



**Women's Health, Family Planning, and
Institutionalized Children in Romania**

Site Visit—March, 1991

TRUST THROUGH HEALTH, INC.

U. S. AGENCY FOR INTERNATIONAL DEVELOPMENT

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EXECUTIVE SUMMARY

I. Introduction

In 1989 the world witnessed an historic political upheaval in Eastern Europe as one country after another broke away from oppressive authoritarian regimes. Romania, perhaps even more than the others, evoked compassion from the United States. Nearly 10,000 women had died during the preceding twenty-five years from the complications of illegal abortions, the result of pro-natalist policies enacted in a bizarre attempt to increase the population from 23 million to 30 million. Maternal mortality soared to levels ten times higher than other European countries. The same policies in the context of profound poverty resulted in the placement of thousands of children in orphanages and other institutions. The poignancy and plight of these children transfixed America.

Congress responded with a mandate for humanitarian aid to Romania. Accordingly, The United States Agency for International Development (USAID) initiated support for several programs for children. Family planning was also identified as a salient issue in Romania. Since contraception had been outlawed during the Ceausescu regime, Romanians had little awareness of modern family planning methods and the supply of contraceptive commodities was limited. In addition there had been a marked increase in legal abortions since the uprising. These facts suggested that US humanitarian aid might also be usefully applied to develop family planning programs.

Our USAID team included experts in obstetrics-gynecology, epidemiology, nursing, public health, child development and family planning program development. It was constituted to assess the current status of family planning in Romania, to review the programs for children and to make recommendations for future US aid in family planning. The team was well received by the Romanian Ministry of Health. We met extensively with health officials and visited facilities in Bucharest and five other cities as well as in several rural locations. We found Romanian physicians and nurses to be concerned, determined and committed to improving the health of the Romanian people. Developing a national family planning program is a high priority for the Minister of Health and US aid for this purpose will be appreciated and well utilized.

II. Analysis of Specific USAID Family Planning Concerns

The apparent elevation of cardio-vascular and cerebrovascular mortality in women of reproductive age.

Romania's cardiovascular mortality is below that of several other Eastern Bloc countries, but considerably higher than Western nations, and it has increased while cardio-vascular mortality in the rest of Europe has declined. A 1989 Ministry of Health survey of 13,774 men and women found that these conditions are concentrated in older people. They also occur in younger women, but primarily are a concern for women 35 years of age and older. The scientifically proven risk factors associated with heart attack and stroke are male sex, older age, cigarette smoking, high blood pressure, abnormal blood lipids (cholesterol), diabetes, obesity, and a family history of early heart attack or stroke. The frequency of these risk factors in Romania is known, and they are infrequent among younger age women.

Recent studies have found that present low dose oral contraceptives are of much less concern in the causation of heart disease and stroke than formerly thought. A respected American study of the 1980's found that fewer than 2 extra cases of venous thrombosis could be attributed to oral contraceptive use in 39,000 women years of observation. Using oral contraceptives may slightly increase risk of heart attack, but most of the women who have heart attacks are cigarette smokers. In the 1980's study mentioned above, no heart attacks were seen. Oral contraceptives were introduced in the West at a time of high cardiovascular disease prevalence, but rates of heart disease fell steadily even so. This is perhaps the strongest argument that introduction of oral contraceptives in Romania will not materially alter risk for heart disease and stroke.

What are the relative risks and benefits in Romania of available contraceptive methods?

Contraceptive benefits of modern methods are obvious: when used properly, very low rates of unwanted pregnancy result, and the need for abortion is considerably reduced. In addition, modern methods provide very important non-contraceptive benefits. Oral contraceptives markedly reduce risk for developing ectopic pregnancy, prevent deaths from cancer of the uterine lining and ovarian cancer, reduce benign breast tumors and ovarian cysts, prevent menstrual pain and reduce menstrual blood loss. The risks of oral contraceptives are small increases in occurrence of venous thrombosis and of heart attacks or strokes, primarily in women over 35, and in the case of heart attacks and strokes, primarily in cigarette smokers.

Intrauterine devices (IUDs) provide excellent contraception with no systemic side effects. They may increase menstrual bleeding and pain which will lead to removal of the device. They are weakly associated with infection and inflammation in the pelvis which can lead to sterility. Most of the risk is seen in women who are exposed to sexually transmitted infection. In the past Romanian women have frequently suffered from pelvic infection, apparently from illegally induced abortion. The frequency of these infections appears to be falling with the legalization of abortion. The use of IUDs by appropriately screened Romanian women should markedly reduce the need for abortion and the post-abort infections formerly seen.

Barrier contraceptives such as condoms and diaphragms offer acceptable contraception, and have as a non-contraceptive benefit a marked reduction in risk for sexually transmitted infections and reduction of the risk for cervical cancer.

Oral contraceptives, IUDs and barrier contraceptives can all be safely and effectively used in Romania with supervision achievable by the existing health delivery system.

Is reproductive health a problem?

Ceausescu's pronatalist policy of severe restriction of contraception and legal abortions was a disaster unparalleled in the developed world. It produced terrible maternal mortality rates, ectopic pregnancies, sterility, chronic pelvic infections, and excessive rates of low birth weight infants (prematurity). The change to modern contraception, backed up by easily available legal abortion, can be expected to produce marked improvement. Producing this shift is the major challenge facing those who provide reproductive health services in the country.

Evidence is surfacing that Romanian women are willing to make this change, yet many women do not know about modern contraceptive choices. When asked whether they would use contraceptive methods to prevent unwanted pregnancies, most women express a desire to do so.

Sexually transmitted diseases (STDs) are of concern in Romania, though there is little known about their incidence in the Ceausescu years. The overall rate of gonorrhoea in 1989 was 35.7 cases per 100,000 population, which is not excessive by Western standards. A Romanian health survey reported that 1.32% women suffered from salpingitis and 2.45% from metritis—conditions that bespeak the presence of STDs but which may also be caused by the practice of unsafe illegal abortions. Limiting IUD

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insertion to specialists as proposed by the Ministry of Health is a sufficient policy to prevent IUD insertion in women with a high risk of infection.

The former illegal practice of abortion has contributed to a high rate of sterility and ectopic pregnancies. The rate for the latter is approximately five times that experienced in the United States. One can anticipate that with the legalization of abortion and the increased use of contraception that these rates will fall. The earlier practice of abortion has also contributed to the high rates of premature infants. Between 20-25% of newborns weigh less than 2500gms. This, too, is expected to improve.

Women in Romania have reproductive health problems. But, extending the availability and judicious use of family planning will improve the reproductive health of Romanian women.

Can the Romanian medical system adequately screen users of family planning?

The Romanian medical system is a modern European one whose advances have been truncated by intervening events of history. Even though contraception has been legal only for a short time doctors are adequately screening patients for oral contraceptives and IUDs, using protocols and patient records that have been developed by the Ministry of Health. Most OB-GYN specialists are quite capable of adequately screening patients, including those who may show a propensity for cardiovascular disease, and to safely oversee contraceptive use. The many family doctors (general practitioners) who are found at the dispensary level, also express an interest in being given an orientation to contraception, including the screening protocols, and there are some who are already trained. But, to adequately screen for cardiovascular disease physicians must have adequate equipment, including such basics as sphygmomanometers which are not always available.

Health Services Research

There is a pressing need to determine the current knowledge, attitudes, and practices (KAP) of Romanian women towards contraception. The design and implementation of this KAP survey should not delay the implementation of USAID's family planning program, but will clearly provide on-going direction. Because the Institute of Maternal and Child Health, with support from UNICEF, is planning a nutrition survey of children in the next few months, serious efforts should be made to combine or at least coordinate the two surveys.

Given the speed with which the use of contraception may be expected to increase in Romania and the likely changes in preferences as the result

of improved contraceptive education and experience, the Ministry of Health should consider conducting field surveys fairly frequently—e.g. every two years—until family planning becomes well established in Romania.

Program Development

Support for the Society for Education in Contraception and Sexuality (SECS), a non-governmental organization, through the Center for Development and Population Activities (CEDPA) is strongly recommended. SECS should be viewed first and foremost as an educational organization, both in terms of educating the general public on issues relevant to family planning and of training health providers. SECS should not be developed at this time as a network of delivery systems which would parallel the government system, particularly in view of the uncertainty with respect to the future of privatization in medicine. There is no prospect at this juncture that such a network could be sustained without continuing external support.

The establishment by SECS of a single model family planning delivery unit is recommended to support the primary mission of SECS, *i.e.* education. Health providers could be trained in the model unit and SECS staff from the model unit could train providers in their own districts. This would complement and work through the government's current delivery system which is the only significant delivery system in the country.

Family planning is a new venture in Romania. Major efforts should be made to bring together a community based advisory group to define policies and to suggest guidelines related to family planning. Currently available surveys and international donor recommendations should be made available in Romanian for comparison. This advisory group can serve to inform CEDPA and SECS in an on-going manner.

III. Recommendations for USAID Family Planning Program Support.

- A. Given the urgent situation in Romania, CEDPA should begin immediately to establish its office and management structure using the readily available documentation from governmental and international sources.
- B. Production and dissemination of family planning literature and training materials in Romanian for the public, for clients attending clinics, and for health care providers should begin immediately.

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- C. To ensure full professional and public participation in the program, a community based advisory board to SECS should be established.
- D. SECS should work with a national counterpart at the Ministry level to coordinate the acquisition, monitoring, and distribution of family planning supplies and equipment.
- E. CEDPA should assist SECS to establish a single model clinic in Bucharest for the specific purpose of enhancement of training, aware that the Ministry of Health will continue to be the realistic sole provider of contraceptive services - pending potential changes in the current political and economic environment.
- F. Every effort should be made by USAID and by CEDPA to coordinate their activities in family planning with the current overall plan of the Ministry of Health and with the current effort by other multilateral and bilateral agencies including, among others, UNFPA, the World Bank, UNICEF, WHO.
- G. USAID should support family planning KAP surveys in the near future.
- H. USAID should consider providing technical assistance to strengthen the Ministry of Health family planning program, specifically in the areas of policy formulation, strategic planning and management.

IV. Care and Development of the Institutionalized Child

The impact of the Ceausescu regime on the lives of Romania's children has been profound. While millions of children live with their families on the brink of destitution the international community has focused on the plight of institutionalized children. Media reports shortly after the revolution generated an enormous influx of volunteers and charitable donations - along with constant pressure on the Romanian people and government to alleviate a problem that was years in the making.

Our group visited orphanages, homes for "irrecoverables", day care centers and creches, pediatric hospitals, and pediatric AIDS wards in Bucharest as well as in Constanza and Iasi.

We were impressed with the cooperation received from all personnel in the institutions we visited. In spite of the international media attention which might have made them defensive, directors and other staff were gracious, patient, and answered questions with apparent openness and

candor. Although these institutions continue to have many problems, it is clear that considerable progress has been made during the last fifteen months. The increasing attention directed to the plight of children and the considerable assistance which has come from a variety of national and international sources have already led to significant changes. The challenge is to coordinate all these offers of assistance into a total system which will enhance the development of the children and ease the burden of their families.

V. Recommendations for Institutionalized Children

Our recommendations are offered in the context of what we have been able to learn in a short visit during a period of rapid change. They were initially offered to the Minister of Health of Romania. They are general in nature and are now submitted as potential guidelines for any future USAID involvement.

- A. Primary emphasis should continue to focus on the reduction of the number of children in institutions through the improvement of the social service capacity of the country; through support of family reinstatement programs; through early, appropriate adoption programs; and through the development of foster homes.
- B. The quality of life in institutions must continue to be improved through the provision of additional personnel and by increasing access to pre- and in-service training for staff at all levels.
- C. Reduction in the size of institutions should be considered along with the initiation of a comprehensive child development framework in all institutions, especially those providing care for "irrecoverables".
- D. The creches program should be expanded as a means of reducing the dependence on orphanages.
- E. All institutionalized children, especially those designated "irrecoverable" should be evaluated by an interdisciplinary team to establish actual medical, social, and educational potential.
- F. A simple instrument (*i.e.* a check list) to assess quality standards should be developed in an attempt to provide objective guidelines for institutional improvements.

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- G. Finally, a procedure should be developed to coordinate the multiple national and international efforts to improve the welfare of institutionalized children.

I. Introduction

Congressional Mandate

The plight of thousands of children interned in institutions in Romania and the dire conditions caused by the prohibition of family planning services, brought to light after the December 1989 revolution, riveted the world's attention throughout 1990. Stark images of children lying passively in overcrowded cribs sparked a worldwide outcry and flow of humanitarian aid. The status of women's health and the devastation wrought by the Ceausescu government's measures aimed at preventing family planning was equally startling. In response, the US Congress mandated short-term humanitarian aid. Because of concerns about potential persistent human rights violations the US government has not approved direct bilateral aid to Romania, but has sought to bring relief through non-governmental organizations (NGOs). A \$2 million contract was signed by USAID with PACT (Private Agencies Cooperating Together) to help improve the conditions of institutionalized children. Concern about the lack of family planning services and equal concern about the high rate of abortion in Romania also generated a Congressional response leading to the appropriation of \$1.5 million to the US Agency for International Development for use in supporting family planning services.

Objectives of Trust Through Health Mission

Trust Through Health, Inc. a 501c3 Massachusetts based NGO, registered with US AID as a PVO was asked to carry out a site visit to Romania in March 1991. Trust Through Health (TTH) was asked to investigate specific concerns about the use of family planning in Romania, to make recommendations for the effective use of US aid to support family planning through NGOs and to

review the progress made in the programs for institutionalized children. The specific concerns included: 1) an apparently excessive cardiovascular and cerebrovascular mortality among women of reproductive age (WRA) 2) the relative risks and benefits of available contraceptive methods in Romania 3) reproductive health among Romanian women and 4) the capacity of the health care system to adequately screen women for family planning.

Approach of the Trust Through Health Mission

The TTH/USAID team was composed of experts in obstetrics-gynecology, epidemiology, nursing, family planning organization, child development and public health. Team members included Dr. Julius Richmond, Professor Emeritus of Health Policy at Harvard University and a former US Surgeon General and Assistant Secretary of Health; Dr. Philip Stubblefield, Chief of Obstetrics and Gynecology at Maine Medical Center; Dr. Roger Rochat, a senior epidemiologist at the Centers for Disease Control in Atlanta; Dr. Bettye Caldwell, an internationally recognized expert in child development; Dr. Marie Farrell, Chair of the Department of Nursing at the University of New Hampshire and former Chief Nurse for WHO/Euro; Mr. John Paxman, a faculty member at the Harvard School of Public Health with a long history of designing and evaluating family planning programs in the developing world; Dr. Richard Bail, Executive Director of Trust Through Health with training in public health; and Dr. Michael Heisler, Associate Director of Trust Through Health.

Dr. Richmond served as Chief of Party and along with Dr. Caldwell reviewed the status of children in institutions in Romania. Together they wrote the substantive components of chapter six of this report, "Children in Institutions." Dr. Stubblefield took the lead in exploring the current status of family planning activities in Romania and is the primary author of chapter five, "Safety of Family Planning in Romania."

Mr. Paxman reviewed the organizational structure of and the operational capacity of the current family planning system. He made major contributions to chapter three, part B, "Family Planning, Current Situation." Dr. Farrell had previous experience in Romania having led the WHO/EURO team that conducted WHO's initial situation analysis just after the uprising. She acted as general advisor to the team and is responsible for segments of the report that deal with the training of health care providers. Dr. Rochat served as epidemiologist for the team. His services were supported by USAID through a Participating Agency Support Agreement with the Centers for Disease Control Division of Reproductive Health. He worked with physicians, statisticians, and demographers within the Ministry of Health and is the

author of chapter four, "Reproductive Health Statistics in Romania." He, along with Mr. Paxman, provided background data for Dr. Stubblefield. Drs. Heisler and Bail provided administrative support for the team and together provided much of the background information included in this report including chapters one and two as well as the first three parts of chapter six. The chief contents of the report were presented to US Embassy staff in Bucharest on Friday, March 22, 1991 and at a Department of State debriefing in Washington, D.C. on Tuesday, April 2, 1991. The full report was reviewed and edited by Drs. Heisler, Richmond, Stubblefield, Bail, and Rochat and by Mr. Paxman.

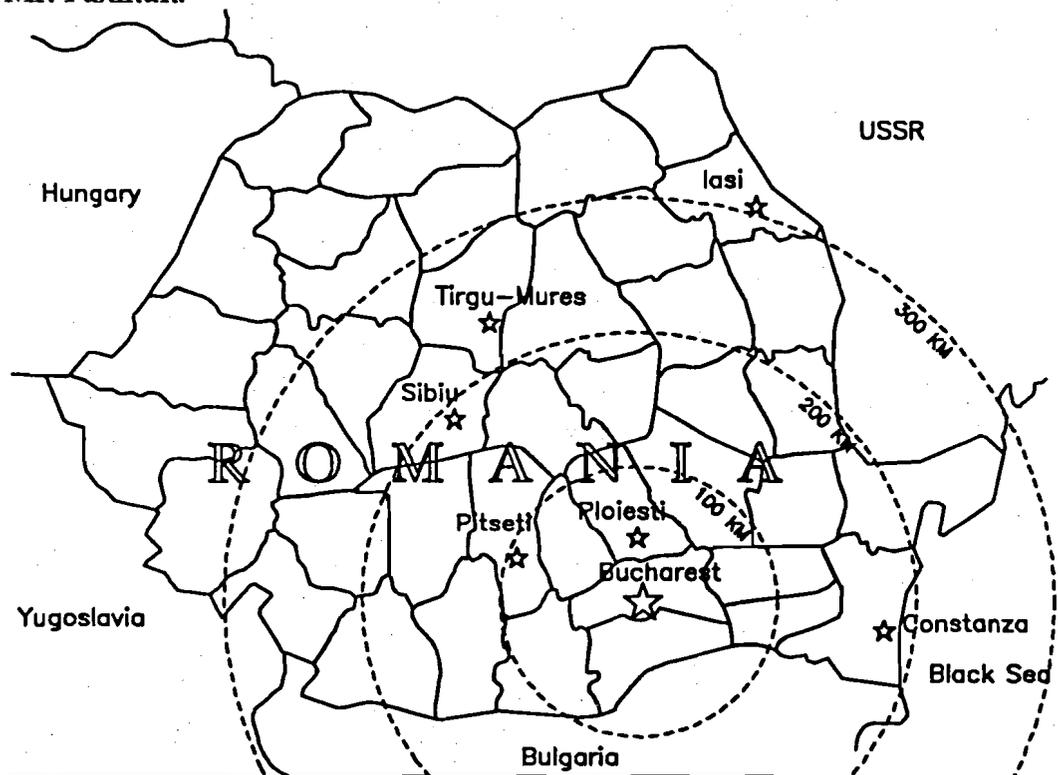


Figure 1 Trust Through Health Team site visits

Before leaving for Romania, extensive efforts obtained background material from and coordinated with the major external donors including the World Bank (WB), The World Health Organization (WHO), the United Nations Fund for Population Activities (UNFPA), the United Nations Children's Fund (UNICEF), and the International Planned Parenthood Foundation (IPPF). Once in country (see Annex D) the team held meetings with health officials and professionals at the national, district and dispensary levels. Members of the team visited institutions in seven Romanian cities (Figure 1). They assessed the status of privatization and NGOs and met with

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several NGOs including the Society for Education in Contraception and Sexuality (SECS), Romanian Save the Children, and the Romanian Association of General Practitioners. The sources of information in this report include the background reports listed in the bibliography (see Annex F); personal interviews conducted by team members; and from data provided by WHO/EURO, the Computing and Health Statistics Center within the Ministry of Health, the World Bank, and UNICEF.

II. Background

Current Political and Economic Conditions

Romania, a southeastern European country bordered by the USSR to the north, the Black Sea and Bulgaria to the south and east, and Hungary and Yugoslavia to the west covers an area of 237,000 square kilometers. The country has rich agricultural plains to the east and in the delta of the Danube, and has the mountains of Transylvania in the west. Forty-one districts called *judets* administer national programs and coordinate the activity of local governments.

In December, 1989 as the Communist regimes of Eastern Europe crumbled, a spontaneous popular uprising occurred in Romania leading in short order to the overthrow and execution of Mr. Ceausescu and the establishment of a provisional government. Over 90 parties were formed after the revolution and the National Salvation Front, which led the country during the interim period, won an overwhelming victory in free elections which took place in May 1990.

