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Welcome to Volumes 14 and 15, a special double issue of the new Entré Nous

It will take some time, but we hope that coming issues will gradually acquire a recognizable "look". Entré Nous will be transformed from a newsletter and information bulletin into a publication closer to a magazine. We believe that it is possible to combine the seriousness and sobriety of a public-health-oriented journal with the attractiveness and accessibility of a magazine. We promised you more photographs, illustrations and cartoons. You will notice that the visual element is somewhat sparse this issue. We have not forgotten our undertaking. Please be patient. We are working on it.

In keeping with magazine practice, there will be regular features and departments, acting as signposts for entry into the magazine. Occasionally, as with the present number, reasons of space will oblige us to suppress a feature or department temporarily. It won't have gone away for ever. Expect to see it resurface three months later.

At the moment you are reading "This quarter", which will contain the editorial material. Our correspondence column "Feedback" will also appear in this section. "Feedback" is your space. Please write to us with your comments, suggestions and criticisms. We look forward to opening a bulging mailbox. Our cover story this issue is the new family planning programme in Romania, followed by four other up-to-the-minute reports. One of our two "Background" features also has a Romanian flavour. In "Spotlight" we interview Dr Petros-Barvazian, for the past 14 years Director of the Division of Family Health at WHO Headquarters in Geneva. Our concentration on Central and Eastern Europe has led to the disappearance of the rubric "Beyond Europe's Borders, a look at the wider world of family planning". It will return in the next number. We certainly do not intend to give the new Entré Nous a narrowly European focus.

The regular department "Your Part of the World" features five other countries of Eastern and Central Europe. We had such a magnificent response to our request for articles that we are holding some over until next issue. In September you may look forward to news from Albania, Bulgaria, Czechoslovakia, and Yugoslavia. "Coming Together" reports on two important conferences recently held in Copenhagen, one on abortion, the other on AIDS.

We will never be short of material for "Resources and Reinforcement", which this issue we have conflated with our "Regional Reports" department. Please forgive us if your publication or conference has not been announced — we had to take decisions based on newsworthiness. After all, it is over a year since Entré Nous last appeared.

Christopher Lawson
How we are reorienting our editorial programme

The dramatic changes occurring throughout Europe are fostering a reexamination of past expectations and a renewed focus on public health prevention efforts. There is increasing emphasis on enhancing the environment, improving the quality of life, and encouraging responsible sexual behaviour.

Against this background Entre Nous is reorienting its editorial programme. We will make it easier to exchange service-oriented experience within Europe. We will bring important developments to the attention of policy makers and service providers. We will promote the use of culturally adaptable resources in developing countries.

The new editorial programme will also correspond to the reorientation of the Sexuality and Family Planning (SFP) programme in Europe. It will place emphasis on the following principal issues:

- Easy access to modern contraception for all
- Moving away from abortion and towards contraception
- Safe partnership and safe sexual practice
- Reducing unwanted pregnancies and eliminating unsafe abortion
- Targeting the appropriate Family Planning information to the appropriate group
- Paying attention to high-risk groups
- No exclusion from family planning for any minority
- Ethics in reproductive matters
- Training health professionals in family planning and sexuality at both basic and postgraduate level
- Promoting adolescent health
- Improving family health through research on lifestyles, the decision-making process, the third child policy, and sexuality
- Assisting the family planning programme in other regions
- Maximizing inputs by strengthening inter-agency networking

This first issue of a new era focuses on Eastern and Central Europe. Inevitably, the point of concentration is Romania.

We requested leading experts on well-known personalities to highlight some ideas or facts they thought would be of interest for readers elsewhere in Europe. We have compiled and edited their articles, whose subjects range from population policy to sexology. Some articles reflect national programmes. Others describe initiatives related to one clinic or one patient. We hope you will enjoy reading them as much as we did, and that we have made a small contribution to spreading wider knowledge about our European brothers and sisters.

We also interviewed Dr Petros-Barvazian, the Director of the Division of Family Health of WHO headquarters in Geneva. Dr Petros-Barvazian is a leading figure in the promotion of family health and issues related to women in WHO. It seemed important to us to remind ourselves here how the FHE programme constantly seeks to be as innovative and dynamic as she is herself. We hope to create new ways to family health in Europe and all over the world.

Dr D. Pierotti, Regional Officer for Sexuality and Family Planning

Entre Nous announces a competition for an SFP logo

The Sexuality and Family Planning Unit was created in 1972. We would like to give the unit a rather special present on the occasion of its 18th birthday. For this, we need our readers’ help. Will you help us to design an SFP logo? The logo should be representative of the SFP programme, and should have all the qualities of a logo: it should be simple, visible, readable, elegant, pleasant to look at, and above all acceptable to all the Member States of WHO. To help you concentrate your minds, let me refer you to the editorial for the main messages of the unit.

The competition is open to all our readers and their families. If you have small kids with artistic leanings, get them busy too. Please send us your sketches of a proposed logo to represent the unit. The deadline is October, 1990. And, as "toute peine mérite salaire", a prize of US$200 will be awarded to the winner.

SFP personnel and selected professionals will choose the logo to represent the unit. The logo chosen will be introduced in the December issue of Entre Nous.

Dominique Dalsgaard
June, 1990

COVER STORY

A new era begins: an official statement by Romanian Vice-Minister of Health Professor Bogdan Marinescu

Dr Bogdan Marinescu, Vice-Minister of Health, is responsible for mother and child care, prevention and care in schools and universities, and the newly created Family Planning Unit. The repeal, on 25 December 1989, of the law on abortion created the legal environment for the implementation of a national family planning programme. The new family planning programme will be offered to all women who want it. Special attention will be given to women having an abortion.

The primary objectives of the overall family planning programme of the Ministry of Health consists of decreasing maternal mortality and morbidity caused by abortion and facilitating the switch from using abortion techniques to modern contraceptive techniques.

The programme will attempt to answer the immediate needs identified in the following framework outlined by the Ministry of Health.

- Education of, the public and specific groups at risk, such as adolescents. It will also disseminate accurate information to the public and health professionals. The Society will not develop its own clinical services. It will work in close collaboration within the government programme, and is fully supported by my Ministry.
- The family planning programme will be progressively established, starting with the university teaching hospitals, and spreading to district and town hospitals, then polyclinics.
- Only obstetricians and gynaecologists will be allowed, at least during this first phase, to prescribe contraceptives. The new contraceptives introduced in the programme consist mostly of combined pills, IUDs and barrier methods. At this stage, it seems essential to disseminate written information on contraceptive technology to all health professionals involved. The counselling part of the programme in family planning ser-
A brighter future for three million Romanian women?

Twice the number of prematurely born children as in other European countries, high rates of maternal mortality, a ten-year ban on the import of condoms, women who have had ten abortions... A special correspondent for Entre Nous accompanied the most recent WHO mission to Romania. Anne Jeanblanc, medical journalist on the French weekly "Le Point", catalogues the human misery caused by the rule of Nicolae and Elena Ceausescu and describes the progress already made in the family planning field since the December popular uprising.

Up to the age of 45, every Romanian woman had to have five children. They had to be under the age of 18 or not working. These were the requirements of the law enacted by Nicolae Ceausescu in 1972. As a result of this pronatalist policy there was no population increase, an exceptionally high maternal mortality rate, principally due to the consequences of clandestine abortions, and a strikingly high number of children placed in "State day nurseries".

With 162 deaths per 100,000 live births in 1988, Romania has a depressing record. In the course of that year alone, there were 380,000 births and 519 maternal deaths, of which 505 were linked to voluntary abortions. This means that the abortions were responsible for 85.3% of maternal deaths, perhaps even more. The exact number is unknown, for women only reported to hospitals when there was a problem, and certain gynecologists did not declare the pregnancies diagnosed and classified the complications of clandestine abortions under the category of gynecological problems.

Before the revolution there were some cases of authorized abortions. They had to be justified by the state of medical health of the mother (fetal malformation, or genetic problems. But because of the number of procedures that had to be undertaken and the inertia in the administration, legal deadlines were often overturned when official approval finally arrived. Numerous unwanted babies were born as a result. These children often have a lower-than-average psycho-affective motor and school development.

A further consequence is that a large number of children were put in places known as "LEAGAN" which means cradle. Of these children who live outside their family home there are 13,000 in Romania and 1500 in Bucharest. The number of State day nurseries designated to accommodate these day-old to three-year-old infants has grown from one to five in the course of the last 15 years.

On December 25 1989, in order to combat the effects of Ceausescu's policies, the Front for National Salvation legalized abortion up to the third month of pregnancy. This was, chronologically, the second law modified by the new regime which hopes, in this way, to see a rapid fall in the rate of maternal deaths. According to estimates, this should soon consist of between 20 and 29 deaths per 100,000 births, or even fall below the 20 per 100,000 mark.

At the moment, Professor Bogdan Marinescu has responsibility for everything concerned with abortion. The professor, a gynecologist and obstetrician and son of a former minister, who resigned from the previous government, is one of the three vice-ministers of health. He is also in charge of mother and child care, school and university health care, as well as the creation of the new department of family planning.

A project on contraception has now been worked out and set up in the 41 districts of the country. If the aid already sent by numerous countries and different organizations continues to arrive, Romania will have access to a sufficient quantity of contraceptives. Condoms will then be provided for the population. (The threat of AIDS is closely linked to this decision.) Women will be able to ask their gynecologists for blister packs of contraceptive pills or to have IUDs inserted. This involves more than three million Romanian women.

