Family planning and abortion in the socialist countries of Central and Eastern Europe : a compendium of observations and readings / Henry P. David.

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FOREWORD

Following the example of the U.S.S.R. in 1955, all of the socialist countries of central and eastern Europe, except the German Democratic Republic and Albania, adopted policies permitting abortion either at the request of the pregnant woman or on broadly interpreted social indications. Two of these countries, Romania and, to a lesser extent, Bulgaria have since reverted to more restrictive policies, presumably because there was concern about the decline in the birth rate.

The official policy in the countries that retain permissive abortion laws is to view contraception as the first line of defense against unwanted pregnancy and abortion as an undesirable alternative. In practice, efforts to promote contraception vary considerably both among countries and within countries, and public response to these efforts appears to vary even more. It is obvious that in some countries and regions with very high abortion rates, contraception is practiced rarely and ineffectively.

The demographic profession owes a debt of gratitude to Henry David, and the colleagues in central and eastern Europe who worked with him, for having prepared this well-documented compendium of observations and readings, as up-to-the minute as possible in a rapidly-developing field. This volume is an indispensable addition to the reference shelves of all those who want to learn about abortion laws and practices, as well as family planning, in the countries of central and eastern Europe, and who seek to apply the relevant experience to other areas of the world.

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April, 1970

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PREFACE

It has been calculated that at the present rate of population growth there will be more people alive by 1980 than have died throughout the whole of history (Huntingford, 1969). The problem of reducing population growth to reasonable limits has evoked thoughtful discussion throughout the world, regardless of cultural traditions, ethnic or religious background, or ideology.

Major attention in recent years has focused on improvements in contraceptive technology and on the delivery of modern devices to women of childbearing age. With growing concern about the present side effects and drawbacks of the pill and intrauterine devices, the pendulum is swinging toward more serious consideration of induced abortion for terminating unwanted pregnancies and as a backstop for contraceptive failure.

Growing awareness of the serious problems engendered by the combination of rapid population growth and lagging resources has raised numerous policy concerns in the United States (Beck, Newman, and Tietze, 1969). Major emphasis has been on making modern contraceptives physically available and psychologically accessible to all citizens, coupled with a rising demand for reform of antiquated abortion laws and legalization of social criteria for induced abortion under medical auspices.

While there has been much discussion of the impact of family planning programs in reducing the birth rate in developing nations, far less attention has focused on the socialist countries of Central and Eastern Europe whose birth rates have been declining, often in association with liberal abortion statutes. Although considerable demographic information is available from these countries, there has not been, to date, a concerted effort to report on the varying factors influencing family planning and abortion-seeking behavior.

This monograph is the result of a proposal to summarize presently available information about procedures and trends related to legalized abortion in

the socialist countries of Central and Eastern Europe. The objective was to present demographic data and to attempt to develop a psychosocial perspective of the complex interplay between socioeconomic aspirations, cultural standards, and the individual practice of voluntary family limitation. In that sense induced abortion was viewed as an optional method of family planning behavior, and as an area for potential joint research with colleagues in Central and Eastern Europe.

Under contract with the Center for Population Research of the National Institute for Child Health and Human Development, and with international travel support from the Ford Foundation, a six weeks' visit was made to Central and Eastern Europe during February-March, 1969. Since time did not permit a detailed study, visits were limited to Czechoslovakia, the German Democratic Republic, Hungary, Romania, and Yugoslavia. The observations recorded here are the result of these visits plus discussions with experienced colleagues and extensive readings. There is no claim to be exhaustive. Chances are that some important contributions were missed, especially in the countries not visited. Additional comments from readers are welcome.

To organize the presentation of the material, an arbitrary decision was made on format and order. The monograph opens with an introductory Overview, including a summary of ideological aspects of population policy trends. The country chapters appear in the order in which abortion procedures were liberalized in the post-World War II years, beginning with the Soviet Union in 1955.

Each chapter follows the same format. After brief mention of historical trends, past and present abortion policies are outlined together with stated reasons for official decisions. Restrictions on induced abortion, procedures, rates of abortion, and observations from research studies are summarized. Estimates of illegal abortions before and after legislation are given, followed by a resume of family allowances and related taxation policies.

Locally produced and imported contraceptives are described, with emphasis on modern contraceptive methods, e.g., pills and coils. Reports of contraceptive practice are abstracted. Next are observations on family planning trends, including organization of family planning associations and establishment of

independent family planning centers, the availability of contraceptive consultation centers, family planning in the curricula of medical schools and postgraduate training institutes, efforts to strengthen sex education in the schools, and dissemination of contraceptive information through public education. There are notes on research activities, particularly demographic and behavioral studies, plus mention of selected research centers and regularly issued publications. Available statistics and their sources are listed, accompanied by brief comments on reliability. Pertinent legislation is reproduced in English translation. Concluding observations are presented in Chapter 11. A numerical style is followed throughout the individual chapters to facilitate subsequent revisions.

Part III offers a variety of resource materials and references. Included are the 1966-68 Report of the Demographic Research Institute of Hungary, the 1968 Statement of the World Health Assembly on "Health Aspects of Population Dynamics," and the suggested guidelines of the International Planned Parenthood Federation on "The Future of Family Planning Associations."

In discussing abortion laws, differentiations are made between (a) "liberal" laws which require that a pregnancy be terminated on request of the woman (Hungary and the Soviet Union); (b) "permissive" laws which lend themselves to flexible interpretation (Czechoslovakia, Poland, Yugoslavia); and (c) "restrictive" laws with more rigid interpretation of social indications (German Democratic Republic, Bulgaria, and Romania). Only in Albania are abortions limited to strictly defined and interpreted medical grounds.

Throughout the monograph distinctions are also made between (a) "natural" methods of contraception, i.e., coitus interruptus or abstinence; (b) "traditional" methods, which include the "natural" means plus such mechanical devices as condoms, diaphragms, jellies, suppositories, etc.; and (c) the "modern" methods of oral contraceptives and intrauterine devices. An attempt is further made to differentiate between administrative factors under direct government control, such as restrictions on abortion, family allowances, maternity leave, etc., and personal decisions by individuals to prevent pregnancy or to terminate it with abortion.

Many persons assisted my efforts. The staff of the Center for Population Research of the National Institute for Child Health and Human Development responded warmly to initial discussions and agreed to support the study phase. Philip Corfman, Arthur Campbell, Norman Hilmar, and Jerry W. Combs, Jr. helped greatly in the delineation of objectives. Norman Hilmar served as Project Officer and devoted much time and interest to the organization of materials and preparation of the final report. Oscar Harkavy, Lyle Saunders, and Howard Swearer of the Ford Foundation provided an opportunity to discuss ideas, shared their expertise, and supported my request for funds to facilitate international travel and manuscript preparation. Parker Mauldin and David Sills of the Population Council, Milos Macura and Gwendolyn Johnson of the U.N. Population Division, James Brackett of the Agency for International Development, and Paul Myers of the U.S. Census contributed much to my knowledge about the field. The Special Assistant for Population Planning to the Secretary of State, Philander B. Claxton, State Department desk officers, and Lawrence C. Mitchell of the National Academy of Science expedited travel arrangements.

Special thanks must be accorded to Christopher Tietze of the Population Council who encouraged the project, gave me the benefit of his extensive experience, and reviewed the draft manuscript. My debt to him is obvious throughout the monograph. Much is owed to K. H. Mehlan, Director of the Institute for Hygiene at the University of Rostock in the German Democratic Republic. His surveys of trends in Eastern Europe provided instructive background information. Egon Szabady introduced me to the pioneering Hungarian studies in fertility and family planning organized under his direction. Malcolm Potts, Medical Secretary of the International Planned Parenthood Federation in London, kindly allowed me to share his observations and materials still in press. Daniel Callahan similarly made available draft chapters of his forthcoming book. Andras Klinger generously contributed to the collection of abortion statistics.

Everywhere I was received with gracious and generous hospitality. Each colleague consulted is identified in the individual country chapters. I would like to record here my warm appreciation to all, and especially to those who coordinated local arrangements: Ludek Kubicka and Zdenek Dytrych in Czechoslovakia; K. H. Mehlan in the German Democratic Republic; Egon Szabady in Hungary; Vasilea Caramelea and Alexandru Ciungu in Romania; and Dusan Breznik

in Yugoslavia. Donka Dimitrova and Dimiter Vassilev provided information on Bulgaria, as did Malgarzota Bulska on Poland. Both before and after the trip I visited Geneva and had stimulating discussions with Alexander Kessler, Chief of the Human Reproduction Unit of the World Health Organization; A. F. Wessen and George C. Myers of the WHO Division of Epidemiology and Communications Science; Boris Lebedev of the WHO Mental Health Unit; George Vukovich, Division of Social Affairs, UN Office at Geneva; and Jacques Bernheim, Willy Pasini, Jean Kellerhals, and Thalia Vergopoulo of the University of Geneva Medical Faculty.

My study tour demonstrated once again the diversity within and among the socialist countries of Eastern Europe. There are wide differences in social, economic, cultural, legal, medical, ideological, ethnic, religious, psychological, and administrative views and practices, each of which exerts an effect on family planning. Some governments are concerned with the demographic implications of fertility trends, and attempt to influence developments through changes in abortion policies, taxation, family allowances, child-care facilities, etc. Motivational/behavioral components of family planning, as expressed through individual decision making, are receiving increasing recognition. Research is encouraged and supported, as is participation in international collaborative endeavors.

As one result of the interest generated among colleagues in the socialist countries of Central and Eastern Europe, several jointly planned research proposals have evolved, focusing initially on psychosocial aspects of family planning and abortion-seeking behavior. A Research Planning Conference on Transnational Studies in Family Planning was held in Budapest, September 18-19, 1969, jointly convened by the American Institutes for Research and the Hungarian Demographic Research Institute with the support of the van Ameringen Foundation (David, Szabady, et al., 1970).

The Budapest Conference was perceived as part of a longer term international and interdisciplinary effort to learn from the experience of other countries through jointly planned programmatic research. The projects discussed in the working groups have already moved closer to realization. Joint feasibility studies will be conducted in Budapest and Prague in early 1970. The International Planned Parenthood Federation and the World Federation for Mental Health will co-sponsor a follow-up meeting of specialists to consider technical questions of

developing rapid, low cost, and reliable instruments capable of assessing psychosocial factors in differing cultural contexts. It is anticipated that the meeting will be convened at the World Health Organization in Geneva, organized jointly by the American Institutes for Research and the University of Geneva Medical Faculty with the support of the van Ameringen Foundation.

The Budapest Conference also provided a welcome occasion for further review and revision of this monograph. As a compendium of personal observations, discussions, and readings, its objective is to summarize available information, identify gaps in knowledge, and stimulate methodologically comparable international and interdisciplinary research on family planning and abortion-seeking behavior. It is not a study in depth. I am most grateful to the Center for Population Research of the National Institute for Child Health and Human Development, to the Ford Foundation, and to the van Ameringen Foundation for their generous initial and continuing support.

Each country chapter, except Albania, has been reviewed by a country consultant. Many colleagues in diverse lands contributed generously. Their interest, support, and dedication, exemplified particularly by Chris Tietze, inspired the cooperative international effort on which we are now embarked.

My colleagues at the American Institutes for Research further stimulated much of my thinking by questioning assumptions and suggesting alternative approaches. I am especially pleased to acknowledge the contributions of Edwin A. Fleishman, Paul Spector, and Nancy Russo. Mj Albert managed successfully the vast correspondence initiated by the project. Ann Rosendall typed the final manuscript with care and dispatch.

Neither geographic, linguistic, nor ideological barriers deter men and women of good will from working together to resolve one of the major problems confronting all mankind. It is to them that this monograph is dedicated.

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International Research Institute
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February 1970
Washington, D.C.

PART I: INTRODUCTION

CHAPTER 1

OVERVIEW OF TRENDS IN FAMILY PLANNING AND ABORTION*

Historical Trends

1. Before World War II the fertility level was relatively high in Central and Eastern Europe in comparison to Northern and Western Europe. There was little "family planning" until the second half of the 19th century when better diets, improved hygiene and sanitation, and advances in medical practice combined to lower the death rate substantially. From about 1880 birth rates began to decrease in much of Europe, with France leading the way. The economic, social, and psychological motives which prompted late Victorian era middle class couples to limit their families have been reviewed by Peel and Potts (1969). Coitus interruptus was the most common method of conception control. Mechanical devices were deemed impractical and inconvenient. The long tolerated practice of illegal abortion became a more acceptable topic of discussion.

2. The socialist countries of Central and Eastern Europe do not constitute a demographic entity. There are considerable differences in social and economic development, urbanization, living standards, social habits, religion, and other characteristics, all of which have influenced and continue to influence population trends in varying degrees (Vukovich, 1969). Since the end of World War II these countries have shared a common ideological system, inducing extensive changes, including industrialization of previously primarily agricultural economies. Rapid industrialization resulted in very intensive internal migrations from rural areas into cities and towns, coupled with great social and occupational mobility, transforming peasants into unskilled and semiskilled industrial workers, and bringing workers--and partly also peasants--into non-manual

*More specific details and references are cited in the country chapters which follow the same outline.

occupations. A large percentage of women joined the labor force, especially in the urban areas, resulting in significant changes in family structure and life patterns. Transformation of the traditional system of farming influenced the daily life and social values of the remaining agricultural community. The demographic consequences of these great and rapid changes were of major proportions, including a marked decline of both fertility and mortality. However, the extent and nature of these changes differ from country to country, reflecting prevailing social and economic circumstances and historical traditions. Each of the socialist countries of Central and Eastern Europe has its own unique features.

3. Each of the socialist countries of Central and Eastern Europe experienced to some degree the holocaust of World War II and the turbulent period of readjustment during which socialist regimes came to power outside the Soviet Union. Between 1938 and 1945, war-related mortality, forced migration, and the deaths of civilians in Nazi-occupied territories were the predominant forces influencing population change. Despite relatively high rates of natural increase during the recovery period, there was little net growth between 1945 and 1950, partially as the result of postwar migrations (Scott, 1965). Czechoslovakia and Poland experienced net declines between 1938 and 1950; Yugoslavia declined between 1938 and 1945 but posted a slight gain by 1950. Hungary's population increased somewhat from 1938 to 1945 but changed little thereafter. Bulgaria, the German Democratic Republic, and Romania registered increases over 1938, both in 1945 and 1950. Poland experienced a loss of 7 million or 22 percent (Scott, 1965; Mauldin and Akers, 1954). Czechoslovakia lost 2.1 million or 15 percent. The 11.5 percent population gain over the prewar population experienced by the German Democratic Republic resulted from the influx of ethnic Germans expelled from other Eastern European countries and the Soviet Union. However, between August 1950 and August 1961, the German Democratic Republic lost 2.1 million persons through migration, equivalent to 11.4 percent of the 1950 population (Scott, 1965). This greatly worsened the already inbalanced age-sex structure, increased the manpower deficit, and influenced much of the GDR population policy of the 1950s.

4. Since 1955 fertility in the socialist countries of Central and Eastern Europe has shown a tendency to decrease (Tables 1 and 2). By 1960 the birth rates of Czechoslovakia, Hungary, Poland, Romania, and Yugoslavia had fallen to 68-73 percent of the rates of 1950. In Bulgaria the decrease was

about 30 percent. This drop was accompanied by the gradual legalization of induced abortions between 1956 and 1960. Also exerting an impact were the war-induced changes in the age-sex structure of the populations, the low fertility of the depression years of the 1930s, decreasing marital fertility, the generally lowered death rates, and the massive migrations from rural to urban areas (Szabady, 1966). Only Albania and the German Democratic Republic had a higher fertility rate in the early 1960s compared to 1950. Albania, with the highest birth rate in Europe, restricts abortion and has shown little interest, to date, in family planning. The German Democratic Republic did not liberalize the interpretation of its 1950 abortion law until 1965, when the flow of out-migration had been stemmed and the drive for the dissemination of modern contraceptives well established. The GDR birth rate subsequently decreased from 16.5 per 1,000 population in 1965 to 14.3 in 1968.

5. The post World War II recovery peak in birth rates was reached in different years in different countries (Table 2). These differences in birth rates have gradually narrowed, with the exception of Albania and the recent dramatic change in Romania. In 1968, birth rates ranged from a low of 14.3 per 1,000 population in the German Democratic Republic and 14.9 in Czechoslovakia to 17.3 in the Soviet Union and 18.9 in Yugoslavia, with 26.8 in Romania and 35.6 in Albania.

6. A major influence on birth rates in Central and Eastern Europe are changing socioeconomic factors, "It is a well known fact that the development of the socialist social system is accompanied by considerable transfer of the structure of the national economy in the individual countries" (Szabady, 1966). Social mobility connected with industrialization decreases the proportion of the agricultural population with its traditional higher fertility. Parallel with the migration into the cities, the ecucational level of the population increases, especially among women. Expectations for a higher cultural and socioeconomic standard of living rise, accompanied by greater economic activity among women. Satisfaction of demands tends to restrict the number of children a couple is willing to have, particularly when adequate housing and child care resources are limited. The relationship of behavioral/motivational psychosocial factors to birth rate is discussed in the country chapters, especially in Czechoslovakia, Hungary, and Romania.

7. The importance of ideology is not consistent in its influence on prevailing population policies, as promulgated or practiced. All the countries profess to being pronatalist. The evolving interpretations of Marxist views are delineated in the next section on Population Policy Notes. It is apparent that overpopulation is no longer viewed as a unique problem of capitalist countries. The opinion is expressed that economic and social policies should be accompanied by demographic policies, especially in the developing world. Within the countries of Central and Eastern Europe, the pendulum has fluctuated between a very liberal policy of abortion on demand to one of sudden reversal and restriction, as in the Soviet Union in 1936 or in Romania in 1966.

Population Policy Notes

1. As summarized by Brackett (1962, 1968), Marx did not believe in a universal law of populations; he held that each social system has a different law. "Overpopulation" was said to be characteristic of capitalism because "variable capital," by which Marx meant that portion of capital available to purchase "labor power," tends to increase less rapidly than population does. The slower rate of growth of variable capital was attributed to the capitalist practice of diverting part of the produce of labor through the process of accumulation. In other words, overpopulation was "relative surplus labor," unemployment created by capitalist production methods. Marx' "discovery of a demographic law of capitalism" has been restated in English by Podyashchikh (1968), U.S.S.R. Representative on the United Nations Population Commission, citing the 1953 Russian edition of The Capital, Volume I, page 637.

2. Marx did not promulgate an explicit socialist law of population. He apparently believed that this new form of society would raise the standard of living of the workers and lower death rates. Marx did not state what he thought would happen to birth rates. He implied, however, that the elimination of the capitalist classes and their practice of diverting part of the produce of labor would cause "variable capital" to rise at the same rate as population (Brackett, 1968).

3. Lenin rejected Malthus' doctrine without evolving a specific socialist law of population. Judging from his writings as summarized in English by

Podyashchikh (1968) and by Vostrikova (1964), Lenin believed that rapid population growth was a source of strength in a socialist country. However, he also expressed the view that the decision on whether or not to have a child should be left to the prospective mother. Writing in Pravda in 1913, Lenin took a strong stand against the policy of reducing the number of births by artificial measures but at the same time advocated abolition of all legislation prohibiting abortion and the unrestricted dissemination of medical works on contraception. Restrictive laws, wrote Lenin, "merely show the hypocrisy of the ruling classes." Podyashchik (1968) comments that Lenin believed that contraceptives should be freely available "since this is a personal matter of the citizen and in deciding on this question they must be free," but that contraceptive devices should not "be forced upon everybody, especially the working class." In November 1920, within three years after Lenin's ascent to power, the Soviet government legalized abortion.

4. In the 1930s Soviet demographic research centers were closed, and problems of population became increasingly questions of ideology. This phase of Soviet history has been well summarized by Brackett (1962, 1968) and by Cook (1967). After the 20th Congress of the Communist Party in 1956, demography revived. One of the first concepts to emerge was a theory of "optimum population development," applicable only to socialist countries. This notion had also been widely discussed in other Eastern European lands. Emphasizing the dynamics of population, the socialist theory rejected the idea of an absolute optimum population size advocated by Western demographers. However, as summarized by Brackett and DePauw (1966), according to the theory of optimum population development the government of a socialist country is responsible for insuring a rate of population growth in rapport with the rate of economic development. "When the birth rate is so high as to threaten the future with more workers than can properly be employed, or so low as to threaten a future labor shortage, the socialist government is authorized to take whatever action it deems necessary to bring the birth rate into line."

5. Some indication of a possible change in the Soviet attitude toward population problems came at the Second United Nations World Population Conference in Belgrade, Yugoslavia, August 30-September 10, 1965. The Soviet demographers in attendance recognized the search of many conference participants for a solution to the problems confronting the developing countries and, according to

Cook (1967), "were obviously striving for a more objective understanding of population questions." Numerous Soviet experts from other fields tended to express more traditional views, advocating the primacy of socioeconomic changes and raising the standard of living by eradicating illiteracy, improving cultural levels, and emancipating women, plus more systematic utilization of available agricultural resources within a planned economy. "They maintained that science can provide the means to support many times the world's present population and that India (which was singled out) should stop wasting money on birth control and concentrate on economic development" (Brackett & DePauw, 1966). However, Boris Urlanis (1965a), Senior Research Worker in the Institute of Economics of the USSR Academy of Science, stated publicly that voluntary family planning and abortion are available in the Soviet Union.

6. On November 23, 1965, about two and a half months after the Belgrade meeting, the intellectual Soviet journal Literaturnaya Gazeta published a report of the World Population Conference by one of the Soviet delegates, Valentei, who noted that the center of attention at the conference was "a search for a solution of the problems confronting the underdeveloped countries." The same issue initiated a series of articles calling for a new interpretation of population problems in developing countries and focusing on the urgency of the need for immediate action (Brackett, 1968; Cook, 1967). The opening article by Urlanis (1965b) emphasized the reality of the population problem, rejected the notion that "science can solve everything," and disputed the argument advocated by several Soviet delegates in Belgrade that urbanization and industrialization will cause a decline in birth rates. Citing contrary data for India, but avoiding direct contradiction of previous Marxist writers, Urlanis blamed imperialism and colonialism, suggesting that the population problem in developing countries is an exception to the general Marxist tenet (Brackett, 1968). Conceding that industrialization and the development of urban life would, in time, bring a reduction of fertility to these countries, Urlanis urged prompt action and official population policies designed to cope with problems of immediate urgency. (A subsequent English-language version of Urlanis' views (1967) was published in the UNESCO Courier.) The following week Literaturnaya Gazeta published a supporting paper by Ya. Guzevaty, Senior Research Worker in the Institute of World Economics and International Relations of the U.S.S.R. Academy of Science. He also pleaded for immediate recognition of the reality of population problems, deeming the present situation in the developing world as an exception to Marxist ideology

rather than a contradiction and blaming colonialism. As quoted by Brackett (1968), Guzevaty justified family planning programs which "are not intended to restrict the size of the family by a legislative edict or to encroach upon the rights of the parents to bear as many children as they please. These 'programs,' as a rule, provide for disseminating information about marriage hygiene and birth control methods." By emphasizing the educational aspects and lack of coercion in family planning, the programs fall within the limits of one of Lenin's principles--that parents should be free to decide whether to have a child.

7. The continuing dialogue in Literaturnaya Gazeta is well documented by Cook (1967) and Brackett (1968). What is important is the obvious intent to convey the changing ideas to readers beyond the Soviet Union. Cook reports that in February 1966 the Soviet Embassy in Washington sent translations of the Urlanis and Guzevaty articles to the editorial offices of the Population Bulletin. The January 13, 1966, foreign language editions of the Soviet magazine New Times, published in English, Spanish, French, German, Polish, and Czech, carried an article by its Executive Secretary, G. Gerasimov, entitled "Overcrowded World?" repeating many of the observations made by Urlanis and Guzevaty. The first opposing article appeared in Literaturnaya Gazeta on February 22, 1966, written by Peter Podyashchik. He disputed Urlanis' interpretation of Lenin, endorsed the position taken by Soviet delegates at the 1965 World Population Conference, and contended that "methods of artificially reducing the birth rate to solve population problems can play a role as a transitory measure, but only when the population has attained the necessary cultural level." This essay has been published in modified form in English (Podyashchik, 1968). On March 3, 1966, a little more than one week after Podyashchik's article appeared, Literaturnaya Gazeta printed the next installment in the dialogue, an essay by Gerasimov criticizing the position taken by Podyashchik, suggesting that not enough time had elapsed to judge India's family planning program, and recommending that the term "planned parenthood" might be preferable to the term "birth control" which, at any rate, might be better translated into Russian as "guidance of the birth-rate." As cited by Cook (1967), Gerasimov concluded by calling for a compromise: "The acknowledgment of the decisive role of socioeconomic reforms for the solution of the population problem should be supplemented by the acknowledgment of the necessity for examining without prejudice auxiliary measures which are called population policies."

8. Also noteworthy is a report by Boyarski and Valentei (1968) on discussions held at the 1966 All-Union Symposium on the Marxist-Leninist theory of population movement. "Planned socialist economy requires to a greater extent than any other economy a profound investing in the material and cultural life of society, especially the study of the reproduction of population. According to the majority of the contributors, the circumstance that the processes influencing the population are hard to control and appear to be of a spontaneous character cannot be explained exclusively by the particular features inherent in these processes; but the fact that they have not been adequately investigated so far also has a considerable part in it." Academician A. M. Rumiantsev noted that there always has been and will be a state-controlled population policy; there is no state "that would not make dispositions for influencing population processes." "The participants of the symposium came to the conclusion that it is high time to take off the signal 'forbidden' from a notion like optimum population. It is to be understood that the establishment of the optimum pattern of the reproduction of population is connected with the elucidation of a whole series of very complicated interrelations existing between the development of the economy and the changing number of inhabitants. The development of the population is submitted to the overwhelming impact of socioeconomic relations, but it is in a dialectic, mutual interaction with the development of the society, which permits to raise the inevitable question concerning the optimal type of reproduction. It has, however, no common features with the bourgeois-apologetic theories of optimum which aim at replacing class conditions by the ratio of the number of inhabitants to the resources."

9. Another indication of changing Soviet views on population policy came during three international meetings in 1966. At the World Health Organization Assembly in May in Geneva the Soviet Union opposed a resolution that WHO should initiate a program of aid on family planning, but supported an amended resolution that WHO be allowed to "advise members, upon request, in the development of action in family planning." In June 1966 at the Executive Board Meeting of the United Nations Children's Fund in Addis Ababa, the Soviet Union opposed a motion to allow UNICEF to consider requests from governments for assistance in family planning programs, but subsequently agreed to a compromise resolution that a joint UNICEF-WHO Committee should advise on UNICEF's possible future role in giving assistance to family planning. The third and most important Soviet decision was made at the United Nations General Assembly in December. For the first time, the

General Assembly, by a unanimous voice vote including the Soviet Union, approved a resolution which calls upon the United Nations Economic and Social Council, Population Commission, and various other specialized agencies "to assist, when requested, in further developing and strengthening national and regional facilities for training, research, information and advisory services in the field of population." In the discussion before the vote, the Soviet delegate, N. I. Filimonov said "that it was gratifying that expert opinion had at long last begun to appreciate the role which economic and social changes could play in solving population problems." (Brackett, 1968; Cook, 1967)

10. At the August 1967 Conference of the International Union for the Scientific Study of Population, held in Sydney, Australia, a paper by Prof. B. Urlanis on "Marxism and Birth Control," was read. In his opening sentence Urlanis says "world literature widely expresses the view that Marxism does not recognize birth control and is opposed to its practice. In fact this is not so at all." Urlanis cites Marx, Engels, and Lenin; summarized the Soviet history of legalizing abortion and disseminating contraceptive information while also providing family allowances and child-care facilities; and explains the trend toward a smaller family in terms of the emancipation of Soviet women and the desire for a better life for parents and children. As for the developing countries, "Soviet demographers believe that together with an economic solution there must also be a demographic solution; that is to say, a lowering of birth rates by means of an effective demographic policy. The aim of such a policy must be to spread planned families, and this implies the use of birth control by the population." Urlanis considers "rapid population growth a millstone around the neck of the developing countries" and urges a policy of "planned fertility." Cook (1967) published a summary of the Urlanis paper. Reflecting the continuing debate in the Soviet Union, Podjacih (1968), Head of the All-Union Population Census Department of the Central Board of Statistics in Moscow, subsequently expressed more traditional views on "Family Planning Policy and Progress in the Developing Countries" at the International Symposium on the Problems of Human Reproduction in Varna, Bulgaria, September 1968.

11. Although the Soviet government continues not to have an official population policy, it has had for some time a de facto population program operating through its own health service. A group of physicians from the Soviet Union and other Eastern European countries is currently working in family planning clinics

in Tunisia (Brackett, 1969). At home, Soviet government programs and practices which tend to encourage childbearing coexist with those tending to discourage childbearing. Although possibly not by design, in actual practice social-economic factors depressing the birth rate are greater than the not very effective Soviet family allowances. In a situation so laden with ideological implications, it is perhaps still too early to expect official statements formalizing actual programs, whether in the Soviet Union or in other countries of Central and Eastern Europe.

12. The political aspects of demography have long been recognized by other Central and Eastern European demographers. Acsadi (1969) quotes Srb as stating that demography was a political science par excellence, with the political function manifest primarily in the sphere of political policy. Macura has similarly cited the socioeconomic aspects impinging on population policy. Acsadi notes, however, that while the decrease in mortality was the result of a deliberate policy, the gradual decrease in number of births was not significantly different from that in other economically developed countries. He cites numerous demographers from the socialist countries who made presentations at the 1965 World Population Conference in Belgrade and ascribed the decrease in fertility to rapid industrialization, intensified urbanization and migration from rural to urban areas, rise in the cultural level and in the standard of living, and desire for attaining an even higher standard. Decline of fertility was the consequence of the complex interplay of multiple socioeconomic, psychological, and demographic factors. Legalization of induced abortion became a means of realizing these effects; not a cause. Whether or not prohibition of abortion has more than a limiting and temporary effect remains to be seen. Acsadi concludes by quoting Macura that "introduction of active demographic policies must be left to the sovereign decisions of each country but each nation has a twofold responsibility in this field--national and international."

Abortion Policy Trends

1. In the socialist countries of Central and Eastern Europe, abortion policies have undergone several changes since November 8, 1920, when termination of pregnancy at the request of the woman was legalized in the Soviet Union by joint decree of the Commissariats of Health and Justice (Field, 1956). In 1936 interruption of pregnancy was again limited to medical and eugenic grounds, but this

restriction was repealed after Stalin's death by the Supreme Soviet on 23 November 1955. In prewar Eastern Europe abortion was illegal (except for cases of rape under the Polish Penal Code of 1932). In 1947 the German Democratic Republic temporarily relaxed legislation to permit abortion for a range of social as well as medical indications, but in 1950 termination of pregnancy was again restricted to medical and eugenic grounds. Interruption for medical reasons was legalized in Yugoslavia in 1951 and Czechoslovakia in 1952.

2. To combat the rise in illegal abortions, laws were gradually revised to permit abortion on request or otherwise liberalize grounds for termination of pregnancy. The view was expressed that each woman should be free to decide about her pregnancy and that the state should establish prerequisites to guarantee this right. In the words of the preamble of the Soviet decree, the aims of the legislation are "the limitation of the harm caused to the health of women by abortions carried out outside the hospitals," and to "give women the possibility of deciding for themselves the question of motherhood." By according equal legal status de jure and de facto to women in all walks of life, optimal health would be assured while also "relating happy maternity to activity in the community" (Mehlan, 1968c).

3. Following the lead of the Soviet Union, liberal abortion laws were promulgated in Bulgaria and Poland in April 1956, Hungary in June 1956, Romania in September 1956, Czechoslovakia in December 1957, and Yugoslavia in February 1960. In March 1965 permissive interpretations were added to the 1950 law of the German Democratic Republic. In 1966 Romania and in 1967 Bulgaria revised their liberal stand and again restricted abortion. The only country of Eastern Europe which prohibits abortion is Albania. In 1968 it had the highest reported birth rate in Europe, 35.6 per 1,000 population.

4. The sharp rise in total registered abortions and legally induced abortions since 1957, accompanied by a declining birth rate, is shown in Table 1. The down-trend in live birth rates 1948-1968 in Table 2 suggests that the decline in birth rates was accelerated by the legalization of induced abortions. The rise in legalized abortion per 1,000 population in selected countries of Central and Eastern Europe, 1955-1968, is also shown in Figure 1.

5. Of some utility in judging the impact of abortions is their ratio to live births in any given year. These data are also presented in Table 1. The recorded national ratio is highest for Hungary where abortions have exceeded

Table 1

Abortions and Birth Rates in Selected Countries of Central and Eastern Europe, 1957-1969*

Country	1957	1958	1959	1960	1961	1962	1963	1964	1965	1966	1967	1968	1969xx
Total Registered Abortions (in thousands)													
Bulgaria	46.2	55.5	63.8	74.1	88.7	97.8	103.8	112.3	116.0	119.5	120.4	109.0	
CSSR+	37.5	89.1	105.5	114.6	120.3	115.9	99.3	99.2	105.8	115.8	121.2	124.1	126.9
Hungary	168.8	183.0	187.7	196.0	203.7	197.6	207.9	218.7	214.0	220.4	222.4	234.8	238.3
Poland**	121.8	126.4	161.5	233.3	229.5	271.8	260.3	246.8	234.6	222.2		155.0	
Yugoslavia			111.8	133.3	164.5	200.0x	215.0x	227.6x	245.4x	265.2x	276.2x		
(Slovenia)	7.7	10.6	11.7	13.7	14.8	15.1	15.5	15.4	16.0	14.8			
Romania		129.0	235.8										
GDR++								44.1					
Legalized Induced Abortions (in thousands)													
Bulgaria	30.9	37.5	45.6	54.8	68.8	76.7	83.3	91.5	96.5	101.4	98.2	85.2	
CSSR+	7.3	61.4	79.1	88.3	94.3	89.8	70.5	70.7	79.6	90.3	96.4	99.9	102.6
Hungary	123.4	145.6	152.4	162.6	170.0	163.7	173.8	184.4	180.3	186.8	187.5	201.1	206.3
Poland**	36.4	44.2	79.0	158.0	155.3	199.4	190.0	177.5	168.1	156.7	146.1	121.7	
Yugoslavia			54.5	76.7	104.0	150.0	146.8	158.6	182.4	195.5	210.7		
(Slovenia)	2.2	4.7	6.5	8.2	9.3	9.5	9.4	9.4	9.9	9.5			
Romania		112.1	219.6						1115.0				
GDR++	0.9	0.9	0.8	0.8	0.8	0.7	0.7	0.8		16.0x	20.0x		
Legalized Induced Abortions per 1,000 15 - 49 year old females													
Bulgaria	16	19	23	27	34	38	41	46	48	55			
CSSR+	2	19	25	28	29	28	22	22	24	27	28	28	28
Hungary	49	58	61	65	69	66	70	79	77	80			
Poland	5	6	11	21	20	24	21	20	20	18			
Yugoslavia			11	16	22								
Romania		26	51						252				
Legalized Induced Abortions per 100 live births													
Bulgaria	22	27	33	39	50	57	63	69	75	76	79	60	
CSSR+	3	26	36	41	43	41	29	29	34	41	45	47	46
Hungary	74	92	101	111	121	126	131	140	136	135	126	130	136
Poland	5	6	11	24	25	33	33	32	42	42			
Yugoslavia			13	18	25	36	36	40	45x	49x	54x		
(Slovenia)	7	16	23	29	32	33	32	31	32	34			
Romania		29	60						401				
GDR++	0.4	0.4	0.4	0.3	0.3	0.3	0.3	0.3		6	8		
Birth Rates per 1,000 population													
Albania	39.1	41.8	41.9	43.3	41.2	39.3	39.1	37.8	35.2	34.0	34.0	35.6	
Bulgaria	18.4	17.9	17.6	17.8	17.4	16.7	16.4	16.1	15.3	14.9	15.0	17.0	16.9
CSSR+	18.9	17.4	16.0	15.9	15.8	15.7	16.9	17.2	16.4	15.6	15.1	14.9	15.5
Hungary	17.0	16.0	15.2	14.7	14.0	12.9	13.1	13.0	13.1	13.6	14.6	15.1	15.0
Poland	27.6	26.3	24.7	22.6	20.9	19.6	19.0	18.1	17.4	16.7	16.3	16.3	16.3
Yugoslavia	23.7	24.0	23.3	23.5	22.7	21.9	21.4	20.8	20.9	20.3	19.6	18.9	18.8
USSR	25.4	25.3	25.0	24.9	23.8	22.4	21.2	19.7	18.4	18.2	17.4	17.3	
Romania	22.9	21.6	20.2	19.1	17.5	16.2	15.7	15.2	14.6	14.3	27.3	26.8	23.3
GDR++	15.9	15.6	16.9	17.0	17.6	17.4	17.6	17.2	16.5	15.8	14.8	14.3	

\+ CSSR - Czechoslovakia ++ GDR - German Democratic Republic x - Estimate xx - Preliminary

* Based on Mehlan (1970), Klinger (1967, 1969), U.N. Statistics, National Yearbooks, and country consultants.

** Somewhat differing statistics have been reported from Poland for the years 1965-67; see page 89.

Table 2

Live Birth Rates per 1,000 Population in the Socialist Countries of Central and Eastern Europe, 1948-1969*

Year	Albania	Bulgaria	CSSR	GDR	Hungary	Poland	Romania	USSR	Yugoslavia
1948		24.6	23.4	13.0	21.0	29.3	23.9		28.1
1949	39.1	24.7	22.4	14.8	20.6	29.5	27.6		30.0
1950	38.9	25.1	23.3	16.9***	21.0	30.7	26.2	26.5	30.2
1951	38.5	21.0	22.8	17.4	20.2	31.0	25.1	26.8	27.0
1952	35.2	21.1	22.8	17.1	19.6	30.2	24.8	26.4	29.7
1953	40.9	20.7	21.2	16.8	21.6	29.7	23.8	24.9	28.4
1954	40.8	20.2	20.6	16.6	23.0	29.1	24.8	26.6	28.5
1955	44.5	20.1	20.3	16.7	21.4	29.1	25.6	25.7**	26.8
1956	41.9	19.5**	19.8	16.2	19.5**	28.0**	24.2**	25.2	25.9
1957	39.1	18.4	18.9**	15.9	17.0	27.6	22.9	25.4	23.7
1958	41.8	17.9	17.4	15.6	16.0	26.3	21.6	25.3	24.0
1959	41.9	17.6	16.0	16.9	15.2	24.7	20.2	25.0	23.3
1960	43.3	17.8	15.9	17.0	14.7	22.6	19.1	24.9	23.5**
1961	41.2	17.4	15.8	17.6	14.0	20.9	17.5	23.8	22.7
1962	39.3	16.7	15.7	17.4	12.9	19.6	16.2	22.4	21.9
1963	39.1	16.4	16.9	17.6	13.1	19.0	15.7	21.2	21.4
1964	37.8	16.1	17.2	17.2	13.0	18.1	15.2	19.7	20.8
1965	35.2	15.3	16.4	16.5**	13.1	17.4	14.6	18.4	20.9
1966	34.0	14.9	15.6	15.8	13.6	16.7	14.3***	18.2	20.3
1967	34.0	15.0***	15.1	14.8	14.6	16.3	27.3	17.4	19.6
1968	35.6	17.0	14.9	14.3	15.1	16.3	26.7	17.3	18.9
1969	NA	16.9	15.5	NA	15.0	16.3	23.3	NA	18.8

* Based on Klinger (1969), U.N. sources, and country consultants.

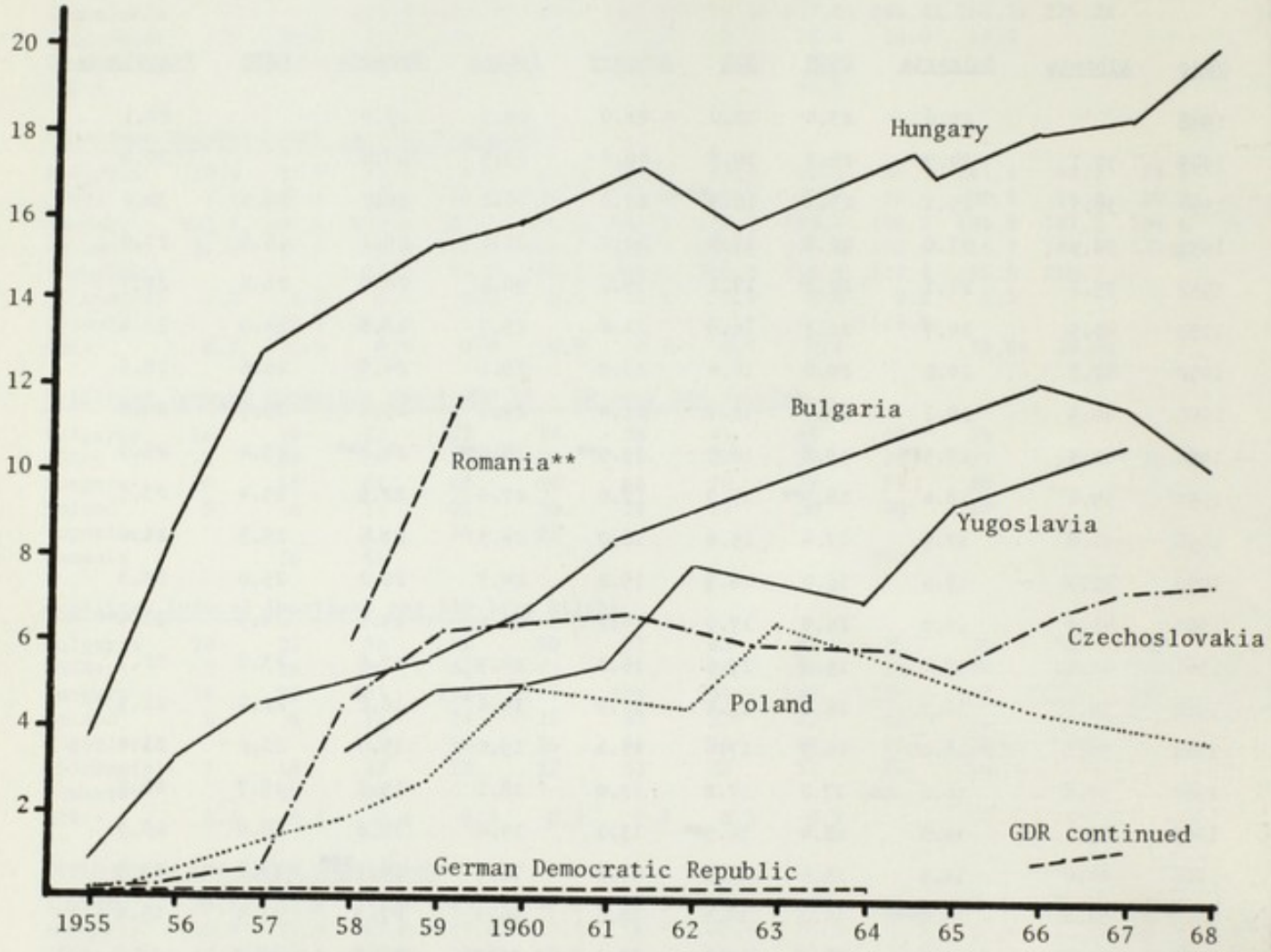
** Year in which abortion law was liberalized.

*** Year in which abortion law was restricted.

NA = Not available.

Figure 1

Legalized Abortion Per 1,000 Population in Selected Countries of Central and Eastern Europe, 1955-1968*



*Based on Mehlan (1968c), country consultants, and U.S. Bureau of the Census.

**The 1968 figure for Romania reaches 58.6. Figures for intervening years are not available.

births since 1959. The evidence is strong that, for a time, Romania had a much higher abortion-birth ratio than Hungary. A similar situation prevailed in numerous Yugoslav and Russian cities.

6. The reported figures on abortion require several notes of caution. The reliability of abortion statistics vary from country to country. In Czechoslovakia registrations of pregnancies and abortions are carefully controlled at the district level and central collection is good. In Hungary all operations are performed in hospitals, the registration system works well, and the small size of the country makes for accurate records. Less reliance can be placed on Polish statistics; many women wishing to avoid the public atmosphere of a hospital seek out private practitioners who may make errors in registering their cases. In Yugoslavia vital statistics are published at the regional level; the less developed regions of the country may not be as reliable as the industrialized areas (Potts, 1967). Registration of births and deaths is good in the German Democratic Republic; however, no statistics on abortion have been published since 1962. Little is known about Bulgaria. No national statistics are available from Albania. Romanian material is limited. Only scattered data have been obtained from the Soviet Union (where vast regional differences render overall figures difficult to interpret).

7. Still another warning flag on interpreting abortion data is raised by Potts (1967). He considers any estimate of the impact of legal abortion on birth rates difficult because it involves computing the number of illegal abortions taking place before the law was changed, and guessing what might have happened to the illegal abortion rate if the law had not been altered.

8. Relative to population, abortions have been most numerous in Hungary and Romania (before 1967). As will be seen from the country reports in Chapters 5 and 6, the use of contraceptives is not considered very efficient in Hungary and was virtually nonexistent in Romania. In such a setting permissive legislation may tend to reinforce contraceptive laxity. In Poland, where an active family planning association had good government support and extensive propaganda resources, the total number of abortions and the rate per 1,000 women of childbearing age has been dropping while the ratio of abortions per 100 live births has continued to rise.

9 The complex interrelationships between abortions and birth rates is explored in detail in Chapter 7 on Czechoslovakia. The studies of Frejka and Koubek (1969) review the impact of administrative restrictions and relaxations in the interpretation of the abortion law, advance announcement of increases in family allowances, longer maternity leave, etc.

10. Statistical data are particularly useful in charting fluctuations in individual behavior related to changes in government policies. Chapter 6 notes the longer-term effects of government restrictions and allowances on individual decision making in Romania. The relationship of environmental conditions to family planning behavior is demonstrated in the migration studies cited in Chapter 8 on Yugoslavia.

11. Commissions granting or denying abortions exist in Czechoslovakia, the German Democratic Republic, Hungary, Romania, and Yugoslavia. These commissions usually consist of three members, including, in varying proportion, at least one or more physicians and representatives of local administrative units, social services, and women's organizations. In Hungary, the commission functions primarily in an advisory capacity since approval must be granted if the woman insists. In the Soviet Union, where abortion is also available on request, gynecological departments counsel each woman. In Poland authorization may be granted by a single physician.

12. In all the countries there are certain limits on when an abortion can be performed. Except in cases where there is grave danger to life, or where serious eugenic reasons apply, the operation is restricted to the first three months of pregnancy Sometimes there is a regulation prohibiting abortion unless a specified interval (usually six months) has elapsed since the previous termination. No distinctions are made between married and unmarried women. Abortion is not permitted in cases of acute or chronic diseases of genital organs (Potts, 1967).

13. The consent of the partner involved is not required in any of the countries. If a request for abortion is approved in Poland, the man is frequently asked to make a contribution to the local blood bank. When minors are pregnant, the consent of parents or guardians is usually sought.

14. Length of hospital stay varies greatly and tends to depend more on social factors and available beds than on strictly medical considerations. Before the change in law, Romanian women were at times aborted in outpatient settings and sent home two hours later. In Hungary, abortions must be performed in hospitals and women are usually kept at least two days. In Czechoslovakia, the preferred hospital stay is three to four days, with up to six days if possible. In rural areas with fewer health facilities, length of hospitalization in "health homes" is more limited.

15. Consistent with prevailing health insurance schemes, abortion is free in each country if performed for medical reasons or if medical attention is required in connection with "spontaneous" abortions. All countries, except the German Democratic Republic and Poland charge a "partial fee" for pregnancies terminated for nonmedical or social reasons. The charges, covering only parts of the actual costs of the operation, may range from $5.50 in the Soviet Union to a week's wage in Czechoslovakia.

16. With the liberalization of abortion laws came a search for an improved method of termination. It was found in Mainland China where Wu & Wu (1958) and Tsaj (1958) reported a new procedure variously called vacuum, suction, or aspiration technique. Observed by Soviet and Yugoslav gynecologists, the procedure was imported to Eastern Europe and has been extensively described by Novak (1966, 1967, 1968a) in Yugoslavia and by Cernoch (1965a, 1966) and Vojta (1967a) in Czechoslovakia. As noted by Kerslake & Casey (1967), the basic technique is to aspirate the conceptus from the uterus using a tube which has a flexible connection to a suction pump. Local and/or general anesthesia is used where instrumental dilatation of the cervix is considered necessary. Uterus-contracting drugs may be given. Aspiration of the uterus content usually takes less than two minutes; the debris can be readily observed as it appears in the glass container. Instructive literature and a demonstration film are available from the Lalor Foundation (1968). A collective survey of Mainland China experience was summarized by Wu (1966). Reports suggest that the new procedure is technically easier, faster, and less traumatic than the traditional dilatation and curettage.

17. Mortality associated with legal abortion has fallen to very low levels. As noted in Table 3, compiled by Tietze (1969), in Czechoslovakia 13 deaths occurred among 413,000 abortions during 1958-62, corresponding to a rate of 3.1 deaths per 100,000 abortions. By 1963-67, mortality had dropped to 2.5 per 100,000

Table 3

Mortality with Legal Abortion:
Selected Countries in Eastern Europe, 1957-67*

Country and Period	Legal Abortions	Deaths	Rate per 100,000
CZECHOSLOVAKIA			
1958-62	413,000	13	3.1
1963-67	406,000	10	2.5
HUNGARY			
1957-58	269,000	15	5.6
1960-63	670,000	22	3.3
1964-67	739,000	9	1.2
SLOVENIA			
1961-67	70,000	4	5.7

*Based on Tietze (1969)

(Cernoch, 1968). Hungary reported a mortality rate of 5.6 per 100,000 abortions for 1957-58 and 1.2 deaths per 100,000 for 1964-67 (Hirschler, 1968). In Slovenia the corresponding rate was 5.7 for the years 1961-67 (Novak, 1968b).

18. Information on the frequency of nonfatal early complications of legal abortion is far less satisfactory than information on fatal complications. One reason is the lack of agreement among investigators as to the severity of the complaints and findings they define as complications (Tietze, 1969c). However, as an example, it may be useful to cite rates of complications reported from Hungary. Among 872,000 women undergoing legal abortions during the years 1961-65, 0.13 percent experienced perforation of the uterus, 0.4 percent had fever of gynecologic origin, and 0.6 percent hemorrhaged after the operation. One half of one percent of the total number had to be readmitted to a hospital because of fever and 1.1 percent because of hemorrhage. The sum of these rates is 2.7 percent. While there may have been other serious complications, some women may have been counted under several headings. The proportion of women who experienced any complications is not directly available, but was probably between 2.5 and 3 percent. Somewhat lower rates have been reported from Czechoslovakia.

19. Table 4 offers a summary of available information on abortion and family planning. Included are indications of existing legislation, who grants permission for abortion, where abortions may be performed, and whether a charge is made. Also mentioned is information on availability of modern contraception, existence of a family planning organization and government support for family planning, year of latest revision of family allowances, and whether or not a tax is imposed on childless individuals.

20. Concluding Observations on the implications of the abortion statistics for Central and Eastern Europe are presented in Chapter 11. It should be stated here, however, that there is wide agreement that induced abortion is not the preferred method of family planning. Major efforts have been initiated to substitute contraceptive practice and to reduce the number of requested abortions by wider and more effective dissemination of modern contraceptives. It must also be said that the chances of complications resulting from induced abortions during the first trimester of pregnancy are less in Central and Eastern Europe than the risks of carrying a pregnancy to term. Liberal abortion policies are being maintained as a means of keeping illegal abortions and associated health risks to a minimum, and to assure the right of women to determine family size and spacing of children.

Table 4

Family Planning Information in Selected Countries of Eastern Europe, 1967

	Albania	Bulgaria	CSSR	GDR	Hungary	Poland	Romania	Yugoslavia	USSR
1967 Population in 1,000s	1.9	8.3	14.3	17.0	10.2	31.9	19.3	20.0	235.5 million
Birth Rates per 1,000	34.0	15.0	15.6	14.8	14.5	16.3	27.1	19.5	17.5
Death Rates per 1,000	8.6	9.0	10.0	13.2	10.7	7.7	9.3	8.7	7.6
Average Percent Yearly Growth, 1963-67	2.8	0.7	0.6	0.2	0.3	1.0	0.6	1.2	1.2
Contraceptives - Pills	d	b	a	a	a	c	d	c	d
Contraceptives - Loops	d	b	a	b	a	c	d	c	1
Abortion	f	g	h	g	e	h	g	h	e
Approved By		i	i	i	i	j	k	i	k
Where Performed		HOSP	HOSP	HOSP	HOSP	H/O	HOSP	H/O	HOSP
Fee		SOCIAL	SOCIAL	NONE	SOCIAL	NONE	SOCIAL	SOCIAL	SOCIAL
Organized Family Planning Association	NO	NO	NO	1963	NO	1957	NO	1967	NO
Government Support of FPA	NO	NO	YES	YES	YES	YES	NO	YES	YES
Latest Revision of Family Allowances		1968	1968	1967	1967		1966	1967	1948
Higher Taxes on Childless		YES	NO	NO	NO	NO	YES	NO	YES

Codes:
a. Locally Produced
b. Imported
c. Produced and Imported
d. Neither Produced nor Imported
e. On Request
f. Medical Indications Only
g. Medical & Social Indications
h. Permissive Social Indications
i. Commission
j. Single Physician
k. Gynecological Department
l. Trial

NOSP = Hospitals
H/O = Hospitals or Outpatient Facilities

NONE = No fee charged for any kind of abortion.
SOCIAL = Fee charged for abortion performed for social reasons.
No country charges a fee for a pregnancy terminated for medical reasons.

Illegal Abortions

1. Estimates of illegal abortions at the national level are difficult but deaths due to complications of abortion are easily diagnosed and are usually so recorded in the vital statistics. In all Central and Eastern European countries, deaths from "other" than legally induced abortions have fallen in the years since liberal legislation was implemented (Potts, 1967).

2. That permissive laws have not eliminated illegal abortions entirely is apparent from the high number of "spontaneous" abortions in the hospital statistics reported from Czechoslovakia and Hungary in Chapters 7 and 5. It is generally conceded that the number of spontaneous abortions is above normal expectation.

3. In some countries a proportion of those requesting abortion are refused. Of those refused in Yugoslavia, for example, a substantial percentage resort to illegal abortions (Potts, 1967). Women having a second unwanted pregnancy within six months of their last legal termination are generally ineligible for legal interruptions and may seek alternative solutions to their problems. Some women prefer a private practitioner to conceal pregnancy and avoid registration of their abortions. And, in certain rural areas, a percentage turn to abortionists from force of habit.

4. Illegal abortion is always a punishable offense but enforcement varies. Assisting a woman in an illegal operation in Poland is subject to a maximum of three years' imprisonment; forcing a woman to terminate against her will carries a five-year sentence. The number of convictions in Poland fell from 514 in 1951 to 47 in 1957, a year after legalization of induced abortion (Wolinka, 1962, cited by Potts, 1967). In Czechoslovakia, the sentence is one to five years, depending on possible impairment of the woman's health. A woman inducing her own abortion is specifically immune from legal prosecution in most of the countries of Central and Eastern Europe.

Family Allowances, Tax Policy, and Marital Age

1. As indicated in Table 4 several countries have significantly increased family allowances over the years. However, Soviet family allowances have not

significantly changed for over 20 years. In Bulgaria family allowances for the fourth child are equivalent to those given for the first child and less than those for the second and third child. Effects on the birth rates are not readily identifiable.

2. Taxes on childless persons, married or unmarried, are imposed in Bulgaria, Romania, and the Soviet Union.

3. Among the Eastern European countries, only Poland officially raised the legally permissible age of marriage for men (from 18 to 21 years) and for women (from 16 to 18 years).

Contraceptive Methods and Practice

1. Historically, the "natural" method of coitus interruptus has been and continues to be most widely practiced. Among the "mechanical" methods, condoms are more popular than diaphragms. In the 1920s, in the Romanian area of Banat, sterilized horsehair was used as a primitive IUD (Alessandrescu, 1969).

2. Condoms may be purchased everywhere without prescription, usually at low cost. Jellies, creams, foams, and diaphragms are also obtainable, but are less popular.

3. Oral contraceptives and IUDs are becoming available, on prescription. Use is gradually increasing year by year. As cited in Table 4, pills are produced in Czechoslovakia, the German Democratic Republic, Hungary, Poland, and Yugoslavia. Coils are manufactured in Czechoslovakia, Hungary, Poland, Yugoslavia, and the Soviet Union. There is importation and exportation throughout Central and Eastern Europe; the exception is Romania which neither produces nor officially imports pills or coils.

