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IPPF Central Committee and Members' Assembly Meetings

A cold, intermittently sunny, grey, wet but beautiful Edinburgh, Scotland, was the venue for meetings which might be described as the end of one era for IPPF and, under the new constitution, the beginning of a new-look IPPF.

Thursday, 8 November was the final meeting of the Management & Planning Committee (M&P) after 17 years of twice-yearly sessions as the caretaker of policy and programme matters between the biennial meetings of the Governing Body. As the retiring Chairman I had to open the session on a sad note, reporting the untimely death in October of Joyce Johns, the Conference Officer at Central Office, who had served the Federation for 18 years. At this meeting and at the subsequent meeting of the Central Council (CC) tributes were paid to her devoted service.

Many topics were on the agenda of both the M&P and the CC, or were brought to the latter via my report as Chairman of the M&P for formal approval or recommendation, so I will cover the business of both in the first section of my report.

1. Management and Planning Committee (8 November) and Central Council meetings (9/10 November)

The Europe Region (ER) representative at M&P was Sten Heckscher; Jürgen Heinrichs was present as Vice Chairman of the Budget & Finance Committee. At the CC meeting, chaired by William Wamalwa (Africa), Lykke Aresin, Albino Aroso and Mikołaj Kozakiewicz and myself made up the six ER representatives. The following were the principal items of discussion and decision:

– *Ethical Issues in Family Planning.* The ER resolutions which deplored the method of launching booklets such as that prepared by Dr. Sai on the topic, and indicating opposition to the content, were noted and discussed. The action taken by the Secretary General (SG) in circulating the booklet was ratified. Member associations were called on to continue examination of the issues, and asked to report their views and comments by September 1978.

– *Effectiveness of Committees.* The CC approved the action recommended by M&P directing the Central Executive Committee (CEC) to undertake during the course of the next year an evaluation of the effectiveness of the operations of the three central standing committees, and an examination of ways to improve the working relationships between central and regional committees. It further requested Regional Councils to undertake an evaluation of the Regional Council, Regional Executive and Regional Standing Committees.

– *Spermicide Testing.* Following legal advice on IPPF's liability in respect of test reports issued by the IPPF, the CC adopted the M&P decision that IPPF should not permit its name to be used in any way as a recommendation or endorsement for any contraceptive product, or in any advertisement for contraceptive products. The Central Medical Committee was asked to consider and report to the CEC whether IPPF should continue testing spermicidal products. It was also agreed that IPPF should withdraw its name from the so-called IPPF Agreed Test for Spermicidal Power (1965), since this test was well-known and available for use by other organisations and could infer IPPF endorsement.

– *Implementation of Governing Body decisions on the unified secretariat.* A progress report, which included proposed personnel policies relating to salaries for the secretariat, was widely discussed by both the M&P and the CC. A resolution from East and South East Asia and Oceania Region caused the greatest comment, revealing continued disquiet and Regional uncertainty about the implications of the unified secretariat, and in particular the authority of the volunteers vis-à-vis the SG in appointment procedures and the role and responsibilities of the Regional Executive Committees. The CC finally agreed to call for a comprehensive position paper from the SG, dealing with staff structure, delegation of responsibility and the content of volunteer participation in personnel matters, to be submitted to the Spring meeting of the CEC. The CC then endorsed M&P approval of modified recommendations on pay policy for the secretariat set out in a Unilever consultant's report and agreed that, "after further review as required", it should be implemented from August 1978. Basically the new pay structure is required because IPPF salaries have now fallen far behind equivalent international standards. At the same time, it is hoped to achieve greater uniformity within IPPF so that equal responsibility attracts equal payment.

– *1977 work programme.* A report on the progress of implementation of 1977 programmes was given to the M&P. This was further reflected in the Regional highlight reports made to the CC. The M&P charged the SG, in consultation with Regional

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directors, to examine means of improving the selection and recruitment of professional staff for member associations. This matter will be further reviewed by the CEC in April 1978. It was stressed that in future more attention should be given in reports to problems and difficulties encountered in the programmes, and that emphasis should not only be on successful achievements.

- *Financial matters.* Rufus Day, the retiring Treasurer, presented his report to the CC on the Budget & Finance Committee (B&F) meeting of September 1977. The audited accounts for 1976 were presented and approved. Some 17 resolutions on budgetary matters, including criteria for resource allocation, were also approved. Periodical reviews of the role, programme, management and finances of grant-receiving associations were also authorised by the CC to determine whether and at what level associations should continue to be funded by IPPF. In brief, the financial position of IPPF remains healthy, with projected income figures for 1977 representing an overall increase of nearly 10% over the actual income for 1976. A worrying feature, however, is the continued high level of under-expenditure mainly due to the implementation of programmes being slower than planned. An important paper on emoluments and volunteer status prepared by B&F is to be circulated to all member associations for guidance.

  At the end of his report tribute was paid to Rufus Day, who first became Treasurer in 1954, for his dedicated service. In his honour the CC established the *Rufus Day Award*, a fellowship to be awarded annually to a selected candidate to study management and financial administration.

- *Central Standing Committees.* The CC received reports from the chairpersons of the various committees:

  Medical (CMC). Dr. Cummins reported on the business discussed at the last meeting, regretting in particular a decision taken not to proceed actively in the field of medical education. As requested by M&P he also made a brief statement on the current position of IPPF in the light of recent British medical press comment on the dangers of the contraceptive pill.

  Communications (CCC). Jørgen Hornemann, in a brief report, outlined the progress made in the past year, and again drew attention to continued failure of volunteer consultation before new publications were issued. The CC was given an assurance that efforts would be made in the future to comply with the M&P resolution made on this matter in 1976. The progress and proposals of the *Social Science Working Party* were also reported, and the CC gave its approval to continuation of the work and policies pending full consideration of the report by the CCC.

  Law and Planned Parenthood Panel. Mrs. Pilpel reported on activities, including the outcome of a joint meeting held with CMC when a number of resolutions were submitted to and approved by the M&P. The CC endorsed an M&P recommendation that the Panel be asked to review its role, functions and composition, taking account of the existence of different legal systems around the world and the way the law programme in IPPF has developed over the last few years. It was agreed that Professor Bouzidi, Chairman of MENA Regional Law Panel should replace Professor Dib and that Sr. Mario Coll Solares replace Professor Moraes on the Panel.

  A report from the *Biological Sciences Panel* (Chairman Sir Alan Parkes) was tabled and approved. The three medical workshops for 1977/78 are on lactation, adolescence, and the menopause and climacteric.

- *China.* The cordial reception and official recognition of the September/October 1977 IPPF mission to China was noted when an interim report was presented, and it was recommended that in 1978 a small mission should visit China to study selected aspects of the birth planning programme in depth.

- *ER Resolutions to the CC from 1977 RC meeting:*
  - Our request to bring a proposal to the Members' Assembly (MA) was accepted, and the outcome is reported under the business of the MA.
  - The CC accepted our proposal that it should prepare a draft three-year plan and circulate it to member associations immediately after each meeting of the CC held in the year before the meeting of the MA.

- *Secretary General.* Julia Henderson gave what she described as her first and last report (she is due to retire in March 1978) to the CC, calling for a return to the old pioneering spirit. She reviewed the developments and major problems during the seven years of her office, including the increase in the IPPF budget from $14 430 000 in 1971 to $45 000 000 in 1978, and the problems of accountability which this raised. She stressed the need for self-reliance within the IPPF system, noting that there are today even more grant-receiving associations than there were in 1971. While concluding that it was too early to say farewell, she announced her intention to take up the role of a volunteer for IPPF as soon as she retired. Her report was given a standing ovation, more a tribute perhaps to her personality and dedication than an acknowledgement of the report. There were further expressions of gratitude to the retiring SG at the end of the meeting when a resolution in glowing terms was unanimously adopted.

