

Divining Alabama

Brian Ellis
2019

For Soloist and Live Electronics

Notes

The score on the following page should be taken as a loose guideline. All directions are subservient to the goal of evoking the episodic nature of the terror and tension that plagued Romania for twenty-five years and might soon be rearing its head in the United States.

I am looking at videos from www.shakennotstuttered.com for extended technique, specifically:

- "stutter"
- "scratch"

But again, as above, if you find some variant of the technique is more evocative, do that.

"**" in the score indicates to press the foot pedal. When this coincides with the end of a phrase, as with the second and third pedal presses, immediately stop playing when you press the pedal.

The piece should slowly change. The only abrupt changes should be where the line is punctuated by rests. Unless otherwise noted, all other markings ("add stutter", "slower tremolo", etc.) are gradual checkpoints that should be eased into.

Similarly, pitch is a general suggestion; rough notes to pass while performing glissando between pitches with liberal varying vibrato. The only pitches that are recommended to be exact are the two highest notes and the final two pitches.

Total duration should be between three and seven minutes.

The score is followed by the sources I utilized while doing research for this piece.

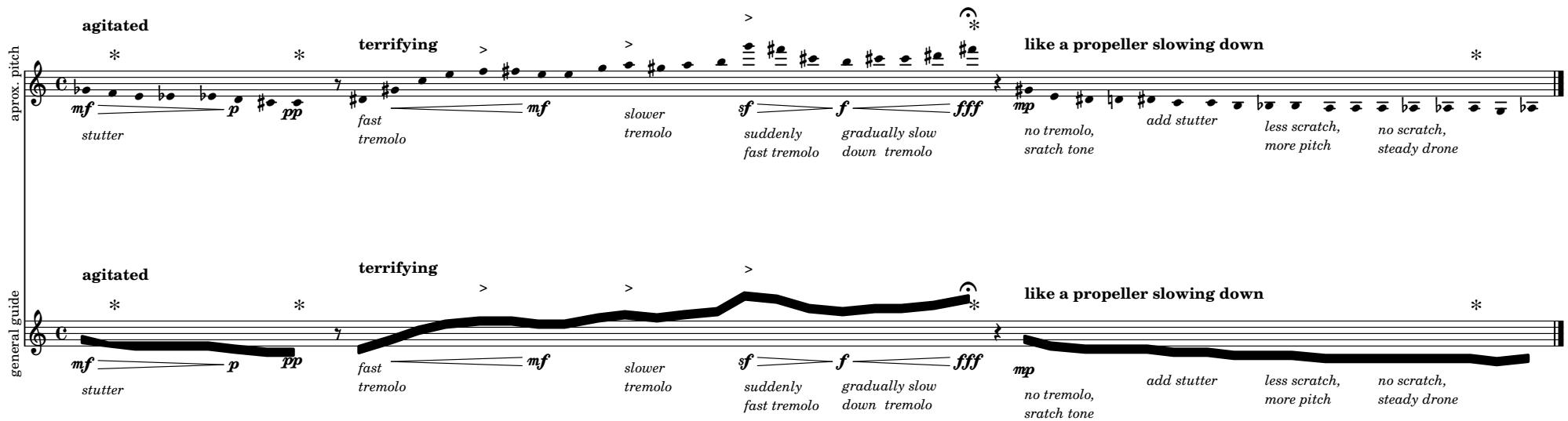
For the mothers who will be lost from our collective inaction on this issue

Divining Alabama

For Violin and Live Electronics

Or Rather: Romanian Maternal Mortality Rates from 1950 to 2015, Highlighting the Communist Ban on Abortion from 1967 to 1989

Brian Ellis



ANALYSIS

What Actually Happens When a Country Bans Abortion

Romania under Ceausescu created a dystopian horror of overcrowded, filthy orphanages, and thousands died from back-alley abortions.

BY **AMY MACKINNON** | MAY 16, 2019, 4:38 PM

As lawmakers in Alabama this week passed a bill that would outlaw abortion in the U.S. state entirely, protesters outside the statehouse wore blood-red robes, a nod to Margaret Atwood's dystopian novel *The Handmaid's Tale*, in which childbearing is entirely controlled by the state. Hours later, the book was trending on Twitter.

But opponents of the restrictive abortion laws currently being considered in the United States don't need to look to fiction for admonitory examples of where these types of laws can lead. For decades, communist Romania was a **real-life test case** of what can happen when a country outlaws abortion entirely, and the results were devastating.

In 1966, the leader of Romania, Nicolae Ceausescu, outlawed access to abortion and contraception in a bid to boost the country's population. In the short term, it worked, and the year after it was enacted the average number of children born to Romanian women jumped from 1.9 to 3.7. But birthrates quickly fell again as women found ways around the ban. Wealthy, urban women were sometimes able to bribe doctors to perform abortions, or they had contraceptive IUDs smuggled in from Germany.

Yet Romania's prohibition of the procedure was disproportionately felt by low-income women and disadvantaged groups, which abortion-rights advocates in the United States fear would happen if the Alabama law came into force. As a last resort, many Romanian

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“Sometimes a woman couldn’t even tell her husband or best friend that she wanted to have an abortion as it would put them at risk as well,” said Irina Ilisei, an academic researcher and co-founder of the Front Association, a Romanian feminist group, and the Feminist Romania website.

“For many women, sexuality represented a fear and not a part of life that can be enjoyed,” Ilisei said.

Another consequence of Romania’s abortion ban was that hundreds of thousands of children were turned over to state orphanages. When communism collapsed in Romania in 1989, an estimated 170,000 children were found warehoused in filthy orphanages. Having previously been hidden from the world, images emerged of stick-thin children, many of whom had been beaten and abused. Some were left shackled to metal bed frames.

Nor did the Romanian law do much to achieve Ceausescu’s goal of dramatically increasing the population. “Making abortion illegal will not lead to women having more babies. So if the goal is to bring about more lives and to protect more lives, this is not the instrument to use,” said Maria Bucur, a professor of history and gender studies at Indiana University.

Born and raised in Romania, Bucur describes herself as a product of the abortion ban, after her mother twice failed to have an abortion.

On Wednesday, a day after it was passed by the legislature, Alabama Gov. Kay Ivey signed into law the country’s strictest abortion law, which bans the procedure at every stage of pregnancy and could send doctors who carry out the procedure to prison for life.

Alabama’s law goes even further than Romania’s, which in principle at least allowed for exceptions in cases of rape, incest, or congenital defect. The new law allows for abortions only when there is a serious threat to the mother’s health.

Romania’s abortion ban was compounded by a ban on contraception, which was not

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Supreme Court, to which U.S. President Donald Trump has appointed two new members. So far this year, over a dozen other states have attempted to outlaw abortions after six weeks of gestation—before many people even realize they are pregnant. Last week, Georgia became the sixth state to successfully pass such a bill. Already, six states in the United States have only one abortion clinic left.

Although the laws may be struck down by the courts, anti-abortion advocates hope that they will eventually reach the Supreme Court to challenge the precedent set by the 1973 *Roe v. Wade* decision, which enshrined the right to seek an abortion.

Alabama State Rep. Terri Collins, a co-sponsor of the bill, which is now the most restrictive in the country, told the news site *AL.com*, “My goal with this bill, and I think all of our goal, is to have Roe vs. Wade turned over.”

On the campaign trail in 2016, Trump promised to appoint conservative justices with a view to overturning *Roe v. Wade*. The confirmation of Brett Kavanaugh in October 2018 gave conservative justices a solid majority on the bench, raising the hopes of anti-abortion advocates.

If the Supreme Court were to change its mind on abortion, it would become the prerogative of individual states to decide how to regulate the procedure.

“We need to take into consideration the long-term consequences of legislation like this,” said Charles Nelson, a professor of pediatrics at Harvard Medical School and the author of *Romania’s Abandoned Children*.

Starting in 2000, Nelson examined the impact that Romania’s orphanages had on children in post-communist Romania and found that many were left with severe developmental impairment and mental health issues. For some, their confinement in orphanages even had a physical impact on the size of their brains.

Nelson said that Romania offers a cautionary tale of what happens when a state tries to control reproductive rights. The new Alabama law raises questions about what kind of support the state would provide if someone doesn’t have the option of ending a

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highly conservative country, and in recent years there have been renewed calls to outlaw abortion, spearheaded by the influential Orthodox Church and other religious groups.

Bucur, the author of *Birth of Democratic Citizenship: Women and Power in Modern Romania*, is skeptical that the new movement will gain any political momentum.

“I think the real, raw firsthand memory is still too present in still too many voters. I don’t think there’s any intelligent politicians who would make it happen,” she said.

Ilisei, the Romanian activist, said that she was worried to see parts of the United States —a country that Romania had once looked to as an example—now pursuing new restrictions on abortion. “In 1989, we aspired to build a stable democracy, a pluralistic society, with equality between men and women, and the United States was the main source of inspiration,” she said. “Now that is not the case any more.”

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TAGS: EASTERN EUROPE, EUROPE, GENDER, SUPREME COURT, UNITED STATES, WOMEN

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How Banning Abortion Will Transform America

May 15, 2019 | MARIA BUCUR , KRISTEN R. GHODSEE

HUNEDOARA, ROMANIA – “It was a horrible time,” recounts one Romanian gynecologist, referring to the period between 1966 and 1990, when abortion and contraception were completely banned under the dictatorship of Nicolae Ceaușescu. “Women refused to have sexual lives, resulting in family fights and abandonment,” she continued. “For a woman, any sexual contact meant only panic and pain.” As another Romanian who lived through the period put it, “It was impossible to have a normal sexual life because of fear of getting pregnant.”

If the Republican Party in the United States has its way, millions of American women could soon come to know the same fear. Republican lawmakers in Georgia, Alabama, and other states have enacted or are proposing outright abortion bans, hoping to bring the issue back before a sympathetic US Supreme Court and overturn or further gut the landmark 1973 decision in *Roe v. Wade*. In the absence of *Roe*’s constitutional protection of a woman’s right to have an abortion, America would become a different society, because, as in Ceaușescu-era Romania, the government would police its members’ most personal choices.

It wasn’t only women who suffered from the Ceaușescu regime’s attacks on their bodily integrity. Far from strengthening the family, Romania’s draconian “pro-life” policies poisoned heterosexual intimacy, strained marriages, and weakened social trust. Monthly gynecological exams brought the state inside women’s uteruses and, by extension, into the bedroom. State surveillance of sexual activity resembled that of a farmer breeding livestock. With provisions prohibiting women from going out of state for an abortion, or from using certain contraceptive methods (such as intrauterine devices), much of the new US legislation, if upheld by the Supreme Court, would expose women to a similar enforcement regime.

After the Ceaușescu regime fell in December 1989, one of the interim Romanian government’s first moves was to decriminalize abortion. While debates about many aspects of the communist legacy soon erupted, few Romanians had any doubt that forcing women to have babies they didn’t want had been disastrous for the country.

Even after three decades under the ban, Romania's birth rate had not increased. Instead, Romanian women had undergone nearly 7.3 million back-alley abortions – an average of three apiece – between 1967 and 1989. At least 15,000 women died as a result of complications and untreated side effects. Romania's infant-mortality rate during this period was the highest in Europe, and anywhere from two to 59 times above that of other countries.

Though most Eastern Bloc countries expanded women's reproductive freedoms after Stalin's death in 1953, by the late 1960s, communist leaders began to worry that declining birth rates would lead to future labor shortages. But while other East European countries addressed the issue through longer paid maternity leaves and higher child-care benefits, the Romanian government took a different path. Prior to 1966, Romania had one of the most liberal abortion policies in the world. But, desperate for population growth, Ceaușescu issued Decree 770, essentially nationalizing Romanian women's wombs. Both abortion and contraception were criminalized for all women age 45 and under who had not borne at least four children (later increased to five). The only exceptions were for rape and incest, high-risk pregnancies, and cases in which the fetus could contract a hereditary disease from either parent. The law was strictly enforced. The Romanian secret police, the Securitate, registered suspected pregnancies and kept tabs on women until the birth of the child. It was the kind of natalist authoritarianism that US "pro-life" advocates have long dreamed of.

With challenges to *Roe* looming on the horizon, and with many US states having already denied access to abortion facilities and reproductive health services through other means, Romania's experience shows what happens when women suddenly lose the right to control their own bodies. Without reproductive freedom, heterosexual sex turns into a game of "Russian roulette" for women, because they quite literally bear the consequences of any liaison. Indeed, Alabama's new law goes further than Ceaușescu's Romania, by eliminating even the exception for rape or incest.

Abortion opponents claim that banning it will promote marriage, strengthen families, and restore traditional gender roles. But the Romanian case shows that a more likely scenario is a rapid increase in maternal mortality, an explosion of unwanted children and orphans, and a "sex recession," as wives choose to avoid intimacy with their husbands altogether. As in Romania, the state's violent intrusion into the private sphere will upset the lives of men and women alike. Americans can look forward to a future of bad sex and wrecked relationships.