4. Pills are available on prescription following gynecological examination. Regular follow-up examinations are required. Concern about the longer-term effects of the pill is expressed. Coils also require prescription. Data on expulsions are being accumulated. Costs of pills and coils are considered low.

In Poland, about 70 percent of the cost is borne by social security/health insurance. It has been suggested in Yugoslavia that modern contraceptives be free of charge and that a fee be charged for abortions of all types.

5. Most of the Central and Eastern European countries are increasing production and distribution of contraceptives. In 1958 the dissemination of contraceptive information and devices was made an integral part of the Yugoslav health service. Implementation was slow (Andoljsek, 1962) until disinterest was overcome through the burgeoning activities of the Federal Council for Family Planning. Considerable success in facilitating modern contraceptive practices has been observed in Poland and in the German Democratic Republic. Propaganda campaigns have been launched in Czechoslovakia, Hungary, and the Soviet Union. Education for contraception is a matter of growing concern, spurred by the rise in abortions, especially in repeated abortions. There is considerable interest in cooperative transnational research on motivation for repeated abortion-seeking behavior and substitution of more efficient contraceptive practice. A pilot study has been initiated in Hungary.

6. Research on contraceptive technology is centered mainly on the development of different dosages and procedures providing protection for longer periods of time. A new product, C-FILM, has been produced in Hungary and is described in Chapter 5.

7. Sterilization is rarely used, but is being considered for special circumstances under the name "irreversible contraception." Vasectomy is even more unpopular, recalling the period of Nazi occupation (Potts, 1967). There are no incentive programs.

8. It is difficult to assess the extent of contraceptive practice: questions may be embarrassing, knowledge of a technique is not the same as practice, a couple may be inconsistent in the use of a method or "forget." Different methods are tried at different times. And, there may be major differences among different socioeconomic, age, and geographically dispersed groups. The studies cited in the country chapters suggest that coitus interruptus remains the most frequent method of birth control, especially among older couples. Acceptance of pills and coils is gradual but rising.

Family Planning Centers

1. Independent family planning associations were organized with government support in Poland (1957), the German Democratic Republic (1963), and in Yugoslavia (1967). In Czechoslovakia, a Preparatory Commission for a Family Planning Association has been established.

2. In the other countries of Central and Eastern Europe, consultation on contraception and abortion is usually available from gynecological units in hospitals and outpatient departments.

Medical and Postgraduate Training

1. The teaching of family planning behavior and contraceptive practice is making gradual progress in the medical faculties of Central and Eastern Europe. Most textbooks barely mention modern contraceptives. There has been little study of resistances to abortion and contraception among senior gynecologists. Reasons for resistance range from economic to more subtle psychological factors.

2. Efforts have been initiated in Yugoslavia to explore the motivation of medical students and the attitudes and practices of physicians of various ages and specialities. Understanding the attitudes of physicians and working more closely with medical authorities would seem essential if modern contraception is to be substituted for a significant number of abortions.

3. Most frequently, medical students receive three or four hours of instruction in contraception during a gynecology seminar in one of their last years at medical school. The only extensive teaching program in family planning is at the University of Rostock Medical School, directed by K. H. Mehlan. His report on teaching family planning in Eastern Europe is available in English (Mehlan, 1969a).

4. Some limited postgraduate training for general practitioners and other medical personnel is organized under varying auspices in nearly all the countries.

Sex Education in the Schools

1. It is generally admitted in Central and Eastern Europe that sex education is a neglected area, compounded by the personal embarrassment of teachers and the unwillingness of many school physicians to devote much time and interest to the topic.

2. Extensive efforts to improve sex education in the schools are reported in the German Democratic Republic, Poland, and Yugoslavia. Of particular interest are the development of teaching materials at the kindergarten level in Zagreb, Yugoslavia, pamphlets prepared by the GDR and Polish Family Planning Associations, and the books by Brückner (1968) and Weber and Weber (1968) in the German Democratic Republic.

Public Education

1. Several of the socialist countries of Central and Eastern Europe have experienced cycles of more or less intensive public education in family planning. The consistent success of the Polish Family Planning Association suggests the productive effect of coordinated campaigns.

2. Public media, including press, radio, and T.V., have become increasingly aware of the wide interest in family planning. Popular books on the topic are sold at low cost and have a wide circulation, as for example the monographs by Hirschler (1958) in Hungary and Czechoslovakia, by Alecu-Ungureanui (1968) in Romania, and by Mehlan (1969b) in the German Democratic Republic.

3. From time to time in the Soviet Union and in Bulgaria, members of the Communist Party or Komsomol have been asked to refrain from requesting abortion except on medical grounds.

Research Notes

1. The role of psychosocial components in family planning behavior is receiving increasing recognition. To facilitate further studies, the

21st World Health Assembly requested the Director of the World Health Organization to foster "encouragement of research on psychological factors related to the health aspects of reproduction." (WHA 21.43, 23 May 1968)

2. Behaviorally oriented research is developing in all the countries, especially in Hungary, Czechoslovakia, and Yugoslavia. Plans have been initiated for joint research efforts and were discussed at the 1969 Budapest Research Planning Conference (David, Szabady et al., 1970).

3. Studies reported from Czechoslovakia, Hungary, Yugoslavia, and Romania suggest that well over 90 percent of legal abortions are performed for personal and/or social reasons. Particularly extensive are the Hungarian TCS reports (Szabady, 1968). Motivations differ from country to country, and have been summarized by Mehlan (1970).

4. The trend toward smaller families has been quite strong in most countries of the region, notably Romania. The most frequent reason given is the expressed desire for a better standard of living, requiring the wife's income. A home and a car often have higher priorities than a baby. (Personal communications.)

5. In all the countries, the number of legal abortions for working women is higher than for housewives. It is three times higher in the Soviet Union and double in Hungary and Czechoslovakia. In the absence of adequate child-care institutions, many women forego having additional children.

6. With the emancipation of women and with the greater educational and professional opportunities, demands of the job appear to take precedence over childbearing, especially if having a child means a long-term career interruption. This is particularly apparent in the Soviet Union where a high percentage of professional workers are women.

7. The incidence of abortion rises with age and parity. Usually, women living in cities are more inclined to resort to legal abortion than country women. As is apparent in the country chapters, the highest frequency of induced abortions is observed in the 25-29 year age group, followed by women 20-24 years old.

8. Nearly 80 to 90 percent of all women terminating their pregnancies are married. Around 1966 the population of unmarried women requesting induced abortion was 20 percent for Romania, 16 percent for Yugoslavia, 15 percent for Hungary, 12 percent for Czechoslovakia, 10 percent for the Soviet Union, with no data available from Bulgaria, the German Democratic Republic, and Poland. Unmarried women, including divorcees and widows, constitute the largest segment of pregnant women resorting to illegal abortions, mostly to keep their situation "secret."

9. In countries where abortion was or is available on request, abortion tends to be a major method of family limitation. In Bulgaria or Romania, married women with 20 or more abortions during their childbearing years are not uncommon. In a study in Leningrad, 70 percent of the women interviewed had had two or more abortions; 16 percent had had more than one interruption annually (Mehlan, 1970). Among the women applying for abortions in Czechoslovakia and Hungary, the proportion of those who have had three or more abortions is growing year by year.

10. Women refused abortion have been followed in Czechoslovakia by Stupkova (1969) and others. Of 555 women who lost their appeal for induced abortion, 313 actually delivered children, indicating a 44 percent rate of "other" abortions. Studies of the behavioral components of unwanted pregnancies and the longer term effects on the children and their mothers are in the planning stage.

11. Studies in contraceptive technology are progressing in all those countries which are manufacturing pills and/or loops, e.g., Czechoslovakia, the German Democratic Republic, Hungary, Poland, Soviet Union, and Yugoslavia. Studies of anticonception injections and sequential pills were reported in the German Democratic Republic and in Hungary.

12. While research in reproductive biology and psysiology exists, contacts made during this brief survey were insufficient to render objective judgment. The field is well covered by the bulletin on Research in Reproduction, issued quarterly since January 1969 by the International Planned Parenthood Federation.

Research Centers

1. Most research on questions of population is conducted in demographic research centers and other institutions listed in the individual country chapters. They are usually supported by government, either directly or indirectly.

2. Research in university or medical school settings is more limited. Behavioral studies are usually of recent origin. Psychologists and/or sociologists engaged in collaborative research were noted in Czechoslovakia, the German Democratic Republic, Hungary, Poland, and Yugoslavia.

3. While there is research in contraceptive technology and reproductive biology, the contacts made were too limited to allow adequate enumeration of research centers and major topics of investigation.

Reported Population Statistics

1. Available population statistics for each country are cited in the individual chapters.

2. A resume of types of available statistics on fertility and nuptiality is presented in Table 5.

3. Consideration should be given to the reservations regarding individual country statistics expressed by Potts (1967) and summarized in the individual country chapters.

Publications

1. Journals on demography and related areas are published in Czechoslovakia, Hungary, Poland, Romania, and Yugoslavia.

2. Specific journals are cited in the country chapters.

Table 5

RÉSUMÉ OF STATISTICS ON FERTILITY AND NUPTIALITY AVAILABLE IN EASTERN EUROPE, 1967*

	Albania	Bulgaria	Czech.	GDR	Hungary	Poland	Romania	USSR	Yugoslavia
NATALITY									
Number of live births	X	X	X	X	X	X	X	-[f,g]	X
Crude live-birth rates	X	X	X	X	X	X	X	(X)[f]	X
Live births by age of mother	X	X	X	X	X	X	X	-[g]	X
Live birth rates specific for age of mother	X	X	X	X	X	X	X	-[f,g]	X
Live births and rates specific for age of mother and urban/rural residence	-	X	-	-	X	-	X	-[h]	-
Live births by age of mother and live-birth order (a)	X	X[b]	X	X	X[a1]	X[a1]	X	-[g]	X
Live-birth rates specific for age of mother, by live-birth order	X	X[b]	X	X	X[a1]	X[a1]	X	-	X
Live births by age of father	X	-	-	-	X	X	X	-	X
Live-birth rates specific for age of father	X	-	-	-	X	X	X	-	X
Live births by legitimacy status, and per cent illegitimate	X	X	X	X	X	X	-	-[i]	X
Live births by occupation of father	-	-	-	-	X	-	-	-	X
Live births by sex	X	X	X	X	X	X	X	-[g]	X
Live births by type of birth	X	X	X	X	X	X	-	-	-
Legitimate live births by age of mother	-	X	X	X	X	X	-	-[i]	X
Legitimate live-birth rates specific for age of mother	-	X	X	-	X	X	-	-[i]	X
Legitimate live births by age of father	-	X	X	-	X	X	-	-[i]	X
Legitimate live-birth rates specific for age of father	-	X	X	-	X	X	-	-[i]	-
Legitimate live births by duration of married life (d)	X	X[c]	X	-	X	X[e]	-	-	X
Legitimate live-birth rates specific for duration of married life	-	-	-	-	-	-	-	-	-
Gross and net reproduction rates	X	X	X	X	X	X	X	-[g]	X

* Compiled by U.N. Working Group on Social Demography; USSR comments provided by U.N. Population Division.

NUPTIALITY	Albania	Bulgaria	Czech.	GDR	Hungary	Poland	Romania	USSR	Yugoslavia
Marriages and crude marriage rates	X	X	X	X	X	X	X	(X)[f,g]	X
Marriages by age of bride-groom and by age of bride	X	X	X	X	X	X	X	-[g]	X

X : Data available as reported in UN Demographic Yearbook, 1965.

(X): Data available from civil registers which are incomplete or of unknown reliability.

- : Data not recorded in Demographic Yearbook, 1965.

a : Birth order is based upon number of previous live births to the mother unless otherwise specified.

a_1 : Birth order based upon number of previous live births and stillbirths.

b : Legitimate live births and stillbirths.

c : Legitimate live births to women married once only.

d : Duration of married life is the number of completed years elapsed between the exact day of first marriage and date of birth of child.

e : First confinements of the existing marriage.

f : CSU SSSR. Narodnoe Hozaistvo SSSR v 1967 godu (Central Statistical Office of the USSR, National Economy in 1967), p. 37 and others.

g : CSU SSSR, Vestnik Statistiki, No. 11, 1967 (Herald of Statistics, No. 11, 1967), pp. 88-95.

h : Crude live-birth rates for urban and rural settlements separately (in source f).

i : All births are considered legitimate.

Resources

1. To complete the presentations, available laws on abortion are reproduced at the end of each country chapter.

2. An alphabetized list of selected references is given in Chapter 12. We would welcome learning about items inadvertently missed.

3. Appended are a report on the Activities of the Demographic Research Center in Budapest, 1966-68 (Chapter 13); a statement issued by the 1968 World Health Assembly (Chapter 14); and a statement of the International Planned Parenthood Federation with available publications (Chapter 15).

PART II. COUNTRY REPORTS

CHAPTER 2
SOVIET UNION*

Historical Trends

1. In the last decades of the nineteenth century, when a decline had already begun in Western Europe, the birth rate remained stable in Russia, fluctuating around 50 per 1,000 population. By 1913, the figure had dropped only slightly to 46 per 1,000. One reason was the youthful age of brides; in 1910 about 55 percent of all brides were under age 20. World War I produced a marked decline in births with the rate dropping to about 24 per 1,000 by 1917. After the October Revolution, the rate began to rise again, reaching a peak of 44.3 by 1928. Since that time there has been a gradual but persistent decline, briefly reversed by the prohibition of abortion in 1936, and reflecting the increasing urbanization and industrialization (Urlanis, 1965a). An extensive report on the demographic transition in the Russian Empire and the Soviet Union, 1861 to 1965, has been published by Heer (1968).

2. The impact of World War II was more severe on the Soviet Union than on any other nation. Although the exact size of the population at the end of the war is not known, an official estimate of 178.5 million made at the beginning of 1950 is about 20 million lower than the population at the time of the Nazi invasion in 1941. Not until the mid-1950s did the Soviet population reattain its prewar level, continuing to grow to 212.3 million at the beginning of 1960 (Brackett, 1964).

*The material presented stems from readings, Soviet publications, and extensive discussions with knowledgeable colleagues. The chapter was initially reviewed by James Brackett (Washington) and by Dr. Boris Lebedev (Geneva).

3. The birth rate dropped from 31.2 per 1,000 population in 1940 to 26.7 in 1950. It remained relatively stable throughout the 1950s at 25-26 per 1,000, despite the relegalization of abortion in 1955. From 24.9 in 1960, the rate then gradually dropped to 17.3 in 1968, as the fertility of married women continued to decrease amidst a changing socioeconomic environment (Urlanis, 1969).

4. Changes in the age-sex structure of the Soviet Union have been of significance. After World War I and the Revolution, the sex ratio of the total population dropped to 93.5 males per 100 females, with only 84 males per 100 females in the age group 25 to 29 years. By 1939, following the decree for the collectivization of agriculture, the sex ratio of the total population decreased to 92 males per 100 females; the age structure also reflected the decline in birth rate during collectivization.

5. At the end of World War II, there were only 60 males per 100 females in the population 20 years old and older. By 1950 the sex ratio had risen to 73 men per 100 women in the reproductive age of 15 to 49 years (Brackett, 1964). By 1960 the ratio had further increased to 84 males per 100 females in the population, with a near normal ratio in the ages under 30 years which includes a large proportion of parents of newborn children. Since the birth rate did not rise it appears that the fertility of married Soviet women decreased substantially and that this decrease in marital fertility was counteracted by the increased proportion of Soviet women who were married (Heer, 1968).

6. Birth rates vary considerably within the Soviet Union. For example, in the Azerbaijan and Turkmen Soviet Socialist Republics, the rate for 1962 was over 40 per 1,000 while in the Baltic Republics (Latvia, Estonia) it was 16 per 1,000. The rate for the entire Soviet Union in that year was 22.4 per 1,000 population. The 1967 birth rate in the Latvian Soviet Socialist Republic was 14 per 1,000 population, one of the lowest in the world (Zvidrins, 1969). While the rate is still declining in some republics, it continues to rise in others (Urlanis, 1965a; Harmsen, 1967). In 1967, of all the U.S.S.R. rural families, less than 7 percent had five or more children under 16 years of age; the percentage in the Central Asian Republics, however, was more than 22 percent.

7. Among the social factors influencing the birth rate, first place is usually accorded by Soviet writers to the emancipation of women. In 1965 about 79 percent of physicians, 70 percent of teachers, and 38 percent of scientists in the Soviet Union were women. Of the total number of women of working age only 17 percent are dependent housewives whose fertility rate is considerably higher than working women in all age groups of childbearing age, except those 15 to 19 years (Urlanis, 1965a).

8. Other factors are the rising socioeconomic-cultural standard of living and the limited child-care resources. In 1963 less than 20 percent of the children under 7 years of age were in kindergartens or crèches (Cook, 1967). At the end of 18 weeks' maternity leave, the mother frequently discovers that many others are ahead of her on the long waiting list for the neighborhood child-care center.

9. Still another factor is the decision, made during the Soviet industrialization drive, to allocate very little money for the construction of new urban housing. From 1929 through World War II the amount of urban housing space per capita declined. Since 1951, and particularly since 1956, great efforts have been made to increase per capita housing. Still, numerous young couples have to double up with parents while waiting for their own flat. Others live in one room of communal apartments. Heer (1968) suggests that if Soviet housing conditions were not improving, the birth rate would probably be declining more rapidly.

10. The continuing migration from rural to urban areas also exerts an influence. The rising ratio of the urban to the total population tends to be a reducing factor on the birth rate, in part because of the greater use of contraception and abortion in the cities. Similarly, the desire of many Soviet girls to complete their education before marriage, and/or acquire economic independence, has resulted in a rise in the age at marriage and postponing the birth of children.

Abortion Policy Trends

1. Field (1956) has made a careful study of the different phases in Soviet abortion policy. The topic has also been summarized in books on the Soviet

family by Geiger (1968), Mace (1963), and Schlesinger (1949), and in volumes on abortion by Callahan (1970) and Lader (1966).

2. During the period 1917-20 abortions were illegal even when medical indications were present. This had been the Czarist law. Illegal abortions mounted. Urlanis (1965a) estimates that nearly half the women who aborted themselves became ill and that of these about four percent died.

3. In his writings Lenin advocated the legalization of abortion and the dissemination of contraceptive information. He contended that one of the basic rights of a woman was that of deciding whether her child should be born. (Works of V. I. Lenin, Volume 19, pp. 206-207, in Russian.) On November 8, 1920, three years after Lenin came to power, the new Soviet government legalized abortion on request of the pregnant woman. A joint decree was issued by the Commissariats of Health and Justice, along with an explanatory commentary (Field, 1956).

4. It is important to note that the 1920 decree, as well as later decrees related to births, were not presented as measures designed to implement a population policy. They were deemed social welfare programs, means of raising the status of women, protecting their health, and recognizing their equal status (Brackett & DePauw, 1966). The 1920 liberalization had been intended to be temporary. The theory was that as social conditions improved and the state took over more of the burdens of child rearing, abortions would become less necessary and the problem of unwanted pregnancy would cease to exist (Callahan, 1970).

5. Abortions were performed, without fee, by licensed surgeons in the arbortoria of local hospitals. Anesthesia was seldom used. The usual length of hospital stay was three days. The mortality rate was estimated to be less than one percent for the U.S.S.R. as a whole (Mace, 1963). The demand for abortions increased as women were exhorted to work and the organization of child-care facilities lagged. A fee was introduced in 1924. At the first Ukrainian Conference of Gynecologists in Kiev in 1927, termination of first pregnancy was strongly discouraged (Meyer, 1933; Schlesinger, 1949). Izvestia published articles warning of the dangers of abortion, and party members were asked to set examples by not resorting to abortion except for major medical reasons.

6. In 1934 a campaign was launched against sexual promiscuity, bigamy, and adultery. Heer (1968) cites a report by Urlanis that in 1934 in the Russian Republic there were 700,000 legal abortions and 3 million births. Lorimer (1958) estimates that in the major cities abortions exceeded births. Production was affected by the two weeks' leave given to women after termination of pregnancy. In 1935 a new decree forbade abortion of the first pregnancy except for medical reasons and then only within the first three months. A six-montn interval was required between any two abortions. The divorce laws were tightened.

7. After further public discussion (Schlesinger, 1949; Field, 1956), legislation was enacted on June 27, 1936, making abortion a criminal offense except for compelling medical and eugenic reasons (U.S.S.R., 1936). The accompanying commentary justified the law of 1920 as a "regrettable necessity." It was felt that the climate had changed and that there were better state provisions for mothers and children, plus assurances of more adequate financial support from fathers. Family allowances were initiated for those with seven or more children and the network of créches, kindergartens, and other child-care facilities expanded. A list of approved medical indications for abortion was circulated (U.S.S.R., 1936). Any physician performing an abortion contrary to regulations was liable to imprisonment of one to two years; the penalty was at least three years' imprisonment if the operation was performed by an unqualified person. Compelling a woman to undergo abortion resulted in two years' imprisonment. The woman involved would receive a social reprimand the first time and be fined up to 300 rubles if the offense was repeated.

8. The immediate effect of the prohibition of abortion was an increase in the birth rate for the U.S.S.R. as a whole from 32.3 per 1,000 in 1936 to 38.7 in 1937. In the cities the impact was more dramatic: Heer (1968) cites jumps of 91.5 percent in Moscow and 68.7 percent in Leningrad. However, the increase was short lived. By 1940 the rate of 31.2 per 1,000 was below the 1936 figure. Illegal abortion had returned. Mace (1963) quotes a Leningrad gynecologist as stating that 70 percent of the beds in his department were occupied by women with complications from illegal terminations of pregnancy.

9. The rising rate of illegal abortions produced increasing concern, especially in the post World War II years. The severity of the 1936 restrictions were

loosened by the decree of 5 August 1954 absolving the pregnant woman from legal liability in the termination of her pregnancy. On 23 November 1955, two years after the death of Stalin, the 1936 restrictions were completely repealed by a decree of the Supreme Soviet (U.S.S.R., 1955). The reasons cited were to reduce "the harm caused to the health of women by abortions carried out outside of hospitals," and "to give women the possibility of deciding for themselves the question of motherhood" (Field, 1956). The 1955 decree was similar to the one promulgated in 1920, stipulating that abortions can be performed only by qualified personnel in medical facilities. No commentary accompanied the decree and little publicity was given to it. On 28 December 1955 the Ministry of Health issued more specific instructions, stating that abortions may not be performed if the health of the woman is threatened or when a previous pregnancy was terminated within the immediately preceding six months. When the gestation period exceeds 12 weeks special permissions are required. Reinstating legalized abortion on demand and fostering dissemination of contraceptive information heralded a return to the Leninist doctrine that a woman has a right to decide whether or not to give birth to a child (Cook, 1967). Relegalization did not result in a sudden birth rate decline, in part because of the large number of previously illegal abortions, but had a depressant effect on fertility of married Soviet women (Heer, 1968).

10. It is now the usual practice that a gynecologist discusses with each woman the reasons for her application for abortion and warns her of possible adverse consequences. In cases of social difficulty, a lawyer is consulted. If the pregnant woman persists in her request for abortion, her application must be approved. Termination is performed in a hospital, with a minimum three days' stay. The vacuum aspiration method is widely used. Anesthesia is rarely given. Cost for an induced abortion is five rubles or $5.50. Therapeutic abortions are free. Mortality and morbidity are low. Although women are expected to go to the maternity center in their locality, they frequently travel to a larger town in an effort to conceal their abortion (Mehlan, 1966a). The impression persists that Soviet physicians continue to oppose abortion in principle but have accepted it as a lesser evil than illegal abortion.

11. At the 1962 International Symposium in Budapest, Vostrikova (1964) reported that abortion statistics are compiled in the Soviet Union. While no country-wide data have ever been published, studies of women requesting abortion and the

wide regional differences in birth rates suggest that the incidence of abortions in the major European Russian cities is probably similar to the Scandinavian experience.

12. The only large-scale Soviet survey of women requesting abortion was conducted in 1958-59 in the Russian SFR, with the results published by E. A. Sadvokasova (1963). As cited by Heer (1965a,b), 20,000 women were from urban areas and 6,000 from the countryside. Respondents were selected from each of the ten economic regions of the Russian SFR, and were asked to complete written questionnaires when contacted at medical establishments. "The overwhelming majority of women having an abortion were married." Of the urban women, 10.2 percent were childless, 41.2 percent had one child, 32.1 percent two children, and 16.5 percent three or more children. Of the rural women, 6.2 percent were childless, 26.9 percent had one child, 30 percent two children, and 36.9 percent three or more children. The median number of children born to rural women was 2.06 compared to 1.47 to urban women. An indication that few of the women were single stems from the comment that only 6 percent of the urban women and 3.8 percent of the rural women were pregnant for the first time. All the respondents were asked why they wished to terminate pregnancy. "Unconditionally Removable" causes (e.g., material need, inadequate housing, and lack of child-care facilities for working mothers) accounted for 35.0 percent of the urban women and 26.3 percent of the rural respondents. The difference in the two groups stems from inadequate housing which was mentioned by 14.0 percent of the urban and only 4.2 percent of the rural women. "Conditionally Removable" causes (e.g., absence of husband, family troubles, and illness of one or both parents) are cited by 16.5 percent of the urban and 18.0 percent of the rural respondents. The "Unremovable" causes (e.g., too many children already or pregnancy too close to previous birth of baby) were given by 10 percent of both the urban and rural women. "Unwillingness" of mother to have another child accounts for 30.2 percent of the urban and 40.1 percent of the rural women. Father's unwillingness and other "unclear" causes total 8.7 percent among the urban and 5.1 percent of the rural women.

13. None of Sadvokasova's published findings indicate directly the incidence of abortion among women of reproductive age in the Soviet Union. Heer (1965a,b) makes some inference from the statement that "In our country the overwhelming proportion of women of productive age are occupied in work . . . the frequency of abortion among women of this group is considerably higher than among those not

occupied in work (105.5 per 1,000 as against 41.5 per 1,000). Heer calculates that, based on 1959 census data, the annual number of abortions would exceed the number of live births. This calculation is further strengthened by the fact that Sadvokasova's survey did not include pregnancies terminated outside a hospital, which, she wrote, "still constitute a sufficiently large number." And, "a considerable portion of them are criminal abortions." Nikonchik (1959) noted that in 1958 abortions performed outside a hospital constituted 20 percent of the total abortions. Another indication of the high rate of abortion among Sadvokasova's respondents is the statement that 15 percent of the urban and 16 percent of the rural women had a previous abortion within the preceding twelve-month period.

14. Mehlan (1970) estimates that there are about six million abortions annually in the Soviet Union. In the cities nearly three of every four pregnancies are believed to be terminated by abortion. Citing a Leningrad study (Mehlan, 1970) notes that of 1,350 women who had legal abortions, 70 percent were found to have had two or more previous abortions and 12 percent had had six or more. Another 16 percent had more than one abortion in the same year; some as many as three abortions. Of 1,000 women, 138.5 had been admitted to hospitals and of these 25 admissions were for abortions. Mehlan suggests that nearly every fifth woman treated in a Soviet hospital in 1965 had a legal abortion and that abortions represented about 18.5 percent of all female hospital admissions.

15. One of the most recent studies comes from the Latvian Soviet Socialist Republic, reported by Zvidrins (1969). The Latvian SSR has one of the lowest birth rates in the U.S.S.R., 14 per 1,000 population. To study factors causing the decrease of the general level of marital fertility, special sample surveys were organized by the Latvian Section of the Scientific Research Institute of the U.S.S.R. Central Statistical Office in cooperation with the Ministry of Health in 1966-67 and in 1967-68. In the first survey 13,900 of 23,000 women married in 1959 were interviewed. The average age at marriage was 25.5 years and 33 years at the time of survey. It was noted that most births were related to conscious decisions by the spouses, with a constantly increasing role played by induced abortions. In the second survey 13.5 percent of the women (9,100) who had abortions in 1967 were interviewed. The average number of children of the women married in 1959 was 1.4 per family (1.29 in the towns, 1.68 in the villages, and 1.19 in the capital city of Riga). After 8-9 years of marriage, 15 percent

of the families had no children, 48 percent had one, and 5 percent had three or more. The fluctuation of the birth rates was studied by socio-occupational groups, nationalities, educational level, income, and housing conditions.

Illegal Abortions

1. Mace (1963) cites reports estimating that between 1923 and 1932 the rate of illegal abortions dropped from 57 percent to 10 percent of total abortions.

2. Mehlan (1970) cites a report by Nikonchik (1959) that in 1954, just before the repeal of the 1936 restrictions, 80 percent of all abortions were illegal. By 1963 estimates of illegal abortions were about 16 percent of total abortions.

3. Reliable current estimates on illegal abortions are difficult to obtain. Avdeeva (1965) reports a study of the causes and conditions leading to illegal abortions and control measures initiated by the Soviet government. Campbell (1965) notes the incidence of illegal abortions among unmarried women.

Family Allowances and Tax Policy

1. The 1936 law prohibiting abortion also established, for the first time, a family allowance policy. Annual allowances were provided for the seventh and subsequent children. In 1944, during the war, the program was improved with lump sum payments for third and subsequent children, and monthly allowances for fourth and subsequent children from their first to the fifth birthday. Both types of payments increased sharply with the number of older living children. Unmarried mothers received additional monthly sums for their first three children until they reached the age of twelve (Heer, 1966). Mothers of the largest families were awarded medals, ranging from "Medal of Maternity" to "Heroine Mother." (Cook, 1967)

2. On January 1, 1948, family allowances were cut in half and have remained at that level for the past twenty years despite the substantial increase in

Soviet wage levels since the end of World War II (Cook, 1967). The schedule of payments is shown in Table 6. The mother receives a separate payment for each of her eligible children. No financial assistance is received for the first two children.

3. Assuming the 1964 average annual wage of a skilled worker to be 1,080 rubles, the yearly payment to a family with four children would be 48 rubles or 4.4 percent of the average wage. Payments for families with five children rise to 12.3 percent or 133 rubles per year. In the rather extreme case of the birth of a tenth child, during the year when two other children are elibible for monthly payments, a total payment of 445 rubles or 41.2 percent of an average wage would be made. About 33 percent of mothers with ten or more children stem from the Moslem segment of the Soviet Union, which constitutes 11 percent of the total Soviet population (Heer & Bryden, 1966a).

4. As a result of the reduction in benefits in 1948, the value of the family allowance payment relative to the rising average wage has drastically declined. For example, for families giving birth to a fifth child, and with their fourth child eligible for monthly payments, the family allowance in 1944 amounted to 51 percent of the average annual wage, compared to 19 percent of the average annual wage in 1948 and 12 percent in 1964. Heer and Bryden (1966a,b) suggest that "at the present time the Soviet program of family allowances in all probability has little overall positive effect on Soviet fertility."

5. In contrast to family allowances, the current program of maternity leave is generous. Wage and salary earners receive 112 days of maternity leave at full pay. Collective farm workers are given half pay for one month before delivery and one month afterwards.

6. All employed men over age eighteen and working married women without children must pay a 7 percent "childlessness" tax. This amount is significant, considering that the average Soviet income tax is 10 percent and the maximum is 13 percent (Medical World News, 10 January 1969). Also, the government will no longer provide support for illegitimate children (Cook, 1967). Divorces are easy to obtain if the couple is childless.

Table 6

1964 Schedule of Payments to Mothers of Large Families and to Unmarried Mothers in the Soviet Union (in New Rubles)*

	Lump Sum at Birth**	Monthly Amount Paid for Child	Period of Payments
A. To Mothers of Large Families			From first to fifth birthday
Number of Older Living Children			
2	20	0.0	
3	65	4.0	
4	85	6.0	
5	100	7.0	
6	125	10.0	
7	125	10.0	
8	175	12.5	
9	175	12.5	
10 or more	250	15.0	
B. To Unmarried Mothers			From birth to twelfth birthday
Number of Living Children			
1	-	5.0	
2	-	7.5	
3	-	10.0	

* Based on Heer and Bryden (1966)[a]

**1 Ruble equal $1.10 at official exchange rates

Contraceptive Methods and Practice

1. In a letter to Literaturnaya Gazeta, published on 11 December 1968, the Soviet Minister of Public Health, Dr. Boris Petrovsky, announced the Soviet Government's decision to begin mass manufacture of intrauterine devices in preference to contraceptive pills (The New York Times, 12 December 1968). Dr. Petrovsky wrote that total production was expected to reach one million in 1968. (The Soviet Union has about 55 million women of childbearing age, 15 to 45 years.) Pilot programs for training medical staff in fitting IUDs have been initiated in Moscow, Leningrad. and Tiflis. At least two types of devices are being produced: Lippes loops and a Soviet configuration resembling a miniature umbrella shaft with several arms radiating from one end.

2. Comparative research with intrauterine devices and with oral contraceptives was conducted over a three-year period by the Scientific Research Institute of Obstetrics and Gynecology of the Soviet Academy of Science and by the All-Union Scientific Research Institute of Obstetrics and Gynecology of the Ministry of Public Health. Dr. Leonid Persiyaninov, Director of the Institute of Obstetrics and Gynecology of the Soviet Academy of Science, noted that both methods were more than 90 percent effective; the decision to mass-produce IUDs was based primarily on differences in side effects (Medical World News, 10 January 1969). Despite the current judgment against the pill, research and clinical trials will be continued with the Hungarian hormonal preparation Infecundin.

3. Available from the maternity centers are condoms, diaphragms, cervical caps, Gramicidin paste, and vaginal tablets (Nicozeptin, containing nicotinic acid; Lutenin, with a vegetable agent; and Galazepnin).

4. The effect of Soviet campaigns to disseminate contraceptive information is difficult to judge. Mehlan (1969a) reports a Soviet study indicating that of the women who have had one or more abortions and continue regular sexual intercourse 40 percent do not use any contraceptive. Heer (1965a,b) cites a field survey by Chernetskii (1961) of women requesting an abortion in a small town near Rostov in the Russian SFR; 52 percent of the respondents did not use any method of contraception. Condoms were the most prevalent method used (20 percent), followed by coitus interruptus (10 percent), lactation (8 percent), douches (5 percent), and diaphragm/jelly (5 percent).

5. Urlanis (1967) commented at the 1967 Congress of the International Union for the Scientific Study of Population: "birth control is a fact now practiced almost throughout the whole of the Soviet Union; this means a responsible attitude on the part of parents to the formation of their families. Only in the Central Asian republics, in the Azerbaijan Soviet Socialist Republic and in the Armenian Soviet Socialist Republic, there is as yet no widespread birth control because of ethnic factors." In a paper presented to the 1969 Conference Urlanis (1969) added that "the native population of the Kazakh SSR and of the autonomous republics of the Russian SFR hardly practise birth control."

Family Planning Centers

1. Following the relegalization of abortion in 1955 there was wide recognition that prevention of unwanted pregnancy was preferable to termination and that instruction in the use of contraceptive methods should be given immediately before or after abortion. Stepanov (1957) urged the reestablishment of counseling centers for women, the training of younger gynecologists by older colleagues experienced in prescribing contraceptives twenty years ago, quality control in the production of contraceptives, and research and development in contraceptive technology.

2. A network of maternity centers, staffed with gynecologists, midwives, and lawyers covers the country. There is one gynecologist for every 3,000 women 15 years and over. Attached to each center is a special unit whose function is to reduce the number of legal abortions and abortions performed outside hospitals, and to encourage the use of contraceptives. The gynecologists and midwives are required to instruct the women in the use of contraceptives. Informational material and contraceptives are available (Mehlan, 1970).

3. There are no independent family planning centers in the Soviet Union in the western sense. The only contraceptive advisory center is located in the Laboratory for Sexology and Sexual Pathology in Moscow, established in 1966. Ada Baskina reported in Literaturnaya Gazeta that the six physicians on duty are booked solid for several months in advance. Patients are accepted only on reference from the Ministry of Health. More than 100 written requests for assistance are received each week. There is only one exception: newly married couples are seen immediately (Stein, 1969).

Medical and Postgraduate Training

1. Lectures on contraception are included in the general course on gynecology taught in Soviet medical schools.

2. Physicians receive additional training during their gynecological specialization and subsequent assignments to maternity centers.

Sex Education in the Schools

1. Writing in Literaturnaya Gazeta, the Soviet journalist Ada Baskina comments on the neglect of sec education in schools, the shortage of qualified experts and teaching materials, and the absence of youth advisory centers (Stein, 1969).

2. A book on "Questions of Sex Education" by Dr. Atarow was published in 1959; he blamed much premarital activity on the "conspiracy of silence" with which parents and teachers surround the topic of sex. A similar complaint was voiced more recently by Komsomolskaya Pravda, the newspaper of the Communist Youth Organization. It reported a survey showing that 65.6 percent of Soviet youth learn about sex "on the street"; 16.8 percent receive instructions in school; and 7 to 8 percent find the information at home (Stein, 1969).

Public Education

1. Russian maternity centers are required to give public lectures on contraceptives, the danger of abortion, and marital problems. Intensive efforts are made to reach husbands.

2. Informational material on contraceptives is produced by the Central Institute for Health Education in Moscow (Geissler and Reis, 1967). Films, pamphlets, exhibits, and posters are produced.

3. According to Medical World News (10 January 1969) the Soviet government has further intensified public education by offering instructional classes

on family planning, literature, and displays of contraception in welfare centers and pharmacies.

4. General observations suggest that despite the official promotion of contraception, many people know little about it. Literaturnaya Gazeta continues its campaign for more public discussion of sexual matters (The New York Times, 13 June 1969).

Research Notes

1. At the World Population Conference in Belgrade, Ovsienko (1965) reported that, based on data from the 1962 U.S.S.R. sample budget surveys, 50 percent of the families of salaried workers (including professionals) had only one child under age 16, 41 percent had two children, and 9 percent had three or more. Among manual workers, 46 percent were one-child families, while 39 percent had two children. Among collective farmers, 40 percent had one child and 32 percent had two children.

2. In a candid article, published in English by the Hungarian Academy of Science, Urlanis (1968) laments the failure of Soviet scientists to conduct research on fertility behavior. Urlanis comments that the Soviet census does not inquire about the total number of living children or duration of marriage. He recommends that questions on fertility be included in at least a 10 percent sample of the U.S.S.R. census questionnaire. Further, anonymous surveys should be conducted about contraceptive practices, dissolution of marriages, frequency of abortion, etc. "They all throw light on that side of human relations which cannot be reached by statistics. Such data permit us to make our knowledge of the spread of birth control more precise and thus to form a more correct picture of the future trend of fertility."

3. A population census is to be conducted in 1969, directed by P. Podyashchikh (1968), whose more traditional views on population policy are also published in the English language volume issued by the Hungarian Academy of Science.

4. A. M. Vostrikova (1964), of the U.S.S.R. Central Statistical Office, reported at a 1962 Symposium of the Hungarian Academy of Science that "certain scientific research institutes dealing with sanitary problems conduct research to

obtain data on the age of women requesting abortion, their marital status and their reasons for abortion."

5. The All-Union Scientific Conference on Problems of the Population of Central Asia, organized by the Tashkent Lenin State University in September 1965, was in essence the first in the U.S.S.R. devoted to the discussion of the complexity of problems of population development in socialist countries considered from the viewpoints of various disciplines (Karakhanov, 1969). The Conference was not limited to the region. Participants came from all the constituent republics of the U.S.S.R. and from Czechoslovakia, Bulgaria, German Democratic Republic, and Poland. Most widely discussed were aspects of the Socialist Law of Population. Population policy was considered an important element of a general socioeconomic policy designed to fulfil economic, humanitarian and public health demands. "Discussion of demographic problems led to the conclusion that population policy in the socialist countries, while always directed at lowering the death rate, may have various aims in relation to fertility, depending upon specific conditions: it may be directed at stimulating fertility in some cases, and of lowering or stabilizing it in others. This does not mean, however, interference of the State in the freedom of families in connection with decisions, whether or not to have children" (Karakhanov, 1969). Aspects of the Marxist-Leninist theory of population movement were discussed at a November 1966 All-Union Symposium, reported by Boyarski and Valentei (1968). Participants recognized the need to consider social and psychological views in their deliberations.

Research Centers

1. Demographic research institutes at the U.S.S.R. Academy of Science in Leningrad and at the Ukrainian Soviet Socialist Republic Academy of Science in Kiev were closed in the mid-thirties. A resurgence of the social sciences began nearly 20 years later, in 1956, after the twentieth Communist Party Congress. A 1961 decision by the Presidency of the U.S.S.R. Academy of Science to reestablish a Demographic Research Institute awaits implementation (Urlanis, 1968).

2. That considerable demographic research activity has been initiated in the Soviet Union is apparent from the paper by Boyarski and Valentei (1968) published in English by the Hungarian Academy of Science: "A revival of demography has begun in the country, and organization of a Marxist-Leninist population research has started free of any dogmatism and narrow-mindedness, although profoundly party-minded in its contents as regards approach of problems."

3. A research team named "Demography in the period of building Communism" was organized in 1962 by the Scientific and Technical Council of the Ministry of Higher and Secondary Education of the Russian Soviet Socialist Republic.

4. In 1963 the Scientific Research Institute of the Central Statistical Office was founded. It is directed by Boyarski and includes a Demographic Section. Attention is mainly on population projections and on the research problems of the reproduction of population. Deputy Chief of the Central Statistical Office is Peter Podyashchikh.

5. A Laboratory of Demographic Questions was organized at Moscow State University directed by Valentei. It is concerned primarily with general theoretical problems of the reproduction of population, population movement, and migration and settlement. Research teams are interdisciplinary.

6. Teams dealing with demography are at work in the Institute of Economics of the U.S.S.R. Academy of Science and at the Ukrainian Academy of Science.

7. In April 1963 the Ministry of Higher and Secondary Education established a Council of Coordination of Population Problems.

Reported Population Statistics

1. The 1937 census was abruptly discontinued because it was claimed census and political questions were intermingled. Another census was conducted in 1939. However, no population data were published in the Soviet Union from the beginning of World War II until after Stalin's death.

2. Available population statistics are sparse, rendering projections difficult (Brackett, 1964; Heer, 1968). There are no published national data on induced abortions. Official records of births and deaths are not always complete. In an English-language paper, prepared for publication by the Hungarian Academy of Science, Urlanis (1968) commented, "The few tables on birth and death rates published in the volume 'The National Economy of the Soviet Union' do not serve as a basis for scientific research. In our opinion there is a need for the publication of demographic yearbooks containing detailed and exhaustive data on all demographic processes taking place in the country. In the Soviet Union, yearbooks of this type were published for the last time in 1929, containing data for 1926."

3. Regularly compiled population statistics are described in an English-language publication by A. M. Vostrikova in 1964, head of the Section for Population and Health Statistics of the U.S.S.R. Central Statistical Office. Sample surveys are conducted from time to time. Some data are published in the periodical "Vestnik Statistiki" (Statistical Indicator) and in "Norodnoye Khoziaistvo" (National Economy). Cogent tables from 1965-67 issues are listed in Table 7

Addendum

Murray Feshbach of the U.S. Bureau of the Census has just called my attention to a recently published volume on Socio-Hygienic Aspects of Regulation of Family Size by Ye. A. Sadvokasova, published by Meditsina, Moscow, 1969. It gives the number of abortions in each year as a percentage of the preceeding year's level during the period 1954-1966. Extrapolating from this material, if the base for 1954 was 100, the corresponding figure for 1966 is 419.9.
Mr. Feshbach also noted a new textbook for physicians, edited by A. F. Serenko (Moscow, 1969). In Lecture XII on "Abortion as a Socio-Hygienic Problem," it is stated that "in our country" there were 1.6 abortions per each live birth in 1960, and 2.5-3.0 abortions per each live birth in 1965. If interpreted correctly, these data suggest an abortion rate higher than any other currently reported from Central and Eastern Europe.

Table 7

Demographic Data in the Union of Soviet Socialist Republics*

Narodnoye Khoziaistvo, 1965
(National Economy, 1965)

Page 42 — Natality, mortality and natural increase of population (per 1,000 population)

For selected years 1913-1965.

Page 43 — Number of births

For selected years 1913-1965.

Total births and births to mothers with three children or more.

Page 43 — Birth rates in urban or rural areas

For selected years 1913-1965.

Page 44 — Age-specific birth rates

1938-1939, 1958-1959, 1960-1961 and 1964-1965.

Five-year age groups.

Pages 46-47 — Natality, mortality and natural increase of population by republic and economic region

Pages 48-49 — Marriages and divorces by republic and economic region (per 1,000 population)

Vestnik Statistiky No. 12, 1966
(Statistical News No. 12, 1966)

Table 2 — Number of births and deaths by months

Table 3 — Births by order of birth

Birth order: first, second .... , ninth and over.

Table 4 — Natality, mortality and natural increase of population in regions, republics, provinces and districts (per 1,000 population)

Table 5 — Marriages and divorces in regions, republics, provinces and districts (per 1,000 population)

Table 6 — Marriages by age of spouses

Five-year age groups.

Vestnik Statistiky No. 8, 1967
(Statistical News No. 8, 1967)

(Special article on indicators of nuptiality and fertility of women)

Table 1 — Medium age of entry into first marriage by cohorts of women

Birth cohorts: 1889 and earlier, 1891-1894, ...1925-1929.

Urban and rural areas.

*Compiled by the U.N. European Working Group on Social Demography

Table 2 — Cumulative indicators of fertility by birth cohorts

Average number of births per 100 women attaining age 20, 25, ... 50 years.

Birth cohorts as in Table 1.

Urban and rural areas.

Table 3 — Frequency of subsequent births among women at completed fertility(%)

Birth cohorts: 1889 and earlier, 1890-1894, ... 1910-1914.

Urban and rural areas.

Table 4 — Cumulative indicators of fertility by marriage cohorts

Number of births per 100 women at duration of marriage: 3, 5, 10, ... 1950-1954.

Marriage cohorts: 1920-1924, 1925-1929, ... 1950-1954.

Table 5 — Fertility trend in marriage cohorts

Average number of births per woman.

Marriage cohorts as in Table 4.

Duration of marriage: 15, 20 and 25-30 years.

Urban and rural areas.

Table 6 — Distribution of births by birth intervals, 1920-1949 (percentages)

Intervals between first and second births, second and third, ... eighth and ninth.

Percentage distribution of births by birth intervals in single years and median intervals in months.

Table 7 — Percentage of subsequent births and birth intervals, 1920-1949

Birth order: first, second, ... , ninth and over.

Average birth intervals in months.

Urban and rural areas.

Table 8 — Net nuptiality tables for women in 1949-1959

Single years of age.

Probability of marriage per 1,000 women at given age.

Urban and rural areas.

Table 9 — Probability of birth of next n^{th} child per 1,000 women of given age having borne (n-1) children

Single years of age.

Birth order: first, second, ... , tenth.

Probability of birth per 1,000 women of given age and parity.

Table 10 — Distribution of women at completed fertility by number of children borne (according to fertility tables)

Number of children born: 0, 1, 2 .... , 10 and over.

Urban and rural areas.

Table 11 — Distribution of women of given age by number of children borne (according to fertility tables) per 1,000 women

Number of children born: 0, 1, 2, 3, 4 and over.

Births at age: 20, 25, ... , 50.

Urban and rural areas.

Table 12 — Number of children born in first marriage at completed fertility (per 1,000 marriages)

Age at marriage: 15-19, 20-24, ... , 30-34 years.

Urban and rural areas.

Table 13 — Distribution of women by number of children born in first marriage (per 1,000 marriages)

Age at marriage: 15-19, 20-24, ... , 30-34 years.

Number of children. 0, 1 .... , 6 and over.

Urban and rural areas.

Table 14 — Distribution of women by number of children born in first marriage by groups of territories (per 10,000 marriages)

As in Table 13.

SOVIET UNION*

Decree of the Supreme Soviet of the U.S.S.R.

November 23, 1955

1. Article I of the Decree of the Central Executive Committee of the Council of Peoples' Commissars of the U.S.S.R., dated June 27, 1936, is abrogated.

2. Performing operations for the artificial termination of pregnancy is permitted only in hospitals and other medical institutions in accordance with an instruction of the Minister of Health of the U.S.S.R.

3. It remains a criminal offense both for the doctor and for the persons without special medical qualifications to perform abortions outside hospitals or other medical institutions.

(Note: A German language translation of the Instructions of 28 December 1955 appears in the monograph series edited by H. Harmsen for the Akademie für Staatsmedizin in Hamburg, 1961, XVI, pp. 64-66.)

*The decree of November 23, 1955, promulgated by the Presidium of the Supreme Soviet, appeared in translation in the Bulletin of the Institute for the Study of the U.S.S.R., Munich, 1955, 2 (12), 44.

CHAPTER 3
BULGARIA*

Historical Trends

1. An overview of demographic trends in Bulgaria is recorded in Births in Bulgaria by Stojmonev et al. (1965). Extensive statistical material is provided.

2. The Bulgarian birth rate dropped from 25.6 per 1,000 population in 1946 to 14.9 in 1966. The yearly growth rate was 20 percent in 1900 and 7.1 percent in 1965. Many individuals tended to limit family size to one or two children, particularly those with higher education in both rural and urban areas.

3. It is held that major reasons for the reduced birth rate include: (a) migration from rural to urban centers, (b) more active participation by women in socioeconomic life and industrial production, (c) growing desire for a better material and cultural existence, (d) more opportunities for higher education for women and postponement of marriage, and (e) the recognition that in an industrial society there is a lesser need for large families.

4. The decree of December 1967 restricts abortion on request, authorizes increased family allowances, and makes plans to provide a better standard of living and more adequate housing for families with two and three children. "The new socialist generation in Bulgaria fights not only for improvement of general economic development, but also for a better living standard towards children." Family planning is part of the program for Mother and Child Aid.

*The material presented is based on interviews with Dr. Donka Dimitrowa (1969), contributions to the 1968 International Symposium on Problems of Human Reproduction at Varna, and review with Dr. Georgi Stojmenov Ivanov and Dr. Dimiter Vassilev of the Research Institute of Gynecology and Obstetrics, Sofia.

5. Bulgarian traditions long favored the double standard and rejection of illegitimate children. Since 1945 women have won increasing opportunities for education and equal rights with men. Younger marriages are less common. The divorce rate is rising.

Abortion Policy Trends

1. Bulgaria was the first socialist country of Eastern Europe to follow the example of the Soviet Union, legalizing abortion in April 1956. Section 4 of the instructions states: "Any woman wishing to have an abortion induced shall notify the woman's consultation centre for the area in which she resides. The staff shall inform the woman of the harmful nature and danger of abortion, of the necessity of carrying the pregnancy to term, etc., and, in short, do everything in their power to dissuade all women who express a wish for the interruption of pregnancy." (Bulgaria, 1957) If the woman persisted in her request, the operation had to be performed.

2. Abortions are terminated in hospitals. A fee is charged except when abortions are for medical indications.

3. Liberalization resulted in a sharp increase in the number of legal abortions and in the ratio of induced abortions per 1,000 women of childbearing age (Table 1). Reported legalized abortions per 100 live births rose to a rate second only to Hungary. The number of births continued to decrease but at about the same rate as before the legalization of abortion (Tables 1 and 2).

4. On 28 December 1967, the Central Committee of the Communist Party and the Council of Ministers tightened the liberal legislation of 1956 "to facilitate better conditions for population growth in Bulgaria." According to the regulations issued in January 1968, interruption of pregnancy is prohibited in the case of a woman without living children except in the presence of serious medical indications, approved by a commission consisting of three physicians, one of whom is a gynecologist. Unmarried women may be aborted if they are under 16 years of age, in cases of rape and incest, or "on serious social indications" established by a woman's health center, provided the pregnancy is not more than ten weeks at the time of examination by the commission.

5. Abortions continue to be available on request, without commission approval for women 45 years or older and for women with three or more children. Women with one or two children may still receive abortions if they persist in their request after a commission has attempted to dissuade them (Bulgaria, 1968).

6. The revised Bulgarian legislation is more liberal than the Romanian revision. The number of legally induced abortions dropped from 98,200 in 1967 to 85,200 in 1968 but appears to be rising in 1969, with the birth rate continuing to increase (Vassilev, 1969).

Illegal Abortion

1. Abortion was the traditional method of birth control when coitus interruptus failed. In the cities it was mostly done by physicians who were exposed to punishment if caught. With the legalization of induced abortion, illegal abortion dropped by at least 50 percent, based on complications seen in hospitals (Starkalev et al., 1961a,b).

2. With restrictions imposed on induced abortions, the number of illegal abortions is believed to be stabilizing at a somewhat higher level.

Family Allowances and Taxes

1. Decree No. 61 of the Central Committee of the Bulgarian Communist Party and the Council of Ministers of 28 December 1967 promulgated revised lump sum payments as of 1 January 1968: $10 for the first child, $100 for the second, $250 for the third, and $10 for the fourth and each subsequent child. Having more than three children is discouraged.

2. As of 1 January 1969 monthly child allowances were paid to all eligible families, regardless of annual income. Allowances are scaled as follows: $2.50 for the first child, $7.50 for the second, $17.50 for the third, and $2.50 for the fourth and each subsequent child. Adopted and stepchildren are eligible for the same benefits. Mothers of illegitimate children or deserted mothers receive $5 per month for the first child. Monthly allowances for subsequent

children follow the same scale as those for all other families. Payments continue until a child reaches the age of 16 years.

3. Paid maternity leave as of 1 January 1968 was provided as follows: 120 calendar days for the first child, 150 days for the second, 180 days for the third, and 120 days for the fourth and each subsequent child. Additional unpaid leave may be requested on the basis of up to 8 months for one child, 9 months for two children, 12 months for three children, and 8 months for four or more children. This leave is credited to the length of service accumulated for pension purposes.

4. Families with three or more children have special privileges in applying for jobs, housing facilities, higher education, etc.

5. Taxes were increased 5 to 10 percent on 1 January 1968 for all unmarried men and women over 30 years of age and those married couples who had no children after five years of marriage.

Contraceptive Methods and Practice

1. No contraceptives of any kind are manufactured in Bulgaria. Condoms are purchases mainly from Czechoslovakia. Some Ovosiston pills are imported from the German Democratic Republic. Trials of loops have been reported by the International Planned Parenthood Federation (1969).

2. Coitus interruptus is the traditional and still most widely practiced method of birth prevention. In a 1966 interview survey of women whose pregnancies had been terminated by induced abortion, Vassilev (1969) noted that 69 percent had relied on coitus interruptus, 5 percent used comdoms, and another 5 percent tried the "safe" period, while 21 percent practiced no contraception of any kind.

Family Planning Centers

1. The decree of December 1967 announced that advisory centers were to be established for pregnant women. In 1969 more than 1,500 women's consultation

centers were functioning. About 230 are in urban centers staffed with gynecologists, while 1,270 are in rural areas, usually under the direction of a general practitioner. Consultation is provided regarding prophylactic practice, contraception, prenatal and postnatal care, etc.

2. To reduce the incidence of abortion, increasing attention is focused on the provision of contraceptive information and materials. Contraceptive counseling is available in all policlinics throughout Bulgaria. Family planning training courses have been organized at the Research Institute of Gynecology and Obstetrics in Sofia.

Medical and Postgraduate Training

1. Contraception is rarely mentioned in the Bulgarian medical school curriculum, but the trend is changing.

2. Postgraduate seminars provide specialist information for gynecologists and obstetricians.

Sex Education in the Schools

1. The need for more adequate sex education is mentioned in the December 1967 declaration of the Central Committee of the Communist Party.

2. The gulf between generations restricts sex education. The sense of morality continues strong: women are expected to be virgins at marriage. However, traditions appear to be changing.

Public Education

1. During the years abortion was available on request, it was held that public education on family planning was not necessary. Little, if any, instruction was given after abortion.

2. With the current emphasis on increasing the birth rate, public sex education receives limited attention.

3. The last paragraph of the decree of December of 1967 appeals to the Central Committee of the Komsomol, the women's organizations, and other cultural groups to cooperate with the Ministry of Health in promoting a rise in the Bulgarian birth rate, safeguarding the health of pregnant women, and fighting illegal abortion.

Research Notes

1. A survey of women requesting abortion in 1957, one year after legalization, was reported by Starkalev, Papasov, and Stojmenov (1961) from eight administrative regions of Bulgaria. Of the 21,000 women surveyed, 3.7 percent had no children, 22.2 percent had one child, 67.8 percent had two children, and 6.2 percent had three or more children.

