Fertility regulation in Europe
In this issue

Although Europe today is characterized by the lowest fertility ever witnessed, there are many different reasons behind it.

In this issue of Entre Nous Dr Chantal Blayo reviews in depth ways and means of regulating fertility in Europe. In some countries there is a great deal of contraception, not too many abortions and only few sterilizations. In another group of countries sterilizations are more widespread and therefore abortions are less frequent. In a group of central and eastern European countries abortion appears to be a favoured means of contraception for various reasons.

We were all wrong when we thought that the eastern European countries would pass smoothly from abortion to contraception, from withdrawal to modern contraception, writes D. Pierotti in his article “Padlocked societies”. A drastic re-thinking is necessary for specialized family planning and population organizations working in the area. That is the key term of a new strategy that might work.

Abortion for social reasons is no longer consistent with the law in Poland. The Senate passed a new abortion law at the end of 1992. Several articles deal with this subject in Entre Nous, but in Hungary, at about the same time, a different and much more liberal law was passed. In this issue of Entre Nous you will find other articles on family planning projects in Eastern Europe. Recently new research has shown an increased risk of prostate cancer following vasectomy. Other studies have not been able to confirm these findings and the impact of all the research is discussed in Dr Van Look’s article.

The next issue of Entre Nous will focus more on male responsibility and involvement in family planning. Because of many substantial articles for this issue, Entre Nous was made a double issue. Hopefully you will enjoy and agree with us that the articles should all be published.

Beth Lilja Pedersen

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Family planning in Europe

by Chantal Blayo

Today Europe is characterized by the lowest fertility ever witnessed. Women on the average have very few children and even the countries which resisted the declining trend for the longest time (Albania, Ireland) today are recording less than three children per woman. To judge by these results, family planning is hardly a problem in Europe. But is it as simple as that? Do couples everywhere in Europe today have a choice of birth control methods?

By simplifying slightly, we can divide Europe into three groups of countries: 1) Countries in which women rely for the most part on medical contraception, where recourse to abortion is only used to correct contraceptive failures, and where irreversible methods are still only used to a limited degree. A great deal of contraception, not too many abortions, few sterilizations.

2) In a second group of countries, the recourse to abortion is less frequent (UK, the Netherlands especially), not because the control of conception is greater but because sterilization is much more widespread.

3) Finally, in the countries of the former Communist bloc, abortion frequently takes the place of contraception and the number of sterilizations is negligible.

In theory, couples have free access to methods of birth control but in practice legal restrictions, administrative conditions, poor reception systems and distribution of information discriminate against those groups of the population who are the least integrated (adolescents, ethnic minorities, migrants, etc.), particularly in certain countries. There remains in fact in Europe a certain inequality with regard to access to the means of birth control.

Administrators of social services are no longer opposed to controlling fertility, they are even rather inclined to be in favour of it, but the legislators occasionally resist, as has been the case in Ireland, or even reverse direction, as in Poland. Furthermore, society does not always allow individuals a real choice of contraception. In some countries, as we have seen, there is little opposition to abortion, as in many eastern European countries, there is a resistance towards the widespread distribution of modern contraceptive methods; other countries less favourable to abortion place more emphasis on sterilization than on greater strictness in the practice of contraception. And finally we note that numerous systems of reimbursement tend to favour abortion rather than medical contraception, and the latter rather than the use of condoms.

The proportion of couples protected by the voluntary sterilization of one of the partners has in no European country reached the 40 or 50% level which was recorded in the US and Canada at the end of the 1980s, but has exceeded 20% in the UK and the Netherlands, which are trend-setting countries in this regard. The recourse to sterilization is a recent phenomenon in Europe and the reasons have not yet been studied, nor has an attempt been made to assess the consequences of its slow but progressive diffusion in European countries where the risks of unplanned pregnancy are no longer great.

This issue is concentrating mostly on a review of fertility regulations. This review is the first step of a project initiated in 1990. The project consisted of generalized, simple and easy to handle indicators to assess and monitor family planning services on a routine basis.

Two meetings took place in 1991 and 1992, letters were sent to all the ministries in Europe and to counterparts to get information on their programs.

The results of this investigation are published here and, unfortunately, will put an end to this project. It was a collective effort spearheaded by Dr Blayo, Research Director at the National Institute of Demographic Studies. She was assisted by the following consultants: Dr A. Leitao, Ministry of Health of Portugal, Ms L. Knudsen, Ministry of Health of Denmark, Ms M. Shabanah and Ms R. Sadana, WHO Regional Office for Europe. D. Pierotti

Europe has made considerable progress in matters of public health with legislation on the recourse to abortion. Conversely, all prohibitions have had catastrophic consequences on public health; the level of maternal mortality in Albania and Romania (before the most recent change in the political regime), testifies to this. One fears that the legal restrictions recently introduced in Poland will result in a deterioration of the health of women.

Much is said and much is written about the use of contraception, on the recourse to abortion, on the needs of women, on the resistance to the spread of modern methods of prevention, but the plenitude of the discussion appears to be in inverse proportion to the wealth of the information gathered, of statistical information in particular.

It is, however, impossible to comprehend a phenomenon properly without an analysis of statistical data regarding its frequency. This would appear evident and yet, even in Europe, a continent with a long-standing statistical tradition, the literature in the field of birth control is rife with analyses based on approximations, biased indexes, and partial statistics. The assessment phase is often avoided because of the numerous political and economic interests which are involved in this area and also because everyone suffers from the illusion that he or she knows these questions well, and their a priori ideas are reassured by reading superficial analyses which do not call for costly verifications in this regard.

The evaluation of a phenomenon which is of concern for public health must not be disregarded. If we wish to comprehend the resistance to the spread of contraception, the reasons for the sociocultural choice of abortion, sterilization, or contraception, we must adopt permanent provisions for the recording of these events, in particular of abortions and sterilizations. We must think about the most suitable indicators of family planning, which can inform us of its spread and of the characteristics of the persons concerned in their various capacities, and adopt provisions on recording which will permit us to evaluate these indicators. These provisions must also be adapted to the specific characteristics of European prevention services, the majority of which depend, as we have seen, on private medicine. However ambitious this objective may be, it is in keeping with the interests at stake and its results will determine the choice of actions to be taken.

Dr. Chantal Blayo
Director of Research
Institut National d’Études Démographiques (INED)
27, rue du Commandeur
F-75675 Paris Cedex 14
France
The various countries of Europe exhibit more similarities than differences as far as conditions of access to contraceptive methods are concerned. Those of eastern Europe, however, are still in a class by themselves in this regard.

The provision of contraceptive pills, coils, spermicidal products, and condoms does not pose problems in the north, west, and south of Europe (excluding Albania), but the supply is less than the demand in the other countries (with the exception of Hungary and the Czech and Slovak republics); this is particularly noticeable in Poland, in the countries of the former Soviet Union, and in Romania. The shortage has been temporarily rectified in Albania and Bulgaria, thanks to the furnishing of significant quantities of these products by international organizations, but their dissemination is hampered by numerous problems of distribution.

As a general rule, only a physician can prescribe an oral contraceptive, and only a physician can insert an intrauterine device (IUD). The services of a specialist are even required in some countries of eastern Europe. Sweden and Turkey, however, have authorised midwives to prescribe contraceptive pills or to insert coils. Actual practice is in accordance with the regulations in the great majority of cases, but in Turkey, Bulgaria, Romania, and perhaps in the countries of the former Soviet Union, the dispensing of pills without prescription, when they are available, is tolerated. Paradoxically Romania, which demands in theory that the prescribing physician should be a specialist, in practice allows the dispensing of pills without prescription in pharmacies, when they are available.

The regulations on spermicidal products are less strict, and they can generally be dispensed in pharmacies without it being necessary to obtain a prescription. Some products, however, are only dispensed on medical prescription in some countries (e.g. Switzerland and France). Today, condoms are sold in both pharmacies and elsewhere, even in Ireland. This is, however, still not the case in all the countries of the former Communist bloc, more often due to economic reasons than to a political decision.

The conditions of access to contraceptive products are regulated within the legal framework and differ greatly in nature according to the country. One must distinguish between countries controlled by very restrictive laws in this area (France, Ireland, eastern European countries especially), which have legislated to abolish these prohibitions, and the more tolerant countries that have not had to make any laws authorizing the distribution of contraceptives (which had never been forbidden), but that later adopted legislation confirming the right to family planning and the right to information in this area. This right is even incorporated in the Portuguese constitution of 1976.

Some countries, such as France, reuse to allow the advertising of contraceptives outside of journals intended for physicians, while on the other hand, some countries, e.g. Denmark, encourage this advertising.

For a long time the sterilizations carried out in Europe have only been on medical grounds. Sterilization for purposes of contraception was an absolute exception and liable to be punished, if it was considered as a violation of the physical integrity of the individual, which was under penalty of law.

Today a certain number of European countries have expressly anticipated in their regulations the possibility of a woman or a man submitting to a surgical operation for the purpose of contraception and defined the conditions under which this operation is to be permitted. The obligation of residence in the country is mentioned in many laws; in Finland a minimum number of children (3) is demanded, and age conditions are set (over 18 years in Turkey, with consent of the spouse, over 25 years in Austria, Denmark, Iceland, Norway, Portugal, and Sweden, over 30 years in Finland and over 35 years in Croatia and Slovenia).

There are still many countries in which a legal vacuum exists in this area, where sterilizations for contraceptive purposes are still in danger of constituting a statutory offence of mutilation. This is the case in France, in all the countries that share a common border with France, in Ireland, Austria, Greece, Malta, and Poland. It is a practice, however, which is tolerated to varying degrees. It is less and less so in Poland, and more and more so in western Germany. Sterilization is still carried out in Spain and Italy, even less in Ireland and Malta, but one can observe a slow progression in this area in Belgium and France.

Voluntary sterilization is legally possible in Hungary and Romania, practiced on a small scale in Albania without there being a legal basis for it, and prohibited in Bulgaria.

Finally, we point out that it is in the Netherlands that the proportion of couples protected by the sterilization of one or both partners is the most numerous, without any legislation existing on the subject. As is the case with abortion, we must make a distinction between law and practice.