It's time to face facts. A century of evidence from around the world shows that coercive reproduction policies correlate weakly with actual fertility rates. The fact is that women's decisions about family size are based on material realities. When basic food supplies are scarce (as in Romania in the 1980s), women will risk their lives

having back-alley abortions, for fear of lacking the means to care for a child. Where paid parental leave and childcare are absent or prohibitively expensive, as they are in the US, women will make similar economic choices, regardless of the laws on the books.

After communism, Romania's people recognized that democratic societies have a responsibility to guarantee women's bodily autonomy, and to respect the right of all citizens to make their own decisions about whether and when to start or add to a family. It is odd that in the "land of the free," one of the major parties would emulate a communist dictator.



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1 Commentary

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1 Commentary

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Reproductive Health in Romania: Reversing the Ceausescu Legacy

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Reproductive Health in Romania: Reversing the Ceausescu Legacy

Charlotte Hord, Henry P. David, France Donnay, and Merrill Wolf

As a result of the restrictive reproductive health policies enforced under the 25-year Ceausescu dictatorship, Romania ended the 1980s with the highest recorded maternal mortality of any country in Europe—159 deaths per 100,000 live births in 1989. An estimated 87 percent of these maternal deaths were caused by illegal and unsafe abortion. Under the Ceausescu regime, all contraceptive methods were forbidden and induced abortion was available only for women who met extremely narrow criteria. Immediately after the December 1989 revolution that overthrew Ceausescu, the new government removed restrictions on contraceptive use and legalized abortion. This legislative change has had beneficial effects on women's health, seen in the drop in maternal mortality in 1990 to 83 deaths per 100,000 live births—almost half the ratio in 1989. In addition, changes instituted since the revolution have led to the improved availability of reproductive health services and to the creation of new educational and training opportunities related to reproductive health. The newly created contraceptive and abortion services have presented health system managers and policymakers with many challenges as they work to expand the availability of high-quality, comprehensive reproductive health care in a setting of economic hardship, political unrest, insufficient infrastructure, and outdated medical knowledge and practice. (STUDIES IN FAMILY PLANNING 1991; 22,4: 231–240)

In December 1989, the uprising that led to President Nicolae Ceausescu's overthrow in Romania thrust the country into the international spotlight. The political repression and difficult living conditions that had characterized the Ceausescu regime were publicly confirmed and openly discussed. Some of the most alarming disclosures concerned legislation that had severely restricted women's privacy in planning and bearing children—with serious health consequences. Recognizing the importance to the Romanian people of self-determination in matters of family planning, on 26 December 1989, its first day in power, the provisional government lifted the prohibitions on importing contraceptive commodities and, effective 1 January 1990, made abortion legal on request during the first 14 weeks of pregnancy (Government of Romania,

1989). This action initiated a year of extraordinary change in the realm of women's reproductive health in Romania.

In the 18 months following the revolution, efforts by the Romanian government and international agencies to address the needs of people seeking to control their fertility have improved many women's lives. An era of openness in which people are permitted to learn about reproductive health and to plan their families has supplanted decades of public control over human reproduction. During the past year, policymakers and reproductive health professionals in Romania have made significant progress toward creating a successful family planning program, essentially from scratch.

This report will review the steps taken since the December 1989 revolution and will discuss the challenges still facing Romania in the areas of reproductive health, family planning, and sex education. It will also suggest several important lessons that health system administrators and reproductive health professionals can draw from the Romanian experience. All observations of the present situation result from visits to Romania by two of the authors; discussions with the Romanian Minister of Health, colleagues from the International Planned Parenthood Federation (IPPF), and other nongovernmental organiza-

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tions; meetings with local representatives of the World Health Organization (WHO) and several Bucharest hospitals; and participation in Romania's first national family planning conference.

Historical Background

During the past 45 years, Romania's population policies have ranged from being pronatalist to advocating contraceptive use and family planning. The social and economic conditions following World War II resulted in an increase in infant mortality, leading the government in 1945 to institute a policy that outlawed abortion (Ionescu, 1990). In 1957, in response to this policy's toll on women's health, the governing party followed the lead of the Soviet Union by legalizing abortion (Government of Romania, 1957). By 1966, the birth rate had decreased to 14.3 births per 1,000 population (from 22.9 in 1957), and the annual population growth rate was less than 1 percent (David and McIntyre, 1981). After attaining the presidency in 1965, Ceausescu took prompt action to reverse these trends, initiating legislation that had a disastrous effect on the reproductive health of Romania's women.

For the next 23 years, during Ceausescu's regime, Romania pursued the world's most rigidly enforced pronatalist population policy. On 1 October 1966, without prior warning, Ceausescu restricted legal abortion to women who were over 45 years of age, or who already supported four or more children, or whose lives would be endangered by pregnancy, or who met other very narrowly defined medical criteria (Ceausescu, 1966). The importation of contraceptives was prohibited, and women who obtained illegal abortions as well as abortion practitioners were subject to fines and imprisonment. The policy worked, for a while. The birth rate rose to 27.4 births per 1,000 population in 1967 but subsequently declined gradually to 13.8 in 1983. Meanwhile, the age limit for access to legal abortion was reduced to 40 years in 1973 and then raised to 42 years in 1984. As lax policy enforcement gave way to renewed drives against illegal abortions, the birth rate rose to 15.5 in 1984 and 15.8 in 1985 (David, 1990a, 1990b, and 1990c).

In 1986, President Ceausescu proclaimed that "the fetus is the socialist property of the whole society. Giving birth is a patriotic duty. . . . Those who refuse to have children are deserters, escaping the law of natural continuity." He again restricted access to legal abortion to women over 45 years of age, and having four children was no longer sufficient grounds for abortion on request; to qualify for a legal abortion, a woman had to have five living children, all under the age of 18 (Ceausescu, 1985 and 1986).

The state involved itself intimately in each woman's reproductive life, requiring employed women to undergo monthly gynecological exams and denying those who refused to appear their rights to dental and medical care, pensions, and social security. Factory physicians received their full monthly salaries only if plant employees had achieved a state-stipulated monthly birth quota. Special taxes of 10 percent of monthly salary were imposed on unmarried individuals over the age of 25, and if a marriage was childless after two years and there was no medically certified reason for infertility, each partner had to pay extra taxes. In addition, the Romanian State Security Police (Securitate) established a special unit to investigate allegations of illegal abortions, posting agents in every maternity ward and obstetrical-gynecological clinic. Self-induced abortion was punishable by imprisonment from six months to two years or by payment of a specified fine. Physicians who performed abortions risked prison terms of up to 12 years and loss of the right to practice medicine (David, 1990a, 1990b, and 1990c). These regulations forced women suffering the medical complications of unsafely induced abortion to stay away from hospitals for treatment, risking permanent injury to their health or, often, death.

At the same time that the regime restricted access to abortion, it also denied women the means to prevent unwanted pregnancies. Although not legally prohibited until 1985, official importation of contraceptives had virtually ceased by that time. Only a few hospitals and research centers were authorized to import or receive oral contraceptives, and all other methods were forbidden (David and McIntyre, 1981). Even these minor exceptions were eliminated in 1985 when all contraception was formally banned. Obstetrician-gynecologists who performed the few legally indicated abortions were not allowed to insert IUDs after the procedure. Patients were hospitalized, and the entire procedure was closely watched by authorities to ensure compliance with these rules. By 1979, rhythm and coitus interruptus were the major methods of fertility regulation, although residents living along the northwestern border with Hungary generally had access to a greater variety of contraceptives smuggled in from that country. It was possible to find locally (but illegally) produced IUDs, pills, and spermicides made from cocoa butter and quinine on the black market, as well as condoms that were said to cost one day's average wage. Permission for sterilization could be granted only by a special medical commission in cases where the woman met even more stringent criteria than those for legal abortion (David, 1990b). Indeed, some physicians now report that they refused to perform essential caesarean sections for fear of being accused of sterilizing the woman during the opera-

tion. These restrictions on birth control contrasted considerably with women's desire to limit their fertility. An informal study conducted in 1989 by the Institute of Hygiene and Public Health in Bucharest revealed a prevailing desire for small family size: Of the 5,000 respondents, 55 percent desired only one child, 28 percent wanted two children, 12 percent wanted three children, and only 5 percent wanted four children (UNFPA, 1990).

Despite government restrictions on abortion and family planning throughout the Ceausescu regime, the birth rate rose only slightly to 16.0 births per 1,000 population in 1989, while maternal death and illness increased significantly (WHO/Europe, 1991). With contraceptive supplies falling so short of demand, many unwanted pregnancies occurred and numerous Romanian women took desperate measures to end them. Anecdotal evidence suggests that women easily obtained clandestine abortions from providers identified by word-of-mouth, paying the equivalent of two months' salary for the procedure (*Financial Times*, 1990). Most of these abortion providers were untrained or unqualified to practice medicine; 90 percent of the persons imprisoned for inducing an abortion were nonmedical providers, mostly women, who likely practiced in unhygienic conditions. Maternal mortality nearly doubled from 86 deaths per 100,000 live births in 1981 to almost 150 in 1984, when 86 percent of maternal deaths were due to abortion. By 1989, there were 159 maternal deaths per 100,000 live births, the highest recorded figure in Europe (WHO/Europe, 1991). Besides claiming lives, unsafe abortion permanently injured many more women. Unofficial estimates indicate that one million of Romania's 5.2 million women of reproductive age may now be infertile, more than twice the number expected for a population of that size (UNFPA, 1990).

Women were not the only casualties of the punitive legislation on fertility. The psychological costs of lack of access to effective contraceptive methods and safe abortion were severe for both women and men. Because it was nearly impossible to have sex without risking an unwanted pregnancy, many couples had sexual relations very infrequently or under great stress (Puia and Hirtopeanu, 1990). Overcoming this conditioned aversion to sex will be a significant challenge, which will be compounded by the shortage of mental health professionals in Romania (opportunities for study in psychology and psychiatry were severely curtailed by the Ceausescu regime in the 1980s) (David, 1990a). But perhaps the most visible testimonies to the insensitivity of the regime's reproductive health policies are Romania's children. The infant mortality rate in Romania remains extremely high, at 26.9 deaths per 1,000 live births in 1989 and 25.3 in the first six months of 1990 (Marinescu, 1990). Of those children who survived their first year, thousands were born to women who could

not support them and instead left them to be cared for by the state. Numerous reports since the revolution have revealed the plight of these children, abandoned in orphanages that lack adequate staff, medication, and even milk (Battiata, 1990). It is estimated that only 2 percent of these children are true orphans; the remaining 98 percent were abandoned at birth (Thomas, 1990). Epidemiological studies of psychological and neuropsychological disorders among children born as a result of unwanted pregnancies since 1966 show higher than normal levels of mental retardation in this population (Grigoriu-Serbanescu, 1990).

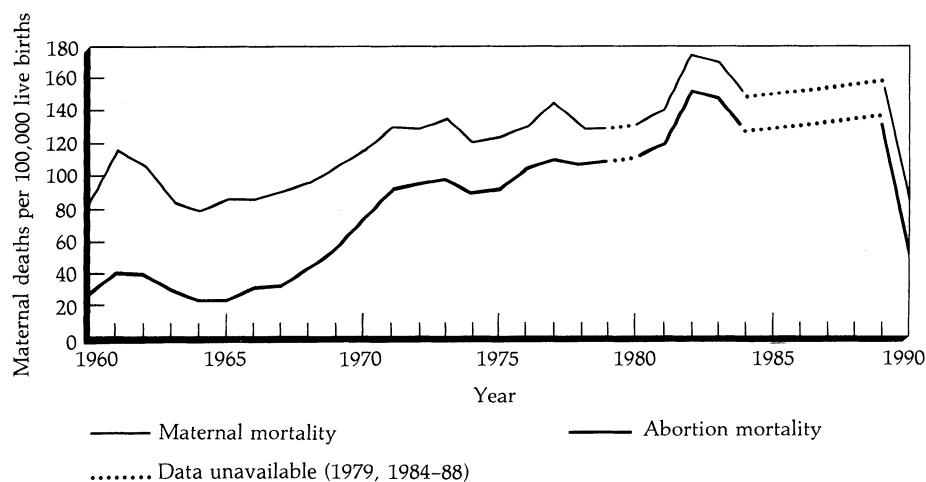
The Post-Revolution Era

Immediate Changes

Following the overthrow of Ceausescu in December 1989, the new government confronted the epidemic of maternal death and morbidity without delay by immediately reversing the restrictive legislation. A law was passed authorizing the use of contraceptives and of induced abortion through the first trimester when performed by an obstetrician-gynecologist. The Romanian Ministry of Health (MOH) quickly established a division to focus on women's and children's health, medical training, and family planning, and removed most barriers to family planning services. The MOH welcomed the efforts of various international nongovernmental organizations to conduct training in family planning and abortion-related care in several regions and began working collaboratively with the World Health Organization (WHO), the United Nations Population Fund (UNFPA), and the International Planned Parenthood Federation (IPPF) in a coordinated effort to meet the country's immediate and long-term reproductive health needs.