2. Vassilev (1968d) studied 700 women at the First Obstetrical and Gynecological Hospital in Sofia during 1967/68. It was noted that women resorting most frequently to abortion tended to be under 30 years of age, either uneducated and illiterate or university graduates. The 700 women had, on the average, 2.1 children and 2.57 abortions. Women with 2 children requested abortions most often, followed by those with one child. About 12.3 percent had no children. "The most frequent causes for abortion are the poor housing and living conditions and the concept that two is the optimum number of children in the family. The next most important causes being recent birth, and the shortage of places in the crèches and nurseries." Of the unmarried women seeking termination of pregnancy, 87 percent blame the hesitating attitude or flight of the partner, while 7.3 percent plead the necessity to continue studies without interruption. Of the 700 women, 61 percent blamed inadequate housing as the reason for their abortion. Vassilev (1968b) infers that every third woman has an abortion due to unsatisfactory housing conditions.

3. Sociologic research has been initiated to study social etiology of induced abortions, illegal abortions, relationship of abortion to contraception, and relation of human reproduction and economic development in Bulgaria. Changes in public opinion concerning abortion and childbirth during the decade 1957-1968 have been studied (Vassilev, 1969).

Research Centers

1. A Fertility Research Center was established at the Sofia Medical Institute following the decree of December 1967. It is administered by the Ministry of Health which has sole responsibility for medical research in Bulgaria.

2. The Sociological Institute of the Bulgarian Academy of Sciences intends to include questions on health protections in its national surveys. Director of the Institute is Prof. Zhivo Oshavkov.

3. Bulgarian interest in family planning was apparent at the International Symposium on the Problems of Human Reproduction, held in Varna 25-30 September 1968.

Reported Population Statistics

1. Available demographic data are listed in Table 8.

2. Data on abortions are based on registered hospital cases.

Addendum

Dr. Jordan Dimitrow and Dr. Donka Dimitrova (Sofia) have informed me that interpretation of the Bulgarian abortion statutes was liberalized in 1970. Abortions are available, practically on request, for all unmarried women and married women having at least one child. It is anticipated that the greater availability of legally induced abortions will reduce the number of illegal abortions which had been increasing. The cost of a legal abortion is 5 leva, about the same as one-month supply of oral contraceptives.

Table 8

Demographic Data in Bulgaria*

1. Births by months.
2. Live-births by sex according to the age of the mother and father (by five-year age groups).
3. Still-births by sex according to the age of the mother and father (by five-year age groups).
4. Live and still-births by sex according to the age of the mother (by age years).
5. Births by age of the mother and by parity.
6. Live-births by age of the mother and by parity.
7. Still-births by age of the mother and by parity.
8. Legitimate births by age of the mother and by parity.
9. Legitimate live-births by age of the mother and by parity.
10. Legitimate still-births by age of the mother and by parity.
11. Multiple births by sex.
12. Multiple births by age of the mother and father.
13. Number of births by the assistance rendered at birth (births in institutions or elsewhere, medical or other assistance).
14. Births by the activity and social group of the mother and father.
15. Births by the social group of the mother and by parity.
16. Age-specific birth rates.
17. Age-specific rates of marital fertility.

The data are also available by communes and towns.

* Compiled by the U.N. European Working Group on Social Demography and based on Demografska Statistica, Sofia, 1964.

BULGARIA

Law of 27 April 1956*

Interruption of pregnancy

Instructions of the Ministry of Health and Social Welfare interruption of pregnancy. (Izvestiia na Prezidiuma na srodnolo s'branie, 27 April 1956, No. 34, pp. 2-3)

1. In conformity with Article 135 of the Penal Code, the interruption of pregnancy (abortion) in any pregnant woman who expresses a desire therefor shall be permitted.

2. Abortions may be induced only in obstetrical and gynaecological institutions, i.e., departments of district, municipal or departmental hospitals, autonomous municipal maternity centres or obstetrical and gynaecological clinics attached to the Institute of Medicine or the Institute for Specialist and Further Training of Physicians.

3. An abortion may not be induced if any of the following contra-indications are present:

(a) Acute or sub-acute inflammation of the genital organs;
(b) A purulent focus, regardless of its localization;
(c) An acute communicable disease;
(d) Any previous operation to induce an abortion during the previous six months;
(e) Pregnancy of more than three lunar months' duration.

Note. Where pregnancy is of more than three lunar months' duration, the operation for interruption of pregnancy may be permitted if examination of the pregnant woman in a hospital shows that continuation of pregnancy and delivery might endanger her health or life.

4. Any woman wishing to have an abortion induced shall notify the women's consultation centre for the area in which she resides. The staff of the consultation centre shall inform the woman of the harmful nature and danger of abortion, of the necessity of carrying the pregnancy to term, etc., and, in short, do everything in their power to dissuade all women who express a wish for the interruption of pregnancy.

5. In particular cases, the health personnel of women's consultation centres shall give social and legal assistance to pregnant women. To this end, the said centres shall maintain contact with social and legal advice bureaux attached to hospitals, with trade unions and people's councils, and,

*Reproduced with permission from the International Digest of Health Legislation, 1957, 8, 605-607.

where necessary, provide in co-operation with these bodies material aid and support for needy pregnant women who agree to carry their pregnancy to term.

6. Local health services, health stations, and women's consultation centres in which there is no obstetrician-gynaecologist shall give a pregnant woman a card (Type B-28) for the nearest obstetrical and gynaecological hospital, in whose women's consultation centre the woman shall be examined and may be given an authorization for interruption of pregnancy.

The said consultation centre may also issue such authorizations to women resident in its area of jurisdiction. The authorization shall be entered on card B-27, which shall be signed by the head of the women's consultation centre.

7. When issuing an authorization for interruption of pregnancy, the necessary analyses (urine, vaginal secretions, blood sedimentation, etc.) shall be made in the women's consultation centre in order to ascertain that there is no contra-indication. In addition to these, additional analyses shall be made, where necessary, in the hospital.

8. The operation shall be performed not later than 5 to 10 days (according to the stage of pregnancy) after the date of receipt of the authorization.

9. On entering the hospital the pregnant woman shall present the authorization and pay 50 levas--the fixed tariff for the operation--against which the hospital shall issue a receipt. The number of the said receipt shall be entered in the patient's file.

10. The usual documents shall be established in respect of each woman admitted to a curative establishment for the purpose of interruption of pregnancy.

The authorization for the operation shall be kept in the patient's file.

The length of a woman's stay in the hospital shall be determined in each particular case according to her state of health, but the period of hospitalization shall in no case be less than two days.

11. No operation for the interruption of pregnancy shall be carried out without the woman in question being hospitalized.

12. Women workers and employees shall be given a certificate of sickness entitling them to sick leave for the period of hospitalization and the necessary rest at home after the operation; members of agricultural co-operatives shall receive a card of leave-of-absence from work.

The procedure for the issue of certificates of sickness for abortions which are begun outside a curative establishment and are completed within such an establishment shall be in accordance with the instructions for the issue of certificates of sickness for incapacity for work.

13. The operation shall be free of charge if continuation of pregnancy and delivery would endanger the health or life of the woman. Whether this is so or not shall be determined by the committees for the interruption of pregnancy on medical grounds, regardless of the stage of the pregnancy.

14. Medical committees for authorization of abortions on medical grounds shall be composed of three members: one obstetrician-gynaecologist (chairman),

one internist, and one specialist in the disease that is the ground for the operation.

The obstetrician-gynaecologist and the internist shall be permanent members of the said committee and shall be selected from among the most competent and highly reputed specialists. They shall be appointed for one year by the chief of the district or municipal health section. The third member shall be appointed by the chief physician of the hospital on the recommendation of the chairman of the committee

15. [Financial provisions]

Law of 16 February 1968*

Interruption of pregnancy*

Instructions No. 188 of the Ministry of Public Health and Social Welfare to regulate the artificial interruption of pregaancy and to prevent criminal abortion.** (D'rzhaven Vestnik, 16 February 1968, No. 13, pp. 1-4)

I. Measures for the restriction of the artificial interruption of pregnancy

1. The artificial interruption of pregnancy shall be subject to the following restrictions:

(a) the interruption of pregnancy shall be prohibited in the case of women having no living children, unless it is medically indicated or there are special circumstances of a grave nature;

(b) the interruption of pregnancy shall be authorized in the case of women having one or two children, subject to the approval of a special medical board. The board shall explain the harmfulness and dangers of abortion, the need to take the pregnancy to full term, the financial support which the family will receive after the birth of the child and. in general, shall make every effort to dissuade every woman who expresses the desire to have her pregnancy interrupted, from doing so. If, nevertheless, the woman concerned persists in asking for her pregnancy to be interrupted, the board shall give its approval to this effect;

(c) the interruption of pregnancy, at the request of the pregnant woman, shall not require the approval of a medical board, in the case of women over 45 years of age and of women who have three or more children;

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*Reproduced with permission from the International Digest for Health Legislation, 1968, 19, 589-602.

**These Instructions have been issued pursuant to Decree No. 61 of the Central Committee of the Bulgarian Communist Party and the Council of Ministers of 28 December 1967 to increase the birth rate.-ED.

(d) the artificial interruption of pregnancy, in the case of unmarried women, shall be subject to approval by a special board, where it is medically indicated or there are special circumstances of a grave nature, as follows:

- if the woman concerned is under 16 years of age, subject to the consent of the parents;
- if the woman concerned has been made pregnant by a person whom she cannot marry, because he is a close relative;
- in the case of rape, if the woman concerned has lodged a complaint in good time with the competent authorities and the stage of pregnancy corresponds to the period which has elapsed since the rape;
- in the case of serious social indications, established by a women's health centre [zhenska konsultatsiya].

2. The interruption of pregnancy on request shall not be authorized if any of the following medical contraindications are present:

(a) acute or sub-acute inflammatory diseases of the sexual organs (acute or sub-acute vulvitis, bartholinitis, acute ulceration of the vulva, condyloma acuminatum or condyloma latum, with inflammation, hard chancre, soft chancre, colpitis, pseudo-erosion and erosion with obvious purulent discharge, endocervicitis, endometritis, parametritis, adnexitis, gonorrhoea and other inflammatory diseases of these organs), or tumours of the genital organs, and their complications;

(b) a source of purulent discharge [gnoini ognishta], irrespective of its site;

(c) an acute infectious disease (when this is not itself an indication for the interruption of pregnancy);

(d) an operation for the interruption of pregnancy has been carried out in the preceding six months;

(e) there is objective evidence that the tenth week of pregnancy has been passed (at the time that the application is considered by the board).

II. Artificial interruption of pregnancy on the basis of medical indications

3. The artificial interruption of pregnancy on the basis of medical indication shall be authorized, irrespective of the stage of pregnancy reached, in every case in which pregnancy or childbirth would endanger the health or life of the pregnant woman, or if there is evidence of a danger that the foetus may be severely damaged by toxic or other agents.

4. The artificial interruption of pregnancy on the basis of medical indications shall be authorized by a special board after the examination of each individual case, if the woman concerned is suffering from one of the diseases included in the list approved by the Minister of Public Health and Social Welfare (see Annex No. 1).

5. In cases where it is necessary for pregnancy to be interrupted on the basis of medical indications but the 12th week of pregnancy has been passed, the operation may be carried out only at a highly specialized treatment establishment (a class 1 district hospital or a municipal hospital of equivalent standing, an obstetrics and gynaecology clinic at a higher medical institute or the ISUL,* a specialized hospital for obstetrics and gynaecology, or a national hospital).

If the pregnant woman cannot be transported, the operation for the artificial interruption of pregnancy must be carried out by a physician, who must be a specialist from one of the above-mentioned establishments, in the locality concerned, in the corresponding district, municipal or rayon hospital.

III. Organizational arrangements in connexion with the artificial interruption of pregnancy

6. The pregnant woman must submit her application for the interruption of pregnancy to the women's health centre in the rayon in which she lives. Unmarried women shall be exempted from this requirement, and shall be permitted to apply directly to the board of the rayon or to the board of another rayon. The medical workers of the women's health centre must make every effort to persuade the pregnant woman to withdraw her application for the interruption of pregnancy, as well as take every opportunity to explain the situation to the woman and help both her and her family in every possible way.

7. The health workers at the women's health centre shall give social assistance to pregnant women in need, and shall refer them to social welfare centres [sotsialnopravnite kabineti], the appropriate trade-union agencies, the people's councils and, if necessary, together with the latter, provide financial and social assistance to those pregnant women who decide to take their pregnancies to term.

8. In cases in which the woman concerned cannot be persuaded to change her mind, and there are grounds for the interruption of pregnancy, as provided for in Section 1 of Part 1 of these Instructions, the local health service, or the women's health centre competent for the place of residence, shall refer her to the appropriate board responsible for deciding as to the interruption of pregnancy. The pregnant woman shall be given a card [obmenna karta-talon] on which shall be entered her personal details [pasportni damii], the number of children that she has, the nature of the grounds for the interruption of pregnancy, and the opinion of the centre.

9. The women's health centre shall be responsible for ensuring that the information given is correct and for the assessment of the case provided. In cases where this is necessary, the appropriate documents from the people's council, the agency of the Militia, the court, another treatment establishment, etc., shall also be included.

10. Pregnant women from villages and towns, referred by a women's health centre, must undergo the necessary clinical and related examinations prior to appearing before the board; the results of these examinations must be entered on, or attached to, the corresponding cards issued by the women's health centre.

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*The Institute for the Specialization and Advanced Training of Physicians.-ED.

11. Every women's health centre must make every effort to diagnose pregnancy at an early stage and to refer woemn to the special board in good time.

12. Boards for the authorization of the interruption of pregnancy shall be set up at independent policlinics attached to district, municipal, rayon and national hospitals, higher medical institutes and the ISUL.

Such boards shall also be set up at district, municipal, rayon and national hospitals, specialized hospitals for obstetrics and gynaecology, obstetrics and gynaecology clinics of higher medical institutes and the ISUL, and the Scientific Research Institute for Obstetrics and Gynaecology. Such boards shall decide as to the interruption of pregnancy only in the case of patients hospitalized in their establishments, and on the basis of medical indications.

13. The composition of the boards shall be determined on the order of the district health department, the dean of the higher medical institute and the ISUL, and the director of the Scientific Research Institute for Obstetrics and Gynaecology, as follows:

Chairman: the assistant chief medical officer of the hospital or the chief medical officer of the independent policlinic;

Members: the obstetrician and gynaecologist working in the women's health centre, and one medical specialist, whose specialty shall depend on the disease from which the woman is suffering.

14. The board shall co-opt or call in consultants, who may be specialists or social workers (from the people's council, social welfare centre or health department, or the representative of a public organization).

The district health department shall determine the list of the specialists who may be co-opted on to the committee or called in as consultants. Their participation in the work of the board shall be subject to the order of the chief medical officer.

15. The board shall meet according to definite time-table, approved by the chief medical officer of the corresponding health establishment, in conformity with the time most convenient for the public, so as to ensure that the necessary number of meetings is held each week.

16. If authorization is given for the interruption of pregnancy, this shall be carried out in the corresponding hospital establishment, namely the obstetrics and gynaecology department of a district, municipal, rayon or national hospital, a specialized hospital for obstetrics and gynaecology, the obstetrics and gynaecology clinic at a higher medical institute or the ISUL, or the Scientific Research Institute for Obstetrics and Gynaecology.

The hospital establishment must carry out the interruption of pregnancy not later than ten days after having received the authorization to this effect.

17. If the interruption of pregnancy is required on the basis of medical indication, the hospital establishment in which the operation is to be carried out shall also be entitled to review the indications and contra-indications.

18. If authorization for the interruption of pregnancy is refused, the board or the hospital establishment shall send back, through the appropriate channels, the card and other documents concerning the pregnant woman, after recording their decision therein.

19. On entry into the hospital establishment, the pregnant woman shall produce her card, on which the decision of the board has been entered, and the medical documents (if the interruption of pregnancy is being carried out on the basis of medical indications). The woman shall pay a fee of 5 leva, for which a receipt shall be issued which shall be included in the patient's file.

No fee shall be paid if the pregnancy is interrupted on the basis of medical indications.

The fees for the interruption of pregnancy shall be included, in conformity with the provisions of Order No. 433 of the Council of Ministers of 28 March 1956, in the revenue for the national budget.

20. A file shall be kept for each woman who enters hospital for the interruption of pregnancy, to which all documents shall be added for purposes of preservation.

21. The length of stay in the hospital establishment shall be determined separately in each individual case, but where it is impossible for the woman to remain for 24 hours, she shall be kept under observation at home by the appropriate health centre. Woman from rural areas must be kept in the hospital establishment, as far as possible, at least until the following day.

22. Professional secrecy shall be observed concerning all matters relating to the work of the board, and information on such matters may therefore be given only to persons legally entitled to receive it, and in the prescribed manner. The chief medical officers of hospitals shall ensure that discretion is maintained as to the work of the boards, and shall hold strictly responsible any member of the medical or other official staff who divulges confidential information concerning pregnant women.

23. The board shall record its decisions in a special form of register [aktova kniga], which must contain the following particulars:

> the number, date, full name, age, address, duration of pregnancy, reason for the interruption of pregnancy, the decision of the board with the grounds on which it is based, the place to which the pregnant woman has been sent for the interruption of pregnancy, etc.

The decision shall be signed by the three members of the board.

The register shall be kept as a document for official use, the provisions of Section 22 of Part III of these Instructions being observed.

24. In special cases, where it is necessary for secrecy to be preserved as to the identity of the pregnant woman, the board may, after having first reach agreement to this effect, send the pregnant woman to an establishment in another rayon for the interruption of the pregnancy. In such cases, the patient shall be provided with all the necessary documents for the interruption of pregnancy, as well as the corresponding card.

25. If the board rejects an application, on the grounds of lack of adequate justification in the particular case or because there are contra-indications, as well as in cases in which the pregnant woman agrees to take the pregnancy to term, the women's health centre for the place of residence shall be obliged to take special care of the pregnant woman so as to ensure that the pregnancy goes to term normally and to prevent criminal abortion.

26. The interruption of pregnancy shall be authorized in the case of women who are citizens of foreign countries as follows:

when the operation is indicated on medical grounds;

in the case of women who are citizens of countries with which Bulgaria has signed an agreement on health matters, and in which the interruption of pregnancy is permitted even on non-medical grounds;

in the case of women who are citizens of foreign countries and who are living or staying in Bulgaria, the procedure being the same as for women who are Bulgarian citizens.

(Payment of the cost of the operation by women who are citizens of countries with which an agreement on health matters has not been signed)

IV. Intensification of measures for the prevention of criminal abortion

27. The Treatment and Prophylaxis Administration of the Ministry of Public Health and Social Welfare, the departments of public health and social welfare of the district people's councils, the chief medical officers and directors of the departments of obstetrics and gynaecology of the treatment and prophylactic system [lechebnoprofilaktichnata mrezha], and the directors of social welfare centres, shall devote their attention to the prevention of criminal abortion, as follows:

(a) by looking for evidence of criminal activities in all cases where abortion has been initiated and completed outside a treatment establishment, and by taking, in every such case, a detailed and thorough case history;

(b) by carrying out an appropriate and thorough examination in every case of abortion, and by looking for the signs of the artificial interruption of pregnancy, such as traces of injuries to the uterine wall resulting from manual massage of the uterus, to the external sexual organs, the vagina or the cervix uteri, traces of the use of probes [ednoz'btsi], the intrauterine introduction of iodine or other objects, etc.;

(c) by the writing up of a detailed case history, by the medical personnel on duty when the patient entered the treatment establishment, in each case in which an abortion is begun or completed outside a treatment establishment.

If criminal activities are suspected in any case, all details must be recorded, as found in the taking of the previous history and the examination of the patient, which indicate criminal abortion,

(the names of the abortionist, the method used for the abortion, the names of the persons who instigated or assisted in the interruption of pregnancy, etc.).

The taking of the previous history in a case in which criminal abortion is suspected shall be effected in the presence of two medical workers (physicians or midwives), who must then sign it, together with the patient, so as to prove its authenticity. If the patient is unable or refuses to sign it, the reasons for this shall be recorded. This is necessary so as to avoid any subsequent disagreement between her and the medical personnel on duty;

(d) if an operation (curettage, etc.) is carried out in cases in which an abortion has been initiated or been completed outside a treatment establishment, especially where criminal activities are suspected, biological tests for pregnancy must be carried out and samples taken for histological examination, for the purpose of obtaining further information;

(e) if it is suspected that a criminal abortion has been carried out, on the basis of the case history, the medical officer on duty must immediately notify, by telephone, the competent public prosecutor's office or the nearest section of the Ministry for Internal Affairs and, in addition, the management board of the establishment must send a written report to the Ministry for Internal Affairs, the public health department of the district people's council and the social welfare centre, in which must be briefly stated the circumstances under which, by whom and with whose participation, the abortion was carried out. The report shall state the circumstances and the facts which led the medical personnel to the conclusion that the case was one of criminal interruption of pregnancy;

(f) health workers employed in women's health centres, on becoming aware, or finding evidence, of criminal activities in connexion with abortion, must inform, in the manner specified above, the competent public prosecutor's office or the agencies of the Ministry for Internal Affairs, the public health departments of the district people's councils and the social welfare centres;

(g) directors of departments of obstetrics and gynaecology, medical personnel on duty and workers employed in women's health centres who have received information as to a suspected or confirmed case of criminal abortion and who do not immediately notify, in writing, the competent agencies to this effect, shall be guilty of a criminal offence.

28. The public health departments of the district people's councils, on the proposal of the directors of the establishments concerned, shall, at the same time as they initiate criminal proceedings, close private consulting rooms for a period of not less than one year, and shall propose to the Minister of Public Health and Social Welfare that criminal abortionists shall be deprived of the right to practise medicine for a specified period.

If a criminal abortion has been carried out by a physician during his working hours or if the carrying out of his official duties or responsibilities is involved in any other way, the following disciplinary penalties shall also be imposed, in addition to any other form of punishment:

(a) assignment to lower paid work for a period of up to three months at the same establishment;

(b) transfer to lower paid work at another health establishment;

(c) dismissal.

In the same way, members of special boards shall be legally responsible and subject to the above-mentioned penalties if there is evidence that they have taken advantage of their official position to act in contravention of the provisions of these Instructions.

29. The directors of social welfare centres, on having received notification or other information concerning a criminal abortion, shall place themselves at the disposal of the public health departments of the district people's councils and shall collect all the necessary additional information for the purpose of establishing and confirming that a criminal abortion has been carried out. They shall co-operate with the investigating and judicial agencies, and shall assist them in the detection of the crime.

30. The social welfare centres shall keep a record of all information and notifications received by them and by the public health departments of the district people's councils, as to the carrying out of criminal abortion, and shall likewise record the necessary particulars, i.e. the result of the investigations carried out, the punishment imposed, etc.

These Instructions shall enter into force on 1 January 1968, and shall repeal the Instructions of 5 April 1956 of the Ministry of Public Health and Social Welfare on the interruption of pregnancy, as amended by the Instruction No. 311 of 2 February 1963 (D'rzhaven Vestnik, No. 22, 1963), and Order No. 3107 of 3 August 1964 of the Ministry of Public Health and Social Welfare.

CHAPTER 4

POLAND

Historical Trends

1. Immediately before World War II the population of Poland was 35.1 million. The 1946 census, taken shortly after the war, enumerated 23.9 million residents. Nearly twenty years later, on January 1, 1965, the population had recovered to 31.3 million. The birth rate dropped from 31 per 1,000 population in 1951 to 28.0 in 1956 (when abortion was legalized), and continued to slide to 16.3 in 1968. It appears that a low point has been reached. The birth rate stabilized in 1969 (Table 1).

2. In 1957, one year after the legalization of abortion, the independent Polish Association for Conscious Motherhood (Family Planning Association) was established. Among the founders was the Vice Minister for Health, the late Dr. Bohdan Bednarsky. The Ministry of Public Health joined with the Association in promoting family planning and instruction in sexual hygiene, discouraging abortion, and providing premarital and marital counseling services, as well as consultation on infertility. The Polish Family Planning Association is a member of the International Planned Parenthood Federation.

3. Studies of the level and changes in age-specific fertility rates during 1950-1960 show a declining trend of fertility in general, and a tendency to shorten the childbearing period, together with a relative rise of fertility in the youngest age group. Family planning was apparently more effective in older age groups (Vielrose, 1965).

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*Material was obtained from Prof. Dr. M. Bulska, Chairman of the Department of Gynecology and Obstetrics of the Academy of Medicine in Warsaw, regional reports of the International Planned Parenthood Federation, readings, and discussions with Polish colleagues, including Prof. Karolina Jus of the Department of Psychiatry, Academy of Medicine, Warsaw.

4. Toward the end of the 1950s the lower limit of marriageable age was raised from 18 to 21 years for men, and from 16 to 18 years for women. This probably contributed to the lowering of the birth rate (Romaniuk, 1965), along with the continuing migration from country to town (Borowski, 1965).

5. By 1960 about 50 percent of all women of reproductive age living in cities and towns were employed outside their homes. As of 1965 there was room in crèches for every tenth infant, and in kindergartens for every sixth child of preschool age (Romaniuk, 1965).

6. In 1965 a Family Protection Law was promulgated by the Polish Parliament. Its objective is to promote and develop the stability of marriage and the family. With the passage of this law, the Polish Family Planning Association was further strengthened.

Abortion Policy Trends

1. Interruption of pregnancy for medical reasons was permitted in 1929. Indications were narrowly defined, following recommendations of medical speciality groups. Three physicians, including at least one gynecologist, were obliged to certify reasons for abortion. Termination for non-medical and/or social reasons could be authorized by the public prosecutor in cases of rape or incest (Bulska, 1969). Illegal abortions were high (Roemer, 1967).

2. The law of 27 April 1956 permits abortion when "medical indications favor it," in the case of "difficult conditions of life of the pregnant woman," and when there is a "justified supposition that the pregnancy arose by a criminal act." (Poland, 1958). The aim of the legislation as stated in the Preamble is "to protect the health of the woman against the ill effects of abortion done in bad conditions and not by a physician." No distinction is made between married and unmarried women.

3. The Minister of Health and Social Security was empowered by the law of 1956 to make more detailed recommendations. An order of December 1959 specified that a statement on the "difficult conditions of life" should be recorded and signed by the pregnant woman, that the woman be given contraceptive advice, and

that the operation be registered and be recorded in detail when not performed in a hospital. Physicians may perform an abortion in an outpatient department.

4. In 1961 the previous requirement that a woman's social circumstances be reviewed by an independent observer was deleted. Any physician can now sign the necessary form. No commission approval is needed. This procedure was believed to delay action. If a woman is refused abortion by a physician, she has a right of appeal to a Municipal Medical Commission. If there is no physician in her community, she may request assistance from a military doctor. A girl under age 18 requires the approval of her parents or guardian before an abortion or any other operation can be performed.

5. When a request for an abortion is granted, the man involved is often asked to contribute to the blood bank (Rettie, 1969).

6. While abortions are usually performed in hospitals, pregnancies can be terminated in outpatient departments. No fee is charged if the abortion is done in an official health service facility. Only qualified gynecologists and/or surgeons are permitted to perform abortions, after giving instructions to the woman on the use of contraceptives.

7. As is apparent from Table 2, liberalization of the law did not have a dramatic effect on the gradually declining Polish birth rate. The number of legalized abortions seems to have reached a peak of 199,400 in 1962. By 1968 abortions had declined to 121,700 without imposition of restrictive legislation. However, legal abortions per 100 live births have been rising (Table 1). Of the 121,700 abortions in 1968, 120,000 were for social reasons and 1,700 for medical reasons. About 33,000 additional abortion cases, mostly spontaneous, were admitted to hospitals with bleeding (Polish FPA, 1969).

8. The general impression is that abortion is performed mainly in women who already have two-three children, and have domestic difficulties (Bulska, 1969). After abortion all patients are offered an IUD insertion or pill prescription.

9. Contraindications for pregnancy are carefully noted, especially in pregnant women with Rh negative factors. Women are counseled about potential difficulties related to abortion (Bulska, 1969).

10. It is widely believed that the energetic public education efforts of the Polish Family Planning Association have contributed to the decrease in the total number of abortions while the birth rate continues to decline.

Illegal Abortions

1. By 1955 the number of hospital admissions resulting from illegal abortions had risen to 80,000 per year (Callahan, 1970).

2. Prosecutions for illegal abortions fell significantly after legalization of induced abortions in 1956.

3. Assisting with an illegal abortion is punishable with a maximum of three years in prison.

4. Forcing a woman to terminate pregnancy is punishable with a five-years' prison sentenance.

5. Estimates are that illegal abortions are less than 10,000 per year (Vojta, 1961b).

Family Allowances

1. Current family allowances are deemed too low to have a meaningful role in family planning.

2. Recent legislation provides up to one year's leave of absence for the mother after the birth of the child; her job must be kept open if she wishes to return within that period (Poland, 1968).

Contraceptive Methods and Practice

1. Pills and coils are manufactured in Poland and are also imported. The Polish oral contraceptive Femigen became widely available in pharmacies in 1969.

IUD production was initiated in 1968 by Semritas, owned by the Family Planning Association. Both pills and coils are available only on prescription. For pills the initial prescription must be by a gynecologist; subsequent repeat prescriptions may be given by any physician. Up to 1969 about 10,000 loops had been inserted, mostly Lippes loops provided by the International Planned Parenthood Federation and by the World Church Service, plus initial Polish production (Polish FPA, 1969).

2. Also produced in Poland are condoms, foams, tablets, creams, suppositories, and cervical caps. The Social Security System pays about 70 percent of the cost. Foaming tablets and condoms are available without prescription. Consumption of condoms doubled by 1958-60 (Brackett and Huyck, 1962). There appears to be little use of diaphragms and caps.

3. Women interested in contraceptive methods are encouraged to come for instruction to the family planning clinics.

Family Planning Centers

1. The first Family Planning Clinic in Poland was founded in 1928 by Dr. Tadeusz Boy-Zelenski, a physician who later became a writer and translator of French literature. He was killed in 1941 during the Occupation.

2. The Polish Family Planning Association operates two independent clinics in Warsaw and Krakow, staffed by gynecologists, psychologists, lawyers, pedagogues, and sociologists. Branch offices are maintained in 310 counties and 150 villages.

3. Family planning information and contraceptive consultation are available in the more than 1,400 hospitals and women's outpatient departments, staffed with gynecologists and midwives. There are over 3,000 consultation centers throughout Poland. Supporting these services is a regulation that every new mother be instructed in family planning plus a reduction of 70 percent of the price of contraceptives under the Social Security System (Callahan, 1970).

Medical and Postgraduate Training

1. Lectures on family planning are incorporated in all curricula for medical students. Technical details are presented as part of the specialist courses in gynecology and obstetrics. State medical examinations include questions on contraception. Practical experience is obtained during the two-year postgraduate internship. The teaching program in midwife schools also includes lectures on family planning.

2. The course arranged by the Polish Family Planning Association is offered in the Association's clinics in Warsaw and Krakow. Training is free of charge, with travel and accommodation expenses reimbursed if the participant cannot live at home. A certificate is awarded.

3. A Medical Conference in June 1969 developed instructions for the use of oral contraceptives and loops, for distribution to all physicians and Public Health Service institutions. The Conference was organized by the Ministry of Health and the Institute for Maternal and Child Health.

Sex Education in the Schools

1. The Polish Family Planning Association publishes educational materials for parents and teachers, beginning with nursery school.

2. By working through its affiliated members in the professions, women's organizations, writers' and educators' unions, and with the Ministry of Health, the Family Planning Association has advanced family planning education throughout the Polish school system.

Public Education

1. Public education is one of the main tasks of the Polish Family Planning Association. Its activities endeavor to: (a) prepare youth for marriage and parenthood; (b) encourage an awareness of the need for family planning; (c) encourage acceptance of contraceptive methods to avoid unwanted pregnancies and reduce the use of abortion as a means of birth control; and (d) promote sexual harmony in marriage.

2. Emphasis is on "responsible family planning" as a major factor in family health and the welfare of children, whether born or unborn. This policy is reflected in numerous publications and programs, and has been widely accepted throughout Poland. More than a dozen films have been produced. Booklets for non-medical readers published in large quantities during 1968-69 included such titles as "It is about me, Mother!," "Am I Pregnant?," and "Unwanted Pregnancy."

3. The activities of the Family Planning Association are directed primarily toward women. Men learn about family planning during their military service. Military medical officers are instructed about contraceptives in courses given by the Army.

4. While Poland is perhaps the most Catholic country in Eastern Europe, resistance to family planning on religious grounds appears to be diminishing over the years.

5. The Polish Family Planning Association celebrated its tenth anniversary in November 1967 with participation by the Minister of Health and Social Welfare. State decorations were awarded to 30 association members.

Research Notes

1. Side effects of oral contraceptives are being studied by all gynecological clinics in Poland.

2. Gynecological teaching centers are continuously observing selected population samples. These are, however, not coordinated and not standardized.

3. A study of contraceptive practice is being planned by the Polish Family Planning Association.

Research Centers

1. There are no research centers specifically oriented to studies in family planning. A group of sociologists and psychologists working with the Polish

Family Planning Association is conducting pilot studies of the modern family. Areas to be covered include marital and non-marital sex life among students in urban and rural communities.

2. The Social Psychiatry Unit of the Department of Psychiatry of the Academy of Medicine in Warsaw is contemplating research in mental health aspects of family planning.

3. The Demographic Research Committee of the Polish Academy of Sciences plans to conduct a survey on fertility and family planning, including a sample of married women under 60 years of age. Most demographic research activities are centered in Warsaw, focusing on fertility, migration, and projections. Demography is taught in economic faculties.

Reported Population Statistics

1. Available Polish statistics are cited in Table 9.

2. The Polish figures on abortion are not completely reliable because numerous women seek abortions from private medical practitioners who may not always remember to register the case (Potts, 1967).

3. The Statistical Yearbook for Public Health, 1945-1967 reports somewhat differing figures on abortions in Poland than those cited in Table 1 (Główny Yrzsad Statystyczny, Warszawa, 1969, p. 410).

4. Dr. D. Peter Mazur informed me that Polish abortion statistics include many visitors from abroad. Since birth rates refer only to residents, the ratio of abortions to live births is not entirely indicative of Polish trends.

Year	Total Number of Abortions	Induced Abortions in Hospitals		Spontaneous Abortions*	Abortions in Outpatient Facilities**
		Medical Indications	Other Indications		
1960	223,795	4,012	146,406	73,377	-
1965	223,682	3,149	121,602	65,082	33,849
1966	215,046	2,119	116,223	66,357	30,347
1967	210,109	1,570	111,214	64,039	33,286

*Also includes abortions induced at home.

**Estimate of abortions performed in hospitals, social or private policlinics, and outpatient dispensaries. Total figures not available.

4. The Demographic Research Committee of the Polish Academy of Sciences has requested the Statistical Office to revise some of its tabulations in demographic statistics in view of the increasing need for special tables based on birth and marriage cohorts.

Publications

1. Studia Demograficzne began publication in Warsaw in 1963.

Table 9

Demographic Data in Poland*

Statistical Yearbook (1966)

Table 26 (45) — Natural movement of population by voïvodship
- Live-births, marriages, deaths, natural increase.
- Urban and rural areas.
- Twenty-two voïvodships.

Table 31 (50) — Live-births by order of birth and age of mother
- Five-year age groups, 40 and over.
- Birth order: 1, 2 .... , 8 and over.
- Urban and rural areas.

Table 32 (51) — Live and still-births among multiple births by age of mother
- Five-year age groups, 40 and over.

Table 33 (52) — Live-birth rates by age of mother
- Five-year age groups.
- Urban and rural areas.

Table 34 (53) — Reproduction rates
- Gross and net rates.

Tables 28 (47), 29 (48) — Marriage rates by age of bridegroom and of bride
- Five-year age groups, 40-49, 50 and over.
- Urban and rural areas.

Statistics on Natural Movement of Population (1963-1965)

(Latest issue of a study periodically published since 1955)

Table 2 (9) for 1963
Table 2 (11) for 1964 — Live-births by order of birth, age of mother and voïvodship
- Five-year age groups.
- Order of births: first to tenth, 11 and over.

Table 3 (10) for 1963
Table 3 (12) for 1964 — Live-births by sex, order of birth and age of mother
- Five-year age groups.
- Urban and rural areas.

*Compiled from the sources indicated by the U.N. European Working Group on Social Demography.

Table 4 (11) for 1963
Table 4 (13) for 1964 — Live-births by age of mother, order of births, source of subsistence and economic activity

Five-year age groups.

Order of births: first to tenth, 11 and over.

Economically active or inactive in agriculture or outside.

Source of income from employment or other than employment.

Table 5 (14)
(for 1964 only) — Births by sex and month

Urban and rural areas.

Table 5 (12) for 1963
Table 6 (15) for 1964 — Live-births by order of birth and age of mother in towns

Five-year age groups.

Birth order: first to fifth, sixth and over.

Towns with 100,000 population and over.

Table 6 (13) for 1963
Table 7 (16) for 1964 — Legitimate live-births by age of parents

Five-year age groups.

Urban and rural areas.

Table 7 (14) for 1963
Table 8 (17) for 1964 — Legitimate live-births by parents' occupation

Father's occupation: industry, construction, agriculture, transport, trade, other, not employed.

Mother's occupation: agriculture, outside agriculture, not employed.

Urban and rural areas.

Table 8 (15) for 1963
Table 9 (18) for 1964 — Illegitimate live-births by age of mother and voivodship

Single year age groups up to 25, 25-29, etc.

Urban and rural areas.

Table 9 (16) for 1963
Table 10 (19) for 1964 — Still-births by age of mother and order of birth

Five-year age groups.

Order of births: first to fifth, sixth and over.

Table 11 (18) for 1963
Table 12 (21) for 1964 — Multiple live and still-births by sex of child and age of mother

Five-year groups.

In Ludność Polski w latach 1945-1965 (The Population of Poland, 1945-1965), Warsaw, 1966, 209 pages, fertility data for the twenty years are summarized covering the majority of the topics listed above, as well as some analytical tables. In addition, tables are presented on fertility projections 1960-1961 - 1980-1981, including projections of age-specific fertility rates for women, urban and rural areas, regions and voïvodships, and projected gross reproduction rates.

POLAND

Interruption of pregnancy*

Law No. 61 of 27 April 1956, determining the conditions under which interruption of pregnancy is permissible. (Dziennik Ustaw Polskiej Rzeszypospolitej Ludowej, 8 May 1956, No. 12, p. 71)

1. (1) Only a medical practitioner may interrupt a pregnancy and only if-

(1) interruption of pregnancy is justified-

(a) on medical grounds;
(b) by reason of the difficult living conditions of the pregnant woman;

(2) there is presumptive evidence that the pregnancy is the result of a criminal act.

(2) A pregnancy shall not be interrupted in the cases mentioned in paragraphs (1) (b) and (2) of sub-section (1) if it is medically contra-indicated.

(3) In the case of a minor, a pregnancy shall not be interrupted except with the consent of her parents, her guardian, or the guardianship authorities.

2. (1) The medical grounds or the difficult living conditions of a pregnant woman which justify interruption of pregnancy shall be medically certified. Presumptive evidence of the fact that pregnancy is the result of a criminal act shall be certified by the public prosecutor.

(2) The Minister of Health shall determine by ordinance at a later date the professional qualifications of medical practitioners who may induce abortions as well as the procedure for the issue of medical certificates attesting the permissibility of such operations.

3. Any person who brings any form of pressure on a woman in order to make her have a pregnancy interrupted shall be punishable by a term of imprisonment not exceeding five years.

4. Any person who interrupts a pregnancy with the consent of a pregnant woman but contrary to the provisions of section one shall be punishable by a term of imprisonment not exceeding three years.

5. Any person who assists a woman in inducing an abortion contrary to the the provisions of section one shall be punishable by a term of imprisonment not exceeding three years.

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*Reprinted with permission from International Digest of Health Legislation, 1958, 9, 319-323; 1962, 13, 140-142; 1964, 15, 793-794.

6. (1) The Law of 28 October 1950 relating to the practice of medicine* is amended as follows:

(i) The following new clause, clause (d), is added to section fifteen, sub-section (2);**
"(d) The induction of abortions";
(ii) Section sixteen*** is hereby repealed.

(2) [Repeal of certain sections of the Criminal Code]

7. [Entry into force]

Ordinance No. 68 of the Ministry of Health of 11 May 1956, relating to interruption of pregnancy.**** (Dziennik Ustaw Polskiej Rzeczypospolitej Ludowej, 16 May 1956, No. 13, pp. 81-82)

1. (1) It shall be the duty of any woman who intends to interrupt her pregnancy to make application to a medical practitioner for the issue of a certificate attesting that interruption of pregnancy is permissible.

(2) When so doing, the pregnant woman shall also submit to the medical practitioner such documents relating to her current state of health and previous medical history (results of supplementary examinations, opinions of specialists, medical records issued by hospitals, etc.) as she possesses.

(3) If a woman intends to interrupt her pregnancy by reason of her living conditions, it shall be her duty to submit to the medical practitioner a certificate in writing concerning these conditions.

2. (1) After examining the said woman, the medical practitioner shall, if he deems it indicated, arrange for a consultation with a competent specialist or refer her (to an institution) to undergo supplementary examinations and shall specify the period within which these examinations should be made, regard being had to the stage of her pregnancy.

(2) If the medical practitioner does not have the necessary specialized knowledge required in the case in question, it shall be his duty to refer the pregnant woman to a competent specialist.

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*See Int. Dig. Hlth. Leg., 1953, 4, 576.
**This sub-section defines the operations which may be performed elsewhere than in a clinical establishment (see Ibid, 579).-ED.
***This section specifies the cases in which interruption of pregnancy is permissible.-ED.
****Ordinance made in virtue of section two, sub-section (2), of Law No. 61 of 27 April 1956, determining the conditions under which interruption of pregnancy is permissible.-ED.

3. (1) If a woman intends to interrupt her pregnancy by reason of her living conditions but the truth of the certificate submitted by her (section one, sub-section (3)) is questioned, it shall be the duty of the medical practitioner to ascertain the living conditions of the woman, in particular by means of direct conversations with the representatives of the social organizations indicated by the woman or by an investigation of her living conditions.

(2) Where the certificate is to be issued by a medical practitioner attached to a public institution of the health services, the living conditions of the woman concerned shall be investigated by a nurse attached to this institution. In all other cases, it shall be the duty of the medical practitioner himself to make the investigation.

4. (1) When issuing certificates concerning the permissibility of interrupting pregnancy, medical practitioners shall take into account the medical indications or the living conditions of the women concerned.

(2) Medical practitioners shall state in such certificates (sub-section (1)) the grounds justifying interruption of pregnancy and shall give their own point of view. They shall attach to these certificates such essential documents relating to the case as are submitted by the women themselves as well as those they have issued to them.

(3) When issuing certificates to pregnant women (sub-section (1)) it shall be the duty of medical practitioners to indicate, when asked to do so, the address of the public institution of the health services in which the operation may be undergone.

5. (1) Where there is no good reason for interrupting pregnancy or there are medical contra-indications to it, medical practitioners shall so inform the women concerned by word of mouth.

(2) Where medical practitioners are of the opinion that the living conditions of pregnant women do not justify interruption of pregnancy, they shall forthwise issue, when asked to do so, a substantiated opinion in writing to this effect.

6. Pregnant women to whom medical practitioners refuse to issue certificates as to the permissibility of interruption of pregnancy by reason of their living conditions, may apply to the health section of the Praesidium of the district people's council (town or ward of a town) to have their case submitted to a medical board. It shall be the duty of the pregnant women to attach the opinion referred to in section five, sub-section (2), to their application.

7. (1) In the case to which section six applies, the health section of the Praesidium of the district people's council (town or ward of a town) shall immediately convene a medical board, composed of three medical practitioners, at the public institution of the health services.

(2) When issuing certificates, the medical board shall conform by analogy, with the provisions of sections three and four and section five, sub-section (1).

8. The certificate as to be permissibility of interrution of pregnancy shall be issued, and the formalities relating to the issuing of this certificate shall be completed, in good time to enable the operation to be carried out under conditions entailing the least possible hazard for the health of the woman concerned, in view of the stage of her pregnancy.

9. (1) The operation shall be carried out by a gynaecologist, obstetrician or by a surgeon.

(2) A medical practitioner who does not satisfy the conditions laid down in the foregoing sub-section, may carry out the operation if he is sufficiently well-trained to do so and to ascertain medical contra-indications, which facts shall be confirmed by the health section of the Praesidium of the voivod people's council (the public health administration of the towns of Warsaw and Lodz), after consultation with a voivod specialist in gynaecology and obstetrics.

(3) A medical practitioner shall not be entitled to interrupt a pregnancy if it was he who issued a certificate to the woman concerned as to the permissibility of such an operation.

10. The public institution of the health services in which the operation took place shall keep the medical certificate as to the permissibility of the operation, in the medical history file of the person concerned.

11. (1) It shall be the duty of all medical practitioners who interrupt pregnancies elsewhere than in public institutions of the health services to maintain, while not divulging any professional secrets, a card index of all such operations, including a brief description of each operation and the personal particulars and address of the woman concerned; they shall keep individual cards for a period of ten years as well as the documents as to the permissibility of the operation.

(2) It shall be the duty of medical practitioners to issue pregnant women, at their request, with certificates as to the circumstances influencing the period of their incapacity for work.

(3) It shall be the duty of a medical practitioner to give the health section of the Praesidium of the district people's council (town or ward of a town), and the voivod specialist acting with the authorization of the above-mentioned health section, access to his card index (sub-section (1)).

12. [Entry into force]

Ordinance of 19 November 1959 of the Minister of Health with regard to the interruption of pregnancy.* (Dziemik Ustaw Polskiej Rzeczypospolitej Ludowej, 13 January 1960, No. 2, Text 15, pp. 32-33)

1. (1) It shall be the duty of any woman who intends to interrupt her pregnancy tomake application to a physician for the issue of a certificate attesting that interruption of pregnancy is permissible.

(2) If a woman intends to interrupt her pregnancy by reason of her living conditions, it shall be her duty to submit to the physician a certificate concerning these conditions. The physician shall enter the information given in this certificate on the medical record card (previous medical history) of the person concerned, which he shall make her sign, after reading it to her.

2. (1) The physician shall draw up the certificate stating that interruption of pregnancy is permissible, in accordance with the form given in Annex 1 to the present Ordinance.

(2) On the basis of the examinations carried out or, in the case of an interruption of pregnancy requested by reason of the difficult living conditions of the woman, of the certificate submitted by the latter, the physician shall determine whether the conditions for an interruption of pregnancy are satisfied and whether there are any contra-indications.

3. (1) All physicians who issue to a woman a certificate attesting that interruption of pregnancy is permissible must:

(i) inform her of the methods of preventing an unwanted pregnancy, issue her a prescription for the appropriate contraceptives, and warn her that she must undergo a check examination after the operation and attend periodically at the gynaecological and obstetrical clinic, and also provide her with the necessary literature on methods of preventing pregnancy;

(ii) give her the address of institutions in which her pregnancy may be interrupted.

(2) If the certificate mentioned in sub-section 1 above is issued by a physician working in an institute in wiich operations for the interruption of pregnancy are carried out, the said physician must, at the request of the woman, determine the periods in which her pregnancy may be interrupted.

4. If it appears that there is no good reason for the operation for interruption of pregnancy or there are medical contra-indications to it, the physician shall draw up a certificate attesting that the said operation may not be authorized, in accordance with the form given in Annex 2 of the present Ordinance.

*Ordinance promulgated by virtue of sub-section 2 of Section 2 of the Law of 27 April 1956 determining the conditions under which interruption of pregnancy is permissible (see Int. Dig. Hlth. Leg., 1958, 9, 319).-ED.

5. (1) All women to whom a physician has issued a certificate attesting that interruption of pregnancy may not be authorized have the right to apply to the health department of the people's council of the district (or town or ward of a town) within the jurisdiction of which their domicile is located, to have their case submitted to a medical board.

(2) The certificate attesting that interruption of pregnancy may not be authorized must be attached to the application by the woman concerned.

6. (1) As a consequence of the application mentioned in Section 5, the health department must convene, within three days of the despatch of the said application, a medical board composed of three physicians.

(2) When issuing certificates, the medical board shall conform, by analogy, with the provisions of Sections 2 and 4.

7. All the formalities relating to the drawing up of a certificate with regard to an interruption of pregnancy must be completed in good time, so that the stage of pregnancy may not constitute a contra-indication to this interruption nor a danger to the life of the woman.

8. (1) Public institutions of the Health Service, medical boards, as well as the physicians who issue certificates with regard to interruptions of pregnancy to be carried out outside a public institution of the health services, must keep a register of the operations carried out.

(2) Public institutions of the health services as well as physicians who issue certificates with regard to interruptions of pregnancy to be carried out outside a public institution of the health services must send to the health department of the Praesidium of the people's council of the district (or town or ward of a town) a quarterly report on the number of operations carried out, before the 10th day of the month following the quarter which has elapsed.

9. (1) The operation for interruption of pregnancy may be carried out by a gynaecolgist-obstetrician or a surgeon.

(2) A physician who does not satisfy the conditions laid down in sub-section 1 above may carry out the operation for the interruption of pregnancy if he is sufficiently well-trained to do so and to ascertain any possible medical contra-indications, his competence being confirmed by the health department of the Presidium of the voivodship people's council (or of the people's council of towns having the status of a voivodship), after consultation with a voivodship specialist in gynaecology and obstetrics.

10. (1) It shall be the duty of all physicians who interrupt pregnancies elsewhere than in public institutions of the health services to maintain, while not divulging any professional secrets, a card index of all such operations, including a brief description of each operation, and the personal particulars and address of the woman concerned; they shall keep individual cards for a period of 10 years as well as the documents as to the permissibility of the operation.

(2) All physicians who carry out an operation for the interruption of pregnancy elsewhere than in public institutions of the health services must, when it is they themselves who have decided that this operations was necessary, mention this fact in the card index.

(3) All physicians who carry out operations for the interruption of pregnancy elsewhere than in public institutions of the health services must send to the health department of the Presidium of the people's council of the district (or town or ward of a town) a quarterly report on the number of operations carried out with the mention of the cases in which they themselves have decided that the operation was necessary, as well as of cases where this decision was taken by other physicians, before the 10th day of the month following the quarter which has elapsed.

(4) It shall be the duty of the physician to issue pregnant women, at their request, with certificates as to the circumstances influencing the period of their incapacity for work.

11. The Ordinance of 11 May 1956 with regard to the interruption of pregnancy is repealed.*

12. [Entry into force]

Annex No. 1

[Form of medical certificate attesting that an operation for interruption of pregnancy is permissible]

Annex No. 2

[Form of medical certificate attesting that an operation for interruption of pregnancy cannot be authorized]

Instruction No. 5/59 of 19 December 1959 of the Minister of Health relating to the interruption of pregnancy. (Dziennik Urzedowy Ministerstwa Zdrowia i Opieki Spolecznej, 15 January, 1960, No. 1, text 2, pp. 3-4)

The health sections of the praesidiums of the peoples' councils at the district level shall prepare and keep up to date the list of establishments which, in the area under their jurisdiction, perform the operations for the interruption of pregnancy, and make the decisions to perform them.

When women come forward expressing a wish to have their pregnancy interrupted, physicians employed in the social establishments of the health service must immediately take all the steps necessary to reach a decision, and ensure that the formalities do not make it impossible to perform the operation in cases where it is justified.

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*See Int. Dig. Hlth. Leg., 1958, 9, 231.-ED.

The health sections of the praesidiums of the peoples' councils at district level must supply all the social establishments of the health service which, within the limits of their competence, receive women wishing to obtain a decision on the interruption of pregnancy, and physicians who are practising in a private capacity, with the necessary information on the means of preventing pregnancy. In all the social establishments of the health service giving decisions authorizing the interruption of pregnancy, and in the establishments which perform the opertions for interruption of pregnancy, health education, especially with a bearing on problems of birth control, should be organized and instruction given at all times.

The health sections of the praesidiums of the peoples' councils at voivodship level organize sales stands for contraceptives in the social establishments of the health service, especially in those which issue authorizations for the interruption of pregnancy or which perform operations for the interruption of pregnancy.

Instruction No. 52/59 of 19 December 1959, of the Minister of Health, relating to the performance, on ambulant patients, of operations for the interruption of pregnancy. (Dziennik Urzedowy Ministerstwa Zdrowia i Opieki Spolecznej, 15 January 1960, No. 1, text 3, pp. 4-6.

Establishments in which operations for the interruption of pregnancy may be performed shall be appointed within the jurisdiction of towns, municipal wards and districts.

Pregnancy may be interrupted by operation on ambulant patients, in hospitals, out-patients clinics attached to hospitals and other open medical welfare establishments which have the necessary premises at their disposal, and fulfil the requirements for the performance of such operations under the strictest conditions of asepsis and antisepsis.

Operations for the interruption of pregnancy may not be performed on the premises of maternity posts.

Operations must be performed with the necessary discretion, on the days and at the times speically determined. They are carried out by specialists in gynaecology and obstetrics, assisted by midwives or nurses.

The operation for interruption of pregnancy may be performed on ambulant patients exclusively in cases where the necessity for the operation is justified because of the difficult living conditions of the person in question, and where the patient's state of health does not require hospitalization after the operation.

Professional procedures which may be performed by nurses and midwives:
injections, intravenous drip transfusions and blood transfusion

Instruction No. 31/60 of 27 June 1960 of the Minister of Health and Social Welfare relating to the performance by nurses and midwives of intravenous injections, drip transfusions and drip transfusion of stored blood and blood products. (Dziennik Urzedowy Ministerstwa Zdrowia i Opieki Spolecznej, 15 July 1960, No. 14, text 62, pp. 97-98)

Nurses and midwives may, within the limits of their duties in the social establishments of the health service, perform the following procedures: (1) intravenous injections, excluding injections of highly active drugs such as strophanthin, euphyllin, urotropin, calcium bromide and calcium chloride; (2) drip transfusion of liquids other than blood or blood products; (3) drip transfusion of stored blood and blood products.

Intravenous injections and drip transfusions may be performed only by nurses and midwives considered as possessing the qualifications necessary for these operations, by the physicians under whose orders they are placed.

The drip transfusion of stored blood or blood products may be carried out only by nurses and midwives who: (a) have undergone the required theoretical and practicial training in a centre for the removal of blood; and (b) are considered by the medical director of the department (or director of the clinic) as possessing the qualifications necessary for such an operation.

Nurses and midwives may not perform intravenous injections and drip transfusions or drip transfusion of blood except on the order of a physician.

The performance of drip transfusion of stored blood or blood products may be entrusted to the nurse or midwife only when: (a) because of the state of health of the patient the operation must be performed without delay and no physician in the department can be personally responsible for it owing to his presence by the bedside of another person who is seriously ill and requires his care; (b) the intervention of the physician can be guaranteed if complications ensue.

Auxiliary nurses, junior nurses and nursing aides may not in any circumstances perform the professional acts described above.

The intravenous injection of highly active drugs and the transfusion of fresh blood may be performed only by physicians and feldshers.

CHAPTER 5
HUNGARY

Historical Trends

1. An overview of demographic trends in Hungary has been published on several occasions by Szabady and his associates (1966-1969). The decrease in birth rates began in the late 1880s, although there were earlier indications in some agricultural areas and towns. The gradual decline continued in the post World War II era, reaching its nadir in 1962 at 12.9 per 1,000 population, the lowest recorded rate in Europe. Subsequently, the birth rate recovered to 15.1 in 1968. This increase is partially attributed to the large number of women, born after World War II, who are now in their most reproductive ages.

2. Social restratification in connection with industrialization led to a decrease in the agricultural population which had had a higher fertility. Migration from villages to towns had a similar result. The growing number of women engaged in economic activity also contributed to the decline of births. Cultural aspirations and the desire for improved living conditions fostered plans for smaller families.

3. Although for some years after World War II the birth rate exceeded 20 per 1,000 population, it began to decrease again in the fifties (Table 10). Rigorous punitive measures against abortions in 1953/54 had only a transitory effect, mostly in Budapest and the larger towns. Illegal abortions were estimated

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*Arrangements for visits in Budapest were coordinated by Dr. Egon Szabady, Vice President of the Hungarian Statistical Office, Director of the Demographic Research Institute, and Chairman of the Demographic Research Committee of the Hungarian Academy of Science. Also consulted were Dr. Imre Hirschler, Chief of Obstetrics and Gynecology at the Kősponti Állami Kórház Hospital; and Dr. Gyorgy Acsadi, Dr. Peter Jozan, Dr. Andras Klinger, and Dr. K. Miltenyi of the Hungarian Statistical Office.

at about 100,000 per year. After 1954 the strict policy aimed at achieving a higher fertility level was relaxed, followed by a rapid increase in the number of induced abortions and a further declining birth rate. Government policy changed in response to the generally accepted opinion that family planning, the decision how many children to bear and at what intervals, is the sovereign right of the couple and of the woman concerned.

4. "In the development of the Hungarian population during the past two decades, the consequences of the absence of a well thought out and consistent concept of demographic policy made itself felt.... It was not only an absence of concrete plans of demographic policy--for which at that time the necessary scientific conditions did not exist--but it was the lack of the recognition of the fact that measures of not explicitly demographic policy character taken in the most different fields of life may have serious consequences" (Szabady, Acsadi, Andorka et al., 1968).