Dr. Bogdan Marinescu

Vice-Minister of Health

Bucharest

Romania
How a restrictive abortion policy affected child mental health

Since 1974 Dr Maria Grigoroiu-Serbanescu of the Bucharest Institute of Neurology and Psychiatry and her colleagues have been doing research on psychological development, psychopathological risk and the epidemiology of psychological disorders in children. In post-revolutionary Romania the opportunity now arises to make explicit the link between restrictive abortion and child mental health.

Over the past 22 years Romania has been one of the countries in the world with the most restrictive abortion legislation. It has fallen to gynecologists, pediatricians and the judicial authorities to have seen the immediate fallout of the 1967 decree outlawing abortion as well as its after-effects. Specialists working in the field of mental health research and genetic counselling have observed the aftermath.

A first consequence of the restrictive abortion legislation was an increase in the premature birth rate. In 1974, when we began the seven-year follow-up study of 540 premature children chosen randomly from the maternity homes of a district of Bucharest, this stood at 16%, compared with rates ranging between 5% and 8% in the industrialized countries of Western Europe. The neuropsychological follow-up of these children showed delayed intellectual, emotional, motor and language development by the age of three when compared to a group of full-term children. In small preterm children (with a gestational age lower than 33 weeks) and especially in very small preterm children (with a gestational age lower than 29 weeks) developmental deficiencies persisted (statistically) until the age of seven. This led to poor school adjustment. Young couples did not want to have children at the very beginning of their marriage but they were denied legal abortion, sometimes even if they already had a mentally retarded child. Before 1973 there was no genetic counselling for mental disorders in Romania. Genetic counselling for psychological disorders was initiated by Dr D. Christodorescu at the Institute of Neurology and Psychiatry in Bucharest in 1975. During the last ten years genetic counselling was less and less taken into account as abortion became more and more restrictive.

A retrospective study performed by D. Christodorescu et al (1977) on the incidence of Down’s syndrome in Bucharest found a higher incidence of this genetic disorder accompanied by mental retardation in the cohort of liveborn children between 1969 and 1973 (127) than in the cohort of liveborn children between 1961 and 1968 (89).

Moreover, when comparing the distribution of Down’s children by age group of the mother, there was a dramatic increase of the percent of Down’s children born to young mothers aged 20-25 over the period 1969-1973 (21.2%) as against the period 1961-1968 (7.8%). The number of young mothers (under age 30) who gave birth to children with Down’s syndrome during the period 1969-1973 increased by 10% as compared with the period 1961-1968 (40% versus 30%).

Another study provided information connected with the consequences of restrictive abortion. This was the nationwide study on the epidemiology of psychological and neuropsychological disorders in children aged 1-16 performed between 1981 and 1984 (D. Christodorescu, M. Grigoroiu-Serbanescu, 1984). Fifteen thousand three hundred children randomly selected from 20 representative counties of Romania were investigated psychologically and psychiatrically. Four sources of information and the DSM-III diagnostic criteria (1980) were used.

The study showed a frequency of mild mental retardation (IQ 50-70) of 3.75% in boys and 3.46% in girls aged 10-11, whereas expectations under the normal distribution of the intelligence (Gaussian distribution) would have been around 2.2%. Many of the mothers of the retarded children did not want the pregnancy from which these children resulted.

The mild mental retardation found in Romanian children was comparable with the figure reported by Nichols (1984) for socioculturally disadvantaged children in the USA. The high prevalence of the mild mental retardation in children reared by their families could simultaneously be explained by unsuccessful attempts at illegal abortion, sociocultural and genetic factors.

I have studied children at psychopathologic risk because of major affective disorders (manic-depressive disorder and endogenous unipolar depressive disorder) present in one of the parents. These studies provided another opportunity of noting the effects of the restrictive decree on abortion. The disorders in question were included among the conditions that allowed a legal abortion. However, because psychiatrists working in clinical practice were afraid of a variety of punishments, they avoided sending patients to seek genetic counselling at our institute and to obtain abortions.

In recent years, even with genetic advice, abortion was postponed until the time when it was too late. Among the many cases of denied abortion seen in practice and research I remember two poor families in which one of the parents had a severe endogenous depression. In each of them there were already four children (because nobody had explained to them that they were allowed to have an abortion). When the mothers underwent a fifth pregnancy, abortion was postponed for so long that they had reached the seventh month of pregnancy. In both these families the first born children had already shown psychopathology at adolescence. Yet the families were compelled by a very restrictive and punitive legislation to have a fifth child which was liable to psychopathologic risk for two reasons: the genetic loading of the parental illness and the poor sociocultural conditions.

In the course of the last 22 years no publicity has been given to the risk of transmissibility of the major psychological disorders. The views of specialists in psychiatric genetics and research findings were never considered in official decisions about population growth in Romania.

Dr Maria Grigoroiu-Serbanescu
Institute of Neurology and Psychiatry
505 Berkeni 10
O.P.61, C.P. 6180
R-75622 Bucharest
Romania
We end our news reports from Romania with Cristina Neagu's hopeful report

In Romania, as a result of the 1966 law forbidding abortion, the use of all contraceptive methods was considered a serious crime and punished by imprisonment. In this situation, the only solution for women was self-induced abortion, which has been the cause of thousands of tragedies for the Romanian population in the years since the law was enacted.

The repeal of the law on 25.12.1989 which became effective on January 1990, facilitated the legal basis for the establishment of family planning activities and the introduction of various methods of contraception in Romania. After the visit of a team of specialists from the UN, WHO and IPPF, the Obstetric-gynecological clinic of Bucharest set up a consultancy in family planning. As no information on the subject has been supplied up to now by the news media the only means of starting up this activity was to bring up the subject with women who had asked for abortions at the Giulesti Clinic.

We began this work on 27 February 1990 and up to the time of writing (17 March 1990) we have registered 107 women who have agreed to family planning and contraception. We began by having discussions on family planning, on methods of contraception, with each individual woman. Afterwards we made out medical cards containing social data, previous hereditary, personal psychological, physiological and pathological history, and previous obstetric and gynecological history. The women were clinically examined. We found numerous examples of cervical lesions for which we recommended further investigations: cytopathological examination of vaginal secretion, Papamicoau cytodiagnostic examination, colposcopic examination, recommending that these women return at a later date to specify the contraceptive method to follow.

We noticed that of the total of 107 women, the number asking for sterilization was only six. These were women aged between 36 and 40, mothers of four to five children, whose previous history included numerous abortions. In the case of the remaining women the choice of contraceptive method coincided, in most cases, with their own choice, so that we recommended the IUD to 47 women and the contraceptive pill to 35. Nineteen women, on request, were given diaphragms as well as two tubes of spermicidal cream per person. From 12 March 1990 we began the application of the first IUDs of the Multi-load Cu250 and we noticed that the IUDs were easily fitted, and well tolerated without loss of blood or pain. To confirm the tolerance we recommended that the women returned to have a check-up a month later.

To the women who preferred the pill as a contraceptive method and who presented the necessary medical indication, we recommended the administration of three cycles of pills. We recommended that the women returned for a check-up after three months. As for the group of 19 women to whom we had recommended the use of a vaginal diaphragm with spermicidal cream, we noted the ease with which these women learned to use the diaphragm and we asked them to return at the end of the month.

This experience is limited, but the number of consultations is rapidly increasing, and we are quite hopeful that the women seen will prefer the advantages of modern contraception compared to abortion.

Dr Cristina Neagu
Assistant Lecturer and OB/GYN Specialist
Giulesti Hospital Clinic
Faculty of Medicine of Bucharest
Bucharest
Romania

No essential changes reported in Danish teenagers' sexual behaviour

At the March 3 conference "Can the Abortion Rate Be Changed?" reported elsewhere in Entre Nous, gynecologist Hanne Wielandt presented the results of two surveys carried out in 1984-85 and 1989. The most recent was designed to check the effect of Denmark's "Safe sex" campaign. Representative samples of 286 and 359 young women and 336 and 400 young men over 16 but under 21 years of age were personally interviewed. The reply percentages were 75.3 and 77.9 for the young women and 77.8 and 76.3 for the young men.

Age of first intercourse is, in general, identical for both women and men, that is to say just under 17. Children of one-parent families have their first intercourse earlier than children who have grown up with both parents. The number of sexual partners of young women—an average of three to four—has been on the increase and is now almost the same as for young men. Sexual activity among teenagers has been rising in the last decade, but intercourse is largely restricted to the age group the young people themselves belong to. No essential changes in sexual behaviour in the course of the five-year period were reported. The age distribution of first intercourse, for example, was unaltered.

Most (80%) used some form of contraception during the first intercourse, either condoms or pills. The use of contraceptive measures was, however, correlated with age in that almost one third with an earlier sexual debut (before age 15) had not used contraception. Among the sexually active young women, almost half (46%) took the pill. Changes in contraceptive use can only be described superficially, as the data has not yet been analyzed in detail. Only 11% of young people in 1989 did not use contraception at first intercourse. Nearly all (96%) thought it was acceptable for a young woman to have a condom with her, and 86% had experimented with condoms.

Further details available from Dr Hanne Wielandt, Department of Social Medicine, University of Odense, Campusvej 55, 5230 Odense M, Denmark

The test is positive

In the afternoon of the same conference a new half-hour film produced by the Danish Family Planning Association was shown. Titled "The test is positive", it followed the course of a young couple's decision to have an abortion. The film was warmly received by the audience, who praised its openness and sensitivity.

Further details available from the Danish Family Planning Association Auretoejevej 2, 2900 Hellerup, Denmark (Tel. 31 22 52 88)

Where do young people in Bucharest obtain information on sex education? Entre Nous received this mini-report from Drs Dimitrii and Michaela Nana

The gynecological problems of adolescents are diagnosed and treated in classic fashion at the obstetric and gynecological departments for adults.