Family planning services as such have been set up by the governments of several countries, but most often the public family planning services are integrated in other services, such as community clinics, hospitals, pre-and postnatal clinics, which, by definition fulfill many other functions.

Whatever the importance of these services may be, which vary depending upon the country, what characterizes Europe as compared to the world of the developing countries, is the very large share of the private sector, in particular of the private practitioner, in the responsibility for informing and prescribing.
A system of registration and statistics

by Chantal Blayo

In 1971 the World Health Organization recommended to countries preparing to legalise the recourse to induced abortion that they make provision in their law for an obligatory reporting of all interventions; there remains, however, no permanent registration of abortions in Austria, Greece, Luxembourg and Portugal. There is obviously none in existence in Northern Ireland, Ireland and Malta, where abortion is prohibited, or in Switzerland, where the conditions for legal recourse are very limited, except in certain cantons. Albania is preparing to institute such a provision.

Registration is, moreover, not always complete where it does exist. This is the case in the former Federal Republic of Germany, France, Italy, Poland, and Spain, and in all likelihood in the republics of the former USSR, particularly Lithuania.

And finally, the information gathered at the time of registration is not always suitable for providing a good analysis of the phenomenon and not always comparable from one country to another. The data gathered is often further impoverished at the stage of the publication of the statistics: it would not require much effort to provide more extensive, more useable, and more comparable data.

Certain estimations, or even results of surveys, make up for these shortcomings, but by no means completely. To survey those who practice abortions is only possible if one has a register of them. A retrospective survey of a sample representing all women of age 15 years or older would theoretically allow us to reconstruct the statistics on abortions of past years, but at the same time the size of the sample would depend on the women who were prepared to respond, and the fact that it would rely on the statements of the women, whereas forgetting and the desire to dissimulate are obstacles which cannot be disregarded.

The magical quality of the survey is often illusory; few surveys, in fact, offer information on the practice of abortion in the countries of Europe.

Nothing can replace systematic registration accompanied by the publication of a well conceived statistical record. As abortion is always carried out in a hospital environment in Europe, the adoption of such a provision is relatively easy and its coverage depends upon the true willingness of the authorities to achieve this.

Sterilization

It is striking to realize that this phenomenon, which appears to be spreading in Europe, is only very rarely the object of
ABORTIONS IN EUROPE

Access to abortion: The legal context, practice and frequency of recourse

by Chantal Blayo

For a long time various types of legislation concerning abortion have only been adopted in order to set the conditions for prohibiting it. Russia was the first country to authorize, in 1920, the recourse to abortion simply on the demand of the woman concerned. The other republics of the Soviet Union adopted an analogous law in 1921. The USSR subsequently prohibited thepractice (in 1936), only to authorize it once again in 1955. A comparable liberalizing trend then immediately spread to neighbouring countries: in 1956 Bulgaria, Hungary, Poland, and Romania adopted laws legalizing abortion, followed by Czechoslovakia in 1957 and Yugoslavia in 1960. The countries of western Europe did not follow suit until 10 to 20 years later, if one excludes the modest extension of the legal grounds for recourse in the countries of northern Europe during the years preceding the second world war. The liberalization of abortion in eastern Europe, however, was followed 12 to 17 years later by restrictions more or less significant depending upon the individual country: the most remarkable instance is that of Romania, where the ruthless limitation in 1966 of the grounds for authorization put an end to a very extensive liberal tradition. These limitations were further reinforced in 1985, while, on the other hand, in Czechoslovakia in 1986 and in Hungary in 1988 new legislation on abortion abolished the requirement of obtaining the permission of a special committee. In 1989 and 1990 Romania and Bulgaria respectively reinstated the legal possibility of abortion exclusively on the demand of the woman concerned.

The right to abortion was incorporated into the Yugoslavian constitution of 1974 and between 1977 and 1979 the various republics adopted more liberal legislation than had previously been in effect. The legal conditions for recourse to abortion remained very restrictive in Albania right up until 1989, and were greatly expanded in 1991. Poland, on the other hand, is today proceeding in the direction of repression and voices have been raised in protest against the liberal laws in Hungary and in the Czech and Slovak republics.

If, in northern and western Europe following the last war, legalized abortion was very rare, a general prohibition against abortion is in fact the exception today. If one excludes the very small countries such as Malta and Monaco, where recourse to abortion is completely prohibited, only Ireland retains legislation so restrictive that abortion is not only illegal but also unconstitutional. Northern Ireland has not benefited from the Abortion Act of 1967 which liberalized abortion in England, Scotland and Wales; it has remained subject to a severe statute dating from 1861. In Switzerland, the legal grounds for recourse are still restricted to medical reasons.

To sum up, recourse to abortion is only prohibited in Ireland and Poland; it is permitted de jure during the first three months of pregnancy in the majority of European nations exclusively at the request of the woman. In those countries where the woman must justify her request by obtaining the authorization of a medical official (England, Scotland and Wales, the former Federal Republic of Germany, Spain, Hungary, Ireland, Italy, Luxembourg, the Netherlands, and Portugal), almost all women desiring an abortion attain one, at least during the first ten weeks of pregnancy.

No European country has, however, actually authorized recourse to abortion without restriction. Furthermore, abortion remains a criminal offence if the prescribed conditions are not respected. Only in Denmark, Norway, Sweden, Bulgaria, the Netherlands, the Czech and Slovak republics, the former Yugoslavish republics, and in the European republics of the former USSR has it been removed from the criminal code.

The recourse to legal abortion is accompanied by various restrictive conditions depending on the individual country (to a limited period of gestation if not on grounds of health, to a minimum length of residence in the country if the woman is a foreign national, with parental consent if she is a minor, etc.) and requirements regarding its administration (the

Continued from page 5

registration, whereas it would be very easy to systematically keep count of the operations carried out in a hospital environment and to gather information on the persons who undergo such an operation. We are thus deprived of precious information. The proportion of couples protected by such an intervention is sometimes obtained by surveys but there is hardly any information on the characteristics of this group.

Contraception
Assessing the practice of contraception poses more problems, as this practice does not depend upon a single action and in the majority of countries dispensing of contraceptives is made through many different channels (pharmacies, public family planning centres, private practitioners). Moreover, certain methods of contraception require no medical aids.

The activities of family planning centres, where they exist, are sometimes a source of statistical data.

In some countries producers' associations make statistics available on the sale of contraceptive pharmaceuticals or other means.

Exact surveys enable us to draw portraits of the users and to get to know the methods they employ. Many countries carried out such surveys at the end of the 1970s, within the framework of the world survey of fertility. Today we are a long way from knowing, in all the countries of Europe, the proportion of women who utilise each of the methods of contraception and even farther from being able to fill in the details of the portrait.

It is urgent that we invest in the search for data suitable for studying these phenomena.
quality of the practitioner, the type of establishment, procedure to be followed, etc.). England and Wales and the Netherlands are the only countries in which abortion is permitted as long as the fetus is non-viable (whether performed on grounds of health or not) and which do not impose conditions of residence for foreign nationals; however, abortion on demand is not practiced.

By a decision of the Ministry of Health, abortion on demand has been possible in Albania since June 1991 without condition if the woman is unmarried and with her husband’s consent if she is married. One must, however, distinguish between legislation and practice. In countries with liberal legislation a woman may, in practice, come up against numerous obstacles to obtaining an abortion. This is, in fact, the case in the west in Austria, in certain Länder of the former Federal Republic of Germany, and in certain regions of Spain where there is still a distinct opposition to abortion. In Portugal the statutes covering the application of the law of 1984 are not always made widely known.

Conversely, liberal practices may become established in countries with a restrictive legislation in this area: the most striking case is that of the Netherlands prior to 1982 and France to a somewhat lesser degree before 1975, and of Belgium prior to 1990, where one could observe frequent violations of the law which went unpunished. Moreover, restrictive laws may be interpreted in a more or less liberal manner: the concept of “dangerous to health” required by Swiss law varies appreciably from one canton to another. Similarly, abortion was tolerated in Greece on numerous grounds well before it was liberalized in 1986.

In northern and western Europe simplified techniques are much more in use than elsewhere in the continent. Due to a lack of the necessary equipment (suction curettes especially), many abortions in Europe are still practiced by curettage. The abortion pill, mifegyne (or RU 486 as it is called, after the initials of the laboratory which produced it) is only available in France, Great Britain, and Sweden.

**Frequency of recourse**

It is in Romania that recourse to abortion is the most frequent (an average of 6 abortions per woman in 1990). Romanian women alone will undergo, during the course of this year, almost half of the abortions carried out in the part of central Europe consisting of Albania, Bulgaria, Hungary, Poland, Romania, the Czech and Slovak republics, and the territories of former Yugoslavia. The practice is also very widespread in Belarus, Serbia, and Russia (more than 3 abortions per woman, almost 4 in Russia). Serbia is the only country outside of the former Soviet Union, with the exception of Romania, to have such a high frequency.

Between 2 and 3 abortions are recorded per woman in the majority of the European republics of the USSR and in Poland. The frequency is the lowest in Lithuania, if the one is to believe the reported statistics (an average of 1.72 abortions per woman). It appears that the social disapproval which has led to the rise of clandestine operations in Poland, a neighbouring country which is also Catholic, may well exist in Lithuania and have the same consequences. A frequency of recourse in Lithuania equivalent to that observed in Latvia and Estonia (an average of 2.6 abortions per woman) would appear to be more credible. The same phenomenon can be observed in the more Catholic countries of western Europe: the recourse to abortion is no less frequent there, quite the contrary, but clandestine practices are more widespread. Thus in Italy under-registration is considerable and, according to the estimates of the Istituto Superiore di Sanita in Rome, indicates that Italy is the western European country in which women have the greatest number of abortions (an average of 0.7 per woman).

In Albania, Bulgaria, Hungary, the Slovak and Czech republics, and the majority of the territories of former Yugoslavia, women undergo an average of from 1.1 to 1.8 abortions.

