (two tablets 12 hours apart). According to this finding the pregnancy rate was 3.5% and 2.9%, respectively. After excluding the patients who had further acts of intercourse during the treatment cycle, the failure rate dropped to 2.6% in the Yuzpe and 2.4% in the Postinor group.

The incidence of nausea, vomiting and fatigue in the Yuzpe group was significantly higher than those in the levonorgestrel group (presented at the SAC meeting in Barcelona, Spain 1992).

In conclusion, Postinor - and other postcoital pills - may be valuable in emergency situations or in case of infrequent intercourse, but can be regarded inappropriate for the majority of women having more or less regular sexual relations.

Dr István Batár is Associate Professor and Head of the Family Planning Center, Department of Obstetrics and Gynecology, University Medical School of Debrecen, Hungary.

* The last resort.

**Summary table on clinical studies with postinor (Hungarian data)**

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<th>Author(s)</th>
<th>Cases (n)</th>
<th>Cycles (n)</th>
<th>Pregnancy (n) [patient failure]</th>
<th>Coitus (n)</th>
<th>Coitus per month (n)</th>
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<tr>
<td>7. Kiss (1983)</td>
<td>50</td>
<td>293</td>
<td>0</td>
<td>707</td>
<td>2.5</td>
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</tbody>
</table>

? = estimated only (as the author mentioned 2-4 months of use only)

* = including 1 ectopic pregnancy

**RU 486 - a once-a-month pill?**

By David T. Baird and Anna F. Glasier

Postcoital or emergency contraception refers to contraception which is taken after intercourse. To be effective it must either prevent ovulation, or fertilization of the ovulated egg, or prevent implantation of the early embryo.

Postcoital contraception is usually taken as an emergency contraceptive i.e. after unprotected intercourse. However, with the development of new approaches it may be possible to devise postcoital methods which can be used regularly as a once-a-month pill.

A major advantage of this approach is that, in contrast to present methods of hormonal contraception, it is necessary only when intercourse has taken place in that month. Progesterone is essential for both the preparation of the endometrium for implantation and for the maintenance of pregnancy. It is hardly surprising, therefore, that the administration of compounds which block the action of progesterone should have antifertility effects.

### Post-coital agent

In 1980, chemists at Roussel UCLAF discovered a synthetic steroid related to norethindrone which blocked the action of endogenous progesterone. Mifepristone (RU 486) has been shown to induce abortion and, in combination with prostaglandin, is a highly effective alternative to vacuum aspiration in the early weeks of pregnancy.

More recently attention has turned to the possible use of this compound, together with other antiprogestoic agents, as post-coital agents.

RU 486 has an extremely long half-life and when given by mouth will persist in the circulation in therapeutic levels for up to four or five days.

These pharmacokinetic properties, therefore, make it ideal for a postcoital contraceptive, because it persists in the body for several days.

Given prior to ovulation, it will block the development of an LH surge and hence prevent ovulation. Given in the early luteal phase, it blocks the action of progesterone on the endometrium hence causing delay in the maturation of a secretory endometrium.

### Recent trial results

In the mid or late luteal phase of the cycle, the biological effect of progesterone is withdrawn and premature menstruation ensues. Mifepristone, therefore, has many of the properties necessary for a postcoital agent which will be effective regardless of the stage of the cycle in which intercourse occurs.

Recently, two large trials have tested the efficacy of mifepristone given in a...
dose of 600 mg within 72 hours of unprotected intercourse.

There were no pregnancies in just over 600 women who had unprotected intercourse. In contrast, a failure rate of 1.5% was observed in a control group of subjects who were treated with the conventional combined oestrogen-progesterone regime (200 µg ethinyl oestradiol and 2 mg levonorgestrel).

Moreover, the incidence of nausea and vomiting was noticeably absent in the group that received mifepristone. In contrast, 40% of women were nauseated in the group that had the combined regimen.

**Delay in menses**

However, the administration of mifepristone in this manner did lead to a delay in the onset of menses in 42% of women, presumably because the mifepristone had been given prior to ovulation and, hence, the onset of the LH surge was delayed.

This delay in onset of menstruation could lead to anxiety in women exposed to the risk of pregnancy; however, with such a high efficacy, they could be reassured that it is unlikely they were pregnant.

Current studies are planned by the World Health Organization to determine the minimum dose of RU 486 which is effective when given as a postcoital agent.

The efficacy of mifepristone given in the early luteal phase of the cycle in preventing pregnancy has recently been tested in trials in Sweden.

Twenty one sexually active women were given 200 mg of mifepristone as their sole method of contraception on the second day after the LH peak for periods of one to 12 months. There was only one pregnancy in a total of 157 ovulatory cycles. There was minimal disruption in the pattern of menstruation with menses occurring at the expected time in most cycles.

This preliminary study confirms that mifepristone given immediately after ovulation is an effective contraceptive.

However, it has to be given in the early luteal phase otherwise disruption in the pattern of menstruation occurs. This can limit its practical use as a widespread contraceptive until a cheap, robust method of detecting ovulation which could be used by women in their own home is available.

**Efficacy can be increased**

It is also possible to use mifepristone to disrupt implantation when given in the late luteal phase of the cycle. However, when given on Day 27 in doses from 200 to 600 mg about 15% of pregnancies continue uninterrupted.