Dr Nana surveyed 488 young people aged between 14 and 18 from five Bucharest secondary schools.

Preliminary results indicate that most young people have satisfactory basic knowledge of physiology and personal hygiene. On the other hand they are totally ignorant about sexually transmitted diseases. Their sources of information are, in declining order: family and friends, magazines, school, and at the end of the list, medical staff (2.4%).

As a result of this survey Dr Nana opened the first clinic for adolescents in Bucharest.

Epidemiological situation in Romania

In an interview with Entre Nous on 26 February Dr Michael George of WHO Regional Office for Europe reported the following epidemiological situation in Romania as of 1 February. Fifty children and 24 adults have AIDS. Five hundred children and 118 adults are HIV positive.
November’s IPPF Openfile. Georgeanne Neamattall and John M. Pile will be posted as assistant directors in the organization’s Asian and North African Regional Offices respectively. Eileen McGinn will replace Neamattall in the New York headquarters as programme manager for Asia. AVSC is a non-profit health organization committed to the availability of effective voluntary sterilization for men and women who want it. It works in the United States and in over 40 other countries around the world.

Global contraceptive use on the rise
Half of all couples of child-bearing age may now be practising some form of contraception, says the United Nations in a recent major assessment that estimates the level of contraceptive use by region and country. Projecting the data results, the study found that surgical sterilization continues to be the world’s most popular form of contraception with 36% of the world’s population favouring it. The IUD comes in second place (19%). The survey reflects the durability of a world-wide trend, already observed in earlier studies, towards rising use of contraception and declining fertility. The study concludes that for the world’s population to reach no higher than 8.5 billion in 2025, global contraceptive use will have to rise from the approximate figure of 50% to 72%. In Africa, where prevalence is lowest, this would imply a rise from 14 to 66%.

The FHE programme
Dr Angelo Petros-Barvazian has worked for WHO for 23 years. For the past 14 she has been Director of the Division of Family Health (FHE), in WHO headquarters, Geneva. The division is one of the largest and most dynamic in WHO.

It is responsible for numerous programmes: mother and child health including family planning, adolescent reproductive health, nutrition, women and development, and the Safe Motherhood Initiative.

Dr Barvazian also represents WHO at numerous national and international congresses and conferences. She is the focal point at WHO Geneva for collaboration with UNFPA (United Nations Fund for Population Activities) and the programme for women, health and development.

She has a staff of 23 professionals. They include medical officers, technical officers, public health administrators, statisticians, scientists, administrators, and nurse-midwifery educators. Their work involves support of national programmes and developing multiple projects.

The Division places its main emphasis on management and evaluation, the provision of information on family planning technologies, research (specifically in maternal mortality and adolescent reproductive health). The support of the division may be technical or financial, or both.

Dr Petros-Barvazian and her colleagues are not often to be found in their offices in Geneva. They criss-cross the entire world, and take particular interest in the poorest countries. Dr Petros-Barvazian took half an hour out of her busy schedule to talk to ENTRE NOUS in March.

Dr Petros-Barvazian, could you give ENTRE NOUS a brief sketch of your international career?
It all started in 1967. At that time WHO was becoming more involved in reproductive health and family planning. There had been a number of discussions and several resolutions had been passed, in particular on the importance of family planning as a health measure. For a period of two years before 1967 I had been receiving a series of letters from WHO asking me if I was interested in joining them.

What was your position at that time?
At that time I was in Iran. I was Director of Special Health Services for the Southern Region of Iran. Special Health Services covered a huge programme. It meant MCH (mother and child health), dental health care, nutrition, family planning, mental health and school health.

And all this was a part-time job because my full-time job was teaching in the Department of Pediatrics in Shiraz Teaching Hospital. I had an appointment there in Pediatrics and I had started a department of community medicine. It was not till 1967 that I received a very thick letter in which I was asked very specifically to give a summary of what I had done in the field of public health planning. I realized that WHO wanted me not only for my mother and child health, but for my public health experience. Their intention was to have someone with family planning experience to start a programme. At the time I had decided to take a year off for further studies, maybe two. So then, I said, yes, all right, I’ll go to WHO for a year or two. I came in April. At that time I didn’t have a permanent appointment. I was a medical officer attached to Mother and Child Health. There were only two of us in the unit here in Geneva. And then my boss fell ill, so immediately I had to see about doing all the work for the health programme. When I first arrived, I’d been told that I should just listen for six months and look around. The tasks at WHO were too complicated, they said. Well, in my second week, I found myself examining the total budget for 1968. I was already trying to see what the whole organization was about. I was doing a little evaluation for myself. And I discovered that the WHO budget for 1968 was 58 million dollars.

Back in those days WHO had all the activities and all the projects in the book, mainly in environmental health, in MCH, in nursing... all over the world. Then I thought this organization must have something beyond purely financial support. Because I knew what research programmes cost, and how much it was to fund a project. And if in one country alone one project cost 58 million, how could WHO carry out a worldwide programme for practically the same amount of money?

Then I thought this organization must have something else, something unique. And so I set out to see for myself what that was. And it was that something else which made me think that this was the kind of organization that I would really love. I would put all my efforts into it.

And so here I am after 23 years. I have very much enjoyed all my work throughout the years. Bringing all countries, all nations together, helping each other, having the strength of one used by the others, learning from each other — that’s what’s unique to this organization.

That’s the something else, the great reward for working for WHO? Absolutely.

Are there any frustrations, perhaps?
Well, I think in big organizations you expect to have difficulties with the bureaucracy, but I must confess that I have always believed that having a big organization is a big support. You can change the things that people think of as obstacles into opportunities and support. It all depends upon your own attitude of mind. If you can always stay optimistic and positive, you won’t experience the frustrations. There may be small ones here and there. But then not to have that sense of frustration one must learn not to seek an im-
BACKGROUND

Romania ends compulsory childbearing

Henry David, a long-time observer of Romania's pronatalist policy, tells the full story

The American public was shocked, following the fall of Nicolae Ceausescu's regime in Romania, by revelations of the terrible human toll resulting from Romania's suppression of access to contraception and safe abortion. The general outlines of the story had for some years been a concern of professionals following demographic developments in Eastern Europe. Now that the fallen regime's abuses have come to public attention, further details of the policy are becoming more widely known.

For 23 years, Romania obsessively pursued the world's most rigidly enforced pronatalist policy. One of the first actions of the fledgling transitional government was to revoke, on 25 December 1989, the Ceausescu laws and decrees that banned the importation and sale of contraceptives, strictly prohibited most abortions, required monthly gynecological examinations of all working women 20 to 30 years old, and imposed a tax on childlessness.

Institution of these laws and decrees began after Ceausescu came to power in 1965. At that time the birth rate had declined to 15.6 per 1,000 population (from 25.6 in 1955). Suddenly, without prior warning, in October 1965 the availability of abortion on request was restricted to women who were over 45 years old, who were already supporting four or more children, whose life was endangered by pregnancy, or who met criteria for very narrowly defined medical conditions.

Ban on contraceptives and prison for abortion

The importation of contraceptives was prohibited, divorce became very difficult to obtain, and strict punishment was imposed on illegal abortion. As one result, the birth rate rose to 27.4 births per 1,000 population in 1967 but then gradually declined again to a new low of 14.5 in 1983. At the 1984 Party Congress Ceausescu announced a goal of achieving a birth rate of 20 per 1,000 population, which, if attained, would increase the population to 30 million by 2000. As lax policy enforcement gave way to renewed drives against illegal abortion, the birth rate rose to 15.5 in 1984 and 15.8 in 1985.

Meanwhile the maternal mortality rate increased from 86 maternal deaths per 100,000 live births in 1966 to 140 in 1981 and nearly 150 in 1984, when 86% of maternal deaths were attributed to abortion (according to official data reported to WHO). In 1986, Ceausescu proclaimed that "the fetus is the socialist property of the whole society. Giving birth is a patriotic duty, determining the fate of our country. Those who refuse to have children are deserters, escaping the law of natural continuity".

Access to legal abortion was further restricted. Having four children was no longer sufficient grounds for abortion on request. The requirement was raised to five children, each of whom had to be under age 18. This meant that, for some women, even having five living children might not be enough to obtain a legal termination of an unwanted pregnancy.

District demographic committees were organized to supervise pregnant women. At the same time, recommendations for pregnancy termination based on previously acceptable medical-legal criteria for fetal abnormalities or on genetic counselling were increasingly ignored in the processing of abortion applications. A special unit was established within the Romanian State Security Police (Securitate) to investigate allegations of illegal abortions. Securitate representatives were posted in every maternity ward and obstetrical/gynecological clinic or service. Physicians were confronted with prison terms of up to 12 years and loss of the right to practice medicine. Self-induced abortion became punishable by imprisonment from six months to two years or by payment of a fine. Reports appeared in the press of criminal proceedings, trials and sentences imposed.

Contraceptives were available only with a physician's prescription, in cases where there was well-defined evidence that a woman's health would be greatly endangered by a pregnancy. Importation and sale of pills, IUDs, condoms, and other contraceptives were prohibited. Black market condoms were said to cost one day's wage. Permission for sterilization could be granted by a special medical commission only in cases where the woman would also meet the very stringent criteria for legal abortion.

Monthly gynecological examinations

Employed women up to age 45 were asked to undergo monthly gynecological examinations in their workplaces. Those who refused to appear, or who could not provide a medical certificate of exemption, were denied their rights to dental and medical care, pensions, and social security, and were also declared ineligible to spend their holidays at the resort maintained by their workplace. Whether or not factory physicians received their full monthly salaries depended on plant employees achieving a state-stipulated monthly birth quota.