In summary, the frequency of recourse to abortions remains at a fairly high level in central and eastern Europe, even in Hungary, where it has dropped markedly, since it is slightly higher than one per woman on an average, and has in Russia (and even more so in Romania), soared to record levels. In western and northern Europe, on the other hand, women everywhere have an average of less than one abortion each (0.15 to 0.63 according to the country). Abortion thus appears to be a favoured means of contraception in central and eastern Europe.
### RECURSSE TO ABORTION: LEGAL CONDITIONS, PRACTICES AND FREQUENCY

<table>
<thead>
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<th>Country and date of most recent legislation</th>
<th>Conditions for legal recourse and practice</th>
<th>Statistics on abortion</th>
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<td>Year</td>
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<td>1986</td>
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<tr>
<td>Austria 1974</td>
<td>On demand (12 weeks)</td>
<td>1989</td>
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<td></td>
<td>Health reasons (24 weeks)</td>
<td>1989</td>
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<td>Belgium 1990</td>
<td>On demand (12 weeks)</td>
<td>1989</td>
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<tr>
<td></td>
<td>Health reasons (unlimited)</td>
<td>1990</td>
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<tr>
<td>Bulgaria 1990</td>
<td>On demand (10 weeks)</td>
<td>1990</td>
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<td>Health reasons, rape, incest (22 weeks)</td>
<td>1990</td>
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<tr>
<td>Czech Republic 1986</td>
<td>On demand (12 weeks)</td>
<td>1988</td>
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<td>Slovak Republic 1986</td>
<td>Health reasons (24 weeks)</td>
<td>1990</td>
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<tr>
<td>Denmark 1973</td>
<td>On demand (12 weeks)</td>
<td>1988</td>
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<td>Health reasons (24 weeks)</td>
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<tr>
<td>Finland 1970</td>
<td>Socioeconomic reasons (12 weeks)</td>
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<td>Germany, former Federal Republic 1976</td>
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<td>Health reasons (22 weeks or unlimited)</td>
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<td>Greece 1986</td>
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<td>difficulties, extramarital birth, older than 35 years, two children living (12 weeks; 16 weeks for minors)</td>
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<td></td>
<td>Health reasons (24 weeks)</td>
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<td>Malformation of fetus (unlimited)</td>
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<td>Iceland 1975</td>
<td>Socioeconomic reasons, rape, incest</td>
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<td>(12 weeks)</td>
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<td></td>
<td>Health reasons (unlimited)</td>
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<tr>
<td>Ireland 1861</td>
<td>Abortion was declared unconstitutional in 1983</td>
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### Notes

Weeks = weeks of gestation following conception. The definition of the length of gestation is not always precise; it is possible that the periods referred to in the table are actually the number of weeks which have elapsed since the last menstrual period. We note that the authorization to perform an abortion on grounds of health after the first trimester of a pregnancy is subject to stricter procedural restrictions than we have described here.

(a) Ministerial regulation; legislation is in preparation

(b) Northern Ireland is still subject to the statute of 1861 which forbids the performance of an abortion regardless of the grounds on which it is requested.

(1) Average number of abortions per woman, calculated according to the cumulative rate of abortion by age; by using the method of weighted mean; *** by multiplying the proportion of abortions to live births by the total birth rate.

Despite the fact that the distribution of abortions according to age differs from the distribution of births according to age, this approximation gives a good indication of the magnitude of the frequency with which abortion is performed.

(2) Abortions conducted in hospital and abortions done without hospitalization. It is probable that abortions were not yet fully reported in 1990.

*ENTRE NOUS 22-23, June 1993*
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<th>Country and date of most recent legislation</th>
<th>Conditions for legal recourse and practice</th>
<th>Statistics on abortion</th>
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<tr>
<td>Italy 1978</td>
<td>Socioeconomic reasons (90 days)</td>
<td>1988  280 000&lt;sup&gt;33&lt;/sup&gt; 0.65*</td>
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<td>Health reasons (viability of fetus)</td>
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<td>Luxenbourg 1978</td>
<td>Socioeconomic reasons (10 weeks)</td>
<td>n.d.</td>
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<td>Health reasons, rape (22 weeks)</td>
<td>1988  18 000&lt;sup&gt;33&lt;/sup&gt; 0.15*</td>
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<tr>
<td>Netherlands 1981</td>
<td>Risk to the life or mental health of the woman (very liberally interpreted) (viability of fetus)</td>
<td>1988  15 852&lt;sup&gt;33&lt;/sup&gt; 0.51*</td>
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<td>Norway 1975</td>
<td>On demand (12 weeks)</td>
<td>1988  15 852&lt;sup&gt;33&lt;/sup&gt; 0.51*</td>
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<tr>
<td></td>
<td>Health reasons, rape (24 weeks)</td>
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<td>Poland 1992</td>
<td>Risk to the life of the woman (unlimited)</td>
<td>1989  400 000-600 000&lt;sup&gt;33&lt;/sup&gt; 1.50***2.20</td>
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<td>Portugal 1984</td>
<td>Risk to the physical or mental health of the woman, rape (12 weeks), eugenic reasons (16 weeks) Regulation on application not yet adopted as of January 1993</td>
<td>n.d.</td>
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<tr>
<td>Romania 1989</td>
<td>On demand (12 weeks)</td>
<td>1990  992 265&lt;sup&gt;33&lt;/sup&gt; 6.00***</td>
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<tr>
<td></td>
<td>Health reasons (24 weeks)</td>
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<tr>
<td>Spain 1985</td>
<td>Rape (10 weeks)</td>
<td>1987  63 900&lt;sup&gt;33&lt;/sup&gt; 0.23*</td>
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<td></td>
<td>Eugenic reasons (22 weeks)</td>
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<td></td>
<td>Risk to the physical or mental health of the woman (unlimited)</td>
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<tr>
<td>Sweden 1974</td>
<td>On demand (18 weeks)</td>
<td>1988  37 585&lt;sup&gt;33&lt;/sup&gt; 0.65*</td>
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<tr>
<td></td>
<td>Health reasons (24 weeks)</td>
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<tr>
<td>Switzerland 1937</td>
<td>Medical reasons (viability of fetus)</td>
<td>1981  13 000&lt;sup&gt;33&lt;/sup&gt; 0.28***</td>
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<td>(interpretation of &quot;mental health&quot; varies from one canton to another)</td>
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<tr>
<td>United Kingdom</td>
<td>Risk to the life of the woman, her physical or mental health, the physical or mental health of the children in her family, risk of malformation of the child to be born (viability of the fetus)</td>
<td>1989  179 463&lt;sup&gt;33&lt;/sup&gt; 0.42*</td>
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<td>England &amp; Wales&lt;sup&gt;63&lt;/sup&gt;</td>
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<td>1989  10 209&lt;sup&gt;33&lt;/sup&gt; 0.26*</td>
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<td>Scotland</td>
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<td>United Kingdom</td>
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<td>1989  179 463&lt;sup&gt;33&lt;/sup&gt; 0.42*</td>
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<td>England &amp; Wales&lt;sup&gt;63&lt;/sup&gt;</td>
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<td>1989  5 769 709&lt;sup&gt;12a&lt;/sup&gt; 3.70***</td>
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<td>Yugoslavia 1977-1979</td>
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<td>Serbia 1991</td>
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<td>Slovenia 1991</td>
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(3) This figure does not include legal abortions performed outside hospital and is an underestimate of the number of abortions performed in Austria.
(4) 16 406 corresponds to the number of abortions reported in the investigation of B. Tissot et al. and abortions performed on Belgian women in the Netherlands and the United Kingdom; 22 144 corresponds to the maximum number of abortions performed on Belgian women in 1989, according to the estimates of the authors.
(5) Estimate by INED. The total rate of abortions has been corrected by the same proportion as the absolute figure.
(6) Statistics reported by Social Security, presumably more reliable than the number of registered abortions.
(7) Abortions on Irish women performed in England and Wales.
(8) Estimate by L'Istituto superiore di Sanita in Rome. The total rate of abortions has been corrected by the same proportion as the absolute figure.
(9) Estimate quoted by M. Kozakiewicz.
(10) Estimates by Spanish family planning; the ratio between this number and the number of abortions reported gives us a corrective factor to be applied to the total rate of abortions calculated on the basis of reported numbers of abortions.
(11) As estimated by P.A. Gloo et al.
(12) Number of abortions performed on women in hospital, of women hospitalized after abortion and of women undergoing suction curettage in a mobile care unit.
Padlocked societies
by Daniel Pierotti

A drastic rethink is necessary for specialized family planning and population organizations working in eastern Europe.

Revolutionary events in eastern Europe have not only transformed the political face of Europe and changed the way of life of millions of people. They have also made the rethink necessary for specialized aid organizations. These countries have benefited from a flood of sympathy, emanating especially from western Europe. They are European, Caucasian, they share our religious and cultural roots: only their political choices, sometimes imposed from outside, differentiate them a little from us.

Family planning, a little dot drowned in the massive expanse of programmes of economic restructuring and institutional development, benefited particularly from the favourable context. Family planning was a familiar concept, and there were no preconceptions regarding particular forms of contraception. A contraceptive industry had been created and exported. Density of medical services was good, there was only a lack of suitable medical equipment, modern contraceptives and the concomitant training. Over five years, western contraception was to become the norm, a way of life. These brother nations would pass smoothly from abortion to contraception, from withdrawal to oral contraception.

We were all wrong

Little by little, disillusionment and discouragement have replaced the feverish enthusiasm of the first few years. What has happened? Where have we gone astray?

Social phenomena that were underestimated at the start had completely invalidated the data. One does not wipe out two generations of enclosure by a few months of good advice.

Certainly, the contacts appear excellent, and there are liaison personnel who are both articulate and brilliant, but with the exception of a few national variants, the unwritten rule remains immutable: those decisions which are made are, without exception, restrictive in nature. The reflex to close up is universal. It is relatively easy to cite a series of facts to illustrate our theme, in the form of a patchwork, drawn from here and there on our visits to various countries.

Those who have been granted fellowships abroad to be trained in the practice of modern contraceptive techniques are reluctant to accept the idea of sharing their new expertise with their colleagues who have remained at home.