It is likely that the efficacy could be increased by giving an oral prostaglandin such as misoprostol 24 to 48 hours after the mifepristone such as has been used to induce abortion.

One of the problems associated with such an approach might be a disruption in the pattern of menstruation. Following induction of abortion with mifepristone and gemeprost, there is a mean delay in the onset of the next menses of seven days with a range from two to 68 days. Thus, there may be great variability in the onset of ovulation and, hence, the next period.

**However, mifepristone has to be given in the early luteal phase otherwise disruption in the pattern of menstruation occurs. This can limit its practical use as a widespread contraceptive until a cheap, robust method of detecting ovulation which could be used by women in their own home is available.**

This would make it very difficult to predict when to take the next “once-a-month” pill. There are also doubts as to whether such a method would be ethically acceptable to all women as a regular method of contraception. In a study conducted in Edinburgh of over 400 women, less that 25% said they would use such a method because they considered that the thought of exposing themselves to the risk of pregnancy and then inducing abortion was unacceptable.

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**ERRATUM**

We would like to thank our attentive readers for pointing out that in the last issue of Entre Nous there has been a mistake in the glossary regarding the definition of the term ‘family planning’ (page 3, bottom).

Following are the WHO-HRP working definitions of the terms: Reproductive Health, Family Planning, and Fertility Regulation:

**Reproductive Health:** Reproductive health implies that people are able to have responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

**Family Planning:** Family planning implies the ability of individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. Family planning is achieved through information and education as well as any means capable of preventing pregnancy, and through the treatment of involuntary infertility. The contraceptive effect can be obtained through temporary or permanent means. Temporary methods include: periodic abstinence during the fertile period; coitus interruptus; utilizing the naturally occurring periods of infertility; through the use of reproductive hormones; by placing a device in utero and, by interposing a barrier preventing the ascent of the sperm into the upper female genital tract. Permanent means for contraception include male and female sterilization.

**Fertility regulation:** Fertility regulation is the process by which individuals and couples regulate their fertility. Methods that can be used for this purpose include, amongst others: delaying child-bearing, using contraception, seeking treatment for infertility, interrupting unwanted pregnancies and breast-feeding.
Teenage parents in Denmark

By Lisbeth B. Knudsen

Only very few teenagers become parents in Denmark. With figures from Danmarks Statistik (Danish Statistical Office) and the newly established Fertility Database it is possible to find out just how many teenagers are involved and what their situation is.

Denmark, in contrast to a number of countries like the USA, has very few deliveries among women under 20.

Very few teenagers become pregnant in the first place, and of these, only roughly a third choose to give birth.

Table 1 shows that the number has been decreasing rapidly over the past 20 years. But it is necessary to look at the age specific birth rates, i.e. calculating the number of births in relation to the number of women.

The birth rate per 1,000 women aged 16-20 years during 1970-1992 appears in Figure 1 (on the following page). A strong decline in the birth rate occurred during the 1970s and the low level which teenage births reached at the beginning and middle of the 1980s has been maintained in the 1990s.

There are differences between the various regions in Denmark, e.g. Copenhagen has the highest birth rate among teenagers.

The number of induced abortions per 1,000 teenagers peaked in 1976 with 26.0 per 1,000 and decreased slowly in the following years. The lowest rate was seen in 1987 where only 15.7 per 1,000 teenagers had an induced abortion. The figure in 1992 was 16.0 per thousand.

Most of the pregnant teenagers choose termination of pregnancy.

Since very few teenagers marry, the majority of the teenage mothers are unmarried - 1,178 unmarried as compared with 434 married in 1991.

Pregnancy leads to marriage

However, the birth rate among married young women is so high that approximately 270 out of 1000 married teenagers had a child in 1991, whereas scarcely seven out of 1000 unmarried teenagers gave birth the same year. It must be presumed that part of the married teenage mothers got married due to onset of pregnancy. Most of the young married women are from immigrant groups.

Almost all women under 20 who give birth are primiparae. In 1991, 1464 out of a total of 1617 teenage deliveries - corresponding to 91% - were first deliveries.

The figures above are all from the current Vital Statistics which is produced by Danmarks Statistik.

The social and educational situation of the mothers can be extracted from the Fertility Database which has recently been established in Danmarks Statistik. (See Note 1.) The following information is based on information from the Fertility Database. It contains annual data on all women aged 12-49 years and men up to 64 years.

Figures from the latest year of the Database - 1988 - show that no girls under 15 had given birth. Among those aged 15-14 girls, of which 10 were Danish, had one child each. Among the 16-year olds, 44 Danish girls out of a total of 67 had one child each. Among the 17-year olds, 155 girls, of which 98 were Danish, also had one child each; only eight girls had two.

This represents a very low proportion relative to the total number of teenage girls in the country. Among the 17-year-old girls, less than 1% of the corresponding Danish population, 9%.