As soon as the use of contraceptives and the practice of induced abortion became legal, health care facilities were overwhelmed by women seeking abortion services. To meet this demand, agencies throughout the world donated family planning commodities, including both electric and manual vacuum aspiration (MVA) equipment, to large hospitals all over the country,¹ which began offering legal abortion on request. As of August 1990, eight months after the lifting of abortion restrictions, most hospitals in Bucharest still reported performing a daily average of 70 abortions, approximately the same level of services provided in January. Official figures show that nearly one million legal abortions were performed in 1990, over three times the number of live births² (WHO/Europe, 1991).

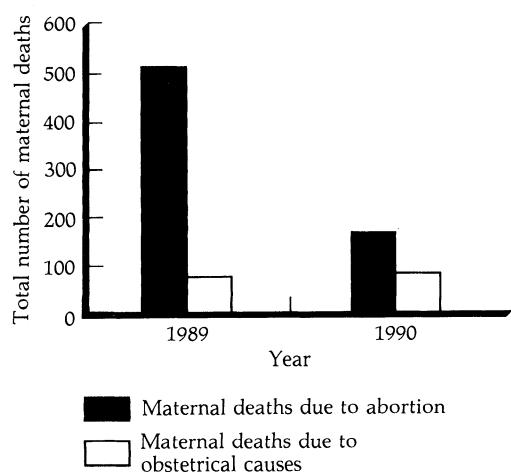
Figure 1 Trends in maternal and abortion mortality in Romania,^a 1960–90



^aData for 1989 and 1990 are based on 11 months.

Source: WHO, 1990.

Figure 2 Causes of maternal deaths before and after liberalization of abortion laws in Romania, 1989–90



Source: WHO, 1990.

The legalization of abortion was followed by notable improvements in women's health. As Figure 1 shows, maternal mortality decreased to 83 deaths per 100,000 live births in 1990—almost a 50 percent drop from the level seen in 1989. In 1990, 69 percent of the 249 maternal deaths were attributable to abortion, a decrease from 87 percent of the 588 maternal deaths in 1989 (Figure 2). After contraception and abortion became available, the birth rate also decreased from 16 births per 1,000 population in 1989 to an estimated 14.2 in 1990 and an anticipated 14 in 1991. Despite the improvements in these health statistics,

in 1990 Romania still had the highest maternal mortality of any country in Europe (WHO/Europe, 1991).

Addressing Family Planning Needs

When the Ministry of Health pledged its full support to the nascent family planning program, the growing public health community eagerly began working to change the primary method of averting unwanted births from induced abortion to the use of modern contraceptives by making family planning services available on a widespread basis. As previously mentioned, international health agencies donated thousands of contraceptive commodities to the MOH to make it possible to meet the target 20 percent contraceptive prevalence rate for 1990. By August 1990, the government had designated 119 family planning centers in hospitals and clinics throughout the country to offer clinical family planning services (Marinescu, 1990). To meet education and counseling needs, a local IPPF affiliate, the Society for Education in Contraception and Sexuality (SECS), was legally approved in April 1990 and began the difficult task of informing the public about the proper use of modern family planning methods. By the end of 1990, SECS had set up six offices in Bucharest and 18 branches in other major cities, had initiated a sex education program in the coastal region, and had established several training programs for health professionals (Societatea de Educație Contraceptiva și Sexuală din România, 1990). Future plans call for the MOH to establish a National Center for Family Planning and Sex Education that will provide training, research, and information about contraception and will serve as a documentation center for family planning issues. In addition,

the MOH will work to open 10 reproductive health reference centers in university hospitals and large cities to offer comprehensive counseling and service delivery, and to expand the number of full-service family planning centers to 230 by 1993 (World Bank, 1991).

The MOH also moved quickly to address the need for training Romanian health workers in contraceptive delivery and atraumatic abortion techniques. During the previous two decades, the medical community had been isolated from general modern medical technology and information, and reproductive health was particularly neglected. The Ceausescu regime discontinued advanced training for nurses in 1978 and specialist training for doctors, including obstetrician-gynecologists, in 1981. Just after the revolution, the MOH estimated that 40 percent of the country's 1,200 gynecologists were over 60 years old and likely to retire soon (UNFPA, 1990). Access to updated medical literature had also been severely restricted by the government, and the available medical literature was usually in English or French, limiting its usefulness to medical personnel who spoke one of these languages. In addition, in 1975 the government closed the national medical documentation center, effectively cutting off health workers from any source of current medical literature (Popescu, 1990). When the extent of Romania's training needs became apparent, a number of international nongovernmental organizations responded by conducting training programs in family planning, abortion counseling, and service delivery for health care personnel in regions throughout the country. These groups included affiliates of Médecins sans Frontières in Belgium and Holland, Marie Stopes International, and the French IPPF affiliate, Mouvement Français pour le Planning Familial. The latter two nongovernmental organizations also sponsored study travel to England and France for family planning training.

After meeting these immediate training needs, the MOH took an important step toward addressing long-term needs by holding, with support from UNFPA and WHO/Europe, a national course on comprehensive family planning for medical personnel representing all 41 districts of Romania. Over 170 obstetrician-gynecologists, general practitioners, and nurses attended the August 1990 seminar, whose primary goal was to provide an overview of the technical aspects of modern contraceptive methods. Also present were representatives from the MOH and the new family planning association, Societatea de Educație Contraceptiva și Sexuală din România. The course was co-sponsored by IPPF affiliates in France and Switzerland, Médecins sans Frontières affiliates from Belgium and Holland, and International Projects Assistance Services (IPAS). Because of UNFPA limitations on supporting abortion-related activities, organizers asked IPAS

to collaborate with the MOH to sponsor and conduct clinical training in manual vacuum aspiration³ for early pregnancy termination in sessions immediately following the family planning course.

The August conference launched Romania's national family planning program by training a core group of health care workers in the basics of contraceptive care; doing so was only a first step in the broad effort required to counteract the misinformation that had circulated for decades throughout Romania. Additional training and practical experience will be necessary before the country's medical personnel will be adequately prepared to meet the family planning counseling and service delivery needs of the Romanian people. In order to increase the availability of safe and cost-effective family planning services, the MOH is planning additional training events (most of which will be smaller and more regionally focused), using physicians and nurses who attended the August course as trainers. As training programs expand, local and regional bodies will assume responsibility for training, follow up, and evaluation activities in order to ensure that local needs are addressed promptly. In addition, the numerous requests from conference participants for reference materials has convinced the MOH of the need to translate and print the texts from all lectures presented at the August seminar and to distribute them widely to the medical community (Nicolescu, 1991).

To complement these training efforts, the Ministries of Finance and Health are now working with the World Bank to design a long-term health plan for Romania, focusing on restructuring health service delivery. On the surface, the basic infrastructure of the country's health system is good. In 1989 there were 425 hospitals, 541 polyclinics, 5,246 dispensaries, and 1,935 pharmacies (World Bank, 1991). There are six major teaching hospitals responsible for the academic training of physicians, 27 nursing schools, and one graduate school for nurses (UNFPA, 1990). Referral protocols exist between institutions at all levels of the health system, with area or workplace dispensaries serving as the first contact, and area polyclinics or district hospitals as the referral centers. After treatment, follow-up care becomes the responsibility of the local dispensary (WHO/Romania, 1990). Despite this seemingly well-ordered system, most health facilities are old and underequipped, the technology used is obsolete, and spare parts are impossible to locate. Dispensaries in the periphery lack emergency drugs and basic medical diagnostic equipment. The result of this disorganization is that the public largely bypasses local health facilities to seek care in secondary or tertiary care centers, thus needlessly overburdening these institutions and underutilizing primary care institutions. In an effort to improve the general management of service delivery, World Bank

consultants will work with Romanian representatives to restructure the health services, alleviate shortages, and improve domestic manufacturing of drugs, equipment, and supplies.

Challenges of the Ceausescu Legacy

The Romanian MOH has spearheaded the progress in improving women's reproductive health in the 18 months since the revolution. As it strives to make the full range of safe reproductive health care services widely and permanently accessible, however, it faces significant and complex challenges. These include challenges arising from the pervasive psychological damage caused by decades of repression and from inexperience with the logistics required to implement change throughout the health system and country. Several of these challenges are reviewed below.

Psychological Barriers to Improving Reproductive Health

To meet the challenges related to the psychological repercussions of the Ceausescu regime, program administrators and health educators will have to effect personal and behavioral changes in the society, a process that requires energy, patience, and time. Chief among the psychological barriers to improving reproductive health in Romania are lack of information about and fear of modern contraceptives among both the public and the medical profession, a tradition of using abortion to regulate fertility, and generalized distrust throughout the society.

Public's Lack of Information, Fear, and Suspicion of Modern Family Planning

Before modern contraceptives can replace abortion as the principal means of fertility control, health educators will need to reverse the public's fear and suspicion of modern family planning methods. Historically, Romanian couples have practiced coitus interruptus and the rhythm method to prevent pregnancy, and relied on clandestine abortion to terminate pregnancies that occurred when these methods failed (David, 1974). Most Romanian women currently know very little about modern family planning but have intimate knowledge of abortion. One report estimates that the average Romanian woman will have undergone at least five illegal abortions by the age of 40 (*The Guardian*, 1990). In a television program aired in late August 1990, most women who were stopped randomly on the street and interviewed regarding family planning did not know what "contraception" meant. Those who did listed their preferred birth control methods as abortion, the IUD, and

oral contraceptives, in that order. These women considered abortion the best option because of its low cost,⁴ perceived low risk, and widespread availability.⁵ Efforts during the last year to educate the public about family planning have been frustrated by gynecologists' limited time and motivation for counseling patients about contraception, by a lack of money, and by a lack of media interest in the subject. The print media, radio, and television give higher priority to Romania's political and economic problems and to other more immediately pressing issues than to reproductive health care.

The difficulty in changing these beliefs and behaviors has been a major factor in the government's inability, to date, to effect significant change in contraceptive use. The MOH had set a target of 640,000 contraceptive acceptors by the end of the first year of legal contraception. According to various reports from government family planning centers, however, during 1990 between 20,000–60,000 women had accepted a family planning method. In contrast, during the same period, nearly one million of the estimated 3.2 million women at risk legally terminated their pregnancies (WHO/Europe, 1991).

Women are still seeking illegal abortions. Obtaining an illegal procedure is easy and has become routine for many women, who may still distrust the government health system. Unfortunately, the health risks associated with illegal abortion are still great: 124 of the 148 maternal deaths in the first nine months of 1990 were attributable to illegal abortion, when women aborted themselves or sought the services of a nonmedical practitioner (WHO/Europe, 1991). According to doctors working in gynecology wards in Romania, the obvious difference since the revolution is that women with complications are no longer afraid to seek medical treatment at hospitals.

Medical Establishment's Reluctance to Promote Modern Contraception

Because of their lack of experience with modern methods of contraception, many members of the Romanian medical profession are reluctant to accept that these methods are safe, and many are unaware of improvements made in recent years to certain methods, such as oral contraceptives. Fears about the safety of modern methods of contraception have greatly restricted the availability of and access to certain methods. For example, the MOH initially considered sterilization to be rarely appropriate and seldom authorized any form of surgical contraception. Although female sterilization is now more acceptable (during 1990 a total of 300 tubal ligations were performed), it is still considered a luxury procedure and is performed only when medically indicated. No vasectomies were documented in 1990 (Potts, 1991). Injectable contraceptives are now considered an acceptable method but are

prohibitively expensive and are used infrequently, and the MOH has no plans to approve NORPLANT® in the near future. It is clear that considerable effort will need to be expended to educate the public and the medical community about the safety of modern contraceptives if the complete range of family planning methods is to be made accessible.

The medical establishment's reluctance to promote modern contraceptive methods may also be influenced by the financial incentive to perform abortions. Under the Communist regime, patients received better quality care when they supplemented officially mandated fees with under-the-table payments to health care personnel. This system persists in Romania and will likely be difficult to reverse. Because performing repeat abortions is much more profitable than providing contraceptives, it is likely that many gynecologists will not encourage their patients to accept family planning. One way the MOH is addressing this problem is by encouraging general practitioners (who are not authorized to perform abortions) to support family planning services to reduce the need for abortion.

Reports in early 1991 reveal a growing "private" practice within the public sector, in which medical services including abortion are provided—often after hours—in public facilities for private clients. Since most restrictions on the provision of abortion services have now been lifted, the fear of legal repercussions is less of an inhibiting factor for medical providers of abortion care, which allows them to offer services in settings that are better and more appropriately equipped than before abortion was legalized.

Suspicion and Lack of Cooperation

Another negative consequence of life under the Ceausescu regime that permeates Romanian society is an atmosphere of suspicion surrounding most personal relationships. For decades, the government discouraged social relationships and forced citizens to report on the activities of neighbors, acquaintances, and even family members. As a result, people are not accustomed to working cooperatively and have found it difficult to know how to begin. In particular, the nation's reproductive health care professionals lack the networks and cooperative spirit found among colleagues of similar disciplines in the West. This change may be particularly difficult to effect, as it involves a significant psychological reorientation. Yet cooperation is vital if the medical establishment is to move forward and improve family planning services by addressing the needs of the Romanian people.