5. "A healthy solution of the population problem cannot be expected from an eventual modification of legal prescriptions in respect of abortions. The future population policy should take into account primarily socioeconomic factors exercising influence on the number of births.... The demographic behaviour of the society was influenced by the fact that mothers with many children and families with many children did not receive sufficient material support and social respect.... The abolishing of the restrictions in respect of abortions was not accompanied by psychological or more significant economic measures propagating child birth" (Szabady, Acsadi, Andorka et al., 1968).

Abortion Policy Trends

1. In the period 1949-1952 interruption of pregnancy was performed for medical reasons only. As shown in Table 10, the number of legally induced abortions and the number of registered spontaneous abortions were fairly constant during this period. Strong efforts to enforce existing laws against illegal abortion in 1952 and 1953 were followed with a temporary increase in births.

2. In 1953 medical boards for the authorization of therapeutic abortions were established. Personal and social indications for abortion were considered

Table 10

Numbers and Rates of Births and Abortions in Hungary, 1950-68*

	Number in 1,000s			Rate per 1,000 population		
Year	Live births	Legal abortions	Other abortions**	Live births	Legal abortions	Other abortions**
1950	195.6	1.7	34.3	21.0	0.2	3.7
1951	190.6	1.7	36.1	20.2	0.2	3.8
1952	185.8	1.7	42.0	19.6	0.2	4.4
1953	206.9	2.8	39.9	21.6	0.3	4.2
1954	223.3	16.3	42.0	23.0	1.7	4.3
1955	210.4	35.4	43.1	21.4	3.6	4.4
1956	192.8	82.5***	41.1	19.5	8.3***	4.2
1957	167.2	123.4	39.5	17.0	12.5	4.0
1958	158.4	145.6	37.4	16.0	14.7	3.8
1959	151.2	152.4	35.3	15.2	15.3	3.5
1960	146.5	162.2	33.8	14.7	16.2	3.4
1961	140.4	170.0	33.7	14.0	17.0	3.4
1962	130.1	163.7	33.9	12.9	16.3	3.4
1963	132.3	173.8	34.1	13.1	17.2	3.4
1964	132.1	184.4	34.3	13.0	18.2	3.4
1965	133.0	180.3	33.7	13.1	17.8	3.3
1966	138.5	186.8	33.6	13.6	18.3	3.3
1967	148.9	187.5	34.9	14.6	18.4	3.4
1968	154.4	201.1	33.7	15.1	19.7	3.3

* After Tietze (1969) with 1968 data provided by E. Szabady

** Registered spontaneous abortions recorded in hospitals (Hirschler, 1968)

*** Abortions legalized in June 1956

along with medical and eugenic grounds (Hirschler, 1968). Table 10 reflects the progressive liberalization of board decisions in 1954 and 1955. There was a sharp increase in legal abortions with registered spontaneous abortions stabilized.

3. On 3 June 1956 a new law was promulgated (Hungary, 1958). It "authorizes a woman to make a conscious determination of desired family size and permits her to interrupt an undesired pregnancy by means of an induced abortion" Klinger, 1966). Authorization depends exclusively on the request of the pregnant woman, not requiring any special social or health indications (Miltenyi, 1965). Subsequently, the rate of legal abortions increased rapidly until it reached 19.7 per 1,000 population in 1968, the highest recorded rate in Europe.

4. A woman wishing to have an abortion must request permission from a commission usually consisting of three members. The chairman is always a physician, mostly a gynecologist. The other two members are the head or representative of the socio-political group of the local administrative unit and the delegate of the women's association. The commission meets twice a week. Before applications can be considered, the woman must undergo a gynecological examination in the course of which the period of gestation is determined (Klinger, 1969a).

5. In addition to health considerations, permission for termination is granted if justified by personal or family circumstances or "if the applicant insists on the interruption of pregnancy after the commission has asked her to think it over."

6. Abortions are usually denied if the woman is more than 12 weeks' pregnant. Exceptions are permitted for women age 16 to 20 years if the pregnancy has not exceeded 18 weeks.

7. Abortions must be performed in gynecological units of hospitals or in maternity homes. Induced abortions may not be done in outpatient departments. In general, hospitalization for three days after the abortion is deemed necessary but, due to overcrowding of hospitals, women may be discharged after two days. Hirschler (1968) has described prevalent operative techniques. Vacuum-aspiration is used in some Hungarian hospitals. There is no charge if the termination is for medical reasons. The fee for an abortion induced on social

grounds is usually about 300 florint ($10 at the current tourist exchange rate). Quite frequently the woman adds a personal gift for the gynecologist.

8. The rather constant number (33,000 to 35,000) of spontaneous abortions registered in the past decade refers to patients treated in hospitals. (Note differences between legally induced abortions and all registered abortions for Hungary in Table 1.) Events occuring outside hospitals are not recorded. As noted by Hirschler (1968), the proportion of spontaneous abortions to live births is about double the 10 to 12 percent expected from the literature. Some experts believe, however, that 15 to 20 percent of pregnancies abort spontaneously. The still higher Hungarian rate reflects the practice of some gynecologists to admit certain women to hospitals under the pretext of spontaneous abortion in order: (a) to avoid charging the prescribed modest fee for abortion on request or (b) because the woman lives outside the geographic region from which the hospital may admit but prefers this hospital to the one in her home area to which the commission has referred her. In cases of imminent miscarriages, if the woman does not want the child, no efforts are made to continue pregnancy. Spontaneous abortions also include illegal abortions if complications necessitate hospitalization. Their number cannot be assessed but is presumed to be small (Hirschler, 1968). It was further speculated that spontaneous abortions have increased because pregnant women work until the last moment and continue smoking and drinking as before. Some spontaneous abortions may be self-induced after the third month when legal abortion is no longer available on request.

9. Hirschler (1961, 1968) has reported extensively on mortality and morbidity of abortions. Mortality rate of legal abortions is minimal. In the period 1957-58, there were 15 deaths among 269,000 legal abortions. Since that time, the number of annual deaths has ranged from 8 in 1962 (0.05 per 1,000 induced abortions) to 0 in 1967. Deaths per 1,000 registered spontaneous abortions have been higher, including complications from illegal abortions, ranging from 0.86 in 1962 to 0.41 in 1965. For 1967 the rate was 0.49 per 1,000.

10. Early complications of hospitalized patients are registered throughout Hungary. According to available statistics, about 3 percent of induced abortions involve complications with some hospitals having better records than others. Later complications are more difficult to determine; little solid data are available.

11. According to a 1964 sample survey, 38 percent of the women applying for induced abortion were in the 4th to 7th week, 57 percent in the 8th to 11th week, and only 5 percent in the 12th to 19th week of pregnancy (Klinger, 1969a).

12. About 12 percent of all abortions are among unmarried, separated, or widowed women. Of 26,100 women queried in 1960, only 10 percent had requested abortion for medical reasons. Of 27,900 women questioned in 1964, only 5 percent gave medical reasons as the basis for requesting induced abortion (Miltenyi, 1965). The percentage of women having had three or more abortions rose from 12 to 17 percent among those requesting abortions between 1960 and 1965 (Szabady, 1969d).

13. Szabady (1969c) reported at the Budapest AIR-DRI Conference that 78 percent of all Hungarian women of childbearing age have had at least one abortion. About 10 percent of the women who had one abortion subsequently gave birth to a child weighing less than 2,500 grams. The incidence increased to 18 percent among women who had three or more abortions before giving birth to a child.

14. As shown in Table 10, the combined rate of induced and spontaneous abortions began to exceed the birth rate in 1958. In 1962 the birth rate fell to 12.9 per 1,000 population, the lowest recorded rate in Europe. By 1964 a peak was reached of 166 registered abortions (induced plus spontaneous) per 100 live births. During 1966-1967 family allowances and maternity leave were further improved. Although the abortion rate has continued to rise, reaching 19.7 per 1,000 population in 1968, the birth rate began to rise also, increasing to 13.6 in 1966, 14.6 in 1967, and to 15.1 in 1968. It will be of interest whether social policies designed to stimulate the birth rate will continue to do so or whether the trend will again be reversed. There do not appear to be any present plans to restrict abortions. (Additional observations are presented in Research Notes.)

Illegal Abortions

1. Despite liberal laws, illegal abortion has not disappeared. The currently mentioned number of 8-10,000 per year is far below the 100,000 per year estimate before liberalization of the abortion laws.

2. Hirschler (1968) suggests that illegal abortions survive for several reasons: (a) Some unmarried, divorced, separated, or widowed women prefer to keep their pregnancies secret, rejecting the relative lack of privacy of commissions and hospital procedures. An absence of three days from the job can create rumors. (b) A minor proportion of women do not know about the existence of commissions and are not familiar with the regulations. (c) A few women fear that their requests for abortion may be refused. And (d) some women believe that a "private" gynecologist will perform the operation with less pain.

3. Informal queries elicited the information that the cost of an illegal abortion is about 1,000 florint ($35 at the current tourist exchange rate), a sum not significantly greater than the cost of a legal abortion plus personal gift to the physician.

Family Allowances

1. Family allowances have been continuously increased "but not to an extent to make it possible to exercise a direct influence on population growth because these increases covered only a small part of the surplus expenditures of families with children" (Szabady, Acsadi, Andorka et al., 1968). Only by 1970 will the families of members of agricultural cooperatives have the same allowances as families of workers and employees.

2. Family allowances are of two kinds. Financial allowances are provided for second and subsequent children. Allowances are also given to facilitate child care until kindergarten age is reached. In 1969 this age was fixed as the child's third birthday.

3. During the first five months after confinement, maternity leave with full pay is provided. After that time the family allowance for child care is operative for an additional 31 months. In the case of several children, the full allowance is granted for each child. This allowance is 600 florints ($20) per month; 500 florints for children of workers in agricultural cooperatives.

4. According to preliminary estimates, some 70 percent of the employed women who gave birth to a child in the first quarter of 1967 made use of allowances

for child care. The majority of these women had their first child in 1967. When compared to data from previous years, fewer women appear to be postponing birth of their first child.

Contraceptive Methods and Practices

1. All kinds of contraceptives are readily available at low cost. Condoms can be purchased in diverse places, from supermarkets to public lavatories.

2. An oral contraceptive, Infecundin, has been manufactured since 1967. It is available upon prescription after physical examination by a gynecologist and laboratory tests. A month supply of 21 pills costs 31 florints, or about $1.00.

3. An IUD designed by Professor Szontagh (1967) at the Gynecological University Hospital in Szeged is manufactured in Hungary. Coils are inserted only in university gynecological clinics. There is no charge.

4. There are about 2.5 million women of childbearing age. In June 1969 pharmacies provided 81,000 females with a one-month supply of Infecundin. Coils are still in the experimental stage. The number of women using them does not exceed 10,000. This means that less than 4 percent of the women between ages 15 to 49 are on modern contraceptives (Szabady, 1969d).

5. Motivation for modern methods of contraception appears to be low, especially if a visit to a clinic, physical examination, and/or prescriptions are involved--and abortion is readily available on request. For some women, abortion is more convenient and perhaps even more economical than regular use of pills. Medical authorities have done relatively little to counteract the continuous discussion of side effects in the public media.

6. The TCS Surveys cited in the Research Notes show that despite general acceptance of contraception and high initial practice, many married couples who do not want to have a child tend to resort to abortion (Szabady, 1968). At the time of the 1966 survey, 63 percent of 8,000 married women in the 15- to 49-year age group reported use of contraception. This percentage does not include women

pregnant at the time of the survey or those who abandoned contraceptives because they wanted to have a child.

7. Among the methods practiced in 1966, the "natural" techniques were most popular. Of the married couples practicing contraception, 62 percent used coitus interruptus; an additional 9 percent resorted to the "safe period," douche, or sexual abstinence. The condom was used by 15 percent; diaphragm and chemical contraception was applied by 8 percent. Sterility was reported by 6 percent. The use of pills and coils was insignificant in 1966; less than one percent.

8. Considerable age, socioeconomic, and educational differences in the use of contraceptive methods were noted. Coitus interruptus increases with advancing age: 61 percent under age 30, and 75 percent of those over age 40. The more recent the marriage and the higher the educational and socioeconomic levels, the greater the use of chemical or modern contraceptives. General ignorance about contraceptive methods was widespread. About four in ten married women replied they had no information about birth control information; two said they had received such information from their husbands; one learned from an acquaintance; and only three mentioned a physician or nurse as a source of information. Lack of information was noted especially among younger women with less education. Insufficient knowledge plus "accidents" may well be a major reason for inefficient contraceptive practice and resorting to easily available induced abortions (Szabady, 1969d).

9. Szabady (1969d) examined the relationship between abortions and contraceptive practice. According to the 1964 TCS data, more than half the aborting women had been unsuccessful contraceptors. It was noted that 44 percent of the women using contraceptives did so irregularly and became pregnant, 27 percent used the contraceptive "wrongly" and in 13 percent the contraceptive method was considered ineffective. Szabady concludes that if satisfactory, acceptable, and effective contraceptives had been available in 1964, almost 25 percent of the induced abortions could have been avoided. Although more effective contraceptives have been introduced in Hungary since 1964, incomplete instructions are believed to give rise to a false sense of security among women, resulting in pregnancies and subsequent abortions.

10. The most recently developed contraceptive device is C-FILM, a plastic film containing a highly active, non-toxic spermicide for local use by men and women. Its developer, Dr. Kalman Hotey (1968) sent the following report to the IPPF Medical Bulletin: "Called the C-FILM, it is a thin, translucent, pliable, water-soluble film, 4cm. square, weighing 0.15 gram. The chemical formula of the spermicide has not been given. The C-FILM is used by the female partner as follows: One plastic film is inserted into the vagina either immediately before sexual intercourse or up to three hours beforehand. No waiting period is needed, as the film starts to dissolve at once. If used by the male partner, one C-FILM is placed on the moistened glans penis just before intercourse. The physio-chemical properties of the vehicle for the spermicide give this method several advantages over conventional spermicides. The surface-active jelly-like solution dissolves in the vaginal secretions and does not run out of the vagina. This means the woman may stand and walk about after a C-FILM has been inserted; and C-FILM makes an excellent barrier in spite of the very small amount used. Clinical trials have been performed in Hungary on 720 highly fertile volunteer couples for a total of 6,300 cycles. In these trials the failure rate was 3.4 pregnancies per 100 woman-years (mainly because of irregular use). C-FILM has been well accepted by the users, causing no interference with sex life and no vaginal complaints. There were no signs of changes in the vaginal mucosa or the bacterial flora, and no signs of local irritation were seen. Since C-FILMS can be used by both men and women, they are of value in societies where contraception is male-oriented. C-FILMS are easier and less cumbersome to use than condoms, and their price is much less as well: a book of ten films sells in Hungary for the equivalent of 15 US cents."

11. It was subsequently reported by Friendly (1969) that according to the International Planned Parenthood Federation the C-FILM is (a) being used by 100,000 couples in Hungary, (b) undergoing tests at University College Hospital in London, (c) being tested with a total of several hundred women by the governments of India, Pakistan, and Egypt, and (d) being tried "with reportedly encouraging preliminary results in West Germany, Australia, Italy, and Sweden. An IPPF representative stated "that the Hungarian product is still of comparatively poor quality and consistency" and that there is a search for a European producer "who will develop the film to a higher and more consistent standard." A spokesman for the U.S. Food and Drug Administration said that it "has no information on any studies involving C-FILM in the United States." Recent Egyptian experience raises some doubts about the effectiveness of C-FILM in its present form (Potts, 1970).

Family Planning Centers

1. There is no official family planning program in Hungary and no separate family planning centers exist. Free consultation on contraceptives is available from gynecologists and in gynecological units of hospitals and outpatient departments, of which there are approximately 200 in the country.

2. The Red Cross and the Hungarian Women's Association attempt to reduce abortion by propagandizing contraception in cooperation with leading gynecologists.

3. Although hopes for a Hungarian Family Planning Association have been expressed for a decade, no such organization exists. There is, however, much cooperation with the European Region of the International Planned Parenthood Federation and it is expected that the 1969 European Regional Conference will be held in Budapest.

Medical and Postgraduate Training

1. Only one lecture on contraception is given in the last year of medical school training.

2. Family planning lectures are given by the Medical Postgraduate Institute for Continuing Medical Education in Budapest, as well as by medical schools in three other cities.

3. A young physician surveyed general practitioners regarding family planning practices in their families. The responses tended to reflect "ignorance about contraception." (Hirschler, 1970).

4. While several Hungarian gynecologists have provided significant leadership, many of their colleagues seem less interested. The comment is frequently heard that some gynecologists have more to gain from abortion than contraception. Until this situation changes, progress may be more promising than actual.

Sex Education in the Schools

1. There is little sex education in the schools. What is provided tends to be more concerned with physiological facts than with emotional and psychological aspects.

2. There is general recognition of the need to do more. Implementation of ideas is awaiting appropriate action.

Public Education

1. Sporadic efforts are made through press, radio, films, and television. The number of printed brochures distributed exceeds 1.5 million. Hirschler's book In the Interest of Women sold 500,000 copies since its publication in 1958. It has gone through six editions in Hungary and five editions in Czechoslovakia. The market and interest exist, but there is limited organizational effort to promote public education.

2. One reason for the limited use of contraceptives may be that until recently government dissemination of information was largely directed to gynecologists rather than encompassing the entire medical profession and the general public. Introduction in 1967 of an Hungarian-produced pill, Infecundin, stimulated a more widely disseminated government effort. Whether or not the small fee charged for the pill is a deterrent to its use has not been clearly determined.

3. Although plans for organizing a Family Planning Association remain to be implemented, Hungary hosted the 6th Conference of the Europe and Near East Region of the International Planned Parenthood Federation in Budapest in September 1969.

Research Notes

1. Hungarian demographers have justly developed an outstanding reputation for imaginative research, going beyond traditional demographic and population census data. Many of the contributions of the past decade were developed under

the energetic leadership of Dr. Egon Szabady who holds the offices of Vice President of the Hungarian Statistical Office, Director of the Demographic Research Institute, and Chairman of the Committee on Demography of the Hungarian Academy of Science. He also edited one of the first volumes considering the various scientific aspects of demography and family planning (Szabady et al., 1968). A compilation of 1968-69 studies conducted by the Demographic Research Institute is presented in Chapter 13.

2. During 1957-1966, four types of studies were repeatedly conducted:

(a) TCS studies in fertility, family planning, and birth control, somewhat similar to the Population Council questionnaires on knowledge-attitude-practice, were conducted in 1958-1960 and in 1965-1966. The TCS '66 study included 0.5 percent of the 15- to 49-year-old married women, 8,000 in all (Szabady, 1968).

(b) Census of fertility and family 1960 with microcensus in 1963.

(c) One month collection of statistics on abortions, covering those who have had a child or had an induced abortion in hospital or maternity home during October 1960, repeated in April 1964.

(d) A longitudinal survey of marriages was initiated in 1966.

3. Technical aspects of the TCS surveys have been described in English by Acsadi (1967) and by Szabady, Klinger, and Acsadi (1967). Findings of the TCS surveys have been reported by Szabady (1968) as well as by Acsadi and Klinger (1959, 1963), Klinger (1969a), Miltenyi (1965), Szabady and Klinger (1966), and Szabady (1969d). The most complete report in English was published by Acsadi, Klinger, and Szabady (1969), including procedures, questionnaires, sampling and field experiences, and a bibliography of Hungarian publications on fertility and family planning 1958-1968.

4. As shown in Table 11, the average number of live-born children in 1965/66 was 1.9 which reflects a slight decrease from the 2.0 noted in the 1960 census. (In 1966 younger women having fewer children replaced the previous group of older women with more children in the 1960 census.) The TCS 1966 study showed that women in active employment had 20 percent less children than those not working. The higher the level of education, the smaller the families.

Table 11

The Average Number of Live-Born, Living and Additionally Wanted Children by Age Groups of Married Females in Hungary 1965/66 (Szabady, 1968)

Age-groups	Average number of		
	live-born	living	additionally wanted
	children per female		
15-19	0.47	0.44	1.43
20-24	0.97	0.94	0.96
25-29	1.53	1.46	0.54
30-34	1.98	1.87	0.28
35-39	2.14	2.00	0.13
40-44	2.33	2.12	0.05
45-49	2.33	2.10	0.03
Total	1.89	1.76	0.33

5. When asked to express their ideal number of children, independent of socio-economic circumstances, 58.2 percent of the women queried in 1966 responded with a desire for two children; 29.3 percent regarded three children as ideal. The wish for a family with four children occurred almost as rarely (6.4 percent) as the one-child family (3 percent). The notion of childless families was rarely mentioned; 2.8 percent expressed no opinion.

6. The Hungarian surveys dealt not only with the acceptance or rejection of family planning in marriage and with the desired number of children, but also with the proportion of marrying women who plan the size of their families, and with the essential features of these plans (time-spacing, stability, etc.). In the 1966 TCS study, 47.1 percent of the women said they had plans before marriage. On the average, planned number of children (2.14) was somewhat higher than the number of living and additionally wanted children of women included in the sample (2.09). Table 12 shows that family planning is far more widespread among younger than older women. There is an inverse relationship between family planning and age. More than two-fifths of the "planning women" plan not only the number of children to be born but also their spacing.

7. One of the basic questions of the TCS surveys related to birth control. It was found that only 40 to 60 percent of the women with a history of legal abortions reported their induced abortions. Due to denials, the number of induced abortions among the responses had to be corrected. This correction was based on the fertility history of the woman. When reviewing the questionnaires, the responding woman was assumed as "unknown" regarding abortion if there was a long interval in her fertility history which could not be explained by her other replies. The method for estimating number of abortions is outlined in Acsadi, Klinger, and Szabady (1969).

8. The majority of married couples (57.4 percent) did not practice family planning during the first year of marriage: approximately one-third of the women expressed the wish to have a child. (About 15 to 20 percent of all first children are conceived before marriage.) During the second year about 51 percent of the couples used contraceptives: an additional 7 percent resorted to induced abortion to terminate unwanted pregnancies. While the proportion of couples practicing contraception in subsequent years rose to 70 percent, it was also estimated that 70-80 percent of all married women eventually request at least one abortion during their marriage. Very few women rely on abortion as the only

Table 12

Proportion of Planners and Average Number of Planned Children by Age Groups in Hungary, 1965-66 (Szabady, 1968)

Age-groups	Percentage of those who planned the number of their children before marriage	Average planned number of children
15-19	68.2	1.96
20-24	58.0	1.98
25-29	53.5	2.02
30-34	45.8	2.11
35-39	45.7	2.18
40-44	39.9	2.25
45-49	39.1	2.49
Total	47.1	2.14

method of birth control. Szabady (1969) concludes that married couples do use birth control methods, but Hungarian practice is based on rather ineffective methods.

9. According to Miltenyi (1965) the main determinant for legal abortion among married women is the number of living children. In 1962, the ratio of legal abortions to pregnancies was 17.0 among childless women, 54.9 among those with one child, 76.5 among those with two children, and 70.8 among those with three children or more. Of 100 women who had abortions in 1963, 56 had two or more children, 29 had one child, and 15 had no children.

10. According to the TCS-66 survey, only 12 percent of the women interviewed did not agree with the legislation making abortion available on demand. Most of the other 88 percent agreed completely with the law, while 31 percent expressed some reservations. Many emphasized the need for more effective contraceptives and better instructions on application. It was concluded that "Hungarian women not only practice abortion but the majority wish to maintain the present liberal system" (Szabady, 1969d).

Research Centers

1. While research on contraceptive technology and in other areas is conducted in a variety of Hungarian settings, major social behavioral studies are conducted by the Demographic Research Institute of the Central Statistical Office. Established in 1963, the Demographic Research Institute is supported by funds from the Central Statistical Office and by specific research contracts with the Hungarian Academy of Science. Direct contact with the Academy is through the Academy's Committee on Demographic Research.

2. The Demographic Research Institute is located at Veres Palne u. 10, Budapest V. In 1969 the Institute had 21 full-time and 18 part-time staff members. Its budget has been expanded from two million florint in 1966 to 2.7 florint. Major areas of research during 1966-1968 were: (a) basic population processes, (b) population projections, (c) social stratification and mobility, (d) economic-demographic problems, (e) bio-demographic studies, and (f) historical studies.

3. A detailed report by Szabady (1969) including institute activities, organization, staff, publications, and international relations during 1968-1969 plus projected plans for 1969-1971 is presented in Chapter 13.

Reported Population Statistics

1. Since 1932 reports are made on every obstetrical event and summarized by the chief obstetrical officers in each of the 20 obstetrical districts in the country for processing by the Department of Statistics of the Ministry of Health.

2. Information in Table 13 is based on hospital figures only. Records are believed accurate.

Publications

1. Demografia, a quarterly publication of the Committee for Demography of the Hungarian Academy of Science and the Central Statistical Office. Editor: Dr. Egon Szabady, Veres Palne u. 10, Budapest V, Subscription: $4.40 per year.

Table 13

Demographic Data in Hungary*

1. Number and rates of births.
2. Birth rates.
3. Births by viability and sex.
4. Births by the age group of the mother.
5. Live-birth rates by the age group of the mother.
6. Live-births from marriage by the age group of the mother.
7. Live-birth rates by the age of the mother.
8. Live-births from marriage by the age group of the father.
9. Live-birth rates by the age group of the father.
10. Number and rates of live-births by the age year of the mother.
11. Live-births by the mother's year of birth.
12. Births by the age group of the father and mother.
13. Live-births by the age group of the father and mother.
14. Order of births.
15. Births by order, viability and sex.
16. Live-births by order of births and age group of the mother.
17. Live-births by birth order, year of birth and age of the mother.
18. Live-births by the age group of the mother and the number of her living children.
19. Live-births by number of the living children of the mother and by order of births.
20. Births by the duration of marriage.
21. Number of births from marriage by the year of marriage.
22. Order of confinements from the present marriage by duration of marriage and the mother's age group.
23. Births by intervals between successive births.
24. Births by the interval between successive births and by order of births.

* Compiled by the U.N. Working Group on Social Demography from the Demographic Yearbook, 1965, Hungarian Central Statistical Office.

25. Births by the interval between births and by the age group of the mother.
26. Weight of the newborn.
27. Weight of the newborn by viability, sex and place of birth.
28. Multiple births.
29. Births according to the assistance at the confinement.
30. Live-births by the socio-economic group of the supporter.
31. Live-births by the socio-economic group of the supporter and the age group of the mother.
32. Live-births by the socio-economic group of the supporter and by order of births.
33. Total births by the educational level of the father and mother.
34. Live-births* (?) by the educational level of the father and mother.
35. Live-births by the order of births and the educational level of the mother.
36. Regional distribution of births by viability and sex.
37. Regional distribution of live-births by the age group of the mother.
38. Regional distribution of birth rates by the age group of the mother.
39. Regional distribution of live-births by months.
40. Regional distribution of births by the order of births.
41. Weight of the live-born by regional units.
42. Still-births by causes.
43. Still-births by causes, by weight and age of the still-born.
44. Still-births by causes and by order of births.
45. Causes of still-births by the age group of the mother.
46. Abortions registered.
47. Induced abortions by age groups.
48. Regional distribution of induced abortions by causes, martial status and the number of living children.
49. Regional distribution of abortions reported.
50. Regional distribution of induced abortions by age groups.
51. Regional distribution of induced abortions by marital status and the number of living children.

* Total births

HUNGARY

Interruption of pregnancy*

Order No. 1047/1956 of the Council of Ministers of 3 June 1956 on the regulation of interruption of pregnancy and repression of abortion. (Törvények és rendeletek hivatalos gyüjteménye, 1956, p. 158)

1. Interruption of pregnancy shall continue to be subject to authorizations and may be effected only in a hospital establishment.

Authorization shall be obtained by submitting an application to the regional boards attached to the hospitals or clinics of departments, towns, or wards of towns. These boards shall meet at least once a week. The chairman of the board shall be designated by the chief medical officer of the capital, of the department or of the main town of the department if he is in charge of the medical services of the department.

Each board shall also include two members appointed by the executive committee of the competent people's council, the head of the social affairs section (or the rapporteur for social affairs), and a woman whose name shall be put forward preferably by the Trade Unions. The board shall be entitled to authorize interruption of pregnancy in the case of disease or when personal or family circumstances justify such a measure.

It shall be the duty of the board, in addition to granting authorizations, to explain to applicants the possible prejudicial effects as far as health is concerned of interruption of pregnancy, and to dissuade those women whose applications do not appear to be justified. When despite these efforts, the applicant maintains her application, the board shall grant authorization. In the case of disease, the board shall take its decision in the light of an expert medical report from the hospital to which it is attached. In cases where authorization is granted on grounds other than disease, the expenses incurred by care and hospitalization shall be borne by the applicant or by that member of her family who is legally bound to provide for her.

The Ministry of Health shall, within thirty days, make detailed regulations governing the application of this Order, after consultation with the Ministry of Finance and the National Trade Union Council.

2. The necessary arrangements shall be made to ensure the manufacture and unrestricted distribution of contraceptives at low prices.

3. [Concluding provisions]

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*Reprinted with permission from the International Digest of Health Legislation, 1958, 9, 536-540.

Ordinance No. 2/1956. Eu.M. of 24 June 1956 on the regulation of interruption of pregnancy. (Törvények és rendeletek hivatalos gyüjteménye, 1956, pp. 311-313)

1. (1) Interruption of pregnancy may be effected only with the authorization of a board established in accordance with the provisions of Order No. 1047/1956 of the Council of Ministers of 3 June 1956.

(2) Interruption of pregnancy may be effected only in gynaecological and obstetric department of a hospital or clinic or in a maternity hospital designated in accordance with Ordinance No. 171/1955 (Eü.K.21) Eü.M. The chief medical officer of the capital of the department, or of the main town of the department (if he is responsible for the medical services of the department) shall determine the area of jurisdiction of these establishments. Public notice shall be given of these areas of jurisdiction.

2. (1) The boards responsible for granting authorizations for interruption of pregnancy shall be organized in association with the gynaecological and obstetrical departments of the hospitals or clinics or of the maternity hospitals designated in accordance with the terms of Ordinance No. 171/1955 (Eu.K.21) Eu.M. (hereinafter called hospital establishments).

(2) The board shall consist of three members. The chairman shall be a medical practitioner designated for this purpose by the chief medical officer of the capital, of the department, or of the main town of the department if the medical officer of the main town is responsible for the medical services of the department. It shall also include two members designated by the executive committee of the competent people's council, depending upon where the hospital establishment to which the board is attached is situated. These two members shall be the head of the social affairs section of the executive committe or the rapporteur for social affairs of the Committee and a woman whose name shall be put forward by the departmental Trade Union Council or, in the capital, by the National Trade Union Council.

(3) The board shall sit on one or more occasions every week and the days on which it meets shall be fixed beforehand. The medical services shall give public notice of these meetings.

3. (1) The board shall authorize interruption of pregnancy:

(a) if it is necessary in order to save the life of a pregnant woman, in the event of a grave illness, in order to prevent the state of a patient giving rise to complications and finally if there is a likelihood that the child would suffer very serious lesions;

(b) if the personal or family circumstances of the applicant justify interruption of pregnancy or if the applicant maintains her application despite the explanations given by the board in virtue of sub-section (3) below.

(2) Interruption of pregnancy may be authorized only on the grounds indicated in sub-section (1) (b) if the pregnancy is of less than twelve weeks duration.

(3) If an applicant requests authorization for interruption of pregnancy in virtue of sub-section (1) (b), the board shall;

(a) try to convince her of the advisability of keeping her child, whenever it deems it expedient to do so;

(b) inform her of the possible prejudicial effects as far as her health is concerned of interruption of pregnancy and especially of a repetition of such an operation.

4. (1) The application for interruption of pregnancy shall be presented in person by the applicant to the board responsible for the area in which she resides. Before submitting her application, the applicant shall report for the necessary gynaecological examination to the designated hospital establishment or the gynaecolgical department of the polyclinic or, in the case of the capital, to the ante-natal consultation service. It shall also be the duty of the applicant to undergo such other examinations as may be ordered by the gynaecologist. All these medical examinations shall be effected if possible on the same day as the applicant reports for examination.

(2) At the time of the medical examination, the form the model for which is set out in First Schedule* of this Ordinance shall be completed.

(3) It shall be the duty of the applicant to present herself to the board together with the form duly completed in accordance with the sub-section (2) above, if possible on the same day as the examination or examinations. If that day is not a day on which the board meets it shall be the duty of the applicant to present herself to the board within seven days after the medical examination or examinations.

(4) The board shall state on the form whether or not authorization has been granted and specify the grounds on which its decision is based.

(5) The board shall maintain up to date a list of the applications examined, the model for which is set out in the Second Schedule* of this Ordinance.

(6) The applicant shall report to the designated hospital establishment on the day fixed by the board and shall bring with her the form constituting authorization.

(7) Interruption of pregnancy shall be effected if possible within six days after the date of authorization.

(8) Interruption of pregnancy may not be effected while the person concerned is an out-patient; the applicant must enter hospital.

5. (1) The chairman of the board shall ascertain from time to time how many persons the hospital establishment can accommodate.

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*These Schedules are not reproduced here.-ED.

(2) When deciding upon the order in which pregnant women are to be sent to hospital, account shall be taken of the duration of the pregnancy. The allocation of beds in designated hospital establishments shall be regulated in such a way that authorized interruptions of pregnancy may be effected regularly.

6. In the case of a patient in a hospital establishment, interruption of pregnancy may also be authorized by the board attached to that institution. In that case the operation shall be carried out by the gynaecological services of the hospital in question.

7. The medical officer in charge of the gynaecological and obstetric service of the hospital or of the maternity hospital may object to interruption of pregnancy being effected on the date fixed on grounds of the state of health of the pregnant woman and may fix a later date. In that case the operation shall be carried out as soon as the reasons justifying its adjournment no longer exist. Authorization for the operation shall be the initial authorization, provided that, in the interim, the term the pregnancy has been carried has not exceeded by more than four weeks the term of twelve weeks (section three, sub-section (2)).

8. The head of the gynaecological and obstetrics service of the hospital or of the maternity hospital shall decide for how long the patient should remain in hospital after interruption of pregnancy.

9. (1) If the applicant is not entitled to social security benefits, the cost of hospital treatment and of the examinations required before interruption of pregnancy shall be borne by the applicant or by her husband. If the applicant is a minor and without means of support, these expenses shall be borne by that member of her family who is legally bound to support her.

(2) If the applicant is entitled to social security benefits and her pregnancy has been interrupted in virtue of section three, sub-section (1) (a), the cost of care shall be borne by the social security fund. In that case, the applicant shall be entitled to all the benefits of social security in accordance with the social security regulations.

(3) If the applicant is entitled to social security benefits and her pregnancy has been interrupted in virtue of the provisions of section three, sub-section (1) (b), the cost of the first three days in hospital shall be borne by the applicant or her husband or, if she is a minor and without means of support, by that member of her family who is legally bound to support her. In that case the applicant shall not be entitled, for the first three days, to compensation for loss of salary or other social security benefits. From the fourth day of hospitalization onwards or from the fourth day of loss of salary, she shall become entitled to social security benefits, in accordance with the social security regulations.

(4) [Hospital costs]

(5) [Causes of interruption of pregnancy to be stated on hospital admission and discharge certificates]

(6) [Issue of certificates of incapacity of work, for the employer, with compulsory indication of whether or not pregnancy was interrupted by reason of disease]

10. (Obligation on hospital establishments to send periodical reports on pregnancies interrupted in the establishment)

11. The hospital establishment in which interruption of pregnancy was effected shall keep the relevant authorization, attached to the corresponding medical file.

12. The board shall make a report on their work once a year before 20 January to the chief medical officer of the department, of the main town of the department, or of the capital; the report shall be based on the list the model for which is set out in the second Schedule of this Ordinance.

13. [Entry into force; repeal of earlier legislation]

CHAPTER 6

ROMANIA*

Historical Trends and Abortion Policies

For Romania the sections on Historical Trends and Abortion Policies have been combined because joint presentation offers a better understanding of the current situation.

1. In 1930 the Romanian birth rate was 34.1 per 1,000 population. According to the 1930 census the average town family consisted of 4.2 members. Generations of Romanians relied on "natural" methods of birth prevention and illegal abortion.

2. After World War II the Romanian rural economy shifted markedly toward industrialization with a large movement toward the towns. On January 1, 1963, over 30 percent of the population resided in urban areas, compared to 21.4 percent in 1930. The birth rate fell from 29.5 per 1,000 in 1938 to 24.2 in 1956 (Ferenbac, 1964). There are considerable variations among regions within the country (Bulgaru, 1966).

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*The visit to Romania was facilitated by arrangements between the (U.S.) National Academy of Science and the Romanian Academy of Science; Lawrence Mitchell (NAS) and Dr. Alexandru Ciungu (RAS) were especially helpful. Coordinator of visits in Bucharest was Prof. Vasile Caramelea, Chief of the Department of Social, Demographic, and Cultural Studies of the Center for Anthropological Research of the Romanian Academy of Science. Extensive discussions were also held with Dr. Dan Alessandrescu, Chief of Obstetrics and Gynecology of the Bucharest Maternity Hospital; Dr. Iosif Ferenbac, Director of the Population, Health, Education, and Cultural Statistical Division, Central Statistical Board; Dr. Petre Muresan, Deputy Chief, Ministry of Health and Chief, Section of Health Statistics and Demography; and Dr. Vladimir Trebici of the Academy of Economic Sciences.

3. On 25 September 1957, by Decree No. 463, tacit approval of abortion became official. Abortion on request. regardless of indication was legalized. The objective was to give the woman the right to decide about having children and to discourage quacks and "witches" by making abortions easy to obtain (Mehlan, 1965a). Centers for therapeutic abortions were established in large and medium hospitals. Abortion outside these centers was a punishable offense. The pregnant woman reported to any one of these centers for termination of pregnancy. No approval was required from a commission. No bureaucratic procedures of any kind were involved. Name, age, number of previous births and abortions, and occupation were recorded in a register without being checked for veracity. In contrast to most other countries, secrecy of abortion was assured. After it had been determined that the pregnancy was of less than 12 weeks' duration, the abortion was usually performed on the same day but not later than one week. Most abortions were terminated on an outpatient basis with the woman remaining in the recovery room for about two hours. Generally, Hegar dilators and curette were used. The fee was 30 lei (less than $2), of which the physician received 16 lei. Doctors worked in shifts and were permitted to perform up to 10 abortions each day (Mehlan, 1965a). Pregnancies of more than three months' duration could be aborted only on a therapeutic basis after medical approval.

4. While there are no official government statistics on abortions, available Romanian publications have been summarized by Mehlan (1965a). The rate of induced abortions per 1,000 population was 6.3 in 1958 and 12.0 in 1959, placing Romania second after Hungary among the countries of the world. The partial reports available from Bucharest and several other Romanian towns suggest that the number of abortions increased considerably during 1960-62 with induced abortions exceeding births at a rate even higher than in Hungary. For example, at Filantropia, the largest gynecological hospital in Bucharest, the rate of birth to abortions rose from 1:0.6 in 1956 to 1:8 in 1958, and to 1:14 through July 31, 1962 (Gheorghiu, 1963). Only one percent of induced abortions were terminated for primarily medical reasons.

5. Tietze (1969) speculates that the annual rate of abortions probably rose to around 60 per 1,000 population by 1966. If correct, the estimated rate for Romania would be more than three times higher than the highest rate reported for Hungary, 18.4 per 1,000 population in 1967. Mehlan (1968c) estimated 401 legal abortions per 100 live births in 1965, compared to 136 abortions per 100 live

births in Hungary. These estimates are given credence by a report presented to the Plenum of the Romanian Communist Party Central Committee by the Ministry of Health, stating that "the number of abortions continued to rise, reaching the figure of 1,115,000 in 1965, or four abortions for each live birth" (Romania, 1968). These figures are astonishing, reflecting a near total dependence on abortion. Meanwhile the birth rate dropped from 22.9 per 1,000 population in 1957 to 15.7 in 1963 and to 14.3 in 1966.

6. The world's most liberal abortion policy was abruptly reversed in October 1966, when the Romanian Council of State issued a decree limiting abortion to cases where pregnancy endangers life, where there is a risk of congenital deformity, after rape, for women over 45 years of age, for mothers supporting four or more children, or those "physically, psychologically, or emotionally incapacitated" (Romania, 1967). More than one hundred medical indications are narrowly defined; the only leeway is in the psychiatric area. While the 1966 Romanian abortion policy is far more restrictive, it remains more liberal than that of any other Western European nation.

7. The Preamble to the 1966 Decree refers to the "great prejudice to the birth rate and rate of natural increase" resulting from the practice of abortion as well as to "severe consequences to the health of women." As Tietze (1969) comments, "in the absence of any reports from Romania on mortality or morbidity associated with legal abortion in that country, one may conclude that the primary reason for the repeal of the law of 1957 was a concern over the decline in the birth rate" and its long-term effects on the country. Discussions in Romania do suggest, however, that procedures for performing abortion had become very lax. Outpatient procedures carried greater risk to health, with more "accidents" than might have occurred in hospital settings. There was also genuine concern over the longer term implications of a sharply reduced birth rate (Bulgaru, 1966).

8. In conjunction with the reversed abortion policy, family allowances were increased and taxes raised for childless individuals. Official importation of contraceptives ceased. Divorces for couples with children under 16 years of age were made more difficult to obtain. A petitioner for divorce must pay a special tax of 3-5,000 lei (about $170 to $280), depending on income. The divorce process was lengthened and now requires a trial period of reconciliation of six months for families without children and one year for those with children. This

explains why the number of divorces granted fell from about 25,000 in 1966 to 48 in 1967, rising again in 1968.

9. The effect on birth rates of the October 1966 legislation, plus related social measures and family allowances, may be perceived from Table 14. It is evident that the birth rate rose dramatically after promulgation of the decree, from 12.9 in December 1966 to 39.9 in September 1967. Since that time the rate has receded slowly, continuing to fall on an almost month-by-month basis, reaching 21.5 in December 1968. Changes in the evolution of birth rates in Romania have been reviewed by Ferenbac (1969).

10. During the first ten months under the new law (1966/67) 35,000 legal abortions were reported along with 104,000 "spontaneous" abortions" (Tietze, 1969b). By 1967 Romanian sources reported "a more than five-fold drop" in abortions from the 1965 peak (Romania, 1968). The number of registered 1969 abortions was estimated to be low by Dr. D. Alessandrescu, Chief of Obstetrics and Gynecology of the Bucharest Maternity Hospital and Adivsor to the Ministry of Health. Most legally induced abortions are performed on women who already have four children. Second in frequency are medical reasons, often based on the psychiatric diagnosis that an unwanted child may induce severe neurosis in the mother.

11. The incidence of so-called spontaneous abortions and complications is rising. It was reported at the 1969 Budapest Conference of the European and Near East Region of the International Planned Parenthood Federation that in the region of the hospital in Baco there were before the change in law about 15,000 induced abortions per year, with no cases of mortality. In the two years after the revision five deaths occurred due to complications from illegal abortions. In the Filantropia Hospital in Bucharest, there were about 12,000 induced abortions without mortality before the Decree of 1966. In the subsequent year there were 1,200 spontaneous abortion cases and two deaths. (Novak, 1969, citing the report of B. Tekavic's visits to Romanian health facilities in September-October, 1968.)

12. Beds have been added to maternity and children's hospitals to alleviate the strain of the sharp rise in births on the nation's favorable doctor to patient and patient to hospital bed ratios. According to official statistics, Romania's cradle-to-grave program of medical care and social security receives 13 percent of

Table 14

Monthly Romanian Birth Rates, 1966-69*

Months	1966	1967	1968	1969
JANUARY	12.7	15.4	29.5	
FEBRUARY	14.8	15.7	29.5	
MARCH	15.1	16.5	29.8	
APRIL	15.4	17.8	28.1	
MAY	15.2	20.7	26.8	
JUNE	14.8	29.9	26.2	
JULY	14.3	38.7	26.0	
AUGUST	14.4	38.5	26.1	
SEPTEMBER	14.1	39.9	27.8	
OCTOBER	14.5**	36.1	26.4	
NOVEMBER	13.9	31.1	24.2	
DECEMBER	12.8	27.7	21.5	
YEAR	14.3	27.3	26.8	23.3[x]

* Anuarul statistic al Republicii Socialiste România 1968, editat de Directia Centrală de Statistică.

** Abortion policy reversed in October 1966.

[x] Statistical Office, United Nations, 1970.

the national budget. There is one physician for every 636 persons. However, some practitioners, all of whom are state employees, have to work around the clock every third day. It has been suggested that a single obstetrician may deliver as many as 30 babies a day (Medical World News, November 8, 1968).

13. To review the present situation, the Council of State announced on February 27, 1969, its intention to establish a National Commission on Demography to study the problem of fertility and advise the government on next steps.

Illegal Abortions

1. There seems little doubt that the Decree of 1957 resulted in a considerable decline in illegal abortions and that this trend was reversed by the 1966 legislation. Only sporadic information is available.

2. Physicians who perform abortions risk losing their licenses and being sent to prison for up to seven years.

Family Allowances and Tax Policy

1. Until October 1966 each family received a salary supplement of 100 lei (about $5.50) per month for each child under age 15 regardless of number; this amount was raised to 130 lei per month when the restrictions on abortion became effective.

2. On the birth of the third child and for each additional child, families received a one-time lump sum payment of 1,000 lei ($55).

3. Paid leave for the mother was increased to 112 days; 52 days before delivery and 60 days afterwards.

4. Expectant and nursing mothers are provided with dietary supplements of powdered milk and vitamins, free to the family, during the child's first year of life.

5. Until a child is seven years old, the mother is permitted to work only one-half time (at half-time wage) while retaining her position and seniority status.

6. If the child is ill, the mother can remain at home at full salary until the child is two years old.

7. About 2.2 percent of the 1967 Romanian budget was devoted to family allowances.

8. After the third child, the family becomes eligible for special income tax reductions.

9. A "childlessness" tax was reintroduced in 1966, levied on men and women of over 26 years of age, whether married or not.

10. Government propaganda exhorts women to have larger families. Mothers with more than four children have been given "heroine" awards.

Contraceptive Methods and Practice

1. Historically, coitus interruptus has been the traditional method of birth control in Romania. In the 1920s, in the area of Banat, sterilized horsehair was used as a primitive IUD (Alessandrescu, 1969).

2. No oral contraceptive or IUD has been developed in Romania. They have been imported from other socialist countries, mostly Hungary. Condoms are manufactured but also imported from China and from the German Democratic Republic. In 1963, a cream was produced and recommended for contraceptive use.

3. Mehlan (1965a) reports that before October 1966 posters with instructions on contraceptive methods were displayed in the abortion centers. Physicians were required to offer instructions to their patients and to suggest insertion of coils after abortion. There is some doubt about how much instruction actually occurred. Contraceptive devices were not part of the Romanian pattern of life.

4. Until the 1966 legislation abortion was the socially accepted method of birth control. (See Research Notes.) It was widely available in a manner that preserved the "secrecy" of the pregnant woman. Inquiries suggest that having twenty or more abortions during a married woman's reproductive age was not uncommon. Mehlan (1965a) reported estimates suggesting that the vast majority of women in Romania used no contraceptives of any kind. No national surveys have been conducted.

5. The Decree of October 1966 made no mention of contraceptives. While sales are not legally forbidden, importation of pills and IUDs was discontinued, as was official propaganda advocating their use. Condoms remain available.

6. Discussions with Romanian women indicate that those who want to obtain contraceptives can usually find them. IUDs and pills are imported clandestinely from Hungary. A month's supply of 21 pills costs approximately 100 lei ($5.50). A well-informed gynecologist confirmed this observation, adding that he could obtain pills for about 50 lei per month. Coils are inserted by physicians on a private basis.

7. Moral and religious factors do not seem to enter discussions of contraception or abortion. The church has no formal position. The restrictions on abortion and the limited availability of contraceptives reflect primarily the government's desire for increasing the birth rate.

8. Research on contraceptives and effects of abortion has been and is being conducted at the Filantropia Maternity Hospital in Bucharest (Alessandrescu, 1968).

Family Planning Centers

1. There are no independent family planning centers. Contraceptive consultation services are available in obstetric and gynecological clinics of hospitals.

2. There is no family planning association in Romania.

Medical and Postgraduate Training

1. No special courses or lectures on family planning exist.

2. Contraception does not receive special attention in gynecology seminars.

Sex Education in the Schools

1. Sex education in the schools is minimal, usually limited to biological information.

2. Informal inquiries suggest that there is rather limited open discussion of sexual matters.

Public Education

1. A popular book on sex and marriage by Maria Alecu-Ungureanui (1968) was published in low-cost paperback format by the Council for Explaining Scientific and Cultural Knowledge. Information on modern contraceptive techniques (pills and IUDs) is included.

2. Informal discussions suggest a growing interest in public education and a desire to discuss more widely what many persons still consider a taboo topic.

Research Notes

1. Summarizing Romanian studies reported during 1963, Mehlan (1965a) noted that 70-75 percent of women having legal abortions were in the 21-30 year age group. Approximately 8-10 percent of the women were below 20 years. About 94 percent were married. More than 50 percent of the women interviewed had four or more previously induced abortions. Women applying for an abortion in Bucharest had had an average of 3.9 previous abortions each.

2. The census of 1966 suggests that in urban areas the number of children was 1.7 per family. In rural areas there were 2.8 children per family. About 16.5 percent of all marriages in Romania were childless in 1966.

3. Mehlan (1965a) reports that in selected hospitals the proportion of childless women requesting abortion was between 26.2 percent and 28 percent. In these centers the rate of women with one child requesting abortion varied between 33.0 percent and 40.4 percent, and that of women with two children between 25 percent and 29 percent. The number of women with three or more children applying for abortion was small. Considering that the main reason given for requesting abortions was "too large a family," it appears that these Romanian women considered two children too many. No data are available for the country as a whole.

4. Mehlan (1965a) suggests that "knowledge of even the most primitive means of contraception among farmers, workers, and employees amounts to practically zero. It is estimated that 96 percent of the women do not use contraceptives." However, no national survey data have been reported to date.

5. Social and cultural anthropology were officially recognized in Romania in 1964, continuing "old concerns in sociology, demography and ethnography against the background of complex anthropological researches" (Caramelea, 1968). A pilot station was established in Beriovoesti and has subsequently been extended to a larger zone comprising the districts of Muscel and Arges. Summaries of research progress were presented at the scientific sessions devoted to the 100th anniversary of the Romanian Academy of Science in 1966, and are published from time to time in the Annuaire Romain D'Anthropologic, (Yearbook of Romanian Anthropology) with contributions in French, English and German.

6. A Committee for the Study of Fertility and Sterility of the Population was recently established by the Romanian Academy of Science. While most of the twenty committee members are physicians, behavioral scientists are also represented, including psychologists, sociologists, demographers, and anthropologists. The Chairman is Professor Milcu, Vice President of the Academy; the Secretary is Dr. D. Alessandrescu, Chief of Obstetrics and Gynecology at the largest maternity hospital in Bucharest.

7. Directed by the Ministry of Health and the Central Board of Statistics a national sample survey has been initiated in cooperation with the Institute of Medicine in Bucharest which is part of the Ministry of Education. The first national study of its kind in Romania, the survey will include questions on socioeconomic aspects, education, standard of living, housing, child spacing, preferred contraceptive measures, etc. The demographic part will be directed by Dr. Iosif Ferenbac of the Central Statistical Board. Results are expected to be available in 1970.

8. The organization of demographic research in Romania was described by Trebici (1968).

Research Centers

1. Department of Social, Demographic and Cultural Studies
   Center for Anthropological Research
   Romanian Academy of Science, Bucharest
   Head: Dr. V. V. Caramelea

2. Population, Health, Education and Cultural Statistical Division
   Central Statistical Board, Bucharest
   Director: Dr. Iosif Ferenbac

3. Institute of Hygiene, Ministry of Health
   Str. Dr. Leonte 1, Bucharest
   Director, Demographic Division: Dr. Petre Muresan

Available Population Statistics

1. Appropriate tables from the 1967 Demographic Yearbook are cited in Table 15.

2. The 1969 Demographic Yearbook is in preparation.

3. Data on birth rates and projection appear from time to time in the Official Bulletin published by the Central Statistical Board.

4. Only scattered data are available on abortions.

Table 15

Demographic Data in Romania*

Demographic Yearbook (1967)

Table 4 Live-births, 1930-1940, 1946-1965

In absolute figures and ratios.

Urban and rural areas.

Table 6 Live-births by month of birth and by sex, in 1965

Urban and rural areas.

Eighteen regions.

Table 7 Live-births by sex and by age group of parents, in 1965

Five-year age groups.

Urban and rural areas.

Table 8 Live-births by sex and by age group of mother, in 1965

Five-year age groups.

Urban and rural areas.

Eighteen regions.

Table 9 Live-births by age group of mother and number of children borne by mother (whether live or still-born), in 1965

Five-year age groups.

Birth order from first to seventh and eighth and over.

Urban and rural areas.

Eighteen regions.

Table 10 Live-births by nationality of parents, in 1965

Urban and rural areas.

Eighteen regions.

Table 11 Live-births according to place of, and assistance at, confinement, in 1965

Place of confinement, hospital, home with doctor, home with qualified midwife, home without medical or sanitary assistance, elsewhere.

Urban and rural areas.

Eighteen regions.

*Compiled by the U.N. European Working Group on Social Demography from the 1967 Romanian Demographic Yearbook.

Table 12 Multiple births, in 1965

Live-born and still-born children.

Urban and rural areas.

Eighteen regions.

Table 13 Fertility of women by age group, in 1965
(live-births per 1,000 women)

Five-year age groups.

Urban and rural areas.

Eighteen regions.

Table 14 Still-births, 1930-1940, 1946-1965

Absolute figures and ratios.

Urban and rural areas.

Table 15 Still-births, 1956-1965

Absolute figures and ratios.

Urban and rural areas.

Eighteen regions.

Table 16 Still-births by age group of parents, in 1965

Five-year age groups.

Urban and rural areas.

Table 17 Still-births by sex and by age group of mother, in 1965

Five-year age groups.

Urban and rural areas.

Eighteen regions.

Table 18 Still-births by order of birth and age group of mother, in 1965

Five-year age groups.

Birth order from first to seventh.

Urban and rural areas.

Table 36 Marriages, 1930-1940, 1946-1965

Absolute figures and ratios.

Urban and rural areas.

Table 37 Marriages, 1956-1965

Absolute figures and ratios.

Urban and rural areas.

Eighteen regions.

Table 39 Marriages by age group of spouses, in 1965

Five-year age groups up to sixty and over.

Urban and rural areas.

Table 40 Marriages by age group of spouses, in 1965

Five-year age groups up to sixty and over.

Urban and rural areas.

Eighteen regions.

ROMANIA

Interruption of pregnancy*

Decree No. 770 of 29 September 1966 of the Council of State regulating the interruption of pregnancy. (Buletinul Oficial al Republicii Socialiste Romania, Part I, 1 October 1966, No. 60, p. 416)

1. The interruption of pregnancy shall be prohibited.

2. Notwithstanding the above, the interruption of pregnancy shall be authorized, in accordance with the provisions of Section 5, in the following exceptional cases:

(a) the pregnancy endangers the life of the woman, there being no other way to eliminate this danger;

(b) one of the parents suffers from a serious disease of a hereditary nature or liable to cause serious congenital malformations;

(c) the pregnant woman suffers from a serious physical, mental or sensory disorder;

(d) the woman is more than 45 years of age;

(e) the woman has already had four children, who are under her care;

(f) the pregnancy is the consequence of rape or incest.

3. In the cases referred to in Section 2, abortions may be performed during the first three months of pregnancy.

In exceptional cases, when a grave pathological condition is found to be endangering the life of the woman, an abortion may be carried out up to the sixth month.

4. The interruption of pregnancy in the cases provided for in Sections 2 and 3 shall be carried out by specialists in obstetrics and gynaecology, in specialized health units.

5. Authorization for the interruption of pregnancy shall be given by a district or municipal medical board established for this purpose by the decision of the executive committee of the people's council of the region or of the cities of Bucharest or Constanza.

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*Reprinted with permission from International Digest of Health Legislation, 1967, 18, 822-837.

6. In cases of extreme medical urgency, when the interruption of pregnancy must be carried out immediately, the physician shall be required to given written notification to the public prosecutor before the operation or, if this is not possible, no later than 24 hours after the operation; the public prosecutor must then determine, on the basis of the opinion of a speicalist in forensic medicine and any other information, whether the operation for interruption of pregnancy was necessary.