Romanian officials within the Ministry of Health and at the regional hospitals we visited suggested that data accumulated prior to the uprising be reviewed with caution. We found no analysis of the quality of data and have no basis other than Dr. Rochat's analysis to evaluate or judge data quality. Nevertheless, the following statistics at least provide a basis for discussion pending completion of the planned 1992 census:

Population	23,150,000
Child Population (0-15)	5,900,000
Child Population (0-5)	1,700,000
Infant Mortality Rate	22/1000
Under Five Mortality Rate	28/1000
Immunization Rate for under 1	92%

Primary School Enrollment	97%
Literacy (15 years and over)	96%
Physicians per 10,000 people	20.1

Although the GNP per capita was \$2969 in 1988, this is misleading because the vast majority of the GNP was not returned to the population or used for human services. Most Romanians live in poverty and struggle daily to simply acquire the basic needs of life.^(25,27,29) Many hours each week are spent waiting in food lines, and even so, many staples are frequently not available. Adequate heat and electricity are lacking for many persons. Potable water and sanitation facilities are not found in many homes. In an effort to move toward a free market economy food subsidies were reduced on April 1, 1991. This resulted in wide-spread apprehension and in public demonstrations during and after our site visit.

Overview of the National Health Services System

Administrative

The health system in Romania is administered by the Minister of Health through 41 judet health offices which are called "directorates of district health." These directorates administer all health activities in their judet: the district hospital, any town hospitals, all polyclinics and all rural and urban dispensaries. Romania has 181 large hospitals, 92 polyclinics and more than 4000 dispensaries. A district typically has a population of 200,000 to 900,000 persons. (see Annex A for organization chart)

Soon after the uprising medical personnel in each district elected new medical directors. Quite often those elected had almost no training or experience in epidemiology, health education, or public health administration. The lack of training and the tradition of continued clinical practice by physician-administrators constrains the development of effective management capacity.

Ministry of Health

The Minister of Health, Dr. Bogdan Marinescu, an obstetrician-gynecologist, has overall authority for policy and administration. The Ministry is assisted by 3 organizations: the Academy of Medical Sciences, the Central Discipline College and the Union of All Medical Societies. Inter-sectoral

coordination occurs through the Health Council. The Ministry of Health is organized into a number of administrative units (Annex A), including the Directory for Mother, Child and Adolescent Health where the responsibility for family planning resides. In addition several state supported academic institutes serve in an advisory capacity and carry out health research. Examples include the Institute of Hygiene and Public Health under Professor Cucu, the Institute for Health Services and Management under Professor Enachescu, and the Institute of Maternal and Child Health under Professor Georgescu.

Budget

The percentage of government expenditures allocated to health care declined from 3.4% in 1965 to 2.4% in the years 1984-1988. This represents about 770 leis per capita or about \$20 per person per year.

Pharmaceuticals

Pharmaceuticals are available through state operated pharmacies or through the parallel market. Many drugs are in short supply, and, specifically, oral contraceptives and intrauterine devices are frequently unavailable in many areas although access to contraceptives seemed to be increasing with the influx of international assistance. Romania does not produce oral contraceptives or intrauterine devices. One factory has the capacity to produce condoms but most are imported. The latter are sold in tobacco shops but not in pharmacies. Additional information about pharmaceuticals and commodity supply can be found in chapter three, part B.

The World Bank Health Project.

A major loan of approximately \$235,000,000 from the World Bank is currently under discussion for health sector development. The project is directed toward restructuring the health system, improving health services including drug availability and institutional development. The government has already taken several of the steps advised by the World Bank. It has established the Institute for Health Services and Management, has appointed a Director for Health Promotion, and has established a locus for family planning in the Directory of Mother, Child, and Adolescent Health. Ministry personnel at all levels emphasized the importance of the World Bank plan. The Bank team returned to Bucharest April 11 for further meetings with the Ministry of Health. The Ministry appears seriously committed to meeting Bank deadlines and the Minister hopes that funds will become available in the summer of 1991.

Health Care Providers

Health personnel for family planning activities in Romania include nurses, general practitioners and specialized physicians, but these providers must cover other services as well. In 1981, all family planning training was eliminated and continuing education in that field was not permitted. However, starting in late 1990 new programs have been designed which will incorporate family planning into medical and nursing school curricula and re-establish training programs for social workers.

Physicians

As of 1991, there are eight university medical centers operated by the Ministry of Education under the technical supervision of the Ministry of Health. About 48,000 physicians (or one physician to 479 people) work for the Ministry of Health. Approximately 1000 are trained in obstetrics and gynecology. Of this number, one third are over 60 years of age and have no clinical training in family planning.

Medical training begins after high school. Students attend six years of medical school, a three year practicum and a three year residency program. They receive little or no supervision in clinical practice. Government family planning services are currently provided through regional maternity hospitals under the supervision of gynecologists. Plans within the Ministry of Health and within the World Bank Proposal include extension of family planning counseling and prescription for contraceptives to general practitioners. Insertion of IUDs will remain the responsibility of gynecologists.

Nurses

About 135,000 nurses work within the Ministry of Health; 25,000 more are needed. 2,000 are prepared each year; 4,000 are required. The government will soon implement a pension system offering retirement to anyone over 50 years with 25 years of service. Presumably many nurses will retire.

As of 1990, 27 nursing schools and one postgraduate nursing school were functioning. Previously, students completed eight years of elementary school and entered high school at age 14. Basic nursing preparation occurred within the four years of high school. After high school a student completed one year of nursing. Continuing education was not available.

Those involved in restructuring the new system envision a "post basic" program (R.N. to baccalaureate) model with subsequent, life long learning possibilities to ensure that Romanian nurses once again have an education similar to others in Europe and to enable them to meet Council of Europe nursing education criteria.

Social Workers

Social work services have historically been an integral part of the Romanian health system. The participation of social workers in health care delivery was reduced over the past 10 years. Additionally, the absence of formal university programs during the same time period depleted the overall number of trained social workers in the country. Currently, there are only 75 social workers in Romania. Consequently, social services were provided by nurses, a practice out of keeping with the nurses preparation and expertise. Current plans within the Ministry include the reinstatement of training programs for social workers, supported through the WHO/EURO Country Program.

III. Family Planning Background

History

The recent history of procreation in Romania has been tragic. For the past twenty-five years the official slogan of the government was to have "as many children as possible." The Ceausescu regime implemented pronatalist policies with an attempt to induce each woman to bear 5 children in order to increase the population to 30,000,000. The impact of that policy on the health of women and children was dramatic. The crude birth rate did increase for a time from 15/1000 in 1966 to 26/1000 in 1967, but the maternal mortality rate soared to over 160 per 100,000 live births or in excess of 500 maternal deaths per year, by far the highest rate in Europe and higher than many developing countries.

The population pyramid on the wall of the Health Directorate in Sibiu graphically tells the story. The births for the years 1969 and 1970 tripled. But as one follows the pyramid down it is evident that Romanian women quickly found a way to limit their births. Within three years of the pronatalist policy the birth rates began declining rapidly. One of the principal adjustments women made was to seek out abortion services, even though they were illegal and dangerous. Review of available data and discussions with obstetrician-gynecologists during our site visit revealed estimates for illegal abortions per year to range between five hundred thousand and one million. No hard data is available to help narrow this range, but in either case the point is the same: the risk to the health of women of child bearing years, as a result of the Ceausescu policies, was significant. In addition to the morbidity and mortality from illegal abortions, the number of unwanted births also in-

creased leading to an equally significant increase in the number of institutionalized children throughout Romania. (see chapter six.)

These illegal abortions were supplanted by legal abortions within a short period of time after the December 1989 uprising. Less than a week after the uprising the restrictive abortion law was repealed and was replaced by the law of the status quo ante exactly as it had been in between 1957 and 1966.

Current Situation

Demographic Data

In 1990 the population of Romania was approximately 23,000,000. The number of women in fertile age range was estimated to be 5,200,000. Of these about 10% or 1,000,000 are estimated to be sterile or infertile, most as a consequence of prior illegal abortions. The number of expected live births was 400,000, and the number of sexually inactive women was 600,000. Thus approximately 3,200,000 women are at risk of becoming pregnant. Approximately 1,000,000 legal abortions occurred in 1990 as a direct result of the repeal of the abortion law and the unavailability of modern contraceptive alternatives.

Overwhelmed by the need to provide family planning services for so many surgical patients so suddenly and lacking familiarity with modern contraceptive methods or supplies, Romanian gynecologists were unable to offer contraception to the thousands of women who came for abortion. Volunteer physicians from the international community again were most helpful. They brought new low dose oral contraceptives and new intrauterine devices. Many maternity hospitals received assistance. Each of the maternity hospitals that we visited had already inserted approximately 1000 donated IUDs and placed 1000 or more women on oral contraceptives depleting most of their supplies.

Currently, the Ministry of Health estimates that of 3,500,000 women at risk of pregnancy 14.8% use OCP's, 26.2% use an IUD, 11.6% use condoms, 8.2% use natural methods, 8.0% use traditional methods, 0.2% are protected by vasectomy, 0.1% have tubal ligation and 32% use abortion.

Current Practice

The maternity hospitals we visited in the capital and other cities were all providing 50-100 abortions a day, 5 days a week. All have very busy abortion services, offering a safe medical procedure done under local anesthesia on an

outpatient basis, similar to U.S. abortion clinics, except that 3 procedures may be done at a time with 3 teams of nurses and doctors working with 3 operating tables in one room (see below). At Hospital Polizu, one of the premier institutions in the country, births in 1990 numbered 4200, legal abortions 18,639, while illegal induced abortions (those done outside the hospital) numbered 2,323. Officials at the Hospital say that the institution serves 250,000 women. That translates roughly into one in eight women having an abortion in 1990 or about 100 abortions per day. The other two hospitals visited outside of Bucharest performed between 11,000 and 12,000 abortions annually, or about 60 to 80 a day.

We obtained abortion complication statistics for the first 7 months of legal abortion. (see chapter four) There were 3 deaths among 443,163 legal abortions, a remarkable safety record, entirely comparable to U.S. statistics. Some self induced abortions are still occurring. Until the arrival of volunteer physicians from abroad legal abortions were performed by cervical dilatation and sharp curettage (D and C). Volunteers brought a limited number of electric uterine aspirator pumps and taught the new technique of suction curettage which is the standard in the West. Suction curettage is safer, quicker, less painful, and less likely to result in long term sequelae than is D and C.

In the Hospital Polizu abortion teams of three consultants, five interns and five fifth-year medical students are assigned for one week rotations. Three teams of a surgeon and a nurse work simultaneously through the day. The women seeking abortions are screened by the nearby polyclinic and appointments are set for the pregnancy termination in two to four days. In the surgery the woman is given information about the nature of the procedure by both the nurse and the doctor while local anesthesia, used in all cases, takes effect. After the abortion, the woman is escorted to the recovery room where she joins ten to twelve other women. In cases where there is extreme discomfort, morphine is administered.

Knowledge, Attitudes, and Practice

Reliable KAP surveys are badly needed to guide the planning and practice of family planning. Knowledge of modern methods is not widely disseminated outside of a relatively small number of OB-GYN specialists. Our contacts believe knowledge of contraceptive practice is very limited among the general population but that women want to know more. Attitudes have been shaped by years of repression, fear and misinformation. The fear that OCP's and IUDs cause cancer is prevalent. For years women were advised by the government and the medical establishment not to use these

many women have since used abortion as birth control. Preliminary information suggests that Romanian women would accept of OCP's, IUDs and barrier methods when properly informed and counselled. Sterilization, male and female, appears not to be a popular option. Women apparently do not know of sterilization and do not request it and doctors say they are reluctant to bring up the subject because of fears generated in the past by the forced sterilizations of the Nazi era. Women who are having a second cesarean section birth are encouraged to have tubal ligation.

There is every indication that despite the restrictive policy on contraception many women discovered ways to obtain modern methods. Particularly in the Transylvania region, with its easy access to Hungary and beyond, oral contraception has been known for many years. The black market cost for a year's supply ran to 1,000 lei, a little less than half of an average month's wages. Even so, it is clear from those interviewed during our field visits that many do not know of the modern methods of contraception. We were able to interview about ten women who were awaiting their turn for pregnancy termination. Most had one or two children and had experienced two to four abortions. The latter were split evenly between those done before the revolution and those after. One woman had had five children and then subsequently four abortions. Under the earlier rules she could qualify for legal abortions, so had never had an illegal one. Two women explained how they had provoked their own abortions before the legal change. Both introduced a rubber catheter and used other "infusions" such as alcohol, citric acid, camomile tea and other toxic brews. Neither had suffered complications. One or two women said that a woman, probably a nurse or a midwife, came to their house and the induction was done anonymously.

Few of the women had heard of contraception. Of those who were aware of oral contraception and the IUD, half had never used them. A few were interested in using contraception to avoid the problem of repeat unwanted pregnancies. Presently an abortion costs 30 lei or about one dollar at the official exchange rate. The cost to the government of providing abortion is said to be six times that. When told that a cycle of pills would cost them 21 lei a month and that an IUD would cost 236 lei, one woman said that if she had to pay 5,000 lei for contraception it would not be too much. The cost of illegal abortion was said to be as high as 10,000 lei, about four months pay at the average salary.

Current Government Family Planning Capacity

Providers

Romania has approximately 48,000 physicians. While this gives a favorable physician-to-person ratio of about 1:500, only a very small fraction carry out family planning (see chapter two, part B for further detail). There are 135,000 nurses in Romania which represents a substantial shortage. Again, as noted previously, there is almost no training or experience in family planning for the vast majority of health care providers.

Facilities

Currently, family planning services are available in only a relatively few sites (207) which are all in government facilities. In some judets only one clinic site exists for the entire population. It is frequently located in the large maternity hospital and staffed by OB-GYN specialists, often on a rotating basis. There are often one or two nurses, usually mid-wives. Women frequently have to make several visits to the clinic in order to undergo tests and counselling and then purchase their preferred form of contraception in a pharmacy away from the clinic since the clinics do not provide the commodities on-site. If the choice is for an IUD they must return again for insertion.

Commodity Supply

Contraceptive supplies can be found in the country. In addition to the supplies that have been donated, the government has entered into contracts for the importation of OCs and IUDs. For 1991 it is planned that 1 million cycles of pills will be purchased. These will be of three types: Ovidon, Marvelon and Rigevidon (all from Hungary). Presently 436,000 cycles have entered the country under the contract. One million cycles is sufficient to provide 77,000 women with one year of contraceptive protection; that is coverage for about 1.5 percent of the women of fertile age. Additionally, the contracts call for the importation of 792,000 IUDs. One-half million of these are to come from Poland. The rest will come from Germany and Canada through WHO support. In 1991 to date 402,000 have entered the country.

All of these purchased supplies are destined for the government pharmacy system. Those supplies presently found in the specialist maternity hospitals are donated (more about this later). We made unannounced visits to five pharmacies at various sites around the country. All had one variety or another of contraception, including condoms. A few had all types.

The pills and the IUDs require a written prescription from a doctor. Most of these are written by specialists but an increasing number of general

practitioners are also prescribing OCs. IUDs are at the present only inserted by the specialists who use screening protocols comparable to those used in the United States. The Ministry of Health has developed a patient screening record for the various methods of modern contraception (see Annex E). Those specialists and doctors that have been oriented either by foreign doctors or in-country specialists are able to appropriately screen women for the contraceptive methods and to supervise their use. Many general practitioners and family doctors at the dispensary level expressed an active interest to be oriented to prescribe contraception, though not all dispensaries have adequate equipment to measure blood pressure, a recommended measure prior to prescribing oral contraceptives.

Donated supplies at the maternity hospitals has facilitated the switch to contraception by many post-abortal patients. For example, staff at the Hospital Polizu have inserted all but 30 of the one thousand IUDs they were given. They have disbursed at least three cycles of pills to each of some 800 women. That means that approximately one in ten of the women who have received legal abortions at the hospital in the last year have accepted contraception in the hope of avoiding future abortions. An estimated 10% experience complications after IUD insertions at Polizu.

At the hospital in Sibiu, of 6,000 IUDs donated by the Dutch, 5,000 have been inserted. Many of these 5,000 IUDs were given to the 12,000 women who received abortions. This demonstrates that if supplies and adequately trained clinicians are available Romanian women will readily accept contraceptive methods.

All of the supplies received at the maternity hospitals we visited had been donated and ostensibly were dispensed at no cost to the patients. Beyond the donated supplies the specialist maternity hospitals appear to have not received contraceptive supplies from the government. Those hospitals with the greatest success in introducing contraception to women are those who have received donated contraceptives, either from IPPF, through SECS, or from *Medicins sans Frontieres* or others. Commodity inputs from abroad have included at least 200,000 cycles of oral contraceptives, 35,000 IUDs, 2.6 million condoms and 7500 doses of injectable deprovera. The prices established by the government for contraception are as follows: 3 leis per condom, 21 leis for a month of OCP's, and 238 leis for an IUD. The price of an abortion, as previously noted, is 30 leis - exactly the price in effect prior to the enactment of the 1966 pronatalist law.

Screening Protocols and Capacity

The MOH has a published protocol for screening and follow-up of FP users as noted above. Some clinics use their own protocols. Provision is usually made for blood pressure measurement, PAP smears, bacteriologic screening and quite often colposcopy. Even though contraception has been legal for a short time, nurses, who provide initial screening, and physicians seemed capable of adequately screening patients for both oral contraceptives and IUDs. Additionally, many of the general practitioners interviewed at the dispensary level expressed an interest in receiving an orientation to contraceptive practices and screening protocols.

Training Inputs

Several institutions have provided family planning training since the uprising. A national workshop sponsored by the MOH and the WHO for 175 gynecologists, midwives, sociologists, psychologists and statisticians was held early in the summer of 1990. Nursing and medical school curricula are being revised to include training in family planning. Three family planning manuals have been translated and will be printed by UNFPA/WHO. Medecins sans Frontieres has also provided some direct training and contraceptive supplies.

Management Capacity

Throughout the health care system there is a pervasive need for upgrading management capacity. After the uprising respected clinicians were placed in positions of authority. Often they frequently were unprepared for policy formulation, strategic planning, budgeting, the logistics of supply, manpower training and other critical aspects of health care management. This is unfortunately true at both the national and the judet levels. The Ministry of Health recognizes this as a critical need and is eager to receive Western technical assistance to improve the situation. The recently established Institute for Health Services and Management under Professor Enachescu is the most likely locus for this type of training to occur.

Current Non-governmental Family Planning Activity

Although a large number of foreign charitable organizations have been active in Romania, only one Romanian NGO is active in family planning-The Society for Education on Contraception and Sexuality (SECS). It was established in March 1990 and now has 250 members and branches in 20 judets. Sixty percent of the members are women; twenty percent are OB-GYN specialists; twenty percent are general practitioners; twenty-two percent are nurses. Most members are between twenty and thirty years of age. SECS'

are education of the public, especially women and youth, education of professionals, reducing abortions, the rehabilitation of women with post-abort complications, and practical research. SECS has operated a number of successful counselling programs in 18 locations and they have provided condoms in some instances. Seventeen training activities have been carried out for 548 clinicians in 5 cities. Five leaflets have been published in Romanian on family planning and contraception. Preliminary research on knowledge, attitudes and practices as well as the psycho-somatic complications of abortion has been performed. SECS has organized radio programs for sex and contraceptive education as well as one television program. They hope to establish a model clinic for direct provision of family planning services in the near future. Currently they are supported only by members dues. A grant of \$40,000 was planned by IPPF, but it is unclear whether this has actually been received. The MOH appears to have a very supportive attitude toward the activities of SECS, and indeed, Minister Marinescu was one of the founders of SECS before his appointment as Minister of Health.

IV. Reproductive Health Statistics in Romania

Introduction

The purpose of this section is to present an analysis of Romanian data that addresses two questions. First, what did the site visit team learn from Romanian data about the reproductive health problems of Romanian women? The most important reproductive health issues are family planning needs, maternal mortality, and infections of the reproductive organs. Second, what did the team learn about risk factors of women for cardiovascular disease? The interest in this second question was based on reported high levels of cardiovascular disease among women of reproductive age.

Background

Previous site visit teams advised us that Romanian statistics might not be reliable. They gave two reasons for a possible lack of reliability. First, under Ceausescu's rule, respondents would not report anything self-incriminating. Second, since the end of the dictatorship, the health districts have not report diseases as well as before. The recently elected district health officers are clinicians who lack public health training.

Before the site visit, we also received a preliminary report stating that 25% of Romanian women had pelvic inflammatory disease. We obtained the source data for this report and present those data in this section. Our analysis suggests that about 2.5% of women actually have active pelvic inflammatory disease—still a high percentage for a population-based survey.

Family Planning Needs

The primary reproductive health problem of Romanian women is their inability to obtain safe, simple, effective methods of fertility control. We base this important conclusion on our analysis of trends in fertility, on the 1978 Romanian fertility survey, on trends in abortions, and on a local study of knowledge and attitudes of pregnant or recently pregnant women toward the use of contraception.