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TABLE 1: Number of births by women under the age of 20 in Denmark - 1969-1990

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<td>497</td>
</tr>
<tr>
<td>19 yrs</td>
<td>3104</td>
<td>2452</td>
<td>1610</td>
<td>1122</td>
<td>842</td>
</tr>
<tr>
<td>Total</td>
<td>7106</td>
<td>4875</td>
<td>3160</td>
<td>1876</td>
<td>1656</td>
</tr>
</tbody>
</table>


for corresponding Turkish population
and 7% for Yugoslav girls.

Profile of young fathers

The Fertility Database makes it possible, for the first time, to obtain a profile of the father. Marriage statistics indicate that generally men are a few years older than the women they marry.

More recent analyses of both married and cohabiting couples show that in relationships where the women is 20 years old, the husband is, on average, 3.2 years older.

Since so few teenagers give birth, it does not make any sense to calculate the percentage distribution of the fathers’ ages each year.

As a general rule, the proportion of the very young men declines with the age of the woman. Among the more than 300 16-year old mothers, 35% of the fathers were under 20. According to the Fertility Database, a total of 12 boys became fathers before they attained the age of 16. 41 did so at the age of 16 and 720 became fathers at the ages of 17-18.

Fate of young mothers

From the Fertility Database, we can follow the fate of some of the teenage mothers who gave birth in the early 1980s and see how they fared later in terms of education, occupations and the number of children they later bore.

Most of the younger women are still attending school because they have not yet completed their general school.

The Fertility Database provides information on a total of 226 women who had had their first child between the age of 14 and 17, had attained the age of 23 years by 1 January 1988 and had completed their general schooling over the period covered by the Fertility Database.

Almost half of the 23 year olds had two children; the average for the group was 1.71 children. This is six times as high as the average for all 23 year old women in Denmark in 1988.

Generally, it can be assumed that women who have their first child at an early age often end up having more children than women who start later.

This theory is borne out by figures which show that of 1152 women who were 23 in 1988 and who had had their first child at the age of 18 or 19, on average, had given birth to 1.65 children.

Among those women who were 23 years old in 1988 and who had had their first child between the ages of 14 and 17, a little less than 50% had left school after the 9th grade and half of them had thereafter only found unskilled jobs.

However, approximately a third of the total number were “outside the labor market”, a category which includes housewives who do not have occupations.

In the group of 23 year old women in 1988, who had their first child 18-19 years old, a third had left school after the 9th grade but also. In this group approximately 50% were in unskilled employment. These women had finished school before having their first child.

Teenage birth-rates declining

In the whole group, a quarter were unemployed. Approximately 5% of the women, who had had a child before the age of 18, had completed secondary school or an education to a similar level.

In contrast, around on third of all women aged 23 in 1988 had completed secondary education. Approx. 15% had left school after the 9th grade and of these 33% had unskilled employment while under 10% were outside the labor market.

On a national scale, there is no indication of a rise in teenage deliveries, neither absolutely nor relatively. Recent years have also shown declining birth rates among teenagers during the same period when the number of women giving birth in their late twenties and early thirties has gone up.

There may be specific groups of women who give birth at an early age. It will be possible to characterize these women further by using the Fertility Database. And some of these women may presumably need special attention.

* This paper was published in Sex og Sundhed, 14, 1993, the magazine of the Danish Family Planning association.

* Notes:
(1) The Fertility Database was established with financial support from the Danish Social Science Research Council. Results from the first analysis are published in: Fertility Trends in Denmark in the 1980s, a register-based socio-demographic analysis of fertility trends.
(2) Familiens ændring - en statistisk besværlighed af familieholdene (The change of the family - a statistical illustration of family relations) by Mogens Nygaard Christoffersen of The Danish National Institute of Social Research, 1993.

Lisbeth B. Knudsen is a sociologist at Danmarks Statistik. She established the Fertility Database and in future will be administering and providing data for the institution as well as analysing the developments in infant mortality based on a grant from the Danish Health Insurance Fund.
Albania: Breaking chains of the past

By Fjodor Kallajxhiu and Orion Gliozheni

Albania, a small country in the southwest of the Balkan Peninsula with a population of 3.2 million, has doubled its population twice this century: between 1923 and 1960, and between 1960 and 1989. The population growth rate is now 2.4% per year, and thus much higher than that of other European countries. The average in the Balkan states is 1.3%, the population growth in Eastern Europe is 0.6%, and that of Western European countries ranges from 0.2 to 0.7%. Turkey is the only country where the population growth is similar to that of Albania.

However, in Albania, fertility rates have gradually decreased, from seven births per woman in 1950 to three births in 1989. This has been paralleled by a decrease in infant mortality rates, so that, on average, the same number of children survive. However, infant mortality rates are still too high, particularly in the rural areas.

Between 1944 and 1992, family planning could not even be mentioned in Albania due to the pronatalist policy of the government. The Albanian government had prohibited abortion, and imposed jail sentences of between two to eight years for women who performed self-induced abortion.

The government had also prohibited the sale and distribution of contraceptives. No family planning training or sex education existed in the medical schools. All this was happening against a background of constant economic decline, and an average per capita income of US$450 per year. Albania is still the poorest country in Europe.

The rapid increase in population not only undermined whatever positive economic development there were, it had a negative influence on the health of women and children.

The maternal mortality in 1989 was 39 per 100,000 live births, and over half of this was caused by induced abortions. The infant mortality rate in 1989 was 30 per 1000 newborns.