7. The interruption of pregnancy under conditions other than those laid down by this Decree shall constitute an offence which shall be punished in accordance with the provisions of the Penal Code.

8. This Decree shall come into force 30 days after the date of its publication. Within this period, the Minister of Health and Social Welfare shall issue instructions for the implementation of this Decree. Decree No. 463 concerning permission for the interruption of pregnancy, published in Buletinul Oficial No. 26 of 30 September 1957, shall be repealed on the date of commencement of the present Decree.

Decree No. 771 of 29 September 1966 of the Council of State to amend the Penal Code. (Buletinul Oficial al Republicii Socialiste Romaniá, Part I, 1 October 1966, No. 60, pp. 416-417.)

Article 428 of the Penal Code is amended to make it a penal offence to induce abortion (with or without the consent of the pregnant woman), except under the conditions prescribed by law. The unauthorized possession of instruments for inducing abortion or other abortifacients is illegal. A physician who induces an abortion in an emergency case without authorization and without notifying the competent agency within the period prescribed is likewise guilty of an offence.

Penalities are specified for these and associated offences.

Instructions No. 819 of 19 October 1966 of the Minister of Health and Social Welfare to implement Decree No. 770 of 1966 regulating the interruption of pregnancy.* (Ministerul Sanatatii si Prevederilor Sociale, Ed. Medicala, Bucuresti, pp. 5-26)

1. On the date of entry into force of Decree No. 770 of 1966 regulating the interruption of pregnancy, the activities of the centres for the interruption of pregnancy on request shall be terminated.

The interruption of pregnancy shall be prohibited on the same date.

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*These Instructions have been issued to implement the provisions of Section 8 of Decree No. 770 of 29 September 1966 and of Section 28 of Law No. 6 of 1957 on the organization and operation of people's councils.-ED.

2. Notwithstanding the above, the interruption of pregnancy shall be authorized in the following exceptional cases:

(a) the pregnancy endangers the life of the woman, there being no other way to eliminate this danger;

(b) one of the parents suffers from a serious disease of a hereditary nature or liable to cause serious congenital malformations;

(c) the pregnant woman suffers from a serious physical, mental or sensory disorder;

(d) the woman is more than 45 years of age;

(e) the woman has already had four children, who are under her care;

(f) the pregnancy is the consequence of rape or incest.

The medical and legal indications on the basis of which the interruption of pregnancy may be authorized shall be those specified in Annex 1, which shall constitute an integral part of these Instructions.

3. When an application is made for the interruption of a pregnancy, the district medical officer, the medical specialist of the out-patient clinic, or the physician of the speicalized department to which the woman has been admitted as a patient shall draw up an "Index-card for interruption of pregnancy" according to the model given in Annex 2.

4. In the cases referred to in items (d), (e) and (f) of Section 2 of Decree No. 770 of 1966, the pregnant woman must present the relevant documentary evidence, i.e. the originals of the birth certificates of the children under her care, her own identity card, and, if appropriate, an attestation of rape or incest drawn up by the judicial authorities.

5. Authorization for the interruption of pregnancy shall be given by the medical board established for this purpose.

The applicant must provide the medicalboard with the "Index-card for interruption of pregnancy", in which the diagnosis of the pregnancy and the reasons justifying its interruption are indicated.

In the cases provided for in Section 4, the documentary evidence specified shall be attached to the card.

6. Medical boards for authorizing the interruption of pregnancy shall be established in districts and in national, regional and district towns which have the appropriate medical staff and specialized units of obstetrics and gynaecology.

In the case of districts which do not have hospitals or departments of obstetrics and gynaecology, applicants must be referred to neighboring districts able to provide medical care in obstetrics and gynaecology.

The medical boards shall be appointed by the decision of the executive committee of the people's council of the region or of the cities of Bucharest or Constanza, which must put forward their proposals by 25 October 1966 at the latest. The medical boards shall be confirmed in office each year and brought up to full strength whenever necessary.

7. Each medical board shall consist of:

- a chief physician or a specialist in obstetrics and gynaecology or, where necessary, in surgery, who shall act as chairman;

- a chief physician or specialist in internal diseases, as member.

The secretary of the board shall be a medical assistant or the medical registrar of the hospital or the department of obstetrics and gynaecology in which the medical board functions.

The decision appointing the members of the medical board must make provision for a deputy for each member.

8. The medical board shall function at the hospital of which the department of obstetrics and gynaecology where the abortion is to be carried out is a part.

The board shall discharge its duties at the times specified in its work programme.

9. The medical board shall register the pregnant woamn in the "Register of applications for interruption for pregnancy" (Annex 3) and shall complete the "Index-card for interrruption of pregnancy" (Annex 2).

10. Where necessary, the medical board shall consult other specialists as required (between one and three). In the case of diseases in which a definite diagnosis requires an additional functional examination, the board shall be empowered to admit the applicant to a specialized department.

The respective medical specialist shall be required to give an opinion on such cases promptly.

11. If authorization is granted, the medical board shall forward the "Index-card for interruption of pregnancy" to the obstetrics and gynaecology hospital to which the applicant is to be admitted for the purpose of undergoing the operation. Should the application be rejected, the index card shall be officially forwarded to the district or municipal out-patient clinic to which the pregnant woman is attached or to the health district centre, in the case of a locality where there is no specialist in obstetrics and gynaecology in the out-patient clinic.

Where the subsequent course of a pregnancy, in a woman whose application has been refused, necessitates its interruption, the necessary measures shall be taken to provide the woman with medical care and she shall again be referred to the medical board.

12. An abortion which has been authorized by the medical board, under the conditions prescribed by Section 2 of Decree No. 770 of 1966, may be carried out during the first three months of pregnancy in obstetrics and gynaecology departments and hospitals, provided that the person concerned has been admitted as an in-patient.

In exceptional cases, when a grave pathological condition is found to be endangering the life of the woman, an abortion may be carried out up to the sixth month. In such cases the operation may be carried out only in a regional obstetrics and gynaecology hospital or department.

The interruption of pregnancy shall be carried out with the least possible delay.

13. Within the obstetrics and gynaecology hospital or department, the same formalities shall be completed as for other hospitalized patients (clinical observation sheet, operation report, discharge voucher, etc.). A special register shall be kept of operations for cases of interruption of pregnancy, while the index-cards for interruption for pregnancy shall be filed.

14. On discharge, the woman shall be given:

- a medical certificate of temporary incapacity for work for the duration of the hospitalization and a period of time after discharge, which shall depend on the gravity of the case and the necessity for treatment;

- health education guidance on the preservation of health and the avoidance of undesired conditions.

15. In cases of extreme medical urgency, when a spontaneous or illegal abortion (abortion in progress, incomplete abortion, etc.) constitutes an imminent danger to the life of the woman, health units of any type (health posts, medico-sanitary district centres, out-patient clinics, hospitals, sanatoria, etc.) shall proceed as in all emergency cases (i.e. medical examination, emergency medical care and, depending on the circumstances, arranging emergency conveyance to the most suitable obstetrics and gynaecology department or hospital, or surgical department or hospital). Where an emergency case occurs in a district having no obstetrics and gynaecology hospital or department, the person shall be hospitalized and cared for in the appropriate surgical department having suitable facilities for dealing with the emergency.

16. A specialist in obstetrics and gynaecology or surgeon who carries out an emergency interruption of pregnancy shall report it, by telephone and in writing, to the public prosecutor of the district or town, either before the operation or, if this is not possible, no later than 24 hours after the operation. He shall similarly be required to note, on the observation sheet, what findings he has made when examining the woman, mentioning whether or not he has detected any signs of induced abortion.

Specialists in obstetrics and gynaecology and surgeons requested to carry out, on an emergency basis (haemorrhage, infection, etc.), a curettage of the uterine cavity for the purpose of an abortion, must examine each case separately, with great discernment and sense of reponsibility, and shall provide emergency medical care in a competent manner.

17. Consultations of pregnant women who apply for an interruption of pregnancy, their hospitalization, and the medical and surgical care of cases, shall be carried out in accordance with the provisions of Decree No. 246 of 1958.

18. At the same time as the "Index-card for interruption of pregnancy" is filled up, the appropriate section of the "Statistical bulletin" shall be completed, the latter being sent at monthly intervals for central statistical analysis.

In the case of a spontaneous abortion, only the final item (emergency) of the "Index-card for interruption of pregnancy" shall be completed.

19.-21. [Disposal of premises and equipment of the centres for the interruption of pregnancy on request, etc.]

22. The General Directorate of Curative and Prophylactic Medical Care, the Directorate of Planning, Statistics, Labour and Wages, and the executive committees of the people's councils of the regions and of the cities of Bucharest and Constanza, through the intermediary of their departments of health and social welfare, shall implement the provisions of these Instructions.

Annex 1

The interruption of pregnancy constitutes a therapeutic operation indicated in the case of a number of diseases which endanger the life of the mother or could have a grave effect on her health or on the product of conception.

The pathological conditions which constitute an indication for the interruption of pregnancy are those enumerated in this Annex.

It must be emphasized that the presence of a disease does not represent a definite indication. Members of medical boards must examine each case separately, with a sense of responsibility, and must be aware that it is not the disease which is important in deciding whether a pregnancy is to be interrupted but the stage of development of the disease or the functional condition it determines. From this standpoint, an attempt must be made to determine the presence of favourable or unfavourable factors, the possibility of a deterioration and, in particular, the harmful consequences of the disease on the pregnant woman and the child.

For the purpose of clarifying various specific features of individual cases, it is recommended that, where necessary, a medical consultation should be conducted or the sick pregnant woman be admitted to a specialized department.

Prescribing a functional examination, an operation or treatment with medicaments for women in the first three months of pregnancy must be undertaken with particular prudence.

When performing therapeutic abortions, specialists in gynaecology and obstetrics must proceed in accordance with the general standards governing operative conditions and techniques, anaesthesia, and functional equilibrium, before, during and after the operation.

When there exist local conditions (inflammation of the female genitalia, purulent cutaneous infections at the level of the vulvo-perineal region, etc.) or generalized conditions (acute intercurrent febrile diseases, major functional disequilibrium, etc.), the necessary treatment shall be administered and, depending on the results and the state of the pregnant woman, a decision shall be made in each individual case as to the opportune time for performing the operation.

Medical indications for the interruption of pregnancy

I. Infectious diseases

Infectious diseases may cause congenital malformations in the child; when the infectious disease occurs in the first three to four months of pregnancy (the period of organogenesis), the embryo or foetus may die or the mother's health may be seriously affected, placing her life in danger.

The following are valid indications for interruption of pregnancy:

1. German measles and measles (in the first four months of pregnancy), diagnosed with certainty.

2. Cytomegalic inclusion disease.

3. Acute poliomyelitis and other nervous diseases of viral origin in the paralytic stage.

4. Smallpox and smallpox contacts vaccinated during pregnancy as a necessary measure.

5. Listerellosis.

6. Toxoplasmosis

7. Severe attacks of acute infectious diseases contracted during pregnancy, such as septicaemia, typhoid and relapsing fever, which require the massive and prolonged administration of antibiotics and other medicaments having a teratogenic effect.

II. Tuberculosis

(a) Pulmonary tuberculosis

In the incipient and moderately advanced forms of the disease, pregnancy is, in principle, permitted, subject to continuous treatment. In practice, each case should be considered separately.

In general, tuberculosis which appears in the course of pregnancy has a more unfavourable prognosis than an older tuberculosis which has been effectively treated before the pregnancy.

When these forms of tuberculosis occur in a young primiparous woman, interruption of pregnancy is not indicated; it is however indicated in a pregnant woman above the age of 35, provided she has already had several children or the pregnancy has occurred less than one to two years after the previous delivery.

The following are valid indications for interruption of pregnancy:

1. Acute tuberculosis with evident toxaemia: miliary tuberculosis, caseous pneumonia, tuberculous bronchopneumonia, serofibrinous pleuritis with prolonged development.

2. Tuberculosis with extensive, disseminated lesions, even when not accompanied by an acute clinical pattern and the presence of toxaemia: cold abscesses; haematogenous, diffuse infiltrative tuberculosis, bilateral tuberculosis, destruction of pulmonary tissues.

3. Chronic limited cavitary tuberculosis either open or in another active form, with tubercle bacilli resistant to tuberculostatics or with lesions which do not show a clear positive response to treatment.

4. Active or inactive pulmonary tuberculosis (sequelae) under various forms of treatment (collapse therapy, resection, drainage, etc.), when accompanied by respiratory insufficiency on exertion or at rest or by other serious complications: amyloidosis, a discharging fistula in various sites, empyema, extensive bullous dystrophy, purulent bronchiectasis, caseous lymph nodes, active gangliobronchial fistulas, etc.

5. Marked reduction of pulmonary functional capacity as a result of a pneumonectomy, bilateral lobectomy, or major thoracoplasty, or associated with various types of collapse therapy of the opposite organ, etc.

6. Active tuberculosis in any form (even regressive forms), in cases where the pregnant woman is the mother of two to four young children or where there is no guarantee that the patient will receive the correct treatment and will observe the rules of prophylaxis. Interruption of pregnancy may be indicated, from the latter standpoint, even in a health gravida, when she lives in the same room as a person suffering from tuberculosis of the pulmonary cavitary form, in a chronic, open, difficult to treat, or incurable form.

In other forms of pulmonary tuberculosis, interruption of pregnancy is not indicated when there is a good response to treatment and no complications are apparent. In the following cases, the patient is placed under observation while undergoing treatment: Benign primary infection, minimal lesions, infiltration, miscellaneous types of processes, recent cavitary lesions in regression, cleared cavities or limited bullae, inactive or torpid tuberculoma, limited fibrotic tuberculosis, primary bronchial tuberculosis without active lesions in the parenchyma, limited sequential lesions whether pleural or pulmonary, detected during various forms of straightforward medical or surgical collapse therapy or subsequent to a limited pulmonary resection or other operations free of complications, etc.

Treatment with streptomycin (or similar preparation) must be avoided, in view of its toxic effect on the child.

After the fourth month, the interruption of pregnancy is contraindicated, since the risks of trauma resulting from tuberculosis or by bringing the pregnancy to term are equal.

(b) Extra-pulmonary tuberculosis

The following constitute indications for interruption of pregnancy:

1. Tuberculosis of the kidneys (parenchymal), active tuberculosis of the urinary tract, and chronic tuberculosis of the urinary tract with a degree of renal insufficiency or morpho-functional and pyclo-ureteroversical sequelae.

2. Active tuberculosis of the genital organs.

3. Tuberculosis of the gastro-intestinal tract, and progressive tuberculosis peritonities or perivisceritis.

4. Osteo-articular tuberculosis, either progressive or within two years of quiescence.

5. Progressive tuberculosis of the upper respiratory passages.

6. Progressive lymph node tuberculosis, with abscesses or fistulas, particularly when widespread.

7. Widespread extra-pulmonary tuberculosis, even if quiescent.

In special cases, boards composed of two to three medical specialists may be constituted; these boards shall assess the indications and give a specialized opinion.

III. Syphilis

Florid syphilis and syphilis resistant or unresponsive to antisyphilitic treatment (penicillin) constitute indications for interruption of pregnancy.

IV. Rheumatic diseases and collagenosis

1. Bouillaud's disease with definite symptoms of carditis.

2. Chronic progressive polyarthritis (stages II and III), spondylarthritis ankylopoietica.

3. Collagenosis, lupus erythematodes acutus, dermatomyosities, progressive diffuse sclerodermia, peri-arthritis nodosa.

V. Malignant tumours

Malignant tumours in any stage and in any part of the body constitute an indication for the interruption of pregnancy, except in the case of curable forms.

VI. Neuropsychic diseases*

Neurological diseases

(a) Nervous diseases of the mother which are aggravated by pregnancy:

1. Demyclinization, multiple sclerosis, myelitis or encephalomyelitis.

2. Polyneurities in the paralytic stage.

3. Cerebral and medullary tumours.

4. Cerebral abscesses and parasitoses.

5. Obvious symptoms of acute circulatory disorders of the brain; angioma, aneurysm.

6. Acute chorea unresponsive to treatment.

7. Myasthenia, familial periodic paralysis.

(b) Motor and sensory infirmities of the mother which may constitute an indication for interruption of pregnancy only in the case of pronounced functional disorders:

1. Hemiplegia, paraplegia, aphasia, ataxia, paralysis of deglutition, severe sequelae of infantile encephalopathy.

2. Epilepsy with frequent crises, and unresponsive to treatment.

3. Extrapyramidal diseases: Parkinson's syndrome, torsion spasm, hemiballismus, bilateral athetosis.

4. Neurosyphilis.

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*Diagnosis only in hospital.

5. Syringomyelia, amyotrophic lateral sclerosis.

6. Serious malformations: myelodysplasia, hydro-encephalocele, malformations of the occipital foramina.

(c) Nervous diseases in the parents liable to be transmitted to the children:*

There is an indication for interruption of pregnancy when one of the parents suffers from a familial disease or when they have previously given birth to a child suffering from a hereditary disease:

1. Familial diseases of the extrapyramidal tracts, Huntington's chorea (cronic), hepatolenticular, degeneration familial torsion spasm, Hallervorden-Spatz disease, Jakob-Creutzfeld disease.

2. Familial disease of the spinal marrow, spino-cerebellar heredo-ataxia, familial spastic paraplegia, chronic anterior poliomyelitis, Oppenheim's disease (myotonia congenita).

3. Familial diseases of the peripheral nerves.

4. Muscular diseases of a familial character; myopathy, myotonia.

5. Familial cerebellar atrophy.

6. Myoclonic epilepsy (Unverricht; Ramsey Hunt), Langdon-Down's disease, Patau's disease, Edwards' disease, Laurence-Moon-Biedl syndrome; tuberous sclerosis, Marinescu-Sörgen's** disease.

Mental diseases

The following constitute indications for the interruption of pregnancy:

1. Chronic or clinical psychoses: Schizophrenia, paraphrenia, chronic hallucinatory psychoses, paranoia (systematic non-hallucinatory delirium), prolonged reactive psychoses (Kretschmer's sensitive delusion of relation), Kraepelin's delusion of pursuit in persons suffering from deafness or hypo-acousia, paranoia and reactive depressions with a prolonged course, epilepsy with interparoxysmal psychotic disorders, chronic toxic psychoses (alcoholism, drug dependence), and prolonged psychoses produced by infection or trauma.

2. Acute psychoses, appearing in the course of pregnancy or with a tendency towards a recurring course determined from the medical history and medical documents drawn up by psychiatric medical institutions; confused episodes of a delirious, crepuscular oneiric, or demented nature, acute paranoid episodes (delirious crises), manic-depressive episodes.

3. Isolated psychotic episodes which appear during pregnancy or when pregnancy occurs within three years of recovery from such episodes.

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*Diagnosis only in hospital.
**Possibly a mis-spelling of Sjögren.-ED.

4. Severe mental retardation, characterized by disorders equivalent to those of psychotic intensity:

- retarded personality or grave oliogophrenia (imbecility, idiocy);

- Irreversible regression of the personality - dementia of a traumatic nature, or associated with alcoholism, drug dependence of various types, or an infection, or after accidents of a vascular, tumoral, degenerative, epileptic, etc., nature.

5. Psychopathic conditions occuring as a consequence of cerebral lesions or in the course of epilepsy constitute an indication only where the behaviour of the person is seriously affected or where personality disorders and psychopathic disintegration create repeated problems in regard to detention in a psychiatric hospital or department or necessitate prolonged massive treatment with psychotropic medicaments.

6. Progressive psychopathies with decompensation constitute an indication for interruption of pregnancy only where a social investigation shows that they are accentuated and persistent.

7. Mental diseases the treatment of which requires the use of large doses of psychotropic substances - Antideprin, Nozinan, Largactil, etc.

VII. Diseases of the endocrine glands*

1. Acromegaly (with reproductive function retained), either progressive or stationary.

2. Pituitary adenomas (chromophobic, mixed or craniopharyngioma) with pituitary insufficiency, arrested in development, irradiated or operated.

3. Diabetes insipidus with diuresis in excess of five litres and urinary density below 1005, particularly when symptoms of deterioration (increased polydipsia and polyuria, worsening of neurotic disorders, and loss in weight) occur in the first two months of pregnancy.

4. Hyperthyroidism in a severe clinical form (Basedow's disease, toxic adenoma, cardiothyrotoxicosis, malignant exophthalmia), treated medically or surgically, is an indication for the interruption of pregnancy in the first year after complete recovery; other indications are hyperthyrodism treated with radioactive iodine within the preceding two years and hyperthyrodism treated with synthetic antithyroid preparations in the first months of pregnancy.

5. Pronounced clinical myxoedema, endemic cretinism.

6. Addison's disease, with or without a history of decompensation and iatrogenic corticosuprarenal insufficiency (after intensive therapy with corticosteroids or after suprarenalectomy).

The interruption of pregnancy in a patient suffering from corticosuprarenal insufficiency (irrespective of the clinical form) must be carried out with protective corticosteroid therapy.

*Diagnosis by a specialist in hospital.

7. Suprarenometabolic syndromes (Cushing's disease, hypercorticalism due to corticosuprarenal tumours or of hypothalamo-hypophyseal origin).

A therapeutic abortion is likewise indicated in the first two years after successful surgical, medical or radiotherapeutic treatment of Cushing's disease.

8. Primary hyperaldosteronism due to tumours or hyperplasia of the corticosuprarenal glomeruli.

9. Phaeochronocytoma and hypertensive paraganglioma (paroxysmal hypertension of medullary or chromaffinoganglionic origin).

10. Hypoparathyroidism (tetania Paratireopriva).

11. Recklinghausen's disease (primary hyperparathyroid adenoma).

VIII. Pulmonary diseases

1. Acute and chronic pulmonary suppurations with pyosclerosis.

2. Acute and chronic empyemas of varying actiology.

3. Extensive bronchial dilatations.

4. sarcoidosis - disseminated form with respiratory insufficiency.

5. Chronic pulmonary mycoses in an active progressive stage.

6. Grade II and grade III pneumoconioses.

7. Polycystic diseases, extensive pulmonary sclerosis, with respiratory insufficiency.

8. Hydatid cysts with complications.

IX. Cardiovascular diseases

The decisions as to whether to continue or interrupt pregnancy in a woman suffering from a cardiac disease shall be taken in accordance with the following criteria.

(a) Functional condition of the heart

In a well-compensated cardiopathies, pregnancy does not as a rule carry a risk significantly greater than in women not suffering from cardiac disease. In consequence, the interruption of pregnancy is not indicated in such cases.

Interruption of pregnancy, during the first three months, is indicated in any cardiac disease:

(1) where the patient demonstrated clear symptoms of cardiac insufficiency before becoming pregnant;

(2) where cardiac insufficiency appears during the first three months of pregnancy;

(3) where a clinical, radiological and electrocardiographic examination demonstrates an extensive myocardiopathy involving a significant risk of the appearance of cardiac insufficiency during the subsequent course of the pregnancy;

(b) Nature of the cardiac disease

In addition to the above-mentioned conditions, interruption of pregnancy is indicated in the following cases:

1. Permanent mitral stenosis with pronounced hypertension in the lesser circulation or with repeated pulmonary embolisms.

2. Aoritic insufficiency accompanied by angina pectoris.

3. Aortic stenosis accompanied by angina pectoris or syncope anginosa.

4. Valvulopathies complicated by arrhythmias and conduction defects (artrial fibrillation or flutter, complete heart block).

5. Complex valvulopathies (mitral and aortic).

6. Rheumatismal cardiopathies with clinical and biological symptoms, which demonstrate with certainty a progressive condition of the rheumatic process.

7. Bacterial endocarditis.

8. Complex cyanosis-producing congenital cardiopathies and aortic coarctation.

9. Constrictive pericarditis.

10. Coronary diseases.

11. Arterial hypertension in stages II and III, and in hypertensives below the age of 40 coming from a family with a history of hypertension and vascular diseases.

12. Venous insufficiency with a history of embolisms.

(c) Stage of the pregnancy

In the conditions referred to in items (a) and (b), interruption of pregnancy is carried out in the first three months of pregnancy. Beginning with the fourth month, the operation entails risks which are no less serious than those involved in bringing the pregnancy to term under appropriate medical surveillance and treatment. During this period, the primary consideration is the viability of the foetus. Towards the end of the pregnancy the haemodynamic conditions generally improve; consequently, induced premature birth is not indicated. Birth in the normal way is preferable. The interruption of pregnancy after the fourth month, with a caesarean section, is indicated when there exist reasons of an obstetrical nature.

(d) Age of the woman

Interruption of pregnancy may be indicated in women below the age of 20 suffering from rheumatismal cardiopathies, there being a marked tendency towards rheumatic relapse at this age. Interruption of pregnancy is indicated in women with chronic valvulopathies (as a rule rheumatismal) above the age of 30, there being a greater risk of the occurrence of cardiac insufficiency.

(e) Number of previous births

Interruption of pregnancy is authorized in cardiacs who have already given birth to two to three children, even where delivery has been well-supported from the cardiovascular standpoint.

X. Diseases of the digestive system and associated glands

1. Megalo-oesophagus, stenosis (produced by caustic substances) of the oesophagus, oesophageal diverticulum with denutrition.

2. Midgastric stenosis and stenosis of the pylorus, intestine or rectum;

3. Severe digestive disorders or malabsorption syndrome, subsequent to gastric or intestinal resection, terminal ileitis, oesophagobronchial fistula, fistula within the digestive system, biliodigestive fistula, external digestive fistula.

4. Intestinal occlusions due to perivisceritis.

5. Severe ulcerohaemorrhagic rectocolitis.

6. Haemorrhagic tumours (schwannoma), diffuse intestinal or rectocolonic polyposis with pronouced clinical manifestations.

7. Diaphragmatic hernias, large umbilical hernias, inguinal hernias in an irreducible form (cu "pierderea dreptului de domiciliu"), substantial or recurrent eventrations.

8. Hepatic abscesses.

9. Prolonged forms of hepatitis with hepatic insufficiency, chronic hepatitis of a progressive type, chronic icterus (excluding subicteric).

10. Hepatic cirrhosis, portal hypertension syndrome with oesophageal varices, chronic pylephlebitis with stenoses.

11. Angiocholecystitis with repeated biliary crises, icterus and a febrile condition.

12. Chlolelithiasis, no operation having been performed.

13. Large hydatid cysts in the liver, post-operative biliary fistulas.

14. Chronic pancreatitis with pancreatic insufficiency, unresponsive to treatment and accompanied by nutritional disorders.

XI. Nutritional diseases

1. Pellagra with neurological disorders.

2. Diabetes mellitus denutrition of insulin-sulfonamide dependence.

3. Reticulosis of metabolic origin, due to acute or acquired metabolic defects (hepatic, hepatosplenic, ganglionic, osseous).

4. Serious hereditary diseases which have an adverse effect on foetal development, lipoidoses of the nervous system, galactosaemia, phenylketonuria, leukodystrophy.

5. Amyloidosis.

XII. Diseases of the blood and the haematopoictic organs

1. Severe hypochromic anaemia (with Schulter's type of tissue disorders), severe myelopathies, severe refractory megaloblastic anaemias, haemolytic anaemias due to haemoglobinopathy.

2. Persistent haemorrhagic disorders.

3. Polycythaemia.

4. Waldenström's disease.

5. Acute and chronic leukaemias.

6. Hodgkin's disease

7. Reticulosis of metabolic origin, malignant reticulosis, reticulosarcoma, lymphosarcoma, and histiocytosis X.

8. Hydatid cyst and splenic tumours; splenomegalies with haematological hypersplenism.

9. Primary or secondary pancytopenia.

10. Diseases due to irradiation, women exposed to excessive rediation or treated with cytostatic substances during pregnancy, as well as those treated with radioactive substances in the preceding year.

11. Rhesus incompatibility after the second or third pregnancy with an increased antibody level in spite of treatment.

XII. Diseases of the kidney and the urinary tract

1. Chronic diffuse glomerulonephritis; chronic renal insufficiency of varying actiology.

2. Suppurating interstitial nephropathies.

3. Hydropyonephrosis.

4. Bilateral nephrolithiasis, pyelo-urethral lithiasis with pyelo-urethral dilatation and pyuria, recurrent lithiasis.

5. Severe recurrent vesicular polyposis.

6. Solitary kidney (after surgery) and ureter-intestinal, ureter-cutaneous or vesicovagnial fistulas.

7. Certain congenital renal anomalies: unilateral renal agenesia and hypoplasia, horseshoe kidney, ectopia of the pelvis renalis, abnormal implantation of the ureter with urinary incontinence, extrophy of the bladder, megalocystis.

8. Certain dysplastic nephropathies: Debré-DeToni-Fanconi syndrome, nephrogenic diabetes insipidus, Albright-Buttler syndrome.

XIV. Obstetrical and gynaecological diseases*

1. Incoercible vomiting unaffected by therapy, with a marked weight loss, latered plasmatic equilibrium, ketonuria, icterus, severe nervous disorders with modification of the reflexes accompanied by mental disorders.

2. Hypertensive disorders of pregnancy associated with oedema and early albuminuria and unresponsive to the correct treatment, evolving towards the pre-eclampsia syndrome or eclampsia.

3. Pseudomyxoma peritonaci (maladia gelatinoasa a peritoneului).

4. Uterine cicatrices:

- recent post-operative cicatrices (within one year), after a caesarean operation, myomectomy, subtotal hysterectomy, various solutions of continuity;

- repeated caesareans (after third caesarean operation).

5. Acute hydramnios.

XV. Orthopaedic diseases

1. Severe hereditary diseases, achondroplasia, Ombrédanne's generalized exostotic disease; Lobstein's disease, polyepiphyseal chondrodysplasia of Hurler's type.

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*Diagnosis after admission to hospital

2. Severe grade III kyphoscoliosis, in cases of cardiorespiratory disorders.

3. Severe physical disability as a result of amputation, deformations or ankyloses, which could impede the course of the pregnancy or the subsequent care of the child.

XVI. Diseases of the ear, nose and throat

1. Pharyngo-laryngo-tracheal stenoses with severe respiratory difficulties and significant further deterioration of the general condition.

2. Paralysis of the vocal cords, with severe respiratory difficulties.

3. Laryngeal papillomatosis operated several times and recurrent, with pronounced difficulties of respiration and phonation.

4. Congenital deaf-mutism of the parents, after having given birth to a first child who is a deaf-mute.

5. Otosclerosis.

6. Scleroma of the upper and lower air passages, with pronounced respiratory and nutritional difficulties and with a deterioration of the general condition.

7. Pronounced syndromes of the cochlear and vestibular labyrinth, unresponsive to treatment.

XVII. Ophthalmological diseases

(a) Diseases existing prior to pregnancy or arising in the course of pregnancy, incompatible with or having an unfavourable effect on pregnancy:

1. High myopia or progressive moderate myopia, with lesions in the fundus of the eye; haemorrhages, detachment of the retina, macular choroiditis.

2. Progressive acute uveitis affecting the entire uvea, of specific or non-specific aetiology.

3. Recurrent retino-vitreous haemorrhages, either monocular or bilateral.

4. Retinopathy of hypertensive origin (gravidic, or with grade III or IV vascular changes associated with pre-existing major hypertension) or of diabetic, haemorrhagic, or eclamptic origin.

5. Idiopathic or traumatic detachment of the retina.

6. Optic neuritis, infectious or non-infectious.

7. Bitemporal hemi-anopia.

8. Incipient glaucoma.

(b) Hereditary communicable eye diseases

1. Hereditary atrophy (retrobulbar) of the optic nerve (Leber's disease)

2. Chlorio-retinal and cerebro-retinal degeneration.

3. Ectopia lentis (associated with Marfan's syndrome).

4. Retinoblastoma (usually named glioma retinae).

XVIII. Dermato-venereal diseases

1. Grave chronic bullous dermatoses: pemphigus and Duhring's disease.

2. Malignant reticuloses (cutaneous manifestations of blood diseases) (Malignant lymphogranulomatosis, mycosis fungoides, Kaposi's sarcoma).

3. Generalized skin diseases (extrodermii).

4. Severe recurrent polymorphous erythema, Behcet's syndrome.

5. Herpes gestationis, impetigo herpetiformis.

6. Hereditary anf familial dermatoses, ichthyosis and ichthyosiform erythroderma, keratoderma pigmentosum, multiple neurofibromatosis (Recklinghausen's disease), familial congenital porphyria cutanea lata, epidermolysis bullosa, keratosis follicularis (Darier's disease), dermatolyisi (cutis laxa), pseudoxanthoma elasticum, hereditary keratoderma palmaris et plantaris (thost Unna type and Meleda disease).

Annex 2

[Model of "Index-card for interruption of pregnancy"]

Annex 3

[Model of "Register of applications for interruption of pregnancy"]

CHAPTER 7

CZECHOSLOVAKIA*

Historical Trends

1. In the time before the establishment of the Republic of Czechoslovakia, before World War I, there were considerable economic, social, and cultural differences between the Czech lands and Slovakia. Between 1900 and 1904 the birth rate was 34.4 per 1,000 in the Czech area and 38.9 in the more agricultural Slovakia. The first Czechoslovak census was conducted in 1929. An English-language report on fifty years of population trends in Czechoslovakia, 1918-1968 has been prepared by Srb (1968a).

2. Open discussion of family planning and contraception began about 1870-1880 in the journal Volna Myslenka (Free Thought). The results are apparent in the decreasing crude birth rates: 38.8 per 1,000 for 1880-1884, 38.6 per 1,000 for 1885-1889, and 37.1 per 1,000 for 1890-1894. Czechs became known for their lower fertility and were characterized as "Frenchmen of the East" (Srb, 1969).

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*Arrangements in Prague were coordinated by Dr. Ludek Kubicka of the Psychiatric Research Institute. Extensive discussions were held with Dr. B. Doubek, Vice Minister of Health; Dr. J. Dubsky, Director, Research Department, Ministry of Health; Dr. A. Cernoch, Chief of Gynecology and Obstetrics, Post-graduate Medical Institute; Dr. Z. Dytrych, Psychiatric Research Institute; Dr. L. Hanzlicek, Director, Psychiatric Research Institute; Dr. J. Hynie, Director, Institute of Sexology, Charles University; Dr. H. Junova and Dr. J. Knoblochova, Charles University Psychiatric Clinic; Dr. J. Koubek, Prague School of Economics; Ing. M. Kucera, Czech Statistical Office; Prof. Ing. V. Roubicek, Prague School of Economics and Scientific Secretary, Czechoslovak Demographic Society; Dr. V. Srb, Chief, Population Branch, Federal Statistical Office; Dr. E. Stupkova, Director, Prague Health Services; and Dr. M. Vojta, Director, Maternity Hospital Thomayerova Nemocnice and Editor, CSSR Journal of Obstetrics and Gynecology.

3. The extent of family planning was detailed for the first time in 1956, following a special survey of almost 11,000 women throughout Czechoslovakia (Srb and Kucera, 1959). A second survey was conducted in 1959 with results published in the 1961 issues of Demografie. Summaries of all studies appear in Srb (1967).

4. During the past decade the birth rate has been affected by the slowly rising standard of living, the liberalized abortion act, and improvements in family allowances. The Czech birth rate was 18.9 per 1,000 in 1957, dropped to 17.4 in 1958, and then gradually sank to 15.7 in 1962. It rose in 1964 to a peak of 17.1 and fell to 14.9 in 1968. A review of the decade has been published by Srb (1968a,b).

Abortion Policy Trends

1. On the basis of Law No. 86/1950, effective from August 1, 1950, induced abortions were declared a crime. The pregnant woman could be punished by up to one-year imprisonment; whoever assisted her was liable for up to 10 years in prison. Exceptions were permitted only on strictly defined medical grounds.

2. Legalization of abortion for non-medical reasons was increasingly discussed in the public media. The rate of induced abortions rose slowly (Table 16) reflecting the changing attitude of the medical profession (Vojta, 1961a,b). The number of illegal abortions was believed to be considerable.

3. On December 19, 1957, a new law (No. 68/1957) was approved by the Czechoslovak Parliament (Czechoslovakia, 1959). Its key phase (Par. 3 Subs. 2) states, "Permission for termination of pregnancy may be granted on medical grounds or other reasons deserving special considerations." The woman must be less than three months' pregnant and should not have had a previous abortion in the preceding six months. As stated in the law, the main reason for the decision to liberalize abortion was to limit detrimental effects of illegal abortions performed by incompetent persons.

4. The "other reasons deserving special consideration" were clarified in Amendments No. 126/1962, No. 94/1964, and No. 54/1966. Mentioned are:

Table 16

Numbers and Rates of Births and Abortions in Czechoslovakia, 1953-68*

	Number in 1,000's			Rate per 1,000 population		
Year	Live births	Legal abortions	Other abortions**	Live births	Legal abortions	Other abortions*
Czechoslovakia						
1953	271.7	1.5	29.1	21.2	0.1	2.3
1954	266.7	2.8	30.6	20.6	0.2	2.4
1955	265.2	2.1	33.0	20.3	0.2	2.5
1956	262.0	3.1	31.0	19.8	0.2	2.3
1957	252.7	7.3	30.2	18.9	0.5	2.3
1958	235.0	61.4***	27.7	17.4	4.6	2.1
1959	217.0	79.1	26.4	16.0	5.8	1.9
1960	217.3	88.3	26.3	15.9	6.5	1.9
1961	218.4	94.3	26.0	15.8	6.8	1.9
1962	217.5	89.8	26.1	15.7	6.5	1.9
1963	236.0	70.5	29.2	16.9	5.0	2.1
1964	241.3	70.7	28.5	17.1	5.0	2.0
1965	231.7	79.6	26.0	16.4	5.6	1.8
1966	222.6	90.3	25.5	15.6	6.3	1.8
1967	216.0	96.4	24.8	15.1	6.7	1.7
1968	213.7	99.7	24.2	14.9	6.9	1.7

*Based on CSSR Statistical Yearbooks, with 1968 data provided by CRB and Kucera

**Hospital Admissions for "spontaneous" abortions

***Abortions legalized on January 1, 1958

Note: Hospital admissions for spontaneous abortions refer to aftercare or treatment for complications following spontaneous or illegal abortions.

(a) advanced age of the woman; (b) three or more living children; (c) death or disability of husband; (d) disruption of the family; (e) predominant economic responsibility for support of family and children placed on the woman; (f) difficult situation arising from pregnancy of an unmarried woman; (g) pregnancy due to rape or other offense; and (h) an additional, unstated reason is failure of prescribed contraception devices such as pills or coil.

5. To request an abortion, the pregnant woman has to forward an application with stated reasons, either personally or through her physician, to the head of the gynecological department of the hospital located in the district where she resides. The woman is then given medical information on the possible consequences of induced abortion. If she does not withdraw her application, it must be placed without delay on the agenda of the abortion commission. The commission has three members: the head of the gynecological department of the district hospital, an elected district deputy, and usually a representative of the local women's organization. If the commission does not approve the request for abortion, the pregnant woman may appeal to a regional commission. (A district is an administrative unit with usually about 100,000 inhabitants; a region has more than one million inhabitants. The composition of the regional commission is similar to that of the district commission. Some concern has been expressed that the commissions frequently lack adequate social background data to make a judicious decision. Having only one physician on a three-member commission has also been questioned.

6. If there are reasons for it, the selection of the hospital where the abortion is to be performed is left to the applicant. Women are usually admitted to the hospital in the morning, with abortion performed in the afternoon or evening. They must remain at least twenty-four hours and may stay two to three days, with a privilege of 7 days' paid leave. In practice, length of stay is frequently determined by availability of beds. The vacuum aspiration method is used in 15 to 20 percent of cases (Kloboria, 1966). A fee is charged for termination based on other than medical grounds.

7. As shown in Table 16, implementation of the liberalized law in January 1958 produced a steep rise in abortions. It continued at a decelerating rate until 1961 when a peak of 6.8 per 1,000 population was reached. The trend was then reversed with a drop to 5.0 in 1963 and 1964. Following the Decree of

21 December 1962, the commission temporarily tightened restrictions, particularly for women having their first pregnancy (Cernoch, 1965a). At the same time, announcement was made of the planned extension of paid maternity leave from 18 to 22 weeks, effective April 1964. The charge for abortion was reinstated; it had been dropped in 1960. The amount was 200 to 500 crowns, depending on income (Decree 126/1962). From mid-1964 the range of the "partial charge," defraying a part of the expenses of the operation, was extended to 800 crowns. By 1965 the rate of abortions was again rising and has continued to rise (Srb and Kucera, 1963, 1968; Frejka and Koubek, 1969), reaching a new peak in 1968. According to a CTK news release of April 18, 1969, nearly 100,000 abortions were performed in Czechoslovakia in 1968, suggesting that every third pregnancy was terminated. While this is the highest number of abortions to date, it also reflects the increasing number of women of childbearing age, especially in the lower age groups. Occasionally, abortions are performed on foreign women, mostly from West Germany or the United States, with charges ranging up to $500 (Cernoch, 1969). Czech women having induced abortions for other than medical reasons are typically charged 300 to 400 crowns, roughly equivalent to a week's salary or wage.

8. Particularly informative are Tables 17 and 18, prepared by Frejka and Koubek (1969). They show, for the period 1958-1967, proportions and annual relative growth or decline of (a) induced abortions performed after approval by a commission, (b) spontaneous abortions seen in a hospital, and (c) "other abortions," including induced abortions performed in a hospital on an emergency basis before commission approval could be obtained, plus various types of illegitimate abortions either performed by the pregnant woman herself or induced by another person. Growth and decline in requests for abortion and proportion of approved requests are also presented. The tables compiled by Frejka and Koubek are especially noteworthy because the permissive abortion legislation in Czechoslovakia tended to foster registration by women wanting abortions, thus allowing compilation of data closely related to the socioeconomic and cultural situation of Czechoslovakia in the 1960s. Failure to register pregnancies and abortions is unusual.

9. About 89 to 90 percent of requests for abortion were approved during 1958-1962. In 1963 the proportion dropped to 86.0 with subsequent rise to 95.0 in 1966 and a slight drop to 92.3 in 1968. The commissions again became more permissive after tight restrictions were relaxed.

Table 17

Composition of Abortions by Type and Proportion of Approved Applications, 1958-1968 in Czechoslovakia*

Year	Total Abortions	Induced Abortions	Spontaneous Abortions	Other Abortions	Proportion of Approved Applications
1958	100.0	69.0	30.4	0.6	88.2
1959	100.0	75.0	24.7	0.3	90.6
1960	100.0	77.0	22.8	0.2	91.1
1961	100.0	78.4	21.5	0.1	89.8
1962	100.0	77.5	22.4	0.1	89.2
1963	100.0	70.6	29.3	0.1	86.0
1964	100.0	71.3	28.6	0.1	88.7
1965	100.0	75.2	24.7	0.1	91.9
1966	100.0	77.9	22.0	0.0	93.0
1967	100.0	79.6	20.4	0.0	92.6
1968	100.0	80.5	19.5	0.0	92.3

*Based on Frejka and Koubek (1969)

Table 18

Annual Relative Growth (Decline) of Abortions by Type of Abortion, 1959-1968 (in percent) in Czechoslovakia*

Year	Total Abortions	Induced Abortions	Spontaneous Abortions	Applications for Induced Abortions
1959	+18.4	+28.8	- 3.9	+25.4
1960	+ 8.6	+11.6		+10.9
1961	+ 5.0	+ 6.8	- 0.9	+ 8.4
1962	- 3.7	- 4.8	+ 0.5	- 4.1
1963	-13.8	-21.5	+12.6	-18.6
1964	- 0.8	+ 0.2	- 2.8	- 2.8
1965	+ 6.6	+12.6	- 8.2	+ 8.7
1966	+ 9.5	+13.4	- 2.3	+12.0
1967	+ 4.7	+ 6.8	- 3.0	+ 7.4
1968	+ 2.2	+ 3.4	- 2.5	+ 3.7

*Based on Frejka and Koubek (1969)

10. Induced abortions account for 70 to 80 percent of all abortions, with lows of 69.0 in 1958 and 70.6 in 1963. Conversely, spontaneous abortions were highest in 1958 (30.4) during the atypical first year of the abortion law, and again in 1963 (29.3) when the commissions approved the lowest percentage of requests (86.0). The data for 1964 are very similar. Apparently, a number of pregnancies which would have been terminated with commission approval under the more permissive conditions before and after 1963-1964 ended up as "spontaneous abortions" during these two years.

11. Regional differences have been noted. For example, the ratio of spontaneous abortions in the Czech regions of Czechoslovakia is 7.4 per 100 conceptions, compared to 6.7 per 100 in Slovakia. Also, in the Czech regions the frequency of spontaneous abortions for the age group 15 to 19 is higher than for the age group 20-24; the contrary is true for Slovakia.

12. The proportion of married women among the total number of women having any kind of abortion has been gradually declining, from 85.9 percent in 1959 to 84.7 percent in 1963, to 81.3 percent in 1967. During the same period there has also been a slight shift in the composition of married and unmarried women among all women of childbearing age (15 to 49 years). About 24.3 percent were single and 70.9 percent married in 1961 compared to 26.7 percent single and 68.5 percent married in 1967. Srb and Kucera (1969) provide data on abortions and marital status for 1966 in Table 19.

Table 19

Abortions and Marital Status in Czechoslovakia, 1966

	Married Women		Unmarried Women	
	Induced Abortions	Spontaneous Abortions	Induced Abortions	Spontaneous Abortions
Per 1,000 women age 15 to 49	31.5	9.4	15.9	3.4
Per 100 live births	34.5	10.4	141.4	29.5

13. Frejka and Koubek's (1969) computations on marital status, age, and type of abortion suggest that the average age of single women having any kind of abortion is slightly over 21 years of age. For induced abortions, average age is declining. The average age of married women having an abortion is also declining,

both for induced and for spontaneous abortions. The data for women by average age, marital status, and type of abortion are shown in Table 20 for 1965 and 1967.

Table 20

Average Age, Marital Status, and Abortions in Czechoslovakia, 1965 and 1967

	Single		Married	
Year	Induced	Spontaneous	Induced	Spontaneous
1965	21.7	21.3	30.5	28.5
1967	21.5	23.1	29.6	27.8

14. More women with fewer children tend to have abortions. For example, Table 21 presents the percentage of women having abortions by number of children for 1959, 1963, and 1967.

Table 21

Percentage of Women Having Abortions by Number of Children for 1959, 1963, and 1967

Women Having	1959	1963	1967
No living child	14.0	15.9	17.3
1 child	15.9	16.6	20.7
2 children	27.6	26.8	30.7
3 children	20.4	21.8	17.9
4 children	10.7	9.5	6.6
5 or more children	10.7	9.3	6.5
Unknown children	0.7	0.1	0.3

15. The Frejka and Koubek (1969) study further suggests that the increase of abortions among all childless women is largely the result of resort to more induced abortion by unmarried women. Only a small proportion (slightly over one percent) of childless married women have an induced abortion, and the size of this proportion is rather stable. However, the increase of abortions among women with one or two children is the result of a growing proportion of married women having induced abortions.

16. Another view of induced abortions per 100 live births relative to the number of living children of the aborting women is provided by Srb and Kucera (1969) in Table 22.

Table 22

Induced Abortions per 100 Live Births Relative to the Number of Living Children of Aborting Women in 1961 and 1967 in Czechoslovakia

	Number of Living Children			
Year	0	1	2	3
1961	1.1	14.8	83.3	162.9
1967	1.1	22.9	119.2	184.3

17. The largest number of abortions are recorded in Prague and Bratislava. In Prague there was in 1968 one abortion per one live birth; in Bratislava it was 1.11 abortions per live birth. Poor living conditions were cited as the major reason (Rudé Pravó, 16 May 1969, p. 5).

18. Kucera (1968) reports that in the total sample of women having an induced abortion in 1966, about 16.2 percent had had two or more previous abortions. Among women over age 30, approximately 25 percent were requesting their third or more abortion.

19. While the reliability of reasons given to commissions for abortion requests is perhaps uncertain, an analysis of the statements made may well reflect actual motivation. (a) Nearly one-third of all women having an induced abortion have at least three children, suggesting they have reached, if not exceeded, their desired family size. The proportion of women giving this reason is, however, rapidly declining. (b) The second most stated reason is the health condition of the woman; the proportion of induced abortions for this reason is rising. Frejka and Koubek suspect that this category may camouflage other reasons. (c) The proportion of women citing family disruption is decreasing. This is in contrast to the rapidly rising divorce rate, especially in the larger cities. (d) The slightly increasing proportion of women giving as the main reason for abortion their unmarried status corresponds with the observations that the proportion of single and divorced women among those who have an abortion is constantly growing. (e) Other more frequent reasons are of an economic nature,

including insufficient financial means or inadequate housing. Families having no apartments of their own and living with parents of either spouse constituted 10 percent of the induced abortions in 1967.

Illegal Abortions

1. Cernoch (1966) estimated that before World War II there were approximately 100,000 illegal abortions per year.

2. Cernoch (1965b) reported that a gynecological follow-up study during the years 1958 to 1964, after the legalization of abortion, showed a considerable decline in illegal abortions (65 to 80 percent) as well as a diminished occurrence of death and morbidity.

3. In 1969 Cernoch gave an estimate of about 3,500 illegal abortions per year. This was confirmed by Kucera (1968).

4. The recorded number of illegal abortions, i.e., those performed by a woman on herself or induced by somebody else, decreased from 548 in 1958 to 55 in 1967 (Frejka and Koubek, 1969).

5. The permissive abortion law made no change in the earlier provision that persons assisting in illegal abortions can be punished with up to 10 years in prison. However, the pregnant woman herself is no longer liable to punishment (Par. 6, Law No. 68, 1957).

Family Allowances

1. Following the decline in the birth rate in 1958-61 (Table 18), family allowances for children were increased. In 1962 the population was informed of a prospective increase in maternity leave from 18 to 22 weeks. By March 1963 a considerable increase in births and a decrease in abortions was noted. However, the increase of the birth rate lasted only 30 months, with a gradual lowering of the birth rate becoming apparent in 1965-67 (Table 18). Family allowances were again increased in July 1968 and paid maternity leaves lengthened to 26 weeks (Srb, 1968a,b).

2. Family allowances are paid according to Law No. 16/1959 for children of employed persons and members of production cooperatives, and according to Law No. 103/1964 to members of farming cooperatives. Allowances are graded according to number of children and gross income, as presented in Table 23.

3. Financial aid is also provided in the forms of scholarships, maternity cash benefits, maternity grants and maintenance allowances. The relatively small amounts and diversity of individual benefits in cash and kind lead to the impression that the allowances are not sufficient (Vohankova, 1967). However, in 1968, preferential loans became available to newly married couples plus opportunities to acquire an apartment through purchase in addition to increased allowances and more favorable income tax treatment.

Contraceptive Methods and Practices

1. As directed by the Ministry of Health every gynecologist has been expected since 1958 to inform women requesting abortions, and men too, about contraception. Oral contraceptives and IUDs are prescribed by the gynecologist after gynecological examination. Obstetrical departments are required to instruct women when they leave the hospital after delivery. In practice, this activity is concentrated in contraceptive advisory clinics established in many obstetric and gynecological hospital departments (Horsky, 1967).

2. The IUD Dana is produced in Czechoslovakia. It costs about 200 crowns, $12.50 at the tourist exchange rate, but more than 10 percent of average monthly income. The oral contraceptive Antigest is also manufactured in Czechoslovakia. A one-month supply of 21 pills costs 20 crowns or $1.25. Both pills and coils are available only on prescription by a gynecologist. Coils may only be inserted by gynecologists in hospitals (Vojta, 1969).

3. There were about 3 million women of childbearing age in Czechoslovakia in 1969. Only a small proportion use modern contraceptives. By 1968 about 50-70,000 loops had been inserted, while 80,000 women were believed to be taking Antigest (Vojta, 1969). More recently, resistance to pills has grown with preference expressed for loops.

Table 23

Family Allowances in Czechoslovakia, 1959-1968

Number of Children	Monthly in Crowns*					Monthly according to the income in Crowns (as of 1959-68)					Monthly
	1945 - 1947	1947 - 1949	1949 - 1953	1953 - 1957	1957 - 1959	1400	1401 - 2200	2201 - 3000	3001 - 3800	3800	As of July/68
1	30	30	38	70	70	70	70	70	-	-	90
2	60	70	86	170	170	170	170	170	100	-	330
3	90	120	144	310	310	430	400	370	330	310	680
4	120	180	212	470	490	690	640	590	530	490	1030
5	150	250	290	630	710	950	880	830	750	710	1270
6	180	330	378	790	930	1210	1210	1070	970	930	1510
7	210	420	476	950	1150	1470	1360	1310	1190	1150	1750
Each additional	+30	+100	+108	+160	+220	+260	+260	+240	+220	+220	+240

*At 1968 Tourist Exchange Rates, 16 Crowns = 1 US dollar

Note: Average Monthly Income in 1968: 1,750 Crowns

4. Condoms and other mechanical devices are freely available in drugstores.

5. In national sample surveys, 20 percent of the respondents preferred the condom in 1956 and 17 percent in 1959. Preference for coitus interruptus was expressed by 75 percent of the national sample in 1956 and 43 percent in 1959 (Srb, 1967). At the time of the 1959 survey, modern contraceptives were not generally available. Despite the greater availability of pills and coils in later years, the rate of abortions has continued to increase, 25 percent from 1965 to 1967. This suggests, at least in part, an increasing reliance on abortion in case of inefficient contraceptive practice (Kucera, 1968).

6. The cost of contraceptives coupled with the ready availability of abortions may account for the rising number of women having repeated abortions. Coitus interruptus remains the most common method of family planning.

7. Research in contraceptive technology is being conducted by Dr. R. Sterba at the Research Institute for Pharmacology and Biochemistry in Prague.

Family Planning Centers

1. The only specifically identified Family Planning Center is in Prague, sponsored by the State Population Committee. Additional centers are to be established by 1970. An independent Family Planning Association is in the process of formation.

2. Consultation on contraception is considered a public service, available at all gynecological outpatient departments. Gynecologists must give advice free on request. The total number of consulting centers concerned with all aspects of fertility is nearly 2,000.

3. Women whose requests for abortion have been approved must be given advice on contraception after abortion.

Medical and Postgraduate Training

1. Most medical faculties provide one lecture of two hours on contraception, usually during the fourth year as part of the gynecological curriculum. A few faculties offer additional lectures on family planning and sexual pathology.

2. At present there are no special courses for postgraduate training of physicians in family planning. In 1966 the Czechoslovak Society of Gynecology held a conference on modern methods of conception. Reports were published in a special issue of Ceskoslovenská Gynekologie, edited by Dr. Vojta (1967b).

Sex Education in the Schools

1. Sex education lectures are usually given by school physicians, not teachers. These generally consist of two hours at the end of the last school year.

2. Sex education has been progressing slowly and is currently an area under study by the State Population Commission.

3. Health education in Czechoslovakia has been reviewed by Geissler and Reis (1967).

Public Education

1. The general impression is that the population is not well informed about family planning, that oral contraceptives are not as widely sought as anticipated, and that many women are concerned about possible side effects of the pill (Vojta, 1969).

2. The Ministry of Health has convened an expert committee on informing and educating the public. The State Population Commission plays an active part.

Research Notes

1. During 1965-66 the Institute for Sexology in Prague and the Secretariat of the State Population Commission (in cooperation with the Outpatient Department of the Psychiatric Clinic in Bruo and the Psychiatric Clinic of the Family Hospital in Kosice) conducted a survey of marital relations, focusing on the sexual life of 293 young urban married couples. This was part of the longitudinal study of 2,000 families initiated by the State Population Commission in 1963 (Prokopek, 1968a). An English-language report of the couples' survey has been made by Prokopec (1968b). Main conclusions were presented at the International Symposium on the Problem of Human Reproduction in Varna, Bulgaria (Prokopec, 1968c).

2. The 293 young urban married couples were interviewed with a standard questionnaire. Husband and wife were seen separately in a medical setting. Problems explored centered on sexual information prior to marriage, marital sex relations, knowledge of contraceptive practice, etc. It was found that 20 percent of the couples entered marriage "entirely uninformed" on sexual matters. The higher the educational levels of the parents, the higher the degree of factual information and understanding. About 96.2 percent of the men had had premarital relations compared to 95.9 percent of the women. Frequency of premarital relations was higher among men who had completed only basic education as compared to university graduates.

3. While over 97 percent of the men indicated that they knew something about contraception before marriage, 25 percent of the women claimed to have no prior knowledge of contraceptive practice, relying entirely on their partners. This situation was especially prevalent among less well educated girls. The most frequent method of contraception in marriage was coitus interruptus (41.6 percent), rising to 73.3 percent when coupled with the rhythm method. Condoms were used by only 5.2 percent. (At the time of the survey oral pills and loops were still in the experimental stage in Czechoslovakia.) About one-third of the women reported that during intercourse they were always afraid of conceiving.