Distribution of contraceptives supplied by agencies is carried out stealthily in a random mixture: a few pills here, a few condoms there. As to the juiciest titbit, the IUD, only a handful of privileged pharmacies have the right to it. Women receive no information on the types of contraception available, where they can acquire what they need, or at what price. This enables certain unscrupulous practitioners to re-sell these luxury products clandestinely.

Family planning services sometimes remain in the abstract, while maternity clinics are only half-open, guarded by an arrogant warden to whom the reasons for the visit must be explained in public view; there is no indication of where and when consultations take place.

Specialist consultations have not yet been introduced, and this reinforces the obscurity and the vague, magical aspect of contraception. As for policy on training of staff, it remains restrictive and obscure.

The address of the family planning centre is passed on from friend to friend, among initiates who pay for the privilege. Information is conspicuous by its absence from the programmes. Nursing and midwifery staff, even when trained, are only used very exceptionally in this capacity. Contraceptive education given to women is carried out in difficult conditions by overworked staff, such as in the pre-abortion or post-abortion ward.

Audiovisual equipment is under-utilized, and is more likely to be covered with dust in a store room than covered with fingerprints in a classroom. It is occasionally lent to projects of this kind when necessary, and after lengthy negotiations.

Medical equipment is distributed without being checked, without written instructions (or instructions in a foreign language), and is to be found either dispersed indiscernibly through the service, or religiously exhibited, still in the original packaging, unused, or jealously guarded by the director's midwives.

Doctors prescribe without written reference such as specifications, books and manuals: so they cannot verify their knowledge or correct their prescriptions.

There is no machinery to monitor the quality of action. The very word seemed to strike our colleagues as obscene. Each one is dug into his or her own territory, jealously defending their own expertise. We need not discuss here the "waltz" of those liaison personnel trained for the project who simply disappear or are mysteriously transferred.

The most symbolic element came to light by chance during a routine ground visit to a maternity facility of average size. In one of the consulting rooms, a sterilizer took pride of place, on a table and in working order, but closed with an enormous brass padlock. Only a chosen few within the service were privileged to possess a key. This piece of equipment, muzzled, on public display, exemplifies the beautiful yet useless gesture.

These few examples could easily be repeated ten times over. Obviously, some will retort (and it is true, as we have also said) that there are great variations, and there are even a few rare places where the quality of service leaves nothing to be desired. But in general, the interests of women simply do not figure in the priorities of health professionals. Initiatives and user-friendliness are not the order of the day, but hesitancy and reluctance have become so.

Our liaison personnel were a dream. Mea Culpa. We must wake up. We must totally rethink our strategy, and relocate it in a new context, by downgrading our initial aims.

Opening up to the outside world, making contraception a part of everyday life, the creation of counter-measures, common language and partnership: these are the key words on which our actions must be based.

Opening up to the world

Study trips are essential. How could one imagine that professionals and managers within the health service, who have never left their own country, could work in any way other than the restrictive one they have always known?

Learning to take contraception for granted

Contraceptives should be everywhere. They should be as readily available in the pharmacy as an antibiotic or an aspirin compound. At the beginning of a programme, one must be generous. One must think big. The common modern methods - IUD, oral contraceptives, condoms should be available in all pharmacies. If local conditions permit, we should introduce injectables and implants. Put contraceptives on sale in grocery stores, but always with a generous hand. It is worse for a programme to be faced with a shortage than to throw away some dated contraceptives.

The cost of contraceptives must be reasonable even for those who are short of money. Recommended prices for contraceptive products should be published, on TV or in print, by the national authorities, in order to avoid opening the floodgates for private entrepreneurs.

Information on consultation hours must be clearly displayed and familiar, and consultations must be carried out in a manner which ensures confidentiality and attains public respect.

In order to accept contraception properly, women must be receptive. This is
not the case at the time of an abortion. Faced with the medical establishment, groups of consumers must be stimulated to act as defenders of the public interest, in order to avoid possible excesses. We should finance specialized associations and women’s groups and train them to make and run their own information services.

We must educate pharmacists for their role of advisers to women. We must distribute posters and pamphlets. Let us not forget the representatives of the specialist media with an interest in the problems of reproductive health: we must put across to them the appropriate message, facilitate their communication with colleagues in other countries, create a network, which will be supported by documentation sent out regularly in the form of updates.

Common language
All those who prescribe must have access to technical information and reference books on contraception, in the language of the country. There must be no elitism in the knowledge of contraception. All concerned personnel - gynaecologists, obstetricians, general practitioners, midwives - would benefit from reference works in their native language.

For the population in general, information must be made available in popularized form: information leaflets in the local language should be produced and distributed at consultations. Posters of all kinds should brighten the countryside. TV should play a dynamic informative and educative role. International agencies need to develop their networks without any preconceptions, so as to avoid the surprise of overlapping, or of fundamental differences of viewpoint. The experience brought to the project by both sides would contribute to its success.

Developing a real partnership
Midwives and nurses are the only health service professionals who are able to give adequate information to women in gynaecological or obstetric care. They are in contact with the women, and they are available. They alone must be entrusted with the responsibility for contraceptive information within the service. These professionals must be regarded as full partners. They should have the benefit of national responsibilities, study trips, and grants, with an equal entitlement to that of doctors. They must have the equipment and the reading matter they need in instructing the women.

When a project is put into practice, we should ensure a more intensive presence. Every two or three months, we should visit for two weeks, instead of making lightning visits once or twice a year, which are more diplomatic than efficacious. We should lay down quarterly plans of action, detailing different activities to be accomplished. Let us act with vigilance and goodwill. Let us reawaken supervision: there can be no harmonious project without objectives, and no coordinated development without supervision. If some find the word distasteful, we may call it “guidance”, but let us retain its essential nature: to keep the project on the rails.

These proposals are not original. They cannot take the place of grants, local training, provision of equipment, schemes of evaluation. They deal solely with the public service centres, because that was our brief. The proposals highlight: a certain number of indispensable measures, which are sometimes neglected or allowed to fade into the background, but which, in the case of eastern Europe, because of their cumulative effects, are essential to the success of the programme.

Dr. D. Pierotti

A sterilizer closed with a padlock illustrates that rethink is necessary in eastern Europe. Photo D. Pierotti®
Adolescents and contraceptive advice
by Marianne Søndergaard

In the Scandinavian countries there is no lower age limit for adolescents’ access to contraceptive advice.

Denmark attaches great importance to avoiding barriers which prevent young girls from seeking contraceptive advice. It is preferable to offer easy access to this information and counselling to adolescent girls having unwanted pregnancies.

There is, in Denmark, no lower age limit for adolescent girls’ access to seeing their general practitioner (GP) for instruction in the use of contraceptive methods. That means that all - irrespective of age and without parental consent - can receive this guidance.

In addition to this, the GP is bound to observe professional secrecy at this counselling which means that parents cannot request any information at all from the GP in this matter. And there must be specially weighty reasons to break this professional secrecy. It is thus stressed that a young woman should not refrain from seeking advice out of fear that her parents will know about her intimate life, and that she protects herself against unwanted pregnancy resulting in a subsequent induced abortion.

It is not desirable to fix any age limit for adolescents’ right to seek this advice because it concerns the adolescents’ actual sex life and not the parents’ - or others’, for that matter - ideas or opinions of how they wish this should be. After the introduction of free abortion, many quite young abortion-seeking girls turned up.

Free of charge
It is the wish to strengthen the development that all children receive the necessary sex education at school, as well as to ensure that there is easy access to information on contraceptive methods. It is likewise important that the GP’s counselling is provided free of charge so that a young woman does not refrain from seeking contraceptive advice for economic reasons.

Finally, it is stressed that there should be an alternative contraceptive counsel-
lng service in case a young woman for some reason or other does not want to consult her GP on this matter. The girl may be too shy and prefer a more neutral place to go to, maybe because the GP is the family doctor and has known her since she was a baby. A number of contraceptive clinics are thus available all over the country.

It is characteristic of Denmark as well as of the other Scandinavian countries that the access to information and counselling on contraceptive methods is given a high priority in view of promotion and improvement. This is done by avoiding all barriers of an economical, geographical, ethical or emotional character.

Marianne Søndergaard
Danish Family Planning Association
Aurahøjvej
2900 Hellerup
Denmark

WHO FILE

WHO in the New Independent States

WHO will act as clearinghouse for information on health assistance to the New Independent States (NIS).

An information newsletter entitled “NIS Health News” is published in English, French and Russian and serves as a diffusion channel for information on all aspects of the health situation, including its evolution and assistance received and cooperation established in the NIS. The first issue was distributed in October 1992.

Besides the existing database and country profiles that together provide some information of the health situation country-by-country, additional material, such as gaps and overlaps in support, is being added.

In order to obtain this information, close collaboration is maintained with the different permanent missions in Geneva to keep track of activities being carried out by countries as well as donations of vaccines, pharmaceuticals and medical supplies in terms of technical assistance and training. The missions are requested to provide information on the nature of assistance, quantities, costing, dates and place of delivery, etc. This should permit an identification of the needs which are not yet met by the donor community.

The main functions of the clearinghouse are: identification, collation, analysis and dissemination of information on priority health care needs; informing the international community on the health situation including analysis of needs and support received; establishment of communication mechanisms through comprehensive databases drawing on multiple information sources; monitoring the evolving health situation in each republic, and maintaining country profiles.

The clearinghouse is assisting Kyrgyzstan in collaboration with the Minister of Health, in the formulation of its health budget for 1993. Three principal categories were highlighted: quick disbursement of drugs, vaccines and medical supplies; technical assistance in the medical field; and long-term investment such as hospital to hospital partnerships, pharmaceutical production, etc.

WHO is working with the OECD in Paris to use its data register and has also intensified its coordination with the Moscow office of the International Federation of the Red Cross, especially in relation to the clearinghouse function. At their request, a technical consultation on pharmaceutical kits for essential drugs for children’s hospitals was organized in October 1992. Collaboration with the European Commission, the World Bank and the European Bank for Reconstruction and Development, and other UN agencies, has increased.