Management Challenges

Many of the difficulties Romanian policymakers, program administrators, and medical professionals face in their ef-

orts to establish a national family planning program are characteristic of new contraceptive introduction programs throughout the world. Several of these issues, and the ways Romania is addressing them, are reviewed below.

Overmedicalization of the Family Planning Program

Two major factors have contributed to the limited access to family planning services and commodities: restrictions on the type of provider that can prescribe contraceptives and perform abortions, and numerous bureaucratic obstacles imposed on family planning clients that delay contraceptive acceptance.

As often happens when modern contraceptives are first introduced in a country, obstetrician-gynecologists are currently the only medical personnel authorized to prescribe or dispense contraceptives or to perform surgical contraception in Romania. The MOH recognizes, however, that this stipulation drastically limits access to contraceptives, given the finite number of trained and available gynecologists, and it is taking steps to improve the situation by working to design a mechanism for decentralizing care. This strategy will eventually include amending restrictions to allow nonspecialists and even trained nonphysicians to provide clinical family planning services. Current plans call for general practitioners (GPs) to be trained by 1992 to prescribe oral contraceptives, for 500 GPs (two from each family planning center) to be trained in IUD insertion, and for 500 nurses to be trained in comprehensive family planning counseling within the next four years.

A second major barrier to contraceptive service delivery in early 1990 was the extensive medical testing that women had to undergo before doctors could prescribe a contraceptive method. Tests were particularly stringent for oral contraceptives, and antibiotics were required for three months following an induced abortion before IUDs could be inserted (Coeytaux, 1990). These restrictions were initially imposed as a temporary means of ensuring that the "new" family planning methods are safe and appropriate. Tests are no longer required, but gynecologists seldom prescribe oral contraceptives, and the poor distribution system leaves most family planning centers without supplies. On the positive side, the waiting period for IUD insertion following abortion has now dropped to one month, which has encouraged interested women to return for the service. A study conducted in early 1990 of 1,000 contraceptive acceptors revealed that 31.4 percent selected barrier methods, 25 percent accepted IUDs, 18.7 percent selected oral contraceptives, 14.8 percent chose injectable contraceptives, and .1 percent opted for (female) surgical sterilization (Köö, 1990). Ministry of Health statistics indicate that overall, 30 percent of the contraceptive acceptors in 1990 chose the IUD (WHO/Europe, 1991).

Reluctance to Use Simple Technologies for Medical Care

Policymakers initially resisted the introduction and use of manual vacuum aspiration (MVA), preferring instead the electric aspirators that they perceived to be more modern and advanced. Despite the benefits of MVA, including its appropriateness for outpatient use, its low cost, and its simple maintenance requirements, governmental fundraising efforts during 1990 focused primarily on obtaining electric aspirators for each of the more than 200 hospitals providing abortion services.

Physicians and nurses at the August 1990 national family planning conference immediately recognized the service delivery benefits of using the simple MVA technology, however. Practitioners attending the conference accepted samples of the equipment and endorsed its use. As a result of this interest, the MOH is now turning its attention toward instituting use of this simpler, more appropriate technology in hospitals and health facilities throughout Romania, and is investigating the possibility of producing either rigid or flexible plastic cannulae locally for use with both electric and manual aspirators. The benefits and cost-effectiveness of MVA will also make it an appropriate technology for use by the fledgling private sector, because individual physicians are unlikely to be able to afford electric pumps. As the medical system becomes less centrally controlled, the demand for simple and low-cost materials will likely increase.

Urban Migration within the Medical Community

One of the few laws during the past regime that benefited rural populations mandated rural service for new physicians. When the law was overturned by the new government, the attraction of urban life began to draw physicians from rural areas and away from small hospitals and maternity homes. Urban migration may be one of the reasons for continuing maternal deaths in rural areas during 1990, and highlights the importance of improving basic health care by strengthening services offered at lower level facilities. If medical backup is available for emergency cases, nonspecialists and nonphysicians could safely and appropriately provide contraceptives and abortion services in rural settings throughout Romania.

Lack of Technical Experience in Running Independent Agencies

Because nongovernmental organizations have been legal in Romania only since the revolution, very little technical expertise exists regarding how to create and run them. This problem is already being addressed through many study-abroad programs sponsored by international agencies, and by technical assistance provided by IPPF and other development organizations. International agency support will supplement the experience that Romanian

nongovernmental organizations and individuals are gaining on their own in new areas such as counseling, public education, communication, administration, and financial management.

Shortage of Medical Supplies and Basic Consumer Products

One of the most immediate problems in the field of reproductive health is the lack of material goods, a condition that affected the entire medical profession throughout the past regime. UNFPA reports that "since 1985 the Ministry of Health was allowed to spend one million dollars on disposable medical supplies for the entire country, about the same amount of money that would be spent per year to equip one 1,000-bed hospital in Western Europe" (UNFPA, 1990). As a result, facilities throughout the health system experience constant shortages of basic medical supplies, such as drugs, gloves, gauze, and disinfectant, and lack the modern medical equipment that has become standard even in many parts of the developing world. Indeed, the Ceausescu regime decreed that medical equipment should last for 25 years, and damaged parts were seldom replaced (WHO/Europe, 1991).

The difficulties experienced by the MOH in providing adequate medical supplies are exacerbated by the pressing demands of the overall economy. Although international donations have met some of the need for medical supplies and the Romanian government is working to revitalize its production capabilities, shortages of equipment and supplies still constitute a major barrier to providing comprehensive reproductive health care. Pressure to improve the availability of contraceptives will likely increase as more women demand a wide range of family planning commodities and as younger physicians trained abroad learn of the variety that could potentially be available.

Lessons from the Romanian Experience

Romania's experience in the realm of reproductive health can guide policymakers, health system administrators, and reproductive health professionals throughout the world. The high number of maternal deaths during the past 25 years vividly illustrates the consequences of restrictive reproductive health policies: In their determination to control their fertility, Romanian women risked their health and lives; as a result, vast numbers of women died or were permanently injured. Romania's experience also clearly demonstrates the difficulty of reversing the effects of misinformation or lack of information. Correcting the broad misconceptions about modern family planning and the overmedicalization of the service delivery program will require extensive and intensive information, education, and communication (IEC) activities di-

rected at all segments of Romanian society, including the medical community. On the positive side, the initiative shown by the Romanian government in offering comprehensive reproductive health services and the unique response by international and bilateral agencies to aid in this effort demonstrate how quickly change can occur when people and institutions work together toward a common goal.

Romania's experience during the 18 months since the revolution also suggests several important lessons for governments and nongovernmental organizations seeking to establish safe reproductive health services in countries that have previously lacked them. Despite Romania's advanced industrial capabilities, many conditions there—such as the lack of hard currency and a reliance on outdated medical information and equipment—resemble those encountered in less developed countries.

The crucial importance of establishing infrastructures to support new programs emerged after the Romanian revolution. For example, although donations of contraceptive commodities were plentiful, no mechanisms initially existed for distributing these and other supplies. As a result, despite the good intentions of those involved, both health care facilities and people in need of contraceptives were unable to obtain them. A participant in the August conference expressed the difficulty of this situation when she commented during the final session, "I feel like a trained soldier going into battle without any munitions." In an attempt to improve the situation, the MOH now plans to coordinate the distribution of commodities through the central state pharmacy system. Regrettably, however, decades of Communist control have left this state entity disorganized and currently unable to meet the demands of maintaining vehicles, working without a comprehensive road system, organizing stock, and keeping accurate records.

Contraceptive demand must increase before the government will devote a significant effort to improving its distribution capabilities. Medical personnel, health educators, and international donor organizations should respect local preferences and cultural traditions to ensure that the commodities or services they offer are both necessary and appropriate. Otherwise, the sustainability of programs and services they help establish will be jeopardized and the beneficial effect of even the most responsive collaboration will be short lived.

A Look to the Future

In less than 18 months, the government of Romania has made the transition from repressing discussion about sexuality or family planning to openly promoting the prevention

of unwanted pregnancy through contraception rather than abortion. The future for family planning in Romania is positive. Romania's people are highly educated and motivated to avoid giving birth to children they cannot support. The medical community is professional, offers relatively high-quality care, and wants to improve its knowledge and experience in family planning. The new medical training system offers an increasing array of learning opportunities for updating the knowledge and skills of the country's health care personnel. However, Romania's growing political unrest and severe economic difficulties pose inevitable challenges to the government as it struggles to maintain recent improvements in reproductive health care.

In the face of such great societal transformation and hardship, it is unlikely that future changes will occur in the reproductive health field as rapidly as they did in 1990. Nevertheless, it is crucial for the success of Romania's national family planning program that the post-revolutionary momentum not be lost. If the objective of achieving a self-sufficient family planning program—one that includes provisions for local production or affordable importation of contraceptives, a system for maintaining trained personnel, and comprehensive services that are available and accessible throughout the country—is to be met within 4–5 years, policymakers, program managers, and health educators will need to continue their strong support for comprehensive family planning services. At a time when reproductive rights are increasingly threatened by conservative forces throughout central and eastern Europe and other parts of the world, the tragic elements of Romania's reproductive health experience under Ceausescu and the country's struggle to reverse that grim legacy can serve as a guide for health care professionals everywhere.

Notes

- 1 Donations of contraceptives and electric aspirators were made by Secours Populaire Français, MarieStopes International, and Médecins sans Frontières in Belgium, France, and Holland. Manual vacuum aspiration syringes and cannulae were donated by International Projects Assistance Services.
- 2 During 1990 there were 992,265 legal induced abortions and 314,746 live births for a ratio of 3,153 abortions to 1,000 live births.
- 3 Manual vacuum aspiration (MVA) is a safe, simple, atraumatic technique of uterine evacuation for the treatment of incomplete abortion and for first trimester induced abortion. Nonelectric and portable, MVA equipment has proved effective in many settings in decentralizing abortion care.
- 4 Governmental prices established in 1990 for abortion and contraception services were 30 lei for a legal abortion, 236 lei for an IUD, and 231 lei for a one-year supply of oral contraceptives. In June 1990, the official exchange rate was 9 lei = US \$1.
- 5 It is unclear if these impressions were based on women's abortion experiences before the revolution or on their knowledge of the current availability of legal abortion.

References

- Battiata, Mary 1990. "A Ceausescu legacy: Warehouses for children." *Washington Post*, 7 June.
- Ceausescu, Nicolae. 1966. Decret No. 770, 29.IX.
- . 1985. Decret No. 411, 26.XII. In *Official Bulletin* No. 76, 26 December 1985.
- . 1986. *Der Spiegel*, 20 October.
- Coeytaux, Francine. 1990. Unpublished trip report, April.
- David, Henry P. 1974. *Abortion Research: International Experience*. Lexington, MA: Lexington Books, DC Heath & Co.
- . 1990a. "Ceausescu's psychological legacy: A generation of unwanted children." *Psychology International* 1, 2: 6–7.
- . 1990b. "Romania ends compulsory childbearing." *Entre Nous* 14, 15: 9–10.
- . 1990c. "Romania ends compulsory childbearing." *Population Today* 18, 3: 4–10.
- David, Henry P. and Robert J. McIntyre. 1981. *Reproductive Behavior: Central and Eastern European Experience*. New York: Springer Publishing Company.
- Financial Times*, London, 20 January 1990 as reported in *IPPF Open File*, 26 January 1990.
- Government of Romania. Ministerul Sănătății din România. 1957. Ordin No. 463, 25.IX.
- . 1989. Ordin No. 605, 27.XII.
- The Guardian*, 24 January 1990 as reported in *IPPF Open File*, 26 January 1990.
- Grigoriu-Serbanescu, Maria. 1990. "How a restrictive abortion policy affected child mental health." *Entre Nous* 14, 15: 6.
- Ionescu, Traian. 1990. Centrul de Calcul și Statistica Sanitara, Bucharest, Romania, personal communication, June 1990.
- Jeanblanc, Anne. 1990. "A brighter future for three million Romanian women?" *Entre Nous* 14, 15: 5.
- Köö, Barbala. 1990. "Experiența serviciului de planificare familială a clinicii de Obstetrica-Ginecologie Panait Sirbu." Presented at National Workshop on Family Planning, Bucharest, Romania, 27–30 August.
- Marinescu, Bogdan. 1990. "Le programme de planification roumain présent et avenir." Presentation made at the National Course on Family Planning, Bucharest, Romania, August.
- Nicolescu, Serban. 1991. Personal communication, January.
- Popescu, Lucia. 1990. Personal communication, June.
- Potts, Malcolm. 1991. Unpublished trip report, January.
- Puia, Sorin and Christian Hirtopeanu. 1990. "Coming out of the dark: Family planning in Romania." *Planned Parenthood in Europe* 19, 2: 5–6.
- Societatea de Educație Contraceptiva și Sexuala din România. 1990. Report of Activity of SECS in 1990. Unpublished.
- Thomas, Lyn. 1990. In *IPPF Open File*, 26 October.
- United Nations Population Fund (UNFPA). 1990. Report on mission to Romania 5–15 March 1990. Unpublished.
- World Bank. 1991. Romania World Bank Health Project Pre-Appraisal Mission. Aide Memoire, 16 January–7 February.
- World Health Organization (WHO), Europe Office. 1991. Reported by the Romanian Ministry of Health, 16 January.
- World Health Organization Collaborating Center, Bucharest, Romania. 1990. *2000 Health for All Newsletter*, No. 14, February.

