1. Welcome (Miguel Oliveira da Silva)

The leader of the Project, Miguel Oliveira da Silva, welcomed all participants warmly to this International Workshop, which is a part of the EU-funded REPRODUCTIVE HEALTH PROJECT on the state of reproductive health and fertility in the European Union. He presented shortly the previous two REPROSTAT projects and the current status of the Reproductive Health Report. The Report is not ready yet, but all participants were invited to critically comment it and correct any mistakes. The Report is to be delivered to the European Union in July 2011. Additionally, a booklet will be prepared to market the Report and its conclusions and recommendations.

Maria do Céu Machado, the current National Health Plan coordinator, the former High Commissioner of Health welcomed the participants to Lisbon and the international workshop after lunch. She told us all that the Project has been funded by EU funds and also by Portuguese funds from her own office.

Discussion:

- Paul Van Look (Switzerland) asked how the five areas (teenage sexual and reproductive health, childbearing policies, contraception, assisted reproductive technologies and induced abortion) were chosen. Miguel Oliveira da Silva (Portugal) replied that the selection was based on experiences on the two previous REPROSTAT projects as well as on data availability.

- Janos Annus (Hungary) asked how the three European areas were chosen (Northern Europe, Southern Europe and Central and Eastern Europe). Miguel Oliveira da Silva (Portugal) told that these were chosen and developed as a tool to analyse the differences between European regions and within them.

- Marija Pavilione (Lithuania) asked how religion and its effect to sexual and reproductive health issues could be covered in the Report.

2. Teenage sexual and reproductive health (Helle Karro)

Helle Karro presented the main findings in teenage sexual and reproductive health. The topic was selected because teenage pregnancy can be seen as one of the main public health problems among teenagers. The chosen indicators included sexual initiation and contraceptive use from the WHO Health Behaviour among School-Children study (HBSC) as well as statistics on teenage abortions and births.

The HBSC collects information on sexual and reproductive health among 15 years old boys and girls every fourth year in most European countries. In 2006, Cyprus and Malta did not participate, and Ireland and Poland did not include the relevant questions in their surveys. The results show a substantial variation in the sexual initiation and in contraceptive use. There is no information on use of double contraceptives.

Data on legally induced abortions was available for 21 member states from national and international sources (Eurostat and WHO). No data was available for Austria, Cyprus and Luxembourg. Ireland and Malta
ban induced abortion, and Poland has very restrictive access to induced abortions. The teenage abortion rate is the highest in Sweden, the United Kingdom and Estonia. The teenage abortion rate has increased in Southern European and Northern European countries, but decreased in Central and Eastern European countries. The quality of official induced abortions may be questioned in some countries. Private abortions, medical abortions and abortions by migrants may be missing from official figures.

Data on live births was available for all 27 member states. The variation was smaller than that for induced abortions. Bulgaria, Romania and the United Kingdom had the highest rates. The rates have declined in all countries, excluding Spain, Belgium, France, Italy and Malta.

One recommendation could propose standardised periodic surveys. International data on induced abortions should be collected more systematically. The validity of data on teenage pregnancies should be confirmed in each country.

Discussion:

- Kristina Gemzell (Sweden) asked, if the Report will include information on abort tourism. Miguel Oliveira da Silva (Portugal) replied that this is not most likely the case due to lack of data. This will, however, be presented in the Chapter on induced abortions.

- Christian Fiala (Austria) commented the quality of data. Data from surveys may not be comparable between the countries.

- Medard Lech (Poland) reminded that the quality of data varies from country to another. Information on European medical abortion initiatives (Women on Waves, Women on Web), which provide women with restricted or no access to induced abortion a way to terminate pregnancy, should be added to the Report.

- Janos Annus (Hungary) commented the title on Tables 3 and 4. Boys do not use oral contraceptives, but their partners do. The need to periodic surveys should be underlined.

- Natalie Bajos (France) commented that the title of Report should be reproductive health only. If the title includes sexual health, the view can be seen very limited, since for example homosexuality is not covered. It is known that HBSC is the only available data source, but it should be kept in mind that the people having sex at 15 years are very different from total population. National data from other surveys should be used, including also sexual health surveys among adults aged 18 years or more. Helle Karro (Estonia) commented that only five countries reported national information, and their comparability was very limited.

- Marija Pavilione (Lithuania) commented that information on sexual education should be collected and commented it the Report. Helle Karro (Estonia) replied that there will be a section on youth-friendly sexual and reproductive health services in the article, which will be based on these results.

- Carla Van Der Wijden (the Netherlands) asked what the use of this Report is. Miguel Oliveira da Silva (Portugal) replied all recommendations will be included in the Chapter 9. All participants were invited to add suggestions to the Report during the meeting and after it. These recommendations should be spread out to promote sexual and reproductive health in Europe.
- Alli Kubba (United Kingdom) reminded that the UK data is of very high quality. A recommendation could be to prioritise teenage sexual and reproductive health. For teenagers, condom use reflects the common culture and availability.