Data on fertility of Romanians show that birth rates have been declining since the 19th century. Alan Minkoff's calculations of fertility indices for 1899, 1930, and 1956 provide the earliest evidence for the desire of Romanian couples to restrict fertility (Table 1) [Coale A & Watkins S (ed.) The Decline of Fertility in Europe, Princeton University Press, Princeton NJ 1986]. These indices show that by 1899 fertility had already declined to about 65% of the natural fertility level achieved by Hutterites. Between 1899 and 1930 the total fertility rate (TFR) declined further—from an average of 6.65 to 4.57 children per woman. By 1956 the TFR was 3 children per woman.

Table 1 Indexes of overall fertility and contributions of proportion married, marital fertility, and out-of-wedlock fertility—1899, 1930, 1956

Year	Fertility indexes (Romania)				Estimated Total Fertility Rate*
	I _f	I _g	I _h	I _m	
1899	0.53	0.65	0.22	0.73	6.65
1930	0.36	0.49	0.11	0.67	4.57
1956	0.24	0.35		0.69	3.02

Source: Coale A & Watkins S (ed) The Decline of fertility in Europe Princeton University Press, Princeton NJ c. 1986

I_f = Overall fertility compared with highest levels natural fertility

I_m = Marital fertility compared with the Hutterite fertility

I_g = Illegitimate fertility index

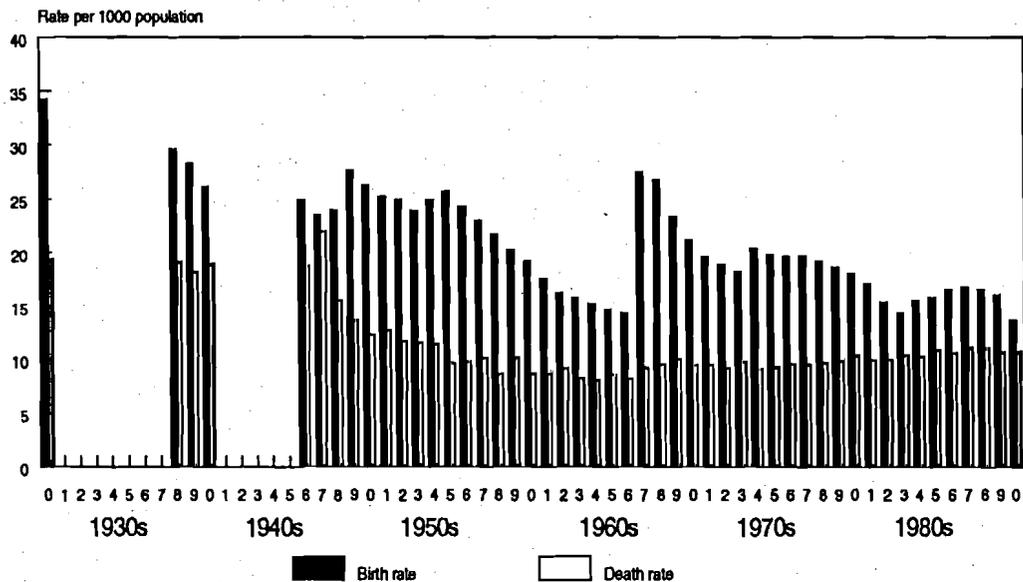
I_m = Proportion of potentially fertile women who are currently married

* Mean number of births in a lifetime

After the liberalization of abortion laws in 1957, the crude birth rate declined from 25.6 births per thousand population in 1957 to 14.3 in 1966 (Figure 1). In 1966 the government—under Ceausescu's leadership—decided to increase the number of people in Romania by restricting access to abortion services. Romanian statistics cited by WHO and American scientists have documented the rapid but transient increase in the birth rate. [Michael

Teitelbaum: The de-legalization of abortion in Romania, Family Planning, July 1974.] The concurrent shift from legal to illegal abortions led to an increase in the number of maternal deaths.

**Figure 1 Crude Birth and Death Rates
Romania, 1930-1990**



Source: an. Statistic al Romaniei 1990

The 1978 national fertility survey—conducted as part of the World Fertility Surveys—reported a total fertility rate of 1.72 in urban and 2.42 in rural areas of Romania. For women age 45-49, 6.57% were infertile. The average age of first live birth for women was 21.9—with an average of 22.7 in urban and 21.2 in rural areas. The average number of children considered ideal for a family was 2.5, but the number of infants desired at the time of marriage was 2.1. Women reported the following as primary reasons for limiting the number of children they have:

They have all the children they want	21.5%
They are young and recently married	19.9%
Concern about health of spouse, of Rh negative, fear of delivery, fear of unhealthy infant	13.4%
Sterility, repeated spontaneous abortions	11.6%
Profession, economic reasons	10.6%
Insufficient income; children difficult to raise	8.5%
Inadequate housing	3.5%
Disagreements with spouse	1.4%
Other reasons	9.6%

Tirgu-Mures District Hospital, Transylvania—A KAP Study

During the team's initial discussions with representatives of the Society of Education Contraception and Sexuality (SECS), Dr. Mihai Horga, an obstetrician-gynecologist from Tirgu-Mures, reported that he had been conducting a study of family planning attitudes and practices among women attending the district hospital for prenatal care, delivery and abortion services. He agreed to share the limited data that he had already entered on the computer. Because Romanian health officials lack essential data on women's knowledge and attitudes toward family planning, we report the findings from this hospital (a 165 bed hospital serving an urban population of 165,000). This study is limited to one hospital, but a comparable national survey could provide a data base for policy development on women's health issues.

Four female health workers interviewed the first 250 women in each of the two service categories (delivery, abortion) who attended the Tirgu-Mures Hospital after September 1, 1990. They interviewed women delivering live births before delivery; they interviewed women having abortions after the abortion. All interviews were completed by February 1991. The questionnaire was short—with only 40 questions; the first 18 on demographic and reproductive history and the next 22 on contraception use and attitudes. Our results are based on data from 102 interviews with women who had abortions and 200 interviews with women who delivered. The remaining interviews had not been coded or entered into the data base when we were given the data.

Compared with women delivering live births, women having abortions were older and slightly less likely to be married (Table 2). They were slightly more likely to work in lower status professions (clerks, peasants)—about 25% of each group were housewives and 50% classified as workers. They differed only slightly in their education, nationality, religion and average monthly income. About 50% were Hungarian, 37% Romanian and 12% Gypsy. About 40% were Protestant, 40% Romanian Orthodox, and 15% Catholic. At the official exchange of 35 lei for one U.S. dollar, the average monthly income was about \$130. At easily available unofficial exchange rates, the average monthly income is about 10-20% of the official exchange rates.

Those having abortions averaged 1.9 more prior pregnancies, 0.4 more live births and 0.4 more children (Table 3). Of those delivering live born infants, 59.8% reported the pregnancy as planned. Of those having abortions, 3.0% reported the pregnancy as planned. Contraceptive failure was the

**Table 2 Demographic Characteristics of Women Obtaining Obstetric Care.
Tirgu-Mures District Hospital, September 1990-February 1991**

Pregnancy outcome	Abortion	Livebirth
Number of women	200	102
Characteristics		
Average age	28.1	25
Marital status		
Married	78.5%	91.2%
Single	13.0%	4.9%
Cohabiting	6.0%	3.9%
Divorced or separated	2.5%	0.0%
Occupation		
Worker	43.5%	51.0%
Housewife	26.0%	24.5%
Clerk	10.0%	4.9%
Peasant	7.5%	6.9%
Intellectual	6.5%	7.8%
Technician	2.0%	2.0%
Student	2.0%	1.0%
Pupil	1.5%	0.0%
Highest education		
University	9.0%	4.9%
Lyceum	66.5%	72.6%
Gymnasium	16.0%	15.7%
Primary	5.5%	3.9%
None	2.5%	2.9%
Nationality		
Hungarian	48.0%	55.9%
Romanian	38.5%	35.3%
Gypsy	13.0%	8.8%
German	0.5%	0.0%
Religion		
Protestant	39.5%	45.1%
Orthodox	40.0%	35.3%
Catholic	16.0%	12.7%
Sectant	2.5%	3.9%
Greek-Catholic	1.0%	0.0%
Atheist	0.5%	0.0%
Don't know	0.5%	2.0%
Average monthly household income (lei)		
—in official U.S. \$	4389	4767
—in unofficial U.S.	\$125	\$136
	\$37	\$40

**Table 3 Reproductive History of Women Obtaining Obstetric Care.
Tirgu-Mures District Hospital, September 1990 - February 1991**

Pregnancy Outcome	Abortion	Livebirth
Number of women	200	102
Average coital events per week	2.6	3.0
Average number of prior pregnancies	4.1	2.2
Average number of prior livebirths	2.4	2.0
Average number of living children	2.3	1.9
Was the current pregnancy planned?		
No	97.0%	38.2%
Yes	3.0%	59.8%
What was the cause of the current (or recently terminated) pregnancy?		
Contraception failed	69.5%	17.6%
Did not use contraception	12.0%	39.2%
Stopped contraception to conceive	3.0%	42.2%
Other reasons	9.0%	0.0%
Took a chance	6.5%	1.0%
When do you want your next pregnancy?		
Want no more pregnancies	70.5%	53.9%
In next two years	11.5%	10.8%
After two years	7.5%	26.4%
Unknown	10.5%	8.8%
What method would you prefer to use—if there are no complications?		
Oral contraceptives	49.2%	43.3%
Don't know	19.1%	18.6%
IUDs	19.1%	10.3%
Withdrawal	4.0%	9.3%
None	1.5%	7.2%
Spermicides	3.0%	1.0%
Voluntary surgical contraception	1.0%	3.1%
Awareness	1.0%	3.1%
Condoms	1.0%	1.0%
Which of the methods that you have used personally protected you the best?		
Oral contraceptives	73.6%	41.7%
Withdrawal	11.1%	25.0%
Awareness	4.2%	8.3%
Spermicides	2.8%	8.3%
Condoms	2.8%	0.0%
IUDs	0.0%	8.3%
None	2.8%	0.0%

reason for 69.5% of the pregnancies ending in abortion and 17.6% of the pregnancies ending in live birth. Most women in each group reported they never wanted to be pregnant again. The preferred contraceptive method was most commonly reported to be oral contraceptives, IUDs and withdrawal. Nearly 1 in 5 women in each group did not know what method of contraception they preferred. Voluntary surgical contraception, fertility awareness, and condoms were least popular. The two methods that couples had used and felt to be most protective were oral contraceptives and withdrawal.

About 40% of each group knew the term "family planning." Over 40% knew that the middle of the menstrual cycle is when a woman is at greatest risk of getting pregnant (Table 4). Fewer than 7% of either group had cultural,

Table 4 Selected Family Planning Knowledge and Attitudes of Women Obtaining Obstetric Care. Tirgu-Mures District Hospital, September 1990 - February 1991

Pregnancy outcome	Abortion	Livebirth
Number of women	200	102
Do you understand the term "family planning"?		
Yes	45.0%	39.6%
When during menses is woman at greatest risk of pregnancy?		
Midcycle	48.0%	40.6%
Don't know	37.0%	35.6%
After period	11.0%	16.8%
Before period	2.0%	3.0%
During period	1.0%	2.0%
Do you have any constraints against contraception?		
No	85.5%	77.5%
Other	9.0%	10.8%
Don't know	2.0%	4.9%
Cultural	2.5%	1.0%
Moral	1.0%	2.9%
Religious	0.0%	2.9%
Do you have any constraints against induced abortion?		
No	73.5%	57.8%
Other	14.5%	10.8%
Moral	5.0%	10.8%
Religious	4.5%	5.9%
Cultural	1.0%	8.8%
Don't know	1.5%	5.9%
Do you consider publicity on family planning in mass media to be sufficient?		
No	73.0%	78.4%
Yes	15.5%	7.8%
Don't know	11.5%	13.7%

moral, or religious constraints against contraception. But nearly 30% of women delivering live births had some cultural, moral, or religious constraint against abortion.

Roughly 90% of each group had not received family planning advice from a qualified person (Table 5). The hospital had not provided contraception nor an appointment to obtain family planning services. Over 75% of each group did not know where to go for family planning advice. Yet, about two-thirds of each group knew sources for obtaining contraception—such as the black market and local pharmacies.

Table 5 Family Planning Services Received by Women Receiving Obstetric Care. Tirgu-Mures District Hospital, September 1990-February 1991

Pregnancy Outcome	Abortion	Livebirth
Number of women	200	102
Have you ever received advice on contraception and family planning from a qualified person?		
No	88.0%	89.2%
Yes	12.0%	10.8%
Did the hospital in which you recently delivered or aborted provide you with the desired contraception or an appointment for family planning services?		
No	93.5%	98.0%
Yes	6.5%	5.0%
Do you know any place to go for advice on contraception and family planning?		
No	76.0%	82.4%
Clinic	13.5%	10.8%
Ob-Gyn	1.5%	4.9%
Territorial	3.5%	1.0%
Premarital	1.0%	1.0%
Do you know any source for securing contraceptives?		
No	32.0%	37.3%
Black market	22.0%	26.5%
Pharmacy	20.5%	15.7%
Abroad	9.5%	8.8%
Multiple or other sources	16.0%	11.7%

In summary, this preliminary analysis of women obtaining reproductive services in one district hospital suggests that the abortion rate could be reduced substantially if Romania improves family planning education and access to contraception services. The women in this study reported little interest in voluntary surgical contraception, but their frequently stated desire to have no more children means that permanent contraception should be readily available.

We interviewed obstetricians who reported that knowledge and use of contraception varies between regions in Romania. This survey was conducted in a community close to Hungary and some Romanians reported that women in this study may have had better access to black market contraception than women in other regions.

Most importantly, this study emphasizes the need to conduct a rapid assessment of the family planning attitudes, knowledge and experiences of the couples of Romania. Given the rapidity with which reproductive changes are taking place in Romania, family planning marketing surveys using national household probability samples should be conducted every 2-3 years until all couples have adequate contraception knowledge and supplies.

Maternal Mortality in Romania, 1960-1990

For the years for which Romanian data is available, maternal deaths may be among the most completely recorded and investigated that has ever been achieved. The national government required that all unexpected deaths of women of reproductive age be investigated—including review by a forensic pathologist. Although we lack detailed individual statistics for each year, the summary data that follow suggest that the quality of classification of specific causes of death improved over time.

For 1960-1965—prior to Ceausescu's rise to power and imposition of restrictions on abortion and contraception—1,811 women died from complications of pregnancy and childbirth—an average of 301 each year. Of these, 457 (25.2%) women—an average of 76 women each year—died from complications of septic abortion. (Table 6)

For the 1969-1978 period—during which deaths were coded using the 8th revision of the International Coding of Deaths (ICDA)—5,255 maternal deaths were reported for 10 years—an average of 526 deaths each year (Table 7). Abortion was the pregnancy outcome for 3,773 (71.8%)—an annual average of 377 abortion-related deaths, or a 5-fold increase from the pre-Ceausescu period. Of these abortions, 99.3% were classified as illegal.

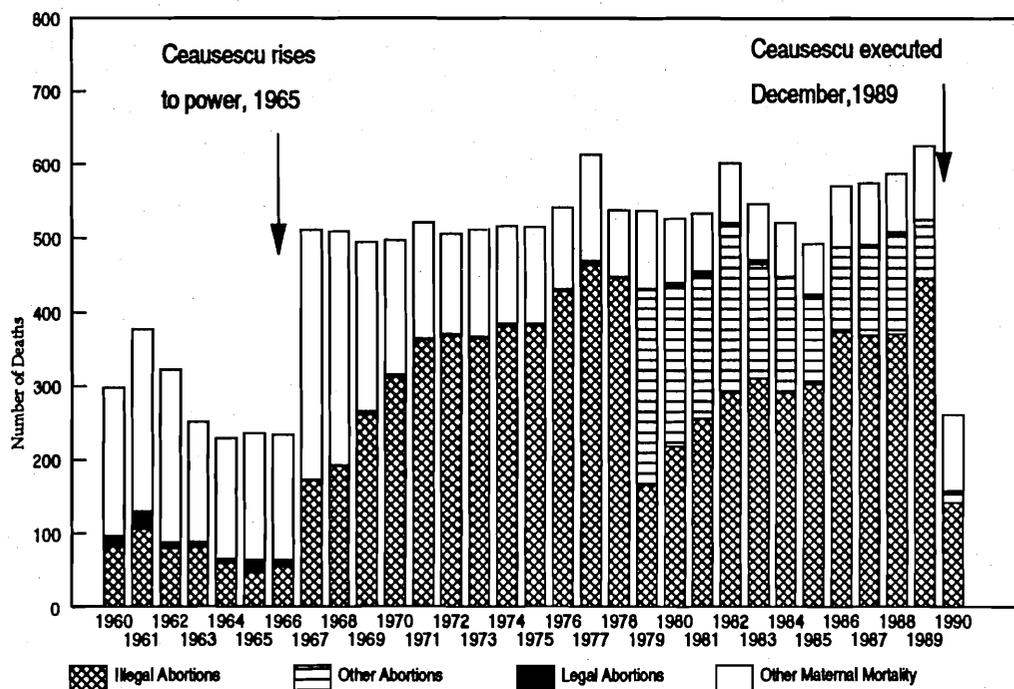
For the 1979-1988 decade—during which deaths were classified according to the 9th revision of the International Cause of Death (ICDA)—5,499 maternal deaths were reported for 10 years—an average of 550 each year (Table 8). Of these, 4,698 (85.4%) were due to abortion and 2,950 (62.8%) of the abortion deaths were classified as due to illegal abortions. An additional 1,519 (32.3%) of "abortion" deaths were attributed to "complications after abortion, ectopic pregnancy, and molar pregnancy"—a classification of deaths that appears to be solely due to deaths from complications after illegal abortion.

Table 6 Maternal Mortality by Cause—Romania, 1960-1968

Code	Cause of death (ICD 7)	1960	1961	1962	1963	1964	1965	1966	1967	1968	Total
115	Infection during pregnancy childbirth and puerperium (incl. postpartum pulm.embolus)	14	18	35	15	7	14	•	•	•	103
116	Toxemia during pregnancy and puerperium (without infection)	36	43	36	27	19	28	•	•	•	189
117	Hemorrhage during pregnancy and childbirth	78	72	67	68	58	62	•	•	•	405
118	Abortion	14	24	8	7	6	17	•	•	•	76
119	Septic abortion	82	106	80	82	60	47	64	173	192	886
120b	Other complications of pregnancy and childbirth	74	114	96	52	80	69	171	338	317	1311
	Total maternal deaths	298	377	322	251	230	237	235	511	509	2970

Note: For 1966-1969 all abortion deaths are grouped together, and all other maternal deaths are classified as other.

**Figure 2 Illegal Abortion and Other Causes of Maternal Mortality
Romania—1960-1990**



For 1966-68 and 1972, the classification of legal and illegal is estimated on the proportion of deaths in other years.

Table 7 Maternal Mortality by Cause—Romania, 1969-1978

Code Cause of death (ICD 8)	1969	1970	1971	1972	1973	1974	1975	1976	1977	1978	Total
214 Genito-urinary infections during pregnancy and puerperium	2	6	6	•	1	0	1	1	0	3	20
215 Imminent abortion	0	0	0	•	0	0	0	0	0	0	0
216 Other hemorrhage	25	10	14	•	2	5	5	8	5	3	77
217 Abnormal presentation without dystocia	2	0	1	•	0	0	0	0	0	0	3
218 Toxemia	22	25	20	•	10	7	13	14	8	10	129
219 Other pregnancy complications	41	30	20	•	19	20	13	15	16	8	182
220 Legal abortion	4	1	1	•	3	4	2	3	5	2	25
221 Other (illegal) abortion	258	314	363	370	364	381	383	429	464	447	3773
223 Placenta previa and other antepartum hemorrhage	21	19	8	•	11	12	12	5	5	3	96
224 Retained placenta and other postpartum hemorrhage	40	27	30	•	31	16	15	8	28	8	203
225 Dystocia											
* pelvic anomalies											
* fetopelvic disproportion											
* abnormal presentation											
* prolonged labor	7	10	9	•	5	13	6	4	3	0	57
226 Other complications of delivery, incl. anesthesia	47	32	24	•	35	28	19	23	20	16	244
227A Puerperal infections and pulmonary emboli	16	19	18	•	18	22	30	24	39	30	216
227B Other specified complications e.g. puerperal mastitis and other nonspecific complications	6	4	8	•	13	9	17	8	21	8	94
Other—not specified					136						136
Total maternal deaths	491	497	522	506	512	517	516	542	614	538	5255

For the years 1966-1989 a total of 9,435 women died during abortion procedures, or from complications after abortion. Most of these deaths resulted from illegal abortions.

In 1990—the first full 12 months after the execution of Ceausescu on December 23, 1989 and the cancellation of the anti-abortion and anti-contraception laws December 27, 1989—the number of maternal deaths was 262. Of these, 153 (58.4%) were due to illegal abortion (Table 9). Deaths classified as due to complications after abortion, ectopic pregnancy or molar pregnancy declined even more rapidly—from 131 in 1988 to 11 in 1990.