Restricting legal abortion: Some maternal and child health effects in Romania

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The dramatic rise of the Romanian birth rate in 1967 following the restrictive abortion decree of late 1966 is well known. Less well known are significant changes in key maternal and child health indicators in the period after 1966. Possible reasons for these changes are discussed as are the implications of the Romanian experience for population policy and abortion research in the United States.

WHEN ROMANIA legalized abortion on request in late 1957, the birth rate was about 24 and had been falling since the 1930's primarily due to illegal abortion.¹ In making abortion available on request, Romania adopted a policy similar to that of other socialist countries. The main argument in Romania in favor of liberalization at the time was to reduce the number of illegal abortions and thus improve maternal health. In order to implement the new policy, abortion centers were set up in large- and medium-sized hospitals, and outpatient facilities were attached to factories having a sizeable female work force. Bureaucratic formalities were kept to a minimum. For pregnancies medically determined to be of less than twelve weeks' duration, approval by an abortion commission was not required, and abortion was usually performed immediately or within a few days after it was requested. Fees were low and medical schedules were organized to permit easy availability. These arrangements have been described by Mehlan.²

Although abortion statistics from Romania since 1957 have been seriously incomplete, the partial information that exists suggests that the number of legal abortions increased rapidly after 1957. By 1965, it appears that Romanian women were nearly totally dependent on abortion as a method of birth

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planning,³ a conclusion now supported by a recent official paper on population policy in Romania.⁴ Efforts to introduce contraceptive information and services in abortion centers seem to have been made in the decade after 1957, but they appear to have had little impact, since it seems clear that abortion was widely practiced and that modern contraception was not.⁵

Following 1957, the Romanian birth rate declined at a faster rate than before, reaching 14.3 in 1966. In 1956, the year before the abortion law was liberalized, the birth rate was 24.2. As early as 1963, the Romanian net reproduction rate had fallen to 0.91, indicating that the population was not replacing itself.⁶ The significant role of abortion in the rapid fertility decline seen in three other Eastern European countries in the late 1950's and early 1960's has been analyzed by McIntyre.⁶

Although the Romanian government had not commented on the country's demographic situation in the early 1960's, West⁷ documented increasing governmental concern in 1966. In a speech to a national conference of Romanian women in June, 1966, the Romanian Premier, Nicolae Ceausescu, appealed to Romanian women to exercise their influence in rebuilding the family. He attributed the low birth rate in Romania, at least in part, to lax divorce laws. Although he did not refer to abortion in his speech, a conference report identified liberalized abortion as a problem and indicated that revisions in the law would be made. Official comment on the fertility situation peaked in September, 1966, coincident with the release of the March, 1966, Census results.⁷

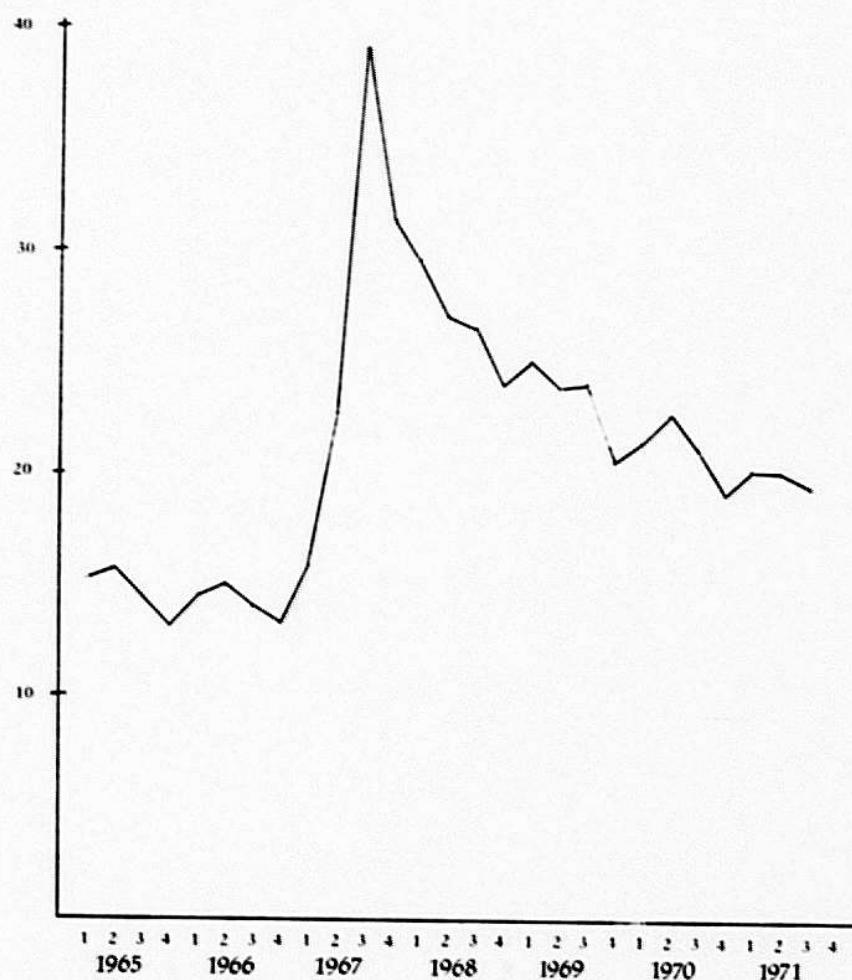


Fig. 1. Romania: Quarterly birth rates per 1,000 population, 1965 to 1971.

Table I. Romania. Per cent increase in age-specific fertility rates by birth order, 1966 to 1967

Maternal age (yr.)	Live birth order						All birth orders
	1	2	3	4	5	6	
Under 20	53	79	100	*	*	*	57
20-24	57	111	144	83	40	0	81
25-29	47	99	194	126	75	50	101
30-34	39	111	253	202	90	43	129
35-39	41	131	321	290	122	72	138
40-44	50	125	262	262	112	66	93
All ages†	50	97	201	170	93	50	89

From data in United Nations Demographic Yearbook, 1969.⁵

*Base too small.

†Including women 45 and over and seventh and later births.

Health officials noted the "excessive" rise in the number of abortions and commented that the overwhelming majority of reasons for abortion were "superficial" and "frivolous." It was further suggested that the complications of repeated abortion were "affecting as many as 60% of women who had had many abortions." The complications were enumerated as secondary sterility, extrauterine preg-

nancy, premature births, spontaneous abortions, infections, hemorrhage, and endocrine disorders.⁷ The preamble to the September 29, 1966, decree restricting abortion (effective 30 days later) spoke of the "great prejudice to the birth rate and rate of natural increase" resulting from the practice of abortion as well as the "severe consequences to the health of women."⁸ Evidence from Hungary suggests that

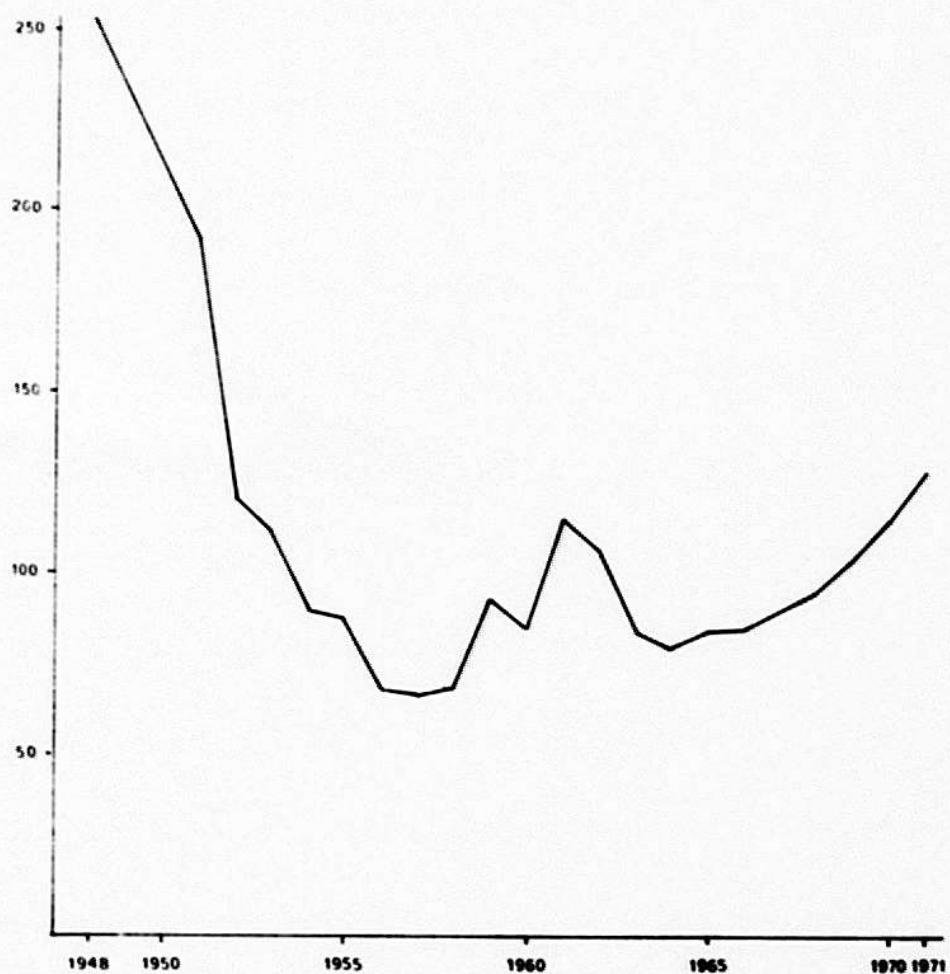


Fig. 2. Romania: Maternal mortality ratios per 100,000 live births, 1948 to 1971.

short-term medical complications associated with induced abortion decreased over time, but no comparable data on the complications of repeated abortion are available for Romania.⁹

The instructions for applying the decree of September 29, 1966, limited the availability of abortion on request to: (1) women over 45 years of age; (2) women who had already borne four or more children with four still under their care; (3) women whose lives, in the judgment of a special commission, were endangered by the pregnancy, who were faced with the risk of congenital deformity, whose pregnancies resulted from incest or rape, or who were "physically, psychologically, or emotionally incapacitated."¹⁰ More than 100 medical indications are carefully defined in the legislation, the only leeway remaining in the psychiatric area. The penal code was also revised to provide penalties for providers, instigators, and seekers of abortion.

Concomitant with the change in abortion policy, several pronatalist measures were introduced. Family allowances were liberalized and increased.¹¹ The

income tax was reduced 30 per cent for families with three or more children.¹² The "childlessness" tax was reintroduced and levied on men and women over 26 years of age, whether single or married. The basis on which the government paid a birth allowance was also changed in late 1966. Formerly, a nontaxable birth allowance was paid to the mother having tenth or later births on the basis of the birth certificate. Mothers having a third or later birth became eligible for this lump sum payment of \$180 beginning January 1, 1967.¹³ The above measures were added to an already well-developed series of benefits designed to protect mother and child welfare.

The official aims of the new abortion regulations and the additional benefits and incentives were to "eliminate abortion as a form of birth control, assuring at the same time, family sizes commensurate with the national purposes"; to "protect the family, mother, children, and youth, and to stimulate natality to reach 18-19 per 1,000. . . ."¹⁴ By these means, and perhaps by others to be added later, it

Table II. Romania: Number of obstetric- and abortion-associated maternal deaths by cause and rate per 100,000 live births or per 1,000,000 population, 1966 to 1970

Causes of death	No. of deaths				
	1966	1967	1968	1969	1970
Obstetric-associated					
Sepsis of pregnancy, childbirth, and the puerperium	14	27	20	16	19
Toxemia of pregnancy and the puerperium	22	36	34	22	25
Hemorrhage of pregnancy and childbirth	58	154	99	86	56
Other complications of pregnancy, childbirth, and puerperium	58	92	132	105	82
Total	152	309	285	229	182
Rate per 100,000 live births	56	59	54	49	43
Abortion-associated					
Abortion without mention of sepsis or toxemia	19	27	29	258	314
Abortion with sepsis	64	143	192	4	1
Abortions induced for legal reasons	NA*	NA	NA	4	1
Total	83	170	221	262	315
Rate per 1,000,000 women 15 to 45 years of age	19	38	49	56	69

From World Health Statistics Annual, 1966 to 1970, and United Nations Demographic Yearbook, 1969, 1970.¹

*Not available.