Focal point: Dr. Aleya El-Bindari Hammad, Special Adviser to the Director-General on Health and Development Policies
World Health Organization
20 Avenue Appia
1211 Geneva 27
Switzerland
Pilot projects in St Petersburg
by France Donnay

Within the framework of the Healthy Cities project of the World Health Organization’s European Regional Office, quite an ambitious programme has been undertaken in St Petersburg: renovation of maternity hospitals, ante- and postnatal services, and family planning centres. The project is supported by the communities of Hamburg, Milan, Rotterdam, Stockholm and Turku, and by the School of Public Health in Nottingham. Four pilot projects have already been launched.

Advice centre for adolescents
Contraceptive advice and prescription, termination of pregnancy, screening and treatment for sexually transmitted diseases (also for boys), psychological advice, groups for young mothers, and teaching of the young at sessions of audio-visual instruction.

The centre is already much visited. During my visit I was struck by the enthusiasm of the staff for an active new dialogue with the young. But I was also struck by the gaps in knowledge, due to the lack of recent medical information, for instance contra-indications against prescribing the pill to young women. On the other hand, the old techniques of physiotherapeutic treatment, forgotten in Western Europe, seemed to have a real role to play here. Following an abortion, for instance, why not enjoy the benefit of a massage, a course of ultrasound or infrared? Why not a face-mask for acne, for a few at a time, in a small, warm room where it is easy to talk.

Home for Single Mothers
A maternity clinic or “lying-in” home, serving young women in very poor circumstances. It offers them material security, clothing, medication, meals provided before and after the birth, as well as an approach to maternity stay which is entirely new to the city: rooming-in, fathers present (not a success), feeding on demand.

Rehabilitation centre for high-risk patients
A residential facility for 125 pregnant women at risk, in a building located outside the city and away from its pollution.

Family Planning Centre
Located in a large hospital in the heart of the city, the centre already covers all aspects of family planning: contraception, terminations, sterilization, investigation of infertility, amniocentesis, laparoscopic surgery, reception and instruction of patients. The balance between the various activities has not yet stabilized. There are too many abortions, too little contraception and treatment of sterility.

A “Consensus Conference” was held from 9 to 11 December 1992, with the participation of representatives of the towns concerned, and delegates from the maternal and infant health services of all the districts of St Petersburg. Resolutions were made, but many new ideas, more concerned with the patient/client relationship than with technique as such, were also discussed.

Dr France Donnay
OB/GYN
Rue Saint-Bernard 57
B-1090 Brussels
Belgium

Contraceptive or abortifacient

In the Maltese islands (in the Mediterranean), a controversy about the IUD functions as an abortifacient or a contraceptive has been going on since February.

More than 98% of the little more than 300 000 of the Maltese are catholics and for the most part practise their faith. Thus the church pays a major role in the culture of the island. Induced abortion for any reason is prohibited. If the IUD can be classified an abortifacient, the IUD will be prohibited too. The controversy got started by a letter to the editor in one of the main papers, written by Dr. J. L. Bonnici, USA. He argues that the IUD is an abortifacient and he supports this argument partly by quotations from Dr Van Look, Acting Director, Human Reproduction, WHO, who writes: “there is no doubt that there is a higher spontaneous abortion rate in women who become pregnant with the device in situ.”

Dr Bonnici and others think this statement strongly support the IUD as an abortifacient. They do not discuss or consider the fact that the increased risk of spontaneous abortions are only increased if the IUD is left in place in the event of an accidental pregnancy. If the device is removed, the subsequent risk of spontaneous abortion is no greater than normal. It is therefore good medical practice to remove the device if an intrauterine pregnancy is diagnosed. Dr Patrick Rowe, Medical Officer, Human Reproduction, WHO, concludes on the scientific data on the IUD. It is a contraceptive: “There is no scientific evidence that the mode of action of intra-uterine devices is abortifacient in nature or that the device disrupts implantation. All available evidence including research that has confirmed the conclusions reached by the WHO Scientific Group indicate that the IUD interferes with sperm migration in the upper female genital tract and/or ovum transport.”

Beth Lilja Pedersen
IPPF’s attention has lately been focused on establishing and supporting non-governmental family planning organizations.

IPPF had member associations in Bulgaria, the former German Democratic Republic, Hungary, Poland and Yugoslavia for many years. Since the political changes that have taken place in these countries the PPAs have been able to review their roles and they can now play an important part, not only in the provision of high quality family planning services, but also in providing training to health professionals and information to the general public.

In addition, contacts in other countries: the Czech Republic, Albania, Romania, the Slovak Republic, and Russia are leading to an increasing number of associations being established.

IPPF has been able to provide seed money for many of these newly formed organizations, enabling them to set up, at the very least headquarters with basic equipment and to employ a coordinator/director.

Each association is in a different phase of development, and each is in the process of planning their future activities.

The Regional Bureau organized a workshop on strategic planning in 1992 for these countries, which provided some guidelines on how a strategic plan could be developed, including the need for the associations to look closely at their country situations, to identify other players in the family planning field and to ensure that they were “doing the right things” and not simply “doing things right”.

Governments should be the main providers of family planning services and these services should be integrated into the national health systems. The role of the NGOs is to work in parallel, to sometimes do the things that governments might find politically difficult - such as services for adolescents - and to advocate for sexual and reproductive rights. NGOs are able to act as pressure groups, encouraging governments to take seriously the problems of women who are faced with abortion as their only means of fertility control and to monitor the quality of such services that do exist.

Impressive speed
The speed with which NGOs can become well established has been impressive. Whilst Ministers of Health are rapidly coming and going and national programmes to introduce comprehensive family planning services are constantly delayed, a PPA can be up and running within months of its conception. The associations in Romania, Society for Education on Contraception and Sexuality (SECS), and the Family Planning Association of Russia are examples of this. SECS was established in March 1990, it now has representation in 26 of the 40 judeis, provides training for general practitioners, is training trainers in FP and is currently developing programmes on sex education for teachers. In 1993, SECS will open its thirteenth clinic, with joint IPPF/European Community funding.

The Russian Family Planning Association (RFPA), established in December 1991 will be opening its second clinic, which will also be a training centre, in the North West Region of Moscow within the next few weeks. In addition, the RFPA has set up more than 25 branches during the year. If sufficient funding can be found, the association will divide the country into eight geographic regions and each will have a model clinic and training centre. The association has also produced videos, translated several IPPF medical publications into Russian and is in the process of producing five television programmes or different methods of contraception and abortion.

With joint IPPF/European Community funding, programmes are also being developed in Albania, Czech Republic, Hungary, Poland and the Slovak Republic. Each programme includes training, development of information and education materials and clinical services, on varying scales.

IPPF is hoping to organize a meeting for our contacts in the Baltic States to discuss future collaboration. In January this year I had the opportunity of meeting people from each of the Central Asian Republics during a meeting on Maternal and Child Health in Alma-Ata organized by USAID, and IPPF is now discussing what kind of support they need. To date our limited resources have kept us from being active in other states of the former Soviet Union, but we anticipate increased activity during 1993 and beyond.

Women’s organizations
An important component of Regional work has been developing and maintaining contacts with different women’s organizations working in the area of reproductive rights, these include the Women’s Global Network for Reproductive Rights, European Network for Women’s Right to Abortion and Contraception, Catholics for a Free Choice, International Women’s Rights Action Watch and many others. The changing political situation in central and eastern Europe is, in many cases, having a negative impact on women’s health, status and reproductive choices and this networking is enabling us to keep abreast of the changes and to work together to help minimize the difficulties they can cause.

More recently we have been collaborating with groups concerned about the torture and rape of women in former Yugoslavia, hoping to provide some practical assistance where possible.

It is a very exciting and challenging time to be working on reproductive rights and health issues in Europe. In the IPPF Europe Region we are optimistic that by responding to needs expressed by our colleagues in central and eastern Europe and being sensitive to their difficult and changing circumstances, much can be achieved in a short space of time by the nongovernmental sector.

Ms Lyn Thomas
Regional Director, Europe Region
International Planned Parenthood Federation
Regent’s College, Inner Circle
Regent’s Park
London NW1 4NS
United Kingdom
Private involvement in Turkish family planning

Involvement of the private sector is considered a must in the Turkish Family Health and Planning Foundation

Turkey is characterized by a wide range of population problems. In addition to excessive population growth with limited resources, which remains one of the most pressing problems, an unbalanced population distribution within the country, unplanned urbanization and explosive growth of cities and poor distribution of human resources all contribute to the urgency of the situation. Furthermore, the pressure to provide for the health, housing and educational needs of the growing population; the burden on urban infrastructure; and the economic and social imbalance associated with internal and international migration pose serious problems for the Government and the economy.

The population in Turkey was 56.4 million in the 1990 Census and with the present growth rate of 2.2%, it will double in 31 years.

The Turkish Family Health and Planning Foundation (TFHPF) was established in order to provide alternative and innovative solutions to the economic and social problems caused by this fast population growth. It is a private non-profit organization that was legalized by a Council of Ministers decree on 14 September 1985 and a civil court decision on 14 November 1985. The purpose of the Foundation is to improve and expand family planning and health services in Turkey.

All goals of the Foundation are to be achieved through the involvement of the private sector. The leaders and creators of the organization are prominent businessmen, university professors and heads of trade and employers' confederations.

A strong commitment to the issues of family planning by the private sector is a must. Our supporters are people who view global population growth as an issue that affects our collective capacity to wrestle effectively with virtually every other issue of human need: health care, literacy, food supply, environmental protection and economic justice.

The goal of the Foundation is to encourage the private sector to be actively involved in improving the quality of life of families in Turkey by expanding and increasing the efficiency of family planning services.

The scope of work for the Foundation includes:

a) Public education, information and motivation in family planning;
b) National and international training and seminars;
c) Publication and dissemination of health information;
d) Establishment and operation of health and family planning clinics;
e) Management and distribution of contraceptives;
f) Activities related to nutrition, maternal and child health;
g) Research, evaluation, demonstration and pilot projects;
h) International and national collaborative activities.

We believe that the final outcome of all our activities is to have healthy mothers, healthy children and consequently healthy and happy families.