4. "When founding their own family, the social and economic situation of the young couple is considerably modified, in the unfavorable sense of the word. On the one hand, they are faced with the necessity to guarantee the social

stability of the family (with the necessary condition to acquire satisfactory living facility), on the other hand the average income per head rapidly falls with the birth of children, in some cases even to the bare subsistence wage. Social and economic measures introduced in Czechoslovakia, for the purpose of improving the conditions of families with children, did not succeed for the time being to make good this contradiction. At the same time, the social ambitions of young people are growing, which often results in an impatient and even neurotic endeavor to reach in the shortest possible period an optimum social position. The inability to reach this goal in a short time after their marriage constitutes with some young people one of the sources of conflict situations" (Prokopec, 1968c).

5. Currently in progress are two very unusual research studies, following children born to women twice refused an abortion (once by the local commission and once by the regional commission). Dr. Eva Stupkova, Director of Prague Health Services, found that of 555 women refused abortions 313 gave birth in the years 1961-1963. About 25 of the children had been adopted and another 20 placed in children's homes, presumably for reasons of physical or mental ill health. An extensive questionnaire was developed and administered to mothers of 150 children. Results are still being analyzed. A control study of wanted children is in the planning stage.

6. A public health nurse, Eva Eliasova in Ostrava, located 338 of 373 women who had requested and been denied an abortion; 82 percent of the 338 women had children, a higher percentage than in Prague. A follow-up study of the children is in progress.

7. An overview of psychological aspects of abortion was presented by Dytrych (1970) at the 1969 World Mental Health Assembly.

Research Centers

1. The State Population Commission, which is part of the Ministry of Social Welfare, conducts research and makes grants to support the research of others. There is coordination with the Ministry of Health and other government agencies. The Secretary of the State Population Commission is Dr. Jiri Prokopec.

2. Within the Federal Statistical Office in Prague, research is conducted by Dr. V. Srb and Dr. M. Kucera.

3. The Prague School of Economics has a demographic research section, directed by Prof. V. Roubicek, who also serves as Secretary of the CSSR Demographic Society.

4. At the Postgraduate Medical Institute in Prague and at the Maternity Hospital, research in contraception and in abortion is conducted by Dr. A. Cernoch and Dr. M. Vojta, respectively.

5. Prof. J. Hynie has been Director of the Institute of Sexology at Charles University since its founding over 30 years ago.

6. The Psychiatric Institute, directed by Dr. L. Hanzlicek, is participating in studies related to problems of mental health and family planning.

7. Dr. Eva Stupkova, Director of the Prague City Health Services, is conducting follow-up studies on unwanted children, as is Miss Eva Eliasova in Ostrava.

8. Research in Reproductive Physiology is directed by Dr. J. Horsky at the Institute of Physiology, Prague.

9. Research in contraceptive technology is directed by Dr. R. Sterba at the Research Institute for Pharmacology and Biochemistry in Prague.

Reported Population Statistics

1. Abortion statistics are based on reports of pregnancy terminations. "As abortions are reported: artificial interruptions of pregnancy applied for by the woman, interruptions of pregnancy performed to prevent the death of the pregnant woman herself, artificial interruptions of pregnancy made or induced illicitly by another person, and spontaneous abortions" (Czech Health Services, 1968).

2. In the statistics the following data are recorded: region and district where application is submitted, region and district of woman's domicile, age of woman, status and occupation of woman, nationality, family status, number of childbirths, number of living children, number of previous abortions, reason for interruption of last pregnancy, month and year of abortion, type of abortion, age of foetus in weeks, weight and height of foetus, complications, decisions of district or regional commission, amount charged, and reasons why district or regional commission approved the application for artificial interruption of pregnancy.

3. Annual reports of abortions, published by Czechoslovak Institute of Health Statistics, are highly reliable. Available material is summarized in Table 24.

4. A Demographic Yearbook is published annually by the Institute of Health Statistics; an English-language summary is usually available.

5. Relevant data from the Statistical Yearbook are summarized in Table 25.

Publications

1. Demografie, a quarterly review with summaries in English and Russian. Issued by the Federal Statistical Office, Sokolovska 142, Prague 8, Czechoslovakia.

2. Demosta, a quarterly review for demography and statistics, published in English, French, Russian, and Spanish by the Federal Statistical Office, Sokolovska 142, Prague 8, Czechoslovakia.

Table 24

Annual Abortion Statistics in Czechoslovakia*

Table	1	Notified abortions and submitted applications for artificial interruption of pregnancy
	2	Abortions by age woman, family status, order of abortion
	3	Abortions by regions of domicile of woman, by type of abortion and number of living children before abortion
	4	Abortions by complications, type of abortion and region of domicile of woman
	5	Applications submitted and decisions of district and regional commissions
	6	Abortions by type, family status and age of woman
	7	Abortions by family status of woman and type of abortion
	8	Abortions applied for by all women, by age and reasons given by commission
	9	Abortions by number of children living before abortion, by type of abortion and age groups
	10	Abortions of married women by number of previous abortions, type of present abortion and age groups
	11	Abortions by reasons given in application, number of living children and age groups
	12	Abortions by regions and district of permanent domicile of woman and type of abortion
	13	Abortions required by woman who had no previous abortion or childbirth by age groups and reasons for interruption of pregnancy
	14	Abortions of all women by number of living children before abortion combined with reason for application
	15	Abortions by type and age of foetus
	16	Abortions by type, duration of pregnancy, weight and height of foetus

* Based on Czechoslovak Health Services (1968) Report on Abortions for the Year 1967

Table 17 Comparison of statistically assessed abortion rate during past years by permanent domicile of woman

18 Abortions on application - charge for artificial interruption of pregnancy

19 Abortions on application by position and occupation of woman and causes for interruption of pregnancy

20 Abortions on application by position and occupation of woman and age groups

21 Spontaneous abortions by position and occupation of woman and age groups

22 Abortions of foreigners by regions

In the first 21 tables there are classified the artificial interruptions of pregnancy and the spontaneous abortions of women of Czechoslovak nationality and only in Table 22 is the number of abortions of foreign nationality recorded.

Table 25

Demographic Data in Czechoslovakia*

Demographic Yearbook

Federal Statistical Office, Prague, 1965

1. Births by intra/extra-hospital confinements, maturity of infant, legitimacy, vitality, sex, birth order, size of community and regions.

2. Births by sex, vitality, legitimacy and nationality of mother; legitimate births by nationality of father.

3. Births by sex, vitality, legitimacy, birth order, and nationality of mother.

4. Live-births by sex, birth order, legitimacy and age of mother.

5. Births by vitality, legitimacy, birth order and age of mother.

6. Legitimate births by vitality, maturity of infant, birth order of current marriage, and interval between birth and marriage.

7. Births by vitality, maturity of infant, legitimacy, birth order, and interval since previous birth.

8. Legitimate births by vitality, sex, birth order, and number of children born in current marriage.

9. Births by vitality, sex, legitimacy and age of mother; legitimate births by age of father.

10. Legitimate births by vitality, sex, month of birth, and occupation and social group of father.

11. Illegitimate births by vitality, sex, month of birth, occupation and social group of mother or bread-winner.

12. Legitimate births by vitality, sex, birth order, gainful activity of mother and occupation and social group of father.

13. Illegitimate births by vitality, sex, birth order, and occupation and social group of mother.

14. Births by legitimacy, birth order, and number of deceased children of mother.

* Compiled by the U.N. European Working Group for Social Demography

15. Births by vitality, legitimacy, and type of help during confinement.

16. Births by vitality, sex, maturity of infant, and legitimacy.

17. Births of twins and triplets by sex, legitimacy, and age of mother.

18. Births of twins and triplets by vitality, sex, and legitimacy.

19. Births by vitality, sex, legitimacy, and length and weight of child.

20. Legitimate births by vitality, sex, weight of child, and age of mother.

21. Illegitimate births by vitality, sex, weight of child, and age of mother.

22. Births by vitality, sex, legitimacy, weight of child, and birth order.

23. Age-specific fertility rates by legitimacy.

24. Age-specific fertility rates by legitimacy and birth order.

25. Net and gross reproduction rates (time-series).

26. Number and type of registered abortions.

27. Registered abortions by age of women.

CZECHOSLOVAKIA

Law of 19 December 1957*

Interruption of pregnancy

Law No. 68 of 19 December 1957 on the artificial interruption of pregnancy. (Shirka zákonu republiky Ceskoslovenské, 30 December 1957, No. 33, pp. 289-290)

INTRODUCTORY PROVISIONS

1. In the interest of extending care for the healthy development of families threatened by injuries, caused when a pregnancy is artificially interrupted to the health and life of women as a result of interventions by unscrupulous persons and elsewhere than in medical establishments, this Law shall regulate the artificial interruption of pregnancy.

REQUIREMENTS FOR THE ARTIFICIAL INTERRUPTION OF PREGNANCY

2. (1) A pregnancy may not be interrupted artificially except with the consent of the pregnant woman and after prior authorization; if a pregnant woman is completely incompetent or by reason of mental disorder, is incapable of looking after her own affairs, her consent may be replaced by that of her legal representative.

(2) A pregnancy may not be interrupted artificially except in a medical establishment for in-patients.

3. (1) A board set up for this purpose shall decide, at the request of the pregnant woman or, as the case may be, of her legal representative, on authorization for the artificial interruption of pregnancy.

(2) Authorization may not be granted except on health grounds or for other reasons which deserve special consideration.

ILLEGAL INTERRUPTION OF PREGNANCY

4. (1) Any person who assists a pregnant woman or persuades her--

(a) to interrupt her pregnancy herself;

(b) to request or permit a third person to interrupt her pregnancy artificially--otherwise than in the manner permitted by this Law--

shall be punished, for having committed a penal offence, with deprivation of liberty not exceeding two years.

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*Reprinted with permission from the International Digest of Health Legislation, 1959, 10, 283-292; 1962, 13, 491-492.

(2) The guilty person shall be punished with deprivation of liberty for a period of one to five years if, as result of the commission of the act referred to in sub-section (1), the health of the pregnant woman is seriously affected or she dies.

5. (1) Any person who, with the consent of the pregnant woman, artificially interrupt her pregnancy otherwise than in the manner permitted by this Law, shall be punished for having committed a penal offense with deprivation of liberty for one to five years.

(2) The guilty person shall be punished with deprivation of liberty for three to ten years--

(a) if he commits the act referred to in sub-section (1) for gain;

(b) if, as a result of the commission of such an act, the health of the pregnant woman is seriously affected or she dies.

6. A pregnant woman who interrupts her pregnancy herself or who requests or permits a third person to interrupt it shall not be liable to punishment.

CONCLUDING PROVISIONS

7. The Ministry of Health shall make, in agreement with the Ministry for Justice, the necessary rules for the application of this Law, in particular those concerning health grounds and other grounds which deserve to be taken into consideration (section three, sub-section (2)), the organization of the board, and the procedure to be followed by the board (section three, sub-section (1)).

8. (1) The provisions of section 218 of Penal Law No.86 are hereby repealed.

(2)-(3) [Quashing of sentences not yet executed and rehabilitation of persons already convicted in virtue of sub-section (1) of section 218 of the above-mentioned Penal Law]

Notice No. 249 of 21 December 1957 of the Ministry of Health for the application of the Law on artificial interruption of pregnancy. (Urean List Ceskoslovenske republiky, 30 December 1957, No. 132, pp. 857-860.

1. In accordance with Law No. 68/1957 on artificial interruption of pregnancy, a pregnancy may be interrupted only with the consent of the pregnant woman after previous authorization and solely in an institution for in-patients. Authorization may be granted only on health grounds or other grounds which deserve special consideration.

2. (1) The health grounds (medical indications) which justify artificial interruption of a pregnancy are enumerated in the Schedule of this Notice.

(2) The following grounds are considered to merit special consideration and justify artificial interruption of pregnancy;

(a) Advanced age of the woman concerned;

(b) Numerous children;

(c) Loss of spouse or disability of spouse;

(d) Broken home;

(e) Predominant economic responsibility of the woman for the maintenance of the family or of the child;

(f) Difficult circumstances of an unmarried woman as a result of her pregnancy;

(g) Pregnancy due to rape or another punishable act.

(3) Artificial interruption of pregnancy shall not be authorized if it is medically contra-indicated:

(a) Pregnancy of more than three months;

(b) Acute or chronic inflamatory disease(s) of the reproductive organs;

(c) Purulent foci likely to prevent the successful performance of the intervention;

(d) Acute communicable disease;

(e) When a pregnancy has been interrupted within the preceding six months.

A pregnancy may be artificially interrupted even where there are contra-indications thereto if the continuation of the pregnancy would endanger the life of the woman concerned.

When one of the parents is suffering from a serious hereditary disease, authorization for the artificial interruption of a pregnancy may be granted even if the term of the pregnancy is more than three months or pregnancy has been artificially interrupted within the preceding six months. However, interruption of pregnancy may not be authorized even in these two cases if such an intervention would endanger the life of the woman concerned.

(4) In deciding whether or not interruption of a pregnancy should be authorized, not only must the main grounds be taken into account but also the total situation of the woman which is brought about by her state of health and social conditions.

(5) In the case of women who have not yet had a child, account should be taken of all the health grounds and the other grounds, special attention being given to the risk that they may become sterile as a result of the first interruption.

3. (1) A woman who wishes to have her pregnancy artificially interrupted shall apply, either directly or through the medical practitioner in attendance, to the head of the women's department of the district health

institution whose hospital is responsible for the place where the woman is resident, and she shall communicate to him the grounds on which her request is based. Nevertheless, a woman may apply if she wishes to any other district health institution to which a hospital is attached.

(2) The head of the women's department shall submit the request to the board. The board shall be established at the district health institution to which a hospital is attached; it shall consist of the director of the district health institution who shall be in charge of its debates (chairman of the board), the head of the women's department of the district health institution, and possibly a medical practitioner who is a specialist in the branch to which the medical indications or contra-indications given relate; another member of the board and his alternate shall be appointed by the committee of the district people's council and this member shall be an experienced, trustworthy, and respected woman.

(3) If the request is not granted, the woman shall be informed that she may apply to the provincial board for her request to be re-examined and if she wishes to take advantage of this opportunity, she must do so without delay. Membership of the provincial board shall be similar to that of the district board.

4. The request shall be duly and rapidly examined so that interruption of pregnancy may be performed within fourteen days and at the latest before the expiry of the third month of pregnancy unless the case is one in which the intervention may be performed even after that time limit.

5. (1) A lump sum of 200 to 500 Czechoslovakian crowns shall be charged for artificial interruption of pregnancy as part payment of the costs of treatment. However, the board may exempt a person from payment of this charge, especially if continuation of the pregnancy imperils the life of the woman or would undoubtedly constitute a serious injury to the health, or if the financial situation of the woman requires it.

(2) The charge shall be paid in cash and the woman treated shall receive a receipt therefor. This receipt shall include neither the name of the woman treated nor any other entries which may reveal her identity.

6. It shall be the duty of all parties concerned not to divulge any of the facts which come to their knowledge when examining a request for the artificial interruption of pregnancy; all documentation relating thereof shall also be treated as confidential.

7. (1) This Notice shall enter into force on 30 December 1957.

(2) The directions relating the procedure to be followed in interruptions of pregnancy (Ministry of Health Circular No. 619/1952) are hereby rescinded.

Schedule

LIST OF DISEASES WHICH ARE MEDICAL INDICATIONS FOR ARTIFICIAL INTERRUPTION OF PREGNANCY

1. Internal Diseases

(a) Diseases of the heart and of the vascular system:

Valvular defects, in particular mitral stenosis and aortic insufficiency with reduced heart performance or valvular defects which, before pregnancy, have given rise to signs of circulatory difficulty or infarction of the lungs or embolisms in the systemic circulation or an acute pulmonary oedema.
Acute or progressive inflammatory diseases of the heart (myocarditis, bacterial endocarditis, progressive rheumatism).
Infraction of the myocardium.
All heart diseases causing up to the end of the third month of pregnancy, arythmias (auricular flutter, auricular fibrillation, heart syncopes), venous statis or cyanosis. Congenital heart defects with circulatory disorders, especially defects accompanied by cyanosis or coarctation of the aorta with noticeable pressure on the upper extremities.
Hypertension.
Marked varicose veins, in particular in the region of the reproductive organs and the lower extermities with antecedent ulcers and thrombophlebitis.

Note: In the case of a slight cardiopathia, consideration must be given to whether the mother can be sufficiently protected from all effort (household duties, employment, care of the infant especially during the first two to three years, several young children in the family who need supervision even at night).

(b) Pulmonary diseases:

Pulmonary diseases with reduced respiratory function (pulmonary insufficiency), bronchietasis, chronic bronchitis, emphysema.
Chronic pulmonary infections.

(c) Renal diseases:

Chronic glomerulonephritis, with symptoms of an active inflammatory process, increased blood sedimentation.
Chronic glomerulonephritis accompanied by nephrotic or hypertonic syndrome.
Chronic pyelonephritis.
Nephrosis accompanied by hyperproteinaemia.
Amyloidosis of the kidneys.

(d) Blood formation diseases:

Haemorrhagic diseases.
All haemoblastoses and all haematoplastomias.
Affections of the bone marrow.
Haemolytic anaemia.

(e) Diseases of the digestive organs:

Complicated cholelithiasis (biliary cirrhosis, choledocholithiasis, biliary empyema, cholangitis, pancreatitis).
Relapsing pancreatitis, pancreatolithiasis.
Ulcer
Colitis ulcerosa.
States of denutrition caused by diseases of the digestive organs.
Chronic parenchymatic diseases of the liver.
State after infectious hepatitis within a period of two years or when there are signs of functional liver troubles.

(f) Disorders of the endocrine glands:

Exophthalmatic goitre.
Goitre with mechanical sequelae, in particular retrosternal goitre with compression of the cervical vessels.
Hypothyreoses.
Hypophysial adenoma with mechanical sequelae, especially with threat to the vision.
Hyperparathyreoses.
Diabetes mellitus: when there is an hereditary taint on both sides (Diabetes mellitus of both parents or in both families); with a tendency towards acidosis; that reacts poorly to insulin treatment; diabetes, accompanied by certain complications, in particularl vascular complications occurring in young people and having repeatedly caused miscarriages or still-births.
Addison's disease: after preparation in a specialized establishment for the purpose of preventing an Addisonian crisis.
Adenoma of the suprarenals.
Other endocrinopathias detected on examination in a specialized establishment.

(g) Infectiousdiseases in the first three months of pregnancy which are transmissible to the foetus and cause malformation or maldevelopment of the foetus.

2. Surgical Diseases

Large abdominal hernias, diaphragmatic and hiatus hernia if the woman concerned does not consent to an operation.
Syndromes following stomach or gall bladder resection.
Relapsing ileus.
Congenital anomalies of the large intestine and of the rectum which have been treated surgically.
Extensive abdominal and pelvic tumours.
State after surgical intervention on the internal secretion organs.
State after lung resection with reduced pulmonary functional capacity.
Pulmonary actinomycosis and pulmonary abscesses.
Advanced organic changes in the peripheric vessels.
Genuine or false arterio-venous aneurysms of the aorta and of the large vessels of the abdomen and the extremities.
Benign anatomic malformations of the cerebral vessels.

3. Urological Diseases

State after removal of a kidney or if a kidney is missing (agenesia) or stunted (hypoplasia).
Cystic degeneration of the kidneys with bilateral renal deficiency.
Haematuria of unknown origin.
Bilateral nephrolithiasis, even if the concretions are not fixed and are often spontaneously eliminated from both kidneys - uratic urolithiasis.
Unilateral nephrolithiasis with reduction of renal function.
Papillomatois of the bladder.
Hydronephrosis.
Dystopic kidney, crossed dystopia, and horseshoe kidney.

4. Orthopaedic Diseases

Pelvic malformation as a result of an accident. Chrobak pelvis, central dislocation of the hip joint.
Symphysiolysis due to delivery.
Scoliosis of the lumbar and thoracic regions of the vertebral column with malformation of the pelvis.
Malformation of the pelvis with osteomalacia and Paget's disease.
Spondylolisthesis.
Subluxation and other malformations of the hip joint, possibly state after Perthes' disease (account must be taken of whether the mother can suitably care for the child when she has difficulty in moving).
Bilateral ankylosis of the hips.
Arthritis deformans of the hips and lumbosacral arthritis.
State resulting from extensive and complicated fractures of the long bones and from intra-articular fractures of the large joints.
Diseases of the skeletal system (such as osteopsathyrosis, Albers-Schönberg disease) even where only the father is suffering therefrom, chondrodystrophia foetalis.
Osteomalacia.
Paralysis of the abdominal muscles after poliomyelitis, especially when the lower extremities are also paralysed.
Relapsing chronic osteomyelitis of the pelvic bones.
Spastic paralysis (Little's disease).

5. Rheumatic Diseases

Spondylarthritis ankylopoietica (Bechterew's disease) when the hip joints are attacked at the same time.
Chronic progressive polyarthritis when the hip joints are especially attacked.
Chronic polyarthritis complicated by amyloidosis.

6. Oncological Diseases

All malign tumours regardless of their site, and states following their surgical removal or irradiation treatment.

7. Tuberculosis

(a) Pulmonary tuberculosis:

(aa) All contagious and potentially contagious forms of tuberculosis.

(ab) All forms of tuberculosis (even where Koch's bacillus has not been isolated) at the progressive stage (decomposition, dissemination, infiltration) or at the resorption stage or with active symptoms (subcomposition, decomposition).

Note: Especially when complex treatment is unlikely to avert the risk of aggravation of tuberculosis in the mother and when it is not possible to prevent the child from becoming infected.

(ac) All non-contagious and inactive forms which may again become active or be aggravated as a result of pregnancy, delivery, or breast feeding, in particular in young mothers where a preceding pregnancy was a factor in the occurrence or aggravation of tuberculosis; when the disease has been inactive for only a short time; when little time has elapsed since the last pregnancy; in maltiparia, when the cardio-respiratory function is diminished; in the case of tuberculosis complicated by a serious non-specific disease which, at the stage at which it manifests itself, would not in itself have constituted a sufficient indication for interruption of pregnancy (diabetes mellitus).

(b) Extra-pulmonary tuberculosis

Tuberculosis of the larynx.
Tuberculosis of the vertebral column, of the pelvic bones, of the hips, of the knee joints, and of the other bones.
Intestinal tuberculosis.
Urogenital tuberculosis.
Tuberculosis of the nervous system and tubercular meningitis.

Note: All forms of tuberculosis in young persons require particularly careful assessment. Contagious tuberculosis in the father is also an indication for interruption of pregnancy if he cannot be isolated because of housing conditions; interruption of pregnancy is also indicated if a tubercular mother is forced to give up her work, thereby endangering the orderly routine of her life.

8. Diseases of the Nervous System

Disseminated cerebrospinal sclerosis and other demyelination diseases.
Paraplegia and serious paraparesis of the lower limbs, of organic origin.
Tumours of the brain, of the spinal cord, and of their envelopes.
Parasitogenic diseases of the central nervous system.
Hereditary ataxia (Friederich's disease) and cerebral heredo-ataxia (Marie's disease).
Hepato-lenticular degeneration (Wilson-Westphal-Strümpell's disease).
Myopathias.
Dystrophic myotonia.
Huntington's disease.

Note: Huntington's disease and distrophic myotonia is an absolute indication for artificial interruption of pregnancy even if only the father suffers therefrom.

Cerebral form of endarteritis obliterans.
Encephalo-malacia regardless of the cause.
Aneurisms and intra-cranial vascular malformations.
Funicular myelosis.
Epidemic encephalitis in the acute or chronic stage.
Other encephalites in the acute stage.
Prolonged acute stages of other neuro-infections.
Myasthenia.
Syringomeyelia and syringobulbia.
Haematomyelia.
Intra-cranial and spinal arachnitis with objective neurological findings.
Meningorrhagia.
Traumata of the brain and of the spinal cord with clear focal symptomatology (including residual states of this type).
Serious post-meningitis residual states.
Double athetosis
Primary atrophia of the cerebellum
Progressive lordotic dysbasia.
Periodic family paralysis.
Serious lumbardiscopathia.
Neuralgia of the trifacial nerve.
Epilepsy accompanied by general degeneration and character changes, when other somatic and psychic deficiencies are present; when the patient is recalcitrant to undergo a modern drug therapy; when the spouse suffers at the same time from severe headache.
Status epilepticus.

9. Psychiatric Disorders

(a) Diseases of the mother.
Delirious states becoming worse during pregnancy.
Progressive paralysis.
Chronic schizophrenia.
Generation psychosis with repeated attacks.
Serious manic melancholia.
Serious psychopathia.
Serious reactive psychic disorders with possible suicidal tendencies.
Serious obsessional and anxiety neurosis.
Heredo-family nervous diseases with psychic disorders.

(b) Diseases of one of the spouses, especially one which may be communicated to heredity.
Oligophrenia.
Serious psychopathias.

(c) When the mother has already had by the same father an oligophrenic or otherwise stigmatized psychopathic child.

(d) Serious chronic alcoholism of one of the spouses showing itself in character disorders.

10. Dermato-venereal Diseases

(a) Veneral diseases.

Syphilis:

Malign sero-positive in the second stage; manifest in women who cannot tolerate specific therapy including antibiotics;
maligin in the third stage especially when organic;
choroiditis, atrophy of the optic nerve, and syphilitic changes in the auditive nerve:
sero-resistant accompanied by fear of passing on syphilis to the child (relative indication after consultation with a psychiatrist).

Neurosyphilis and tabes dorsalis.
Syphilitic spondylitis.
Extensive cicatricial and ulcerous changes in the region of the genital organs and of the perineum in the case of Nicolas-Favre's disease.

(b) Skin diseases.
Pemphigus vulgaris, p. foliaceus, p. vegetans and Senear-Usher syndrome.
Erythrodermia.
Pruriginous diseases persisting over several years accompanied by psychopathic disorders.
Diffused scleroderma.
Acute dermatomyositis.
Mycosis fungoides.
Necrobiosis lipoidica diabeticorum
Purpura becoming worse during pregnancy.
Impetigo herpetiformis.
Advanced ichthyosis.
Hereditary palmar and plantar keratosis.
Hrythematodes acutus, possibly acute disseminatus.
Hereditary bulbus epidermolysis.
Xeroderma pigmentosum.
Bourneville-Pringle's disease (epiloia).
Dermatitis herpetiformis Duhring.
States following serious burns accompanied by cicatricial and cheloidal changes on the bosom and around the genital organs.

11. Eye Diseases

(a) Toxic inflammations of the optic nerve.

(b) Certain diseases of the organ of sight, when a permanent lesion of the eye may be averted by means of interruption of pregnancy; mechanical lesions of the optic nerve, inflammation of the retina and of the choroid membrane, haemorrhage in the corpus vitreum, serious lesion of the cornea, acute glaucoma.

(c) Pronounced myopia with displacement of the retina or vascular lesion, with haemorrhages of the retina or when degenerative changes at the back of the eye occur.

(d) Congenital total cataract in the mother or in one of her children accompanied by other congenital phenomena.

(e) Hereditary and family degeneration of the retina and the optic nerve.

12. Ear, Nose, and Throat Diseases

(a) Otosclerosis accompanied by serious psychosis (opinion of a psychiatrist together with an ear specialist); when serious reduction of hearing has occurred as a result of a preceding pregnancy; otosclerosis in both the father and the mother.

(b) Hereditary deafness or serious hereditary impairment of hearing.

13. Gynaecological and Obstetrical Diseases.

(a) Hyperemesis gravidarum, ptyalism.

(b) Late gestosis, especially when associated with hypertension or albuminuria and regardless of the stage of pregnancy.

(c) Pathological states in the obstetrical anamnesis.
Repeated atonic haemorrhages after delivery.
Repeated haemorrhages associated with adherence of the placenta which would have to be removed by hand.
After two deliveries which have required Caesarian operations.
When there is habitual uterine inertia.
After adjustment by operation of a support or suspension apparatus, if the woman has two living children.
When there is venter pendulus caused by diastasis of the rectus after two deliveries.
Late gestosis especially when pregnancy follows shortly on delivery.

(d) Chorea gavidarum.

(e) Foetal anomaly, repeated births of children suffering from foetal erythroblastomatosis if there have been two prior still-births or the foetuses have been damaged.

(f) Conception occurring after temporary sterilization by X-rays or if the ovaries have been damaged during irradiation by X-rays administered for other purposes.

(g) Conception before the age of 16 if pregnancy has been discovered by the third month.

(h) Conception after the age of 45 years.

Medical supervision of physicial education

Order No. 89 of 10 August 1961 on the medical supervision of physical education. (Sbírka zákonů Československé socialistické Republiky, 30 August 1961, No. 42, pp. 322-323)

The aims of medical supervision of physical education shall be to promote the wide development of such education and to raise the athletic standards of workers and youth with a view to improving the state of health and evolution of the individual, and thus also his working capacities and fitness for national defence.

Medical supervision of physical education shall comprise: (a) supervision of the state of health of persons participating in organized physical training activities; (b) the medico-pedagogical supervision of physical training and gymnastic displays; (c) supervision of the hygiene of physical culture establishments and practices; (d) health services in connexion with gymnastic displays; (e) health education of persons engaged in the organization of physical education and of the general public.

The implementation of health supervision of physical education shall be effected by public health establishments in close cooperation with the Czechoslovak Red Cross.

In connexion with the general medical examination of adolescents and adults, medical practitioners and public health bodies shall also investigate their physical maturity and their state of preparedness for the practice of physical culture; special examinations shall be conducted by the health services for the medical supervision of physical education.

Supervision from the point of view of hygiene of physical culture establishments and the conduct of physical education activities shall be effected subject to the authority and advice of the organs of the hygiene and epidemic control service which shall also be responsible for preventive control in connexion with any construction, transformation or improvement of physical culture institutions.

Persons participating in organized physical training activities shall be bound to undergo the medical examinations required by medical officers of public health establishments and to comply with the latter's orders regarding the conditions in which they may continue to practice physical culture.

The Notice No. 391 of 19 December 1952 (see Int. Dig. Hlth Leg., 1954, 5, 48) is hereby repealed.

Interruption of pregnancy

Notice No. 104 of 14 September 1961 governing application of the Law on the artificial interruption of pregnancy. (Sbírka zákonů Československé socialistické Republiky, 30 September 1961, No. 49, pp. 362-367)

The present text issued in application of Section 7 of the Law of 19 December 1957 (see Int. Dig. Hlth Leg., 1959, 10, 283) repeals the

Notice No. 249 of 21 December 1957 (see Ibid., 1959, 10, 284) and reproduces the majority of the provisions contained therein with the following principal differences.

Items (b) and (e) of paragraph (2) respectively of Section 2 are replaced by the following: "(b) the existence of at least three living children;" "(e) risk to the standard of living in cases where predominant economic responsibility for the maintenance of the family or the child devolves upon the woman".

Section 5 is replaced by the following provision: "Performance of artificial interruption of pregnancy shall be free of charge".

A new Section 6 embodying the following provisions is introduced, as follows: "6. (1) In order that all circumstances may be taken into account, the Commission may summon for a hearing the husband of the woman or, as the case may be, the man responsible for her pregnancy and also, in the case of girls below the age of 18 years, the parents.

(2) In special cases the Commission may recommend a woman (and particularly an unmarried mother) to place her child after birth in an infants' or children's home until the reasons given by her for the interruption of pregnancy shall have ceased to apply, the child then being returned to her or placed with adoptive parents with the mother's consent."

Former Section 6 becomes Section 7.

The Annex specifying the diseases deemed to be medical indications for artificial interruption of pregnancy is reproduced without amendment.

CHAPTER 8

YUGOSLAVIA*

Historical Trends

1. Yugoslavia is a federal republic, composed of six republics: Bosnia-Herzegovina, Montenegro, Croatia, Macedonia, Slovenia, and Serbia, plus two autonomous provinces within Serbia, Kosovo-Metohija and Vojvodina. There is considerable local autonomy amidst divergent customs and traditions which have considerable effect on population programs. The country is a vast laboratory for social-psychological research, as reflected, for example, in the studies on migration reported by Breznik & Sentic (1966) and by Sentic (1968). Differential fertility factors have also been noted by Breznik (1968).

2. The population of Yugoslavia has the greatest ethnic and religious diversity in Eastern Europe. According to the 1961 census, the 18.5 million Yugoslavs include five "nations": 7.8 million Serbs, 4.3 million Croats, 1.5 million Slovenes, 1.0 million Macedonians, and 0.5 million Montenegrins, as well as 1.0

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*Arrangements for consultations in Belgrade were coordinated by Dr. Dusan Breznik, Director, Demographic Research Institute of the Institute of Social Sciences. Discussions were held with Dr. Dolfe Vogelnik, President, Federal Council for Coordination of Research and President, International Union of Scientific Study of Population; Dr. Svetislav Jaukovic, Associate Director, Federal Council for Public Health; Dr. Vojin Matić and Prof. Nikola Rot, Institute of Psychology, University of Belgrade; Dr. Slavka Moric-Petrović and Dr. Dusan Petrovic, Institute for Mental Health; Dr. Bosa Milosevic and staff of the Gynecological Clinic, University Hospital; Dr. Angelina Mojic, Retired Chief, Mother and Child Section, Federal Public Health Institute; Mrs. Nevenka Petric, Vice President, Federal Council of Family Planning; Dr. Miroslav Rasevic and Dr. Milica Sentic, Demographic Research Institute; and Miss Nevenka Perovic and Dr. Zoran Sretenovic, Serbian Institute for Mother and Child.

million Moslems and 317,000 ethnically non-declared Yugoslavs. Other nationalities are also represented: Albanians (914,000), Hungarians (504,000), Turks (183,000), Slovacs (86,000), Bulgarians (63,000), and Romanians (61,000). There are three major religious groups. The 16.9 million Yugoslavs counted in the 1953 census included 7.0 million members of the Orthodox Church, 5.4 million Roman Catholics, and 2.1 million Moslems, plus 2.1 million inhabitants without religious affiliation. Moslems, Serbs, Croats, and Montenegrins speak the same language. The Slovenian and Macedonian languages enjoy equal status with Serbo-Croatian. Over 55 percent of the population are under 30 years of age. With burgeoning industrialization, the agricultural population constituted about half the population in 1961. Longer term population projections have been summarized by Macura (1967).

3. A historical survey of Yugoslav population policies was published by Klauzer (1968). Except for a few post World War II years, the birth rate has been in a long-term declining trend, decreasing from 36.7 per 1,000 population in 1921 to 18.9 in 1968. Klauzer notes the considerable differences in fertility and natality among and between the different regions of Yugoslavia. For example. in 1965 birth rates in Kosovo and Methohija were 40.0 per 1,000 population, or 2.6 times higher than in Vojvodina (15.5 per 1,000). By 1967 the difference was still the same: Kosovo and Metohija had a birth rate of 37.9 per 1,000 while Vojvodina had 14.1 per 1,000 (Anicic, 1969). Klauzer suggests that "fertility in socialism should be reduced to the extent where it will no longer exert a harmful influence on the health and life expectancy of women and the intensity of infant mortality ... to allow the woman to become equal in her role of producer and self-manager ... should not be allowed to exceed a level preventing a rise of the general education of the entire population ... should be reduced to an extent which will make it possible to reduce demographic investments to a reasonable measure."

4. An independent Federal Council for Family Planning was established in 1967 as an outgrowth of activities jointly sponsored by women's organizations and professional groups in the several republics. It is a member association of the International Planned Parenthood Federation.

5. President Tito signed the U.N. Declaration on Population and sent a letter to U Thant stating that it is a basic human right for individuals to decide how many children they will have. In Early 1969 the Yugoslav Federal Council on

Family Planning was instrumental in having a resolution on family planning introduced in the Federal Assembly. As approved on 25 April 1969 the resolution stated that (a) "It is one of the basic human rights and duties for parents to be able to plan the size of their families and the spacing between births.... (b) For this to be feasible society should make it possible for married couples to get information about modern methods of birth control and provide them with adequate means to plan their families.... (c) The realization of society's views on family planning and birth control ... calls for an active role and certain obligations on the part of the social services, research institutions, social and other organizations, associations and institutions.... And (d) the right of parents to decide on the number of children and on spacing between births should be primarily realized through the use of contraceptives. Interruption of pregnancy, as the least desirable form of birth control, is only an extreme means which should be resorted to to enable women to interrupt undesired pregnancy when this has already occurred" (Yugoslavia, 1969a).

Abortion Policy Trends

1. In 1951 abortion was allowed only on medical grounds. Social-medical indications became acceptable in 1952 (Yugoslavia, 1952). The permissive law of February 1960 authorized abortion if birth of the child "would result in a serious personal, familial, or economic situation for the pregnant woman which cannot be averted in any other way" (Yugoslavia, 1961). Interpretation of social conditions for abortion is usually liberal. The purpose of the law was to reduce the number of illegal abortions and the threat to women's health. The liberal standards for abortion are reaffirmed in the 1969 General Law on the Interruption of Pregnancy (Yugoslavia, 1969b), cited in paragraph 9 below.

2. A pregnant woman requesting abortion applies to a commission which consists of two physicians and a social worker; one physician usually is a gynecologist. The law specifies that the commission must point out the dangers of abortion and the advantages of contraception. "A health worker should regard abortion as biologically, medically, psychologically, and socially harmful. Corresponding to the principle of socialist humanism and medical knowledge, human life must be respected from the beginning" (Hren, 1964). Occasionally gynecologists apply considerable psychological pressures to get a woman to change her mind but, if

she insists, the request is usually approved, at least on the first occasion. Social workers on the commission are obliged to inform the woman, or couple, about contraception before a request for abortion can be approved. Instructions are again provided after abortion. On the second request for abortion, the commission may be stricter but an appeal can be lodged with the regional commission. It is usually most difficult to obtain approval of the third request, especially if there is no evidence that contraception has been used. Considerable variations have been reported in the attitude of commissions. In 1960, for example, approvals in Serbia ranged from 59 percent in Kosmet to 92 percent in Belgrade; in 1965, it was 96 percent in Kosmet and 93 percent in Belgrade.

3. Abortions are performed by gynecologists in hospitals. The vacuum-aspiration technique described by Novak (1968a) is widely used, especially in Ljubljana. Usual length of hospitalization is four to five days, with three days minimum. Yugoslav-produced coils are often inserted at that time. In small towns, abortions may be performed by a visiting team on an outpatient basis. There is a "health home" in every community where a gynecologist visits at least once a week. The cost of abortion for non-medical reasons is 50 dinars ($4). A working woman receives paid leave. There is no special compensation for gynecologists to perform abortions. In hospitals gynecologists generally terminate about 10 pregnancies per day; they are usually rotated through the abortion service for six-month periods.

4. Although it is obligatory to register all legal abortions in Yugoslavia, data on annual terminations are not readily available. No figures are given in the Statistical Yearbook. A study of "Fluctuation in Abortions and Births in the Health Establishments of the Yugoslav Socialist Federal Republic--1963-1967" was conducted by Angelina Mojic for the Federal Institute for the Protection of Health and is awaiting publication.

5. It is generally estimated that the total number of induced, spontaneous, and "other" abortions is about 300,000 per year, thus exceeding the number of live births (Beric, 1969). There are wide variations within the country. In certain Moslem regions there may be seven or eight times as many births as abortions, whereas in Serbia the number of abortions may be twice that of births. Trends are apparent in the publications of Beric et al. (1954), Mojic (1967a,b), Novak (1967a), and Popovic (1968).

6. The sharply rising number of abortions in Belgrade and its excess over deliveries is noted in Table 26, prepared by the Institute for Protection of Mother and Child of Serbia. Whereas in 1960 the number of induced abortions (13,023) was only slightly more than number of births (12,011), by 1965 the difference had grown to 29,635 induced abortions versus 13,664 births. By 1969 the ratio of all abortions to births was reported to be four to one.

7. In Slovenia the number of legal and other abortions has been constant during the period 1961 to 1966. Nearly 95 percent of the legal abortions were performed on social indications, with the disparity between family size and the desire for a higher standard of living playing an important role (Mojic, 1967b). Of the women having legal abortions, 78 percent were married, 16 percent unmarried, and 6 percent widowed or divorced. About 11 percent were childless, 55 percent had one or two children, 27 percent had three or four children, and 7 percent had five or more children. The ratio of abortions to births was 2.5 to 1.5 for wage earners, 2.4 to 1.2 for salaried employees, and 2.8 to 2.7 for housewives (Mehlan, 1966a).

Table 26

Births and Abortions in Belgrade, Yugoslavia, 1960-1965*

Year	1960	1961	1962	1963	1964	1965
Number of deliveries	12,011	13,057	12,769	13,109	13,192	13,664
Crude birth rate	14.5	14.6	14.4	14.1	13.5	13.6
Number of legal abortions	13,023	15,969	20,454	24,564	26,690	29,635
Number of incomplete abortions	5,984	7,646	9,292	7,351	9,244	4,108

*Based on material compiled by the Institute for Protection of Mother and Child, SR Serbia.

8. At the beginning of 1969 the Catholic Church strongly attacked the practice of legalized abortion and requested a reversal of policy. This occurred at about the same time that the Federal Assembly was considering more liberal abortion legislation.

9. The General Law on the Interruption of Pregnancy, as promulgated by the Assembly in April 1969, states in Article 4 that "the interruption of pregnancy will be done on the demand of the woman if during pregnancy and after birth she could fall into serious personal, family, material and other troubles." The law urges that more emphasis be placed on sex education and dissemination of information on contraception.

Illegal Abortions

1. It is believed that about 30 percent of all abortions are illegal, or about 60,000 of the 200,000 hospital abortions estimated by Mehlan (1968c). In 1967 public health institutions admitted 65,515 women with "incomplete abortions"; 67 died subsequently (Novak, 1969).

2. The general impression is that illegal abortions are especially prevalent in Eastern Serbia among less educated and/or unmarried older women. Younger women resort less frequently to illegal abortion.

Family Allowances

1. According to the Law of 1967, family allowances are provided for families earning less than 500 dinars per month. The average income in Yugoslavia is estimated to be 800 dinars per month ($64).

2. Family allowances are promulgated in each of the republics. Those in Serbia are typical and are presented in Table 27.

Contraceptive Methods and Practices

1. A Yugoslav IUD, Beospir, is produced by Plastika Zemun in Belgrade, which offers descriptive material in English. It is available on prescription with insertion by a gynecologist in a hospital or clinic.

2. A variety of oral contraceptives are produced under license, including Ovulen, Anovlar, Edginon, and Lyndiol. These are available on prescription.

Table 27

Family Allowances in Serbia*
1969

Number of children	Monthly Family Income (in dinars)			
	up to 350	351-400	401-450	451-500
1	52	27	21	15
2	103	51	39	27
3	149	72	55	38
4	191	89	68	47
5	228	101	77	54
For each of other children above 5	37	13	10	7

* Table prepared by Demographic Research Institute

3. Other locally manufactured products include: jellies (Contrafer, Patentex, Genosan), creams (Genotan), suppositories (Nona Gel), foam tablets (Contrafer), and foam (Emko). They are usually sold in drugstores.

4. Diaphragms and condoms may also be purchased directly. Clinicians reported in 1969 that diaphragms were not very popular.

5. It has been suggested that fees be charged for all abortions and that contraceptives be made available at no charge, as is already the case in some cities (through the Social Security System).

6. The Federal Council on Family Planning has recommended that the privilege of writing prescriptions for contraceptives be extended beyond the 680 gynecologists to general practitioners; the objective is to make contraception an integral part of preventive medicine. The proposal has been accepted by the professional societies of gynecologists and general practitioners.

7. Representative studies of contraceptive preferences, motivation, and child spacing are being planned by the Demographic Research Institute of Belgrade. Previous regional investigations suggest that birth planning is widely practiced. Coitus interruptus continues to be the most common method, especially in rural settings. Andoljsek (1964) noted that 50 percent of 1,960 women interviewed in 1963 relied exclusively on coitus interruptus. Mehlan (1967) cites a 1963 report by Andoljsek that 30 percent of all women interviewed declared induced abortion to be the only method of birth control acceptable to them. It is this "epidemic of abortion" which the Federal Council on Family Planning wishes to combat through education in the use of modern contraceptives.

8. Breznik and Rasevic (1970) have summarized data from several regional studies on family planning, contraceptive practice, and abortion. The Institute of Health Education in Serbia conducted a study of 17 rural settlements in the region of Srem in Vojvodina during 1966/67. Of the women interviewed, 74.6 percent stated that they practiced some method of birth control. According to a 1965 study in East Serbia, 96 percent of 458 respondents declared that they either used contraceptive devices or terminated an unwanted pregnancy by abortion. Family planning is least common in some regions of Kosovo and Metohija. Of 5,000 women aged 15 to 49 years, only 25 percent used contraception.

9. It was reported in 1969 that pills are preferred to coils by certain women who object to touching or being touched in the vaginal area. This may also account for the relative unpopularity of diaphragms. Some women stated that their husbands reject contraception and prefer abortion; in such cases wives may be advised not to mention their use of contraceptives to their husbands.

10. Among the few Central and Eastern European studies of psychological aspects of contraception is one by Kapor (1967) from the Serbian Institute of Mother and Child in Belgrade. Pills were favored by almost 3,500 of 4,000 women. Acceptance of pills seemed to be based on acceptance of other medically prescribed pills. Coils were less popular, with indications that women objected to the presence of a foreign body in the uterus. Diaphragms were preferred by a small number of unmarried women. Others did not like to because they themselves did not wish to touch their vaginal area.

11. Research in contraceptive technology: (a) At the University of Belgrade Gynecological Clinic, Dr. Radmila Matić is exploring tests of new pills, including an Israeli pill (Sinova). Some studies are supported by the Pathfinder Fund. (b) In Ljubljana, Dr. Lidija Andoljsek is conducting multiple research, including studies of pills produced by the Yugoslav firm "Galenika" and others. (c) At the Serbian Institute for Protection of Mother and Child in Belgrade, research is continuing with American jelly and pills produced by Ortho, and with after-coitus pills developed by Sandoz. (d) The Galenika Company maintains its own research laboratory.

Family Planning Centers

1. There is only one independent family planning center in Yugoslavia, the Family Planning Institute in Ljubljana, directed by Dr. Lidija Andoljsek. It is a self-supporting unit within the Ljubljana University Hospital and is staffed by gynecologists, psychologists, and social workers. The Institute gives advice on contraception and also provides consultation on infertility and sexual disorders (Andoljsek, 1964).

2. In 1958 the dissemination of contraceptive information and devices was made an integral part of the Yugoslav Public Health Service (Andoljsek, 1962).

About 500 Advisory Centers exist, operating through Gynecological Departments, Mother and Child Institutes, factories, or other facilities. A few are in student homes. All are supported by the government. Most are open full time. Others are part-time, depending on location and availability of staff. Gynecologists, general practitioners, midwives, and visiting nurses give instruction on contraception. No fees are charged. Cooperation with social welfare and health agencies is encouraged. All methods of contraception are offerred.

3. The 1967-68 Annual Report of the International Planned Parenthood Federation cites the following clinic facilities available in Yugoslavia:

(a) Bosnia and Hertzegovina: in different centres 5,463 women were covered by the family planning scheme.

(b) Crna Gora: seven dispensaries, family planning services, specialized gynaecological hospitals, etc., perform this work.

(c) Croatia: 195 medical units and institutions have examined 42,519 cases.

(d) Macedonia: there are 25 institutions for contraception, dispensaries, clinics, hospitals, etc.

(e) Slovenia: 122 institutions in 1966 had 51,046 cases.

(f) Serbia: 3 gynaecological clinics, 1 gynaecological hospital, 51 gynaecological departments, 96 consultation services for pregnant women and 36 specialized gynaecological ambulances perform this work.

(g) Vojvodina: 10 specialized consultation services in hospitals, 27 specialized consultation services at the dispensaries for women, 73 specialized consultation services at the medical centres and 10 gynaecological ambulances work in this field.

4. Typical of Yugoslav advisory centers is the one established in 1966 at the Mother and Child Institute of Serbia in Belgrade. Its 1968 program included the following activities (Kapor, 1968):

(a) Regular collection of data about legal, spontaneous and incomplete abortions in Serbia.

(b) Preparation of material reporting on the actual situation about family planning and recommending future measures, to be presented to the Assembly of Serbia.

(c) Participation in visits to the territory of the republic; the aim is to coordinate and orient the work on women's health protection and family planning.

(d) Organizing courses on family planning outside Belgrade.

(e) Follow-up of the efficiency and convenience of already known means for family planning.

(f) Investigation of new methods and means for family planning.

(g) Using the mass media for the dissemination of family planning information.

(h) Studying mental health aspects of contraception.

(i) Collaboration with other organizations and institutions in the country and abroad concerning family planning.

(k) Taking part in the work and organization of lectures or courses for marriage and parenthood preparation.

(l) Following the articles from all daily newspapers printed in Serbia having the theme: women's health protection, family planning, abortions, contraception, sexual education, etc.

Medical and Postgraduate Training

1. In March 1968 the Federal Council on Family Planning sponsored a conference for deans of medical schools and related faculties, recommending that lectures on contraception be included in the medical curriculum. This recommendation was accepted and has been implemented by all seven medical faculties and in several schools training paramedical personnel. The medical schools also provide postgraduate training in family planning, especially for rural physicians.

2. The Serbian Institute of Professional Training offers a six-months' course on social gynecology and obstetrics for general practitioners. Contraception and family planning are included. Two-day workshops are available for general practitioners working in dispensaries for women.

3. The Municipal Institute for Health Protection in Belgrade includes presentations on contraception in its training courses for health workers.

4. The Department for the Prevention of Abortion in the Obstetrical and Gynecological Clinic of the University Hospital in Ljubljana has been replaced by the independent Family Planning Institute which organizes special courses for gynecologists from all parts of Yugoslavia. In cooperation with

the International Planned Parenthood Federation the Institute gave an eight-day workshop for general practitioners from developing countries in October 1968.

5. Annual meetings and conferences of diverse professional groups frequently include discussions of family planning trends and abortion policies.

Sex Education in the Schools

1. Sex education was introduced into Yugoslav elementary schools in 1960 (Andoljsek, 1964). The position of the Federal Council for Family Planning is that sex education should be an integral part of all education, beginning with kindergarten and extending through all the grades and the army. Experimental programs have been introduced in the Zagreb school system and several other selected centers. A group of gynecologists and behavioral scientists have prepared teaching materials for different age groups, including kindergarten and primary grades.

2. The Federal Parliament has approved resolutions of the Federal Council on Family Planning, recommending that information on contraception and sex education be provided in the schools.

Public Education

1. For some years the question of family planning has been of concern to the Conference of Yugoslav Women's Organizations. In 1963 a forum was organized to consider education of women in the sexual area and prevention of unwanted pregnancies. A Federal Coordinating Council of women's organizations and interested social and professional groups was founded, which in 1967 became the Federal Council for Family Planning.

2. The Federal Council has four permanent Commissions: (a) Sex Education, (b) Problems of Contraception and Abortion, (c) Demography, and (d) International Relations. The Council is a voluntary body, supported by numerous organizations and individuals. It is a member organization of the International Planned Parenthood Federation.

3. The 1969 Forum of the Council focused on social-psychological aspects of the relations between the sexes.

4. At this writing, the Council's resolution on abortion and contraception is being discussed by the Federal Parliament. The position of the Council is that women should not have the right to abortion but the right to knowledge and methods. The intent is to eliminate abortion as a major method of birth control and to reserve it for medical intervention under specified conditions, while at the same time urging women to use modern contraceptives.

5. Special agencies for the prevention of abortion and the encouragement of contraception have been organized by local and regional health councils which have broadly based memberships. Trends in family planning are propagated with considerable discussion in the press, magazines, radio, etc. There is much emphasis on premarital education, including men. "Schools for Living" and "Schools for Parents" have been organized and are well attended.

Research Notes

1. Under the provisions of (U.S.) Public Law 480, Yugoslav dinars are available for joint U.S.-Yugoslav research. Provisions for obtaining funds are as follows: (a) a proposal for research, initiated by a Yugoslav researcher, is sent to the appropriate office of the Yugoslav republic in which the research institute is located; (b) if approved by the republic, the proposal is forwarded to a committee of the Federal Administration for International Technical Cooperation; (c) if approved by the Federal Administration for International Technical Cooperation, the proposal is translated and forwarded to the Scientific Attaché of the United States Mission for transmittal to the Department of Health, Education and Welfare in Washington; (d) if the Yugoslav proposal includes a U.S. co-sponsor, review by the Department of Health, Education and Welfare could be greatly speeded. Public Law 480 provides dinars only, not dollars (U.S. Mission, Belgrade).

2. There are currently about 65 collaborative research projects in operation in Yugoslavia, funded under Public Law 480. Included are studies on: (a) "Effects of Intensive and Extensive Application of Contraception on Abortion Rate," a joint

project of the Federal Institute of Public Health and the U.S. Children's Bureau; (b) "The Demographic Transition in a Changing Society," a joint project of the Demographic Research Institute (Belgrade) with the U.S. National Center for Health Statistics; and (c) "Factors in Infant Mortality," a joint project of the Federal Institute of Public Health and the U.S. National Center for Health Statistics. In June 1969 the Food and Drug Administration signed contracts with the Yugoslav Government to conduct a series of studies on the safety of oral contraceptives.

3. The joint project of the U.S. Children's Bureau with the Yugoslav Federal Institute of Public Health on "Effects of Intensive and Extensive Application of Contraception on Abortion Rate" is directed in Yugoslavia by Dr. Angelina Mojic, Retired Chief ot ehe Division of Mother and Child of the Yugoslav Federal Public Health Institute. Dr. Mojic provided the following observations: (a) The study is proceeding in three Yugoslav cities of varying size, population composition, and annual abortion rate: Belgrade, Sarajevo, and Subotica. Sarajevo, although influenced by Islam, is Croatian. Subotica is in Voivodina which is ethnically Serbian. (b) Matched experimental and control groups consisting of 1,000 married women each have been established in the three cities, a total sample of 6,000 women. Groups were formed immediately after the women had an abortion. Many of the women had a history of nine to ten prior abortions. (c) Women in the experimental group receive an intensive course on contraception, are free to choose any method they prefer, and are seen every three months (in the home if clinic appointments are missed). The control group had the same access to family planning as the normal population, but were not followed so intensively. (d) Initial follow-up studies discovered 50 to 60 pregnancies per 1,000 in the experimental group compared to over 200 in the control group, many of whom failed to respond to invitations for appointment. A November 1969 report by the U.S. project monitor Edwin Gold, to Emily Moore (1969), indicates that 99.2 percent of the experimental group and 37.7 percent of the control group were using contraception at the end of the three-year study. Dr. Gold (1970) subsequently wrote that the pregnancy rate per 100 women was 5.5 in the experimental group and 24.1 in the control group. There were 124 legal abortions performed on women in the experimental group versus 508 in the control group during the period of study.

4. The project on "The Demographic Transition in a Changing Society" is headed in Belgrade by Dr. Dusan Breznik, Director of the Demographic Research

Institute. Project Officer for the (U.S.) National Center for Health Statistics is Arthur A. Campbell. (a) The full range of demographic transition from high to low birth rates is represented in Yugoslavia within definable areas having identifiable social, economic, cultural, and ethnic characteristics. (b) In 1969 the study was in its first year, devoted largely to tooling up and retabulating already available data in terms of regional differences and long-term trends in fertility patterns. During the second year, a national survey will investigate changes in fertility and seek more detailed information concerning changing patterns, including knowledge and practice of birth control methods as well as attitudes toward family size. The third and fourth years will be devoted to analysis and publication of results. (c) The total sample will include 6,000 women, age 15 to 49.

5. The project on "Factors in Infant Mortality" began in July 1964. It is directed in Yugoslavia by Drs. Cedomir Vukmanovic and Djordje Jakovljevic of the Federal Institute of Public Health and the Secretariat of Health and Social Policy in Serbia, respectively, with Dr. O. K. Sagen, Associate Director of the (U.S.) National Center for Health Statistics serving as Project Officer. Dr. Sagen reports that: (a) Differences in the rate of infant mortality among republics and provinces in Yugoslavia are very large, ranging from 29 deaths per 1,000 live births in Slovenia to 127 per 1,000 in the province of Kosmet. For Yugoslavia as a whole, the rate was 82 per 1,000 live births in 1961. (b) After existing data on fertility and infant mortality had been analyzed, four diverse study areas were selected which had a history of contrasting infant mortality, socioeconomic conditions, and fertility. Household interviews were conducted during October 1966 to identify (1) the total population distribution, (2) women of childbearing age (15 to 49 years), (3) childbearing history of all women aged 15 to 49, (4) pregnancies and their outcome during the two years preceding the interview, and (5) women admitting to being pregnant at time of interview. (c) The women who reported being pregnant in October 1966 were interviewed in October 1967. (d) The interviews included questions on child spacing together with knowledge, attitude, and practice concerning family planning. (e) The data are now being tabulated and analyzed.