Thus the situation we inherited was a very difficult one. Fortunately, it was recognized that a national family planning policy would contribute considerably to the improvement of family health. In May 1992, the Albanian government approved the development of family planning activities, and in July 1992 the implementation of a national Family Planning project, financed by UNFPA and with technical assistance from WHO Regional Office for Europe began.

This project aimed at improving the health of mothers and children, promoting knowledge of family planning methods among Albanian families and achieving a contraceptive coverage for 10% of Albanian women.

The strategy consists of training medical personnel, organizing FP structures in urban areas of the country, producing information material for the public, and providing medical equipment and contraceptives.

This strategy is implemented in full conformity with the National Health Reform policies, and takes into account regional and decentralization policies.

Family planning service provision is integrated into maternal and child care.

Since the beginning of the programme, we have trained 200 gynecologists and midwives and 300 pharmacists throughout the country.

Family planning centers are now functioning in all the maternity hospitals of Albania as well as in pre-natal outpatients consultancies.

One of the results we have achieved over two years is a 5% contraceptive coverage of women of reproductive age. We think that the number may be higher but it is difficult to have the exact data. We have also encountered quite a few problems in project implementation.

These are largely a result of the very poor economic conditions of health and health education centers.

In addition, the originally very low level of knowledge of reproductive health and preventive medicine, both within the general population and in the medical community have been major obstacles. Although doctors and midwives are generally well trained, it is difficult to shift attitudes away from curative to preventive health care.

Despite the problems, we are convinced of the vital necessity to improve the physical and social well-being of the Albanian families, and are committed to the continuation and expansion of our present programme in order to make it as successful as possible.

Dr Fjodor Kallajxhiu is the Chief of the Albanian National Family Planning programme and of the Maternal and Child Health Division of the Ministry of Health of Albania.

Dr Orion Gliozheni is an Obstetrician and Gynecologist at the University Hospital of Tirana.

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Infant mortality rate, per 1000 live births

Maternal deaths, per 10000 live births

Source: Ministry of Health, Albania
My years at WHO Europe

By Daniel Pierotti

After a number of years wandering as an independent consultant, sailing from one continent to another, tired out by time differences, resolving problems within a short period of time, and uncompleted projects, I responded to the entreaties of my family to rejoin my old UN comrade.

On the 28th of August, 1988, almost six years ago, I took on the functions, duties and privileges of the post of "Adviser for Sexuality and Family Planning" at the WHO Regional Office for Europe. I was the second person to occupy this relatively luxurious position which my friend and accomplice, Miss Wadad Haddad had served successfully and efficiently during the 15 years preceding my arrival. I do not intend to list here successes and fluffs of these six years at the European Office, but to attempt to examine the conditions, the means, and the strategies put into practice and hope to extract from them lessons for the future.

At the time of my arrival, the major reproductive health problems for Western Europe (apart from the omnipresent AIDS), centred on the widespread fall in the birth rate, the lack of generational renewal and, occasionally, on the ethical debate surrounding in vitro fertilization. As to the countries of Eastern and Central Europe, their crying needs went unheared. What little information we did receive was fragmentary or media-manipulated.

On our side, lacking a clear strategy and the means to assist these countries, our hands were tied, apart from rare and extremely limited projects. With its limited resources, the Sexuality and Family Planning (SFP) Unit of the European Regional Office, has always attempted to respond to a bewildering variety of needs. The volume of the unit's activities in the field varies according to its available budget. The largest contributor, and privileged partner, remains the United Nations Population Fund (UNFPA).

A WHO regional advisor responsible for a technical unit must develop his or her programme based on the policies of the Head Office, keep the mandates of his financial supporters in mind, and work on the needs clearly identified by the Member States. However, two major events over recent years have totally reoriented the programme strategy of the unit. These were, one, the resounding collapse of the communist regime in Eastern Europe and, second, the evolution of relations between UNFPA and the agencies traditionally carrying out its projects. These two events occurred at about the same time.

Before the fall of the Berlin Wall, the unit had developed some activities involving countries of the East, but never at national level. Our counterparts, most often institutes of maternal and infant health, or an obstetric and gynecological service, implemented projects involving research, grants or training with our assistance. The themes dealt with were not necessarily limited to family planning.

With the socio-political transformations in the East, however, our activities have suddenly evolved in a radical fashion, becoming much more open and visible and much more in demand.

It was no longer a question of regional mini-projects, but of responding globally to complex, costly and delicate national problems. This redefining of the rules and the unexpected appearance of new international demands for assistance came as a sudden shock. Eastern Europe suddenly entered into competition with the developing countries of other continents. Since then, the agencies have had to adapt as best they can and attend to the most urgent matters.

In actual fact, the volume of technical and financial assistance received by the countries of Eastern and Central Europe and the NIS in matters of family planning and reproductive health remains well below the hopes and needs of these countries.

At the beginning of the 1990s, UNFPA modified its strategy and took on a large segment of the execution of national projects: local expenses, equipment, purchasing of contraceptives, evaluation ... leaving the international consultation and education to the WHO. This new situation took us away from the sphere of execution, making the management of our role more complex.