District demographic committees supervised the mandatory quarterly pregnancy tests for all women 20 to 30 years old. Unmarried persons over age 25 were assessed a special tax of 10 percent of monthly salary. If after two years a marriage was childless and there was no medically certified reason for infertility, each partner had to pay extra taxes.

The demographic effect of the strictly enforced policies is not known. As of January 1, 1986, birth registrations for 1985 and 1986 had not been published by the Central Statistical Office or reported to the United Nations. Total fertility rates have not been available since 1983. However, a 30-day delay was imposed on birth registration in an effort to avoid acknowledging infant deaths occurring in the first month of life, as a statistical ruse to reduce the infant mortality rate.
Nosocomial transmission of the HIV virus in the Soviet Union and Romania

There are fewer AIDS cases in Eastern Europe compared to Western Europe. There are however some specificities in the chain of infection. The cases of the USSR and Romania are unique in Europe. Dr. Alexandre Gromyko, Medical Officer in the Regional Programme on AIDS in WHO EURO, has documented these alarming findings of AIDS cases caused by nosocomial infection in the USSR and Romania

1. The case of Elista

At the end of 1988, a woman living in Elista, a city in the Kalmykian Autonomous Republic of the USSR, decided to give blood to a woman friend. In the USSR, all blood donations are tested obligatorily. As a result of this practice, HIV serosity was discovered when she was tested.

Elista lies in the steppes between the Black Sea and the Caspian Sea. It is at least 500 kilometres from other major cities such as Rostov on Don and Volgograd. The local health authorities were greatly surprised to find an HIV-infected person in such a remote area. Then, almost at the same time, a child in a children’s hospital was also found to be HIV-seropositive. When the woman donor and the mother of the child met and recognized each other in a doctor’s surgery it became evident that the woman donor’s child had died a few months earlier in the same hospital where the HIV-infected child was found.

At that time, of 16,000 donors in Kalmykia, no HIV-seropositive donors had been found. No other seropositive persons were known in the area apart from the child already mentioned. Since both women had been hospitalized with their children a few months earlier in the same hospital it was postulated that the infection might have occurred in the hospital. The first tests among other children hospitalized at that time revealed several seropositives.

The investigation gets under way

A thorough epidemiological investigation was launched with the participation of scientists, epidemiologists and clinicians from the Moscow Central Institute of Epidemiology, the Ministry of Health of the Russian Federation and local public health staff.

All children who had been hospitalized in two children’s hospitals in Elista since January 1988, their parents, the parents’ sexual partners, blood donors, and medical personnel were identified. They were tested for HIV infection. Seropositive analyses were done on medical equipment used for parenteral injection. More than 140,000 persons were tested in connection with this outbreak. The following were found to be seropositives: one man, 11 women (including mothers of hospitalized children), 75 infected children in the following age groups: 0-1 (49 children), 1-2 (9 children), over two years (17 children).

The husband of the donor whose child had died in the hospital in April 1988 was found to be the only HIV-seropositive man in this remote area of the USSR.

Identifying the chain of transmission

Retrospectively, after the detection of all HIV-infected children and adults, a chain of transmission was identified. In 1981, a male citizen of the USSR had returned to his home town of Elista. He had just completed a one-year contract in the Republic of the Congo. While there, he became infected with HIV. He got married and infected his wife. The infection was transmitted to their child who was hospitalized in a children’s hospital in Elista and died there. Although it has not been documented that the child was infected with the HIV virus, the entire scope of the epidemiological investigation suggested one central finding: this was the index case of HIV infection which spread to other children in Elista and later to other cities in the USSR.

While in the hospital the child was in a reanimation ward, and with other children in the ward, received multiple injections of various medications. In a number of children, in order to administer multiple intravenous injections, a catheter had been inserted into the tibial veins for ten or more days.

Several children were given drug injections with the same syringe. After the drugs had been administered through the catheter, a small portion of blood was drawn into the syringe to verify that the catheter was still in the vein. Various intramuscular or subcutaneous injections were performed with the same syringe. Only the needles were changed, not the syringes.

The infection spreads further

All the hospitalized children were suffering from very serious infections or other diseases. They required multiple injections of various drugs. As a result, those children who were hospitalized at the same time as the index case became infected. Later the infection continued to be transmitted to other children whose period of hospitalization had partly overlapped with those who had previously been infected. In this way it continued to be spread for several months. It was only in December 1988 that the outbreak was discovered. During the April-December 1988 period some children were cured and left the hospital. Subsequently, however, when their illness worsened, they were hospitalized in other hospitals in Elista or in other cities. In this way, the infection spread to three more cities (Volgograd, Rostov-on-Don, Stavropol). All of them were more than 500 kilometres from Elista. As a result of these outbreaks there are now more than 200 HIV-seropositive persons detected in the entire USSR.

---25.6 infant deaths per 1,000 live births were reported in 1985.

Overcrowded orphanages

Western media recounted that young women were increasingly abandoning unwanted babies in overcrowded orphanages. Until recently, couples from Belgium, France, Israel and Italy were permitted to adopt babies in exchange for hard Western currency. When asked about the lack of official statistics on fertility, a Romanian colleague at the 1989 IPPF Regional Meeting in Varna quietly commented, "No numbers: no problems."

A January 1990 broadcast from the Municipal Hospital in Bucharest noted that condoms and other contraceptives are again imported and abortions are being performed at a cost of about $3 per procedure (compared to $50 and up for previously illegal abortions).

Currently, about 2,500 abortions per week are performed in 12 Bucharest hospitals. Women are still coming to hospitals for treatment of complications of self-induced abortions; they were not aware that abortion is now legal. Plans to implement a national family planning program are being developed in cooperation with WHO Regional Office for Europe.

Note: Cited demographic data, based on official government statistics, and other information have been reported in issues of Abortion Research Notes, published by the Transnational Family Research Institute. This article was originally published in the March 1990 edition of Population Today, to whose editor we extend our thanks for permission to reproduce.

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Dr Henry P. David
Director
Transnational Family Research Institute
8307 Whitman Drive
Bethesda, MD. 20817
USA
Nosocomial transmission
of the HIV virus in the Soviet Union and Romania

Summary of Epidemiological Investigations

White: seronegative
Black: seropositive
Squares: males
Large circles: females
Small circles: children
Arrows (straight and dotted): HIV transmission
Straight lines: sexual relations
Lines with crosses: transfer from one hospital to another

OUTBREAK OF HIV-INFECTION:
ELISTA, USSR

1988 APR

1989 JAN

HOSPITAL 1

HOSPITAL 2

1988 APR MAY JUN JUL AUG SEP OCT NOV DEC 1989 JAN
A similar incident of nosocomial transmission of HIV was detected in 1989 in Romania. As the epidemiological investigation of this outbreak is still in progress, the full extent of the epidemic is not yet known. However, as of February 1990, 650 cases of HIV infection, ARC or AIDS had been reported to the Romanian Ministry of Health. Of these 539 (83%) were children under four years of age. One hundred and twenty-one of these children have died. This is equivalent to 22%.

The first cases were reported in 1985. Six hundred and five or 92% of the cases have been reported since 1 January 1989. Four districts account for 87% of the reports. Constantza has reported 295 (46%) cases, Bucharest 137 (21%), Giurgiu 76 (12%) and Vrancea 56 (8%).

Preliminary results of the investigation have shown that some of the infected children received the virus from microtransfusions of blood which had not been tested for the presence of HIV. For example, 37 blood donors in Constantza whose blood had been given to the children were retrospectively identified and tested for HIV. Seven of them were found to be HIV-seropositive. The microtransfusions of blood were given to children in hospitals because many of them were malnourished and did not respond to therapy with drugs. These microtransfusions were supposed to serve as immune stimulators, as a source of basic proteins and iron.

As a result of the acute shortage of all kinds of sterile medical equipment, especially the lack of syringes and needles, and frequent electricity cuts, infections in hospitals continue to spread further.

At the present time, the Ministry of Health, with assistance from WHO, is continuing epidemiological investigations in all orphanages and children's hospitals. All children aged from 0 to 3 who were hospitalized for some period of time during the last three years are being HIV-tested. It is expected that the infection will be present in several orphanages of the districts mentioned above. Romania is in acute need of basic materials to treat and manage perinatal AIDS cases and HIV-infection among children. WHO has mobilized international support for Romania to improve health in general and to prevent the further spread of HIV in particular.

Even though Romania is an exceptional case, these incidents show that there is no room for complacency. Just a small portion of an infected blood supply has the potential for rapid spread. AIDS disasters can happen anywhere.

A. Gromyko, M.D.
Medical Officer
Regional Programme on AIDS
WHO Regional Office for Europe
Scherfigsvej 8
2100 Copenhagen 0
Denmark

2. The children of Constantza

In its development from abortion to contraception, the Hungarian practice of modern contraception provides us with a textbook case. Ferenc Kamarás, Hungary's leading fertility statistician, reports

In Hungary between 1956 and 1973, at the request of the women themselves, practically all abortions were authorized. From 1974 onwards the authorization process has been restricted to a certain extent. For women under 35 years (since 1980 under 40 years) abortion was automatically authorized in the case of three previous obstetric events. Social and health reasons, however, play a considerable role in the decision.

The number of legal abortions reached its peak at the end of the 1960s. At that time every second known pregnancy ended in abortion. There were 130 abortions per 100 live births and the value of the total abortion rate (TAR) was equal to 2.7 per female. In other words, if the abortion practice of that time had become stable, then every woman would have undergone an average of 2.7 abortions in the course of her reproductive life.