6. An "Analysis of the Demographic Determinants and Consequences of the Socioeconomic Development of Yugoslavia" is a project of the Demographic Research Institute of the Institute of Social Sciences in Belgrade in cooperation

with the Demographic Institute of the Faculty of Economics (Ljubljana University), the Department of Demography of the Institute of Economics (Skopje University), and the Department of Demography of the Institute for Social Research (Zagreb University). The project will last three years (1969-1971), directed by Dr. Milica Sentic (Demographic Research Institute, Belgrade). Family planning is one of the areas to be explored.

7. Studies in contraceptive preference and research in contraceptive technology are mentioned in the section on Contraceptive Methods and Practices. Rasevic (1965) reported on socioeconomic factors as determinants of fertility.

8. Potts (1967) cites the studies of Professor Beric (Novi Sad) of the effects of legal and illegal abortion on the size of completed families born to women (a) who are natives of Vojvodina, an industrially and agriculturally developed region of SR Serbia, situated in the North-East of Yugoslavia, (b) who have immigrated to Vojvodina, and (c) who are sisters of immigrants but remained in the regions of their birth, such as the less well developed Bosnia and Herzegovina. Two thousand families have been followed. Women born in Vojvodina have smaller families than do immigrating women, and they in turn have smaller families than their sisters. Women born in Vojvodina had 2.6 children, those migrating from Hercegovina to Vojvodina had 2.7 children, and those from Bosnia had 2.8 children. Siblings remaining in Herzegovina had 3.2 children and those in Bosnia had 5.1 children. The total number of pregnancies in the three different areas is comparable but the average family size in Vojvodina has been kept smaller by greater use of abortion. Immigrant women to Vojvodina used abortion only slightly less frequently than native born women. Differences occurring between generations suggest an increasing incidence of abortion and preference for fewer children as a region develops economically and becomes more urbanized.

Research Centers

1. Founded in 1962, the Demographic Research Institute of the Institute of Social Sciences in Belgrade is an independent organization, not connected with any ministry or university. It seeks its own research funds, much like any non-endowed, non-profit U.S. research organization. The present staff consists of 14 full-time researchers, of whom four are at the Ph.D. level. The director is Dr. Dusan Breznik.

He and his staff have made numerous contributions to the literature, focusing primarily on population trends in Yugoslavia and its regions. The Institute has published a bibliography of pre-1961 papers by Yugoslav demographers and also issued a list of available publications.

2. Other demographic research centers in Yugoslavia include:

   (a) Demographic Research Centre of the Institute of Social Sciences, Narodnog fronta 45, Belgrade

   (b) Demographic Institute of the Faculty of Economics at the University of Ljubljana, Gregorciceva 27, Ljubljana

   (c) Demographic Department of the Institute for Social Researches at the University of Zagreb, Jezuitski trg 4, Zagreb

   (d) Demographic Department of the Faculty of Economics at the University of Skopje, Partizanska bb., Skopje.

3. The teaching of demography and statistics at Yugoslavia Universities has been described by Sentic (1967).

4. Behavioral research centers in Belgrade include: (a) The Psychological Institute of the University of Belgrade, directed by Prof. N. Rot, and (b) The Mental Health Institute, directed by Dr. Slavka Moric-Petrovic.

Reported Population Statistics

1. There are no data on abortions in the Statistical Yearbook. Informal discussion suggests that health workers do not always complete the required "individual reports" for each case of induced abortion.

2. Vital statistics are published at the regional level. The statistics of developing regions may not be as reliable as the industrialized areas. Processing of individual abortion report forms by the republics and their delivery to the federal health service tend to be delayed.

3. Relevant demographic information published by the Federal Institute for Statistics is presented in Table 28.

4. In addition to the Demographic Statistical Yearbook, published by the Federal Institute for Statistics, the Yugoslav Federal Institute of Public Health issues a Statistical Yearbook.

Publications

1. Stanovnistvo (population), published quarterly by the Demographic Research Institute in Belgrade.

Table 28

Demographic Data in Yugoslavia*

Demografska Statistika

Savezni Zavod za Statistikum Beograd, 1964

(Federal Institute of Statistics, Belgrade, 1964)

1. Births by viability and sex.
2. Births by age of the mother and by sex (by five-year age groups, by age years up to the age of 34).
3. Live-births by parity.
4. Live-births by the assistance rendered at birth (medical assistance, etc.).
5. Live-births by place of birth (institutions or other places).
6. Live-births by legitimacy.
7. Age-specific live-birth rates.
8. Gross and net reproduction rate.
9. Live-births by age of the mother and by parity.
10. Live-births by age of the mother, by parity, and by the educational attainment of the mother.
11. Number of live-births by parity and by the occupation of the mother and father.
12. Number of live-births by age of the mother and by nationality.
13. Number of live-births by parity and by the nationality of the mother.
14. Number of legitimate births by parity and by the duration of marriage.
15. Number of live-births by the age and occupation of the mother.
16. Number of still-births by age of the mother and by parity.
17. Still-births by age of the father and mother.
18. Still-births by the age and nationality of the mother.
19. Multiple births by age of the mother, by sex and viability.

All data are available by republics too.

*Compiled by the U.N. European Working Group on Social Demography.

YUGOSLAVIA

Interruption of pregnancy*

Decree No. 27 of 11 January 1952, relating to justifiable interruption of pregnancy.** (Službeni list Federativne Narodne Republike Jugoslavije, 19 January 1952, No. 4, pp. 50-51)

1. Interruption of pregnancy shall be authorized in the following cases:

(1) Where, in the light of medical knowledge, it is established that there is no other means of saving the life of a pregnant woman or of preventing serious injury to her health;

(2) Where there is good reason to believe that, owing to an hereditary disease, the child may be born suffering from serious physical or psychic deficiencies;

(3) Where pregnancy is the result of a criminal act, such as: rape (Article 179 of the Penal Code), carnal knowledge of an infirm person (Article 180), carnal knowledge of a minor (Article 181), seduction (Article 185), carnal knowledge procured through misuse of position (Article 182) or incest (Article 198).

In exceptional cases, the interruption of a pregnancy may be authorized where there is good reason to believe that the birth of a child may be injurious to the health of a pregnant woman because her living, personal or family conditions are particularly difficult.

2. A pregnancy may only be interrupted if the pregnant woman concerned agrees.

3. Interruption of a pregnancy may not be authorized or undertaken if more than three months have elapsed since conception, save in the cases specified in Article 1, sub-section 1 of the present Decree.

4. Application for the interruption of a pregnancy shall be submitted by the pregnant woman; in the cases specified in Article 1, sub-sections 1 and 2 of the present Decree the application may also be submitted by the physician in attendance.

5. Applications for the interruption of pregnancy shall be examined, and decisions thereon shall be taken, by a medical board attached to a general hospital or gynaecological clinic.

The board shall comprise three physicians, one of whom shall be a gynaecologist. The chairman, and members of the board and their alternates, shall be nominated at the beginning of each year by the director of the hospital or the head of the gynaecological clinic.

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*Reprinted with permission from the International Digest of Health Legislation, 1952, 4, 450-453; 1961, 12, 619-622.

**Decree made in application of Article 140 of the Yugoslav Penal Code (see p. 449).-ED.

6. The board shall conscientiously and duly examine whether the circumstances of the case justify an authorization for the interruption of pregnancy. To this end, the board may, where it deems it necessary, require the submission of all supporting documents which may supplement those already furnished to it.

Where the case specified in Article 1, sub-section 3 of the present Decree is in question, the board shall take its decision in the light of the statement of the public prosecutor or tribunal concerned, to the effect that proceedings have already been instituted and that there is good reason to believe that a criminal act of the type specified has been committed.

7. The board shall keep minutes of its work. These minutes shall include the date and place at which the pregnant woman was examined, her surname and given names, age, profession, civil status, number of previous births, number of children alive, full address, as well as an opinion as to the period of pregnancy.

Where a case specified in Article 1, sub-section 1 of the present Decree is in question, the reports shall include the medical history of the disease as well as the anamesis and diagnosis, a description of the present state of the disease or morbid condition in question and the gynaecological condition of the patient; in the cases specified in Article 1, sub-section 2 of the present Decree, the reports shall mention the supporting documents which were taken into account when the board made its decision.

The minutes shall include the grounds on which the board made its decision.

The minutes shall be drawn up in duplicate, one of which shall be sent to the director of the hospital (or of the gynaecological clinic) and the other to the gynaecologist who is to carry out the interruption.

8. The decisions of the board shall be taken by simple majority.

Where any member or members of the board expresses a divergent opinion, such an opinion shall be recorded separately in the minutes.

9. As soon as the board has given its authorization, the interruption may be carried out.

Where the board refuses authorization, the pregnant woman may request that a second medical board attached to the Council for Public Health and Social Welfare of the People's Republic concerned re-examine the problem. In such cases, the board shall forward the minutes in question to the second medical board.

The second medical board shall comprise three physicians, one of whom shall be a gynaecologist. The chairman, and the members of the board and their alternates, shall be nominated at the beginning of each year by the President of the Council for Public Health and Social Welfare of the People's Republic concerned.

The decisions of the second medical board shall be final and binding.

10. The minutes of the board and other files shall be kept in the confidential archives of the hospital.

11. The interruption of the pregnancy shall be carried out in a general hospital or in a gynaecological clinic.

When deciding on the appointment of a physician to carry out the interruption, the director of the hospital may take into consideration the choice expressed by the pregnant woman for any particular physician.

Any gynaecologist who, as a member of a board, voted against an authorization being granted may refuse to carry out an interruption.

12. In extremely urgent cases where the life of a woman is endangered or her state of health is such that the decision of the board cannot be awaited, a pregnancy may be interrupted by any physician.

In such circumstances, the interruption may be carried out elsewhere than in the hospital.

In the above-mentioned cases, the physician who has carried out the interruption shall, within three days, submit a report thereon to the medical board of the nearest hospital. The report shall include the information specified in Article 7 of the present Decree, as well as the grounds justifying the urgency of the interruption.

13. An abortion which has already been induced may only be completed by a physician in a hospital.

In areas where there is no hospital, a physician may, in cases of extreme urgency, complete an abortion under suitable conditions.

14. Any physician who shall have completed an abortion elsewhere than in the hospital shall, not later than three days thereafter, inform the Council for Public Health and Social Welfare attached to the People's Council of the locality or municipality concerned.

Where the abortion has been completed in a hospital or in a gynaecological clinic, notification thereof shall be given by the director of the hospital or the head of the gynaecological clinic.

Where, at the time of such an intervention, there is reason to believe that the abortion was induced illegally, the Public Prosecutor concerned shall be informed to this effect.

15. The notification that an abortion has been completed shall include the surname and given names of the patient, her age, profession, full address and the exact stage at which medical treatment was first given and the diagnosis made at that time (imminent, incipient or incomplete abortion, etc.), data relating to the manner in which the abortion was induced and the place at which it was completed.

The notification shall also state whether or not there are grounds for believing that the abortion was induced illegally. If so, it shall be the duty of the Council for Public Health and Social Welfare attached to the People's Council of the locality or municipality concerned to inform the Public Prosecutor thereof.

The notification shall be kept and graded confidential.

16. [Penalties to which physicians are liable if they fail to submit the notifications or reports prescribed in the present Decree]

17. Detailed provisions for the enforcement of the present Decree shall be promulgated by the Council for Public Health and Social Welfare of the Government of the Federative People's Republic of Yugoslavia.

18. [Entry into force]

Decree No. 33 of 16 February 1960 on the conditions and the formalities required for the interruption of pregnancy. (Sluzbeni list Federativne Republike Jugoslavije, 2 March 1960, No. 9, pp. 221-222)

1. The interruption of pregnancy can only be authorized for the cases covered, and according to the formalities prescribed, by the arrangements of the present Decree.

2. The interruption of pregnancy can be authorized with the consent of the pregnant woman:

(1) When it is established medically that no other method can save her life or prevent serious damage to her health during the pregnancy, or during child-birth, or after this;

(2) When the conclusion can be reached on medical grounds that, because of a disease suffered by the parents, the child will be born with grave physical or mental defects;

(3) When the pregnancy has been caused by a criminal act such as: rape (Section 79 of the Penal Code), sexual act with a person unable to resist (Section 180), sexual act with a minor (Section 181), sexual act committed by abuse of official position (Section 182), seduction (Section 185) or incest (Section 188);

(4) When it can be reasonably expected that the pregnant woman will find herself placed, as a result of the birth of the child, in difficult personal, family or material conditions, which cannot be remedied by any other means.

If the conception dates from longer than three months previously, interruption of pregnancy can only be authorized in the cases laid down in points (1) and (2) above.

The interruption of the pregnancy will not be authorized if it involves any risk to the life of the pregnant woman, even if the conditions of points (2)-(4) above are satisfied.

3. The formalities for the authorization of the interruption of pregnancy take place at the request of the pregnant woman.

If the pregnant woman is a minor or unfit to look after her own affairs, the request can also be made by her father or her guardian.

4. Requests for authorization of the interruption of pregnancy are examined by the commissions of first instance and of appeal.

These commissions are set up by the health establishments possessing a properly organized gynaecological service and, in the first place, by the general hospitals, the maternity hospitals, and the gynaecological and obstetric clinics.

The commission of the municipal people's council responsible for questions of public health or the public health commission of the people's council of the territory, for the territory of Kossovo-Metochija, or the Public Health Commission of the Republic, for the People's Republic of Montenegro, decide at which health establishments the commissions mentioned in the proceeding paragraphs must be set up.

5. The formalities carried out at a commission of first instance or of appeal are urgent in character. The commissions must give their decisions within three days of the request being made or, if this is not possible, for valid reasons, at least within a week.

6. The commission of first instance or of appeal (see Section 4) is made up of two physicians and a social worker. One of the physicians must be a specialist in obstetrics and gynaecology.

The members of the commission of first instance and their substitutes are appointed at the beginning of each year by the public health commission of the people's council of the commune in whose jurisdiction the health establishment is located at which the commission has been set up: the members of the commission of appeal and their substitutes are appointed by the public health commission of the people's council of the municipality in whose jurisdiction the establishment is located at which this commission has been set up. In the autonomous territory of Kossovo-Metochija, the members of the commission of appeal and their substitutes are appointed by the public health commission of the people's council of the territory and, in the Republic of Montenegro, by the Public Health Commission of the Republic.

If a sufficient number of persons to constitute a commission of appeal do not exist at the headquarters of the health establishment at which the commission of the first instance has been set up, the commission of appeal will be composed of the members of the commission of first instance and two other members, of whom one must be a specialist in obstetrics and gynaecology.

7. The commission of first instance examines whether the conditions for authorizing the interruption of pregnancy have been satisfied. If the members of the commission have not been informed of facts which justify the request for the authority to interrupt pregnancy, or if these facts cannot be established by the rapid dispatch of the necessary information, the commission must demand that this information be provided with the least possible delay by the person making the request. When the authorization to interrupt pregnancy is requested for the reasons mentioned in point 3 of Section 2 of the present Decree, the commission of first instance takes its decision on the basis of a declaration by the public prosecutor or the competent tribunal, certifying that a prosecution for a criminal act has been brought, and that there are reasons for assuming that one of the criminal acts mentioned has been committed.

If the pregnant woman is a minor or unfit to look after her own affairs, the commission which examines her request for authorization to interrupt pregnancy may, before making its decision, take the advice of her father or guardian.

8. The commission of first instance takes its decisions by majority vote except when one of the physicians belonging to the commission states that there are medical contra-indications.

The decision of the commission of first instance is communicated immediately. When interruption of pregnancy is authorized, the commission gives the order for it to be carried out, which can happen immediately.

If the request is rejected, the commission of first instance must inform the person concerned that a request for the case to be considered by the commission of appeal can be made immediately. The decision of the commission of first instance is communicated verbally; it can also be given in writing, according to the circumstances, if the person making the request is not present.

9. If the person concerned approaches the commission of appeal, this must without delay obtain the report from the commission of first instance, together with the papers relating to the request.

The commission of appeal takes its decisions by a majority vote.

The decision of the commission of appeal is final and is notified in accordance with the arrangements of the preceding Section.

10. The commissions mentioned in Section 4 of the present Decree keep an account of their activities.

In this account, mention is made of the names of the members of the commission, the date on which the decision was taken, the character of this decision together with a concise report, and also the differing views of the members of the commission. Remarks on the notification of the decision will also be made in the account, and it will also be noted whether the person making the request has approached the commission of appeal.

11. Interruption of pregnancy is carried out in health establishments where commissions of first instance exist.

If valid reasons justify carrying out the interruption of pregnancy in another health establishment, or if the establishment at which the commission of first instance exists does not satisfy the required conditions, the pregnant woman shall be sent to another establishment, in principle, the nearest.

12. Interruption of pregnancy can be carried out without waiting for the decision of the commission if there is any immediate danger to the life or health of the pregnant woman.

An abortion already begun can also be completed without waiting for the decision of the commission.

In cases mentioned in the preceding paragraph, the interruption of pregnancy will be carried out or completed in a health establishment; it can only take place outside such an establishment if it is necessary to carry out an urgent medical intervention.

The director of the health establishment or the physician who has carried out or completed the interruption of pregnancy, if this has taken place outside a health establishment, shall send to the commission of first instance a detailed report when the operation has taken place without waiting for its decision. This report must be sent within three days of the date on which the interruption of pregnancy was carried out or completed.

When it is assumed that an abortion already begun constitutes a criminal act, the director of the health establishment or the physician who has completed the interruption of pregnancy, when this has taken place outside a health establishment, will report this fact to the competent public prosecutor.

13. All facts coming to the knowledge of the members of the commission, during the formalities for authorizing an interruption of pregnancy are regarded as professional secrets.

The accounts, together with all the documents relating to the activities of the commission, are regarded as confidential documents of the archives of the health establishment at which the commission is constituted.

14. The commission will warn the pregnant woman, in the prescribed manner, of the harmful effects on her health of the interruption of pregnancy and must inform her of the methods that she can use in the future to prevent pregnancy. For this purpose, the commission will make available to the pregnant woman the necessary information and the recommendations to follow to prevent conception, and will advise her of other health establishments where she can go for advice on this subject.

15. [Costs of the commission]

16. [Penalties]

17. [Arrangements for application]

18. [Repeal of the Decree on the legal interruption of pregnancy[a]]

19. [Entry into force]

Instruction No. 06-1164 of the Secretary of Public Health to the Federal Executive Council of 28 October implementing the Decree of the conditions and formalities for authorizing the interruption of pregnancy. (Službeni list Federativne Narodne Republike Jugoslavije, 28 December 1960, No.52, pp. 962-963)

This Instruction, issued by virtue of Section 17 of the Decree on the conditions and formalities for authorizing the interruption of pregnancy (see supra) gives details of the provisions with regard to the initiation of requests, the work of the commissions, the forms to be filled, etc.

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[a]Decree No. 27 of 11 January 1952 (see Int. Dig. Hlth Leg., 1953, 4, 450).-ED.

FEDERAL ASSEMBLY

RESOLUTION ON FAMILY PLANNING*

At separate sessions of the Federal Chamber and the Chamber of Welfare and Health held on April 25, 1969, the Federal Assembly passed the following Resolution on Family Planning:

It is one of the basic human rights and duties for parents to be able to plan the size of their families and the spacing between births.

For this to be feasible society should make it possible for married couples to get information about modern methods of birth control and provide them with adequate means to plan their families so that they can decide how many children they will have and at what intervals.

The new status of women in society has changed the structure of the family and family relations and has essentially affected the role of women. One of the consequences of these changes is a reduction in both birth rate and infant mortality. The size of families is increasingly coming to be governed by a desire for a more decent life and is part of man's strivings to attain a higher standard of living. Family planning is in the interests of both the parents and society. The creation of conditions under which each birth will mean a wished-for child is of special importance for women, for their psychological integrity, for the creation of conditions of conscious parenthood, and for ensuring healthy children. Family planning, as a lasting human and social effort, will bring about very significant social, health, economic, political and other advantages.

Birth control is still largely exercised by the most primitive method - artificial interruption of pregnancy. Because of this, a method of birth control which enables people to control the laws of biological reproduction and thus eliminate spontaneous and uncontrolled elements in this delicate and vital sphere, is an important aspect of the struggle against artificial interruption of pregnancy, which has a very harmful, sometimes even fatal effect on the health of women.

This calls for an extensive study of family planning and birth control problems, and for a coordination of educational measures and action as a component part of health measures for preventing undesired pregnancies.

The realization of society's views on family planning and birth control, as a means of providing the necessary conditions for the execution of society's policy in this field, calls for an active role and certain obligations on the part of the social services, research institutions, social and other organizations, associations and institutions.

Among the numerous questions of essential importance for the health of women and sound family relations, particular attention should be paid to family planning and birth control problems, especially in view of the following facts:

*The translation of the 1969 Law was courteously provided by the Yugoslav Federal Council on Family Planning. The April 25, 1969, Federal Assembly Resolution on Family Planning was published in English in Yugoslav Survey, 1969, 10(3), 103-106.

(1) A survey of demographic trends shows that birth control and certain forms and methods of family planning are already successfully being used in many areas of Yugoslavia;

(2) Interruption of pregnancy, which is not only a backward and primitive method but also a harmful and dangerous one, is still the most widespread means of birth control, and contraceptive measures are slow in expanding;

(3) Provisions pertaining to pregnancy interruption have been aimed at preventing illegal interruption of pregnancy and at ensuring that abortions are made in hospitals on the basis of health and social indications. These provisions should, however, lay greater stress on health care, the protection of women's mental health, and the protection of interests of the family and society. They should support and lay main stress on the prevention of undesired pregnancy as the principal form of birth control;

(4) Making contraception possible has proved itself to be the most suitable method of family planning

II

Accepting the view that deciding on the number of children and spacing of births through the use of the latest methods of birth control is the right of the parents, it is necessary to point out the principal tasks and duties of the public services, research institutions and other organizations and institutions.

(1) Within the framework of the educational system, special attention should be devoted to preparing young people for a better understanding and humanization of inter-sex relations, for harmonious and responsible material relations and parental duties in the family. Sexual education should become the concern of all educational institutions, due attention being paid to the age and psychophysical development of the pupils. On this basis and according to the level and kind of school relevant curricula should be worked out for regular instruction in all educational institutions. Pertinent programmes should also be drawn up for other environments with considerable concentrations of young people, such as young people doing national service in the Yugoslav People's Army or taking part in youth labour projects, student and youth centres, pre-military training and health courses in the countryside and other village youth organizations, advisory centres for young parents, schools for parents, etc.

Workers' and people's universities should include these problems in their curricula and should spread this knowledge in every way.

Education in this field primarily stems from the need for the humanization of inter-personal relations, respect for the human personality, and the promotion of health. In developing education on inter-sex relations, an important role should be played by the press, radio, television, cinema, lectures, etc.

(2) Health and welfare institutions, and especially general practitioners, should pay particular attention to the systematic spread of information on the use of contraceptive in line with the needs of marital partners. It is particularly

necessary to follow and study new methods of contraception and new contraceptives. In the training of educational, medical and welfare personnel special attention should be devoted to this aspect of birth control and prevention. In the implementation of the views laid down in this Resolution a decisive role will be played by specialized staff trained for the purpose.

(3) Steps should be taken to solve financial problems in this sphere as successfully as possible, relying on health insurance funds, other sources of finance for preventive health care, the funds of unions of education, and other resources, including personal contributions by those concerned. The need for federal allocations will, at the request of a Republic or Autonomous Province, be considered by competent federal agencies, which will, in conformity with general social interests, propose appropriate solutions to the Federal Assembly.

III

(1) The right of parents to decide on the number of children and on spacing between births should primarily be realized through the use of contraceptives. Interruption of pregnancy, as the least desirable form of birth control, is only an extreme means which should be resorted to to enable women to interrupt undesired pregnancy when this has already occurred.

(2) In the event of undesired pregnancy, the health and social services should advise the parents not to interrupt pregnancy, with the explanation that any interruption of pregnancy, even when performed in a health institution, is a surgical intervention which is bound to have certain physical and psychic effects on the health of the woman. This should at the same time be used as an opportunity to advise partners how to prevent undesired pregnancy. If a woman still insists on interrupting pregnancy, abortion will be performed in conformity with medical and other regulations.

(3) In order to promote interest in the use of contraceptives, users of health services should be made to bear part of the costs of medical intervention. In determining their share, the material potentialities of those concerned should be taken into account.

In order to ensure a more humane relation to women in performing abortions in health institutions, it is necessary to simplify the administrative procedure and adjust it to different environments. Because of this federal legislation should only regulate basic principles regarding the conditions under which pregnancy may be legally interrupted.

(4) In view of existing differences in the level of development of the health service, its activity in contraception and its accessibility to marital partners, the general level of health culture, tradition, prejudices etc. in individual Republics and Autonomous Provinces, these matters should be regulated in agreement with relevant social factors in a way which best suits any particular environment. Special attention should be paid to the specific needs of rural areas.

(5) Social action in the field of family planning, especially educational measures and birth control, should, on the basis of scientific information, be coordinated with demographic research, statistical reporting and analyses of relevant indicators in this field, and with other relevant activities.

IV

Taking this stand on family planning and on birth control, the Federal Assembly points out that its realization requires full involvement of educational, welfare and health institutions, socio-political and other organizations and association, administrative agencies and other social factors.

The Federal Executive Council and competent agencies shall attend to the implementation of this Resolution and regularly inform thereon the Federal Assembly.

GENERAL LAW ON THE INTERRUPTION OF PREGNANCY*

(Official Paper SFRY, No. 20/69) - 1969

Article 1.

The interruption of pregnancy as a special medical intervention, can be done in cases and under conditions which are regulated by law.

Article 2.

The interruption of pregnancy can not be done after the period of three months from the day of conception.

Article 3.

The interruption of pregnancy can be done on the approval i.e. on the demand of the pregnant woman:

1. When on the bases of medical indications it is established that in no other way can a life be saved or can one prevent a serious threat to the health of the woman during pregnancy, birth or after birth;

2. When on the bases on scientific research it can be expected, that the child, because of a sickness of the parents, will be born with serious physical and psychological defects;

3. When the cause of conception was an act of the Penal Code: rape (article 179 PC), adultery over a powerless person (article 180 PC), adultery over an under-age person (article 181 PC), adultery done by the misuse of position (article 182 PC), seduction (article 185 PC) or incest (article 198 PC).

The interruption of pregnancy in paragraph 1 point 1 of this article will be done according to medical indications, no matter what time period has passed from the time of conception, while the interruption of pregnancy from paragraphs 2 and 3, point 1 can be done, even though there are more than three months from the time of conception, only under the condition that the interruption of pregnancy will not cause serious damage to the health or that it will not be a direct danger to the life of the pregnant woman.

Article 4.

The interruption of pregnancy will be done on the demand of the woman if during pregnancy and after birth she could fall into serious personal, family, material and other troubles.

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*Translation provided by the Yugoslav Federal Council on Family Planning.

Article 5.

In order to acquaint the woman in time with the consequences which may arise as a result of the interruption of pregnancy and the means which may be applied in the prevention of undesired pregnancy, it is ensured;

1. that social and educational institutions and other organizations which deal with the problems of the security of mother and child, within its duties, acquaint women and youth with the harmful consequences of the interruption of pregnancy and with the advantages of the application of means and methods of contraception;

2. that teaching and educational institutions include in their educational work sexual education and the education of youth;

3. that the health institutions warn the pregnant woman and her partner in marriage that the interruption of pregnancy is harmful to the health of the woman and to acquaint them with the possibilities and methods of preventing undesired pregnancy.

Article 6.

In undergoing an interruption of pregnancy, the skill and the responsibility is secured in that way that the interruption of pregnancy can be done only in medical institutions which in that respect fulfil the conditions as regards the equipment, rooms, skilled and other necessities for the accomplishment of the interruption of pregnancy and the care of the health of the woman after the interruption of pregnancy is accomplished.

The act of the interruption of pregnancy is an urgent one and in it the preservation of an official secret is guaranteed and also the respect of the dignity of personality of the pregnant woman.

Article 7.

The health institution in which the interruption of pregnancy is done or in which an already started interruption of pregnancy has been accomplished is responsible in any case to submit a report about the death of the foetus to the responsible organs within 3 days.

If during the execution of an already begun interruption of pregnancy there arises a justifiable doubt that a penal act is in question, the director of the health institution in which the already begun interruption of pregnancy has been completed is responsible to immediately submit a report to the responsible public prosecutor.

Article 8.

The regulations of articles 3 and 7 are implemented directly.

Article 9.

For passing laws which would regulate the questions which are not regulated by this law, will be applied, in case its regulations are not in opposition to the principles of this law:

1. the regulations of the conditions and the proceedure for the allowance of abortions (Official Paper FPRY, No. 9/60);

2. the guide for the execution of the regulation of the conditions and the procedure for the allowance of abortions (Official Paper FPRY, No. 9/60).

Article 10.

This Law comes into force on the eighth day from the day of it being published in the "Official Paper SFRY."

CHAPTER 9
GERMAN DEMOCRATIC REPUBLIC*

Historical Trends

1. In pre-Hitler Germany contraception was fostered by several gynecologists and clinics established in Berlin and Hamburg. In 1933 the use of contraceptives was prohibited by police decree. Production was terminated.

2. The directives of the Nazi period were abolished immediately after World War II. Contraceptives became available again but major public health emphasis was on increasing the birth rate. In the area of the German Democratic Republic, the birth rate reached its lowest level at 10.4 in 1946. With the number of unmarried women of childbearing age more than double that of men, the number of illegitimate pregnancies rose sharply, often terminated by illegal abortions.

3. As outlined in the section on Abortion Trends, concern for the life and health of women led to a temporary relaxation of strictly medical grounds for abortion. Social indications were accepted as a basis for termination of pregnancy, the first such action in postwar Eastern Europe, preceding liberalization of the Soviet abortion law in 1955. By 1950, however, abortion was again restricted

*Visits in Berlin were coordinated by Prof. Dr. D. Müller-Hegemann, Director of the Griesinger Hospital, and Herr J. Raeck, International Relations Section, GDR Ministry of Health. In Rostock, arrangements were made by Prof. Dr. K. H. Mehlan, Director, Institute for Hygiene, University of Rostock Medical School. Discussions were held in Berlin with Dr. H. Krause, Chief, International Section, GDR Ministry of Health; Dr. K. Höck and the staff of the Hirschgarten Center; Dr. A. Katzenstein, GDR Academy of Science; and Dr. K. Winter and the staff of the Institute of Hygiene, Humbolt University. In Rostock meetings were arranged with university representatives and the staff of the Institute of Hygiene of the Medical School, including Dr. A. Geissler, Dr. H. Lellbach, and Dr. K. Reis.

to medical and eugenic grounds. A more permissive interpretation of the law was not adopted until 1965, a decade after the Soviet action.

4. The pioneer of family planning in the German Democratic Republic is Prof. Dr. K. H. Mehlan, Director of the Institute for Hygiene of the University of Rostock Medical School. He founded the Institute in 1956 and has worked closely with the Ministry of Health and professional and public organizations in fostering family planning. His English-language publications include presentations of public health services in the German Democratic Republic (1963b), current trends in abortion (1968c), and teaching family planning (1969).

5. In May 1963 Professor Mehlan and his colleagues founded the Association for "Ehe und Familie" (Marriage and Family) as a section of the "Gesellschaft für Socialhygenie" (Society for Health Protection), the GDR medical scientific organization. The Association for Marriage and Family is a member of the International Planned Parenthood Federation and will henceforth be referred to as the GDR Family Planning Association. According to Mehlan (1969a), its aims are:

(a) Improving the health of women and mothers which may be endangered by illegal abortions, insufficient birth spacing, too many children, and other conditions.

(b) Securing reproduction of the population by promoting the wish for a child. State interests shall correspond to a healthy and harmonious family.

(c) Educating for marriage and family responsibilities; supporting sex education for youth to reduce the number of early marriages, illegal births, and divorces; promoting the stability of marriage and the family.

(d) Promoting harmony, health, and welfare of the family, including the use of contraception and treatment of sexual disharmonies.

6. In December 1965 the Family Law was passed, requiring the Ministry of Public Health to establish the medical branch of marriage and family counseling, called "marriage and sexual advisory centers." To facilitate international communication, these centers will here be called family planning centers, although their work is more extensive. Legal authorities, national education groups, women's organizations, and public health services joined in developing plans (Mehlan, 1969a).

7. In May 1966 the GDR Ministry of Public Health, in collaboration with the Family Planning Association, promulgated an order establishing family planning

planning centers in all districts of the country. In 1967 the Ministry affirmed the guiding principles for family planning centers evolved by the Family Planning Association; they are now the legal basis for the activities of physicians and all others engaged in family planning. The result has been an integration of family planning into the GDR public health services.

8. Although in recent years the number of women of reproductive age has declined by 25 percent, the number of births has remained constant. The general fertility rate increased from 66.0 in 1957-58 to 90.1 in 1963. The crude birth rate moved from 10.4 in 1946 to 17.2 in 1964, but dropped to 15.8 in 1966 and to 14.8 in 1967.

9. The GDR policy on family planning is well delineated in a speech given by the Vice Ministry for Health, Prof. Dr. L. Mecklinger (1968) at the October 1967 Rostock Conference. It is further summarized in the following points:

(a) Family planning is perceived as a task of the total society and is integrated with public health services, especially for protection of mother and child.

(b) Every woman has the right to determine when she prefers to give birth. That is not a right for abortion, but a right for access to contraceptives.

(c) Each family has the right to determine the number of children it desires to have.

(d) There is no pressure for births.

(e) The woman has the biological possibility to reproduce but not the duty.

(f) Each individual has the right to receive information about prevention of pregnancy.

(g) Every married couple has the right to use contraceptives and to select the preferred choice.

(h) All physicians have the duty to counsel married couples and unmarried individuals and to prescribe contraceptives.

(i) Preference is for families with two to three children, in contrast to families with no, only one child, or many children.

Abortion Policy Trends

1. To reduce the number of illegal abortions in the aftermath of World War II, restrictions in the abortion law were temporarily relaxed in 1947 to include

social indications as well as medical and eugenic grounds (Mehlan, 1961b). By 1950 induced abortions had increased to 26,000. While the number of illegitimate abortions was not believed to have been sharply reduced, deaths due to complications were significantly lower.

2. The liberal temporary rules of 1947 were rescinded at the end of 1950. Along with Albania's laws, the abortion statutes of the German Democratic Republic became the strictest among the socialist countries of Central and Eastern Europe. The incidence of induced abortion was reduced from one abortion per one live birth in 1947 to one abortion per three live births in 1954 (Mehlan, 1970).

3. During the years 1959-1964, about 750 legal abortions were performed annually, an annual rate of less than 0.5 per 100 live births, the lowest abortion rate in Eastern Europe (Mehlan, 1970). Despite the restrictions on abortions, the birth rate remained relatively stable, going from 16.9 per 1,000 population in 1950 to 17.2 in 1964 (Table 2). One reason was the decline by 25 percent during much of this period of the number of women of childbearing age in the population. Another reason was the sharp rise in illegal abortions, which were estimated to terminate one in every four pregnancies (Mehlan, 1965b).

4. In March 1965 permissive instructions were added to the Law of 1950. Abortion is authorized when there exists a serious danger that the physical and mental health of the woman will be impaired by the pregnancy, delivery, or child care, considering all the facts of the "life situation" for the mother and the expected child. Pregnant women considered especially endangered are those over 40 years or under age 16, those with five or more living children, or rapid succession of pregnancies, or with intrauterine damage to the embryo, or victims of rape.

5. A pregnant woman may address her request for abortion to a district commission, which must reply within 14 days. The commission usually consists of the medical head of the district health services or his medical deputy (chairman), the head of the gynecological department in the district hospital serving the area in which the pregnant woman resides or a designated deputy who must be a gynecologist, a specialist in obstetrics-gynecology appointed by the district physician, a social worker, and a representative of the local woman's organization. If a request is denied, the woman may appeal to a regional commission.

6. Pregnancies are terminated by gynecologists in hospitals. There is no charge. Every aborted woman is required to report soon afterwards to a family planning center for contraceptive counseling; home visits are made to encourage compliance (Lellbach, 1968).

7. The more liberal interpretation of the law raised the rate of legal abortions to about 6.1 per 100 births in 1965-67. With the more extensive propaganda for contraception, there appears to be a decline in the abortion rate in 1968. Abortions have increased faster than births in the age groups up to 21 years, among the unmarried, among women with one child or none, and in larger towns (Mehlan, 1970).

Illegal Abortions

1. Investigations in 1963 yielded an estimate of about 60-80,000 illegal abortions per year, mostly self-induced.

2. The 1969 incidence of illegal abortions is believed to be lower.

Family Allowances

1. Monthly family allowances are provided under the Law of 27 September 1950, with subsequent amendments dated 28 May 1958 and 3 May 1967. Allowances are generally small, beginning with about $15.00 for the fourth child (60 MDN has more purchasing power than its $15.00 exchange value).

2. Lump sum payments are made as indicated in Table 29.

Contraceptive Methods and Practices

1. Traditional devices freely purchasable at low cost include condoms, diaphragms, Tutus Cream, Nova Gel, and suppositories.

2. Ovosiston, an oral contraceptive manufactured in the GDR, is available on prescription. It was estimated in 1968 that 13 percent of all married women

Table 29

Lump Sum Payments for Children in the German Democratic Republic 1969

Children	MDN*	Dollars
First Child	500	125
Second Child	600	150
Third Child	700	175
Fourth Child	850	212
Fifth Child	1,000	250
Each Subsequent Child	1,000	250

* Based on Exchange Rate of 4 MDN per dollar

Note: MDN are also known as East Marks

age 15 to 49 are regularly taking pills. Ovosiston and other pills are available from gynecologists in clinics, hospitals, and family planning centers if there are no medical contraindications.

3. A one-month supply of 21 pills costs about $0.85 at the official exchange rate. There is no charge for women with five or more children.

4. To counteract opposition to oral contraceptives and promote systematic care of advice-seeking clients, the Family Planning Association in cooperation with the Ministry of Public Health prepared and distributed a leaflet on the use of Ovosiston.

5. IUDs have been available since 1965. Their use is being gradually extended through the Family Planning Center network. Dana IUDs are imported from Czechoslovakia. The cost is $2.50. Lippes loops are used in research studies. Plans are being developed for producing loops in the GDR.

6. The staff of the Rostock Family Planning Center suggests that Ovosiston is preferred by younger, occupationally active, and higher educated women. Initial studies show that the use of oral contraceptives increases libidinal energies.

7. Coitus interruptus continues as the most commonly used contraceptive method, especially among rural and less educated individuals. Condoms are widely available and are the second most frequent method of birth prevention. The use of diaphragms is decreasing while oral contraceptives and loops are increasing in acceptance.

Family Planning Centers

1. In the German Democratic Republic, family planning is one of the services provided by marriage and sexual guidance centers (Aresin & Aresin, 1969). Separate marriage and sexual advisory centers were established in the immediate postwar years, e.g., from 1949 at the Leipzig University Gynecological Clinic. The Family Law of 1966 made the organization of family advisory centers the responsibility of the state.

2. As of 1969 there were approximately 200 family planning centers or about one per 50,000 inhabitants. In accordance with their comprehensive goals, these centers are staffed by full- or part-time physicians, psychologists, and social workers with consultants available from other specialties, including gynecology and psychiatry. Not all centers are fully staffed and some are open for only limited time periods during the week. The GDR Ministry of Health provides a budget for the payment of staff and maintenance. All methods of contraception, including pills and coils, are available. No charges are made for services rendered. The number of family planning centers is expected to reach 300 by about 1970.

3. The tasks assigned to the family planning centers are, according to Mehlan (1969a):

(a) Education toward family living and promotion of positive attitude toward children.

(b) Family planning counseling and advice in contraception, birth spacing, regulation of date of pregnancy and the number of children.

(c) Counseling and therapy in the case of sexual disturbances.

(d) Support for the sexual education of youth.

(e) Treatment of medically caused disturbances in marriage.

(f) Prevention of illegal and legal abortion by supplying contraceptive advice and by taking women into dispensary care.

4. A more extensive presentation of family planning center activities will be found in German-language publications by Dolberg and Geissler (1966, 1968).

Medical and Postgraduate Training

1. As early as 1931, Dr. Edward F. Stöckel, Professor of Gynecology in Berlin discussed prevention of pregnancy as an objective of clinical training in the German Journal of Gynecology. He related contraception to demography and health, and characterized prevention of pregnancy as "responsibility of the physician toward the community" (Mehlan, 1969a).

2. Hitler's emphasis on large families eliminated contraception from the medical curriculum. More than two decades after World War II family planning is of

limited interest to many German gynecologists. Contraceptive methods were seldom mentioned in German texts on gynecology until 1967. This resistance to family planning is slowly changing.

3. A 1967 survey indicated that contraceptive techniques were incorporated into the curriculum of all lectures in gynecology for three hours during the fifth (next to the last) year of medical school. Some departments of public health and preventive medicine provided theoretical background in family planning (Mehlan, 1969a). In 1969 family planning became a mandatory topic requiring about 30 hours in all GDR medical schools.

4. Since 1961 the Institute of Hygiene of the University of Rostock Medical School offers a training program of about 80 hours in family planning for medical students. It is well described in English in Mehlan (1969a).

5. Since 1965 the Family Planning Association has organized annual "Rostock Postgraduate Training Courses in Problems of Family Planning," open to medical and paramedical personnel. Length is usually three to five days. The first and fourth courses were for medical specialists working in family planning centers, the second was for midwives and social workers, and the third for general practitioners.

6. The Association also organizes training courses for the GDR Academy of Continuing Medical Education to qualify physicians in the specialty of family planning.

Sex Education in the Schools

1. Sex education is being integrated into primary and secondary school curricula; information on contraception is included.

2. Teachers in secondary schools receive special instructions for classes in sex education. The youth magazine New Life regularly provides information.

3. Several excellent texts have been produced, including Brückner (1968) and Weber & Weber (1968).

4. In 1967 the Scientific Council of the Ministry of Education established a research group on sex education.

Public Education

1. Until 1963 public discussions of sex were considered taboo; now the subject is popular.

2. Members of the Family Planning Association and the Family Planning Center staff use all public media for propagating family planning information plus offering discussion groups, lectures, and individual consultation to all segments of the population.

3. A Committee for Family Planning was recently established in the Ministry of Health to promote family planning "as a preventive measure of socialist health protection." The Minister of Health chairs the committee.

Research Notes

1. Social research studies, conducted in the postwar decade, including the years 1947-1950 when restrictions on induced abortion were temporarily relaxed, have been summarized in German by Mehlan (1961b,c).

2. Current research in contraceptive technology focuses on refinement of Ovosiston pills. A newer, lower dosage pill is 2mg of chlormadinone acetate and 0.08mg of mestranol. Several preparations are in development, including sequential pills and an anticonception injection.

3. Prof. Dr. R. Rennert at the University Psychiatric Clinic in Halle is conducting interview surveys of the sexual behavior of university students. Prof. Dr. Grassel is studying non-university students.

4. Prof. Dr. Lykke Aresin, Director of the Family Planning Center at the University Women's Clinic in Leipsig, is engaged in studies of sex behavior, ovulation and sexuality, and functional sexual disorders.

5. At Rostock, Dr. H. Lellbach is exploring the dynamics of repeated abortions. A preliminary presentation by Dr. Lellbach (1968) reports on the difficulty of reaching such women and persuading them to use modern contraceptives. Research with Dana and Lippes loops is conducted by Dr. Neumann.

6. Also at Rostock, Dr. Karin Reis (1968) has developed group procedures for counseling with pregnant women, designed to prevent illegal abortion.

7. A study of infertility and subfertility in 500 Rostock couples, stratified by duration of marriage and number of children, is directed by Alfred Geissler (1969). Interview data and psychological test results will become available in 1970. Topics covered include reproductive history, attitudes, and behavior related to family planning, socioeconomic and sociocultural conditions, marital adaptation, attitudes to children, parenthood, family and society, etc.

Research Centers

1. Institute for Social Hygiene, University of Rostock
   Director: Prof. Dr. K. H. Mehlan

2. University Gynecological Clinic, Karl Marx University, Leipzig
   Directors: Prof. Dr. N. Aresin and Prof. Dr. L. Aresin

3. Institute for Social Hygiene, Humbolt University, Berlin
   Director: Prof. Dr. K. Winter

Reported Population Statistics

1. Abortions are not reported in the Statistical Yearbook.

2. Cogent data from the 1968 Statistical Yearbook are presented in Table 30. Additional tables are available on birth order and births according to marital status, length of marriage, time of previous childbirth, and mother's occupation.

Table 30

Demographic Data from the German Democratic Republic*

Table	Topic
2	Population for the GDR
54	Marriages, divorces, live and still births, 1966 and 1967
58	Marriages, births and deaths, 1966
70	Marriages, live births, deaths per 1,000 population; also infant mortality
77	Marriages, live and still births, and deaths according to months, 1966
96	Divorces according to age groups and sex
100	Live births
103	Still births
104	Births, live and still, according to age of mother
105	Age specific fertility rates
107	Cumulative fertility rates

* Compiled from the 1968 Statistical Yearbook

GERMAN DEMOCRATIC REPUBLIC

Law of 22 September 1950*

Protection of the mother and the child

Law of 22 September 1950, relating to the protection of mothers and children and the rights of women.** (Geselzblatt der Deutschen Demokratischen Republik, 1 October 1950, No. 111, pp. 1037-1041)

Part I

STATE ASSISTANCE FOR MOTHERS AND CHILDREN

1-2. [Allowances for large families]

3. [Education and maintenance of children solely supported by the mother]

4. For the protection of children and the radical improvement of medical care for children, there shall be established during the period 1951-1955:

1. Fifteen policlinics for children in large towns and industrial centres;

2. Paediatric departments with a total of 1,000 beds in new hospitals at present under construction;

3. Homes for infants with a total of 60,000 places.

5. (1) In order to enable women to participate in socially useful work, to work in the administrative departments of the central and communai authorities, and to pursue political and cultural activities both in urban and rural areas, there shall be established during the next five years:

1. Crèches with a total of 40,000 places, for which the sum of 40 million marks is made available.

2. Day nurseries with a total of 160,000 places.

(2) In the establishment of day nurseries and crèches, special regard will be had for the needs of working women in rural areas.

*Reprinted with permission from the International Digest of Health Legislation, 1952, 4, 58-60.

**Only certain provisions of Part I relating to public health have been reproduced here. Parts II-IV deal with marriage and the family, working women, the protection of their work and the participation of women in public and social activities. Part V contains concluding provisions.-ED

6. (1) The Government of the German Democratic Republic and the governments of the Länder shall, during the period 1951-1955, open, in addition to those already existing, a further 190 maternal and child health clinics so that there will normally be in each district [Kreis] not less than 3 such clinics.

(2) The functions of these clinics shall be as follows:

(1) registration of all pregnant women;

(2) continuous medical care of pregnant women;

(3) health education of pregnant women;

(4) the giving of general advice on social and legal questions;

(5) medical care of nursing mothers;

(6) medical observation of the health and development of infants up to their third year.

(3) [Financing of such clinics]

7. (1) For the recuperation of pregnant women with poor health, there shall be established before 1st May 1952, by the Ministry of Labour and Public Health, convalescent homes with a total of 2,000 places.

(2) The standard supplementary rations for pregnant women shall be doubled from the sixth month of pregnancy onwards and those for nursing mothers throughout the whole period until the child is weaned, provided that such period does not exceed one year.

8. In order to provide nursing care for lying-in women, there shall be established:

1. in large towns and industrial centres, 10 model maternity homes each with from 60-100 beds; and

2. in already existing hospitals, new maternity departments with a total of 2,000 beds.

9. The German Republic attaches extreme importance to the protection of the health of mothers and children. The government of the German Democratic Republic and the governments of the Länder shall therefore devote special attention to the construction and functioning of maternal and child health clinics, maternity homes, crèches, day nurseries and nurseries.

10. [Maternity leave]

11. (1) In order to protect the health of women and to make for an increase in the number of births, the artificial interruption of pregnancy shall only be made where the life or health of the pregnant woman would be seriously endangered if she carried the child to full term or where one of the parents suffers from a serious hereditary disease. The interruption of pregnancy for any other reason is forbidden and will be punished by imprisonment.

(2) A pregnancy may only be interrupted on the permission of a commission composed of physicians, representatives of the public health services and of the League of Democratic Women. The members of this commission shall maintain professional secrecy and any offences in this connexion will be punished by imprisonment.

(3) The interruption of pregnancy may only be made by specialists in hospitals.

(4) The relevant detailed regulations will be decreed by the Ministry for Labour and Public Health in agreement with the Ministry of Justice.

Announcement of Instructions for Application of Paragraph 11 of the Law for the Protection of Mother and Child and the Rights of Women 22 October 1964 (VuM No. 23/24)*

The work to date of the regional and district commissions for interruption of pregnancy reflect considerable conscientiousness of the basic principles and directions contained in the instructions of 15 March 1965 for the application of Paragraph 11 of the Law of 27 September 1950 regarding the protection of Mother and Child and the Rights of Women.

There are, however, several indications that Paragraph 11 of the above law is not applied in all cases with due consideration of the essential scientific interpretation. This fact is especially noteworthy because the Instructions were not accompanied with a new legal conceptualization nor an extension of Paragraph 11. The goal was--as already mentioned in the Preamble to the Instructions--to assure consistent application of the Law.

Publication of the Instructions provides an occasion to familiarize with the text of these instructions not only the appointed members of the commissions for the interruption of pregnancy but also physicians serving as experts and co-workers in the counseling centers for pregnant women.

Instructions for the Application of Paragraph 11 of the Law for the Protection of Mother and Child and the Rights of Women of 27 September 1951 (with supplement of 5 June 1965)

It is stated in Paragraph 11 of the Law for the Protection of Mother and Child and the Rights of Women of 27 September 1950 that an artificial interruption of pregnancy is permitted only when the carrying to term of the child seriously endangers the life or health of the pregnant woman or when one of the parents is the carrier of a serious hereditary disease.

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*Translation by H. P. David from text provided by K. H. Mehlan

The objective of this legal regulation is, within a framework of promoting an increase in the number of births, to safeguard the life and health of the pregnant woman and to contribute to the assurance of healthy development of the children. An evaluation of approved applications for interruption of pregnancy in the German Democratic Republic in the last years shows clearly that the regional and district commissions for the interruption of pregnancy applied different measures regarding the recognition and judgment of medical indications and that more than occasionally injury to health was inflicted through too narrowly determined judgments.

To provide a basis for a scientifically sound medical indication it is essential, according to the experience of modern medical science, to base recognition of medical indication not only on the somatic complaints as advanced by the pregnant woman but also to make a prognostic determination of how pregnancy, care, and education of the infant will effect the physical and mental health of the applicant within her total life situation. To assure uniform measures in the consideration of requests for interruption of pregnancy according to Paragraph 11 of the Law, the Ministry of Public Health decrees the following instructions:

1. Permission for interruption of pregnancy is granted, with the exception of the reasons cited in No. 2,

a) when a diagnosis based on medical examination and a prognosis considering the total life situation of the pregnant woman lead to the expectation of a danger to her life or a serious threat to her physical and mental health as the result of carrying the pregnancy to term or through the burdens of child care. Justification for approval exists also
b) when the pregnant woman is in her fortieth year or older,
c) when the pregnant woman is younger than 16 years,
d) for a pregnant woman who has four children within the average time space of less than 15 months between each delivery and whose current pregnancy began no less than six months after the previous pregnancy,
e) for a pregnant woman, who alone or with her husband has legal responsibility for five or more children living in the family,
f) for a pregnant woman who became pregnant as the result of a criminal act. and
g) when it can be expected with great certainty that the children will be mentally ill or will suffer from other serious abnormalities.

2. Justification for approval of pregnancy interruption, except in those cases in which it can be determined with reasonable certitude that the carrying to term of the pregnancy endangers the life of the pregnant woman, does not exist when the pregnancy is of more than 12 weeks' duration, when a previous pregnancy was interrupted within the preceding six months, when as a result of the pregnancy interruption it can be expected with reasonable certitude that an existing illness will be exacerbated, and when, according to the pregnant woman, the pregnancy is the result of a criminal act but when after investigation of the complaint no preliminary proceedings are initiated by the state attorney or other investigatory bodies.

The Commission has the duty, in cases of requests for interruption of the first pregnancy, to explain clearly to the woman making the request, that sterility can follow interruption of pregnancy.

3. Each pregnancy interruption requires the decision of the pertinent commission. Excepted are only such individual cases which as medical emergencies are inevitable and unforeseeable.

4. The request for interruption of pregnancy, using the specified request form (No. 6812 VLV Dresden), will be made by the pregnant woman, through the counseling center for pregnant women located in the area of her residence, to the public health authorities of the district. In the case of minors or those adult pregnant women who have a legal guardian, approval or request from the legal guardian are required. The request for pregnancy interruption must be accompanied by a statement from the counseling center for pregnant women serving the area in which the pregnant woman resides, and in which a judgment is made on the reasons cited by the applicant and pertinent information provided about her previous pregnancies, condition of health, life situation, etc.

Every physician treating a pregnant woman has the obligation, if deemed in the interest of the pregnant woman, as described in the guidelines for the activities of counseling centers for pregnant women of 1 August 1964 (VuM No. 17/1964, p. 125), to advise the pregnant woman regarding the appropriate legal decrees concerning artificial interruption of pregnancy. On that occasion the pregnant woman is also to be informed about the potential risk connected with pregnancy interruption. At the same time physicians should encourage close cooperation with the counseling center to be established in each region for the systematic solution of problems of ethical sex education, marital life, promotion of the desire for a child, removal of sexual- and fertility disorders, pregnancy prevention, and the fight against criminal abortions.

5. The decision regarding approval of a pregnancy interruption is to be made by the district committee for pregnancy interruption, serving the area in which the pregnant woman resides, on the basis of thorough medical examination, including review of the findings of already available examinations and expert opinions as well as careful review of the life situation of the pregnant woman. The results of such examinations and reviews are to be recorded in written form.

The woman making the request is to be given an opportunity to present her request orally to the commission. This procedure may be waived when it is apparent from the request that the indications mentioned in paragraph 1, b through e, are applicable. Waiver may also occur when, on the basis of the request, the commission chairman reaches the conclusion that the commission will probably approve interruption.

The decision on the request must be made within at most 14 days from the day the request arrives at the district public health service office. The decision is determined by a majority vote of the commission members. Registration of the decision of the District Committee is recorded on the formal request form for interruption of pregnancy (Request Form No. 6812 VLV Dresden).

Reasons and arguments which motivated commission members to reach a contrary opinion are to be fully recorded in the minutes of the meeting.

6. The members of the District Commission for Pregnancy Interruption are appointed by the head of the district public health services and are to be confirmed by the Regional Physician. Members of the District Commission for Pregnancy Interruption are: the medical head of the district public health service or a medical deputy designated by him (serving as chairman); the head of the obstetrical-gynecological department of the district hospital serving the area in which the pregnant woman resides or a specialist in obstetrics-gynecology named by him as deputy; a medical specialist appointed by the head of the district public health

service who can give expert testimony on the health of the pregnant woman and its potential negative influence on the expected child; a social worker experienced in the area of maternal and child health; the district chairman of the League of Democratic Women or a regular representative named by her with the consent of the head of the district physician.

The physician treating the pregnant woman has the opportunity to participate in the deliberations of the district commission and to explain the request for pregnancy interruption. When the woman making the request wishes that her request also be presented by a member of the appropriate women's board, this wish is to be honored.

7. If a request for the interruption of pregnancy is refused, the woman making the request can lodge an appeal within at most 8 days to the regional office of public health and social welfare.

The decision on appeal is to be made by the Commission for Pregnancy Interruption established by the regional office of public health and social welfare on the basis of the total case file. If necessary, additional medical examinations and reviews of the pregnant woman's life situation are to be conducted as soon as possible, to be recorded as expert opinions in written form. The decision on the appeal has to be made within no more than 8 days from the day of its receipt in the regional office of public health and social welfare. The decision is determined by majority vote of the commission members. The decision of the Regional Commission for Pregnancy Interruption is final.

8. The members of the Regional Commission for Pregnancy Interruption are appointed by the Regional Physician and are to be confirmed by the Ministry of Public Health. Members of the Regional Commission for Pregnancy Interruption are: the Regional Physician or a medical deputy named by him (as chairman); the head of the obstetrical-gynecological department of the regional hospital or a specialist in obstetrics-gynecology named by him as deputy; a specialist in obstetrics-gynecology appointed by the Regional Physician to examine the illness seriously affecting the health condition of the pregnant woman and/or that of the expected child; a social worker from the Section Mother and Child of the Regional Office of Public Health and Social Welfare; the regional chairman of the League of Democratic Women or a regular representative named by her with the consent of the Regional Physician.