This has necessitated relearning modesty, how to share and collaborate with other agencies.

In this context, activities have continued to be divided into two distinct and sometimes complementary types: national projects, carried out at the request of individual states, and regional or interregional projects. National projects have traditionally begun with a request for assistance from a European state with regard to a specific need. Most often this request is addressed directly to UNFPA which examines it and, on approval, arranges financing, then subcontracts the execution, in whole or in part, to the WHO.

Most ambitious projects

Our role is rarely that of initiator, but rather has become that of executor. These projects account for two levels of activity. Each year the Sexuality and Family Planning Unit regularly carries out from two to five national projects; the most recent ones with co-executors in Albania, Estonia, Romania, Portugal and Turkey.

Regional projects, on the other hand, are conceived by the unit from the beginning. They are set up in response to a common need in a number of countries. These are flexible projects, including everything from interregional conferences to the creation of a magazine, the carrying out of research, or training programmes.

Each of these activities is often in response to an urgent, immediate need which has suddenly flared up. The efforts are then made more lasting through technical guidance, new strategies, consensus or coordinated interagency action.

One of our two most ambitious regional projects consisted of organizing the Tbilisi conference "From Abortion to Contraception", which brought together 170 international experts. This conference was organized and realized within the space of 18 months, thanks to an intensive collective effort.

The transformation of the newsletter Entre Nous into a respected magazine on reproductive health in Europe is the second cause for satisfaction in interregional affairs. At the time of my departure, the magazine was distributed to almost 10,000 recipients in all continents and published in five lan-
guages. This creative force will increase yet more now that a Russian translation is added to the other five languages.

It is ironic just at the moment when the need for reproductive health is becoming more pressing and clamorous in Eastern Europe (including the former USSR), the resources for SFP are dwindling.

Inter-agency cooperation must be boosted. Several potential partners are working in closely related areas. The International Planned Parenthood Federation (IPPF) is among those organizations which complement our public-sector approach with that of a private-sector association.

At the Regional Office, inter-unit cooperation should be linked to several groups or themes: adolescents, women, unwanted pregnancies and prevention of sexually transmitted diseases. In reproductive affairs, SFP is the executive arm of the Head Office. Among our positive points we can include:

- Privileged access to Ministries of Health,
- WHO liaison officers on location,
- Special databases,
- A network of consultants, counterparts and collaborating centres.

We exist only for and because of the countries themselves: meeting the needs of countries in reproductive affairs is the raison d'être of SFP.

At the same time, the unit must answer expressed needs or bring them into focus, while maintaining its priority themes: easy access to diversified contraception with respect for individual choice, replacement of abortion by less costly pure contraception, and safe abortion practiced with full security.

It must direct attention to forgotten or neglected groups: refugees or displaced women and migrants, and link the struggle against HIV-seropositivity with the regulation of fertility.

This list, although far from exhaustive, is an indication of how SFP could develop its programmes while sliding out of its solo role into one of a sought-after partner.

Dr. D. Pierotti,
Chief,
Family Planning and Population,
Family Health Division,
World Health Organization,
CH-1211 Geneva 27,
Switzerland.

ICPD now on computer networks

ICPD 94, The newsletter of the International Conference on Population and Development (and other information about the conference) is now available on several electronic communications networks.

A population information “gopher” on the Internet computer network has been organized by the Population Information Network (POPIN) of the United Nations Population Division, Department for Economic and Social Information and Policy Analysis (DESIPA), in collaboration with the United Nations Development Programme (UNDP) and with financial support from UNFPA. This is located within the UNDP gopher (server address: gopher.undp.org). Access is free to Internet users world wide.

The POPIN gopher will soon include Conference documents; newsletters and press releases of the ICPD Secretariat. The POPIN gopher includes Conference documents; newsletters and press releases of the ICPD Secretariat. For information, contact: POPIN, Population Division, DESIPA, 2 United Nations Plaza, New York, NY 10017 (e-mail: popin@undp.org). Within the Association for Progressive Communications system - EcoNet (U.S.), Web (Canada), GreenNet (U.K.), Pegasus (Australia) and Alternex (Brazil) - an electronic conference called “icpd.general” contains ICPD documents and a variety of information posted by NGOs, and provides a forum for Conference-related dialogue. For information: Institute for Global Communications, 18 De Boon St., San Francisco, CA 94107 (e-mail queries: igcoffice@igc.apc.org). The TogetherNet (The Together Foundation for Global Unity, 130 South Willard St., Burlington, VT 05401) also maintains an electronic conference on ICPD which is accessible to TogetherNet users and through an Internet gopher (e-mail queries: martha_vargas@together.org). E-mail queries regarding the ICPD 94 newsletter may be sent to the ICPD Secretariat (ryanw@unfpa.org).
**SFP COUNTRY ACTIVITIES**

**BALTIC STATES**

**Estonia**

The sexuality and Family Planning (SFP) unit of WHO Regional Office for Europe is implementing a family planning project funded by Swedish SIDA jointly with Göteborg University, Department of Public Health. A project monitoring mission took place in April 1994 to discuss project progress, and to review future activities. So far, project activities had concentrated on two centers in Tallinn, where special information and contraceptive counselling and services were set up for young people. In the next project phase, these activities will be extended to other towns in Estonia.