Yaşar Yaşar
Executive Director
Turkish Family Health and Planning Foundation
Ulus Mahallesli Güzel Konutlar Sıtesi
A Blok - Daire 3-4
80600 Etiller/Istanbul
Turkey

Berdel

The Turkish movie “Berdel” can only be highly recommended for everybody involved in family planning. The importance of the movie goes way beyond the borders of Turkey.

The movie “Berdel” tells the story of Hanım and Omer who were deeply in love with each other until they came into conflict after the birth of their sixth daughter. The birth disappointed Omer, because he wanted a baby boy and he blamed his wife for his lack of a male offspring. Given local custom he took a second wife, hoping she would bear a son.

The first wife Hanım, the second wife, the daughter exchanged by Omer in order to marry the Kuma under the “Berdel” all became the victims of tradition.

“Berdel” is directed by Atif Yılmaz and produced by Gülsevin G. Yaşar. It is made for the Turkish Family Health and Planning Foundation (TFHPF).

TFHPF Board decided that the motto of the Foundation, which is “Have as many children as you can afford and make happy”, could most effectively be spread by mass media, that is cinema, radio and television and a family planning campaign, to increase awareness, should be started.

To this end, in March of 1987 a scenario competition was started by the Foundation. “Berdel” was chosen as the best scenario out of 96.

Contact: The Turkish Family Health and Planning Foundation.
Poland turning against the stream

A law on the protection of the fetus was passed by one vote in the upper chamber of the Polish parliament in early 1993. This extremely restrictive law led to heated debates in both houses of parliament. Many people who wish to be heard on this subject have been in touch with Entre Nous, but we lack space for all they have written. Poland is the first country in Europe to turn against the stream, in reversing an arrangement of abortion on demand.

In Romania and Albania, in contrast, the alteration in the abortion law has proved a real case study, and has produced spectacular effects.

Legalization of abortion, and its practice in a secure surgical environment, has led to an immediate and massive drop in the maternal mortality rate - over 50% in Romania and Albania, in under two years.

Once abortion is legal, women do not die of it. It should be noted that the conditions prevailing are far from offering the comforts of western countries: limited availability of instruments, obsolete technique (dilation and curettage), shortage of anaesthesia and pain control, and lack of post-abortion contraceptive advice.

Legalized abortion in these two countries is still practised, albeit now legally, as a method of controlling fertility, specifically due to the fact that the environment is hostile, or at least indifferent, to contraception.

While the major result of the legalization of abortion is a drop in the rate of maternal mortality, the changeover from abortion to contraception, in a hostile context, is clearly more difficult, and slow to take root. The introduction of contraception in a hostile environment is similar to the introduction of modern agricultural technology into a traditional rural society.

Poland will constitute a reverse case study to that of Romania and Albania, i.e. the maternal mortality rate could rise again among the poorest women, who would resort to the services of untrained abortionists. Thus economic discrimination will emerge, as the more wealthy women travel abroad for abortions.

Without taking sides in any way, one must recommend, at the very least, an active and broadly-based policy on modern contraception which would include: public information, training of personnel, arrangements for modern contraceptive methods to be available, easily accessible, inexpensive, and for them to be distributed without discrimination by age, marital status or sex.

Abortion law in Poland

The Senate has passed the Abortion Law without modification and by one vote. This means that indications for legal termination of pregnancy include threat to life and health of the mother, pregnancy resulting from criminal activity and congenital disorder of the fetus. Social indications will no longer be consistent with the law.

Concerning sex education and family planning. Article 2, point 2 of the law states that the local authorities according to their terms of reference, defined elsewhere, are obliged to ensure unhindered access to methods and articles used in informed parenthood. In Article 4 sex education, information concerning informed and responsible parenthood, family values, life in-utero and methods of informed procreation will be introduced into the school curriculum. The responsibility for the details of the curriculum will rest with the Minister of Education.

The Law requires the President’s signature before its contents can be implemented.

Dr. Jolanta Sabbat
WHO Liaison Officer

Dr. D Pierotti
Two forms of argument

Professor M. Kozakiewicz, a member of the Polish Diet, has served as president of the parliament, president of the Polish Association for Family Planning, and vice president of the IPPF. To some he is an eminent and respected person, while to others he is the enemy. Professor Kozakiewicz has sent us the contents of his two speeches in the Polish Diet, made respectively on 30 June and 30 December, 1992. Due to lack of space, we are not able to publish them in their entirety, but we highlight here the principal ideas. Two forms of argument are developed: on the one hand juridicopolitical, on the other hand arguments on public health, justice and equality.

Juridicopolitical arguments
The law on voluntary termination of pregnancy concerns all Poles.

Instead of a vote in parliament where only eight members are women, would it not be preferable to hold a referendum, which would be far more representative? Professor Kozakiewicz asks himself what the profound motives can be of certain groups of members: is it possible that a group of members want to impose their view of voluntary termination of pregnancy on everyone? Is it possible that the members are proposing the transformation of a moral standard into a constitutional law which is also binding on non-Christians? Is a juridical precedent being created whereby constitutional law will be submitted to the church’s moral authority? Is it possible that certain people wish to make Poland into a model state where all legislation will conform to the church’s moral standards?

Each member of parliament will make his or her decision, not from profound conviction, but on the basis of assessment of the chance of reelection, depending on whether he or she supports or opposes the law on abortion.

Arguments of public health, justice and equality
Professor Kozakiewicz reasserts that voluntary termination of pregnancy is an evil, but a necessary evil. It should not be a means of birth control, but an emergency exit. To campaign against VTP is to propagate sexual education and knowledge of contraceptive methods. The law will discriminate. It will affect women in poor circumstances, while those who are wealthier will travel abroad, as Spanish, French and German women did in 1970. This is demonstrated by the fact that when legislation on voluntary termination of pregnancy was liberalized in those three countries, the flood of mass migrations for abortion slowed down, and then ceased. The law as it stands makes no mention of sex education, but demands the inculcation of “respect for human life from the moment of conception”.

For Professor Kozakiewicz, the law in its present form does not correspond to the real sexual lives of men and women at the end of the 20th century. One clause of the law discusses homicide. Professor Kozakiewicz wonders, if voluntary termination of pregnancy is homicide, why is the doctor condemned, but not the woman.

The Editor

New abortion law in Hungary

by Dr. István Batár

In December 1992, the Hungarian Parliament revised the abortion law.

The new law is in some ways more liberal than the former one. A woman can now have an abortion on demand within the first 12 weeks of pregnancy, if she is in a “crisis situation”. A compulsory consultation has also been introduced with a nurse who informs the woman on issues of contraception, maternity allowance, etc.

Under certain circumstances abortion is legal beyond the first trimester. These include for example misdiagnoses of the pregnancy, if the women is under 18 years, or in case of genetical or teratogenic risk.

Abortion performed for medical reasons is free of charge. In other cases the fee is HUF 5000, the equivalent of US $60, which can be reduced according to the economical status of the family. In one way the new law can be considered more restrictive; previously, an abortion was free of charge for women who became pregnant with an IUD, whereas now the woman has to pay the abortion fee.

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

ENTRE NOUS 22-23, June 1993
Vasectomy and risk of prostate cancer

Two studies concerning the risk of prostate cancer following vasectomy, conducted in the USA have recently been published in the Journal of the American Medical Association (JAMA). In contrast to many studies on this question these studies used a prospective design in which groups of men are followed over time; one is a historical cohort study and the other a concurrent cohort study. Both studies are of high scientific quality and their prospective nature avoids many of the problems of bias in the earlier case control designs. The results indicate that there is an increased risk of prostate cancer (1.6 times) following vasectomy, and a trend of increasing risk with time since the procedure, up to a relative risk of about 1.9 among men vasectomized at least twenty years previously. The two studies were conducted among men in the USA who were above average socioeconomic status and educational level - one group consisted of health professionals and physicians, and the other of husbands of registered nurses. Two other prospective studies among different groups of men in the USA have not shown any increased risk of prostate cancer after vasectomy, even many years after the procedure.

The study of risk factors for prostate cancer, in particular environmental and behavioural factors, including vasectomy, is difficult because little is known about the underlying pathophysiological causes of the disease. It remains to be established whether or not the recently reported associations represent a true causal relationship between vasectomy and the risk of prostate cancer. It is possible that, among the two groups of men studied, the factors leading to vasectomy and to risk of prostate cancer are similar.

Vasectomy widely used
Vasectomy is one of the more effective and widely used forms of contraception. Worldwide, about 42 million couples are estimated to rely on vasectomy as their method of family planning. Studies in the 1970s and 1980s of short- and long-term effects of vasectomy have indicated that the procedure is safe. In 1990, epidemiological studies suggested an increase in risk of cancers of the testis and prostate following vasectomy. These reports prompted the World Health Organization to convene a meeting in 1991 to review available biological and epidemiological evidence on the safety of vasectomy with regard to the two diseases. The meeting concluded that there was no known biological mechanism to account for any association, that any causal relationship between vasectomy and cancers of the prostate or testis was unlikely, and made recommendations concerning further research. It anticipated that epidemiological studies under way at that time would provide further information on such relationships. Concerns about vasectomy and testicular cancer have not been substantiated.

The incidence of prostate cancer varies widely between countries. In developed countries it is one of the most common cancer sites among men, while in developing countries it has a much lower incidence. There is a fifty-fold difference in the incidence of the disease, for example in part of the USA the annual incidence is 91.2 per: 100 000 men, while it is as low as 1.8 per 100 000 in Shanghai, People’s Republic of China. Men in Bombay, India have an incidence of 8.2 per 100 000. Nevertheless, the findings reported in JAMA raise questions about the long-term safety of vasectomy, and are of potential public health importance in countries where both prostate cancer and vasectomy are common. In countries where the disease is rare the public health impact of any association is small. In countries where prostate cancer is more common, but less so than in the USA, the public health impact may be greater, but only if the association observed in the high socioeconomic group in the USA is also present. This has yet to be established. The risk factors for prostate cancer are so poorly understood and the incidence rates so varied between countries that it is not justified to extrapolate the results from the USA to other countries, particularly those in the developing world.