- Dirk Pyck (Belgium): Registration data is not scientific data, which limits their use in decision making and in preparing recommendations. Existing recommendations on sexual and reproductive health should be used in the Report.

- Ine Van Wesebeeck (the Netherlands) urged the standardisation and harmonisation of data in the Europe.

- Bojana Pinter (Slovenia) commented that the Report includes very useful both for nationally and internationally. The HBSC data has shown important trends in some countries, e.g. in Slovenia. For many countries, data on induced abortion is very reliable.

- Philip Hannaford (United Kingdom) asked all the countries to evaluate the quality of induced abortion in their country.

- Seppo Heinonen (Finland) asked if post-coital pills were included in the HBSC survey. Helle Karro (Estonia) commented that the data was not available. For some countries, data is available from surveys or consumption statistics, but their comparability is challenged due to several methodological issues.

- Inês Fronteira (Portugal) told how country profiles were build up from international sources (Eurostat, WHO Health for all – database) and then completed from national sources by Reprostat partners in each country.

- Alli Kubba (United Kingdom) commented that religion is a very important factor, which explains for example the differences between Denmark and Bulgaria, shown by Helle Karro. It is important that also younger teenagers (12-14 years) are included in the Report. Issues related to migrant teenagers should be covered.

- Serena Donati (Italy) commented that in table 6 has misleading information for Italy. The data is reliable.

- Jean-Jacques Amy (Belgium) seconded that migrant issues should be included. Migrants play a role in the increasing teenage pregnancy rates, but this cannot usually be proofed, since data on ethnicity must not be collected due to data protection issues.

- Natalie Bajos (France) commented that social differences in teenage pregnancy rates should be taken into account. The increased adolescent abortion rates should also be reflected. Helle Karro (Estonia) commented that the percentage of teenage pregnancies ending in birth/induced abortions will be analysed in the Report.

- Thomas Rabe (Germany) preferred to present both the source of data and its quality. Data should also be given by population subgroups, e.g. Roma population in Romania.

- Valentina Mihaila (Romania) replied that the teenage pregnancy rate is very high for this population. It is important to show the tendency by country, but not concentrate on country comparisons.
Kristina Gemzell (Sweden) commented that the countries with increasing teenage birth rates should be analysed in more detailed to find out, what can be explained the trend.

Carlo Alviggi (Italy) said that we need tools for the future. The different contraceptive use patterns can be seen in teenage pregnancy rates. Also Chlamydia rates should be analysed by country.

Todor Chernev (Bulgaria) commented that the Bulgarian rates for condom use are not correct; at least they do not reflect the reality. The sexual and reproductive health issues among Roma population should be taken on the political agenda at the EU level.

Vit Unzeitig (Czech Republic) asked, if ethnicity data is collected in Bulgaria and Romania. The countries replied that data can be received on live births, but not on induced abortions. The evidence comes from everyday life, not from statistics.

Gabriel Bianchi (Slovakia) said that the project should not be concentrating on hard data only, since the availability and comparability of data can always be questioned. An EU study on Roma Health estimated that the teenage pregnancy in Romania is 40/1000 for the total population, but 400/1000 among Roma people. This kind of existing literature should be added to the Report.

Christian Fiala (Austria) requested to include information on teenage pregnancies on migrants and ethnic minorities in the Report.

Marija Pavilione (Lithuania) reminded that it is important to remember the historical and culture differences e.g. between the new and old states. Data collection should not be only technical.

Alli Kubba (United Kingdom) recalled the importance of being pragmatic. It is important to benchmark teenage pregnancy and abortion rates against the use of contraceptives.

Thomas Rabe (Germany) notified that it is important to provide free contraceptives to teenagers.

Janos Annus (Hungary) told that migrant issues are not relevant to Roma people only, but also covers migrants outside Europe and even people migrating within EU.

Bojana Pinter (Slovenia) reminded that we cannot proof any causal effect from the statistical, descriptive information. The aim of the Report is to provide a general overview on sexual and reproductive health in the Europe. Migrant issues should be included in the recommendation, but new projects and even improved national data collections are required.

Paul Van Look (Switzerland) told that it should be very clear that only recommendations based on evidence are selected in the Report.

Charles Savona-Ventura (Malta) asked that the trend data on teenage pregnancies should be analysed very carefully. The importance of continuous sexual education should be highlighted and emphasised in the Report.

Audrey Simpson (United Kingdom) commented that is has been shown that to reach low teenage pregnancy and birth rates it is important to ensure access to comprehensive sex education, access to sexual health services and to create supportive climate for teenage sexuality.
- Seppo Heinonen (Finland) requested to include also data from United States, Canada and Australia. Inês Fronteira confirmed that this data has been collected already.

- Marija Pavilione (Lithuania) wanted to add reference to feminist theory and women movement and women history in the Report.

- Dick Pyck (Belgium) reminded that sexual rights of youth should be remembered when writing the recommendations.

- Kristina Gemzell (Sweden) commented that high abortion rates may also reflect the choices of young people, e.g. in Sweden with high a teenage abortion rate, but a long history of compulsory sex education.