At the beginning of the 1970s the number of abortions began falling. The fall was moderate at first but since 1974, it has been significant. The restriction of the abortion law mentioned above naturally also played a role in the decrease of about 40 percent. The yearly number of abortions was lowest at the beginning of the 1980s. At that time there were 55 abortions per 100 live births and the TAR was equal to 1.0 per female. Since the middle of the 1980s the number of abortions has been growing moderately but continuously and by 1989 it was about 15 percent higher than at the beginning of the 1980s.

How family planning sample surveys tell the story

Family planning sample surveys most clearly illustrate the relationship between the development of abortion and the population's attitude to birth control.

In the 1960s abortion was a widespread method of birth control. At that time contraception methods effective in the present sense were not yet available (pill, IUD). More than half of the females underwent an abortion in the course of their lives. The ratio of repeated abortions was also high. Coitus interruptus and the condom were the two most popular contraception methods. In other words, it was mostly men rather than women who used contraception methods. A change occurred in 1967 when the first oral contraceptive was introduced. In the beginning it could be used only under medical control, but in spite of this, its use increased rapidly. In the early 1970s as many as one quarter of married women took oral contraceptives. This fact certainly played a role in the decrease in the annual abortion figures. Between 1969 and 1973 the number of abortions fell by about 20 percent although the legal rules did not change.

In 1974, in parallel with the restriction of the authorization of abortion, all females over 18 years could buy and use oral contraceptives without medical supervision. It is therefore difficult to state to what extent the approximately 40% decrease in abortions can be attributed to the change in the legal rules, and to what extent to more effective contraception. It is a fact that the use of oral contraceptives continued to grow. In the mid-1970s 35% of married women under 40 years took oral contraceptives. In the second half of the 1980s the figure was nearly 40%. In this way Hungary led the world in the use of oral contraceptives.

From the mid-1970s onwards the use of intrauterine devices began to accelerate. This can be partly ascribed to the fact that a proportion of the women could not take oral contraceptives for health reasons or because of the appearance of side-effects. Over a period of ten years the use of IUDs doubled and from the mid-1980s onwards one fifth of married females under 40 years were using IUDs. In Hungary the use of the condom was never "popular". This can be partly attributed to the fact that in Hungary condom production and supply were not continuous, and that imported condoms frequently failed to meet demands of quality control. At present only 3-4% of the families use condoms for contraception. In the case of unmarried females with male partners this ratio is almost certainly much higher.

Fewer abortions among married women — but still an unsatisfactory situation

Thus contraception practice has changed considerably in the last few decades. Its effect can be illustrated best by saying that at present one quarter of the married women use abortion as a birth control method. This ratio is half of what it was in the 1960s but it still seems to be high given the use of effective contraceptives. The number of repeated abortions also fell considerably. Thus after six years of marriage there were 28 abortions per 100 married women at the end of the 1980s. Twenty years earlier this number was equivalent to 67 after a similar duration of marriage.

If we take into consideration the possibilities and practice of effective contraception we can say that in Hungary the abortion situation is not satisfactory. Even now, more than one third of known pregnancies end in abortion. Compared to the situation in Western Europe the Hungarian ratio is very high. The reasons lie in the contraception culture, in the lack of health education, especially among young people. At present unmarried females have more abortions than married ones. Abortions among unmarried women
women represent one third of the total number of abortions and this ratio shows an increasing trend. This also plays a role in the growth in the number of abortions observed since the middle of the 1980s. The non-married young females deserve special attention because among them the abortion rate grew more than the average for recent years. At present the contraception culture and practice of teenagers and young unmarried persons falls well below a desirable level. Some progress should be seen in the near future, chiefly concentrated in this field.

Table 1
Development of the ratio of induced abortions by age-group of females (per 1000 females)

<table>
<thead>
<tr>
<th>Years (average of years)</th>
<th>Age-groups</th>
<th>Total abortion rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1969-1970</td>
<td>39</td>
<td>128</td>
</tr>
<tr>
<td>1973</td>
<td>38</td>
<td>102</td>
</tr>
<tr>
<td>1975</td>
<td>26</td>
<td>52</td>
</tr>
<tr>
<td>1980</td>
<td>26</td>
<td>39</td>
</tr>
<tr>
<td>1985</td>
<td>27</td>
<td>43</td>
</tr>
<tr>
<td>1988</td>
<td>26</td>
<td>47</td>
</tr>
</tbody>
</table>

Table 2
Distribution of 15-39 year old married females by birth control methods

<table>
<thead>
<tr>
<th>Years</th>
<th>Of hundred 15-39 year old married females</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Those who control the number of their childbirths</td>
<td></td>
</tr>
<tr>
<td></td>
<td>only through contraception</td>
<td>only in both ways interruption of pregnancy</td>
</tr>
<tr>
<td></td>
<td>Non-users</td>
<td>Users</td>
</tr>
<tr>
<td>1958</td>
<td>21</td>
<td>17</td>
</tr>
<tr>
<td>1966</td>
<td>32</td>
<td>10</td>
</tr>
<tr>
<td>1977</td>
<td>53</td>
<td>3</td>
</tr>
<tr>
<td>1986</td>
<td>62</td>
<td>1</td>
</tr>
</tbody>
</table>

Table 3
Distribution of 15-39 year old married females using contraception
By main methods of contraception

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Natural methods</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rhythm method</td>
<td>7</td>
<td>4</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Coitus interruptus</td>
<td>52</td>
<td>63</td>
<td>23</td>
<td>11</td>
</tr>
<tr>
<td>Vaginal irritation</td>
<td>8</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>68</td>
<td>72</td>
<td>28</td>
<td>15</td>
</tr>
<tr>
<td>Mechanical methods</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condom</td>
<td>21</td>
<td>17</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Pessary</td>
<td>4</td>
<td>6</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>IUDs</td>
<td>0</td>
<td>0</td>
<td>13</td>
<td>26</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>23</td>
<td>19</td>
<td>31</td>
</tr>
<tr>
<td>Other methods</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemical methods</td>
<td>5</td>
<td>4</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Oral methods</td>
<td>0</td>
<td>0</td>
<td>49</td>
<td>54</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
<td>5</td>
<td>53</td>
<td>54</td>
</tr>
</tbody>
</table>

Total 100

Of 100 females

<table>
<thead>
<tr>
<th>Users</th>
<th>Non-users</th>
</tr>
</thead>
<tbody>
<tr>
<td>59</td>
<td>67</td>
</tr>
<tr>
<td>41</td>
<td>33</td>
</tr>
<tr>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>72</td>
<td>73</td>
</tr>
<tr>
<td>28</td>
<td>27</td>
</tr>
</tbody>
</table>
Poland's Other Thirty Years' War

Political, economic and religious forces gathering in the 1990s threaten the very existence of TRR, the Polish Family Development Association. Professor Mikolaj Kozakiewicz, President of the Association, and Speaker of the Polish Parliament, gives a frank and authoritative account of the state of the battle, and describes how the opposing ranks are marshalled.

For 32 years the Polish Family Development Association (TRR) has been waging relentless warfare. Its foes are deeply entrenched and fight on many fronts. The Polish Family Development Association or Towarzystwo Rozwoju Rodziny (TRR) was founded in 1957. That makes us 32 years old now. We don't just devote ourselves to preaching family planning, sex education and counselling. We offer practical help in these fields as well. At the end of 1988 TRR owned and ran eight medical clinics, 25 pre-marital and family counselling centres, five youth centres and six ante-natal training schools. Altogether these institutions served 140,000 patients in 1988 and a similar number in 1989. But in a number of institutions there was a noticeable decline; the number of pre-marital and family counselling centres fell to 22 at the end of 1989, and to 16 in the first three months of 1990. The reason was simple. The non-communist government of Tadeusz Mazowiecki was taking crisis measures. From January 1 onwards the Polish government suspended all kinds of subsidies for NGOs in Poland. I should add that the subsidy from the Ministry of Health amounted to 50-60% of the entire TRR budget. This measure compelled TRR to dissolve 12 local branches.

Nineteen centres and 105 local branches. It's a real disaster. In other sectors the employees had three months' notice, with the possibility of being taken on again if... If only the Ministry of Health would give us some specific tasks to do such as running medical clinics and counselling centres, or giving lectures! And if only they'd give us some kind of subsidy for doing it. In the coming weeks we'll know whether the Minister will give us jobs of this kind. Then we'll know whether we can survive. If not... It's better not to think about it. Nothing is certain these days, as everything has been changed, including the Minister of Health.

From the date of its inception the campaigning activities of the TRR led to tensions, and sometimes even to conflicts with the Catholic church. Poland's Catholic church is against legal abortions, contraception, secular, modern sex education. It's virtually against everything TRR promotes and fights for. Because of the church's opposition to modern contraception, the abortion rate is very high.

Official statistics register only the number of abortions performed in hospitals. The real extent of abortion is a subject of controversy. The church claims that the real number of abortions is one million a year. This is a ridiculously high figure, which combined with the high number of live births would place the fertility of Polish women on an African level. We estimate that the real number of abortions ranges from 400,000 to 600,000 a year, resulting in a ratio of 70 to 100 abortions per 100 live births. The powerful Pro-life organization is partly financed and supported by American Pro-life interests and partly by the Solidarity movement (which is split over the issue). Pro-life campaigns for the abolition of the 1975 abortion law. Seventy-six per cent of the population in towns and 87% in villages rely solely upon the natural methods accepted by the church.