**Latvia**

The Directorate for Maternal and Child Health of the Ministry of Health requested technical assistance in designing a national strategy in family planning and its integration into primary health care, as well as in the preparation and design of project proposals for submission to donors. The costs of the mission were kindly covered by UNDP/UNFPA, who felt that reproductive health is a priority issue in the development of the social sector. Neither UNFPA nor WHO Regional Office for Europe have additional regular funds for family planning activities in Latvia. A framework for a family planning policy was developed, and will be elaborated further during a Strategic Planning workshop held in Autumn with the support of the European Union (EU)- PHARE and the German Agency for Technical Cooperation (GTZ).

**Lithuania**

As in the case of Latvia, the Minister of Health of Lithuania has requested technical support in the development of national family planning strategies. Dr. France Donnay went to Lithuania in January as a consultant to the Sexuality and Family Planning Unit. Due to the growing influence of the Catholic Church and western anti-choice groups, the issue of national family planning services has become very difficult to discuss in public.

The Ministry of Health of Lithuania will therefore need enforced technical and political support on this issue if a national programme/policy is to be implemented. The consultancy to Lithuania was covered by the WHO Regional Office regular budget.

**CENTRAL ASIAN REPUBLICS**

**Tajikistan**

An Inter-Agency needs assessment mission on Maternal and Child Health/Family Planning took place in August 1993 with the participation of the Sexuality and Family Planning unit and the Global Programme on AIDS unit of the WHO Regional Office for Europe, the International Planned Parenthood Federation (IPPF) and Family Health International (FHI).

Tajik girls can look forward to a healthier future as a result of the recent inter-agency assessment mission.

As a follow-up to this mission, emergency contraceptive supplies were sent by IPPF, and training activities started by FHI. The mission report has been translated into Russian and reviewed by the Ministry of Health, who has proposed some changes and now endorsed the report. This was the first report of a multi-lateral mission to Tajikistan that was translated into Russian, and though this procedure may be more lengthy, we would like to recommend it for future practice in the Central Asian Republics, since hardly any of the leading professionals speak English. The report has also served as background material for a WHO-mission on essential pharmaceuticals, hospital equipment, and epidemiological data collection and we hope that it will give useful background material to the UNFPA regional field officer to be posted in Tashkent.

The Ministry of Health of the Republic of Tajikistan is also using the report and recommendations in the development of the national strategy for the improvement of maternal and child health under the responsibility of the Republican Institute for Obstetrics/Gynaecology and Pediatrics. The mission was co-financed by the participating agencies.

The Ministry of Health of Uzbekistan requested the support of the Sexuality and Family Planning (SFP) and the Women and Child Health (WCH) units of the WHO Regional Office for Europe in organizing a regional conference on Maternal and Child Health in Tashkent in November 1994. To this purpose, preliminary preparations have taken place during the World Health Assembly in May 1994. A further mission of the Regional Adviser for Women and Child Health took place in July 1994 to finalize arrangements for this conference. The funds for this activity are covered by the WHO Regional Office for Europe regular budget through the mid-term programme of collaboration.

**NIS**

**Moldova**

At the request of the UNDP office of Moldova and the Ministry of Health, a Needs Assessment Mission for MCH/FP took place in June 1994 with the participation of IPPF. The report on this mission has been finalized. Following a call for the emergency supply of contraceptives, IPPF has donated contraceptives to the value of US$75,000. SFP and IPPF Europe Region will jointly support the first national family planning conference to take place in October 1994, as well as the 2-week training course for district coordinators of FP-services to take place in November 1994. The Needs Assessment Mission was funded by UNFPA and IPPF. Support to the national conference and the national training course will be given through the WHO Regional Office for Europe.
regular budget funds, as laid down in the mid-term programme of collaboration.

**OTHER COUNTRIES**

**Portugal**

The project “Family Planning Assistance for the General Directorate of Primary Health Care” in Portugal was completed in 1993 with good results. Through workshops and services for young people, the programme contributed to a change in adolescent reproductive behaviour. Between 1987 and 1990, adolescent fertility decreased by 16% in under 20 years olds. In the 15-19 year old age group, fertility decreased by 3.1% between 1989 and 1992. The use of contraceptives by adolescents increased from 14% to 33.8%.

The experience of the Portuguese programme will be shared with participants from other Portuguese-speaking countries in a workshop scheduled for later this year.

**Romania**

A technical adviser, Dr Katy Shroff has been appointed Resident Consultant to the project “Strengthening of the Romanian FP Programme”. She will start work with the MCH/FP Directorate in October. The first phase of the programme will consist of adapting project training and service activities to the constantly evolving situation in Romania.

**Turkey**

The project “Integrated MCH/FP Services in 11 Provinces” began in 1989 and is implemented by the General Directorate of MCH/FP of the Ministry of Health, Turkey. Up to 1993, nearly 4000 midwives, 700 health officers and 1400 doctors have been trained in the theory and practise of family planning. In addition, about 500 nurses received in-service training. Although most of the trained health staff is already providing family planning services in the institutions in which they work, there is a worryingly large turnover of health personnel which will have to be addressed in the future.