- *The new Secretary General.* After Mr. Wamalwa had described the search carried out for a new SG following Julia Henderson's decision

to retire, the CC authorised the honorary officers to offer the post of SG of IPPF to Mr. Carl Wahren of Sweden. (See P. 8).

- *New officers of IPPF.* At the conclusion of the Members' Assembly after the President of IPPF had been elected, the CC reconvened to elect its new officers. The results were as follows:–

Chairman:	Mr. W. Wamalawa (Africa)
Treasurer:	Mr. B. Boal (Western Hemisphere)
Vice Chairmen:	Rev. H. Henri (Africa)
	Professor D. V. I. Fairweather (Europe)
	Dr. C. C. Lee
	Professor C. Wendell-Smith (East & South East Asia & Oceania)
	Miss S. Farman-Farmaian (Indian Ocean)
	Dr. F. H. Ghali (Middle East and North Africa)
	Mr. J. Dear) (Western
	Professor S. Moraes) Hemisphere)

2. Members' Assembly Workshop (11 November)

This exercise was in the nature of a warm-up before the first meeting of the Members' assembly (MA). Mrs. Avabai Wadia, President of the FPA of India, introduced her paper *Who is the IPPF?*, tracing the history of IPPF and its fortunes during the first two decades of its existence, ending, perhaps unwisely, with a reference to the healthy financial resources of IPPF. This financial tenor set the scene for the majority of questions, which came to the first panel of volunteers, chaired by Rufus Day and representing those with a long record of service to the Federation. Some discussion was also raised relating to the autonomy of associations.

The SG then presented results from the Unmet Needs study, indicating that more than 360 million women remain unprotected from pregnancy. A paper on the *IPPF and the International Community*, had indicated that FPAs had grown at a faster rate than other organisations between the years 1967 and 1976. The IPPF, it was claimed, had gained respect over the years as the most experienced international family planning organisation. Despite the fact that 95% of the world's population lives in countries which have an organised family planning programme, and though in theory they are covered, the SG reported that half the world's couples lack sufficient knowledge to practise family planning.

Discussion on these papers was routed through a second panel, this time of younger volunteers chaired by Sten Heckscher. No notable points emerged, except perhaps the vital nature of relationships between FPAs and governments, which could sometimes be difficult and strained when FPAs really fulfilled their watchdog or innovative roles.

In the final session of the workshop, with the theme of *Community Participation*, five projects were described in different parts of the world which were based on community self-determination. These ranged from mothers' clubs in Korea to CBD programmes in Colombia, and community development projects in India and in East Java. Discussion from the floor touched on the dangers of pill distribution without medical supervision, the allegation of permissiveness in young people being fostered by availability of contraceptives, and some of the other problems faced by FPAs in their education and service activities.

3. Members' Assembly (12/13 November).

Delegates from 87 countries participated actively in this first meeting of the Assembly. Discussions were full and free, and a notable feature was the absence of any really politically charged talk throughout the meetings. The principal items on the agenda and the decisions taken were as follows:–

- *Retiring President's address.* The meeting opened with Dr. Tamayo, who chaired the Assembly, addressing the delegates at the end of his six year term as President of IPPF. He stressed the need for innovative activities and the function of the Federation in the interchange of knowledge at Regional and National levels. In closing he reiterated that "stimulating and strengthening voluntary family planning organisations, always permitting their independence of action in accordance with local existing conditions" continued to be an essential part of the aims of IPPF.
- *Ratification of amendments to IPPF Regulations and Procedural Bylaws relating to the MA.* Ostensibly a routine matter, this soon engendered considerable heat when members questioned one of the powers and duties of the MA which appearedd limited to "*ratification* of amendments to the Regulations *in the form adopted by the CC*". A motion put to alter this to read "to ratify or change and ratify" was narrowly defeated (37 votes for, 41 against, and one abstention). The amendments to regulations were then agreed unanimously with one exception – where it was proposed to qualify membership of the MA to read "one representative from each member organisation *who shall be a volunteer*". After considerable discussion this amendment was agreed (66 votes for, 9 against, and two abstentions).
- *Membership of IPPF.* New associate members were accepted from Togo, Yemen Arab Republic, and Bahrain. Ethiopia, Sierra Leone and Bangladesh were promoted to full membership. The CC had previously agreed that the Government of Swaziland should be an affiliate member, and had also noted the resignation of Venezuela from membership.
- *Appointment of Patrons.* Three pioneers from the early days of IPPF were appointed Patrons – Senator Shidzue Kato (Japan), Mrs. Constance Goh Kok Kee (Singapore) and Dr. Helena Wright (UK).
- *Election of new President of IPPF.* From a field of five candidates, Mrs. Aziza Hussein (Egypt) was elected President.

– *Draft 3-year plan 1978–80.* This was introduced by the SG and produced considerable debate resulting in several amendments. The goals, modified and re-ordered, now read:–

Goal I. IPPF will strengthen its efforts to stimulate greater community awareness and the participation of significantly larger numbers of people in the mission and activities of FPAs and of the Federation, and greater acceptance of the relevance of family planning to the work of other organisations in the field of economic and social development, health and education.

Goal II. IPPF will greatly accelerate its efforts to persuade all governments which have not yet accepted responsibility for providing family planning information and services to adopt appropriate policies and mobilise resources for their implementation.

Goal III. IPPF will intensify its influence on all governments whose policies and resource allocation for family planning are inadequate, to take effective steps to ensure full access to family planning information and services.

Goal IV. IPPF will strengthen its management through manpower and organisational development, especially its capacity to articulate and achieve objectives, evaluate experience objectively and apply the information gained; to manage resources responsibly and account satisfactorily for their utilisation.

Among other modifications introduced to the plan was insertion of a clause calling for efforts to increase male responsibility for family planning. An attempt by some delegates to remove a clause concerning voluntary sterilisation from the section dealing with service delivery was defeated on a majority vote.

Some omissions from the plan were discussed, eg. teenage pregnancy problems, but as this and other topics had been fully discussed and commented upon during debate on the future of IPPF, it was felt that the will and intention of the Assembly was clear and that the 3-year plan and the discussions on the *Forward Look Study* should be complementary in terms of programme guidance and implementation. The amended plan was then accepted by the Assembly, with the exception of one delegate who registered an abstention on a technical point relating to the use of an English text.

– *IPPF and its Future – the "Forward Look Study".* The document set out the findings of the eight-member group of honorary officers and two senior staff who formed the steering committee charged with the responsibility of carrying out the forward look study. This document was a synthesis of the findings of task force visits, questionnaires to member associations and other information sources, and represented the personal views and assessments of this group.

Preliminary discussion took place at the CC meeting, but the major discussion on the tentative "conclusions and recommendations" section (Chapter III of the document) was conducted in the MA. At the outset it was made quite clear that the document was a "working paper" and not a policy document. Many issues were raised including the role of the male, marriage counselling, abortion alternatives (adoption and care of the child), sex education directed to the general public (not only to youth) and the use of communications systems. FPAs were warned against taking on services that more properly should be provided by other institutions. This latter was crystallised particularly in relation to the provision of treatment for incomplete abortion, which the Assembly decided should be made available only "when applicable and where necessary". The need for IPPF to continue to strive for changes in the legal situation in relation both to abortion and to raising the age at marriage in some countries was also stressed. Many delegates pointed to the need for the IPPF to contribute to reducing the high infant death rates prevailing in many countries.