Dr. Petru Muresan reports that 7,244 women died from illegal abortion during the Ceausescu era (1966-1989)—or an average of 302 each year for 24 years. During this period the average annual number of abortion-related deaths increased steadily until the end of 1989 (Figure 2). The abrupt decline

Table 8 Maternal Mortality by Cause—Romania, 1979-1988

Code Cause of death (ICDA-9)	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	Total
3800 Spontaneous abortion	2	6	7	3	5	2	3	0	3	4	6	41
3810 Legal and therapeutic abortion	5	1	1	1	0	1	1	2	1	3	0	16
3820 Illegal abortion	167	218	256	291	311	291	303	374	369	370	445	3395
3830 Abortion—unspecified	16	0	8	0	0	0	0	0	0	0	0	24
3840 Sarcina care det abortion	16	22	10	25	12	8	18	12	12	14	20	169
3850 Tetanus after abortion	3	0	0	1	0	0	0	0	0	1	0	5
3890 Complications after abortion, etc.	223	194	174	200	143	147	100	100	106	132	74	1593
3900 Hemorrhage early in pregnancy	5	2	0	0	0	0	0	0	0	0	0	7
3901 Hemorrhage ante and postpartum	23	19	18	22	33	17	14	18	22	18	25	229
3910 Toxemia	14	14	13	7	6	11	8	6	7	7	5	98
3920 Infection of urinary tract	0	0	1	0	1	0	0	0	0	0	0	2
3930 Dystocia—obstructed labor	6	0	0	0	0	0	0	0	0	0	0	6
3940 Postpartum complications	30	40	30	31	26	30	36	42	36	28	38	367
3941 Puerperal tetanus	0	0	0	0	0	0	0	0	0	0	0	0
3950 Other complications of childbirth	12	6	10	12	6	10	6	16	16	11	11	116
3990 Other direct obstetric causes	14	5	5	9	4	5	4	1	3	3	3	56
4000 Indirect obstetric causes	1	0	1	0	0	0	0	0	0	0	0	2
Total	537	527	534	602	547	522	493	571	575	591	627	6126

to 153 deaths in 1990, the first year after the change in government, can be attributed, at least in part, to international assistance in providing contraception to Romanians and to women choosing legal instead of illegal abortions.

We obtained limited data on the reasons for legally sanctioned abortions during Ceausescu's era. For 1983-1987 the reasons changed rapidly from one year to the next (Table 10). We speculate this may be due to rapid changes in permissible reasons for legally sanctioned abortion—but we did not document the specific changes in policy. These rapid changes in reasons chosen for legally sanctioned abortion—during a period of very restrictive abortion laws enforced by police—seem consistent with advice received about lack of reliability of data.

The total number of legally sanctioned abortions performed each year ranged between 405,569 and 62,194 and appears to have declined rapidly between 1985 and 1987. The most common legally sanctioned reason used to obtain abortion was family size limitation. 29.4% of interrupted pregnancies occurred because women obtained abortions because they already had 4 or more children. Even during this era with restrictive abortion laws, the proportion of pregnancies terminated by abortion ranged between 11.0% and 53.1%.

Table 9 Maternal Mortality by Cause—Romania 1988-1990

CodeCause(ICDA-9)	1988	1989		1990	
		Subtotal	Subtotal	Subtotal	Subtotal
6301 *Hydatidiform mole	0		1		1
6303 *Hydatidiform mole	0		0		1
6310 Other abnormal product	1		0		1
6320 Missed abortion	2		4		0
6321 *Missed abortion	0		0		3
6330 Ectopic-abdominal	0		0		2
6331 Ectopic-tubal	11		15		11
6332 Ectopic-ovarian	0		0		2
6339 Ectopic-unspecified site	0		0		1
Ectopic—Total		11		15	16
6340 Spontaneous abortion—infection	1		4		0
6341 Spontaneous abortion—hemorrhage	2		1		0
6346 Spontaneous abortion—embolism	1		0		0
Spontaneous abortion—Total		4		5	0
6350 Legal abortion—infection	2		0		2
6351 Legal abortion—hemorrhage	0		0		2
6356 Legal abortion—embolism	0		0		1
6358 Legal abortion—unspecified complications	1		0		0
Legal abortions—Total		3		0	5
6360 Illegal abortion—infection	247		319		111
6361 Illegal abortion—hemorrhage	24		29		5
6363 Illegal abortion—renal failure	36		24		14
6365 Illegal abortion—shock	0		1		0
6366 Illegal abortion—embolism	48		60		9
6368 Illegal abortion—unspecified complication	16		14		3
Illegal abortions—Total		371		447	142
6390 Complications after abortion, etc.—infection	91		53		7
6391 Complications after abortion, etc.—hemorrhage	16		10		2
6393 Complications after abortion, etc.—damaged pelvic organs	18		7		1
6396 Complications after abortion, etc.—embolism	5		1		0
6398 Complications after abortion, etc.—other	1		2		1
Complications after abortion or ectopic—Total		131		73	11
6410 Placenta previa-no hem.	0		1		0
6411 Placenta previa-hemorrhage	1		3		1
6412 Premature separation	6		8		15
6413 Antepartum hem.-coag defects	0		0		2
6416 *Antepartum hemorrhage	0		0		1
6424 Mild pre-eclampsia	0		0		1
6425 Severe pre-eclampsia	1		0		0
6426 Eclampsia	6		5		5
6584 Infection amniotic cavity	0		1		0
6598 Other indications for care..	1		0		0
6611 Secondary uterine inertia	0		1		0
6650 Rupture of uterus before labor	1		0		0
6651 Rupture of uterus during labor	8		10		4
6661 Immediate postpartum hemorrhage	6		13		9
6663 Postpartum coagulation defects	5		1		1
6680 Anesthesia-pulmonary complications	1		1		1
6682 Anesthesia-CNS complications	1		0		0
6693 Acute renal failure after labor & delivery	1		0		0
6700 Major puerperal infection	14		23		23
6715 Phlebitis & thrombosis	0		1		0
6731 Amniotic fluid embolism	6		9		11
6732 Obstetrical blood-clot embolism	7		4		7
6741 Disruption of cesarian wound	0		1		1
Total	588		627		262

*Refers to ICD codes whose fourth digit is not listed in ICD-9-ICM

Table 10 Legally Sanctioned Interruptions of Pregnancy by Reason for Interruption. Romania, 1983-1987

Reason	1983	1984	1985	1986	1987	Five-year	Total
Spontaneous	199,867	121,045	20	1	118,390	439,323	30.0%
>4 children	151,846	120,782	128,372	59	30,388	431,447	29.4%
Maternal health	27,778	20,619	20,940	154,640	22,046	246,023	16.8%
Rape	54	32	127,601	4,516	29	132,232	9.0%
Provoked	1,401	951	99,166	6,896	995	109,409	7.5%
>40 yrs	29,765	22,596	21,923	712	1,151	76,147	5.2%
Maternal Handicap	5,087	3,721	3,840	169	3,385	16,202	1.1%
Hereditary	4,448	3,560	3,707	9	4,200	15,924	1.1%
Subtotal (Induced Ab)	220,379	172,261	405,549	167,001	62,194	1,027,384	
Total	420,246	293,306	405,569	167,002	180,584	1,466,707	100.0%
Births	321,498	350,741	358,797	376,896	383,199	1,791,131	
Reported pregnancies	741,744	644,047	764,366	543,898	563,783	3,257,838	
Ind. Ab. per 1,000 livebirths	685	491	1130	443	162	574	
Ind. Ab. per 1,000 pregnancies	297	267	531	307	110	315	

During the first 7 months of 1990, the health districts (judets) reported 443,163 legal abortions (Table 11). Of the women obtaining abortion 3 died of abortion complications and 5156 (1.2%) had complications. The overall death and complication rates are about the same as in the United States and other developed countries. But the complication rates were high for a few districts, particularly complications due to uterine perforation in Arad (Figure 3). Public health officials should investigate clinical services in districts with high complication rates to determine whether the high rates are due to clinical skill deficiencies, to the difficulty women have in obtaining early—and safer—abortions, or to inadequacy of equipment and supplies to perform safe abortions, or to other reasons.

Table 11 Abortion Complications, By Health District—Romania, January 1-July 25, 1990

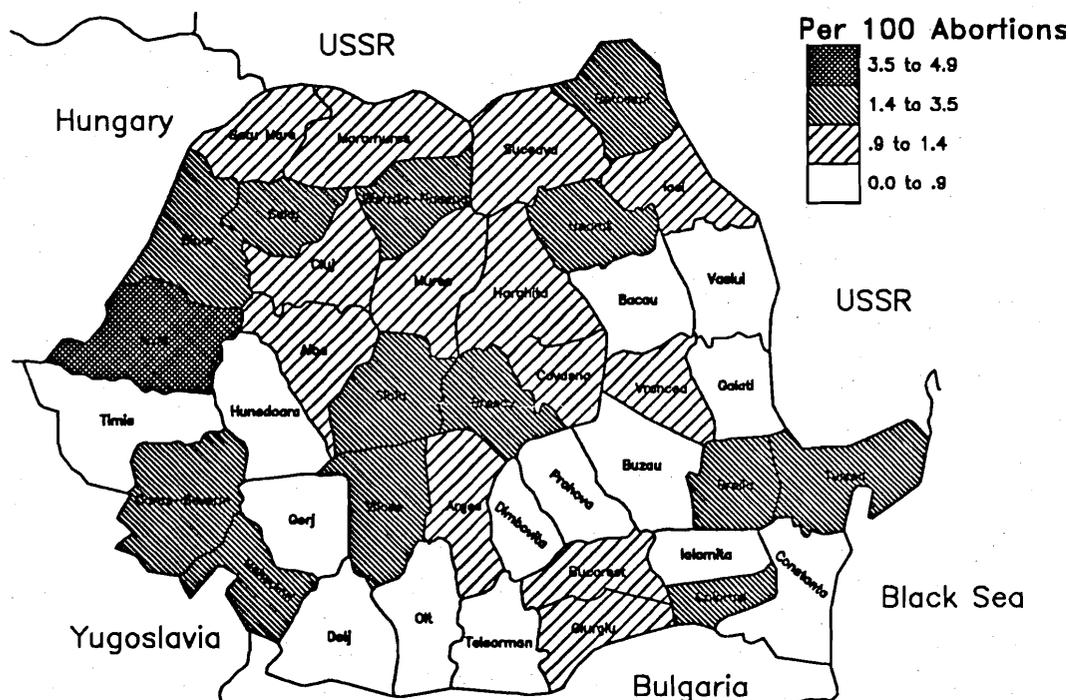
Health Districts (Judets)	Abortions	Complications			Deaths	Complication rates			Death Rate*		
		Total	Infection			Total	Infection				
		Perforation	Hysterectomy			Perforation	Hysterectomy				
Arad	6855	335	181	150	4	4.9%	2.6%	2.2%	0.1%		
Neamt	8419	288	10	270	8	3.4%	0.1%	3.2%	0.1%		
Bihor	7070	215	21	188	6	3.0%	0.3%	2.7%	0.1%		
Braila	8600	257	12	235	10	3.0%	0.1%	2.7%	0.1%		
Bistrita-Nasa	4298	128	1	127	0	3.0%	0.0%	3.0%	0.0%		
Brasov	13355	353	21	313	19	2.6%	0.2%	2.3%	0.1%		
Sibiu	7942	193	19	169	5	2.4%	0.2%	2.1%	0.1%		
Vilcea	10313	211	6	203	2	2.0%	0.1%	2.0%	0.0%		
Calarasi	7883	148	13	127	8	1.9%	0.2%	1.6%	0.1%		
Botosani	5174	95	5	90	0	1.8%	0.1%	1.7%	0.0%		
Salaj	2324	40	5	32	3	1.7%	0.2%	1.4%	0.1%		
Caras-Severin	7659	130	4	120	6	1.7%	0.1%	1.6%	0.1%		
Tulcea	5275	86	9	72	5	1.6%	0.2%	1.4%	0.1%		
Mehedinti	5599	80	9	71	0	1.4%	0.2%	1.3%	0.0%		
Maramures	5763	80	6	70	4	1.4%	0.1%	1.2%	0.1%		
Vrancea	7504	97	5	92	0	1.3%	0.1%	1.2%	0.0%		
Alba	5349	65	7	56	2	1.2%	0.1%	1.0%	0.0%		
Iasi	16431	197		196	0	1.2%	0.0%	1.2%	0.0%	10	
Satu-Mare	3469	39	1	37	1	1.1%	0.0%	1.1%	0.0%		
Covasna	3358	37	13	19	5	1.1%	0.4%	0.6%	0.1%		
Giurgiu	6847	74	3	70	1	1.1%	0.0%	1.0%	0.0%		
Cluj	9454	95	26	52	17	1.0%	0.3%	0.6%	0.2%		
Suceava	8982	88	3	82	3	1.0%	0.0%	0.9%	0.0%		
M.Bucharest	72951	702	106	568	28	1.0%	0.1%	0.8%	0.0%		
Arges	16421	158	11	144	3	1.0%	0.1%	0.9%	0.0%		
Harghita	3542	34	5	25	3	1.0%	0.1%	0.7%	0.1%	30	
Mures	7205	69	13	49	7	1.0%	0.2%	0.7%	0.1%		
Constanta	22769	176	14	160	2	0.8%	0.1%	0.7%	0.0%		
Olt	13779	102	11	84	7	0.7%	0.1%	0.6%	0.1%		
Dolj	19290	136	18	115	3	0.7%	0.1%	0.6%	0.0%		
Gorj	10444	68	17	49	2	0.7%	0.2%	0.5%	0.0%		
Dimbovita	14651	85	14	68	3	0.6%	0.1%	0.5%	0.0%		
Hunedoara	10780	60	6	53	1	0.6%	0.1%	0.5%	0.0%		
Bacau	12316	54	15	38	1	0.4%	0.1%	0.3%	0.0%		
Ialomita	8908	38	9	29	0	0.4%	0.1%	0.3%	0.0%		
Prahova	19524	70	27	39	4	0.4%	0.1%	0.2%	0.0%		
Vaslui	8350	26	8	14	4	0.3%	0.1%	0.2%	0.0%		
Teleorman	8756	27	4	22	1	0.3%	0.0%	0.3%	0.0%		
Galati	15267	14	6	4	3	0.1%	0.0%	0.0%	0.0%	10	
Ruzau	10287	6	2	4	0	0.1%	0.0%	0.0%	0.0%		
Timis			23	53	5						
Total	443163	5156	689	4359	186	3	1.2%	0.2%	1.0%	0.0%	1

Source: Romanian MOH/MCH reporting system

* Death rate per 100,000 abortions

Figure 3 Abortion Complication Rates

by Health District—Romania, January 1 - June 27, 1990



The increased access to legal abortions and to contraception during 1990 led to a 14.8% reduction in the number of births in 1990 (314,746) compared with 1989 (369,544).

Reproductive Health Problems and Mortality

A list of the frequency of causes of death for one year in Romania shows the wide range of preventable causes of mortality—including pregnancy complications, which in 1988 caused 591 deaths (Table 12). The special tragedy of maternal deaths is that nearly all are preventable, the mothers are young, and they leave behind many motherless children.

Infections of the genital tract caused 44 deaths. Choriocarcinoma—resulting from molar pregnancies—caused three deaths which should have been prevented. The detailed maternal mortality statistics do not include any indirect maternal deaths from chronic conditions that the pregnancy exacerbated, such as rheumatic, congenital and ischemic heart disease, malnutrition, tuberculosis, etc.—yet these causes of death appear prominently in a list of causes of death.

Table 12 Major causes of death—Romania, 1988

Circulatory	148,219		
Other ischemic heart dis	29,703	Digestive system	12,425
Atherosclerosis	19,223	Cirrhosis of liver	6,771
Hypertension	13,108	Gastric ulcer	974
Other cardiopathy	12,567		
Chronic cor pulmonale	11,019	Genito-urinary tract	3,728
Acute infarction	10,744	Prostate hyperplasia	1,000
Intracerebral hemorrhage	8,273	Nephrotic syndrome	883
Hypertensive heart disea	6,919	Renal insufficiency	845
Atherosclerotic cerebrov	5,968	*Salpingitis, ovaritis	13
Chronic rheumatic heart	1,438	*Other female genital	13
Subarachnoid hemorrhage	319	*Uterine inflammation	10
Hypertensive renal disea	237	*Parametrial inflammation	8
Other ischemic heart dis	149		
		Congenital anomalies	2,771
Cancer	32,739	Perinatal	1,603
Stomach	3,987	Mental psychoses	1,471
*Breast cancer	2,353	Alcoholism	673
Other digest	1,965	Schizophrenia	185
*Cervical cancer	1,640	Alcohol psychosis	34
Intestine, large	1,404	Other Nervous	2,531
Pancreas	1,379	Encephalitis	605
Rectum	1,263	Epilepsy	493
Leukemia	964		
Bladder	925	Endocrine	1,936
Mouth	924	Diabetes mellitus	1,732
*Ovaries,adnexae	803	*Pregnancy Complications	591
Brain	789		
Larynx	738	Malnutrition & blood disorder	230
Trachea,bronchi,plami	648	High anemia	96
*Uterus	646	Protein-calorie malnourishment	27
*Testicles	63	Marasmus nutritional	7
*Choriocarcinoma	3		
		Skin diseases	169
Respiratory disease	25,734	Poorly defined	77
Pneumonia	10,137		
COPD	7,027		
Emphysema	3,791		
Chronic bronchitis	1,778		
Asthma	1,369		
Infectious	2,541		
Tbc,pulm	1,129		
Trauma & poisonings	16,393		
Other trauma	4,778		
Trauma to thorax abdomen	3,400		
Other intracranial traum	2,151		
Nonmedicine intoxication	1,843		
Skull fracture	1,186		
Burns	988		
Foreign body in natural	820		
Poisonings	218		

* Reproductive system disease

The most common causes of mortality of males and females of all ages in Romania in 1988 were diseases of the circulatory system (148,219), cancer (32,739), respiratory disease (25,734), trauma and poisonings (16,393), and genitourinary tract diseases (3,728). Cancer of the female and male reproductive organs was a major cause of cancer deaths: breast (2,353), cervix (1,640), ovaries (803), uterus (646) and testicles (63).

Health conditions among women of reproductive age based on the National Health Examination Survey—June, 1989

In June 1989 the Ministry of Health conducted a health examination survey of 13,774 individuals—a representative sample of the entire population selected through a 3 stage sample design. In the first stage, 6 zones—Banatui + J. Arad, Transylvania, Moldova, Subcarpatii meridionali, Cimpia Dunarii, Dobrogea—and Bucharest were selected. In the second stage, the 6 zones were stratified into rural and urban. In the third, 166 urban and rural communities were selected. (See Ancheta Starii de Sanatate a populatiei—metodologia anchetei, Ministerul Sanatatii Centrul de Calcul si Statistica Sanitara, 1989, 91 pp.; and Ancheta Starii de Sanatate a Populatiei Vol. II: Morbidity prevalence, 1990, 114 pp.) Local community physicians and clinical specialists obtained health histories and conducted physical examinations, including obtaining laboratory specimens.

The history or medical examination revealed health problems in 43% of the 3,396 women age 15-49 who were included in the survey (Table 13). The three most commonly identified health conditions among women of reproductive age were high serum cholesterol (21.3%), smoking (14.6%), and obesity (6.3%).

Given our initial concern with the reported cardiovascular disease rate, we decided to focus our analysis on myocardial ischemia as a valid marker for cardiovascular disease. We were able to examine the association between myocardial ischemia and several risk factors (age, cholesterol levels, smoking, obesity, hypertension, and urban/rural status), and the following discussion summarizes the results of the analysis.