Besides the training, national study tours are also being organized for provincial health teams in order to offer them the opportunity to exchange experience and gain a global perspective on MCH/FP problems. Contraceptives, antibiotics, and midwifery kits have also been distributed through the project. The project is contributing significantly to reducing regional differences in maternal and child health in Turkey.

However, the country still faces a major public health problem in this area and this situation is likely to continue in the near future. Continuous attention by health policy makers will be needed.

**The Former Yugoslav Republic of Macedonia:**

in September three SFP consultants visited The Former Yugoslav Republic of Macedonia to offer training for Nurses, Doctors and Teachers. We shall report on this in the next issue of the magazine.

**INTERCOUNTRY ACTIVITIES**

SFP organized an inter-agency meeting in February for better coordination of aid to MCH/FP activities in Eastern Europe. Further activities in 1994 include a European Survey on Adolescent Health. The first special issue of Entre Nous in Russian has just been published.

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**Dynamic Regional Adviser for SFP**

I am delighted to introduce to you Dr Assia Brandrup-Lukanow, who has been recently appointed as WHO Regional Adviser for Sexuality and Family Planning, in replacement of Dr Pierotti. On behalf of the Disease Prevention and Quality of Care Department, welcome to the team.

Assia Brandrup-Lukanow worked with the SFP unit, first in Albania and Tajikistan, then in Denmark on a consultancy basis for 6 months, earlier this year, so she is already very much involved in all the work of the unit.

Assia Brandrup-Lukanow qualified as a doctor of medicine and Master of Science in Tropical Medicine. She is also qualified in psychology and is experienced in clinical work, counselling and the training of nurses and midwives. She has worked as a coordinator of health and family planning projects in developing countries with the German Agency for Technical Cooperation (GTZ), in Eschborn, Germany, and subsequently with the International Planned Parenthood Federation (IPPF), in London. Besides all those qualifications, Dr Brandrup-Lukanow mastered many languages and is fluent in all four official languages of the WHO European Office (English, French, German and Russian).

In her capacity as Regional Adviser for Sexuality and Family Planning for Europe, Dr Brandrup-Lukanow is also responsible for the Entre Nous Magazine, and as you will see from this issue, very engaged in promoting family planning issues.

**Dr Mark S. Tsechkovski**

Director, Disease Prevention and Quality of Care

WHO Regional Office for Europe.
RESOURCES

Books

Medical and Service Delivery Guidelines for Family Planning, by Carlos M. Huezo and Catherine Briggs, IPPF Medical Department (1992).

De Halfdan Mahler, IPPF Secretary General explains in the preface that guidelines have been developed by IPPF as part of a strategy to improve the quality of care in family planning services.

The guidelines set out in this book are intended for professionals working in family planning education and services. The guidelines have been carefully developed to comply with the three dimensions of technology assessment which are important for any project: it (the project) must be scientifically sound (supported by scientific research, surveillance, etc.); it has to be socially sound (acceptable to those for whose benefit it is being applied as well as being acceptable to those who are applying it); and it must be operationally sound, i.e. validated and updated regularly.

This invaluable handbook comes in English, French, Spanish, Russian, Albanian and Arabic. It is available from: International Planned Parenthood Federation, Regents College, Inner Circle, Regents Park, London NW1 4NS, United Kingdom. Tel. (44)71-4860741, Fax (44)71-4877950. ISBN 0 86089 089 9. Price: US $16.00 ($8.00 UK only) including postage.

It can be obtained free of charge to those experiencing special difficulties in payment, such as currency restrictions.


This book is intended mainly for physicians, midwives and managers involved in family planning in developing countries. It is designed as a training tool and as a reference book on problems encountered at FP services and programme levels.

It answers the following questions: how to ensure the prescription and follow-up of contraceptive methods in developing countries, based on the principle of the lowest risk; how to make family planning services attractive, despite limited resources; how to rationalize decision-making at all levels in order to optimize the resources and to ensure the best possible service; and, to establish the basis for an evaluation of family planning services and programmes.

The book was made in collaboration with gynaecologists and public health specialists from the Department of Organization and Evaluation in Public Health of the School of Public Health of the ULB (Université Libre de Bruxelles). It received technical and financial support from UNFPA.


This practical handbook provides essential information on determinants of fertility, maternal health and the main risk factors in pregnancy.

It explains all the different contraceptive methods and in an easy-to-read style, summarizes their efficiency, their side-effects, how to select the right contraceptive method. The authors also provide practical guidance on counselling clients with contraception risk factors and those suffering from contraceptive side-effects.

A small but important chapter deals with setting up and integrating family planning into primary health care in developing countries. This handbook is invaluable to both medical and non-medical field personnel working in family planning services as well as in community health and primary health care.

Medical, midwifery and nursing students as well as general practitioners and lecturers in health will also find it useful for quick reference purposes.


Copies must be prepaid. Copies are available at no cost to developing country institutions, upon written request, with a brief explanation of need.

Documents


The document details how the World Health Organization is working to alleviate the burden of suffering borne by women, children and families through its Maternal Health and Safe Motherhood Programme.

The programme seeks to reduce levels of maternal and neonatal mortality and ill-health significantly by the year 2000 by working closely with non-governmental health and women's organizations.