At the last session of the MA, the Resolutions Committee tabled a four-page summary of the main points of discussions on the document, together with a number of formal resolutions relating to specific topics. These included incomplete abortion, criteria for resource allocation (taking into account cultural, social and religious difficulties facing individual FPAs), and the educational use of mass media. The resolution referred from Europe Region was incorporated into a new resolution concerning support of FPAs which now reads: "In respect of the first three objects of IPPF (as stated in the 1977 IPPF Act), this Members' Assembly recognises and declares that IPPF should aim to achieve these objects through the support of national associations and as an integral part of an overall development process to be implemented within the framework of the general progress of the communities concerned". After considerable debate the resolution was adopted by a large majority.

A further resolution, concerning the provision of family planning through FPAs, was also passed which in effect clarified the position of IPPF working through bodies other than the FPA in any country, making it clear that "where an FPA exists, its agreement in such an arrangement will naturally be requested and it will be expected to be the point of contact with any other agency. If the FPA is unwilling, its stand will be respected but it cannot have a veto where arrangements reflect the conviction of regional and central organs that the aims of the Federation will be furthered and its policies respected".

A resolution seeking to make it mandatory that nothing should be published on behalf of IPPF without the prior consent of an appropriate volunteer committee was not

supported by a majority vote, but it was noted that a previous recommendation of CCC, accepted by the M&P, was still operative, and that at the CC meeting an assurance had been given that it would be followed.

Finally, regarding the fate of the document *IPPF and its Future*, after much discussion a resolution was agreed: "Having received the comments of the CC on the document; having debated many points from the conclusions and recommendations and passed certain resolutions appended hereto; this Assembly, being in broad accord with those conclusions and recommendations, transmits its commentary to the CC for active consideration and guidance in development of policies and programmes".

It was further agreed that the document in its present form should be used as an IPPF working paper – a step taken again to ensure that its true status was clearly understood by anyone who might see it in the future. (The Central Executive Committee subsequently agreed that all copies should carry a sticker indicating "This is an IPPF working paper and not a statement of IPPF policy".)

The session closed with a laudatory resolution to Dr. Fernando Tamayo, thanking him for his efforts on behalf of IPPF during his six years as President.

The length of this report indicates the problem of trying to give a resumé of a week of meetings, but I hope I have conveyed the main points. I think this first Assembly was really quite successful, and the availability of simultaneous translation into French and Spanish enabled maximum participation of delegates in the debates. Europe was well-represented, and many European views were incorporated into decisions taken.

Denys Fairweather
President, Europe Region

Oral Contraceptive Mortality

In 1968, on the basis of a case-control study in the UK, Inman and Vessey (1) estimated the pulmonary, cerebral or coronary thrombo-embolic mortality risk, attributable to oral contraceptives, at 2.2 per 100 000 woman-years for users aged 20–34 years, and 4.5 per 100 000 woman-years for users aged 35–44 years. The overall thrombo-embolic mortality risk due to oral contraception was therefore estimated to be about 3 per 100 000 woman-years. Also in 1968, the Royal College of General Practitioners (RCGP), and the Family Planning Association/Oxford University, began prospective studies of women taking oral contraceptives in the UK.

In May 1974, the RCGP published the first interim report on its Oral Contraception Study, *Oral Contraceptives and Health* (2). The RCGP concluded: "the estimated risk at the present time of using the Pill is one that a properly informed woman would be happy to take". The RCGP report also noted: "The number of deaths reported amongst the Study subjects is small and no conclusions can be drawn about the possible influence of oral contraceptives".

In June 1974, in a letter to the *Lancet*, Beral (3) used the published RCGP Oral Contraceptive Study deaths to calculate the (unstandardised) mortality rates of oral contraceptive users and nonusers. The oral contraceptive excess mortality is given in *Table 1*. (Oral contraceptive users enrolled in the RCGP study had been previously healthier than their age-matched controls, i.e. never-users).

TABLE 1: Oral contraceptive mortality by cause (RCGP).

Cause of death	Oral contraceptive excess mortality rate per 100 000 woman-years
ALL	+26
Circulatory	+17
Suicide	+11
Cancer	– 4
Pregnancy	– 5
Other	+ 6

Beral acknowledged that this oral contraceptive excess could be due to chance, and that the absolute mortality risk was small, but questioned whether it was "one that a properly informed woman would be happy to take".

In May 1975, on the basis of a retrospective case-control study of deaths of women under 50 years of age in England and Wales in 1973, Mann and Inman (4) estimated the oral contraceptive excess mortality rate from myocardial infarction at 3.5 per 100 000 woman-years for users aged 30–39 years, and 43 per 100 000 woman-years for users aged 40–44 years. In August 1976, on the basis of further data, Mann *et al* (5) re-estimated the oral contraceptive myocardial infarction mortality risk at 20 per 100 000 woman-years for users aged 40–44 years; 1.1 per 100 000 for women aged 20–34 years; and 8.1 per 100 000 woman-years for users aged 35–44 years. The oral contraceptive excess mortality was not explained by an association between oral contraception and hypertension or diabetes (both risk factors for myocardial infarction).

In November 1976, on the basis of trends in oral contraceptive use and mortality among women aged 15–44 years in 21 countries, Beral (6) reported a statistically highly significant correlation ($r = +0.67$) between the estimated proportion of women aged 15–44 years taking oral contraceptives (ranging 0–27% between Romania and Canada) in 1971–2, and the change in the age-standardised, nonrheumatic cardiovascular mortality rate between 1961–2 and 1971–2. (In 1961–2, the proportion of women aged 15–44 years taking oral contraceptives was practically zero in all countries). Beral estimated the excess nonrheumatic cardiovascular mortality rate, due to oral contraception, at 20 per 100 000 woman-years; and noted that, by 1971–2, most oral contraceptives prescribed contained no more than 0.05 mg estrogen daily.

In October 1977, the RCGP Oral Contraception Study reported on deaths recorded between 1968 and June 1976;

Beral was the principal author (7). Oral contraceptive excess mortality rates, standardised for age, parity, social class, and smoking, were as in *Table 2.*

TABLE 2: Oral contraceptive mortality by cause, 1968–76 (RCGP).

Cause of death	Oral contraceptive excess mortality rate per 100 000 woman-years
ALL	+16
Circulatory	+20**
Accidents & violence	+ 7
Cancer	− 5
Pregnancy	− 2
Other	− 5

** Statistically significant ($P < 0.01$).

The oral contraceptive excess *circulatory* mortality rate was 20 per 100 000 woman-years for ever-users, 21 per 100 000 for current users, and 18 per 100 000 woman-years for ex-users. Although these excesses were all statistically significant ($P < 0.01$), the excess for ex-users may reflect women stopping oral contraception after ill effects.

Unstandardised oral contraceptive excess mortality, especially from circulatory causes, increased with *age at death*, as in *Table 3.*

TABLE 3: Oral contraceptive mortality by age (years) and cause (RCGP).

Cause of death	Oral contraceptive excess mortality rate per 100 000 woman-years		
	ALL	15–34	35–49
ALL	+14	+10	+30
Circulatory	+21	+ 5	+49*
Noncirculatory	− 7	+ 5	−19

* Statistically probably significant ($P < 0.05$).

Oral contraceptive excess circulatory mortality increased with *duration of use*, independently of age. Among continuous users of oral contraception, the age-standardised excess circulatory mortality rate increased from 12 per 100 000 woman-years for use lasting under five years, to 45 per 100 000 woman-years for use lasting five years or over. (The linear trend was statistically significant: $P < 0.01$).

Standardised for age, parity, and social class, *smoking* increased oral contraceptive excess *circulatory* mortality considerably, as *Table 4* shows.