The demand and the supply of modern contraceptives is unreliable. There have been times (1978, 1981, 1982 and 1988) when the contraceptives donated by IPPF and distributed through TRR clinics have been almost the only ones available at all.

All of Europe admires the profound changes in Poland which are doubtless very positive and promising. But for now and for the foreseeable future the profound political changes under way in Poland in 1990 may paradoxically have a negative impact on family planning and sex education. Unfortunately, Solidarity, which now rules Poland, is closely linked to the church. In its attitudes to sexuality, sex education and family planning the Catholic Church is highly conservative and not at all democratic. It is only a part of Solidarity, which is made up of many complex internal factions. But it is big enough to make a lot of trouble.

Sex education (from the age of 11) in the narrow sense of telling the pupils "Where do babies come from?" and so on, has been compulsory since 1972. But real sex education tackling the subjects of sexuality, contraception and different forms of sexual behaviour only became compulsory in 1987, under the title "Preparation for family life". This is taught in all secondary schools (15-19 year olds) for one hour every other week.

The syllabus and textbooks for pupils and teachers were prepared by TRR members and experts. Five hundred thousand textbooks were published. Originally intended as compulsory, set texts, they had to be withdrawn after violent attacks from the Catholic church, and reintroduced as an "optional aid for teachers". A new law on education threatens the very existence, the whole content of sex education. The future is overcast. We cannot even glimpse the shape of its horizons. Now our main task is to defend what has already been achieved in terms of legal abortion and sex education. The present economic situation is very difficult, and getting worse. Voluntary sterilization is still illegal. Artificial insemination is not legally regulated. As well as this, Polish doctors experimenting in this field may only use the sperm of the husband. Every "test-tube baby" born is welcomed into the world by bitter public controversy and criticism.

Seven hundred cases of AIDS were reported up to February 1990, compared to 120 in Spring 1989. A new campaign must be mounted. TRR has begun preventive action. Other NGOs have followed suit. We are also helping homosexuals to organize themselves in an open association for self-defence against all these very serious threats. The financial difficulties I have already described make it less and less possible for TRR to take action. The very real likelihood that we will disappear altogether has put a question mark against all these vitally important tasks. Let's hope that the situation will not get any worse. After 32 years of existence Polish Family Development Association must try and survive this most difficult period in its history.

Professor Mikolaj Kozakiewicz
President of the Polish Family Development Association (TRR)
ul. Piekna 11m.1
00-549 Warsaw
Poland
Why modern contraception is poorly understood in Poland: the experience of Professor Zbigniew Lew-Starowicz

- Low availability of modern contraceptive supplies on the market
- Women have a negative attitude to modern contraception
- Pressure from the Church prevents women from using the so-called "abortive" methods (IUDs). In contrast they have no trust in the effectiveness of so-called "natural" methods
- Abortion is still considered a method of contraception

Polish men on the sexual defensive

Matriarchal features stamp Polish culture. For centuries there has been a cult of the Virgin Mary. These are just two of the reasons why women play a dominant role in Poland today. Professor Zbigniew Lew-Starowicz shows that, in Poland anyway, the hen-pecked husband is rather more than a music-hall joke.

Over the last twenty years, the number of men requiring sexological consultation in Poland has shown a marked increase. In 1970, approximately 350 men turned for help to the Specialist Medical Clinic of the Family Planning Association in Warsaw. In 1989 the number was 1150. A similar phenomenon can be observed at other sexological clinics. The predominant complaints among patients were impotence (68%), hypoactive sexual desire disorder (19%) and sexual phobias (9%). In comparison to 1970, the number of men suffering from premature ejaculation had decreased noticeably while the number of men diagnosed as having sexual phobias had increased fourfold. The majority of the patients who displayed psychological causes for their disorders had completed secondary or higher education. Fifty-nine percent of the men are between the ages of 20 and 30 years, while 34% are between 31 and 40 years. They therefore represent a relatively young sector of the population. The results of research carried out on 400 marriages of 7 years and under show that 22% of men have sexual disorders of a mainly psychological character. In comparison to 1970, this means that the number of men qualifying for sexological help has doubled.

Magazine readers write for advice

For the past 20 years I have been giving sexological advice through the advice column of a magazine. An analysis of the letters I answer further supports these observations. My research allows us to conclude that the background to psychological sexual disorders among Polish men is most frequently connected to factors of partnership. These have resulted from changes in lifestyle. These are the most important conclusions:

- In Poland we have observed an increase in masculine anxieties towards women and the feeling that male roles are threatened. The growing process of female emancipation has affected this. Matriarchal features have left a lasting impression on Polish culture and lifestyle. Other factors reinforce these fears. The legal system treats women generously. Polish Catholicism practices a cult of the Virgin Mary. Women play a dominant role in the family. The powerful stereotype of the Polish mother has endured for centuries.
- From childhood onwards, women are the most influential people throughout the whole course of the development process of psychosexual gender awareness. They are mothers at home and teachers in the educational system. In the medical profession most doctors are women. Boys are either deprived of male role models or have contact with insignificant fathers.
- As sexual patterns evolve, we may observe several changes. Girls and young women have ever-increasing sexual experience. They are more demanding of their partners. The extent of their expectations is higher. When living with a man, a woman imposes on him her own scenario of a partner-like relationship. In this scenario the woman aims for and often achieves the dominant role. Married life sees a reversal of sex roles.
- The number of working women in Poland is high. The majority work full-time. Increasingly, men are no longer the proverbial head of the family.
- It is partners of similar age, education and profession who form most partner-like relationships. In this situation the woman frequently takes control and subordinates the man.
- An increasing number of men tend to have weak egos, neuroses, a lack of confidence in their sexual role. Many take the role of a child. The daily work of a sexologist confirms these conclusions. Men who are afraid of and feel threatened by women display sexual nervous disorders, anxiety about their work, a need to prove themselves to their partners, to fulfill their needs and expectations.

appointments for their partners to visit the sexologist. It is the women who make the interviews, the women who attend them, the women who make the demands for treatment and then mother their partners. Not one of these phenomena helps treatment.

Professor Zbigniew Lew-Starowicz
Specialist Medical Clinic of the Family Planning Association, Ul. Karova 31
00-324 Warsaw
Poland
Professor K-H. Mehlun, a leading international figure in the family planning world and the founding father of the Family Planning Association in the GDR, met our copy deadline despite all the exciting changes happening in his country. He provides a full account of the history and philosophy underlying government policy, and gives details of the abortion rate and the distribution of contraceptives.

These points provide a brief summary of government policy:
- Family planning is a responsibility for the whole society. It is integrated into public health services, particularly for the sake of the protection of mother and child.
- Every woman has the right to choose when she wishes to become pregnant. She also has the right to obtain an abortion as well as easy access to modern contraceptives.
- Each family has the right to determine the number of children it desires.
- Women have the opportunity, but not the duty, to reproduce.
- Each individual has the right to receive information about preventing pregnancy.
- All physicians have the duty to counsel both married couples and unmarried individuals and to prescribe contraceptives free of charge.

In May 1963 my colleagues and I founded the Family Planning Association (FPA) of the GDR. Its aims are as follows:
- to improve the health of women and mothers which may be endangered by illegal abortions.
- to provide education for marriage and family responsibilities, to support sex education for young people, to reduce the number of early marriages, illegitimate births, and divorces, and to promote the stability of marriage and the family.
- to promote the harmony, health and welfare of the family, including the use of contraceptives, and treatment of sexual disturbances.

In December 1965 the Family Law was passed. It required the Ministry of Public Health to establish the medical branch of marriage and family counseling. The institutions they set up are called Family Planning Centres (FPC), although their work is more extensive. The cooperate, for example, with communities, youth groups, women’s organizations, and public health services. In accordance with the Ministry of Health, the FPCs were integrated into the Medical Services and the staff is fully paid by the government. In 1989 there was a network of 250 centres, one centre per 10,000 women of fertile age.

The following tasks have been assigned to the FPCs:
- education towards family life and the promotion of positive attitudes towards children;
- family planning counseling and advice on contraception;
- counseling and therapy in the case of sexual disturbances;
- prevention of illegal and legal abortion by supplying contraceptive advice and by taking women into dispensary care;
- advice in cases of infertility and genetic counseling;
- treatment of medically caused disturbances in marriage.

Abortion
In March 1972 abortion in the GDR was legalized. Its provisions are as follows:

Paragraph 1: A woman has the right to decide on termination on her own responsibility. An abortion may only be carried out by a doctor in a recognized clinic within twelve weeks duration of pregnancy. The doctor is obliged to explain the risks of the operation to the woman and to advise her on contraception for the future.

Paragraph 2: A pregnancy of more than twelve weeks duration may only be terminated if there are risks to the life of the woman or if other serious medical reasons exist. The decision will be made by a commission of medical specialists.

The operation, hospital care and contraceptives are free of charge. Immediately the laws had been passed there was a fivefold increase in abortions. This "legalization effect" parallels the experience of nearly all countries after a change in the law.

The number of legal abortions decreased from 114,000 (abortion ratio 57) in 1972 to 80,000 in 1988 (abortion ratio 37.2) (Table 1). This was accompanied by a slight increase in live births. The percentage of wanted abortions related to all pregnancies was 39% in 1972. In 1986 it was 28%. In the age group 35 and older the figure is 95%.

Women with two or more children accounted for 75% of all abortions. A comparison of the abortion rates of some other countries with legal abortion shows the GDR among the countries with a relatively low ratio. One of the causes is the increasing use of contraceptive methods. Nearly 75% use contraceptives, which are free of charge and available on prescription from an FPC or a medical doctor. Since 1965 the pill users have risen to 70%. Up to the present we have not experienced a "pillcrack". The IUD takes second place with 5-10%.