Information about benefits and risks
In countries where vasectomy is a widely used method of contraception, the impact of these recent results from the USA on the long-term safety of vasectomy may create concern among couples already relying on vasectomy for fertility regulation, and reduce its acceptability. Couples seeking family planning should be informed of the benefits and risks of different contraceptive methods, and also the risks and consequences of not using any family planning method at all. Furthermore, it is important that couples receive information relevant to the health situation of their own setting. As already mentioned, in many developing countries the risk of prostate cancer is very low and a possible slight increase in risk with vasectomy should be weighed against the benefits of the method and the drawbacks and advantages of other means of fertility regulation.

It is essential, however, that studies be undertaken in developing countries where vasectomy is widely used and the availability of other effective and affordable contraceptive methods is limited. Such studies supported by WHO are under way - the feasibility has been assessed, and pilot studies will be conducted in 1993 in four developing countries. The main epidemiological study, using case control methodology, is expected to start in 1994. In the meantime, WHO will continue to monitor and disseminate any new information that emerges.
Control of fertility in the People’s Republic of China

by Yves Blayo

The new regime took control of society by destroying the traditional structures and replacing them with social institutions and a new administrative system. The Marriage Act of 1950, intended to break up a family system which stood between the State and the individual, and in the way of the agrarian reform in the countryside (1950) and the campaign against the anti-revolutionaries in the cities (1951), contributed to the reshaping of society. In the urban areas the work units and the district and residents’ committees, and in the country the people’s communes, brigades and teams, kept individuals under supervision and comprised the administration which effectively applied the instruments of population control. These were both political, in the form of mass campaigns and permanent mobilization, and administrative, in the form of registration of households reinforced by rationing and the monopoly of the State on the recruitment of personnel.

The system, implemented gradually during the 1950s, was paralysed by the Great Leap Forward of 1958 and its after-effects, and then by the Cultural Revolution in 1966. These events interrupted and reduced the effects of the first two campaigns for birth limitation in 1956 and 1962. The progressive restoration of the machinery of the State enabled the launching, in 1971, of the third campaign which introduced the system of birth quotas and set the standards for precreation.

Candidates for pregnancy

Every year the government determines the total number of births in the country for the following year and distributes them among the provinces. Each of them in turn apportions a birth quota to municipalities and districts under its jurisdiction. The procedure is repeated right down to the basic units and the women permitted to bear children are in the end selected at a meeting held among the candidates for pregnancy.

The law sets the minimum age for girls to marry at 18, and 20 for boys, but nonetheless girls are strongly urged not to marry until they are 23 in rural and 25 in urban areas, and the boys not until they are 25 or 28 years. An interval of three years is required in the countryside between the first and second birth and from four to five years in urban areas. The number of infants is limited to two in urban areas and to three, then from 1977, to two, in rural areas. Unplanned pregnancies should be terminated.

The programme was more or less universally applied by 1975-76; the drop in natural increase, although rapid, from 2.2% in 1972 to 1.2% in 1978, was insufficient to achieve the goals of the Four Modernizations, set for the end of 1978: the campaign became a campaign for a single child in 1979.

Ideological education of couples is accompanied by a string of material incentives and economic sanctions. Parents of one child who commit themselves to not having another can obtain a single child certificate giving them the right to a monthly bonus, amounting to about one-tenth of the couple’s income, until the child reaches its 14th birthday. Both they and the child are accorded a number of privileges. All these privileges are withdrawn and the bonuses must be repaid if the couple has a second child, and penalties are imposed if they have a third: wage reductions, loss of social advantages, etc.

Economic reforms encourage more births

Other measures, taken with the same objective of realizing the Four Modernizations, conversely encouraged a greater number of births. Economic reforms in rural areas returned to the family its function as a unit of production, for which abundant personnel was an advantage. The abolition of people’s communes took away from the rural administration the administrative means of control and the possibility of financing the inducements. The surplus rural human resources freed by the increase in agricultural productivity formed in urban areas, from 1984 onwards, a “floating” population which escaped the control of the birth planning workers. At the same time the Marriage Act of 1981 set a lower minimum age (20 for girls and 22 for boys) than was required by the standards of the third campaign and brought about a lowering of the age of nuptiality and an increase in fertility.

The authorities attempted to reverse these trends by strengthening the application of the campaign for a single child. The “new mobilization” of January 1983 introduced sterilizations and compulsory abortions. A connection was established between the production and reproduction of the family, contracts of responsibility imposed a double objective upon them, both economic and with regard to planned births. The responsibility of the local administration and collective responsibility further strengthened a system whose functioning necessarily implied the use of coercive measures. Reactions to the excesses of 1983 led to their withdrawal. In 1984 the rural parents of a girl child were permitted to have a second child. But the condition of sex was ignored and the proportion of couples having two children rose from 5% prior to 1984 to 50% in 1986. In 1983 it was estimated that unplanned births constituted one-third of all children born. The floating population of the urban areas comprised approximately 5% of the country’s population in 1989 but produced 10% of births, all of them unplanned. Resistance to political propaganda is also visible in the concealing of births and the falsification of statistics by local administrations.

Finally, the campaign for a single child was doomed right from its instigation because of the contradiction between the constraints placed upon the planning of births and the liberalization associated with the economic and administrative reforms which has given couples the means of evading those restraints.

Mr Yves Blayo
Institut National d’Etudes Démographiques
27, rue du Commandeur
75675 Paris Cedex 14
France

Entre Nous 22-23, June 1993
MANAGEMENT

The scheduler, the register and the monthly report card

by Gaston Legrain and Pierre Delvoye

Management of basic statistical data in family planning: three easy to use and effective tools for health care personnel

The scheduler
The scheduler is a simple, effective, and inexpensive working tool. Its support material could be a file case, either a box or even a cabinet, depending upon the importance of the number of women monitored by the health centre concerned.

The example we advocate here has been in general use in Burundi and Togo. It consists of a wooden box with the following dimensions: height 20 cm, width 25 cm, and length 35 cm. There are 18 partitions (wooden or cardboard partitions which serve as dividers). The space between two dividers represents one month. These partitions are not fixed, as the number of consultants can vary greatly from one month to another. The model suggested can be used by a health centre where the number of women monitored does not exceed 500.

Method of use
It is extremely simple: at the end of each consultation, the health care personnel file the visit card (see article in: Entre Nous No. 20) in the section of the scheduler corresponding to the month of the next appointment. In other words, if a woman who came in for consultation in January is to return six months later in July, her visit card will be filed in the July section of the scheduler.

Functions
The scheduler is thus intended to serve three essential functions:
• an archival function: all the cards are arranged in the same place and can be easily retrieved;
• a statistical function: the number of women using contraceptive methods can be assessed at any time; it enables the calculation of the prevalence of contraceptives within a population, totally or according to individual method;
• an operational function: at the end of each month those who have not turned up can be located; they will be the patients whose cards remain in the compartment of the past month.

Having identified them: it is possible to make contact with these “dropouts” once more, by a visit to the home, for example.

The number of women using contraceptive methods can be assessed at any time with the scheduler. Photo Ann Eriksen©MIRANmaj

ple, or some other means depending upon the local situation. The scheduler in this way contributes to improving the continuity of contraceptive guidance and thus, in the end, to better coverage.

A statistical tool
In this manner it is possible at the end of each month to obtain the following basic statistical data:
• the number of women protected, in total and by method;
• the number of women who have dropped out, in total and by method;
• the number of women who have given up using contraceptive methods, the number of withdrawals, in total and by method.

This basic statistical data can be reported on a monthly report card (see below) and sent, after a preliminary analysis, to regional or central supervisory centres (regional or central administrative departments).

The consultation register
The visit card remains in the health care centre, filed in the scheduler. It serves an archival and statistical function and as an aid to decision making.

The consultation register is essentially to make an assessment possible: its function is quantitative, not qualitative. It permits a rapid inventory of the number of consultations and consultants.

The model we suggest has a standard format (A4), is easy to use and takes up limited space. The following data at least should be collected:
1. Date of the visit
2. Number of the visit for the current month
3. Number of the patient’s card: - number of the existing card, for previous cases - number assigned to a new patient when a new visit card is begun
4. Type of method utilised: pill, injection, IUD, etc. (previous cases vs new cases)
5. Previous patients vs new ones
6. Date of the appointment.

At the end of each month, the summary of the consultation register should be able to provide us with the following information:
1. The total number of women seen during the course of the month. This is the final number in the column, number of the visit for the current month.
2. The number of previous cases seen during the course of the month. This is the total number of PC-cards (for previous cases).
3. The number of new patients accepted. This is the total number of NC-cards (for new cases).
4. The breakdown of the cases according to method and by previous or new case.

We note that there is no single standard for defining previous cases and new cases. There are many cases of confusion between previous cases and previous users, new cases and new acceptors. It is important that each country adopt and make official its accepted definitions, for example in a document on “Policies and standards for Family Planning services”. In the centres under our direction those considered as:
1. New cases (NC): include any woman for whom a new visit card is begun:
• if it is the first time a woman comes in for consultation;
• if it is a woman who has already
used a method of contraception, but
who was monitored by another cen-
tre and who is consulting our centre
without having brought her visit card
from the former centre; - if it is a
woman who begins once more to use
a contraceptive method after having
ceased for a specified period of
time (more than three months for
hormonal methods, more than two
years for an intrauterine device
(IUD));

2. Previous cases (PC): include any
woman who already has a visit card
and who returns regularly for her
appointments for consultation.

This basic statistical data can be
reported on a monthly report card and
sent, after a preliminary analysis (self-
evaluation), to regional or central super-
visory centres (regional or central admi-
ministrative departments) for final epide-
miological processing.

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**Activity report for (month)........................... 1993**

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**The monthly report card**

The monthly report card gives an
overview of the incidence and preval-
ence of contraceptive usage at a given
health care centre; it also offers a break-
down by method.

This card reports, in the form of a
table of basic statistical data on family
planning, the information deriving from
the two instruments previously descri-
ded, the scheduler and the register.

The statistical analysis of this card
by GEDOSTA (Management of statisti-
cal data in family planning), simple and
commercially available software, will be
the subject of a future article.