TABLE 4: Oral contraceptive mortality by smoking habit and cause (RCGP).

Cause of death	Oral contraceptive excess mortality rate per 100 000 woman-years	
	Nonsmokers	Smokers
ALL	14	19
Circulatory	11	31**

** Statistically significant ($P < 0.01$).

Also in October 1977, Vessey *et al* (8) reported on deaths known to have occurred, between 1968 and April 1977, among participants in the Oxford/Family Planning Association Contraceptive Study, comparing women using oral contraceptives (56%) with those using diaphragms (25%) or IUDs (19%) in the UK. Oral contraceptive excess mortality rates, standardised for age, parity, social class, and smoking, were as in *Table 5.*

TABLE 5: Oral contraceptive mortality by cause (Oxford/FPA).

Cause of death	Oral contraceptive excess mortality rate per 100 000 woman-years
ALL	+8
Circulatory	+14*
Accidents and violence	− 3
Cancer	− 7
Other	+ 4

* Statistically probably significant ($P < 0.05$).

The *total* mortality rate of women initially using either oral contraception (50 per 100 000 woman-years), or a diaphragm or IUD (42 per 100 000 woman-years), was much lower than the age-standardised mortality rate in England and Wales in 1973 (92 per 100 000 woman-years). This finding is consistent with the Oxford/FPA study participants being healthier than average (e.g. fewer were grossly overweight or smoked heavily), and being weighted towards the higher social classes.

Vessey *et al* (8) concluded that the circulatory mortality attributable to oral contraception is of an appreciable magnitude in the UK. The RCGP Oral Contraception Study (7) also noted that the excess total mortality rate in ever-users, mainly due to circulatory causes, is substantially larger than previous estimates, based only on thrombo-embolism and myocardial infarction.

Indeed, the circulatory mortality of oral contraception (14–20 per 100 000 woman-years), estimated in 1977 on the basis of two independent, prospective studies, was *five to seven times greater* than its thrombo-embolic mortality (3 per 100 000 woman-years), estimated in 1968 on the basis of a nationwide, retrospective case-control study (1). In 1968, oral contraceptives containing more than 0.05 mg estrogen daily were still being widely prescribed.

The *Lancet* editorial (9) concluded: "Little in the week's *Lancet* is going to dismay the many women who regard oral contraceptives as a blessing which carries a minute risk of premature death". The Committee on Safety of Medicines, in a letter circulated to all physicians in the UK on 6 October 1977 (10), expressed the view that: "the present studies do not indicate the necessity for any change in the warnings and precautions for oral contraceptives, except to emphasise the importance of the increased risk for women in the later age group, especially those who are cigarette-smokers".

It is unclear whether *overweight* is a risk-factor. *Hypertension* is believed to

be a risk-factor (8), though whether previous (or oral contraceptive-induced) hypertension increases the oral contraceptive mortality risk remains unknown. Neither UK prospective study determined the *blood-group* of ever-users. Jick *et al* (11) showed that users of blood-group O were *less* likely than users of blood-groups A, B or AB (by a factor of 1:3) to develop (nonfatal) venous thrombo-embolism.

Table 6 compares certain mortality risks to women aged 15–49 years, by age and cause, in England and Wales in 1974 (12). The overall circulatory mortality rate (24 per 100 000) is consistent with the RCGP estimates for oral contraceptive ever-users (26 per 100 000) and never-users (6 per 100 000), applied to women aged 15–49 years, of whom about half are ever-users. (About a quarter of women aged 15–49 years currently use oral contraceptives in the UK).

TABLE 6: Female mortality by age (years) and cause: England and Wales, 1974.

Cause of death	Mortality rate per 100 000 women		
	15–49	15–34	35–49
ALL	113	46	218
Cancer	45	11	98
Circulatory	24	5	54
(ORAL CONTRACEPTIVE USERS)	(14*)	(10)	(30)
Motor accidents	6	7	4
Suicide	6	4	8
Other accidents/ violence	6	5	9
Pregnancy	1	1	0
Other	25	13	45

(* Smokers: *add* 27 per 100 000 woman-years).

I acknowledge with pleasure the assistance rendered, in writing this article, by Dr Valerie Beral (London School of Hygiene and Tropical Medicine, Department of Medical Statistics and Epidemiology), and by Professor Martin Vessey (Oxford University Department of Social and Community Medicine).

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Philip Kestelman, Europe Regional Office

Contraception in the later part of the fertile period in Denmark

In 1955 there were 77 000 livebirths and 5400 legal abortions in Denmark. The figures for women aged over 40 years were 2400 and 530 respectively. In 1974, after the legalisation of first trimester abortion on request, by which time knowledge of effective contraception was widespread, births had fallen to 71 000 while legal abortions had increased to 21 000. For women aged over 40 there were 550 livebirths and 1650 abortions. In 1975 the number of abortions for women aged over 40 had risen to 1730. The high number of abortions compared to the number of deliveries indicates that pregnancy in this age-group is mostly unwanted. Pregnancy in women aged over 40 years presents more complications than in younger women. The perinatal mortality rate is three times higher among women aged over 40 compared to women in the 20s. In spite of this, in Denmark about half of women in this age-group use a female method of contraception, and of these the majority use the rhythm method.

This age-group has special requirements regarding a method of contraception and here I shall only mention those methods I consider relevant.

A diaphragm and spermicide may be recommended to women in the later part of their fertile period. Several studies show that the use-effectiveness of this method is high in this age-group, with pregnancy rates of 1–2 per 100 woman-years. and continuation rates of about 85% after 1 year. The method is specially well suited to women over 40, and after the 45th year when fertility is very low, the woman could use a spermicide only.

Intra-uterine contraception, especially a copper IUD, might equally be the first choice in this age-group. Several studies show that the continuation rate is higher for older than for younger women, as

the expulsion rate and the removal rate for the IUD, due to bleeding and pain, are lower among women over 40 years of age than among younger women. The risk of infection and pregnancy with an IUD is also less in this age-group, which is reflected in a lower morbidity rate among older women compared with younger women.

The oral contraceptive should on the face of it be ideal for women late in the fertile period. It is almost 100% effective, and a sequential preparation should regularise any bleeding disturbances and remedy any incipient menopausal troubles. However, the continuation rate for oral contraceptives tends to fall with increasing age. Furthermore, a number of studies indicate that the risk of thrombo-embolic disease and death increases significantly with age in pill-users, so that mortality after the 40th year is far higher in pill-users than in users of other contraceptives, exceeding that associated with pregnancy and delivery. In general, therefore, oral contraception for women late in the fertile period is contra-indicated.

Male or female sterilisation are alternatives to using the diaphragm or IUD, and is well suited to this particular age-group. Very few complications are associated with sterilisation, which is irreversible.

It may be concluded that the diaphragm + spermicide or the IUD, with sterilisation as an alternative, should be recommended to women aged 40–45 years. After the 45th year, a spermicide may be recommended. Generally, the woman should continue to use a contraceptive up to six months after the menopause, which occurs at about the age of 52 years in Denmark.

Jørgen Wiese
Randers

New IPPF Secretary General Appointed

Carl Wahren (Sweden) has been appointed IPPF Secretary General. He takes up his appointment in April 1978, on the retirement of Miss Julia Henderson, Secretary General since 1970.

Carl Wahren, who is 44, is presently Director of Population, Health and Nutrition in the Swedish International Development Authority (SIDA). He has been with SIDA since 1962, becoming Head of the Family Planning and Research Section in 1965, and Head of the Population Division in 1970.

In 1968 he became Senior Consultant to the Population Programme at the OECD Development Centre in Paris. He has been associated closely with UN activities (especially WHO and UNICEF) in family planning, health, population and development, and has been consultant to the UN Fund for Population Activities.