Fewer than 10% of couples use condoms. Sterilization is possible only on the basis of medical indications, not for contraceptive reasons.

In 1984 Starke published "Sexual behaviour of young people under 30". He describes the age of sexual debut as 15.3 years for men and 15.9 years for women. Nearly 100% of youth had some knowledge of contraception, but only 27% made use of any method at first coitus. In this age group the permanent use of condoms is low (10%), occasionally as high as 30%. The most commonly used method in this age group is the pill (68%). Until now sex education has not been taught in schools as a result of practical problems caused by the curriculum.

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Number of live births, legal abortions and abortion rates and ratios in the German Democratic Republic

<table>
<thead>
<tr>
<th>Year</th>
<th>Total number of live births</th>
<th>Number of interruptions</th>
<th>Abortion rate per 100 live births</th>
<th>Abortion rate per 1000 women aged 15-44 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>1972</td>
<td>200,443</td>
<td>114,000</td>
<td>56.9</td>
<td>32.4</td>
</tr>
<tr>
<td>1978</td>
<td>232,151</td>
<td>80,292</td>
<td>34.6</td>
<td>22.2</td>
</tr>
<tr>
<td>1982</td>
<td>240,102</td>
<td>96,031</td>
<td>40.0</td>
<td>26.5</td>
</tr>
<tr>
<td>1986</td>
<td>222,269</td>
<td>85,387</td>
<td>38.4</td>
<td>24.4</td>
</tr>
<tr>
<td>1988</td>
<td>215,734</td>
<td>80,184</td>
<td>37.2</td>
<td>23.1</td>
</tr>
</tbody>
</table>

Note: The number of pregnancies from 1972 to 1988 increased by 8% and the number of abortions for the same period decreased by 30%.

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Professor K.-H. Mehlun Schliemannstr. 41 2500 Rostock German Democratic Republic
COMING TOGETHER

Can the Danish abortion rate be changed?

After a steady fall, the Danish abortion rate has shown a 6% increase since 1985. Can it be changed? Entre Nous attended a conference recently held in Copenhagen. Christopher Lawson reports

Of the 100 participants from every corner of Denmark a full 85% were women. The whole-day conference, jointly organized by the Danish Association of Women Doctors and the Danish Family Planning Association, was addressing a topic of particular interest to women. The audience included doctors, nurses, psychologists, midwifery teachers, lawyers, social workers, researchers, medical students and even two members of the Danish Parliament. They had gathered on 3 March 1990, in the auditorium of Copenhagen’s showpiece Herlev hospital to address a troubling theme: “Can the Abortion Rate Be Changed?”

What the figures tell us

The number of abortions in Denmark rose from 19,919 in 1985 to 21,199 in 1988, a rate of 6%. This was a worrying tendency because the previous eight-year period had shown a steady decrease from a figure of 25,662 in 1977, explained Libeth Knudsen from the Danish National Statistical Office in the introductory lecture. The trend was especially notable in women under 25. (Denmark has a very low incidence of pregnancies among teenagers - among the lowest in Europe. A high proportion of these pregnancies are terminated, so that the birth rate among teenagers in Denmark is also low.) At the same time the birth rate had climbed by almost 10%. A large proportion of Danish women want to take their pregnancies to term. Most babies born, in short, were wanted babies, and among women over 25 the birth rate has been rising steadily since 1981. Dr Hanne Risoe, a G.P. and Vice President of the Danish Family Planning Association, surveyed the situation in the rest of Europe. With the exception of individual countries such as Ireland, access to free abortion — within certain time periods and for different indications — is widespread in the vast majority of European countries. Denmark’s own abortion law was passed in 1973. There are generally very serious reasons behind the decision to have an abortion, and many experience the decision-making process as difficult and painful, said gynecologist Bo Lorey Hej from Aarhus. Although abortion for most is relatively uncomplicated, mental and physical reactions before and afterwards are rare.

Do women have a real choice? Not really, in the opinion of social worker Aase Aagaard from Odense in her wide-ranging discussion of the social, economic and ethical issues. Since the Danish abortion law was enacted in 1973, there had been few major investigations of the reasons behind women’s choice of abortion, which may often be an existential problem.

Why prenatal diagnosis is life-preserving
Senior Doctor Margareta Mikkelsen from the Kennedy Institute for Chromosome Research in Glostrup introduced evidence to answer the question “Do villus biopsies and amniocentesis affect the figures?” Prenatal diagnosis was introduced in Denmark in 1970 and the investigation of placental biopsies in 1983. The number of first trimester diagnoses rose sharply afterwards.

After a 1980 figure of 57,000 live births, this fell to a low point of 30,000 in 1983 and rose again to 58,000 in 1988. Over the whole period the number of legally induced abortions lay between 20,000 and 23,000. The number of spontaneous abortions rose from 8,000 to over 9,000. There were about 70 abortions on the basis of prenatal diagnosis of an abnormal fetus. This figure reached a peak of 133 in 1980. Women aged 35 and above have made increasing use of prenatal diagnosis, and it has been on this group that it has had a major impact. This is also reflected in the number of legally provoked abortions in the age group above 35.

After the introduction of widespread prenatal diagnosis the number of legal abortions fell. Forty-two per cent of pregnant women over 35 carried their pregnancies to term and 46% chose legal abortion. In the age group 40 and above, 18% gave birth and 66% opted for legal abortions. In 1985, 48% of pregnant women aged 35-39 carried pregnancies to term and 38 chose legal abortion. In the age group over 40, the figures were 23% and 60% respectively. Prenatal diagnosis can in fact be life-preserving, concluded Dr Mikkelsen, as there is no doubt that numerous pregnant women have risked carrying pregnancies to term because amniocentesis specified any possible birth defects.

Most Danish teenagers do know about contraception

Dr Hanne Wielandt from the Department of Social Medicine, Odense University, reported an investigation of a target group for more intensive sexual counselling. Data from 140 abortion seekers on the island of Funen (reply percentage 73.6) was compared with parallel data from 201 sexually active young people who were not pregnant and did not wish to have children, taken from the same national reference group of young people who were over 16 but under 21 years of age.

The group of women seeking abortion showed no significant difference from those not pregnant. However, significantly more among the abortion-seekers had started sexual intercourse within the first two years after menarche, and they had on average had many different sexual partners. Among the abortion-seekers, 73.9% used contraception at first intercourse compared to 82.1% among those not pregnant.

In other words, by far the majority of young people know that pregnancy can be avoided and have used contraception. In the abortion group about one third became pregnant despite the use of contraception (generally a condom). Forty-four per cent provided the information that the most recently used means of contraception was the pill. The fact is, however, that most of those who became pregnant did so not when using the pill, but after stopping use. They may have been afraid of continuing. They may have had side effects, or they may not have taken out a new prescription. The indications are that contraceptive measures are adapted to present needs. Dr Wielandt also reported that efforts are being made to follow up the surveys, in order to maintain continuous discussion of the acceptability of the methods and possible changes in need.

Afterwards the conference participants were divided into eight working groups to discuss possible new initiatives. Entre Nous joined a fascinating discussion on new approaches to sex education, on ways of getting young people’s attention in their own milieu.

Denmark’s first abortion law was passed in 1939. The legislation was very strict. The law was altered and liberalized in 1956 and 1970. Finally, in 1973, a law was passed permitting free abortion before the end of the twelfth week of pregnancy. Before 1973, abortions were most common among married women who had had two or three children. In the last 17 years abortions have become more frequent among young career women who postpone pregnancy for a host of socio-economic, educational and personal reasons. The average age of first pregnancy in Denmark is now in the very late twenties, and it is “a shame” as Association President Vibke Joergensen puts it, that a woman’s first pregnancy should end in abortion.

“Women have to be protected against pregnancy for perhaps 10 years,” she said, “and that must mean unwanted pregnancies, even when couples do their very best, and especially if they use barrier methods which are less safe than the pill. In many cases unwanted pregnancies are an inevitable risk.” A new strategy is needed to combat this, to confront this changed situation, to change attitudes. Denmark’s two associations have accumulated large quantities of information, but for the moment they cannot give a straight answer to the question “Can the Abortion Rate Be Changed?” Although everything is possible it is beneficial of the to reduce the need for abortion, no espeial changes in the present trend may be expected.
Central and East European AIDS specialists convene in Copenhagen

"We know from experience in other regions of the world that low figures can easily be followed by high ones as the disease moves into the next stage of its epidemiological pattern. Thus it is conceivable that the 250 known cases of AIDS in Eastern Europe could quickly expand into many thousands.

That is why we urgently need a strengthening of AIDS control programmes in these countries to help them to build quickly a structure that includes an educated and informed public, well prepared and knowledgeable health professionals, properly trained counselors, an effective monitoring system and reliable means of protection. These activities had been planned but now have had to be strongly accelerated. AIDS can cross borders faster than people think, so let's stay one jump ahead of it, learn from experience elsewhere in the world and be prepared."

WHO press release.

The official title of the conference itself was a bit of a mouthful, but there could be no doubt of its timeliness and importance. One of the likely consequences of the political changes sweeping across Central and Eastern Europe is a sharply increased movement of people. This and other factors will probably accelerate the incidence of HIV infection and increase the risk of AIDS transmission substantially.

In response, the Regional Programme on AIDS from the WHO Regional Office for Europe recently convened a meeting on the European AIDS National Programme Support Initiative for Selected Low Prevalence Countries. The conference addressed two priority areas in the global fight against AIDS — the prevention of HIV transmission and the reduction of morbidity and mortality associated with HIV infection. Delegates considered the present situation in each country in terms of epidemiology, prevention, control and care, and afterwards formulated an action plan.