Available from: Maternal Health and Safe Motherhood Programme, Division ENTRE NOUS 26-27, December 1994
of Family Health, World Health Organization, CH 1211 Geneva 27, Switzerland (Ref. No. WHO/FHE/MMM/92.3).

**Abortion Policies: A Global Review**

Presented in three volumes, this is a country-by-country examination of national policies concerning induced abortion and the context within which abortion takes place.

Comparative information on all 166 Member States of the United Nations and eight non-Member States is provided over three volumes.

The countries are arranged in alphabetical order: vol.I, Afghanistan to France (United Nations publication, Sales No. E.92.XIII.3); vol.II, Gabon to Norway (United Nations publication, Sales No. E.94.XIII.2); and vol.III, Oman to Zimbabwe (United Nations publication, forthcoming). Available from: Population Division, Department for Economic and Social Information and Policy Analysis, United Nations, New York, NY 10017, USA.


District team problem-solving (DTPS) is a process during which teams of health workers are guided in conducting their own analysis of a high priority public health problem.

The process can be applied to MCH or FP projects in a district. It includes designing and implementing solutions over a one-year period; conducting and presenting the results of evaluations, developing the ability to gather and use data, and developing good team-work and managerial skills.

These guidelines have been prepared mainly to assist facilitators of DTPS workshops. They may also be useful to national programme managers, training institutions and other agencies.

DTPS guidelines are available from the Division of Family Health and the Division of Epidemiological Surveillance and Health Situation and Trend Assessment, World Health Organization, CH-1211 Geneva, Switzerland. (Ref. No. WHO/MCH-FPP/MEP/93.2).

**Youth at Risk: Meeting the Sexual Health Needs of Adolescents**, prepared by Stephanie L. Koontz and Shanti R. Conly.

This is one of the latest in the series of Policy Information Kits produced by Population Action International. It includes an overview of current issues in adolescent sexual health and appropriate strategies for addressing the needs of young people, abstracts of articles from scientific and social science journals on a range of topics relating to adolescent pregnancy, childbearing and sexual health, as well as several inserts providing more specific information.

Special attention is given to the choice of a contraceptive method by young people; lessons learned from programmes which serve youth; brief profiles of existing programmes; and strategies for changing policies on adolescent sexual health.


**Wall-charts**

**Closing the Gender Gap: Educating Girls**

112 countries are ranked on a Female Education Index based on five measures of educational attainment for girls. The wall-chart is available for purchase by the public from: Population Action International, 1120 19th Street, N.W., Suite 550 Washington, DC 20036, USA.

World Abortion Policies 1994. (Sales No. E.94.XIII.8)

World Contraceptive Use 1994 (Sales No. E.94.XIII.15)

Inquiries should be addressed to: Population Division, Department for Economic and Social Information and Policy Analysis, United Nations, New York, NY 10017, USA.


**Magazines/Newsletters**

World Health Statistics Quarterly

This publication deals with the detailed analysis of selected health topics of current interest. It contains articles in either French or English with a summary in both languages. WHO dedicated an issue to Health and the Family (Vol. 46, No.4, 1993) and the following issue to Family Planning and Health (Vol. 47, No.1, 1994). Available from: Distribution and Sales, World Health Organization, CH-1211 Geneva 27, Switzerland. Annual subscription Fr. 100.- Price per copy Fr. 28.-.

**DIARY**

International Seminar on Women and Disability, Tel Aviv, Israel, January 30 - February 2, 1995.

International Course on Sex Counseling for Disabled Persons, Tel Aviv, Israel, February 5-10, 1995

For details please contact: Dr. E. Chigier, Israel Rehabilitation Society, 18, David Elazar Street, Tel Aviv 61909, Israel. Fax: 972-3-6919885.

**Book review**

**Between Marx and Muhammad - The changing face of Central Asia**

by Dilip Hiro. Published by Harper Collins, 77 Fulham Palace Road, Hammersmith, London W6 8JL.

With the disintegration of the Soviet Union, several countries which the older generation in the West had virtually forgotten all about and those of us who are younger never even knew existed, suddenly reappeared on the map of the world.

Dilip Hiro, the author of this remarkable book, takes the reader through the recent economic and political history of the young Republics of Kazakhstan, Kyrgyzstan, Turkmenistan, Uzbekistan and Azerbaijan. As each of these newly independent states struggle to find their new, modern identities, they face not only bitter internal cleavages but also a barrage of cultural, political and religious influences from the neighbouring countries such as Turkey, Iran, Afghanistan as well as from Western countries and emerging Asian economic and cultural giants such as China.

For professionals working in international development, be it in the political, economic or social sector, this excellently researched book provides essential background reading and a deeper understanding of the present social reality in these countries.

*We understand that the hardcover version of the book is out of stock but that a paperback edition will be published early next year.*

ENTRE NOUS 26-27, December 1994
A Russian edition of Entre Nous has just been added to the five language editions already published. It is a special 36-page issue with a selection of articles from previous issues of the magazine.

From this issue on, Entre Nous will be produced in Russian on a regular basis. Congratulations to our colleagues in Bishkek for the first issue of Entre Nous in Russian.