Carl Wahren holds a PhD in Political Science from Uppsala University; he has studied international relations in Los Angeles, and social sciences in Paris. He taught international politics at Uppsala and Stockholm universities for six years, and has written and broadcast extensively on population policy and development assistance. He has represented his government at the annual review by donor governments of IPPF activities (the Swedish government was the first to make a grant to the IPPF, in 1965.) He was an external assessor of a study of IPPF's role in the next 10–15 years.

Carl Wahren is married, with two children.

Polish FPA 20th Anniversary

On the occasion of its 20th anniversary in November 1977, the *Towarzystwo Planowania Rodziny* was awarded the government Medal of National Education. The Regional Executive Committee, meeting in Warsaw, attended a session of the TPR meetings and congratulated the TPR on its achievements on behalf of the Polish Family. On this occasion members of the REC were presented with copies of the proceedings* of a seminar on *Family Planning and Sex Education in Socialist Countries* organised by the TPR in December 1976 (see *Regional Information Bulletin,* January 1977).

*Copies are available in Polish and English on request from Towarzystwo Planowania Rodziny, Ul. Karowa 31, Warsaw.

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Legal Abortion in Europe

AUSTRIA

In January 1976, first trimester abortion, performed by a physician, following obligatory counselling, became legal in Austria. Abortion is also legal on medical and eugenic grounds, and if the woman was under 14 years of age at conception. Physicians may abstain conscientiously from performing abortion.

Mainly in west Austria (Salzburg, Tyrol and Vorarlberg), where christian democrats (the Österreichische Volkspartei) predominate, and in religious hospitals, abortions are not performed on non-medical grounds. In other areas (notably Kärnten and Niederösterreich), a few hospital physicians perform early abortion, on the basis of the woman's social conditions, but refuse subsequent requests for abortion.

In Vienna, where it is easiest to procure abortion, private physicians and counselling centres perform legal abortion. However, physicians are not obliged to notify their abortions, and no statistical data are available.

The cost of legal abortion on nonmedical grounds is not refunded by the social security system. Prices vary widely between hospitals, and between private physicians, depending partly on the type of anesthesia involved.
Correspondent: Elisabeth Jager, Vienna.

DENMARK

Before 1970, abortion was legal in Denmark on specific (e.g. medical, fetal, and judicial) indications. In 1970, abortion became legal for women over 37 years of age, or with over three children. In 1973, the right to first trimester abortion on request, performed free-of-charge in public hospitals, was legalised for Danish residents over 17 years of age. (For more details, see *Regional Information Bulletin*, October 1976)

The legal abortion rate in Denmark increased steadily between 1968 and 1972 (an average of + 21% p.a.). Between 1972 and 1974, the rate increased more rapidly (by + 37% p.a.), but only slightly between 1974 and 1976 (by + 3% p.a.), as the following table shows:

Legal abortion rate per 1000 women aged 15–44 years (ratio per 100 live births): Denmark, 1966–1976

Year	Abortion rate	(ratio)
1966	5.9	(7)
1967	6.4	(8)
1968	6.1	(8)
1969	7.3	(10)
1970	9.4	(13)
1971	11.1	(15)
1972	12.8	(17)
1973	16.2	(23)
1974	24.1	(35)
1975	26.9	(39)
1976	25.8	(41)

Correspondent: Jørgen Hornemann, Copenhagen.

FINLAND

In 1950, abortion was legalised in Finland on medical grounds (bearing in mind social conditions), and on eugenic and judicial grounds. Two physicians certified permission for abortion, performed by one of them. Refusal could be appealed to the National Health Board.

In the mid-1960s, legal abortions reached 6000 p.a. (7 per 100 births), varying widely between different parts of the country. Surveys showed that abortions were associated with urban life; high income, education and access to medical services; a high incidence of divorce; a low incidence of sterilisation; and low fertility. Public and medical attitudes favoured the liberalisation of abortion availability.

A government committee was established to consider amending the law on abortion. The complications of illegal abortion had remained problematical: the incidence of illegal abortion was estimated at 18 000–19 000 p.a. (24 per 100 births). In 1969, parliament revised the law (effective in 1970), extending legal abortion to include social grounds, women under 17 or over 40 years of age, or with four or more children, or where parental ability to care for the child is limited.

Two physicians may certify abortion performed up to 16 weeks since last menstrual period; National Health Board permission is required between 17–20 weeks since LMP; and thereafter abortion is only legal on medical and eugenic grounds. The National Health Board ensures sufficient certifying physicians, hospital facilities, and the uniform application of the law throughout the country. Physicians may not refuse requests for abortion without good cause. Nearly all requests are now granted, and illegal abortion is rare. After abortion, the woman must receive contraceptive advice.

In 1972, a new Public Health Act required health personnel to provide contraceptive advice in health centres. IUD insertion, and the initial supply of

oral contraceptives, are free-of-charge. In practice, however, health centres are unable to give contraceptive advice to all who need it. Some women must rely on private physicians, and pay for their contraceptives, without reimbursement by the social security system.

The incidence of legal abortion in Finland is tabulated below:

Legal abortion rate per 1000 women aged 15–44 years (ratio per 100 live births): Finland, 1966–1976.

Year	Abortion rate	(ratio)
1966	5.1	(7)
1967	5.4	(7)
1968	6.0	(9)
1969	7.8	(12)
1970	14.6	(23)
1971	20.2	(34)
1972	21.4	(38)
1973	22.4	(41)
1974	21.7	(37)
1975	20.5	(32)
1976	18.7	(30)

As may be seen, after a sharp increase in legal abortion between 1970 and 1972, the peak was reached in 1973. Its incidence has since decreased steadily. On the other hand, the minimum birth rate (12.2 per 1000) was reached in 1973, increasing to 14.2 per 1000 in 1976. (The 1973–6 increase in births was 2.8 times the decrease in abortions). The low birthrate is regarded as problematical in Finland.

A parliamentary motion now proposes to liberalise the law to allow first trimester abortion on request (without the frustrations of medical certification); and later abortion on medical or eugenic grounds only.

Although sex education is not taught systematically in Finnish schools, public attitudes to sexuality are now liberal enough to ensure the widespread availability of information on all methods of fertility regulation. A Ministry of Education committee, on which Väestöliitto was represented, has recommended systematic education on human relationships in schools. Meanwhile, young people may seek advice and assistance from public health nurses in schools.

Correspondents: Tynne Martikainen and Juhani Toivonen, Helsinki.

FRANCE

In January 1975, first trimester abortion on request was legalised for French residents. The woman seeking abortion must first visit a physician, who must inform her of the medical risks to herself and to her future pregnancies; and give her written information, listing the benefits guaranteed to mothers and children, the possibilities of adoption, and the addresses of approved counselling agencies. She must then consult such an agency for appropriate help and advice, and receive a certificate to that effect. If she then confirms her request for abortion, she must submit it in writing to the physician, who may only accept it after the expiry of one week since her original request.

The physician may then perform the abortion in a public hospital or approved private clinic. Otherwise, he returns the woman's request to her, for referral to her chosen physician, and gives her a certificate that he has fulfilled his legal requirements. The woman must present the physician's certificate, the counselling certificate, and her written consent, to the establishment to which she seeks admission.