Age is the major risk factor for myocardial ischemia. In the survey, only 1 in 220 women aged 20 to 29 was diagnosed with myocardial ischemia, but 1 in 14 of the 40 to 49 cohort had symptoms consistent with a myocardial

Table 13 Prevalence of Health Conditions in Women Which May Affect the Choice of Contraception. National Health Examination Survey—Romania, June 1989

Condition	Age Group			Ratio*
	15-49 N=3396	15-34 N=1913	35-49 N=1483	
No health problem	57.0%	68.3%	33.9%	0.5
Cholesterol >225mg/dl	21.3%	11.9%	33.3%	2.8
Smoking	14.6%	14.3%	14.9%	1.0
Obesity	6.3%	3.6%	9.8%	2.7
Hypertension	2.3%	0.6%	4.5%	7.5
Heart disease, hepatitis, diabetes, and cerebrovascular disease				
Ischemic heart disease	1.6%	0.6%	3.0%	4.9
Rheumatic Heart Disease	1.1%	0.9%	1.2%	1.3
Chronic hepatitis	1.0%	0.6%	1.6%	2.7
Diabetes	0.7%	0.6%	0.9%	1.6
Cerebrovascular disease	0.2%	0.1%	0.4%	7.7
Pelvic inflammatory disease				
Acute salpingitis	0.8%	1.0%	0.5%	0.5
Chronic parametritis	0.6%	0.4%	0.8%	1.9
Chronic metritis	0.3%	0.3%	0.4%	1.5
Hydrosalpinx	0.2%	0.2%	0.2%	1.0
Acute parametritis	0.2%	0.2%	0.3%	1.7
Chronic endometritis	0.2%	0.2%	0.3%	1.3
Acute endometritis	0.1%	0.1%	0.1%	1.3
Acute metritis	0.1%	0.1%	0.1%	1.3
Subtotal		2.5%		
Vulvo-vaginal conditions				
Vulvo-vaginitis	2.5%	2.1%	3.0%	1.5
Cervical erosion	2.2%	2.7%	1.5%	0.5
Polyps	2.1%	0.2%	0.2%	1.3
Uterine retroversion	0.7%	0.5%	0.9%	1.7
Perineal rupture	0.2%	1.0%	3.6%	3.6
Prolapse	0.2%	0.1%	0.3%	6.4
Vaginal atrophy	0.1%	0.1%	0.1%	1.3
Uterine prolapse	0.0%	0.0%	0.1%	
Utero-vaginal prolapse	0.0%	0.0%	0.5%	
		8.0%		

*= Ratio of 35-49/15-34

ischemia diagnosis. thus it is a disease which primarily affects women who are past their child bearing years.

Other risk factors for myocardial ischemia are least common among young women (20-29) who have the highest fertility rate and the greatest likelihood of needing hormonal contraception (Table 14). The age-specific-fertility-rate (ASFR) is 147 births per 1000 for women aged 20 to 29; 43 per 1000 for those 30 to 39; and 4 per 1000 for those 40 to 49. Most childbearing occurs among women below age 30, while all risk factors for myocardial ischemia—except smoking—are more prevalent among women age 30 and older.

Myocardial ischemia is about 50% more common in urban than rural areas. Table 14 presents data on the prevalence of various risk factors by age group and urban/rural residence status.

Table 14 Prevalence of Myocardial Ischemia, Serum Cholesterol >225, Obesity, Hypertension and Smoking Among Women—Overall, Urban, and Rural. National Health Examination Survey—Romania, June, 1989

	Prevalence						Population
	ASFR*	Myocardial Ischemia	Cholesterol >225 gms	Hypertension	Obesity	Smoking	
Overall							
20 TO 29	146.8	0.4%	10.4%	0.6%	4.5%	19.0%	848
30 TO 39	42.5	1.8%	26.2%	2.9%	12.9%	18.7%	1151
40 TO 49	3.8	7.2%	35.3%	10.3%	19.6%	12.2%	894
50+	N/A	23.0%	50.5%	38.3%	22.7%	6.2%	2309
Urban							
20 TO 29		0.4%	9.4%	0.6%	4.0%	23.7%	498
30 TO 39		2.3%	26.6%	3.2%	12.0%	25.7%	665
40 TO 49		8.6%	36.9%	8.4%	20.9%	18.1%	474
50+		27.9%	53.0%	35.9%	25.8%	10.1%	1188
Rural							
20 TO 29		0.3%	11.7%	0.6%	5.1%	12.3%	350
30 TO 39		1.2%	25.7%	2.5%	14.0%	9.1%	486
40 TO 49		5.5%	33.6%	12.4%	18.1%	5.5%	420
50+		17.8%	47.8%	40.9%	19.3%	2.1%	1121
Urban-to-rural ratio of prevalence rates							
20 TO 29	1.4	0.8	1.1	0.8	1.9		
30 TO 39	1.8	1.0	1.3	0.9	2.8		
40 TO 49	1.6	1.1	0.7	1.2	3.3		
50+	1.6	1.1	0.9	1.3	4.9		

* Age Specific Fertility Rate

The prevalence of smoking was highest (1 in 4) among urban women 20 to 39 and lowest among rural women 40 to 49. Smoking is the most common risk factor for myocardial ischemia among women aged 20 to 29 in both urban and rural areas. It is the only risk factor that is more common among younger than older women. For each age group it is about twice as common in urban as rural areas.

The prevalence of high serum cholesterol (>225 mg) among women 30 and older is slightly higher in urban than rural areas. Overall it increased with age—from 10.4% among women aged 20-29 to 35.4% among women aged 40-49.

Hypertension is the only risk factor that—for older women—is slightly more common among rural than urban women. Obesity was more common among the older group (9.8%) than the younger (3.6%).

The relationship of myocardial ischemia and its associated risk factors with increasing age is shown in Figure 4. Smoking is most common under age 40. The prevalence of high serum cholesterol and obesity increases rapidly and steadily with increasing age. Hypertension is the last risk factor to become prominent as a woman increases in age.

Figure 4 Prevalence of Myocardial Ischemia

And selected risk factors, women 20+, Romania, June 1989



One reason cigarette smoking was not significantly associated with myocardial ischemia is that only 72 women in the survey reported they

smoked 20 or more cigarettes per day. However, the age-adjusted summary odds ratio for a dose effect showed that the more cigarettes a woman smoked the more likely she was to have myocardial ischemia (Table 15). Compared with nonsmokers, women who smoked more than 20 cigarettes per day had a 1.7-fold increased prevalence of myocardial ischemia ($p=0.04$).

Table 15 Risk of Myocardial Ischemia by Average Daily Number of Cigarettes Smoked, Women 15+ by Age Group—Romania, June 1989

No. cigs.	Myocardial Ischemia(MI)			Prevalence of MI	Relative Risk	Confidence	
	Yes	No	Total			Lower	Upper
15-34							
20+	0	20	20	0.0%	0.0		
10-19	1	91	92	1.1%	1.8	0.2	13.7
<10	1	172	173	0.6%	0.9	0.1	7.3
0	10	1618	1628	0.6%			
Total	12	1901	1913				
35-49							
20+	2	28	30	6.7%	1.3	0.4	5.2
10-19	7	73	80	8.8%	1.8	0.8	3.7
<10	4	98	102	3.9%	0.8	0.3	2.1
0	63	1208	1271	5.0%			
Total	76	1407	1483				
>49							
20+	8	14	22	36.4%	1.6	0.9	2.8
10-19	14	38	52	26.9%	1.2	0.8	1.9
<10	18	51	69	26.1%	1.2	0.7	2.1
0	490	1676	2166	22.6%			
Total	530	1779	2309				

Summary Statistics - All Agegroups

No. Cigs	Odds Ratios	
20+	1.73	
10-19	1.44	Chi Square for linear trend=4.078 p=0.043
<10	1.08	
0	1.00	

The diagnosis of myocardial ischemia among women is rare (0.35%) below the age of 30, so we have examined the importance of risk factors for myocardial ischemia among women aged 30-49 (Table 16). Cholesterol, hypertension and obesity were associated with elevated risks of myocardial ischemia. Over 43% of the women had elevated serum cholesterol (>225 mg/dl)—with an associated 1.96 times greater likelihood than women with lower cholesterol levels of having myocardial ischemia. Without correcting for the presence of other risk factors, we estimated that 22.4% of myocardial

ischemia might have been prevented if all women had normal serum cholesterol levels.

Table 16 Risk Factors for Myocardial Ischemia among women 30-49. National Health Examination Survey—Romania, June 1989

Risk Factor		Myocardial Ischemia			Relative Risk	Prevalence Risk Factor	Population Attributable Risk
		Yes	No	Prevalence			
Cholesterol	>225	39	579	6.3%	1.96	43.3%	22.4%
	<=225	46	1381	3.2%			
Hypertension	Yes	19	106	15.2%	4.42	6.5%	17.3%
	No	66	1854	3.4%			
Obesity	Yes	21	302	6.5%	1.75	18.8%	10.6%
	No	64	1658	3.7%			
Smoking	Yes	14	310	4.3%	1.05	18.8%	0.7%
	No	71	1650	4.1%			

Hypertension was more specifically associated than any other risk factor with a diagnosis of myocardial ischemia. Hypertensive women aged 30-49 were 4.4 times more likely than normotensive women to have myocardial ischemia. Since 6.5% of these women had hypertension, we estimated that 17.3% of the women might not have had myocardial ischemia if they had not had hypertension.

Obesity is the third most important risk factor for myocardial ischemia among women in Romania. Nearly 19% of these women were obese and an estimated 11% of myocardial ischemia might have been averted by prevention of obesity.

Since high cholesterol levels, hypertension, and obesity are associated with each other, multivariate analysis is required to determine the exact contribution of each to the cardiac problems of women in Romania. Cigarette smoking makes a small, and, in this table, a statistically insignificant contribution to the risk of myocardial ischemia in this population.

Conclusions

The women of Romania have nearly a century's experience in limiting the number of children they have. They have limited the size of their families by sexual abstinence before marriage. They have delayed marriage until economically affordable. They have used abortion to prevent having more children than they can afford to raise.

When contraception is available they use it—those interviewed in Tirgu-Mures stated a strong preference for oral contraceptives. If modern contraceptives—including permanent contraception—were widely available to meet the needs of Romanian couples, we would expect a rapid reduction in incidence of induced abortion in Romania.

The most common reason for using contraception and abortion is to have no more children. Therefore, physicians and men and women should be informed of the effectiveness and safety of permanent methods of contraception. The study in Tirgu-Mures suggests that contraception is more acceptable than induced abortion, but shows a reticence toward permanent contraception that may be a consequence of ignorance about the method.

Providers of contraception—and of abortion services—should be informed of the prevalent health conditions of women in Romania. Moreover, they should be provided the training, equipment and supplies to ensure that they can treat women's health problems adequately. Given the economic conditions in Romania, international assistance and collaboration should provide some equipment and supplies and training to improve the safety and acceptability of fertility control methods in Romania.

Conducting a nationwide family planning survey to determine the family planning knowledge, attitudes and practices of Romanian couples is an essential initial step in developing a strategy to respond to their needs. This study should also assess the health status and needs of children in Romania.

The chief identifiable risk factors for myocardial ischemia among women of reproductive age—high cholesterol, obesity, high blood pressure, and smoking—can be reduced by changes in food choices, exercise and smoking prevention and cessation campaigns.

For most of the data we examined, we found no evidence of data being particularly unreliable. In particular, the data on maternal mortality, the data from the 1989 Health Examination Survey, and the family planning survey from Tirgu-Mures were internally consistent and appeared to be fairly errorless. Data on infant mortality—not presented in the report—has been evaluated in Romania and may be less reliable—with incomplete reporting of low birthweight infants and of infant deaths. Finally, we could not evaluate changes in the completeness of reporting of sexually transmitted diseases—that appear to have declined during the last year.

V. Safety of Family Planning in Romania

Cardiovascular Mortality in Women of Reproductive Age and the Use of Oral Contraceptives

Romanian rates of cardiovascular death are below that of other Eastern Block countries, but higher than rates in Western Europe, and have increased while the rest of Europe has declined.¹ Cardiovascular mortality rates correlate strongly with age, and are uncommon among young Romanian women. For women in the reproductive years, Romanian cardiovascular death rates are slightly greater than those of Western Europe and the United States.² Actual prevalence of disease data is available from the Ministry of Health. In 1989, a national probability sample of 13,774 Romanian men and women had standardized health examinations.³ Rates of ischemic heart disease were 1.6 per 100 among women aged 15-49, and 0.5% among women 15-34. Rates of cerebrovascular disease were 1.0% for women 14-49 and only 0.05% among women 15-34 (see chapter four).

The effect of the introduction of OC's on country-wide cardiovascular mortality in the West is known. In the years following introduction of OC's, in the 1960's, cardiovascular disease rates fell steadily, for both men and for women, and actually fell more rapidly for women.⁴ This occurred even though the OC's used in the 1960's had much higher doses of hormones than those currently used. Also, physicians prescribed OC's for women then for whom they are now considered contraindicated. Since the 1960's, epidemiologists have documented risk factors for cardiovascular disease which are

exacerbated by the use of OC's (for example, women with a history of a previous myocardial infarction).

Current OC's are thought to be much safer than those available earlier because of the reduction in dose of both hormonal components, estrogen and progestin. Bottiger⁵ in Sweden and Meade⁶ in England documented this decline in venous thrombosis and thromboembolism with reduction in estrogen doses from 100-150 mcg daily to 50 mcg daily. Current OC's contain even less estrogen, 30-35 mcg. Additionally, two English studies found reduction in arterial disease risk with reduction in dose of the progestational component, from 3-4 mg of norethindrone acetate to 1 mg, or of levonorgestrel from 0.25 mcg down to 0.15 mcg. Current OC's contain 0.4 to 1.0 mg of norethindrone and 0.15 mg or less of levonorgestrel.⁶

Venous thrombosis or thromboembolism must still be considered as a risk of OC use, but with better selection of patients and lower dose preparations, the risk is very low. Porter⁷ reported on 39,807 woman-years of OC use (the equivalent of observing 39,807 women for one year each) comparing them to 98,556 woman-years of observation of non users of OC's from 1980-1982 in the U.S. Three women who were OC users had venous thromboembolism (0.08 per 1000 women years) and six of the nonusers did (0.04 per 1000 women years), a 2.0-fold increase in risk with OC use. Even with this large number of women observed, this apparent increase in risk was not statistically significant. There was a 10% chance the findings could have been accidental. If we accept that the increased risk is real and not accidental, then 1.6 venous thromboembolisms would have been seen among oral contraceptive users whether or not they were using OC's, and the extra cases that were caused by OC's were only 1.4, out of the equivalent of 39,807 women followed for one year. Risk today would be expected to be even less because in the Porter study, a substantial portion of the women were on OC's containing more than 50 mcg of estrogen and today they would all be given 30-35 mcg estrogen pills. None of the pill users died from the thromboembolism.⁸

Heart attack and stroke are potentially of much greater concern because they are more likely to result in death or long lasting illness. In the Porter study^{7,8} only one heart attack occurred, to a non OC user and no pill users died from cardiovascular causes. The rate of stroke was very low, 7 among nonusers and 1 among the OC users. The rates 0.04 per 1000 women years for non users and 0.03 for users were virtually identical. In this large sample, OC use did not increase stroke risk.

Other workers have found an apparent increase in heart attack among women taking OC's, but most of the cases are of women who both smoke cigarettes and take OC's. An example of this is the U.S. Nurses' Health Study⁹

where OC use was associated with a 2.5 fold increased chance of having a heart attack, but 7 of the 10 women who developed heart disease were cigarette smokers. The same study provides very reassuring information about the safety of past use of OC's. 49,269 women who had used OC's in the past (415,488 women years) were compared to 62,718 women who had never used OC's. (484,096 women years) There was no increased heart attack risk for past users, even if they had used OC's for as long as 10 years. Prolonged use was associated with a possibly slight increased risk for stroke (1.3 fold), but this very small increase was not statistically significant, *i.e.*, could easily have happened by chance alone if OC's have nothing to do with stroke. Among women who had developed diabetes or high blood pressure, past use of OC's was actually associated with some apparent reduction in heart attack risk. These new studies differ somewhat from English studies which did not find current use to increase risk but did find a weak association with past use.¹⁰ However, heart attack prior to age 40 is an exceedingly rare event and the primary users of OC's are young women.

Risk of heart attack and stroke is very strongly related to age, male sex, cigarette smoking, high blood pressure, diabetes, marked obesity and family history of heart attack or stroke at a young age. Romanian data on the prevalence of several of these factors is given in chapter four. We feel that use of OC's by young women (35 or younger), or by older women who are not smokers will not add materially to cardiovascular risk. Standard practice in the U.S. is to avoid prescribing OC's for smokers who are older than 35. Formerly, physicians in the U.S. did not prescribe OC's after age 40, but recent expert opinion concludes that modern low-dose pills can be used after 40 provided the woman has no other risk factors for vascular disease and still needs this form of contraception.¹¹ Romanian doctors with whom we spoke were aware of the risk factors. With instruction, these physicians are capable of determining which women would have increased health risks if they used OC's: women with hypertension, diabetes, marked obesity, heavy cigarette smokers (more than 1 pack per day), or whose parent or sibling had heart attack or stroke before age 55.

We have been told that Romanian women and some physicians believe that OC's cause genital cancer. The scientific answer to this question is complicated. There is strong evidence that OC use prevents later development of cancer of the ovary and cancer of the endometrium (uterine lining). These benefits have been found in many studies, and confirmed in very large trials carried out by the U.S. Public Health Service Centers for Disease Control.^{12,13} Since cancer of the ovary is common in the West, and in Romania, and usually results in death of the victim in spite of treatment, this reduction

in cancer risk is important. On the other hand, OC use may be a weak risk factor for progression of pre-malignant lesions of the uterine cervix to cancer. The main determinants of cervical cancer risk are the onset of sexual activity at a young age (under 20), exposure to multiple sexual partners, cigarette smoking, and most important, infection with sexually transmitted condyloma virus (Wart virus). Since women who take OC's are also more likely to have begun sexual activity at an early age, and since barrier contraceptives actually reduce risk by approximately 50%, it is still not possible to be certain whether OC use increases cervix cancer risk or not. Women who use OC's, and all women who have been sexually active are advised to have annual cervical cytology (Pap smears), a service now beginning to be available once again in the maternity hospitals in the capital. In any case, the benefit of marked reduction in ovarian cancer deaths from OC use by Romanian women would more than offset any small increase in cervix cancer.

Benign adenomas of the liver are increased by OC use, but these are exceedingly rare, a few per 100,000 women. Some workers have linked OC use to cancer of the liver, but this issue remains unsettled. During the years since OC's were introduced into the U.K. and the U.S. there has been no increase in these tumors in the female population.¹⁴ This uncertain risk is more than offset by the health benefits of OC use. The possible role of OC use in the development of breast cancer is currently debated. Part of the answer is clear: overall, there is no increase in breast cancer among OC users. What remains unsettled is whether OC use may increase risk for some small subgroups of women. Young women who have used birth control pills for a prolonged period may have some increased risk of breast cancer; on the other hand, the same studies are now showing reduction in risk for the oldest women in the samples. Since breast cancer is seen much more commonly in older women than younger, a current expert opinion expressed by investigators at the U.S. National Institutes of Health is that the net effect of OC use may turn out to be fewer cases of breast cancer than would otherwise be expected.¹⁵

Reproductive Health: Pelvic Inflammatory Disease, Sexually Transmitted Diseases, and the Use of Intrauterine Devices

The 1989 health examination of 13,775 representative Romanians, previously described¹⁶ reported the prevalence of pelvic infection as 2.2% overall,

among 3,396 women aged 15-49. Among this number, 0.8% had salpingitis (inflammation/infection of the uterine tubes), 0.8% parametritis (inflammation/infection through the uterine wall), and 0.7% endometritis or metritis (inflammation of the uterine lining)(see chapter four). In considering the possible impact of IUDs in Romania it is important to distinguish between postabortal infections which will be prevented if pregnancy is prevented, whether by IUDs or by other means, and uterine and tubal infections that are unrelated to pregnancy. Since abortion was illegal, the 1988 survey did not attempt to determine which infections were the consequences of abortion and which were not.

Gonorrhea is a reportable disease. A 1989 Ministry of Health publication¹⁴ reports 35.7 cases of gonorrhea per 100,000 population. The peak rate for women was 85 per 100,000 women in the 20-24 year old age group. Unfortunately, sexually transmitted diseases are often underreported, and many Romanian women are cared for in settings where such testing is not possible.

The other major sexually transmitted pathogen that causes uterine and tubal infection is chlamydia, a virus-like bacteria which requires special tests for diagnosis apparently not available in Romania. In the U.S. there are approximately as many cases of chlamydia as of gonorrhea, so whatever assumption we make as to the true rate of gonorrhea should probably be doubled in order to estimate the prevalence of sexually transmitted diseases that can lead to pelvic inflammatory disease. Compared to Western Europe, the reported rate of gonorrhea is low. Our interviews with gynecologists and general physicians suggest that they are seeing much less pelvic infection since abortion was made legal. We conclude that other than illness caused by complications of illegal abortion, Romanian women are probably not at higher risk for sexually transmitted tubal and uterine infections than other European women.