The deliberations, which took place in Copenhagen from 27 February - 1 March 1990, brought together representatives from Central and Eastern Europe, WHO staff members from the Global and Regional Programme on AIDS, and observers from the Council of Europe and the World Bank. In all, there were 29 representatives from health ministries, hospitals and research centres in Bulgaria, Czechoslovakia, the German Democratic Republic, Hungary, Poland, Romania, the Soviet Union and Yugoslavia.

The current number of AIDS cases in Central and Eastern Europe is small compared to Western Europe. As of 22 February 1990 the figures were 306 versus 32,579. The limited studies to hand at the moment indicate a best estimate of over 16,000 HIV seropositives in the countries concerned. But the incidence of new AIDS cases is increasing and can be expected to continue. Only in Albania is there no recorded AIDS or HIV infection.

Based on the known seropositives, the infection rate per 1000 population varies from 0.009 in the USSR and Czechoslovakia to 0.018 in Hungary. These estimates, however, may only reflect the magnitude of testing programmes and not the real rate. Only the USSR has carried out comprehensive testing on a large number of the total population and target groups.

The number of AIDS cases has increased dramatically from 1987 in all countries. There is, however, variation by transmission group. Czechoslovakia, the German Democratic Republic, Hungary and Poland have a clear majority of AIDS cases within the homosexual/bisexual group. In Romania and Bulgaria the heterosexual community provide the majority of cases, while the USSR and Yugoslavia exhibit a range of transmission patterns. Only in Yugoslavia and Poland are there AIDS cases among intravenous drug users. They are the prevalent group in Yugoslavia, while in Poland they are becoming so. In the course of the last 12 months, two new alarming situations have arisen in the Soviet Union and Romania. (Editor's note. Readers are referred to Dr Gromyko's article for a detailed account of these cases.)

All represented countries have National AIDS Committees (NAC), but committees and programmes require intersectoral representation and linkages. In addition, non-governmental and other community based organizations should be considered for membership as appropriate and/or be consulted on an ad hoc basis.

In order to build on the existing national programmes, a WHO team will visit each country. The quality of AIDS information needs to be improved. It also needs to be more specifically targeted. Drug abuse, including self-injecting drug use, is expected to increase in the region. Since the incubation period for AIDS is lengthy, this will require active surveillance and sensitive mechanisms. Gay and bisexual men will be encouraged to organize themselves so that they can play an active preventative role in the HIV/AIDS epidemic. In Western countries they had already played a major role in preventing the further spread of infection. Support and non-discrimination were important. The participants recognized that prevention of sexual transmission of HIV is a high priority in the region. Organized STD services serve to identify individuals who persist in high risk sexual behaviour and such services can be used to increase health promotion for primary prevention of HIV in such individuals.

The status of prostitutes varies considerably within the region. It is essential to make a rapid and forceful commitment in efforts that reduce HIV infection in prostitutes, clients of prostitutes and other partners of prostitutes. Campaigns aimed at changing HIV-related risk-taking practices associated with prostitution must be urgently promoted.

There is some variability in the testing of foreign nationals but compulsory testing according to certain criteria is common in the region. Governments were asked to review this issue. Nosocomial HIV infection, defined as the transmission of infection in a health care setting, is present in this region as in others. The epidemiology of nosocomial HIV infection does not differ from other nosocomial infection, for example, Hepatitis B. The source is infected blood. Needles and syringes are not the only vehicle for nosocomial infection - surgical equipment and other skin-piercing equipment are also important. To prevent nosocomial HIV infection the WHO "Guidelines on Sterilization and Disinfection Methods Against HIV" and "Guidelines for Nursing Management of People Infected with HIV" should be adapted/translated or incorporated into existing guidelines at national level and used widely in training of all health staff. In addition, countries should review their policies and the use of disposable medical equipment and non-disposable, sterilizable equipment which can be used safely if properly sterilized.

Within the region, the organization of blood transfusion services is similar. Specifically, these services are managed by the state and centrally organized with any differences reflecting the individual character and legislation of each country. The recent events in Romania have raised concern over the efficacy of some practices and brought forward questions on the safe usage of plasma and other blood products. In this context, technical support from WHO was seen as a priority area.

It was recognized that counselling and comprehensive care services in relation to HIV are an essential component of an overall AIDS prevention and control programme. Participants agreed that there is substantial benefit in monitoring their prevention and control programmes. As a starting point, specific programme indicators should be included in such plans.
Karaté and Lisa get the message over KICK! BAM! With a karate yell, he kicks the car door shut in the face of the Smiling Man. Jimmy is angry. "Why did you do that?" he shouts. Other kids come to see what happened.

"Because that man wanted to fuck you. And maybe you would get sick with AIDS... There is no cure for it, and you will die."

With his mean right foot, street leader Karaté, dark-skinned, T-shirted, red bandanna tied round his curly locks, has just seen off another street villain, a Smiling Man with a black car.
Karaté and Lisa, his level-headed girlfriend, live in an abandoned building and work as street health educators. Lisa tells their friends Anna, Peter, and Dingo the Dog: "AIDS can come from sex, so when Karaté and I make love, he always uses a condom. This way, we protect each other from AIDS." But the message doesn't get through to Jimmy...

The Karate Kids cartoon is action-packed, chock-full of fun, excitement and information about how people get AIDS, how to prevent it, and how to care for people with AIDS. Karate, Lisa, and their pals feature in the Karate Kids comic book and video package produced by the Survivors Project of Street Kids International, a private, non-profit-making organization dedicated to promoting independence and self-respect among street children around the world.

Address: 56 The Esplanade, Suite 202, Toronto, Canada M5R 1A7 (Tel: (416) 867 1816. Fax (416) 367 1553. Telex 0686766).

Young, scared and pregnant
Adolescent fertility—often unwanted—is a pressing problem. The International Center for Population and Family Health, now in its tenth year of international training, is running a Workshop on Adolescent Fertility Management from 3 September to 28 September 1990 at the Allerton Hotel, 701 N. Michigan Avenue, Chicago, IL 60611, USA. WHO, USAID, UNFPA, IPPF, FPFA and the Pathfinder Fund are among the agencies and institutions who may be able to provide scholarships.

For further information and services, please contact Dr Andre Singleton, President, International Center for Population and Family Health, 14130 W. 9th Street, Zion, IL 60099. Tel: (708) 746 8332. Fax (708) 746 8352. Cable: ENCENPFH.

First announcement of IAAH conference
The Fifth International Congress on Adolescent Health, organized by the International Association for Adolescent Health (IAAH) will be held in Montreux, Switzerland from July 3 to July 6, 1991. IAAH has just sent out its first announcement. If you wish to attend, or present a poster or paper, please contact O. Jeanneert or P.A. Michaud, IAAH Cinq-ième congrès, Office de Tourisme, Case postale 97, CH-1820 Montreux, Switzerland.

Laparoscopy and female sterilization
The Second International Postgraduate Training Course on Fertility Management Techniques, a project funded by UNFPA and organized jointly by the Department of Obstetrics and Gynecology, University Medical School of Debrecen, Hungary, and the WHO's Regional Office for Europe, will take place in Debrecen from 24 September to 19 October, 1990. The course title is "Laparoscopy and female sterilization" and there will be five modules: Introduction (general aspects), Female sterilization, The laparoscopic technique, Cure of equipment and Practical training. Further information from Project Manager Istvan Batar, MD, UNFPA/WHO courses, Dept. Ob/Gyn, UMSD, Debrecen, P.O. Box 37, Hungary 4012.

The Indonesian experience
The National Family Planning Coordinating Board of Indonesia (KBBI) will conduct a special programme for high-level policy-making officials of family planning and health programmes from 5-18 December 1990. The course is called: Planning and Managing a National Family Planning Programme: the Indonesian Experience.

For further information, please contact: Program Coordinator, International Training
Aspects of
Sexuality and
Family Planning
Module 7

Guidelines on
Diagnosis and
Treatment of
Infertility

SFP publications
The seventh module in the "Aspects of Sexuality and Family Planning" series is now available. Entitled "Guidelines on Diagnosis and Treatment of Infertility", it contains four chapters: Definition, Etiology, Testing and Treatment. Regional Officer Daniel Pierotti writes in the introduction: "Infertility can be an excruciating experience: informing people that they have a fatal illness robs them of their earthly life, but declaring them infertile kills their immortality". Write to SFP Unit, WHO Regional Office for Europe.

A French-language report of the international workshop on evaluation of family planning programmes which took place in Rennes from 26-28 September 1989 will be published before the end of 1990.

Hungarian-language menstrual diary
For our Hungarian-speaking readers willing to use fertility awareness methods Dr Pereszlenyi Zoltan has designed and edited (in Hungarian) a "menstrual diary" with detailed explanations. Please write to Dr Pereszlenyi at Berzsenyi u. 8, 7101 Szekszard, Hungary.

New fundal height measuring tape
Dr John D. Baeyertz, Consultant Obstetrician and Gynecologist at Wanganui Maternity Hospital, Wanganui, New Zealand has designed a fundal height measuring tape. This assesses gestation, fetal weight and growth rate and also helps to detect small-for-dates fetuses. The tape is available from Baeyertz tape, 216 Wicksteed Street, Wanganui, New Zealand at a cost of 10 NZ dollars for delivery by surface mail or 15 NZ dollars by air mail. Please write your address in BLOCK LETTERS, requests Dr Baeyertz.