According to analyses and statistics published by the Institut National d'Etudes Démographiques (INED), in 1976, the first complete year under the new law, 133 926 legal abortions were notified, representing 12.5 per 1000 women aged 15–44 years (19 per 100 live births). The abortion ratio ranged widely between regions: from 10 per 100 live births in Lorraine and Nord, to 43 per 100 live births in Paris, as the following table shows:

Legal abortion ratios (per 100 live births) by region: France, 1976

Region	Abortion ratio
FRANCE	19
Paris (City)	43
Languedoc Roussillon	27
Limousin	24
Poitou Charentes, Provence Côte d'Azur, Alsace	21
Centre, Rhône Alpes, Basse Normandie	20
Haute Normandie, Aquitaine, Bretagne, Franche Comté	19
Auvergne, Bourgogne, Paris (Region *less* City)	18
Corsica, Midi Pyrénées, Pays de la Loire	16
Champagne Ardenne, Picardie	12
Nord, Lorraine	10

However, it should be remembered that the law limits the number of

abortions performed in an establishment to 25% of the total number of operations; abortions performed in private clinics above this quota are not notified. Consequently the total abortions notified in 1976 is a significant underestimation of the real total, of which it may constitute only a quarter.

This total has been more or less constant in recent years. Estimates before the change in the law ranged from 180 000 to 2 million, according to research conducted by those either opposed to a change in the law or favouring a change. The only difference now is that formerly illegal abortion has, since 1975, largely entered the sphere of medical supervision, although not always notified, as prescribed by the law. Hospitalised cases of unskilled abortion have virtually ceased.

In the light of the widespread practice of abortion, one is entitled to question whether the 1976 law on contraception is really being implemented. The influence of socio-economic factors on couples' decisions on whether or not to have children may also be relevant.

The numbers of women giving addresses in France, aborted in the UK between 1969 and 1976, were as follows:

Legal abortions in the UK on women from France, 1969–1976

Year	Number
1969	471
1970	2 267
1971	11 986
1972	25 189
1973	35 293
1974	36 443
1975	14 809
1976	4 459

In addition, 9000 Frenchwomen were estimated to have procured skilled abortions in the Netherlands in 1975.

During the four week period, 10 January–10 February 1977, the Mouvement Français pour le Planning Familial (MFPF) studied 4000 requests for abortion in 47 Départements. Just over half the women (52%) were aged 25 years or over; 53% were married; and two-thirds had children. Over two-thirds (71%) were under 9 weeks since last menstrual period; a further quarter (25%) were 9–12 weeks since LMP; while the remaining four per cent were 13 weeks or over since LMP (including only one per cent over 16 weeks since LMP).

Under half (42%) the women were aborted in public hospitals, one third (35%) locally. Under half (45%) were aborted in approved private clinics, one third (33%) locally. Altogether, two-thirds (68%) of the women were aborted locally, while 19% had legal abortions elsewhere in France. In addition, 5% had skilled illegal abortions; while a further 7% were aborted in the Netherlands.

After abortion, three-quarters (75%) of the women were prescribed oral contraception; 17%, an IUD; and 2%, tubal ligation. Antibiotics were prescribed in two-thirds (64%) of all cases. At follow-up, 80% of the women stated that they were using oral contraception.

The MFPF refer their clients only to relatively inexpensive facilities, charging about 500–700F (£55–£75) per abortion. Exorbitant prices are certainly charged. For example, one clinic in the South of France performs saline abortions for 4000F!

The MFPF favours first trimester outpatient abortion by aspiration, with appropriate counselling, at a low price. The woman herself (and not primarily the physician) should be able to choose whether or not to have anesthesia. Manifold difficulties still obstruct the woman seeking legal abortion in France: the legal requirements alone are discouraging enough, not to mention the humiliating attitudes of some health personnel, and the distressing uncertainties of the delays involved in processing her application.

Although first trimester abortion is now legal in France, it is very far from being guaranteed on request. The MFPF advocates the woman's right to choose both abortion and contraception. (A 1920 law still prohibits publicity on contraception, and simple information is by no means widespread).

A change in attitudes towards contraception and abortion will only come with the abolition of guilt associated with resisting biological laws, and when the overvalued social function of the mother is replaced by the notion of the parental function, allowing equal play to the role of men and women in all social relationships.

Correspondents: Daniel Comte, Grenoble, and Colette Mamy, Paris.

GERMAN DEMOCRATIC REPUBLIC

The law on abortion in the GDR was first liberalised in 1947, and amended in 1950: relatively restrictive sociomedical indications were prescribed. The incidence of legal abortion (unpublished for the whole country) is believed to have remained relatively low (below 1 per 1000 women aged 15–44 years, 3 per 100 live births). In the late 1960s, legal abortions began to increase, reading about 7 per 1000 women aged 15–44 years (10 per 100 live births), after the grounds for abortion were extended in 1965.

In late 1972, first trimester abortion on request was legalised. The incidence of legal abortion increased substantially,

but has decreased steadily since 1973, as the following table shows:

Legal abortion rate per 1000 women aged 15–44 years (ratio per 100 live births): GDR, 1972–76.

Year	Abortion rate	(ratio)
1971	6.0	(9)
1972	33.1	(57)
1973	32.2	(62)
1974	28.8	(55)
1975	25.2	(49)
1976	22.0	(41)

Correspondent: Karl-Heinz Mehlan, Rostock.

FEDERAL REPUBLIC OF GERMANY

In June 1974, the FRG Bundestag legalised first trimester abortion on request (*Fristenlösung*). However, the matter was immediately referred to the Federal Constitutional Court, whose judgement was announced in February 1975: the *Fristenlösung* was unconstitutional. Accordingly, in May 1976, the Bundestag legalised first trimester abortion on judicial and grave social grounds; and any abortion on medical and eugenic grounds.

Apart from abortion performed on medical grounds, the woman must receive both medical *and* social counselling from a physician or approved agency. The physician must certify the ground for abortion, which may then be performed by *another* physician, in an approved establishment, after three days have elapsed. Different Länder apply different procedural regulations. Some regions (within Länder) prohibit hospital abortions on grave social indications, ostensibly on grounds of conscientious objection. (Religious hospitals rarely if ever perform such abortions.) It may be easier to procure an 'indication' than an abortion in hospital.

In the second half of 1976, according to the Federal Ministry for Youth, Family and Health, 13 044 abortions were notified; and, in the first half of 1977, about 30 000 legal abortions. (These figures exclude abortions performed before 9 weeks since LMP, in physicians' consultations). Accordingly, between July 1976 and June 1977, the legal abortion ratio was about 7 per 100 births. In addition, in the first half of 1977, about 30 000 women had skilled abortion abroad, most in the Netherlands (only 1033 in the UK). Between 1969 and 1976, the following numbers of abortions, performed in the UK, were notified as performed on women from the FRG:

Legal abortions on FRG residents: UK, 1969–1976

Year	Number
1969	1 559
1970	3 621
1971	13 560
1972	17 531
1973	11 326
1974	5 991
1975	3 417
1976	2 376

In the second half of 1976, over half (57%) of legal abortions in the FRG were performed by curettage; one third (33%) by aspiration; and the remaining 10% by other techniques. Over three-quarters (79%) of abortions are requested on grave social grounds; but only half such requests are accepted by physicians: less so by clinic physicians and gynaecologists, but more so by family physicians. As a result, only 45% of abortions were performed on grave social grounds (51% in 1977); 38% on medical grounds (33% in 1977); and 17% on other grounds (16% in 1977).

In May 1977, the Deutsche Gesellschaft für Sexualberatung und Familienplanung (*Pro Familia*) National Council noted the heavy (and increasing) load of abortion counselling borne by *Pro Familia* bureaux with insufficient public support; deplored the consequent diversion from its main task of preventing unwanted pregnancies, which were nonetheless unavoidable; and felt that counselling aimed exclusively at continuing pregnancy reinforced women's guilty feelings, especially in view of the generally anti-child attitude of modern society. *Pro Familia* urges society to shoulder the burden of its own law, which has created an intolerable situation both for *Pro Familia*, and for women seeking abortion in their own country.