Case reports from the 1970's suggested a strong connection between IUD use and pelvic infection, even though large, carefully done studies had initially shown a very low rate of infection with IUDs. Reasons postulated to explain the difference include:

- A "sexual revolution" in the West which resulted in larger numbers of men and women being exposed to risk of sexually transmitted diseases because of break down of traditions of sexual monogamy and...
 - The impact of one specific IUD, the Dalkon shield, introduced into the U.S. in the early 1970's which was eventually found to strongly correlate with infection. A large hospital based epidemiologic study found the
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Dalkon shield to cause an 8 fold increase in the likelihood of hospitalization for pelvic inflammatory disease when compared to women not using contraception. The other IUDs increased risk only slightly or not at all.¹⁵

A further analysis of this important study found that when Dalkon shield wearers were excluded, the woman's report of number of sexual partners in the last 6 months strongly determined her risk. Women who were either married or living with one man and who said they had no other sexual partners in the past 6 months had no increase in pelvic infection risk when they wore IUDs. Women who were single, but not living with a man did have increased risk. All of this strongly suggests that it is exposure to sexually transmitted disease that confers the risk, and that IUDs (other than the Dalkon shield) are not important risk factors. In the Romanian setting, doctors will learn to exclude women with history of severe pelvic infection or physical examination findings consistent with this diagnosis. Toward this goal, the Ministry of Health is limiting IUD insertion to gynecologists who are best able to make this decision.

We were told first hand that Romanian women fear that IUDs cause uterine cancer. The scientific evidence is otherwise. No increase in cancer has been found in IUD wearing women. Barriers, the condom or diaphragm, offer protection from cervical cancer by preventing spread of sexually transmitted factors that are causal.¹⁷ Current scientific opinion suggests that wart viruses (human papilloma virus) and not IUDs are the causative agent.

Contraceptive Choices: Risks and Benefits

Contraceptive benefits of modern methods are obvious: when used properly, very low rates of unwanted pregnancy result, and the need for abortion is considerably reduced. In addition, modern methods provide very important non-contraceptive benefits. Oral contraceptives markedly reduce risk for developing ectopic pregnancy, prevent deaths from cancer of the uterine lining and ovarian cancer, reduce benign breast tumors and reduce ovarian cysts, prevent menstrual pain and reduce menstrual blood loss. The risks of oral contraceptives are small increases in occurrence of venous thrombosis and of heart attacks or strokes, primarily in women over 35, and in the case of heart attacks and strokes, primarily in cigarette smokers.

Intrauterine devices provide excellent contraception with no systemic side effects. They may increase menstrual bleeding and pain which will lead to removal of the device. They are weakly associated with infection and/or inflammation of the uterine tubes which can lead to sterility. Most of the risk

is seen in women who are exposed to sexually transmitted infection. In the past Romanian women have frequently suffered from pelvic infection, apparently from self induced abortion. Frequency of these infections appears to be falling with the legalization of abortion. Use of IUDs by appropriately screened Romanian women should markedly reduce the need for abortion and the postabortal infections formerly seen.

Barrier contraceptives, condoms and diaphragms offer acceptable contraception, and have as a non-contraceptive benefit a marked reduction in risk for sexually transmitted infections and reduce the risk for cervical cancer.

Family planning by use of illegal abortion in Romania has been a disaster unparalleled in the developed world and has produced markedly elevated maternal mortality rates, ectopic pregnancy, sterility, chronic pelvic infections, and high rates of low birth weight babies. The change to modern contraception, backed up by easily available legal abortion, can be expected to produce marked improvement. Producing this shift is the major challenge facing those who provide reproductive health services in the country.

Adequacy of Screening

The medical system is a modern European one whose advances have been truncated by intervening events of history. It is organized principally around doctors who are accessible throughout the country. Even though contraception has been legal in the country only for a short time doctors are screening patients for oral contraceptives and IUDs. They are using protocols and patient records that have been developed by the Ministry of Health. Those specialists who have been oriented by foreign doctors are able to appropriately screen patients, including women who may show a propensity for cardiovascular disease.

Recommendations

1. Given the urgent situation in Romania, CEDPA should begin immediately to establish its office and management structure using the readily available documentation from governmental and international sources. Because the work to establish contraceptive services in the country will be labor intensive CEDPA should consider placing its staff for this project in country for the duration of the contract.
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2. Production and dissemination of family planning literature and training materials in Romanian for the public, for clients attending clinics, and for health care providers should begin immediately. The need for public education through every avenue possible, from mass media to individualized counselling, is underscored by everyone who has reviewed the situation in Romania. Immediate support and technical assistance should be given to this aspect of the family planning program. All kinds of materials have been translated into Romanian and are awaiting publication. CEDPA should move rapidly to facilitate publication of these materials. It should consider printing them outside the country as in-country printing appears to be where the present bottle-neck exists. Under the present circumstances it is not necessary to re-invent materials. The need is to publish, distribute, and utilize. Other complementary materials can be developed later.

Educational materials for the medical and health care professions are also urgently needed. Again, it is the publishing that needs to be done. CEDPA and its partners should provide immediate assistance in this area.

3. To ensure full professional and public participation in the program, a community based advisory board to SECS should be established.

4. SECS should work with a national counterpart at the Ministry level to coordinate the acquisition, monitoring, and distribution of family planning supplies and equipment.

5. Because of a lack of management capacity within SECS, CEDPA should move quickly to provide support and training to SECS in the areas of organizational structure, financial planning, personnel, and over-all management style.

6. As a way of speeding the conversion from abortion to contraception, donated supplies of contraceptives should be disbursed to hospitals, maternities, and polyclinics where abortions are performed. This will permit doctors, principally specialists, to screen women and dispense contraceptives to those who are willing to make the switch. The distribution can be done through SECS, in close collaboration with the Ministry of Health. This does not mean that other avenues for the distribution of contraception should be ignored, but only that in the short-term this approach seems to be a feasible way of initially promoting contraceptive use as well as creating a training experience.

7. CEDPA should assist SECS to establish an initial model clinic in Bucharest for the specific purpose of enhancement of family planning training, aware

that the Ministry of Health will continue to be the realistic sole provider of contraceptive services - pending potential changes in the current political and economic environment.

8. There are plans for the training of the medical and health care professions in family planning throughout the country. CEDPA, through SECS, can make a substantial contribution to this process, by accelerating and complementing current government plans. CEDPA should coordinate its training efforts in the country with the government. Given limited resources, it should consider focusing its efforts in designated regions or districts of the country.

9. At the moment some space is being created for private initiative in the economic sphere. Some 4,000 doctors have asked for permission to commence private practices. CEDPA and its collaborators should explore how it might provide assistance to this movement as a means of enhancing the availability and use of contraceptives. CEDPA should also explore possible links with other in-country NGOs interested in family planning services (for example, the Romanian General Practice Association).

10. Under present arrangements, except for contraceptives that are donated, pills, IUDs and other family planning supplies are available only from pharmacies or the black market. CEDPA and its partners should assess whether this system will adequately handle the demand for family planning as it grows. If not, then other alternatives should be explored.

11. Every effort should be made by USAID and by CEDPA to coordinate their activities in family planning with the current overall plan of the Ministry of Health and with the current effort by other multilateral and bilateral agencies including, among others, UNFPA, the World Bank, UNICEF, WHO.

12. USAID should support family planning KAP surveys and reproductive health surveys in the near future.

13. USAID should consider providing technical assistance to strengthen the Ministry of Health family planning program, specifically in the areas of policy formulation, strategic planning and management.

VI. Children in Institutions

History and Magnitude of Problem

The plight of abandoned and disabled children in Romanian institutions came to the attention of the world shortly after the overthrow of the Ceausescu regime in December 1989. A combination of political, social, and economic factors had resulted in the institutionalization of approximately 150,000 children, often in bleak conditions. Those factors include:

- The Ceausescu regime's program in population engineering designed to increase the population from 23 million to 30 million. As part of the program, abortions were made illegal in 1966 and family planning information and contraceptive commodities were banned. As a result the number of unwanted births increased dramatically with a corresponding increase in the number of abandoned and subsequently institutionalized children.
- In the early 1980's the Ceausescu government initiated a series of austerity programs aimed at reducing the country's foreign debt. Living conditions became increasingly difficult as domestic food consumption fell and per capita income fell to among the lowest in Eastern Europe. It became increasingly difficult for families with both parents working to provide for large numbers of children many of whom were becoming progressively malnourished and at risk from deteriorating living and sanitary environments. With migration from rural to urban settings in search of employment, the safety net of an extended family also disappeared. The result, once again, was an increase in the number of abandoned and then institutionalized children.

- An outbreak of pediatric AIDS thought to result from the transfusion of infected blood and from the repeated use of unsterile needles for injections. In many instances, these children became wards of the state.
- The "medicalization" of child care. Children with often minor ailments (otitis media for example) are referred to the pediatric hospitals for evaluation by the pediatrician instead of receiving treatment at home with the assistance of the local dispensary or polyclinic. Reasons given include simple concurrence with long held tradition as well as the lack of available antibiotics at the local site. Once admitted to the hospital however, children are permitted few if any visits by family members, remain hospitalized for extended periods of time, and undergo various procedures that often extend hospital based care. Not infrequently, the result is the development of a child suffering the effects of "institutionalization".

Overview of National System Responsible for Children in Institutions

The responsibility for the care of institutionalized children involves four separate government agencies. Specific areas of responsibility and the number of agencies involved may well change as a result of on-going evaluation. Currently they are:

- The Ministry of Health which provides care for children aged 0 - 3 in orphanages, pediatric hospitals, or "dystrophic" centers. At age three, all children are screened at the district level by a board made up of a pediatrician, a social worker, and a Ministry representative. (There is currently a plan under consideration to extend the responsibility of the Ministry of Health to include all children from age 0 through 6 delaying transfer to the care of the other agencies.) Pending the decision of the board, a child becomes the responsibility of one of the following:
 - The Ministry of Education: providing homes for "normal" children from age 3 - 18.
 - The Secretariat of State for Handicapped Children: provides care in "special" schools for children, aged three and greater, who are blind or deaf (previously the responsibility of the Ministry of Labor and Social Protection), or who have other minor disabilities.
 - The Secretariat of State: providing care for all those children not included
-

in the previous two categories in institutions called "Homes for Irrecoverables".

According to the UNICEF Mission Report from August 1990, at least 142,000 children were institutionalized in more than 628 facilities at the time of the uprising, 14,800 of whom were in "orphanages". These are estimates at best and should be regarded with care. The Table below, found in the UNICEF report, attempts to summarize the types and number of children receiving care. The listing is incomplete, however, and entire categories of institutions are not included. For example, "creches" (extended "day care" centers) are not included nor are the institutions for delinquent youth who have committed serious crimes.

Residential Institutions for Children in Romania		
Ministry Responsible and <u>Type of Institution</u>	<u>Number of Institutions</u>	<u>Number of Children</u>
Ministry of Health		
Homes for infants (0-3 yrs)	65.....	14,800
Ministry of Education		
Homes for children (3-6 yrs)	214.....	38,915
Schools for youth 14-15 yrs without parents	—.....	12,000
Homes for pre-school children with common handicaps	43.....	3,018
Schools for children with minor disabilities 138.....	31,000	
Secretariat of State for Handicapped Children		
Homes for children with minor disabilities	14.....	4,465
Vocational training for those 14-22 years, with disabilities — primarily visual and auditory	32.....	15,253
Schools for those 14-22 years with minor disabilities	5.....	400
Schools for delinquent and other children ...	3.....	1,365
Residential workshops for handicapped persons 16-55 years	3.....	1,090
Secretariat of State		
Homes for children 3-18 years thought to be severely handicapped	88.....	15,800

A paragraph from the UNICEF mission report summarizes the impact of what is often a non-uniform and at time arbitrary screening system:

"With little or no opportunity for reassessment, children are locked into inescapable systems of institutionalized care. These children have little or no experience to life outside the institution and remain isolated from all aspects of community life. Even children with normal capacities have not been integrated into the school system and proposed efforts to do so must proceed cautiously recognizing the existing attitudes of teacher, and communities towards handicapped and orphaned children. Although the Church has expressed some recent concern, given the quest for survival of Romanian society during the past four decades, it is not surprising that little energy and resource is left for society's most vulnerable groups."

Current Situation—Current Response

New Legislation and Government Inputs

Information provided in this section is derived from interviews with personnel in relevant ministries along with major input from the UNICEF August 1990 report.

Significant actions since the uprising include:

- **Abortion Legalized:** Enacted on December 26, 1989 the law authorizing legal abortion was the second formal law passed by the coalition government. In 1990 there were 1.2 million legal abortions in Romania. Although there is no hard data available, during the same time period there was significant decrease in the number of institutionalized children. The number of children in orphanages, for example dropped from approximately 14,800 to 7,000. While this decline is surely the result of a combination of factors, the impact of legalized abortion is significant.
 - **Maternity leave:** maternity leave was increased substantially to allow mothers to stay with their children for one year while receiving 85% salary for the four months and 60% for the next eight months. Women are also prohibited from working at night after they are five months pregnant and have the right to remain at home with full pay from the eighth month of pregnancy.
 - **Adoption liberalized:** As of August 1990 new legislation on adoption was enacted simplifying adoption procedures making it a matter for the lower
-

court, eliminating some of the previously limiting factors. The new law, while requiring that a home study be supplied by the prospective parents, leaves areas open to abuse.

- **Provisional budget and staff increases:** Budgets and staff for institutions with abandoned and orphaned children, chronically ill, and mentally disturbed patients was significantly increased in provincial legislation. There remains, however, a severe shortage of trained and qualified personnel.
- **Training and educational programs reopening:** a critical factor compounding the problem of appropriate care for institutionalized children was the closure during the previous ten years of almost all specialized training programs that dealt with children in institutions. Now programs in medical schools, as well as basic education for nurses, programs for social workers and specialists in mental and physical handicapped are being re-instituted.

International, Bilateral, and NGO Assistance

Humanitarian assistance, targeted mainly at children in institutions began to arrive in Romania in March 1990. These international efforts have been complemented over the past year by efforts of newly emerging Romanian NGOs and established institutions like the Romanian Orthodox Church and the Catholic Church. Unfortunately, there has been no effective method to coordinate the now enormous influx of aid from large donors as well as the various NGOs. At the time of our visit there were, by one count, 220 different NGOs working at various sites throughout the country with no requirement to register with any governmental agency. A listing of the activities of major donors follows:

- The World Health Organization has assisted in the development of a national AIDS program and has provided sufficient equipment to test all blood products for presence of HIV at the District level. This program is essential since the majority of HIV positive babies seroconverted after exposure to contaminated blood transfusions.
 - The WHO completed a Maternal Child Health assessment in March 1991 and has made a commitment to play a major role in improving MCH capacity.
 - WHO and UNFPA ran a joint training program on family planning for 75 doctors and 100 nurses in September 1990. UNFPA has also just com-
-

pleted its second situation analysis in Romania and has committed approximately \$385,000 per year for each of the next five years to family planning education and commodity procurement.

- The EEC commissioned a comprehensive survey of all facilities for orphans and abandoned children below seven years of age. The commission's report was submitted to the EEC meeting in September 1990. As of March 1991 discussion between the Romanian government and the EEC were continuing with large scale funding and long term technical support forthcoming.
 - PACT (Private Agencies Cooperating Together) received a \$2,000,000 USAID contract to assist Romanian children. One grantee is World Vision which manages projects in child development training in medical schools, in community linked medical education, and in training for orphanage personnel.
 - UNICEF has assigned a Special Representative to a two year post in Bucharest with the specific task of appropriate allocation of the \$4.5 million received as unsolicited funds shortly after the uprising. Approximately one half of the funds will be used for direct relief and the other half for training and infrastructure development.
 - Medecins San Frontiere and Medecins du Monde are each carrying out many activities ranging from distribution of pharmaceuticals to providing training and fellowships for Romanian health professionals and paraprofessionals. Programs include educational materials for nursing schools, hepatitis B vaccination for all children and pregnant mothers, nutritional programs for orphanages, and distribution of European medical journals.
 - The League of Red Cross and Red Crescent Societies have contributed materials and supplies valued at more than \$2 million dollars and are providing assistance in the AIDS program, with training, and with the establishment of an AIDS surveillance system.
 - The Ministry of Health/World Bank program includes components that will directly impact institutionalized children; it has been discussed elsewhere in this report.
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Future Directions: Care and Development of the Institutionalized Child - Recommendations

During our visit we were impressed with the cooperation received from all personnel in the institutions visited in Romania. In spite of the international media attention which the orphanages have received, which might have made them defensive and on guard with us, directors and other staff were gracious and patient and answered questions with apparent candor. Although these institutions have many problems, it is clear that considerable progress has occurred during the past 15 months. The increasing attention directed to the plight of children and the considerable assistance which has come from a variety of national and international sources have already led to significant changes. The challenge is to coordinate all these offers of assistance into a total system which will enhance the development of the children and ease the burden of the families. Our recommendations are offered in the context of what we have been able to learn in a short visit made during a period of rapid change.

In the following section, we offer a series of recommendations to the Ministry of Health of Romania and to USAID. They are offered with humility in recognition of the brevity of our visit and the lack of opportunity to observe more facilities at first hand and to talk with more people directly. Although a more extended visit might have led to additional recommendations, it is unlikely that greater exposure would have invalidated any of the recommendations we offer at this point.

1. Continue to reduce populations in orphanages.

It is encouraging that the population in the orphanages has been reduced from 14,800 to approximately 7,000. We were told in a number of personal interviews that this trend has occurred primarily through a liberalization of Romania's adoption policies and through attempts to reinstate some of the children with their families. We were also told that the legalization of abortion may have had an impact on the number of children at risk for institutionalization.

There are other important ways to reduce the population of children in the orphanages which need to be instituted. Again, initial steps are apparently being made in several areas, but progress has been tentative. A major deterrent to deinstitutionalization is the almost complete absence of a national social service program. Training for social workers was terminated in 1978, and there has been only minimal redevelopment since that time. It is difficult to determine whether mothers who eventually "abandon" their

children receive any counseling during the prenatal or perinatal period. Such counseling is essential to enable parents to make a reasoned decision about whether to release custody of the baby.

There are other types of service which would help reduce population in the orphanages. So far as we have been able to determine, there is no sort of foster care available for children in Romania. Also, adoptive efforts need to be accelerated so that infants can be placed with adoptive parents prior to beginning to show a decline in development. There are humane reasons for delaying adoption, and the personnel in the orphanages should be commended for these. For example, they want to keep the children long enough to make certain that they are not handicapped. Unfortunately, however, the longer infants remain in an institution—no matter how high the quality—the more likely they are to develop mental and social handicaps.

This process of institutional decline can be illustrated by the usual course of development of the babies labeled dystrophic ("failure to thrive" in America) and of low birthweight and SGA (small gestational age) babies. If the newborn is of low birthweight or SGA, apparently a referral to the orphanage/hospital is routine. As Romanians do not accept the idea of keeping handicapped children in the home and community (an attitude that is prevalent in many parts of the world), the strategy is to hospitalize the children until they gain weight and show signs of normal development. These infants are hospitalized for long periods, presumably to give them an opportunity to gain weight and begin to thrive. However, as is now well known from studies from many parts of the world, prolonged hospitalization has exactly the opposite effect on many of the children. Instead of thriving, they deteriorate socially and intellectually. Furthermore, such prolonged separation denies parents the opportunity to bond to the infants during the critical early infancy period. Such infants, with no opportunity to attach to a single adult figure and extremely deprived of stimulation, gradually decline with little potential for recovery.

2. Improve the quality of life in institutions.

This has obviously been a major goal of personnel within the Romanian institutions and of the individuals and groups from all over the world that responded to the evidence of need. Toys and learning materials, formerly in short supply, are now abundant in some of the facilities. In fact, some of the institutions have supplies that they have not even had time to sort and make available to the children. Likewise, better and more nutritious food, sanitation materials and equipment, and medicines are coming in from many parts

of the world. This is most encouraging, and the Romanians are extremely grateful for this help.

These materials, so desperately needed, are not enough to alter quality by themselves. It is the way they are dispensed by the personnel working in the institutions that will have the greatest impact. In order for them to be maximally utilized, additional training will need to be offered to staff in the facilities—from directors to custodians. In one of the orphanages we visited (#1 in Iasi), the director told us that they now screen applicants carefully and give them several psychological tests prior to hiring them. In general we were impressed with the concern, the love, the devotion shown by the people in the institutions we visited.

However, they often seemed to compartmentalize their activities. That is, there were times in which they were dispensing health care and other times when they were offering child development activities. Rarely were these integrated. Of course, in some institutions they simply do not have enough personnel to allow any major changes in practice. However, some of the activities can be put in place without any addition of staff—talking to the babies while diapering and feeding them, smiling in response to the smiles of the babies, responding verbally to any verbal or vocal output from the children, etc.

3. Launch a total child development approach.

It is obvious that much has already been done to improve the quality of life for young children in the orphanages. Several of the facilities we visited have hired educators to work with the children in small groups for part of the day. Also, there are occupational and physical therapists working with some of the children at scheduled times.