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**UNFPA FILE**

**Two decades in population politics**

In the last two hundred years, the world’s
population has increased five-fold, from
one billion in 1800 to over five billion
today. Every day, that figure increases by
over 200,000. In thirty years, our planet
will be home to a staggering ten billion
people. The pressing nature of this prob-
lem has resulted in the formulation and
implementation in many developing
countries of population policies and
programs, research and training activi-
ties, international, national, and regional
conferences, and censuses and demo-
graphic surveys geared to resolving this
urgent dilemma.

In *Population Policies and Program-
mes: Lessons Learned from Two Deca-
des of Experience*, the Executive Direc-
tor of the United Nations Population
Fund, Nafis Sadik, provides a compre-
hesive distillation of the information
assembled by this diverse population
taskforce. An invaluable resource to any-
one interested in population policy, the

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**11 July 1993 - World Population Day**

"... The world's population will double in 43
years if we continue to grow at our current
rate. Lasting solutions to problems of the
environment and poverty can be found if we
can resolve population issues."

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ENTRE NOUS 22-23, June 1993
Pregnancy and parenthood - Heaven or Hell. There is no one way, or “right” way to have a baby. Each person’s experience of birth is different. The book prepares mothers for any of the eventualities of birth and it is not directed towards “changing the system”, or does it decry any current practice. Beverly Chalmers PhD, Pregnancy and parenthood - Heaven or Hell, Bere Publications CC, P.O. Box 107, River Club, South Africa, 2149. Reprinted 1991. ISBN 0-620-15349-0.

The Pan American Health Organization has just published the book Pro Salute Novi Mundi about the history of the Organization, and how it has worked to fulfill its mission. The publication is available in both English and Spanish from: Pan American Health Organization, Pan American Sanitary Bureau, WHO, 525 Twenty-third Street, NW, Washington, CD 20037, USA. ISBN 92-75-12079-X.

Correction of address: In Entre Nous No. 20 we mentioned the publication Induced Abortion: A World Review, 1990 Supplement, by Stanley K. Henshaw and Evelyn Morrow. There is an error in the address provided for the Alan Guttmacher Institute. The correct address is 111 Fifth Avenue, New York, N.Y. 10003, USA.

Women in figures
Over the recent years Spanish women have played a more visible role in society. The daughters’ standard of education is way above that of their mothers and only 2 percentile points below the figure for men at the same age, 30-33 years. But it should not be forgotten that most women work in services, Education, Health and Public Administration.


Female genital mutilation
There are now reports of female genital mutilation in the western world. Programmes which had once seemed so promising, in Sudan and Somalia have now collapsed. Efua Dorkenoo has done a major revision of the report Female Genital Mutilation: Proposals for change, to bring it into the 1990s. The report was first published in 1980. Available from Minority Rights Groups, 379/38/Brixton Road, London SW9 7DE, UK. ISBN 0946690 90 1.

Fertility level in developing countries
Thailand has nearly achieved replacement level fertility, whereas in Uganda, if current fertility rates prevail in the future, the average woman will have more than seven children by the end of her childbearing years. These are some of the results in a comparative study from Demographic and Health Surveys about fertility variations in 25 developing countries. The results are examined in conjunction with previous surveys and provide information of fertility levels and recent trends. Demographic and Health Surveys, Comparative Studies No.2: Fertility Levels and Trends, Fred Arnold, Ann K. Blanc, IRD/Macro Systems, 8850 Stanford Boulevard, Suite 4000, Columbia, MD21045, USA.


Reports
The pill and cancer
Over 60 million women around the world are now using oral contraceptives. Despite their advantages, there is concern about the links between oral contraceptives and the risk of cancer. While they reduce the risk of certain tumours, such as cancers of the ovary and endometrium, there have been reports of positive associations with the risk of others, such as cancers of the breast and cervix.

A WHO Scientific Group evaluated the data available on different neoplasias, and the results are published in the WHO technical reports series. While acknowledging that oral contraceptives appear to increase the risk of certain forms of neoplasia, the Scientific Group noted that all the effects, including the prevention of unwanted pregnancies, should be taken into account by women who are deciding whether to choose this method of contraception. Although, on the basis of the evidence currently available about neoplasia the Scientific Group recommends no changes to family planning policies concerning the use of oral contraceptives. The report, Oral Contraceptives and Neoplasia, WHO technical reports series, No. 817, can be ordered from Distribution and Sales, WHO, 1211 Geneva 27, Switzerland., Price: Sw.fr.9.-/Price in developing countries: Sw.fr.30.

MINORITY RIGHTS GROUP INTERNATIONAL

FEMALE GENITAL MUTILATION:
Proposals for change

ENTRE NOUS 22-23, June 1993

Magazines/newsletters

Family Planning Today is the quarterly Bulletin published by the UK Family Planning Association for professionals in sexual health and family planning. It covers the latest developments in family planning, sexual health, personal relationships and related areas and is read by hundreds of doctors, family planning experts and other health professionals. It is available on subscription from the FPA, 27–35 Mortimer Street, London W1N 7RJ, at £10 a year.

Love and the family
Issues No. 191 and 192 of Arrouet et Famille, the magazine of C.L.E.R. - the Centre de Liaison des Equipes de Recherche - deal with the themes of Adolescents and The Longstanding Couple (Le couple et la durée). These journals will be of particular interest to young people about it. Price 30 French francs per issue; annual subscription for six issues 150 francs. Write to C.L.E.R., 65 Boulevard de Clichy, 75009 Paris. Tel: (33) 1.4874.8760.

The British Journal of Family Planning is published quarterly by the National Association of Family Planning Doctors (NAFPD). It contains original research papers and review articles dealing with family planning and reproductive health, as well as news items, book reviews, correspondence, notices of meetings and relevant abstracts from other journals. Information from: The British Journal of Family Planning, 27 Sussex Place, Regent’s Park, London NW1 4RG, United Kingdom.

Advances in Abortion Care is an occasional publication of IPAS. It addresses issues related to the quality of abortion care, including: introduction of appropriate technologies, clinical update information, women’s perspectives, research results, and experiences from IPAS and other ongoing projects in the developing world. Single copies are available free of charge. To order multiple copies, contact: IPAS, P.O. Box 100, Carrboro, NC 27510 USA. Tel: (919)967.7052. Fax: (919)929-0258.

Network is published quarterly in English by Family Health International and is distributed without charge. The organization is dedicated to contraceptive development, family planning, reproductive health and AIDS prevention around the world. Information from: Family Health International, P.O. Box 13950, Research Triangle Park, North Carolina 27709, USA.

Planned Parenthood Challenges is a new biannual publication in English and French produced by the International Planned Parenthood Federation. It aims to debate and report on issues of topical interest to all those concerned with reproductive wellbeing, sexual health and family planning. It is available free of charge to family planning workers and associated individuals and organizations from: Distribution Unit, Public Affairs Department of IPPF, Regent’s College, Inner Circle, Regent’s Park, London NW1 4NS, United Kingdom.

Suaide da Mulher is a biannual magazine published by the Portuguese General Directorate for Health in order to inform physicians and nurses from health Centres on the state of art, studies and events regarding family planning and maternal health in Portugal. Information from: General Directorate for Health, Alameda D. Afonso Henriques, 45 - 1056 Lisbon Codex, Portugal.

IN/FIRE - International Network of Feminists Interested in Reproductive Health and Ethics, serves as a clearinghouse and information centre for feminists with a professional interest in ethical issues in reproductive health and rights. Also a newsletter Ethics is published quarterly. IN/FIRE, 1436 U. Street, NW, Suite 301, Washington, DC 20009, USA.

General

Questionnaires for surveys
Module questionnaires to conduct fertility and family surveys are available from the Fertility and Family Surveys Questionnaire and Codebook. Hopefully the questionnaires will contribute to the standardization and comparability of data.


Family planning and environment
As a supplement to publicize its quarterly international review Population Reports, Johns Hopkins University in the USA has published a dramatic folder entitled "Protect the environment. Practice family planning." The six-leaved folder is printed mainly in silver and gold on black, and reflects the soaring human population of the planet from 50 million 2,000 years ago to 50 million in 1992. The last fold shows the year 2100 with the warning "If we do nothing, 19,000 million." For further information, contact: Stephen M. Goldstein, Associate Editor, Population Information Program, 527 St. Paul Place, Baltimore, Maryland 21202, USA. Tel (410)685.6300. Fax (410)659.6266.

Training opportunities

UNFPA has published the 1992/93 edition of the Directory of Training Courses: Family Planning and Maternal and Child Health. A total of 115 organizations offering a total of 281 courses are represented. The publication is available from UNFPA, 220 East 42nd Street, New York, NY 10017, USA, and the cost is US $15.00. ISBN: 0-89714-160-1.

Indonesia

Indonesia has a population of 180 million people - with an equal number of smiles - but is also a country where family planning is not simply a parasite. At the entrances to villages one can often see small monuments intended to catch the attention of travellers and remind them that two children are sufficient. One can also see the letters KB painted very visibly on certain houses, indicating that under this roof a contraceptive method is practiced. If one adds that all those practicing family planning (successfully) can take part each year in a contest with particularly attractive prizes, then one begins to understand that the message of birth regulation is not only achieved by a two-way discourse with the practitioner, but also depends upon its acceptability being widely recognized throughout the entire population. Remember that Indonesia is the most populous Muslim country in the world!

By Xavier Bonnefoy Regional Adviser, Environmental Health Planning/Ecology WHO Europe

Drug utilization studies - Methods and uses

How many drugs do people take and what sort, how much do they cost, and who influences the way they are prescribed and the way they are actually taken?

The answer is that we do not know as much as we should. But drug utilization research is rapidly filling in the gaps.

The book, edited by M.N.G. Dukes, describes the latest research methods and their use by the members of the WHO Drug Utilisation Research Group.

Every country needs a drug policy to make the most rational and cost-effective use of a very expensive part of the health service. Drug utilization research provides the tools for them to do so. This book is not just a record of achievements in that field; it is also a guide to students and researchers as well as people in the pharmaceutical industry.

It can be ordered from:
Distribution and Sales
World Health Organization
CH-1211 Geneva 27
Switzerland

ISBN 92 890 1308 7
Price: Sw.fr. 36.-