The Federal Ministry for Youth, Family and Health has appointed a committee, which will take advice on many aspects of the problem, and which is expected to report towards the end of 1978.

Correspondent: Margarete von Seckendorff, Frankfurt.

HUNGARY

"Planned Parenthood Developments in Hungary" (*Regional Information Bulletin*, October 1977) described the general situation currently prevailing in Hungary. More specific details on legal abortion follow. In 1956, first trimester abortion became legal on request. In January 1974, a new population policy became effective (Appendix 2 in *Induced Abortion and Family Health: A European View*: IPPF Europe, 1974).

Sociomedical indications for abortion were prescribed: first trimester abortion is available on request to unmarried women, and to married women with at least two children. As a result, the incidence of legal abortion was halved. However, applications for abortion are seldom refused: less than 3% in 1976. The ten-year trend in the

incidence of legal abortion is presented below:

Legal abortion rate per 1000 women aged 15–44 years (ratio per 100 live births): Hungary, 1966–76.

Year	Abortion rate	(ratio)
1966	82.8	(134)
1967	83.1	(126)
1968	88.8	(130)
1969	90.6	(134)
1970	83.5	(126)
1971	81.1	(122)
1972	77.5	(117)
1973	73.4	(108)
1974	44.1	(55)
1975	41.4	(49)
1976	40.9	(51)

Between 1971 and 1976, the birthrate increased by 21% (from 14.5 to 17.5 per 1000 population). The use of effective contraception has certainly increased over recent years.

Correspondent: Péter Józán, Budapest.

NORWAY

Abortion was first legalised in Norway in 1961, but did not become effective till 1964. Abortion became legal on medical grounds, including the woman's mental health, but was performed with a latitude ranging widely between the various counties. In 1974, the Government's proposal to legalise first trimester abortion on request was defeated.

In 1975, legal abortion indications were explicitly broadened to encompass sociomedical, judicial and eugenic grounds. Emphasis is now placed on how the woman requesting abortion regards her total situation. Since the general election in September 1977, there has been a parliamentary majority for abortion on request, which is expected to be legalised in the foreseeable future.

Between 1965 and 1975 in Norway, both the proportion of requests accepted, and the incidence of legal abortion (performed only in public hospitals), have increased steadily, as the following table shows.

Proportion of abortion requests accepted, and rate per 1000 women aged 15–44 years (ratio per 100 live births): Norway, 1965–1975.

Year	Requests accepted (%)	Abortion rate	(ratio)
1965	73	4.8	(5)
1966	78	6.3	(7)
1967	81	7.1	(8)
1968	81	7.3	(8)
1969	84	8.9	(10)
1970	86	10.8	(12)
1971	89	14.1	(16)
1972	91	16.3	(19)
1973	93	18.2	(22)
1974	94	19.8	(25)
1975	95	19.7	(27)

(The numbers of abortion requests accepted approximate closely to the numbers of abortions performed). It seems that the incidence of legal abortion in Norway has stabilised below 20 per 1000 women aged 15–44 years (30 per 100 births). It remains to be seen how further legalisation will affect the situation.

Correspondent: Kari Kromann, Oslo.

POLAND

In 1956, abortion was legalised in Poland, on medical, judicial and social indications. The Ministry of Health issued regulations prohibiting abortion after the first trimester. Abortion may be performed in public health facilities, or in private consultations, by authorised physicians (gynecologists, obstetricians, surgeons, and other, specially trained physicians). The 1969 Penal Code punishes involuntary abortion by imprisonment for six months to eight years; and voluntary, but illegal abortion by imprisonment for up to three years.

In practice, first trimester abortion on request prevails. Nearly all (97–98%) of abortions in public hospitals are performed on social indications. In addition, abortions are performed in both public and private outpatient facilities. It is believed that private abortions are not fully notified to the government. Over recent years, the proportion of notified abortions performed in outpatient facilities has increased, as the following table shows:

Legal abortion outpatient proportion, and rate per 1000 women aged 15–44 years (ratio per 100 live births): Poland, 1964–1974

Year	Outpatient (%)	Abortion rate	(ratio)
1964	19	26.2	(32)
1965	20	24.2	(31)
1966	19	22.3	(30)
1967	21	21.6	(30)
1968	21	21.0	(29)
1969	24	20.0	(28)
1970	26	19.9	(27)
1971	28	17.7	(24)
1972	35	17.8	(24)
1973	37	17.9	(23)
1974	39	18.3	(23)

An investigation conducted in Poland in 1973 showed an incidence of 2% early, and 29% late complications after legal abortion. After termination of first pregnancies, the spontaneous abortion rate is 10–30%; but after full term first pregnancies, the rate is significantly lower. The Roman Catholic Church has proposed that first pregnancies should no longer be terminated on request.

Correspondent: Mikołaj Kozakiewicz, Warsaw.

SWEDEN

Abortion was first legalised in Sweden in 1938, and slightly liberalised in 1946 and 1963, on medical, eugenic, sociomedical, and judicial indications, with the approval of the National Board of Health and Welfare. In 1965, the government appointed a Committee on Abortion. In 1971, the Committee recommended the woman's right to abortion on request. Following public discussion, parliament approved new legislation in 1974.

In January 1975, abortion became the woman's right in the first trimester. Between 13–18 weeks since LMP, the woman's request is subject to counselling, absence of medical contra-indications, and review by the National Board of Health and Welfare in the event of refusal. Abortion is performed only in public hospitals on Swedish residents.

In the 1950s, the legal abortion rate remained low (below 5 per 1000 women aged 15–44 years) and even decreased steadily (to below 2 per 1000 in 1960–61). In the early 1960s, the rate increased slowly. In the late 1960s and early 1970s, the rate increased more rapidly, unaffected by the legal change in 1975:

Legal abortion rate per 1000 women aged 15–44 years (ratio per 100 livebirths): Sweden, 1966–76.

Year	Abortion rate	(Ratio)
1966	4.7	(6)
1967	6.2	(8)
1968	7.0	(10)
1969	8.7	(13)
1970	10.0	(15)
1971	12.1	(17)
1972	14.5	(22)
1973	16.0	(24)
1974	18.5	(28)
1975	20.1	(31)
1976	20.1	(33)

Between 1968 and 1975, the proportion of first trimester abortions increased from 43% to 87%. Over the same period, the proportion of abortions with sterilisation decreased from 9% to 1%. In 1975, 91% of all abortions were performed by aspiration or curettage. First trimester abortion may be performed in outpatient facilities. Between 1971 and 1976, the outpatient proportion of legal abortions increased from 16% to 69%.

Contraceptive advice and fitting is free-of-charge; contraceptives, only partially so. Caps, IUDs, and limited quantities of condoms and spermicides, are free-of-charge. Oral contraceptives cost the same as other drugs: up to Skr. 20 (£2.30) per prescription.

The government subsidises contraception services with a grant of Skr. 85 per physician consultation, or Skr. 42 per midwife (or other) consultation. Midwives are being trained to give contraceptive advice, to insert IUDs and to prescribe oral contraceptives (under medical supervision). From 1 January 1978 these specially trained midwives will become legally competent to prescribe oral contraceptives.

Until recently, male sterilisation was illegal, while female sterilisation was only permitted on medical, eugenic and sociomedical indications. In January 1976, male and female sterilisation, for contraceptive purposes, was legalised for Swedish residents aged 25 years or over, on request; for those aged 18–24 years, on eugenic grounds (and for women only, on medical grounds), with the approval of the National Board of Health and Welfare; but not for those under 18 years of age. Presterilisation counselling is obligatory.