However, these activities are generally carried out in a way that is completely separate and removed from the remainder of the child's day. What is essential to facilitate the development of the children, and to prevent decline in the very young ones who come into the institutions with normal potential, is that the regular caregivers appreciate the importance of every single interaction they have with the children. That is, it is one thing for the educator to smile, clap, and hug a toddler who correctly places a disc on a color cone. But, if that same child vocalizes after the educator leaves to work with another group and no one responds to the vocalization, then the child's likelihood of continuing to vocalize and try to communicate will not be strengthened. Every diaper change, every feeding, every bath, every entry into a room to pick up toys or change a bed should be utilized to interest the

young child in the activities of his or her world and to reinforce any instance of desirable behavior that occurs during those chance encounters.

Obviously it is easier to do this when there is a favorable child:adult ratio—not more than four children per adult. The realities of funding do not always make this feasible. But careful training of the nurses and their aides can markedly increase the likelihood that such growth-fostering behavior will occur.

It is easy to validate the importance of this by simple observation on any of the wards. As long as the educator is present, talking to and stimulating the children, they are involved with her and display age-appropriate behavior. During this time, they play contentedly with their toys. As soon as the educator goes to another ward, however, the rocking or swaying in the cribs begins, and what toys are in the room tend to be ignored. Until infants and toddlers become able to do a reasonably good job of pacing their own development, they need these stimulating and reinforcing interactions with adults throughout their waking hours.

Formal training is not the only way to impart this skill of responsive caregiving. Informal ward training offered when staff members are working with the children, thus providing live opportunities for caregiver behavior of the desired type and giving the trainer the opportunity to offer immediate reinforcement of newly acquired skills, can be very effective. When caregivers realize that responding to the children in the way described here does not require any more work and/or time on their part and yet results in children who will be essentially easier to care for, they actually enjoy their work more—and communicate that joy to the children.

Use of the word "joy" leads to another important quality of an environment in which young children can develop optimally—emotional liveliness. People who work effectively with young children have to be lively, must let their emotions show, and must encourage the children to do likewise. Many of the wards are rather somber places. The staff all wear stiff white uniforms and appear more concerned with appearing "professional" than with their care of the children. We understand that the presence of foreign visitors (almost always accompanied by the director of the facility) has a way of suppressing spontaneity and liveliness. But, over the years, we have developed a way of observing in such situations: we always look back to the unit just observed after the crowd of visitors moves on to the next ward. Caregivers whose behavior was inhibited and distorted while the visitors were present will relax and act more naturally as soon as they are gone—will pick up and hug a baby, laugh or talk, etc. In most of the orphanages we

visited, this post-visit behavior did not differ from what we observed during our official stop on a particular ward.

A caregiver with many children to care for cannot remain too long by the crib of any one child. Thus it appears that what is probably needed in most of the orphanages is not more toys but more people. If some of the aid being supplied in the form of educational toys could be deflected into funds which would allow the hiring of more staff, and then if special training in responsive caregiving could be provided both the new and the present staff, the benefits to the children would undoubtedly increase exponentially.

4. Reduce the Size of the Institutions.

This recommendation is perhaps more easily made than followed. In order to minimize costs, it is always tempting to build bigger institutions. But, all over the world, there is now a recognition that the bigger the institution becomes, the more depersonalized and dehumanized the care provided in it becomes.

This depressing correlate of size (among other things) was nowhere more apparent than in the Institute for Irrecoverables we visited in Negra Voda. The large number of severely retarded children in one ward saturated the air in the entire building with the scent of urine. Children were cleaned and dried, then lined up on large cots or cribs to await the next cleaning or feeding. One could not escape the feeling that all children were being treated alike and were expected to behave in the same way and function at the same level—irrecoverable, so why bother! And yet in this institution there were active boys who knew a little about cars, who knew a few words of English, who knew the institution routine well enough to take you anywhere you wanted to go and to find anyone you needed to see. Also there were physically restricted boys who functioned well enough to sing the Romanian national anthem for us.

It is obvious that many of the children in the institutions would benefit from placement in smaller group homes that would allow them more contact with the outside world. Also it is possible that smaller institutions would encourage more family contact with the children—certainly a worthwhile goal.

This recommendation may be even more relevant for the orphanages. The one we visited that had the most wholesome emotional atmosphere was also the smallest one (about 110 children). Of course, there were other features about this orphanage that made for a different atmosphere—the nurses did not wear white, dystrophic and presumably normal children were kept in the same group, the director allowed children to come into her office

and even sit on her lap while she had visitors (something that would most likely have been considered unprofessional in some of the other orphanages we visited). Because the size of the facility was small, it was possible for children assigned to one group to participate in activities with other children from time to time.

5. Consider the creche as an alternative to the orphanage.

We offer this recommendation cautiously, as we visited only one creche. The personnel and the program in this particular creche were outstanding and may not be representative of all the creches in the country. However, there are many aspects to life in the creches which would warrant serious consideration of expanding them as an alternative to an orphanage arrangement.

When one considers that, in many parts of the world, residential facilities for young children have been closed, this may seem like a strange recommendation. After all, the children remain in the creche from Monday morning until roughly noon on Saturday and spend only the weekend with their families. Can this much separation from the families ever be a good thing? It is obvious from visiting a "good" creche that it can be a great deal better than the total termination of family contact that characterizes life in the orphanages. It is quite possible that, if more "respite care" of the sort provided in the creches were available, fewer parents would totally abandon their children to the orphanages. This needs to be investigated in a systematic way.

It was interesting to hear the response of the creche staff to the question, "What are the children like when they come back on Monday morning?" Each person asked this question gave the same response: "They are terrible. They might not be clean, or they might be hungry, or they might not have had a good place to sleep. It takes a whole day to get them back into a good mood." This kind of response at first sounds as though the creche personnel are being unduly critical of the families and expressing a pejorative attitude toward them. However, reflection makes one realize that this is a response of a group of people who really care about the children and who care about the kind of environment they can offer them. They quickly go on to add that in the creche the children are fed better, have more toys to play with, more people who truly enjoy interacting with them, and a more comfortable place to sleep.

We have no data indicating whether creche availability actually keeps parents (mothers) from placing their children in orphanages and then abandoning them. Nor do we even know whether it is considered desirable to have a child enrolled in one or whether there is a stigma associated with it. (The driver of one of our vehicles excitedly reported that one of his children

had attended that particular creche and that he thought it was a good one.) The national attitude toward such programs is also likely to be important in determining the extent to which parents would use them. At any rate, when the future of the orphanages is being debated, the possibility of increasing the availability of and funding for the creches should be considered. Furthermore, these facilities should not be neglected in the light of all the recent attention to the orphanages. It would appear extremely worthwhile to launch a major research project comparing the development of children in the creches with that of children from comparable social backgrounds who remain at home during the week and with children in the orphanages.

One final point regarding the creches. We did not have an opportunity to learn anything about center-based child care which allowed the children to go home every night. Such care must be available, and its availability and quality should be evaluated along with that of the residential creches.

6. Provide an interdisciplinary evaluation of all children in the orphanages and in institutions for the irrecoverables.

This is obviously a big job but one which should definitely be done. We are not recommending official endorsement of a particular test or procedure, certainly not of one for which there are no data available on Romanian children. Nor are we advocating an update of the IQ's of all the institutionalized children. Rather we are suggesting that an objective assessment of life skills of the institutionalized children (something like the Finland Scale of Social Maturity) which has been shown to be useful in different cultures and which can be administered by someone with less than full professional training. In fact, a cadre of paraprofessionals could be trained to use such a procedure and then carry out a screening program in the various institutions. Information which is discrepant with the current institutional assignment would be noted and a more formal assessment carried out. To give one example, in the Institution for the Irrecoverables in Voda Negra we met one adolescent girl who could write well and do simple computations. We were told that this girl had been allowed to live outside for a while but that she was unable to adjust and had been brought back to the institution. For such a girl, a meaningful evaluation would surely have identified some middle ground between being diagnosed as "irrecoverable" and being released for completely independent living. Undoubtedly there are hundreds of other children for whom a current evaluation would identify skills and capacities that would prepare them for certain types of employment and semi-independent functioning. (This girl, for example, would probably be an invaluable assistant to the nurses in one of the orphanages. She was young and lively

and would probably find it easy to "have fun" with the babies without worrying about whether she was acting unprofessionally.)

In Bucharest at the headquarters of World Vision we met a physiotherapist who had done a study of motor development in the infants in one of the orphanages in Iasi. There are psychologists on the World Vision team who could contribute to a broader interdisciplinary evaluation. Also in Iasi we were given a copy of an assessment procedure developed by a psychologist at the University of Bucharest. Personnel there were also familiar with the Denver and Portage assessments. So it should not be too difficult to launch a large-scale evaluation of this sort which would facilitate more placement of the children in more developmentally appropriate environments. We strongly urge consideration of such a screening program.

7. Develop an instrument which would describe quality of institutional life.

There are many admirable features of the care provided in the orphanages and other institutions. For example, spread of infection is apparently minimal, and the death rate in most of the institutions has been dramatically reduced in recent years. However, there are important features of the institutional environment other than health and safety that must also be considered in an index of quality.

For example, are there enough adults available to be able to give attention to the children? Is the staff emotionally and verbally responsive to the children? Are there minimal restrictions on mobility and exploratory efforts? Is the day organized into predictable segments but with enough flexibility to avoid monotony? Are toys and learning materials available for the children (not just in a storage closet), and do significant adults invest them with interest and value? Do adults play "learning games" with the children, sing and read to them? Is there some variety in the daily experiences? Is an increasing amount of independence and autonomy allowed and expected of the children?

These represent example of the kind of index that needs to be put together to assess the quality of institutional life. It should be used not as a means to allow some governmental or regulatory agency to "grade" institutions but rather as a needs assessment by personnel in the institutions to allow them to plan and set goals for improvements. There are a number of people who have developed instruments for assessing the quality of the environment who would be willing to help in this process.

8. Develop a procedure for coordinating assistance offered to the orphanages and other institutions.

We realize that everyone is aware of this need, and we do not have much in the way of specific help to offer. Knowledge of the existence of the orphanages in Romania has resulted in an out-pouring of concern and of offers to help from countries all over the world. This is a wonderful manifestation of the fact that most of us think globally today.

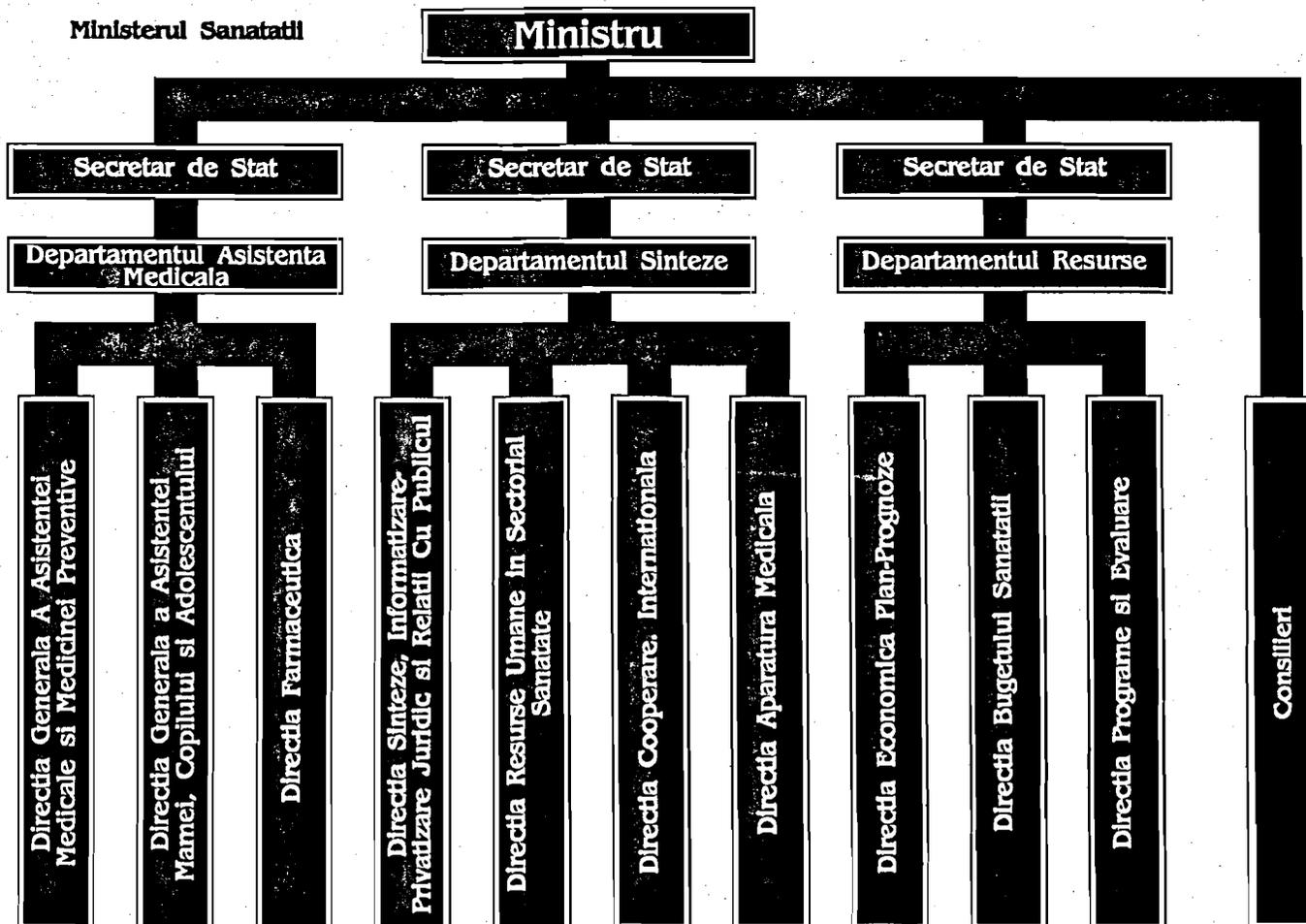
However, it has also resulted in overloading the capacity of the Romanian institutions to respond. We visited offices in which boxes containing toys, nutritional supplements, toys, clothing, etc. were stacked floor to ceiling. The staff had not had time to unpack the boxes or see to it that the materials reached the places they needed to reach. Chances are that some institutions received more than they needed and that others got little or nothing.

It is obvious that some procedure for coordinating such aid should be developed. It was equally obvious to us that one of the greatest needs in the orphanages—more people—did not come in boxes! It was our hope that some organizations could provide the sort of financial aid that would allow the hiring of additional staff so that those persons working with the children could more adequately meet the needs of the children.

These recommendations are offered with humility, in recognition of the fact that we visited only a few institutions and that we had no control over the selection of the facilities we actually visited. Also we recognize that we viewed what we saw from a western perspective and acknowledge that we do not have the experience with the Romanian culture that would enable us to evaluate what we saw totally in context. Nonetheless, we hope these observations are helpful in planning ways to facilitate the work of the personnel in the institutions and thereby facilitate the development of the children.

Annex A

Structure of the Ministry of Health



Annex B.
Vital Statistics 1980-1990

INFORMAȚII STATISTICE OPERATIVE



ROMÂNIA - COMISIA NAȚIONALĂ PENTRU STATISTICĂ
 BUCUREȘTI - Str. Stavropoleos nr.6 Sector 3.

Telefon: 15 82.00 Telex: 1 11 53 - 1 14 50 Fax: 14 55 60

Nr. 1 Februarie 1991

4 pagini - 2 lei

MIȘCAREA NATURALĂ A POPULAȚIEI

MISCAREA NATURALA A POPULATIEI IN ROMANIA
 IN PERIOADA 1980 - 1990

Anii	Nascuti- vii	Decedati	Spor natural (col.1-col.2)	Casatorii	Divorturi	Decedati in virsta sub 1 an
A	1	2	3	4	5	6
Date absolute						
1980	398904	231876	167028	182671	34130	11691
1981	381101	224635	156466	182973	33635	10886
1982	344369	224120	120249	174448	33164	9653
1983	321498	233892	87606	163826	34634	7676
1984	350741	233699	117042	164110	32853	8211
1985	358797	246670	112127	161094	32587	9191
1986	376896	242330	134566	167254	34662	8746
1987	383199	254286	128913	168079	34110	11077
1988	380043	253370	126673	172527	36775	9643
1989	369544	247306	122238	177943	36008	9940
1990	314746	247086	67660	192652	32966	8471
Proportii						
la 1000 locuitori						la 1000 nascuti-vii
1980	18,0	10,4	7,6	8,2	1,54	29,3
1981	17,0	10,0	7,0	8,2	1,50	28,6
1982	15,3	10,0	5,3	7,8	1,48	28,0
1983	14,9	10,4	3,9	7,3	1,53	23,9
1984	15,5	10,3	5,2	7,3	1,45	23,4
1985	15,8	10,9	4,9	7,1	1,43	25,6
1986	16,5	10,6	5,9	7,3	1,51	23,2
1987	16,7	11,1	5,6	7,3	1,49	28,9
1988	16,5	11,0	5,5	7,5	1,60	25,4
1989	16,0	10,7	5,3	7,7	1,56	26,9
1990	13,6	10,7	2,9	8,3	1,42	26,9

Annex C

List of Contacts

Ministry of Health and Related Institutes and Commissions

Bogdan Marinescu, M.D.
Minister of Health
Ministerului Str. 2-4
Bucharest Sector 1

Arlin Stanescu, M.D.
Director, Section of Maternal and
Child Health
Ministry of Health

Michaele Badai, M.D.
Section of Maternal and Child Health

Manole Cucu, M.D.
Director, Institute of Hygiene and
Public Health

Professor Dan Enanchescu, M.D., Ph.D.
General Director
National Institute for Health Services
and Management
R-76256-Bucharest
Str. Dr. Leonte 1-3
Romania
Tel: 38.43.15
Fax: 106685
Telex: 11939 CBTX R

Rodica Maties, M.D.

Director of International Cooperation
Ministry of Health
Ministerului Str. 2-4
70 052 Bucharest

Aurelia Marcu, M.D.

Chief, Department of Social Medicine
Ministry of Health

Vasile Ghetsau, D.Sc.

Director General
Population Census Division
National Commission of Statistics
6 Stavropoleos Str.
70075 Bucharest
Romania
Tel: 813785
Fax: 145560
Telex: 11153 dcs r; 11450 dcs r

Adrian Georgescu, M.D.

Medical Director, Institute for Mother
& Child Care
Bucharest 72309
Bd. Lacul Tei 120
Tel: 872790

Dr. Traian Ionescu

Director, Computing and Health
Statistics Centre
Ministry of Health
Tel: 140890

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Petru Muresan, M.D.

Deputy Director, Computing & Health
Statistics Centre

Mr. Stelian Popa

Programer, Computing & Health
Statistics Centre
Ministry of Health

Ms. Ileana Plopeanu

Administrative Assistant
Computing and Health Statistics
Centre

**Romanian Society for Education in
Contraception & Sexuality (SECS)**

Sorin Puia, M.D.

President, SECS
Director, Maternity Hospital #6
Spit. Clinic prof. P. Sirbu cal. Giulesti 5
Bucharest
Tel: 372550

Ms. Gabriela-Luiza Bocec

Vice-president, SECS
Director
Post Basic School of Nursing, MOH
Str. Bodesti No. 1 Sec 2
72437 Bucharest
Tel: 27 35 45 14 10 71

Mihai Horga, M.D.

SECS
Obstetric & Gynecology Clinic
Str. Gh. Marinescu 50
4300 Tirgu-Mures
Tel: (954) 2 65 60, 3 06 77, int. 213

Hospital Directors and Staff

Traian Dumitrescu-Negru, M.D.

Director of Health Services
Pitesti
Aleea Spitalului 1
Tel: 27928

Grogor Busoi, M.D.

Romanian General Practice Associa-
tion
Str. Conductei nr. 29-39
Bloc 61, Sc. A, Et. II, Ap. 9
Bucharest, sect. 6
Tel: 603810

Constantin Gorgos, M.D.

Director of the University Polyclinic
and
Mental Health Center, Titian
Bucharest
Bd. Leontin Salajan, 41
74641 - Sector 3
Tel: 443505

Ancar Virgiliu, M.D.

Faculty of Medicine (Obstetrica-
Ginecologie)
Seful Clinic
Tel: 274090

Calit Erinet, M.D.

Director, Home for Irrecoverables
Str. Ion Creanga nr. 11 A
Judet Constanza
Tel: 918/1 46 12

Matusa Rodica, M.D.

Director, Pediatric AIDS Ward
Central Hoapital
Constanza - 8700
Tel: 60857

Gabriel Banceanu, M.D.

Dept. of Ob/Gyn
Hospital "Polizu"
Str. Polizu no. 40
Bucharest

Virgil Anker, M.D.