Table III. Romania: Late fetal death ratios by maternal age, 1965 to 1970

Year	Maternal age*						
	Under 20	20-24	25-29	30-34	35-39	40-44	All ages
1965	12.8	11.9	14.0	16.6	22.1	33.1	14.5
1966	13.4	12.7	13.3	18.3	21.4	32.6	14.9
1967	14.7	14.8	16.8	21.5	28.0	36.0	18.9
1968	13.8	12.9	14.5	18.9	25.7	37.2	16.4
1969	12.5	11.4	13.6	17.5	23.9	34.8	14.9
1970	12.6	10.5	12.3	15.8	20.5	27.7	13.4

Data for 1965-1968 from United Nations Demographic Yearbook, 1969¹ (Reporting judged to be complete). Figures for 1969 derived from data in Anuarul Statistic al Republicii Socialiste România, 1970. Figures for 1970 derived from data in Breviar De Statistica Sanitară—1971, Ministerul Sanatatii, 1972.¹²

*Excludes women aged 45 and over.

was hoped to reach a national population of 24 to 25 million by 1990. The population in 1960 and 1970 was 18.4 and 20.3 million, respectively.¹

Official importation of contraceptives ceased but their sale was not prohibited. As Teitelbaum¹¹ has pointed out, oral contraceptives and intrauterine contraceptive devices continued to be available at high prices through the black market, and condoms and creams were still produced in Romania. Divorces were made much more difficult to obtain by lengthening the divorce process to include a trial period of reconciliation and by increasing the legal fees.

Fertility change

Fig. 1 illustrates the response of the Romanian birth rate to the sudden restriction of abortion in late 1966. The birth rate began to rise in the spring

of 1967, since women who became pregnant in the summer of 1966 were cut off from abortion in the early months of gestation by the new decree. The birth rates peak in the fall of 1967 and then decline, although consistent seasonal variations are seen through 1971. From a high of 27.3 in 1967, the yearly crude birth rate declined without interruption to 18.8 by 1972.¹³ Quarterly birth rates for 1972 are not yet available, however. The increase in the crude birth rate from 1966 to 1967 was sharper in urban areas, perhaps suggesting more dependence on abortion than in rural areas.¹⁴

Table I demonstrates that the increase in fertility between 1966 and 1967 was not uniform by maternal age or live birth order. Women in all the reproductive age groups and at all live birth orders contributed to the fertility increase, but the highest increase was among women 30 years of age, or

Table IV. Romania: Observed and expected neonatal and postneonatal deaths, per cent difference, and observed infant mortality rates, 1966 to 1971

<i>Year and status</i>	<i>Observed</i>	<i>Ex- pected*</i>	<i>Per cent difference</i>	<i>Observed infant mortality rates</i>
1966				
Neonatal	4,048	3,950	+ 2	14.3
Postneonatal	3,693	3,400	+ 4	31.3
Total	12,746	12,350	+ 3	46.6
1967				
Neonatal	12,506	7,625	+64	23.7
Postneonatal	12,084	12,900	- 6	22.9
Total	24,590	20,525	+20	46.6
1968				
Neonatal	13,351	7,606	+76	25.4
Postneonatal	17,966	17,375	+ 3	34.1
Total	31,317	24,975	+25	59.5
1969				
Neonatal	9,899	6,725	+47	21.2
Postneonatal	15,685	14,825	+ 6	33.7
Total	25,584	21,550	+19	54.9
1970				
Neonatal	7,971	6,175	+29	18.7
Postneonatal	13,139	13,400	- 2	30.7
Total	21,110	19,575	+ 8	49.4
1971				
Neonatal	6,214†	5,775	+ 8	15.5†
Postneonatal	10,588†	12,375	-14	26.5†
Total	16,987	18,150	- 6	42.5

Observed deaths and infant mortality rates from Breviar de Statistica Sanitara—1971, Ministerul Sanatatii, 1972.¹⁶

*Figures rounded to nearest 25.

†Preliminary data. Observed neonatal and postneonatal deaths and rates do not equal the respective totals which are final.

older, having their third or fourth child. The overall increase in the age-specific fertility rate between 1966 and 1967 was 89 per cent. There are several possible explanations for these findings. The relatively smaller contribution of women at birth order 1 to the 1966 to 1967 fertility increase may have been due to greater acceptance of first births by married couples in 1966 and earlier. Later birth orders were presumably more likely to be aborted in 1966 although the smaller increases in fertility rates for fifth and sixth births suggest that some women, perhaps rural women, did not often resort to abortion even in 1966. It seems surprising that the increase between the two years for fifth and sixth births is as great as it seems to have been. Women

progressing to the fifth live birth order in 1967 may not have been aware that legal abortion was still available to them, or else the bureaucratic mechanism under the new decree was too cumbersome to permit easy access to abortion for these women. These explanations are clearly speculative.

Maternal and late fetal mortality rates

There were important changes in maternal and child health-related death rates after 1966. Fig. 2 gives perspective to the change in the maternal mortality rate. A rapid decline in the rate is seen after 1948, there is a period of instability between 1958 and 1963, and there is a continuous increase after 1964. By 1971, the maternal mortality rate was 130 per 100,000 live births, higher than that in any year since 1951.^{15, 16} In order to probe recent changes more carefully, maternal deaths by obstetric- or abortion-associated causes and rates for 1966 through 1970 are presented in Table II. The maternal death rate per 100,000 live births from obstetric causes rose slightly in 1967 but declined steadily in the 1968 to 1970 period. However, maternal deaths associated with abortion rose sharply from 19 per 1,000,000 women 15 to 45 years of age in 1966 to 38 in 1967, 49 in 1968, 58 in 1969, and 69 in 1970. Maternal health in Romania deteriorated after 1966, principally because of maternal deaths associated with septic abortion, presumably illegal abortion. Some of the deaths in 1969 and 1970 are associated with legal abortion, but there is no available information on the number of legal abortions performed in those years.

Late fetal deaths (stillbirths) also increased after 1966. Table III presents late fetal death ratios per 1,000 live births by maternal age. Between 1966 and 1967, the total ratio increased 23 per cent. Late fetal death ratios fell steadily from an average of 21.6 in 1950 to 1954 to 14.5 in 1965. The 1966 to 1967 increase occurred at all maternal ages but was slightly more pronounced among women 35 to 39 years of age. After 1967, late fetal death ratios fell in all age groups and by 1970 were lower than those in 1965 or 1966.

Infant mortality rate

Infant mortality rates changed markedly after 1966. The rate prevailing in 1950, 115.5 per 1,000 live births, declined rapidly, reaching 74.9 in 1960 and 44.1 in 1965. It remained stable at 46.6 in both 1966 and 1967 and then rose 27 per cent to 59.5

in 1968. In 1969, the rate fell to 54.9 and continued falling to 42.5 in 1971¹⁶ and 39.9 in 1972.¹⁷

Since the rapid change in numbers of live births after 1966 might have influenced the infant mortality rate, a cohort analysis was carried out. The expected number of deaths were computed on the assumption that: (1) the 1965 infant mortality rate was 45 (actually 44.1) and remained constant for succeeding years; (2) the distribution of infant deaths by month of life remained constant in the 1965 pattern; (3) deaths occurring in the first month of life were assigned to the calendar month of birth, etc. Expected infant deaths calculated under these assumptions were separated by neonatal and postneonatal status by year. The results appear in Table IV.

In 1966, there is little difference between observed and expected neonatal and postneonatal deaths. In 1967 through 1970, however, observed and expected neonatal deaths differ substantially, in marked contrast to postneonatal deaths. These differences diminish after 1968, although preliminary data for 1971 suggest that observed neonatal deaths are still higher and postneonatal deaths are lower than expected. Final data from 1971 show that observed total infant deaths are less than expected infant deaths, a consequence of the fact that the Romanian infant mortality rate reached a level below that prevailing in 1965. The major conclusions of the cohort analysis are that the post-1966 increase in the Romanian infant mortality rate was not produced by the changing numbers of live births, although the breakdown of the observed infant mortality rate in 1967 does reflect the rapid change in cohort size, and was largely confined to neonatal deaths. The excess neonatal deaths that occurred in 1967 were masked by the unchanging observed infant mortality rate. The difference between observed and expected neonatal deaths differ substantially, in the per cent difference column of Table IV.

When a closer look is taken at neonatal deaths between 1966 and 1967, deaths under one day, at one to six days, and at seven to 27 days increased by factors of 4.6, 3.7, and 2.4, respectively. The total increase in the number of neonatal deaths for 1966 to 1967 was by a factor of 3.1. The first-week and first-month findings are similar when 1966 is compared with 1968 through 1971, though less marked after 1968. Thus, the excess neonatal deaths that occurred following 1966 were concentrated in the first week of life, particularly the first day.

Table V. Romania: Infant mortality rates by selected major causes and rate change per 100,000 live births, 1966 to 1968

Cause	Rate			Rate change, 1966-1968
	1966	1967	1968	
Bronchopneumonia	1,518	1,077	1,647	+129
Infections of neonate	570	646	698	+128
Gastroenteritis and colitis, except diarrhea of the neonate	550	374	547	-3
Birth injuries	456	1,070	1,082	+626
Primary atypical, other, and unspecified pneumonia	225	189	302	+77
Postnatal asphyxia and atelectasis	76	153	235	+159
Hemolytic disease of the neonate	50	77	87	+37
Spina bifida and meningocele	47	42	47	—
Accidents, poisoning, violence	108	85	117	+9
Other causes	1,057	946	1,191	+134
Total	4,657	4,659	5,953	+1,296

From World Health Statistics Annual, 1966, 1967, and 1968.

Table VI. Romania: Number of live births inside and outside health institutions, total, and per cent of institutionalized live births, 1960 and 1965 to 1970

Year	Number of live births			Per cent institutionalized
	Institutionalized	Outside	Total	
1960	245,864	106,377	352,241	69.8
1965	230,205	48,157	278,362	82.7
1966	230,984	42,694	273,678	84.4
1967	461,266	66,498	527,764	87.4
1968	461,907	64,184	526,091	87.8
1969	411,270	54,494	465,764	88.3
1970	382,195	44,839	427,034	89.5

From Breviar de Statistica Sanitara—1971, Ministerul Sanatatii, 1972.¹⁸

Causes of death

There were large changes in several major and pertinent minor causes of infant death in the 1966 to 1968 period. Table V shows that almost one half of the 1966 to 1968 point increase in the total infant mortality rate was contributed by birth injuries as a cause of death. Increases in causes of death associated with the neonatal period account for almost 75 per cent of the change between 1966 and 1968. Bronchopneumonia was the only major cause of death associated with the postneonatal period which

increased between 1966 and 1968. Although the infant mortality rate remained the same in 1967 as in 1966, the rates of the major causes of death were quite different. Causes associated with the postneonatal period generally declined sharply, reflecting the fact that because of the rapid increase in the birth rate there were many more neonatal "at risk" months, relatively speaking, in 1967. As might have been predicted, the death rate for spina bifida and meningocele remained constant over the three-year period. The rate for accidents, poisoning, and violence rose slightly after a sharp decline in 1967, perhaps also because of the relative increase in neonatal "at risk" months during the year and the fact that newborn infants are generally better protected against these causes of death than infants in the postneonatal period. It seems likely that the increase in deaths ascribed to hemolytic disease of the neonate reflects higher levels of Rh sensitization produced by widespread use of abortion before 1967. Rh-immune globulin was not available for routine prophylaxis until the late 1960's.¹⁷

Comment

The temporary increase in late fetal and neonatal deaths after 1966 may be considered together since the causes of death in both perinatal periods are similar. Several possible explanations are worth mentioning. It may be that the rapid increase in pregnancies carried to term overwhelmed the available antenatal care, delivery, and postnatal care facilities leading to temporarily lower standards of care and more deliveries outside the hospital and without professional attention. As medical care facilities expanded and the number of term pregnancies declined after 1968, the then available facilities presumably were better able to cope with the demand. According to West,⁵ maternity beds in 1967 were in very short supply and authorities were urging women to have their babies at home. In addition, hospitals were short of personnel because a large number were absent on maternity leave, a problem that was anticipated early in 1967 by Romanian authorities.

It can be seen in Table VI that, although the proportion of live births occurring in health institutions continued its upward trend, the number of births outside health institutions increased 55 per cent, from 42,694 to 66,498, between 1966 and 1967. As late as 1970, the number of births outside health institutions remained higher than that in 1966. Official health statistics document a twofold

increase in the rate of temporary incapacity of workers due to childbirth and more intensive use of maternity beds—higher utilization rates and shorter average stay—in the post-1966 period.¹⁶ Unfortunately, there are no available data comparing infant deaths by place of birth.

A second possible explanation of the increase in the perinatal mortality rate may lie in the revised system of birth grants. The new system may have encouraged reporting of previously unreported live births in which death occurred early in the neonatal period. Given the new scheme, there may have been sufficient incentive to fill out both birth and death certificates. This notion implies about a one per cent underreporting of live births before 1967. It does not, however, explain the temporary increase in late fetal deaths.