Correspondent: Kajsa Sundström, Stockholm.

UNITED KINGDOM

In the UK (except Northern Ireland), the Abortion Act 1967 legalised abortion in April 1968. Two physicians must certify that continuing pregnancy would involve risk to the woman's life, or to her health or that of any children (taking account of her environment), *greater* than terminating the pregnancy; or that there is a substantial risk that the child would be seriously handicapped. Since the mortality risk of at least first trimester abortion is less than that of full term pregnancy, the law may be liberally interpreted. In practice, the availability of abortion is primarily limited by the restrictive attitudes of some National Health Service (NHS) physicians.

NHS abortion rates range widely across the country. Consequently, about half the abortions of residents are performed in private (nonNHS) clinics, including those of the nonprofitmaking British Pregnancy Advisory Service, and Pregnancy Advisory Service (in London). In addition, nearly all the abortions of nonresidents are performed in nonNHS (mainly profitmaking) premises.

Legal abortion nonresident proportion, resident NHS proportion, abortion rate per 1000 women aged 15–44 years (ratio per 100 live births), and total abortion deaths: Britain, 1968–76.

Year	Nonresidents (%)	Residents: NHS (%)	Resident abortion rate	(ratio)	Abortion deaths (% maternal)	
1968	5	67	3.4	(4)	51	(24)
1969	8	69	5.2	(6)	38	(23)
1970	11	64	7.9	(9)	32	(20)
1971	24	59	9.8	(12)	29	(20)
1972	30	55	11.3	(15)	29	(23)
1973	32	53	11.4	(16)	14	(13)
1974	31	53	11.2	(17)	13	(13)
1975	22	51	10.9	(17)	8	(10)
1976	19	52	10.2	(17)	7	(8)

The resident abortion rate increased steadily between 1968 and 1972, remaining constant between 1972 and 1974 (at 110 000–120 000 p.a.), and decreased slightly thereafter. Before the Abortion Act 1967, a frequently quoted estimate of the incidence of illegal abortion was 100 000 p.a. Prosecutions for abortion, septic abortion hospital admissions, and illegal abortion mortality, fell sharply between 1968 and 1975. The incidence of unskilled abortion has presumably decreased even more steeply.

In 1971, the government appointed the Lane Committee on the Working of the Abortion Act. In 1974, the Lane Committee unanimously concluded: "the Act has relieved a vast amount of individual suffering . . . the gains facilitated by the Act have much outweighed any disadvantages for which it has been criticised". It supported the Act, and recommended administrative, professional and educational solutions to the problems identified in its working. Restrictive legislation would "increase the sum of human suffering and ill-health, and probably drive more women to seek the squalid and dangerous help of the back-street abortionist". The Lane Report also recommended first trimester, outpatient NHS abortion, and avoiding the delays encountered in NHS treatment in much of the country. (See also the *Regional Information Bulletin*, April 1974).

Also in 1974, NHS contraceptive advice and supplies became free-of-charge. Contraceptive practice, by the more effective methods, increased between 1968 and 1975:

Roughly estimated current use of contraception (% women aged 15–44 years) by method: UK, 1968 and 1975.

Method	Year (%) 1968	1975
ALL (± method)	100	100
All (+ method)	71	82
None (– method)	29	18
Oral contraception	10	26
Condom	25	23
Withdrawal	20	13
Rhythm	7	4
IUD	2	3
Cap	3	2
Spermicide	3	1
Sterilisation	1	10

Induced abortion is plainly not being used as a routine method of fertility regulation in Britain. Between 1969 and 1976, the birth rate decreased from 16.4 to 11.9 per 1000 population (the lowest ever recorded, and latterly below the death rate). However, the *decrease* in live births was 3½ times the *increase* in legal abortions of residents.

NHS abortion is frequently combined with female sterilisation. The proportion of married NHS abortees sterilised concurrently has decreased slowly: from 55% in 1968, to 34% in 1974.

The first trimester (under 13 weeks since LMP) proportion of resident abortions increased from 62% in 1968, to 83% in 1974. Between 1968 and 1974, resident abortions performed by aspiration increased from 24% to 79%; by curettage, decreased from 42% to 11%; and by hysterotomy, decreased from 27% to 3%.

Minority opposition to legal abortion continues. In 1974 and 1976, there were major attempts to restrict the Abortion Act, both lapsing through lack of parliamentary time. In May 1976, a public opinion poll showed that 55% favoured "abortion for all who want it", against 31% who were opposed.

Note: Legal abortion mortality in Britain (1968–73) will be analysed in the next issue of the *Regional Information Bulletin*.

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YUGOSLAVIA

According to the Yugoslav Constitution, effective in 1974, free decision on childbirth is a human right, which may be limited only on health grounds. Implementing this right is a task within the competence of each socialist republic and province. These regulations

must settle the medical aspects of fertility regulation as a whole: abortion, contraception and sterilisation, as well as subfertility treatment, especially artificial insemination.

So far, only the Socialist Republic of Slovenia has legislated fertility regulation as a whole (effective, 1 July 1977). The Socialist Republic of Croatia has also examined the matter in detail, but the law has not yet passed the Republican Assembly. The remaining socialist republics and provinces have only regulated (or will shortly regulate) abortion. Nevertheless, they also intend to take further legal steps concerning other methods of fertility regulation.

Since abortion is the constitutional right of every woman, the regulations of all republics and provinces determine that the pregnant woman may herself decide on abortion. If the duration of pregnancy is under 10 weeks, abortion must be performed at the pregnant woman's request, without committee approval.

The right to terminate pregnancy beyond 10 weeks is limited by law on health grounds. According to the Slovenian law, termination of pregnancy may be performed only in conformity with the committee's decision, based on the relative risks to the woman's life and health, and future motherhood, of continuing or terminating her pregnancy. According to the regulations of other republics and provinces, the decision on abortion after 10 weeks is left to the committee, on the basis of a wide range of indications (medical, eugenic, judicial, and socio-economic).

In Slovenia, every pregnant woman capable of deciding reasonably about abortion (i.e. with the capacity of discernment) may request abortion, regardless of gestation period. Consequently, even minors, with the capacity of discernment, do not require parental consent. Parents are informed about abortion (requested or performed) only if in the interest of the minor. According to the Croatian law, parental consent is not required if the pregnant woman is over 16 years old.

The law of the socialist republic of Bosnia and Herzegovina additionally requires that women under age must work for a living.

The laws of other socialist republics and provinces stipulate that minors may not be aborted without parental consent. Being an individual right, and not a right of the couple, its realisation is not subject to the partner's consent.

The committee deciding on abortion, after 10 weeks of pregnancy, must decide within a short period of time (3–7 days, depending on the republic). The pregnant woman may appeal against a refusal to a higher committee, which must also decide within a short period of time (7–8 days, depending on the republic). All republics require the committee to include physicians and a social worker, who must inform the pregnant woman about alternatives to abortion, and about prenatal and social welfare services.

The woman pregnant for less than 10 weeks may address herself for abortion directly to a medical institution. Those pregnant over 10 weeks are sent through the committee.

Medical institutions must perform abortion by an optimal technique, with appropriate hospitalisation. After abortion, the woman must have adequate care and sick-leave. All personnel participating in the procedure must inform the pregnant woman about the technique and consequences of abortion, about her legal rights, and especially about contraceptive methods.

Apart from the Slovenian law, the regulations of certain other republics also contain fundamental stipulations on the rights of both men and women to be instructed, advised and informed about other methods of fertility regulations, as well as on the right to their use.

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