Dept. of Ob/Gyn
Hospital "Saint Pantelimon"
Soseaua Pantelimon no. 340
Bucharest

Moldovan Vasile, M.D.
Director, Scholl of Nursing
Str. N.D. Cocea nr. 5
Sibiu Romania
Tel. 2 02 85

US Embassy Staff
Ambassador Green
Tel: 104040

Mr. Larry Napper
Deputy Chief of Mission

Mr. Don Booth
Econ Officer

Ms. Marina Nicolaescu
Economic Assistant

**International, Bilateral Agency, NGO
Contacts**

WHO/EURO
8 Scherfigsvej
DK-2100 Copenhagen, Denmark
Tel: 45 31 29 01 11
Telex: 15348
Fax: 45 31 18 11 20

David Macfayden, M.D.
Interagency Coordinator

Mr. Jaques Bury
Program Manager, Countries of
Central & Eastern Europe

Ms. Elisabeth Stussi
Nursing, Midwifery, Social Work

Sergiu Luculescu, M.D.
Deputy Director - Director Program
Management

Daniel Pierotti, M.D.
Regional Officer, Family Planning

Marsden Wagner, M.D.
Maternal and Child Health

Mr. Dan Hornea
Executive President
Romanian Save the Children
Str. Onesti 11
Sector 1, Bucharest 70 119
Tel: 14 70 32

Ms. Rosemary McCreery
UNICEF Special Representative
Tel: 13 08 39
FAX 41 50 25
Telex: 11 658

Dr. Cristian Havriliuc
WHO Liason Officer
Str. Pitar Mos nr. 7-13
70151 Bucharest

Ms. Lyn Thomas
Acting Director IPPF Europe Region
International Planned Parenthood
Federation
Regents College, Inner Circle
Regents Park, London, NW1 4NS
Tel: 01-486 0741
Fax: 01-487 7950
Telex: 919573

Mr. Robert Pearson
Director, PACT
Str. Dr. Staicovici 19, Apt. #2
Bucharest, Sector 2
Tel: 38 78 24

Mr. Stefan Toma
Director, World Vision Romania
Calea Calarasilor 55
Bucharest, Sector 3
Tel: 21 59 75

Dr. Solbritt Murphy
Director, Project Concern International
Str. Dr. Staicovici 19, Apt. #1
Bucharest, Sector 2
Tel: 38 69 37

Mr. G. Noteboom
Director, HOLT
Str. Ariesului Nr. 9
Bucharest, Sector 1
Tel: 17 77 05

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Mr. Erik Palstra
UNFPA Eastern Europe
220 East 42nd St.
Daily News Building
New York, New York 10077
Tel: 212-297-5289

Mr. Habib Siddiqui
Team Leader
UNFPA Romanian Situation Analysis
March 1991
UN Department of Technical Coopera-
tion for Development
New York, NY 10017
212-963-8398

Nancy Geyer, Ph.D.
Special Representative
Peace Corps Program - Romania
Office at Citizen Democracy Corporation
Inacci Cavaler de Flonder, 2
73114 Bucharest Sec. 2
Tel: 35 28 70

Robert Castadot, M.D. ; Dr. Julian
Schweitzer
World Bank Romanian Assessment Team
Tel: 202-473-2325
Fax: 202-477-1996

Restian Adrian, M.D.
Romanian General Practice Association
Str. Aviator Sanatescu, 43
Bucharest, Romania

Service Contacts

Translators

Ruxandra Popovici Tel: 53 24 94

Anda Maxim Tel: 11 49 87

Daniella Dragovici Tel: 66 93 74

Auto Rental

IMPACT

"Mr. Pop"

Carmen Sandulescu
PO Box 18-55 Bucharest
Tel: (90) 35 59 92

Computer Services

Mr. Peter Peterson
Tel: 59 37 43 59 37 85 59 32 79

Hotels

Hotel Continental
56 Calea Victoriei - Bucharest 1
Tel: 14 53 49
Telex: 1 03 80 Cable BUHCONTI

Lido Hotel
Tel: 14 49 30

Hotel Intercontinental

Hotel Trainan - Iasi
Tel. 981/43330

Imparatul Romanilor Hotel
Sibiu

Annex D.

Schedule - USAID Team/ Romania

First Week: Sunday, March 10 - Friday, March 15, 1991

Sunday, March 10

Dr. Rochat, Dr. Heisler WHO/EURO Copenhagen
Dr. Marsden Wagner
Maternal and Child Health

Monday, March 11

Dr. Rochat, Dr. Heisler WHO/EURO Copenhagen
9:00 am Dr. David Macfadyen
Interagency Coordinator
9:30 am Mr. Jacques Bury
Program Manager, Countries of Central and
Eastern Europe
10:00am Ms. Elisabeth Stussi
Nursing, Midwifery, and Social Work
11:00am Dr. Sergiu Luculescu
Deputy Director
Director Program Management
10:00pm Dr. Daniel Pierotti
Regional Officer, Family Planning
WHO/EURO(via phone to Paris)

Mr. Jerry Norris On-site Bucharest
Meetings with: Dr. Bogdan Marinescu, MOH

Mr. Larry Napper
Deputy Chief of Mission US Embassy
Ms. Nancy Hazleton
Humanitarian Aid Officer US Embassy

Tuesday, March 12

Mr. Jerry Norris & Dr. Richard Bail

Meetings with:

Mr. Don Booth
Econ Officer
US Embassy
Ms. Nancy Hazleton
Dr. Arlin Stanescu
Dep. Sec. MCH,
Ministry of Health
Mrs. Letitia Popovich, RN
Nurse Training/Family Planning
Ministry of Health
Dr. Mikaela Badea, OB-GYN
Maternity Hospital #6 (With members of
MOH, discussed Hx Ab, rationale for FP,
and FR Program)

Wednesday, March 13

Mr. Jerry Norris, Dr. Roger Rochat, Dr. Richard Bail

Morning meetings:

Dr. Manole Cucu
Director Inst. of Hygeine & Pub Health
Dr. Aurelia Marcu
Chief
Department of Social Medicine
Ms. Sandra Apostolescu
Dep of Health Education, MOH
(Discussion on role of Institute, potential
for regional surveys on diet, smoking,
alcohol)

Afternoon meetings:

Dr. Sorin Puia
Chief OB-GYN
Maternity Hospital #6
President, Romanian Society for Education
in Contraception and Sexuality (SECS)

	Ms. Gabriela-Luiza Bocec Vice-president SECS
	Dr. Mihai Horga SECS
5:00pm	Dr. Cristian Havriliuc WHO Liason Officer
Dr. Michael Heisler	
9:30am - 2:00pm	Ms. Nancy Hazleton
3:00pm - 4:30pm	Ms. Rosemary McCreery UNICEF Special Representative
5:00pm - 6:00pm	Dr. Cristian Havriliuc
<i>Thursday, March 14</i>	
Mr. Jerry Norris, Dr. Richard Bail	
Travel to Ploiesti	
Meetings with	Directorate of District Health, Director of the District Hospital Visits to District Hospital, Maternity Hospital, Polyclinic, FP Unit, and a rural and urban dispensary
Dr. Roger Rochat	
Morning meetings:	Computational Center, MOH Dr. Traian Ionescu , Director Dr. Muresan Petru Mr. Stelian Popa
3:00pm	Dr. Cristian Havriliuc
4:00pm	Dr. Marinescu & Dr. Stanescu
Dr. Michael Heisler	Administrative work
<i>Friday, March 15</i>	
Dr. Heisler, Mr. Norris	
Travel to Pitesti.	
Meetings with	Dr. Traian Dumitrescu Directorate of District Health - & staff
Visits to	District Hospital, Maternity Hospital, Poly- clinic, & local dispensary

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Dr. Rochat, Dr. Bail

7:00am - 8:30am

9:00am - 11:00am

Computation Center, MOH
Prof. Dan Enachescu, MD, Ph.D
General Director,
National Institute for Health Services &
Management

11:30am - 1:00pm

1:00pm - 5:00pm

National Computing Center/Census
Computation Center

Second Week: Sunday, March 17 - Saturday March 23, 1991

Sunday, March 17

2:30pm

Remainder of team arrives
Austrian Air from Vienna - Flight 841

2:30 - 7:30pm

Rest

7:30 - 9:00pm

Dinner & Briefing for newly arrived team
members - Room 301.

Monday, March 18

9:00am - 9:30am

US Embassy meeting for entire team.

After 9:30 the team will split into groups:

GROUP I: Dr. Richmond, Dr. Caldwell, Dr. Bail, Mr. Norris

GROUP II: Dr. Stubblefield, Mr. Paxman, Dr. Farrell, Dr. Heisler

(Translator: Ruxandra Popovici)

GROUP I

9:30am - 11:00am

PACT
Mr. Bob Pearson
Director

11:00am - 12:30pm

World Vision
Mr. Stefan Toma
Director

12:30pm - 2:00pm

Lunch

2:00pm - 3:00pm

HOLT
Mr. G. Noteboom
Director

3:00pm - 4:30pm

World Vision,
Dr. James Bascom
Topic: Current status of Family Planning in
Medical & Nursing School curricula

Dr. Caldwell & Dr. Bail

5:00pm - 6:00pm

Mr. Dan Hornea

Exec. President

Romanian Save the Children

4:30pm - 7:30pm

Rest

7:30pm - 9:30pm

Team Dinner with Ms. Rosemary McCreey

UNICEF Special Representative

Restaurant: Casa Capsa

GROUP II

10:30am - 1:30pm

Maternity Hospital #6

Dr. Puia

2:00pm - 4:00pm

University Hospital & Polyclinic Titian

3:30pm - 7:30pm

Rest

7:30pm - 9:30pm

Dinner

Tuesday, March 19

GROUP I

Dr. Richmond, Dr. Caldwell, Dr. Murphy, Mr.

Norris, Ms. Hazleton, Dr. Farrell, Dr.

Heisler (Translator: Daniella Dragovici)

7:00am

Travel to Constanza to visit:

Central Hospital Pediatric AIDS Ward

Dr. Matusa Rodica

Home for Irrecoverables

Dr. Calit Erinci

Negru Voda

8:30pm

Arrive back in Bucharest

9:30pm - 11:00pm

Dinner & group discussion - Rm 301

GROUP II

Dr. Stubblefield, Mr. Paxman, Dr. Rochat, Dr.

Bail (Translator: Ruxandra Popovici)

9:00am - 11:30am

Hospital Polizu/Hospital Pantelimon

2:00pm - 4:00pm

Institute for Maternal & Child Health

Dr. M. Badai

4:00pm - 5:00pm

Primary Health Care & Family Planning

Dr. Cristian Havriliuc, et al.

7:30pm - 9:00pm

Dinner - Rm 301

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Wednesday, March 20

GROUP I

Dr. Richmond, Dr. Caldwell, Dr. Bail, Dr. Badai
(MOH) (Translator: Daniella Dragovici)

10:00am

Travel via air to Iasi to visit World Vision
Project, pediatric hospitals, and rural poly-
clinic Hotel: Trainan tele: 981/43330

5:00 pm

Observation at Orphanage #1

7:30 pm

Discussion at District Maternity Hospital with
Director on Family Planning

GROUP II

Dr. Stubblefield, Mr. Paxman, Mr. Norris, Dr.
Farrell, Ms. Lititia Popovici (MOH)

7:30 am

Travel by auto to Sibiu for meetings and visits
to Regional Hospitals, polyclinics, dispen-
saries. Site visits to rural facilities as well.
Overnight at Imparatul Romanilor Hotel
Return Thursday 2:30 pm

Thursday March 21

GROUP I (Iasi)

8:30 am

Observation at Orphanage #1

10:00 am

Observation at Creche #1

11:30 am

Observation at Center for Receiving and Clas-
sifying Minors

12:30 pm

Group I departs Iasi for Bucharest

2:30 pm

Meeting with UNFPA Delegation Dr. Heisler,
Dr. Rochat

Friday, March 22

9:00am - 10:00am

Debriefing at Ministry of Health with Dr.
Marinescu

10:30am - 11:30am

Debriefing at US Embassy

12:30pm - 2:00pm

Lunch hosted at the home of Mr. Don Booth

3:00pm

Mr. Norris & Dr. Bail depart Bucharest

7:30pm

Closing dinner

Saturday, March 23

7:40 am

Remainder of group departs from Bucharest
for Frankfurt via Pan Am 1073. (Leave for
airport 4:30am)

Annex E.
Screening Forms

DISPOZITIV INTRAUTERIN (TIPUL)..... data.....

DATA CONSULTULUI									
La cite luni de la aplicare									
MOTIVUL VIZITEI: 1=rutină, 2=metroragii, 3=dureri, 4=expulzie, 5=Sarcină, 6= infectie, 7= altele									
MENSTRUATIA									
DURATA (in zile)									
CARACTERE (0=amenoree, 1=moderatã, 2=apreciabilã)									
SINGEPARI NEREGULATE									
DURATA (in zile)									
CARACTERE (1=apreciabilã, 2=pete, 3=la contact sexual)									
ALTE SEMNE									
DURERI (0=abs, 1=putin, 2=moder, 3=puter)									
LEUCOREE MAI ABUND. CA ÎNAINTE (0/1)									
T.V. (REACTIE INFLAMAT. ANEXIALA (0/1)									
FIRUL ESTE: 1=prezent; 0=absent)									
FIRUL ESTE RESIMITIT DE PARTENER (0/1)									
POZITIA STERILET (Rx., Echo): 1=bunã, 2=anormalã, 3=nevizibil									
SUSPICIUNE SARCINA EXTRAUTER.(0/1)									
SUSPICIUNE SARCINA (0=nu / 1=da)									

FIȘA DE TRATAMENT ANTICONCEPȚIONAL

Numele _____ Prenumele _____

Nr. de înregistrare _____

Data nașterii _____

Vîrsta la prima menstruație _____

Menstre — regulate _____

neregulate _____

frecvența _____

Antecedente medicale:

Migräne

Hepatită

Cancer

Diabet

Tensiune

Epilepsie

Alte boli grave / intervenții chirurgicale:

Antecedente ginecologice:

Număr total de sarcini _____ Nr. de copii născuți vii _____

Număr de copii născuți morți _____ Avorturi _____

Avorturi spontane _____ Vîrsta și sexul copiilor rămași în viață _____

Antecedente medicale în familie:

Tensiune

Cancer

Diabet

Boli cardiace

Îndrumări

Metode discutate

Metoda aleasă

Se recomandă

A reveni la data de _____

JUDETUL POLICLINICA FISA NR.
 Cabinetul

FISA DE TRATAMENT ANTICONCEPTIIONAL

NUMELE PRENUMELE

DATA NASTERII VIRSTA: femeii = partenerului =

ADRESA: localitatea str. nr.

DATA PRIMEI CONSULTATII:

TRIMITERE DE LA MEDIC (D/N) []

STAREA CIVILA (C=căsăt., N=necăsăt., V=văduvă, D=divorțată) []

PROFESIA: (C=casn, N=munc.necabil, M=m.calif., []

T=tehnice, F=funcțion., S=stud., E=elevă, A=agric., PROFESIA FEMEII []

P=pers. studii sup., X=alte situații) PROF. PARTENERULUI []

MEHSTRUATIA: data U.M.:

Durata medie a ciclurilor (zile) []

Durata medie a menstruației (Zile) []

Cantitatea sîngerării (0=lipsă, 1=mică, 2=medie, 3=mare) []

NASTERI: []

din care pe cale naturală ; prin cezariană []

COPII IN VIATA: []

AVORTURI []

din care cite spontane ; cite provocate: []

ANAMNEZA

EXAMENE DE LABORATOR

A utilizat anterior pilula? 0=nu, 1=da [] HEMOGRAMA (gr.) []

Dacă DA, cauză: întrerup. trat.: (1=dorin- [] LEUCOCITE (mi) []

te nec, 2=mulan, 3=control periodic [] V. S. H. []

difficil, 4=sarcină, 5=alte) [] LIPIDEMIE []

DIABET (0=nu, 1=da) [] COLESTEROLEMIE []

HEPATITA EPID. (0=nu, 1=da) [] GLICEMIE []

VARICE (0=nu, 1=da) [] T.S. i T.C. []

TROMBOFLEBITA (0=nu, 1=da) [] TYMOL []

HIPERTENSIUNE ARTER. (0=nu, 1=da) [] TRANSAMINAZE []

MIOM (0=nu, 1=da) [] ALTE (dozări hormonale) []

CANCER (0=nu, 1=da) [] EX. CITOBACTERIOLOGIC []

EPILEPSIE (0=nu, 1=da) [] EX. CITONCOLOGIC B.P. []

EXAMEN GINECOLOGIC

COLPOSCOPIE

INFLAMATA
RIZOMET



INFLAMATA
TR. CANE. T.



METOD. CONTRACEPTIVA: în funcție de ex.clinic și datele de laborator:

TRAT. HORMONAL (0=nu, 1=da) [] DISPOZ. INTRAUTERIN (0=nu, 1=da) []

METODA DE BARIERA (0=nu, 1=da) []

DATA CONTROLULUI:

TRATAMENT HORMONAL CU:

DATA CONSULTULUI																				
CICLUL NR.																				
GREUTATE CORP. (0=const, 1=cresc, 2=scadz)																				
TENSIUNE SISTOLICĂ-DIASTOLICĂ																				
TRATAMENT (1=corect; 2=incorect)																				

MENSTRUATIA

ÎNCEPUTUL (zile de la ultima tabl.)																				
DURATA (zile)																				
SÎNGERARE (0=abs, 1=puțin, 2=moder, 3=mult)																				

SÎNGERARI NEREGULATE

Apreciabilă=1, pete=2, ambele=3																				
ÎNCEPUTUL (zile de la prima tabl.)																				
DURATA (zile)																				

EFECTE SECUNDARE *

GREUȚĂ (0=abs, 1=puțin, 2=moder, 3=mult)																				
VARSĂTURI (0,1,2,3)																				
CEFALEE (0,1,2,3)																				
MASTOPATIE (0,1,2,3)																				
TULBURARI VENOASE (0,1,2,3)																				
SCURGERI VAGINALE (0,1,2,3)																				
NERVOZITATE (0,1,2,3)																				
DEPRESIE (0,1,2,3)																				
LIBIDO (1=cresc, 2=scadz, 3=const.)																				
ALTE (0,1,2,3)																				

* Intrebată pacienta „cum vă simțiți?” Notati efectele secundare exprimate spontan fără a sugera unele indispoziții.

Annex F.

List of Available Documents

1. WHO 1990 Eastern European Health Statistics Data.
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8. Porter, J.B., Jick, H., Walker, A.M. "Mortality among oral contraceptive users" *Obstetrics and Gynecology* 70 (1987):29.
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10. Mant, D., Villard-Mackintosh, L., Vessey, M.P., et al. "Myocardial infarction and angina pectoris in young women" *Journal of Epidemiology and Community Health* 41 (1987):215.
11. Mishell, D.R. "Correcting misconceptions about oral contraceptives" *American Journal of Obstetrics and Gynecology* 161 (1989):1385.

12. Centers for Disease Control and the Steroid Hormone Study. "Oral contraceptive use and the risk of ovarian cancer" *Journal of the American Medical Association* 249 (1983):1596.
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 15. Stadel, B.V., Schlesselman, J.J., Murray, P.A. "Oral contraceptives and breast cancer" *The Lancet* 1 (1989):1257.
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 17. Ministerul Sanatatii *Bolile Venerice in Romania* Centrul de calcul si statistica sanitara. Bucharest, 1989.
 18. Burkman, R.T. "The Women's Health Study: Association between intrauterine device and pelvic inflammatory disease" *Obstetrics and Gynecology* 57 (1981):269.
 19. Lee, N.C., Rubin, G.L., Borlicki, R. "The intrauterine device and pelvic inflammatory disease revisited: New results from the Women's Health Study" *Obstetrics and Gynecology* 72 (1988):1.
 20. Vessey, M., Doll, R., Peto, R., et al. "A long-term follow-up study of women using different methods of contraception—an interim report" *Journal of Biosocial Science* 8 (1976):373.
 21. Peterson, H.B., Lee, N.C. "The health effects of oral contraceptives: misperceptions, controversies and continuing good news" *Clinical Obstetrics and Gynecology* 32 (1989):339.
 22. Romania World Bank Health Projects Pre-Appraisal Mission January 16 - February 7, 1990.
 23. Draft MCH Plan for Romania - WHO/EURO February 20, 1991.
 24. WHO/EURO - Pierotti report "Travel Report Summary" November 11 - November 21, 1990.
 25. US AID report on Preliminary Technical Approach on Family Planning in Romania September 13 - September 21, 1990.
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 27. WHO/EURO Report of a Mission to Romania - Farrell, et al. December 29, 1989 - January 15, 1991.
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 32. US AID Trust Through Health Romania Grant - March 7, 1991.
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 35. PACT Implementation Plan.
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 41. United Nations Population Fund - Report on Mission to Romania. March 5-15, 1990.
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 43. WHO/EURO background Telefax - dated March 6, 1991.
 44. Romanian Health Project - "Contraceptive Prevalence by Method, 1980 - 1990".
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