A third possibility is that many Romanian women may have resorted to late illegal abortion after the law became restrictive. This could have increased late fetal deaths and also early neonatal deaths among babies born alive after intervention. As channels to illegal abortion opened up again after 1966, these abortions presumably would be performed earlier and the proposed effect on the perinatal mortality rate would decrease. Some recent evidence from the United States bears on this possibility. Since legal abortions became available in New York State in 1970, observers at two hospitals have noted a sharp drop in the rate of immature births (under 1,000 grams) per 1,000 deliveries. They hypothesize that early legal abortions had replaced many of the late illegal abortions occurring formerly.^{18, 19}

The changing distribution of live births by maternal age and birth order after 1966 cannot account for any substantial part of the increase in late fetal and neonatal deaths. In the case of late fetal death, the change in distribution of live births by maternal age accounts for only ten per cent of the increase in the ratio between 1966 and 1967. A similar analysis based on 1950 United States data relating maternal age and birth order with neonatal death suggests that the Romanian neonatal mortality rate might have been expected to decrease slightly between 1966 and 1968. In fact, it increased 72 per cent.

Finally, information from Hungary and Japan indicates that women who have had induced abortions are more likely to have premature births when they continue pregnancies and that the incidence of prematurity is directly related to the number of previously induced abortions.²⁰⁻²² More re-

Table VII. Standard ratios for prematurity and early neonatal death by previous pregnancy status and per cent of total live births (Hungary, second half, 1970)

Previous pregnancy status	Standard ratios		Per cent of total live births
	Pre-maturity	Death, age 0-6 days	
One live birth	68	72	18
Two live births	80	97	4
None	83	65	42
One spontaneous abortion	98	113	3
One live birth and one spontaneous abortion	101	135	3
Four live births	108	132	1
Two induced abortions	109	94	1
Two spontaneous abortions	114	155	1
One live birth and one induced abortion	118	139	5
One induced abortion	124	120	5
One spontaneous and one induced abortion	125	123	1
One live birth and two induced abortions	130	114	2
Three live births	131	123	1
Two live births and one spontaneous abortion	132	159	1
Two live births and one induced abortion	135	76	1
One live birth and two spontaneous abortions	136	226	1
One live birth, one spontaneous abortion, and one induced abortion	181	174	1

From data in Perinatal Mortality, Hungarian Central Statistical Office, 1972.²²

cent, but preliminary, survey data from Hungary suggest that the relationship between induced abortion, prematurity, and the perinatal mortality rate is not a simple one. Some of the confounding factors are socioeconomic status, smoking history during pregnancy, maternal age, and prior reproductive history.^{23, 24} Given these qualifications, Table VII presents standard ratios for prematurity and early neonatal death (Days 0 to 6) as calculated from the Hungarian data. With very few exceptions, past induced and/or spontaneous abortions increase the risk of prematurity and early neonatal death. On a scale of 100 for over-all risk, women with one live birth and one induced abortion previously were 18 per cent more likely to bear a child under 2,500 grams and that child carried a 39 per cent increased risk of dying in the first week of life. Anomalies are evident in Table VII, however. Women with two previous induced abortions have

Table VIII. Romania: Annual per cent distribution of live births by weight to 2,500 grams, 1960 to 1971

Year	Birth weight			Total under 2,500 grams
	Under 1,500 grams	1,500-1,999 grams	2,000-2,499 grams	
1960	U*	U	U	5.0
1961	U	U	U	5.2
1962	U	U	U	5.4
1963	U	U	U	5.8
1964	U	U	U	6.1
1965	U	U	U	6.3
1966	0.5	2.0	5.6	8.1
1967	1.1	2.8	6.6	10.6
1968	1.0	2.5	6.3	9.8
1969	0.8	2.3	6.2	9.3
1970	0.7	2.2	6.1	9.1
1971	U	U	U	8.5

Data for 1966 to 1970 from Breviar De Statistica Sanitara—1971, Ministerul Sanatatii, 1972.¹⁶ Data for 1960 to 1965 and 1971, Personal Communication, Romanian Ministry of Health, 1972.

*U = unavailable.

a 9 per cent increased risk of bearing a premature baby but a 6 per cent reduced death risk to the infant in the first week of life. The Hungarian data characterizes 91 per cent of live births during the survey period.

In the first few years after 1966, many Romanian women who had previously relied heavily upon abortion to control their fertility had live births. If prematurity rates were higher, one would expect higher perinatal death rates. Table VIII demonstrates an increasing prevalence of prematurity from 1960, perhaps related to the trend toward more complete institutionalization of births, as seen in Table VI. The Romanian data on distribution of live births by weight classes is available from 1966 only. Figures on the total proportion of low-weight births (under 2,500 grams), however, are available from 1960. The increase in the proportion of premature births between 1966 and 1967 is only slightly more impressive than the increase between 1965 and 1966. The over-all prevalence declines slowly after 1967 and approaches the 1966 level by 1971. It should be noted that the 1966 to 1967 increase is greatest in the under 1,500 grams weight class. One concludes that the years following the abolition of legal abortion in Romania show a disturbance of the earlier trend in the prevalence of prematurity, namely, a transient rate increase, particularly in the lowest weight classes. As mentioned above,

this latter finding may represent an increase in late illegal abortions.

The dramatic 1966 to 1967 changes in distribution of births by maternal age and birth order seen in Table I did not contribute to the increase in prematurity. In fact, these changes, on balance, would have tended to decrease the prevalence of prematurity. Standardization carried out with the use of 1950 United States data relating maternal age and birth order to birth weight suggested that prematurity would have been unchanged by the shift in the mother's age but that birth order distribution changes might have been expected to cause a small decline in prematurity in 1967. The 1967 increase in the prevalence of prematurity occurred despite these expected effects.

It is likely that all four of these hypotheses help explain in some measure the changes in late fetal and neonatal mortality rates shown in Tables III to IV. Without additional data, it is difficult to assess their relative contribution, but the shortage of maternity beds and maternal and child health personnel and increasing prematurity are likely to be important factors in explaining the post-1966 changes in perinatal deaths. In the United States, Levy and colleagues^{24a} have described how sensitive the neonatal mortality rate is to critical personnel shortages. The increased perinatal mortality rates seem to have been temporary and, by 1971, appeared to be resuming the pre-1966 secular trend. Increasing utilization of early illegal abortion by Romanian women may explain, in part, the return to earlier levels of prematurity and perinatal death.

Shortly after the 1966 restrictive abortion and pronatalist decrees were announced, *Pravda* commented:

. . . while such incentives deserve approval, one can hardly approve of the prohibition of abortion as the experience of many countries, including the USSR, shows that such a measure has never, no matter where, led to any real and prolonged rise in the birth rate. It has merely caused women to put an end to an unwanted pregnancy by having an abortion secretly, the danger of which to a woman's life and health is considerably greater than an abortion performed in a hospital.¹²

After 1935 to 1936, when abortion availability was restricted and then made a criminal offense except for compelling medical and eugenic reasons, the USSR experienced a transient rise in the birth rate accompanied by increasing illegal abortion.¹³ Teitelbaum¹⁴ suggests that the re-establishment of

illegal abortion services in Romania took some time, but that they were re-established seems clear from the increasing numbers of maternal deaths caused by abortion with sepsis. There is evidence from Yugoslavia that a very high proportion of women who are denied legal abortion resort to illegal abortion.²⁵

Regulations governing abortion were liberalized somewhat by Romanian authorities in 1971, perhaps in response to the increase in illegal abortions. Women aged 40 or more were given access to abortion on request as were women under 14 and mothers caring for 4 or more children.¹ There also appears to have been some liberalization of the 1966 regulations for pregnant women 14 to 16 years old, and, finally, several other diseases were specified as grounds for abortion. In 1971, 330,000 legal abortions were performed¹ and there were 400,164 live births.¹⁶ In 1972 and 1973, hospital-registered spontaneous and induced abortions totaled 380,600 and 375,700, respectively.^{25a} The data on deaths caused by legal abortion in 1969 and 1970, as seen in Table II, suggest that a substantial number of legal abortions were performed in those years as well.

There is limited evidence that family-planning practices changed somewhat after 1966.³ Coitus interruptus is said to be widely practiced again, and, although official importation of oral contraceptives and intrauterine contraceptive devices was discontinued in late 1966, these methods are available, at least in Bucharest.

The restrictive abortion decree of late 1966 had a dramatic effect on births, but the effect has been short-lived. Since 1967, the Romanian birth rate has fallen steadily, although at a progressively slower annual rate of decline through 1972. It is not yet clear whether the rate will plateau at the desired level.⁴ Of course, part of the post-peak birth rate decline is the result of demographic causes. In late 1966, the number of Romanian women at risk of live birth was at a maximum. As these women remained pregnant and carried their pregnancies to term, the proportion of fecundable women declined, which, in turn, led to birth rate decline.

Although the birth rate dropped steadily between 1967 and 1972, the decline was not uniform by the mother's age or birth order. Available data on age-specific fertility suggest that women 25 years of age and over were generally, but not uniformly, more successful in reducing their fertility between 1967 and 1971 than were younger women. However, information on numbers of live births by birth

order indicates that births at orders 4 and above (20 per cent of all births in 1972) fell between 1 and 8 per cent between 1967 and 1971, whereas those at orders 1 through 3 all fell by 25 per cent or more.⁴ This finding is surprising in view of the greater access of higher-parity women to legal abortion under the 1966 decree and its 1971 liberalization. Without more information, it is difficult to interpret these trends, but it does appear that the combination of pronatalist incentives and abortion restriction, presumably more the former, may be differentially promoting higher-order births. Should this trend persist, the Romanian birth rate might stabilize at or near the desired level of 18 to 19 per 1,000 population.

However, it seems likely that the restrictive abortion and pronatalist decrees did not seriously change the traditional Romanian preference for small families. The policy lesson may prove to be that in the absence of fundamental change in motivation concerning family size, legal restrictions on abortion, as well as pronatalist measures, may lead to no more than a short-term increase in the birth rate. In Romania, the increase has been associated with increased mortality rates and probably morbidity of mothers and children. Further, the rapid upswing in numbers of live births will lead to social problems later, probably the earliest of which will be the problem of accommodating the swollen 1967 to 1968 birth cohort in the educational system.

Implications for population policy and abortion research in the United States

One of the recommendations of the Final Report of the Commission on Population Growth and the American Future is the desirability of population stabilization in the United States. The Report goes on to warn that:

In the long-run future, we should understand that a stabilized population means an average of zero growth, and there would be times when the size of the population declines. Indeed zero growth can only be achieved realistically with fluctuations in both directions. We should prepare ourselves not to react with alarm, as some other countries have done recently, when the distant possibility of population decline appears.²⁶

The cautionary advice in the Report is well taken, judging by the Romanian reaction to low annual birth rates suggesting population decline and the apparent consequences of policies designed to correct the situation, even after allowance is made for Romania's unique demographic situation.

Given the January, 1973, decision of the Supreme Court,²⁷ medically safe induced abortion soon will be widely available in the United States. Judging from the experience in New York City, where induced abortion has been available since mid-1970, it can be anticipated that many abortions under the new dispensation will replace illegal abortions, but some will be "new" and lead to fertility decline. There is no evidence to suggest that contraceptive practice in New York City deteriorated after induced abortion became legal, but contraceptive services have been readily available there for several years.²⁸ In contrast with Romania, contraception is more widely practiced in the United States, although the pattern is uneven by age and marital status. Many women seeking abortion in the United States since 1970 were under 20 and unmarried. Few of these women had ever practiced contraception, and those few tended to use less-effective methods.²⁹ Special efforts will be necessary to make contraceptive information and services available to this difficult-to-reach group. Continued general promotion and support of contraceptive services to women of child-bearing age are also called for to reduce the need for curative abortion.