The physician treating the pregnant woman has the opportunity to participate in the deliberations of the regional commission and to explain the request for pregnancy interruption. When the woman making the request wishes that her request also be presented by a member of the appropriate women's board, this wish is to be honored.

9. The execution of a pregnancy interruption is to be conducted exclusively in the obstetrical-gynecological departments of a facility under the jurisdiction of the Ministry of Public Health, as determined by the regional physician, and the obstetrical-gynecological facilities of the State Secretary for Higher Education, by physicians specializing in obstetrics-gynecology or by a physician in training to be an obstetrician-gynecologist specialist functioning under the personal direction of the head of the faculty. Responsible for the prompt but proper execution of pregnancy interruption, after approval by the district or regional commission for pregnancy interruption, is the head of the obstetrical-gynecological department of the district hospital serving the area where the pregnant woman resides.

The pregnancy interruptions approved by the district commissions are in general to be performed in the obstetrical-gynecological facilities within their jurisdictions. The pregnancy interruptions approved by the regional commissions are, as a rule, to be performed in the facility serving the area where the pregnant woman resides. However, the regional commission can transfer the execution of the pregnancy interruption to other facilities.

10. Work on the request for pregnancy interruption is without cost to the woman making the request. The appropriate social insurance is responsible for the treatment and care required in connection with the pregnancy interruption.

11. After the execution of the pregnancy interruption, supplementary Form A to the Request for Pregnancy Interruption--approved requests (No. 6813 VLV Dresden)--is to be forwarded together with the request for pregnancy interruption (No. 6812 VLV Dresden), at the latest seven weeks after the completed interruption, and after a postoperative examination by a medical specialist, to the agency responsible for public health service in the district. Supplementary Form A is to be signed by the head of the obstetrical-gynecological department of the district hospital serving the area in which the pregnant woman lives.

12. When a request for pregnancy interruption is disapproved, the counseling center for pregnant women serving the area in which the pregnant woman resides is to be informed and assumes responsibility for especially solicitious care. After the pregnancy has been carried to term, Supplementary Form B to the Request for Pregnancy Interruption--refused requests (No. 6814 VLV Dresden)--is to be forwarded by the head of the counseling center for pregnant women as soon as possible to the agency responsible for public health service in the district.

13. The district representative of the regional office for public health and social welfare is to report quarterly to the Ministry of Public Health about the decided requests for pregnancy interruption, about the outcome of the approved pregnancy interruptions, as well as the outcome of pregnancies whose interruption was refused. The quarterly district reports are to be made on April 1, July 1, October 1, and January 1, while the regional reports are to be made on April 15, July 15, October 15, and January 15.

14. In view of the importance of continued promotion of the wish to have a child, a goal-oriented ethical sex education, marital counseling, removal of sexual- and fertility disorders, birth spacing as well as a guarantee of consistent procedures for the approval of pregnancy interruption through district and regional commissions, the Ministry of Public Health will establish a commission whose members are to be appointed by the Minister of Public Health. Members shall include the Deputy Minister for Health Protection and Hygiene (as chairman); two professors of obstetrics and gynecology; one professor of social hygiene; one professor of neurology and psychiatry; a regional physician; the head physician of the obstetrical-gynecological department of a regional hospital; the head of a district public health service; the head physician of an obstetrical-gynecological department of a district hospital; a medical specialist for obstetrics-gynecology whose responsibilities are primarily with ambulatory patients; a representative of the Board of the League of Democratic Women; a representative of the Attorney General's office; a representative of the Demographic Division of the Central Board of Statistics; a social worker member of a district commission for pregnancy interruption; and a secretary.

CHAPTER 10
ALBANIA*

Available information on Albania is sparse. Although the sources cited are believed to be accurate, there was no opportunity to check data directly with Albanian colleagues.

Albanian Notes

1. There is little doubt that Albania has the highest birth rate in Europe. United Nations reports show a birth rate of 44.5 per 1,000 population in 1955, gradually declining to 34.0 in 1967, and then rising again to 35.6 in 1968.

2. The World Health Organization (1968) reports that Albania in 1964 had a population of 1.8 million, a birth rate of 37.8 per 1,000 population, an infant mortality rate of 81.5 per 1,000 live births, and 2,300 inhabitants per physician.

3. Albania has the most restrictive legislation on abortion in Eastern Europe. Termination of pregnancy is prohibited except on narrowly defined medical conditions.

4. Modern contraceptives are neither produced nor imported. Little is known about contraceptive practice. Moslem traditions are believed to be strong in most of the country. There is no family planning movement.

5. Article 17 of the Constitution of the People's Republic of Albania states, "The State gives special protection to the interests of mother and child by securing the right for paid leave before and after childbirth and by setting up homes for expectant mothers and homes for bringing up and sheltering children." Little is known about implementation.

6. There was no representation from Albania at the World Population Conference in Belgrade in 1965. The roster of the International Union for the Scientific Study of Population does not list any member from Albania.

7. Vukovich (1969) noted that the level and pattern of fertility in Albania differ considerably from the rest of Europe, showing more similarity with the developing countries of North Africa. "The fertility of Albania seems to be rather constant and only a slight decrease could be observed during the past few years, mostly in ages 15-19 and 30-34, which may be due to the slow tendency of postponement of marriages because of schooling and to the fact that family planning had probably started to gain some ground."

CHAPTER 11
CONCLUDING OBSERVATIONS*

It is difficult to distill the mass of accumulated information from readings and interviews into a single set of conclusions. Dissemination of modern contraceptives is still too recent and too limited in most of the countries to assess longer term impact on changing contraceptive practices. Within these confines, the following observations are offered as tentative conclusions, open to revision as more definitive data are reported. Topics adequately summarized in the Overview will not be repeated here.

1. As emphasized throughout the monograph, Central and Eastern Europe do not constitute a homogeneous entity. Each country has a distinctive level of social, economic, and cultural development, with more or less strong ties to Western European traditions. Spurred by industrialization, massive migrations have shifted the rural-urban balance in several countries. A higher standard of living is widely sought. Many women have attained career positions equal to men. While ideology has at times influenced legislation related to abortion and family allowances, government actions appear to have been more effective over the longer term when attuned to the popular desire for a smaller family than when attempting to reverse population trends.

2. Population policies per se are not readily delineated. None of the Central and Eastern European countries has an avowed policy aimed at restricting population growth. None pays bonuses to married women who remain non-pregnant or to "finders" bringing women to clinics for coil insertion. Some governments permitting family limitation through liberal abortion legislation may also attempt to encourage family growth by improving family allowances and providing additional child-care facilities. Others may permit allowances to stagnate far below rising wage levels or restrict payments to low income families. Measures favoring

*It is suggested that reference be made to the Overview for additional summary statements.

the family have been promulgated everywhere. A few countries impose a special tax on childless adults, single or married; none levies assessments on families with, say, five or more children. Implementation of abortion legislation varies, preserving governmental capability of making administrative adjustments in response to perceived demographic or other needs. Interpretations of Marxist-Leninist views on population policy, as delineated in the Overview, reflect an evolving pattern, increasingly attuned to international as well as national trends. Technical assistance in family planning is rendered to developing countries.

3. Available statistics suggest that most families in the region wish to avoid having many children and do engage in family planning and child spacing, whether by traditional or modern methods of contraception, by legal or illegal abortion, or both. The desire for fewer children appears to be especially prevalent among better educated, working women, living in cities with limited housing and child-care facilities. Their income is often essential to attain a better socioeconomic-cultural standard of living for the family. And, the example set by these women appears to be spreading through the urban population and increasingly into rural areas.

4. The extent to which a woman has a legal right to determine the fate of her pregnancy is differently interpreted in the different countries. Only in Hungary and the Soviet Union is abortion available on request during the first twelve weeks of pregnancy, provided the woman had no previous abortion during the immediately preceding six months. Czechoslovakia, Poland, Yugoslavia, and, to a degree, Bulgaria tend to be permissive in authorizing abortion if the pregnant woman persists in her request. Romania has moved toward more restrictive legislation but is still more liberal than many Western European countries. The German Democratic Republic has added more liberal instructions to a restrictive law. Only Albania limits abortion to strictly medical reasons.

5. In the opinion of some observers, the availability of legal abortion has sharply lowered the incidence of illegal abortions and the associated threat to the health and welfare of women (Mehlan, 1966b). Statistics are not, however, completely reliable. The incidence of "spontaneous" abortions has risen at a greater than normally expected rate in some countries. Even where abortions are available on demand, certain women prefer to conceal their pregnancies and seek out "private practitioners." When complications occur, illegally induced abortions

may be registered in the hospital as "spontaneous." Estimation of induced abortion becomes a special problem of fertility surveys (Acsadi, Klinger, & Szabady, 1969).

6. Mortality associated with legal abortion induced in the first trimester of pregnancy has fallen to such low levels that the risk is less than that of carrying a pregnancy to term. The proportion of women who experience any complication is not directly available but is estimated to be less than 3 percent (Tietze, 1969c). International comparisons are rendered difficult by the absence of generally accepted definitions of what constitutes complications. Much needed are studies of the frequency of early and late complications experienced with different methods of abortion and different periods of gestations in women of good health . Tietze (1969d) concludes that in terms of the risk to life, the most rational procedure for regulating fertility is the use of a perfectly safe, although not 100 percent effective, method of contraception combined with the termination of pregnancies resulting from contraceptive failure.

7. The relationship between abortion and birth rates is more complex than it appears. Women resort to abortion in different ways and with a differing frequency in the separate countries. Assessment is rendered difficult by the many intervening variables, including the changing demographic context over time (age-sex structure, age at marriage, rural-urban migration, emigration, etc.), shifting contraceptive practices resulting from the introduction of the pill and the coil, the continuing conservative attitude of the medical profession, and varying socioeconomic-cultural motivational/behavioral influences.

8. Tietze (1969b) has noted that abortion rates are usually computed per 1,000 population per year or per 1,000 women of childbearing age per year. Abortion ratios may be computed per 1,000 pregnancies or per 1,000 live births. The primary effect of abortion, whether legal or illegal, induced or spontaneous, is that it increases the potential number of pregnancies in a given woman in the sense that a woman who aborts is capable of becoming pregnant again much earlier than a woman who carries her pregnancy to term. In the absence of contraception, two or three abortions may be required to replace one live birth but, with successful contraception plus low pregnancy rate, only slightly more than one abortion is required to replace one live birth. Thus, to evaluate the relative impact of abortion and contraception, it is necessary to estimate the number of

pregnancies which would occur in the absence of contraception. The interrelationship between abortion and contraception remains to be further explored.

9. Scott (1965) also observed that liberalization of the abortion laws produces an increase in the gross pregnancy rate. This rate indicates the number of female children that would be conceived by 100 women during their reproductive lives if a given set of age-specific pregnancy rates remain in effect. In calculating the gross pregnancy rate, it was assumed that the distribution of abortions by age of the women having them would be the same as the distribution for live births. With the shift from illegal to legal abortions, the expected pattern was noted in Hungary. The gross pregnancy rate rose from 146 in 1950 to 224 in 1963. Similar patterns were observed in the other countries of Central and Eastern Europe except Poland. An increase in the number of abortions can be expected to produce a rise in the pregnancy rate, if the level of contraceptive practice remains low or unchanged, because of the difference in size of the "risk" population. However, improvement in contraceptive practice and effectiveness would significantly reduce such "risk."

10. Induced abortion and contraception are often viewed as alternatives. It would be preferable to regard them as complementing elements in total fertility control. As noted by Moore (1969) there are several possible life patterns which the individual woman may follow: (a) no contraception and no abortion, (b) regular contraceptive practice and acceptance of accidental pregnancies, (c) regular contraceptive practice with abortion used to terminate accidental pregnancies, (d) initial use of contraception with subsequent reliance on abortion, (e) one or more abortions with subsequent reliance on contraception, and (f) continuous reliance on abortion alone. Known relationships between abortion and contraception are by no means well established. Further research is needed to clarify understanding of their interaction.

11. Klinger (1969b) attempts to demonstrate the role of induced abortions in birth control by citing Hungarian data on the number of pregnancies during a woman's reproductive life. By knowing how many conceptions ended in live births and how many in induced abortions, it is possible to obtain a ratio of abortions to wanted births. If Hungarian women during their entire reproductive life (15 to 49 years) interrupted pregnancies or were delivered of a child at the same rate as in 1967, they would bear an average of two children, while having

0.5 spontaneous abortions and 2.6 induced abortions. This means that Hungarian women, according to Klinger's calculations, would have an average of 5.1 pregnancies, half of which they would interrupt by induced abortion. Applying biological and historical studies of natural fertility, Hungarian women would be expected to have about 6.5 pregnancies during their reproductive years if no conception control were used. Based on actual Hungarian figures of 5.1 pregnancies and 2.0 births, only about 20 percent of possible pregnancies are prevented by contraceptive practice, while more than half of recorded pregnancies are terminated by induced abortion. Viewed in the historical perspective of Hungarian birth rates, Klinger's findings are less dramatic, suggesting rather that legalization of abortion has shifted abortion from previously illegal into legal channels, a conclusion shared by Peel and Potts (1969).

12. Potter (1963) reasons that in a non-contracepting population the average time involved in induced abortion is 9 months; for a live birth it is 21 months (30 months where lactation is involved). Under these conditions, 100 induced abortions account for 900 months of marriage duration, during which 43 or 30 live births (900/21 months or 900/30 months, respectively), might have occurred. Thus 100 abortions are needed to avert 43 or 30 live births (roughly two to one or three to one). When combined with effective contraception, an induced abortion becomes more nearly equivalent to averting a live birth. Assuming 90 percent effectiveness of the contraception, mean length of ovulating exposure is increased to 50 months. One hundred induced abortions now require 5,400 months of marriage duration, equivalent to 81.8 live births where there is no lactation (5,400/66 months) and 72 births where lactation (5,400/75 months) is prolonged (Moore, 1969).

13. There appears to be a general consensus that the legalization of induced abortion has had an effect on fertility as evidenced by declining birth rates (Table 2). Specific relationships between contraceptive practice and legally induced abortion are less clear. In countries where "natural" techniques of contraception are widely practiced, permissive abortion laws may contribute more to a diminution of the effective practice of contraception than to a significant reduction in birth rate below the level already obtained by contraception (Frederiksen & Brackett, 1968). In Bulgaria, for example, the birth rate continued to decline at about the same rate as before despite rising abortion rate following liberal legislation (Tables 1 and 2). Comments on other countries follow in items 14 through 18.

14. In countries with initially higher birth rates, e.g., the Soviet Union and Yugoslavia, the decline in birth rate following abortion legislation was less immediate and slower. The reason may be the great diversity of subgroups as noted, for example, in the vast differences in regional birth rates.

15. Liberalization of abortion laws in 1956 speeded the decline in the Romanian birth rate. The drop was more rapid and steeper than in Hungary. The estimated rate of abortions per 1,000 population rose to become the world's highest. The October 1966 restrictive legislation, coupled with major increases in family allowances, taxes on childless adults, and halting of official importation of pills and coils produced a dramatic rise in the birth rate. However, comparison of monthly figures for 1967-1969 suggests that the peak may have been passed. Romanians appear to have adjusted to the new law, primarily through resort to traditional contraceptive methods and clandestine purchase of modern contraceptives. Estimates of illegal abortion are unreliable.

16. The German Democratic Republic offers another case of governmental policy reversal but the effects of the shift to a tighter abortion policy in 1950 are clouded by the considerable emigration of women of childbearing age. Not enough data have been published to assess the more liberal 1965 interpretations. The abortion rate is relatively low.

17. The country with the longest government-supported family planning campaign, Poland, also is the only one with a declining birth rate and a gradual drop in the total number of abortions (which peaked in 1962). The abortion ratio per 100 live births has risen from 33 in 1962 to 42 in 1967. There are maternity counseling centers throughout the country and contraceptives are low in cost, but general availability of supplies is erratic. Polish abortion statistics are distorted by numerous visitors from abroad while birth rates refer only to residents. Poland is perhaps the most catholic country in the region, but this factor does not appear relevant to contraceptive practice.

18. Czechoslovakia is an example of a lag in the effect of modern contraceptive practice on the abortion rate. While the rate continues to rise, stocks of Czech-produced pills are mounting in warehouses. Interested gynecologists are unable to handle the numerous requests for required examinations which must be completed before pills can be prescribed or coils fitted.

19. Moore (1969) speculates on "why" some women may prefer the "risk" of abortion to regular contraceptive practice. Except for sterilization and the intrauterine device, no other birth-prevention technique is a one-event operation. Abortion is coitus-independent, is 100 percent effective under the proper circumstances, and does not require the knowledge or consent of the sexual partner. It is not based on the probabilities of prevention, but on the certainty of a recognized pregnancy. It is the only method to avert a birth which may have been desired at the time of conception but which, for whatever reasons, may no longer be wanted. Compared with mechanical and chemical means of contraception, abortion is technically simple. It appears particularly important to initiate studies of repeated abortion-seeking behavior, especially in circumstances where modern methods of effective conception control are readily available and accessible. It would also be desirable to compare abortion knowledge with contraception knowledge, and how attitudes vary with level of knowledge.

20. The extent to which large segments of women depend on abortion or contraception may be determined as much by availability as by individual preference. Among the socialist countries of Central and Eastern Europe, Romania was especially conspicuous for the availability of abortion and the difficulty of access to imported modern contraceptives. In Albania, where neither abortion nor contraceptives are available, the birth rate is the highest in Europe.

21. The experience of Poland and certain regions of Yugoslavia suggests that concerted family planning programs can result in decreased birth rates while also reducing the number of abortions. A changeover from reliance on abortion to dependence on contraception does seem feasible, but this development is in need of much more intensive study. Such a process would appear consistent with Requena's (1969) model of the three stages through which a society must pass from (a) no birth prevention, through (b) primary reliance on abortion, to (c) major dependence on contraception. However, it will still be necessary to have abortions as a backstop for contraceptive failure, cases of rape or incest, or the emergence of critical health, social, or economic problems after conception has occurred. In most of the socialist countries of Central and Eastern Europe, permission to terminate a pregnancy is automatic in instances of proven contraceptive failure, e.g., with IUD in situ.

22. The economic costs of legally induced abortions have not been well documented. Comparative data are needed on the costs of pregnancy tests and hospital

bed-days, payments to medical and paramedical personnel, production days lost by the woman, etc. One difficulty of recommending induced abortion for developing countries is the scarcity of medical manpower and facilities. One possible solution is to train midwives to terminate pregnancies, as well as deliver babies, preferably on a day-care basis with ready access to prompt medical assistance when needed. Comparable studies might well be initiated in such countries as Japan and the United Kingdom.

23. Attitudes toward contraception and contraceptive practices are being increasingly surveyed in Eastern Europe, especially in Czechoslovakia, Hungary, and Yugoslavia. Coitus interruptus remains the most widely practiced method of conception limitation, with younger couples favoring more modern contraceptive techniques. In terms of the number of women of childbearing age in the countries studied, the use of pills and coils is still very limited, e.g., about 4 percent in Hungary and 5 percent in Czechoslovakia. Bureaucratic requirements for physical examinations and systematic follow-up checks tend to stifle initiative, especially when abortion is readily available.

24. Wider use of the pill is encountering opposition from women concerned about possible side effects. Public media are more oriented to complications, especially in the face of lagging endorsements of contraception by medical practitioners. Networks of contraceptive consultation centers are, however, being greatly expanded in an effort to make modern contraceptives more widely accessible. The desirability of preventing conception rather than terminating pregnancy is often expressed, but the support given to family planning education differs widely within and among the countries of Central and Eastern Europe.

25. The 1968 Annual Report of the Rockefeller Foundation, summarizing the experience of the past few years in population research, suggests that "the oral pill and the IUD, while far superior in many respects to contraceptive methods available previously, have serious drawbacks that limit their effectiveness.... We are faced with the danger that within a few years these two 'modern' methods, for which such high hopes have been held, will in fact turn out to be impracticable on a mass scale.... It is clear that major improvements in contraceptive methodology are required.... First-rate research is today well below the level needed to bring about major developments in reproductive biology." In the light of this authoritative assessment of the current state of contraceptive technology

and the long time span between research and clinical application, legally permitted induced abortion gains further importance as a complementary method of family limitation, especially for those segments of the population which do not accept modern contraception or fail to use it efficiently.

26. There is little or no evidence that the abortion laws of Central and Eastern Europe have led any significant proportion of the population to be sexually irresponsible or that they have in any way undermined the basis of family life. In reducing the number of unwanted children, they may well have contributed to the health and welfare of established families (Potts, 1967). There are some suggestions that for many people traditional values have been replaced by a "morality of events." Among the younger generation there seems to be a more cynical view of the world, less interest in politics, and a drive for earlier gratification of personal wants. It remains to be seen how these changes will be reflected in future family formations and dissolutions.

27. With varied intensity and support, public health campaigns endeavor to substitute contraception for abortion. Motivation for family planning is fostered in several countries through open discussion of human sexuality, beginning in the early school years. Special efforts are made in the gynecological hospitals to reach women just before and after abortion, and in the immediate postpartum period. Family planning centers are developing especially rapidly in the German Democratic Republic, Poland, and Yugoslavia. Each of these countries has family planning associations affiliated with the International Planned Parenthood Federation.

28. The impression prevails that the medical profession is the single most resistant group to implementing methods of family limitation. In some countries, gynecologists derive an income from abortion and have no compensating economic gain from prescribing pills or inserting coils. In other nations the philosophical arguments against abortion persist with strong efforts made to persuade women not to terminate. While medical congresses have repeatedly passed resolutions endorsing the principle of family planning and contraception, individual practitioners have frequently resisted implementation, most likely for personal reasons. Discussion of human sexuality and its ramifications in family planning appears personally distasteful to numerous physicians. Some oppose abortion,

others reject modern contraception. Medical school lectures on contraception are recent phenomena and are seldom accorded more than a few hours. Rarely are the urgency and importance of family planning or the broader significance of population matters conveyed to medical or paramedical students. Only one medical school in the region has established a research institute on family planning. It is directed by a physician whose training is in public health, not in gynecology.

29. Little, if any, empirical research has been conducted about the attitudes of physicians and paramedical personnel to family planning and abortion-seeking behavior. Studies of individuals of varied ages and years of experience might well be illuminating in terms of the multiplier effect of the attitudes of such "gatekeepers." Such a study is in the planning stage in Yugoslavia.

30. Awareness of socioeconomic factors in family size limitation is particularly apparent in the changing role of women. Active encouragement of women to participate in the labor force has been shown to have negative effect on reproduction. The need for the wife's income, coupled with inadequate housing, is a frequently expressed reason for requesting abortion. Little is known, however, about the emotional conflict of subordinating family and sex roles to professional responsibilities, the effect on the husband of changing masculine values or psychological acceptance of the woman as an equal partner, or the relationship of family size to a woman's role in society.

31. In the economically developed countries it is primarily the decision of the parents which determines the number of children and thus family size. This decision evolves from a complex of interrelated factors with economic, social, psychological, legal, and ideological components. As recognized by Acsadi, Klinger, & Szabady (1969), under such circumstances conventional methods of demographic measurement, i.e., vital statistics and fertility data from population censuses, are no longer sufficient. The Hungarian demographers have demonstrated the importance of studying the concept of the ideal number of children a woman wishes to have, actual family plans, and knowledge and practice of fertility limitation. Also recognized are the special problems of obtaining valid and reliable information in such personal areas of human life, particularly if the objective of international comparability of data is to be achieved.

32. Following the pioneering Hungarian studies, there is growing interest in coordinated national surveys of family planning practices. Significant contributions have been made by the Committee on Comparative Studies of Fertility and Family Planning of the International Union for the Scientific Study of Population, by the United Nations Population Commission, by the Working Group on Social Demography organized within the European Social Development Program, and by the Division of Social Affairs of the United Nations Office at Geneva (United Nations, 1968, 1969). The Research Committee on Family Planning Trends of the International Planned Parenthood Federation (IPPF, 1969) has also been a major stimulant.

33. In discussions with Central and Eastern European colleagues, considerable interest was expressed in collaborative research on psychosocial components of family planning behavior and abortions (David & Russo, 1969; David, Szabady et al., 1970). Possibilities for cost sharing exist in several countries. Joint studies could be developed to explore a range of topics including: (a) psychosocial aspects of abortion-seeking behavior; (b) characteristics of women resorting to multiple abortions in preference to modern contraceptive devices as methods of limiting family size; (c) differences, if any, between repeaters and non-repeaters in resorting to abortion; (d) characteristics of women whose requests for abortion have been denied, whether they do or do not give birth to unwanted children, and the psychosocial effects of these births on the mothers, the children, siblings, and society over time; (e) methodological problems of obtaining appropriate control groups to study the outcome of pregnancy, authorized versus rejected requests for abortion, and "wanted" versus "unwanted" children; (f) overt and covert attitudes of medical students and physicians of varied ages to family planning in general and in their own families; (g) determinants in the choice of contraceptives or shifts from one method to another; (h) conflicts about acceptance or rejection of contraception; (i) socioeconomic, cultural, personal, and other factors in decisions to limit family size by wife, husband, or both, and at what stage of the marriage; (j) psychological effects of different methods of limiting family size; (k) longer term effects of sex education in the schools at various ages, public education, and other programs to disseminate family planning information; (l) impact of changes in sex behavior and "the new morality" on family life; (m) development of guidelines for counseling the population at risk, etc. Techniques and tools for appropriate psychosocial studies are sparse and need to be further developed. Another objective of such studies

would be to strengthen operational programs in family planning by improving currently available information on contraceptive practice, testing hypotheses related to family planning behavior, enhancing family planning education in diverse cultures, etc.

34. While some existing research resources are mentioned in this monograph, a more specific inventory or index of already available data, interested personnel, and other resources remains to be compiled. At this time of growing concern about population problems and abortion law reform, systematic analysis of experience gained in the developed countries of Central and Eastern Europe, as well as Northern Europe, appears particularly useful.

35. Throughout the world, the dynamics of family planning have proved to be far more complex than the processes of reducing mortality. Freedom to determine the size and spacing of one's family is proclaimed a fundamental human right by men and women of diverse persuasions, including Americans who are petitioning their state governments for liberalization of abortion legislation. Differences in ideology should not deter utilization of experience abroad or joining with colleagues in other lands in studying social and behavioral components of all aspects of family planning, including abortion. Learning from diverse successes and failures is certain to enhance progress toward joint solutions of one of the most urgent problems facing mankind.

PART III: RESOURCES

CHAPTER 12

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Chapter 13

REPORT ON THE ACTIVITY OF THE DEMOGRAPHIC RESEARCH INSTITUTE Budapest, Hungary, 1966-68*

REPORT ON THE ACTIVITY OF THE DEMOGRAPHIC RESEARCH INSTITUTE OF THE CENTRAL STATISTICAL OFFICE IN 1966-1968

In order to concentrate all research activities the Demographic Research Institute was concerned with six main research topics in the last three years period of 1966-1968. Based on earlier research it continued to study the basic population processes, it extended research on population projections, on socio-demographic and economico-demographic problems, started biodemographic research and dealt also with historical demography.

In the period under review, the Institute dealt, on the average, with 30 research topics every year. Most of these studies last, of course, several years, in many cases they constitute a constant and continuous TASK.

It should further be considered that the importance, labour intensity and costs of these studies are highly different. For instance, an analysis of the demographic aspects of social mobility, lasting several years, is just one topic as a study requiring much less research work and much less costs.

I. Research by topics

1. Study of the basic population processes Fertility, family planning, birth control

As a continuation and extension of earlier studies in 1965-1966 the Institute surveyed 0,5 percent of the women in the reproductive age to reveal

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the demographic, social and economic factors affecting the attitude of Hungarian Women towards fertility, family planning and birth control. This study plays an important role in working out the scientific basis of the population policy in Hungary.

The study concerning the family plans of married couples, based on a continuous survey of 5 percent of the marriages contracted in 1966, belongs also to these studies.

Two studies were started to reveal the efficiency of the up-to-date methods of contraction and the demographic composition of women applying them: one of them was performed with regard to intrauterine devices at gynaecological clinics in 1966, the other with regard to oral tablets at gynaecological dispensaries in 1967.

The study of the use of the maternity allowance, introcued in 1967, is intended to reveal the effect of this highly important measure of population policy. The first results are already published by the Institute.

The regional analysis of fertility trends in the countries of Eastern Europe by counties is a research conducted in co-operation with the Population Center of the Princeton University; it forms an important part of the international series of studies covering Europe.

Mortality

A comprehensive study is going on concerning the mortality differences of the Hungarian population. It is concerned with the differences in mortality by age, socio-economic conditions and causes of death, with special regard to infant mortality.

As part of life table computations life tables were constructed--for the first time in Hungary--for all countries of Hungary.

Life tables by causes of death were also contructed by the Institute on the basis of 9 selected causes of death.

Parallel with the research on fertility history, there started also--with similar methods and similar objectives--the regional analysis of mortality trends in the countries of Eastern Europe.

2. Research on Social Demography

One of the central problems of the research work of the Institute was the social stratafication and mobility in Hungary in the last decades. One of the most voluminous works of the plan period under review was the processing and analysis of the data of about 16,000 persons interviewed in the course of the series of studies in 1962-1964. The material published so far gives a manysided survey of the inter- and intrageneration mobility, of the mobility of migrations, marriages and the educational level of the population of Budapest and the towns and evaluates the interrelations between mobility and the different demographic factors such as fertility, marriages, divorces and migration.

The study of the interrelations between school attainment and qualifications has been closed.

The study concerning the impact of demographic factors on culture covered all branches of culture.

Research is going on with regard to the demographic characteristics and attitudes of the different social strata and groups. In this context mention should be made of the studies on the position of persons cared for in social welfare institutes and on the social causes and factors of alcoholism.

To assess the objective and subjective housing needs of the families the dwelling conditions of the population were studied.

Though the number and proportion of the nationalities in Hungary are rather insignificant, beside their different vital statistics and different demographic structure studies of this type were also necessitated by practical needs.

3. Research on Economic Demography

The analysis of the relations and interactions between the economic development and demographic factors played an important part in the research programme for 1966-1968. The most important result was the drawing up to the method of the so-called "economic age pyramids." The Institute dealt also with the impact of the reproduction of the population on the reproduction of the economic phenomena and began to study the economic losses due to mortality by causes of death, drawing up the method of economic life tables by causes of death.

Research was also continued as to how the up-to-date methods of mathematico-statistics and economico-mathematics can be used to study the interactions between the economic and demographic development. In this field successful attempts were made to analyse the economic and social factors affecting the fertility of the Hungarian population by means of correlation and regression computations. Though only the first steps have been made so far, mention should be made of the model experiments used in order to approximate the function expressing the demographic sttitude of the population The attempt to formulate the initial assumptions of a new population projection model in a methematical way should also be mentioned.

4. Biodemographic Research

This new branch of Hungarian demographic research deals with the biometrical and physiological status and changes of the population by comparing them with the demographic characteristics of the characteristical age groups and occupational groups of the population.

The biologic study of those who applied for admission to universities and institutions of higher education was ended with a comparative analysis of the first year students of the academic years 1940/41, 1941/42 and 1945/46.

Significant results were attained in the study of the demographic conditions, physical development and health of those who applied for admission to apprentice training in 1966, 1967 and 1968.

In the course of the demogenetic and population-genetic study of endogamous populations (research on isolated areas), about 40,000 marriages, contracted since the middle of the 18th century and the tendencies in the choice of mate were studied in 25 settlements, then immune-biological studies were conducted in 25 settlements in co-operation with the Anthropological Institute of the University of Mainz.

5. Population Projections

The projection of the number and composition of the population is one of the most important practical tasks of the Institute. The refinement of the methods of projection and on this basis the preparation of new variants is a constant and continuous part of the research programme.

The computer-programme of the projections was also finished and on this basis Hungary's population number was projected till 2000. Work has also started to draw up the computer-programme for the projection of Hungary's population by marital status.

The regional projections of the Institute have given considerable assistance to planning work.

6. Historical demographic research

The voluminous work of discovering, processing and evaluating demographic

sources has been going on for years. One of the main tasks is to reconstruct the time series of the main vital statistics by localities since 1828.

A study was prepared concerning the demographic aspects of the development of the Hungarian school of descriptive statistics. An annotated bibliography about the sources of Hungarian historical demography after World War II was also compiled (in English). The Institute has also published the proceedings of the historical demographic colloquium held in Budapest in 1965 (in French).

Furthermore, the Institute dealt with the history of the Hungarian life table computations as well as with the computations of historical life tables for the years 1822-1828, based on mortality estimates from archival sources.

As a part of palaeodemographic research on the history of human mortality the sex and age of the skeletal finds of the 10th-11th century cemetery of the village of Majs were determined.

7. Research on Regional Demography

Attempts were made to clarify some definition problems such as the criteria of towns and villages, the level of development of settlements, the problems of their classification.

An overall analysis was prepared by the Institute about the regional development of the demographic conditions and the characteristical tendencies of urbanisation in Hungary.

In 1967 an extensive survey was conducted with regard to 200 inhabited places in outskirts (hamlets) of settlements to asses the changes in the number and composition of the population living in such places, and to evaluate their future intentions and their supply with public utilities.

On the basis of a special proassing of the data of the population census of 1960 the Institute published a rich collection of data about the demographic,

occupational and family statistics of the settlements by size (population number) categories.

8. Other Activities

The Institute takes part in the work of different committees created to prepare the 15 year perspective plan. A study was prepared concerning the evaluation of the population of Hungary.

The teaching of demography started at the "Karl Marx" University of Economics in 1966, then at the Faculties of Political Science and Law of other universities. The detailed programme of teaching was prepared by the Institute, staff members of the Institute take also part in the teaching.

Furthermore, the Institute took part in the organisation and work of the Statistical Scientific Conference and Itinerary Session on Statistical History, held in 1967, on the occasion of the centennary of the Hungarian official statistical service.

II. Organisation, Publications and Relations of the Institute

1. Organisation, staff, budget

The Institute comprises two sections--the Section for Methodological Questions and for General Demography as well as the Section for Social and Economic Demography--; besides, it includes the editorial board of "Demografia", the Library and the Financial Section.

In the last years the Research Group has become centre of demographic research in Hungary. The scope of its research activities has widened, the importance of its work has increased; it has attained international reputation. Taking into consideration all this, in accordance with the Board of the Section

for Economics and Political Sciences IX of the Hungarian Academy of Sciences the President of the Central Statistical Office ordered to change the name "Research Group for Population Studies" into "Demographic Research Institute" as from January 1, 1968.

According to the suggestion put forward and approved when establishing the Research Group for Population Studies, the final number of the staff members was fixed in 25 for 1965; as against this, in 1955 the number of the staff members of the Group was only 12. The work could be performed only by employing part-time workers. With the increase of the staff as from January 1, 1967, the most urgent problems are solved.

In the years under review the proportions of the personal expenditures were 74, 79 and 69 percent respectively. During 3 years 211 thousand Forints were spent all in all on the increase of the fixed funds, of which 65 thousand Forints were spent on the development of the Library.

2. Publishing

The results of research are regularly published in the series of publications of the Institute and in the population scientific review "Demografia."

The volumes of the series "Publications of the Demographic Research Institute" appear, generally, in 300-500 copies; the volumes of international interest are supplemented with a separate booklet containing an English or Russian summary.

Besides methodological and analytical papers the Institute also publishes voluminous data collections or publications of a data source character. This two-type character of the publications manifests themselves in their form, too. The papers and methodical materials appear in the form of small books easy to handle, while the analyses containing many tables, mainly of a statistical character, are published in greater format. (See the titles of the Volumes published in 1966-1968 under "Publications of the Demographic Research Institute" on page ...-...).

The editing of "Demografia", entering now the 11th year of its publication, is performed by the Institute. The editing of the jubilee volume containing papers by prominent foreign-demographers, published on the occasion of the 10th anniversary of the review in the last year, was similarly performed by the Institute. The volume "World Views of Population Problems" published in English by the Publishing House of the Hungarian Academy of Sciences in 1968 contains 35 papers of 34 foreign and 5 Hungarian authors (See the content of the volume in No. 2, 1968 of "Demografia" on pages 303-304.)

In 1966-1968 the staff members of the Institute published 22 papers and communications in the "Demografia" and 84 ones in other reviews: of them 31 were published in foreign languages, in different publications and foreign reviews.

It was a recognition of Hungarian population science that the textbook "Introduction to Demography" was published in Polish in 1967.

The popularizing booklet entitled "The Population of the World," published in 17,000 copies in the series "Miniature books" of the Publishing House "Kossuth," served the popularization of demography.

The Institute organized a show of its publications at the exhibition of the Hungarian Academy of Science held at the International Fair of Budapest, in 1968.

3. Relations of the Institute

1. Demographic Committee

Not only is the Institute executor of the working plans approved and suggested by the Demographic Committee but it also actively takes part in the work of the Committee. The director of the Institute is vice-chairman of the Committee and four staff members of the Institute are members of the Committee. The Institute takes part in the direction of the working parties, in

developing their working programmes, in organising their sessions, in discussing different topics.

2. External relations, cooperation, practical relations

The external relations of the Institute have two directions. The Institute contributes to the demographic research of different organs or gives professional assistance to them. Beside the fulfilment of its own research programme, the Institute performs direct research work for several organs to meet their practical needs or co-operates in the fulfilment of such tasks.

Many staff members of the Institute are members of the Hungarian Economic Society; they represent the Institute in the Society for Urbanistics, in the Committee for Anthropology of the Hungarian Academy of Sciences, in the Hungarian Society for Biology, in the "Loránd Eötvös" Society for Physics.

A new form of practical relations is the Demographic Group established within the framework of the Society for the Dissemination of Knowledge, in the direction and work of which the Institute participates actively.

3. International Relations

In the period under review the international relations of the Institute have developed further.

The studies listed below were performed in international co-operation:

a) A European comparative study of fertility, family planning, birth control, in co-operation with the International Planned Parenthood Federation.
b) Regional analysis of the fertility and mortality patterns in the countries of Eastern Europe in co-operation with the Population Center of the Princeton University.
c) Research on isolated areas and studies concerning endogamy within the framework of studies of biology under the International Biologic Programme directed by UNESCO.

d) Human genetic study of the isolated area of Bodrogkoz in co-operation with the Institute for Anthropology of the University of Mainz.

In 1966-1968 the director and staff-members of the Institute took part in the work of conferences, congresses, seminars etc. held abroad in 58 cases all in all.

The Director of the Institute and six of its staff members are members of the International Union for the Scientific Study of Population.

Within the framework of the technical assistance programme of UN the staff members of the Institute acted abroad as UN experts on four occasions.

During 3 years the Institute received about 50 foreign demographer guests who partly delivered lectures, partly studied the organisation and work of the Institute.

THE THREE YEAR RESEARCH PLAN (1969-1971) OF THE DEMOGRAPHIC RESEARCH INSTITUTE OF THE CENTRAL STATISTICAL OFFICE

Below a brief summary of the main research topics is given and the planned new studies are reviewed in more detail. Two major topics requiring further development will be dealt with separately.

The results of a complex study of fertility, family planning and birth control will serve as a good basis to take population policy measures. The longitudinal study of the marrying persons will give information about their family plans, the realization of their housing plans and the changes in their social status. The studies in the efficiency of up-to-date birth control methods will contribute to the wide use of these methods and will thereby promote the decrease of the number of abortions. The continuous observation of the use of the maternity allowance will make it possible to evaluate the impact of this important population policy measure.

As far as research on mortality is concerned, the Institute plans to study infant mortality in more detail, with special regard to the problems of perinatal mortality and early births. The construction of life tables by causes of death and occupations will offer new possibilities to study mortality.

In the research field of social demography, social mobility, changes in the family structure, causes of divorce, oldaged persons, some deviant social attitudes, for instance, alcoholism and suicide are traditional research topics of the Institute. New surveys in these fields are destined to give a picture of their changes.

The well-known process of ageing of the population and its social and economic consequences make it especially timely to survey the demographic composition, state of health and social position of the old-aged (persons above retiring age) at the national level. The results of this survey, to be performed with the application of methods developed in the course of cross-national studies, will make it possible to perform international comparisons on a wide basis.

To become a widow means, in general, a radical change in the way of life. The planned new study intends to determine the demographic composition of the women who lost their husband in the two years before the survey and aims to reveal how the widows accommodate themselves to the change in their life caused by the death of their husband and what role social security benefits play in shaping their new life.

With regard to juveniles, exposed to the danger of delinquency one of the planned two studies intends to measure the frequency, way and character of endangerment by using the reports and informations made at the social groups of the councils, while the other aims to reveal the crimes committed at the expense of juveniles or committed by juveniles, their motives and their demographic and social background by using the documents of the judicial authorities.

Great emphasis will be laid by the Institute on studies concerning economic demography. Studies in the relations between population and economic phenomena,

especially in the economic causes and consequences of the population phenomena are highly important not only for the analysis of the past development and present state of our planned economy but also for the extension and methodological improvement of our economic planning. By using the methods applied to the construction of economic age-pyramids further studies will be carried out to reveal the economic importance of the number and composition (by age and other criteria) of the population. In the framework of these studies the following topics will also be investigated; economic lonest due to mortality; the distribution of these lones according to causes of death the costs of the elimination of certain causes of death and their economic consequences; the prices of one year of the average length of life expressed in terms of working time, in value produced, in the value of consumption, in the value added; the demographic factors of labour productivity and consumption efficiency and; further development of the method of economico-demographic forecasts.

The Institute plans to make further studies concerning the application of up-to-date mathematical, statistical and economico-mathematical methods, by using, above all, correlation and regression computations and matrix computations: the former will help to analyse the economic and social causes of population growth, the last will be used in model experiments to determine the state functions expressing the demographic attitude of the population.

In the first three year plan the basic aim of biodemographic research is to supply information on the biologic conditions of all important age groups of the population and on their changes with advancing age. The longitudinal demographic and developmental biologic study of industrial apprentices will be an important research for manpower management and planning; this study will be carried out partly through the yearly observation of those who applied for admission to apprentice training in 1966, partly by starting a new series of studies.

Another important research in this field will be the demographic and population genetical study of the endogemous populations. The study of the isolated area of Bodrogköz will be continued, while the elaboration of the results of the study in the isolated area of Ivád will be ended.

One of the most important fields of demographic research is the projection of the number and composition of the population. On the basis of the results of the population census of 1970 the projections will be reviewed and new, partial projections (projections of families, households,etc.) will be made. Additional studies will be carried out to prepare mechanical programmes for the automatization of the projections.

The most important topics of the studies in regional demography will be the following: regional differences and factors of fertility and mortality, demographic and economic factors of internal migration; demographic causes and consequences of urbanization; demographic characteristics of urban agglomerations.

As far as research on historical demography is concerned, the reconstruction of the major data of vital statistics by communes, retrospectively for 150 years, will be the most important task (a work lasting 10 years). The reconstruction of the composition of Hungarian families in the 18th century, by using representative methods, will be a new project.

Palaeodemographic research on the mortality, length of life and demographic structure in the Middle Ages intends to treat the skeletal finds of the 10-11th century cemetery of the village Majs.

Methodical research is closely connected with the different research topics. The topics of a purely methodical character will also be discussed at the respective groups of topics.

New research topics requiring further development

1. Study of the public opinion on pupulation problems

By interviewing about 2000-3000 persons the Institute intends to take a sample survey in 1969 to state: how far the Hungarian public is informed about the timely population problems, what views it holds about the development of

the number of births, about family planning and some population policy measures. The 1969 public opinion poll on population problems will be the first stage of a new public opinion research on population problems. Later on - possibly in 1971 - by repeating the study, it will be possible to register the changes in the opinions on population problems.

2. Computations concerning the economies alness of education (by the demographic structure of the population)

On the basis of these computations studies will be carried out to determine the size of the educational investments by level of education and by the demographic compositione, occupation and residence of the population. A closely related research topic will be the study of the utilisation of qualifications. The synthesis of these studies will be the analysis and international comparisons of the development and importance of the volume of intellectual resources by different strata of the population.

Reserch carried out by international co-operation

1. Comparative study of fertility, family planning and birth control in Europe in co-operation with the International Planned Parenthood Federation.

2. Regional analysis of fertility and mortality patterns in the countries of Eastern Europe, within the framework of a study covering Europe as a whole, in co-operation with the Office of Population Research, Princeton University.

3. In the field of developmental biologic studies research on isolated areas and studies of endogamy under the International Biological Programme of UNESCO.

4. Human genetic study of the population of the isolated area of Bodrogkoz in co-operation with the Institute for Anthropology in Mainz.

RESEARCH TOPICS

1. Fertility, family planning, birth control

1.1 Fertility, family planning and birth control attitude of Hungarian women

1969. In the frame work of an international comparison, a further detailed analysis of the (0.5 percent) sample survey of 1965.

1970. New survey based on the population census of 1970.

1971. Analysis of the survey of 1970.

1.2 Longitudinal study of the marrying persons (based on a 5 percent sample)

1969. Survey of the realization of the family plans and housing plans and of the changes in the socio-economic position of those who married in 1966.

1970. Comparative assessment of the results of the surveys of 1966 and 1969.

1971. Execution of the third survey.

1.3 Study (continuous) of the spread and efficiency of the up-to-date methods of birth control as well as of the demographic structure of the women applying them

1.3.1 Intrauterine contraceptives.

1.3.2 Oral contraceptive tablets.

1.4 Utilization of the maternity allowance and its expected impact on fertility trends. (Continuous.)

1.5 Regional analysis of fertility trends in the countries of Eastern Europe (retrospectively for about 100 years).

1969. Further data collections with regard to administrative units smaller than counties.

1970. Evaluation of the results (indices of overall fertility, computations of indices of correlation and dependence between indices of fertility, and other demographic and socio-economic characteristics).

2. Mortality

2.1 Factors and causes of infant mortality in Hungary. In this respect the study of perinatal mortality and early births.

2.2 Life table computations

2.2.1 Construction of life table for 1969-1970 (by the country as a whole and by countries).

2.2.2 Life tables by causes of death

2.2.3 Life tables by occupations

2.2.4 Possibilities of applying life table methods

2.3 Study of the double causes of death

2.4 Regional analysis of mortality trends in the countries of Eastern Europe (retrospective analysis for about 100 years). A study to be performed with methods similar to those used in the analysis (Tropic 1.5) of fertility trends.

3. Social demography

3.1 Study of the public opinion on population problems. It is a recurrent sample survey to state how far the Hungarian public opinion is informed about the timely population problems and how these opinions change.

3.2 Demographic study of the working class. Analysis of the demographic and social position of the working class; in the first stage primarily a compilation of a documentation character, based on available materials.

3.3 Study of social mobility

1969. Analysis of the survey of the occupational changes, in connection with the microcensus of 1968.

1970-1971. New survey concerning the further processes of mobility, in connection with the population census of 1970.

3.4 Studies in family demography

3.4.1 Further study concerning the development of the family composition, the causes and factors of decrease in family size, based on the data of the microcensus of 1968 and the population studies of 1970.

3.4.2 Construction of models describing the life cycle of families, construction of models for family changes.

3.4.3 Demographic circumstances and social problems of the families with many (3 and more) children in the country of Baranya.

3.5 Studies concerning the aged. Studies in the demographic composition, social position and state of health of the population over the age of retirement (based on the microcensus of 1968 and the sample survey to be carried out in connection with the population census of 1970).

3.6 Causes of divorce.

(Repetition of the survey of 1962 in 1970.)

3.7 The position of widowed women.

(Demographic structure, adaptation etc., on the basis of a sample survey to be carried out in 1970.)

3.8 Deviant social behaviors.

3.8.1 Social causes and demographic factors of alcoholism.

1970. Impact of the alcoholism of the parents on their children.

1971. Repetition of the survey of 1966 in order to assess the changes in the status and position of alcoholists.

3.8.2 The role of the joint causes in the increase of the number of suicides and in the growth of the consumption of tranquillizers (with the application of correlation and regression analysis).

3.8.3 The problems of juveniles exposed to the danger of delinquency. (Source, characteristics of the endangerment, motives of the crimes committed by juveniles) Their demographic characteristics.

3.9 Demographic characteristics of the nationalities in Hungary.

Study connected with the population census of 1970, possibly supplemented with a separate survey to assess the demographic socio-economic position of the nationalities.

4. Economic demography

4.1 Economic causes and consequences of the population phenomena.

4.1.1 Study of the economic losses due to mortality by causes of death.

4.1.2 Study of the demographic factors of labour productivity and consumption efficiency.

4.1.3 Study of the applicability of the stable population model to economico-demographic analyses.

4.1.4 Improvement of the methods of economico-demographic projections.

4.1.5 Internal migration, study of the interaction between the regional location of the population and the economic phenomena.

4.2 The application of up-to-date mathematico-statistical and economico-mathematical methods to economic demography.

4.2.1 Analysis of the economic and social causes of population development by means of correlation and regression computations.

4.2.2 Model experiments aiming at the determination of the state functions expressing the demographic attitude of the population by using matrix computations based on the principal relations of the socio-economic system.

4.3 Computations concerning the economic efficiency of education, by the demographic structure of the population.

1969. Elaboration of methods. Analysis of the educational costs, based on a sample survey covering 5 percent of the educational institutions.

1970. Analysis of the educational investments by level of education; calculation of the size of educational investments by taking demographic factors into account, based on the respective data on the level of education of the microcensus of 1968.

1971. Development of the volume of intellectual capital in Hungary, according to different strata of the population, based on the data of the 1970 sample survey.

5. Biodemography

5.1 Longitudinal, developmental biologic study of industrial apprentices (continuation of the study started in 1966, new surveys in 1970 and 1971).

5.2 Demographic and population genetic studies concerning endogamous populations.

5.2.1 Demographic and population-genetic study of the population of the area of the Bodrogköz and its sub-populations, a comparison of the demographic immune-biological results.

5.2.2 Family reconstruction concerning the population of the village "Cigánd."

5.2.3 Demographic study of the isolated area of the village "Ivád."

5.2.4 Development of local endogamy in Hungary.

6. Population projections

6.1 Projections by regions (1969). Projection of the population number of counties, county boroughs, economic regions till 1986.

6.2 Projection of the number of the active population and the population, in working age, within it projection of the agricultural population till 1976, based on the population census of 1970.

6.3 Projections of the number of people having completed the secondary school, or university (higher eduction) studies till 1976, based on the data of the population census of 1970.

6.4 Projection of the population number by marital status and on this basis.

6.5 Projection of the number and size of families and households for the country as a whole, for Budapest, and for towns and villages till 1986, based on the population census of 1970, possibly experimental computation on the basis of the microcensus of 1968.

6.6 Projections concerning housing needs.

6.7 Preparation of mechanical programmes in connection with the automatization of population projections.

7. Regional demography

7.1 Study of vital statistics by regions. Regional differences and factors of fertility and mortality.

7.2 Study of internal migration by regions, its demographic and economic factors.

7.3 Analysis of the interrelations between internal migration and fertility.

7.4 Demographic causes and consequences of urbanization.

7.5 Demographic characteristics of the agglomerations of Budapest and the county boroughs, demographic attitude of these agglomerations.

8. Historical demography

8.1 Reconstruction of the main data of vital statistics by villages, since 1828 (an extensive research work lasting since several years and exceeding the plan period by several years).

8.2 Completion of the fragmentarily published material of the population census of 1941.

8.3 Discovering and processing of vital statistical data from the 18th century and the early 19th century.

8.4 Reconstruction of the composition of Hungarian families in the 18th century, by using the representative method.

8.5 Research on historical demography. Mortality patterns in the first third of the 19th century.

8.6 Paleodemographic research. Treatment of the skeletal finds of the cemetery of the village of Majs (county of Baranya 10th-11th century), discovered in 1965-1967.

Chapter 14

STATEMENT OF THE 1968 WORLD HEALTH ASSEMBLY

TWENTY-FIRST WORLD HEALTH ASSEMBLY

WHA21.43
23 May 1968

Health Aspects of Population Dynamics

The Twenty-first World Health Assembly.

Having considered the report of the Director-General on health aspects of population dynamics;[1]

Noting with satisfaction the development of activities in reference services, research, and training, and the provision of advisory services to Member States, on request, on the health aspects of human reproduction, of family planning, and of population dynamics within the context of resolutions WHA18.49, WHA19.43, and WHA20.41;

Emphasizing the concept that this programme requires the consideration of economic, social, cultural, psychological and health factors in their proper perspective;

Reaffirming the considerations expressed in these resolutions;

Recognizing that family planning is viewed by many Member States as an important component of basic health services, particularly of maternal and child health and in the promotion of family health and plays a role in social and economic development;

Reiterating the opinion that every family should have the opportunity of obtaining information and advice on problems connected with family planning included fertility and sterility;

[1] Document A21/P&B/9.

Agreeing that our understanding of numerous problems related to the health aspects of human reproduction, family planning and population is still limited,

1. CONGRATULATES the Director-General on the work accomplished during the year 1967;

2. APPROVES the report of the Director-General; and

3. REQUESTS the Director-General

(a) to continue to develop the programme in this field in accordance with the principles laid down in resolutions WHA18.49, WHA19.43 and WHA20.41 including also the encouragement of research on psychological factors related to the health aspects of reproduction;

(b) to continue to assist Member States upon their request in the development of their programmes with special reference to:

(i) the integration of family planning within basic health services without prejudice to the preventive and curative activities which normally are the responsibility of those services;

(ii) appropriate training programmes for health professionals at all levels;

(c) to analyse further the health manpower requirements for such services and the supervision and training needs of such manpower in actual field situations under specific local conditions; and

(d) to report on the progress of the programme to the Twenty-second World Health Assembly.

Seventeenth plenary meeting, 23 May 1968
A21/VR/17

Chapter 15
STATEMENT OF THE INTERNATIONAL PLANNED PARENTHOOD FEDERATION ON THE FUTURE OF FAMILY PLANNING ASSOCIATIONS

The Future Role of Family Planning Associations

Experience in the Europe and Near East Region of the IPPF has led us to believe that a new form of family planning council is emerging in several countries that we consider to be suitable to many countries of different cultures.

This new form is suitable both for:

(a) countries where voluntary family planning associations existed, and where now governments are showing increased interest, and

(b) countries where governments have taken the initiative, and where associations do not exist.

A non-governmental coordinating national council replaces the old type of family planning association. It is composed of representatives of relevant university faculties, (medical, sociological, economic), of the medical and para-medical professions, womens organisations, youth organisations and, where these previously existed, of the former family planning associations. Representatives of relevant ministries (Health, Social Welfare, Education) can also be members of coopted members of the board.

This national family planning council can, where appropriate, have branch committees of similar structure at regional level. The board would have government approval, and it is to be hoped, government financial support.

It is, however, essential that the family planning board should be non-governmental, so that it may be flexible, effective, acceptable to the people, and removed as far as possible from political implications. A government

family planning board can suffer from handicaps which produce an exactly opposite situation.

The following can be the national aims and objects of such a council to be implemented in the order as listed:

1. To eliminate misunderstanding, competition and confusion between the government and a voluntary association.

2. To establish short courses of essentially practical training in family planning for all doctors and paramedical personnel, and all medical and paramedical students. The training to be organised mainly by university and government hospitals.

3. To urge the government to include family planning facilities in all government hospitals and health service units.

4. To help establish additional services if necessary, but only as supplementary to the government facilities.

5. To ensure that all methods of contraception are available.

6. To encourage, instigate and supervise testing, trials, and evaluation of existing and new contraceptive methods, and to encourage research.

7. To ensure that all doctors and paramedical personnel be given adequate payment for their services to contraception, thereby helping to reduce abortion rates.

8. To offer sex education and information on family planning to everyone by means of discussion groups, films, etc., but always from the point of view of individual welfare and never from the point of view of government interest in population problems.

The National Family Planning Council can have the following international aims:

1. To be the national member of the International Planned Parenthood Federation
2. To act in liaison with their own government in activities for aid to developing countries.
3. To act as a negotiating body for other governments giving aid to their own country
4. To negotiate on behalf of their own government with any other grant giving body.

National family planning councils as envisaged in this memorandum may not be easy to establish in countries where family planning associations have hitherto existed, but it is our view that this is the best possible way in which to achieve co-operation at national and international level, and it should be possible to make this system acceptable to almost every country in the world.

2nd Novermber, 1967.

Publications

A list of publications available from the International Planned Parenthood Federation may be requested by writing to IPPF, 18-20 Lower Regent Street, London, S.W.1, England. Regularly issued publications include:

1. IPPF Medical Bulletin: quarterly in English, French, Spanish, and German. Free to researchers on request.
2. Calendar of International Meetings: published quarterly, English only, no charge.
3. Library Bulletin: published quarterly, English only, no charge.
4. Research in Reproduction: published quarterly, English only, no charge.