A high proportion of young women having legal abortions in the United States are likely to carry wanted pregnancies to term in the coming years. The Eastern European, but particularly the Romanian, experience suggests the need for more information on the long-term health effects of abortion in the United States.³⁰ We know a good deal about short-term health effects,³¹ and the need to administer Rh-immune globulin to vulnerable women is clear.³² All of this is reassuring, but we know far less about the later risk, if any, of prematurity and perinatal death, complications of delivery, secondary sterility, extrauterine pregnancy,³³ and second-trimester spontaneous abortion.³⁴

REFERENCES

1. David, H. P.: Family Planning and Abortion in the Socialist Countries of Central and Eastern Europe, The Population Council, 1970.
2. Mehlman, K. H.: J. Sex Res. 1: 31, 1965.
3. David, H. P., and Wright, N. H.: Stud. Fam. Plann. 2: 205, 1971.
4. Muresan, P., and Copil, I. M.: Romania, in Berelson, B., editor: Population Policy in Developed Countries,

- New York, 1974, McGraw-Hill Book Company, Inc., chap. 13.
5. United Nations Demographic Yearbook, 1969.
 6. McIntyre, R. J.: The Fertility Response to Abortion in Eastern Europe, Paper presented to the 1972 Meeting of the Population Association of America, Toronto, Canada.
 7. West, G. V.: Romania's Reluctant Mother Heroines of 1967. Unpublished manuscript, 1969.
 8. Romania: Government Decree No. 770, September 29, 1966.
 9. Klinger, A.: Int. J. Gynecol. Obstet. 8: 680, 1970.
 10. Romania: Laws, Statutes, etc., Interruption of Pregnancy, Int. Dig. Health Legis. 18: 822, 1967.
 11. Social Security Programs throughout the World, Research Report No. 31, Office of Research and Statistics, Social Security Administration, United States Government, 1969.
 12. Sadovasova, E. A.: Socio-Hygienic Aspects of the Control of the Size of the Family, Moscow, 1969, Meditsina Publishing House.
 13. Romania: Government Decree No. 954, November 30, 1966.
 14. Teitelbaum, M. S.: Popul. Stud. 26: 405, 1972.
 15. Statistical Yearbook of the Romanian Socialist Republic, 1973.
 16. Breviar De Statistica Sanitara—1971, Ministerul Sanatatii, 1972.
 17. Judelson, R. G., Berger, G. S., Wallace, R. B., and Tiller, M. J.: Am. J. OBSTET. GYNECOL. 114: 1031, 1972.
 18. Lannan, J. T., Kohl, S. G., and Bedell, J. H.: Am. J. OBSTET. GYNECOL. 118: 485, 1974.
 19. Swartz, D. T.: The Harlem Hospital Experience, in Osofsky, H. J., and Osofsky, J. D., editors: The Abortion Experience, New York, 1973, Harper and Row, Publishers.
 20. Barsy, G., and Sárkány, J.: Demográfia 6: 427, 1963.
 21. Miltényi, K.: Demográfia 7: 73, 1964.
 22. Moriyama, Y., and Hirokawa, O.: The Relationship Between Artificial Termination of Pregnancy and Abortion or Premature Birth, in Harmful Effects of Induced Abortion, Tokyo, Family Planning Federation of Japan: Sub-Committee on the Study of Induced Abortion, 1966, p. 64.
 23. Hungarian Central Statistical Office: Perinatal Mortality, Budapest, 1972. (Mimeographed English Version.)
 24. Bognár, Z., Tusnády, G., et al.: Br. J. Prev. Soc. Med. 24: 146, 1970.
 - 24a. Levy, B., Wilkinson, F., and Marine, W.: AM. J. OBSTET. GYNECOL. 109: 50, 1971.
 25. Stampar, D.: Stud. Fam. Plann. 4: 267, 1973.
 - 25a. Abortion Res. Notes 3: 25, 1974.
 26. Population and the American Future, New American Library, 1972.
 27. New York Times, January 23, 1973.
 28. Tietze, C.: Fam. Plann. Perspect. 5: 36, 1972.
 29. Wright, N. H.: Adolescent Pregnancy: Health and Social Implications, Paper presented at the 1972 Meeting of the American Public Health Association.
 30. Stewart, G. K., and Goldstein, P.: Obstet. Gynecol. 40: 539, 1972.
 31. Tietze, C., and Lewit, S.: Stud. Fam. Plann. 3: 97, 1972.
 32. Council on Population, American Public Health Association: Am. J. Public Health 62: 1669, 1972.
 33. Panayotou, P., Kaskarelis, D. B., Miettinen, O. S., Trichopoulos, D. B., and Kalandidi, A. K.: Am. J. OBSTET. GYNECOL. 114: 507, 1972.
 34. Wright, C. S. W., Campbell, S., and Beazley, J.: Lancet 1: 1278, 1972.



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Delegalization of Abortion in Romania Led to Increased Rates of Infant, Maternal Mortality

What happens when ready access to legal abortion is halted and abortion becomes, in effect, illegal? Two articles explore the effects of the sudden 'delegalization' of abortion in Romania in late 1966, and conclude that it has led to higher maternal and infant mortality and, temporarily, to higher neonatal mortality and higher fertility rates.

For nine years, beginning in 1957, abortion on request in the first trimester was readily available to Romanian women. Costs were kept low and privacy was assured, according to Nicholas H. Wright of The Population Council¹ and Michael Teitelbaum, currently of Nuffield College, Oxford University.² The permissive law was promulgated, they explain, in large part to reduce the number of illegal abortions and to improve maternal health. Since contraception had not been equally available, "... Romanian women were nearly totally dependent on abortion as a method of birth planning," observes Wright.

One consequence of the permissive abortion law was that the Romanian birthrate, which had been dropping steadily for some years, began to fall more rapidly. The year before legalization, the birthrate was 24.2 per 1,000. By 1966, it reached a low of 14.3 per 1,000; and even before then, the net reproduction rate had fallen to 0.9, indicating, Wright points out, "that the population was not replacing itself."

In an effort to boost the birthrate and to stem what health officials called the "excessive" rise in the number of abortions, a sharply restrictive decree was issued late in 1966. Abortion was to be available only to women over 45 years of age, to women who had already borne four or more children with at least four still under their care, to women whose lives would be threatened by the pregnancy, and to those who were faced with a congenital deformity or whose pregnancy resulted from incest or rape. In addition, more than 100 medical indications were defined in the legislation, Wright points out, "the only leeway remaining in the psychiatric area." The penal code was also revised to provide penalties for providers, "instigators" and seekers of abortion.

Other pronatalist measures were also passed, both authors observe, including

increased family allowances, income tax reduction of 30 percent for families with three or more children, an increased tax on childless individuals over the age of 25, a nontaxable birth allowance to mothers having a third or later birth (instead of a tenth child, as had previously been the case) and more restrictive divorce laws. Official importation of contraceptives ceased, although their use was not prohibited, and condoms and contraceptive creams continued to be produced inside the country.

The immediate objective was achieved: In 1967 the crude birthrate nearly doubled (to 27.4), as did the total fertility rate and the gross and net reproduction rates. Teitelbaum comments: "In all likelihood this Romanian experience represents the largest one-year fertility increase ever experienced by a large human population." The fertility increase, he observes, varied with the parity of the women: It was greatest for women of parity two or three (i.e., women who would therefore be having their third or fourth child), and, at these parities, the increased fertility rate was highest for women aged 30 or more. These women "are more likely to have reached their planned family size, and additional births not averted . . . would represent 'excess' fertility to them. . . ."

Teitelbaum points out:

Resort to illegal abortion and/or contraception was undoubtedly increased by the 1966 restrictions on legal abortion, but this is not likely to have been important in the short run. The free availability of legal, cheap abortions for nine years must have severely damaged the previously existing facilities and communications network for illegal abortion. Reestablishment of the availability of illegal abortion would require some time. Additionally, the near total dependence on abortion for fertility control and the newly imposed restrictions on oral contraceptives and IUDs could be expected to slow any resort to modern contraception as an alternative to abortion.

But these alternatives did slowly develop, and the birthrate began to decline again, dropping back to 18.8 per 1,000 popula-

tion by 1972. That illegal abortion accounts for a portion of the fertility decline since 1967 is suggested by maternal mortality data. Wright points out that while the rate of maternal mortality from obstetric-related causes fell between 1967 and 1970 (from 59 per 100,000 live births in 1967 to 43 in 1970), the rate of abortion-associated maternal deaths more than tripled—from 19 per million women aged 15-44 in 1967 to 69 in 1970. In 1970, only one of 315 such deaths was attributed to legal abortion.

Stillbirths also increased immediately after the change in abortion laws. The late fetal death ratio (stillbirths per 1,000 live births) had fallen from an average of 21.6 in 1950-1954 to 14.5 in 1965. It rose slightly to 14.9 in 1966 and then jumped by 27 percent to 18.9 the following year. In 1968, the decline in stillbirths resumed again, dropping to 13.4 per 1,000 live births by 1970. The infant death rate also increased, but this was not immediately apparent: the infant death rates remained unchanged between 1966 and 1967 at 46.6 per 1,000 live births, then rose by 27 percent to 59.5 per 1,000 in 1968. (As with stillbirths, the infant death rate declined again, to 42.5 per 1,000 live births in 1971.) Almost half the increase from 1966 to 1968 was caused by birth injuries as a cause of death.

To some extent, these increases in stillbirths and infant deaths may have been related to the restrictive abortion law, because of the greatly increased pressures it placed on an unprepared medical care system. "It may be that the rapid increase in pregnancies carried to term overwhelmed the available antenatal care, delivery, and postnatal care facilities leading to temporarily lower standards of care and more deliveries outside the hospital and without professional attention," Wright explains.

As medical care facilities expanded and the number of term pregnancies declined after 1968, the then available facilities presumably were better able to cope with the demand. . . . maternity beds in 1967 were in very short supply and authorities were urging women to have their babies at home. In addition, hospitals were short of personnel because a large number were absent on maternity leave. . . .

A longer term effect of the 1967 spurt in births is its impact on the educational and economic system, Teitelbaum points out.



Romanian women: Prefer few children.

"As the children born in 1967 reached school age (in 1971 and 1972), an important problem must have arisen for educational administrators in accommodating a cohort twice as large as the one immediately preceding," he notes. "Similar, if attenuated, difficulties will arise as the 1967 birth cohort enters universities, the labour force, etc."

These problems will be temporary, however, since fertility has fallen again since 1967. "It seems likely that the restrictive abortion and pronatalist decrees did not seriously change the traditional Romanian preference for small families," Wright notes. "The policy lesson may prove to be that in the absence of fundamental change in motivation concerning family size, legal restrictions on abortion, as well as pronatalist measures, may lead to no more than a short-term increase in the birthrate."

References

1. N. H. Wright, "Restricting Legal Abortion: Some Maternal and Child Health Effects in Romania," *American Journal of Obstetrics and Gynecology*, 121:246, 1975.
 2. M. Teitelbaum, "The De-Legalization of Abortion in Romania," *Family Planning*, 23:38, 1974; and "Fertility Effects of the Abolition of Legal Abortion in Romania," *Population Studies*, 27:405, 1972.
- Women who have IUDs inserted immediately after an abortion do not have higher pregnancy, expulsion or removal rates than women whose IUD insertions are not connected with an abortion, according to a report by Alfredo Goldsmith, David A. Edelman and William E. Brenner of the International Fertility Research Program (IFRP) of the Carolina Population Center.¹ Several other recently published studies support this finding, and also show that women having IUDs inserted after their abortions do not have significantly higher complication rates following the procedure than women who do not have devices inserted postabortion.
- The IFRP investigators noted that, while sterilization has often been combined with abortion and "there appears to be no reason to delay initiating oral contraceptives after abortion," insertion of IUDs has often been delayed after an abortion because of "fear of increased rates of complications and a higher expulsion rate" as the uterus returns to its nonpregnant size. But one advantage to postabortion insertion, they pointed out, is that "the cervix is already dilated," which should make the insertion easier. Goldsmith and his colleagues reported on several studies in Eastern Europe and Latin America which indicate postabortion insertion works well:
- In Ljubljana, Yugoslavia, 661 women who had Lippes loop Ds inserted after suction or dilatation and curettage abortion had lower rates for pregnancy, expulsion and removal for bleeding and pain than women who had devices inserted after menstruation. Two years after insertion, 4.5 percent of the women in the postabortion group had become pregnant, compared with 5.6 percent in the postmenstrual group; only 3.9 percent of the postabortion women had experienced expulsions, compared to 19.6 percent of the controls. Eighty-three percent of the postabortion women were still wearing their loops after two years, seven percent more than in the control group.
 - Up to a year after insertion of loop Ds in two hospitals clinics in Santiago, Chile, 1,470 women who received the device following incomplete abortions (an unknown proportion of which were illegally induced) had fewer pregnancies per 100 women than did 14,577 women in whom the device had been inserted after menstruation. Expulsion and especially re-
- moval rates were higher among the postabortion women, however.
- Preliminary results of postabortion insertions of the Lippes loop and Dalkon shield in Maribor, Yugoslavia, showed event rates for the loop similar to those reported in Chile, and even lower event rates for the shield.
- Postabortion IUD insertion has several nonmedical advantages, the authors observed. "Women are perhaps more highly motivated to use contraceptives at this time than they would be later," they said. In addition, since the insertion "does not require an additional hospital [or clinic] visit, . . . it is a more convenient time for the women. Medical resources may be more efficiently used when the procedures are combined."
- Similar observations were made by two Finnish researchers, reporting in *Contraception*, who inserted copper T-200 (TCu-200) devices in 154 women following legal abortion by dilatation and curettage under general anesthesia.² After 18 months, the continuation rate was 81.5 percent: There had been one expulsion during the fourteenth month, 3.3 percent of the women had become pregnant, and 12.5 percent had the device removed for medical reasons.
- These 154 women were compared for complication rates with 144 women who also underwent abortion but did not have IUDs inserted. Within eight weeks following the procedure, 7.1 percent of the women in the IUD group had experienced complications (bleeding, fever, pelvic infection and mechanical injury), compared with 12.5 percent of the controls. Only 1.3 percent of the IUD users had been readmitted to the hospital, compared with 3.5 percent of the controls. Since the women in the TCu-200 group were, on the average, somewhat older and of higher parity than the controls, no statistical evaluation of the data was made.
- Similarly, an evaluation of 1,104 postabortion insertions of Lippes loops in Korea found that IUD "acceptors experienced side effects no more often than did a nearly equal number of ordinary abortion patients at the same hospital."³ The frequency of "severe" side effects (as judged by one doctor who examined all the women who returned with complaints) was twice as high in the IUD group, however (7.6 percent vs. 3.5 percent). The incidence of