- Christian Fiala (Austria) did not want to end the session with young people’s choice to have a high induced abortion rates. In many times, the high rates are related to their wish to have contraceptive and reliable information.

3. Childbearing policies (Albrecht Jahn)

Europe is ageing and the number of old people is increasing. No country exceeds the replacement level of 2.1 children per woman. Postponement of childbearing and decreased number of birth and total fertility rates have been acknowledged by European countries and European institutions.

From 1998 to 2009 the mean age of mothers increased by 2 years (from 0.4 years in the Netherlands to 4.9 years in Hungary). All countries are converting to 29-31 years. The total fertility rate has decreased from the 1960 to bottom 1.47 in 2003, but now slightly increased to 1.56 in 2009. France, Ireland, United Kingdom and the Nordic countries have high rates, near the replacement rate. Portugal, Slovakia, Hungary, Germany, Poland and Romania have very low fertility of less than 1.4. Also total fertility rates are converting, despite these differences.

The maternity leave models differ from countries. The shortest is in Germany (14 weeks), the longest in Bulgaria (59 weeks). The European Parliament has suggested introducing the minimum length to 18 or 20 weeks. Full or partial (55-70%) payment of salary is paid for mothers, and their jobs are secured. Parental leave can be shared between mother and father, and in some countries a part of the leave cannot be transferred to other parent (usually from father to mother). Paternity leave is shorter than maternity leave. Some countries have chosen financial support, some others by providing services, such as day care services.

There is no strong link between model of support and total fertility rate. There is, however, evidence that gender equity is important. There is also evidence, that societal services have a stronger impact than benefits in cash. The effect of different incentives, however, varies from country to country. There is,
however, a clear consensus that the fertility rates have to be increased for sustainable development in the future.

A system should be elaborated to analyse the impact of childbearing policies to support policy makers and stakeholders. Childbearing policies should use a multisectorial approached and represent a balance between different forms of support and incentives. Child care facilities should be developed near parental workplaces.

Discussion:

- Paul Van Look (Switzerland) asked how large the variation in fertility rates between the 27 member states is, and how much the rates converge. Albrecht Jahn (Germany) told that the countries with the lowest fertility rates have had a more significant increase than other countries.

- Jørn Olsen (Denmark) commented that the fertility rates are based on current rates, not on completed fertility rates.

- Christian Fiala (Austria) commented that also that the number of childless women is increasing.

- Mika Gissler (Finland) told that the existing international statistics has been deteriorating, since less information is collected by Council of Europe and Eurostat. It is important to get information on completed fertility rate to be able to compare fertility rates in different countries.

- Carlo Alviggi (Italy) asked it is true that Catholic countries have lower fertility rates than other countries. The questions remained unanswered.

- Gunilla Lindmark (Sweden) asked to add a recommendation to give young people accurate information on biological factors on childbearing.

- Elina Hemminki (Finland) asked, if the following indicators are available: age of mother at first birth, the number of men and women without child at 45 years, and the contribution of migrants in increasing fertility rates. Mika Gissler (Finland) replied that these data for the two first indicators have been available, but they remain unavailable currently. Albrecht Jahn (Germany) replied that only legal migrants are included in the statistics, so the figures may be underestimations.

- Todor Chernev (Bulgaria) reminded that pregnancies after 40 years can still be considered as a medical problem. There is no legislation – and thus no age limits - on ART services in Bulgaria. This causes extreme cases of pregnancies and births of post-menopausal women.

- Jan-Steffen Krussel (Germany) supported that it is important to educate the people, but also gynaecologists on the effect of women’s age on biological fertility. It could also be good to get women earlier to ART services than nowadays.

- Dick Pyck (Belgium) asked, if ethnic monitoring is done in the countries. Philip Hannaford (United Kingdom) replied that no uniform data is available currently.
- Natalie Bajos (France) wondered, why having no children is a health issue. Social stigmatisation may be the consequence of our recommendations against postponement of childbearing.

- Dick Pyck (Belgium) asked, if we have information on childcare by grand-parents. Albrecht Jahn (Germany) told that no European data is available. Inês Fronteira (Portugal) told that there are several studies on the issue, for example from Portugal.

- Bojana Pinter (Slovenia) asked, if there are information on child care facilities in the EU. A student in Portugal is searching this kind of data, which seems to be not easy to find. For the future, this can be a very important issue to study and collect data on.

- Paul Van Look (Switzerland) notified that the current practices to promote childbearing are not very effective. We should provide proved and functioning solutions.

- Ine Van Wesebeeck (the Netherlands) wondered why the role of fathers has been omitted from the Report.

- Alli Kubba (United Kingdom) asked, if the information on support for single mothers has been collected. Albrecht Jahn (Germany) told that this data has not been collected in the project.

- Janos Annus (Hungary) told that the policy does not work. Hungary has a very long maternity leave, but very low fertility rate. Support should be given also to young people in education.

- Jan-Steffen Krussel (Germany) told that it is important to distinguish between voluntary and involuntary childlessness.

- Serena Donati (Italy) commented that the fertility rates in Italy would be even smaller without migrants. This information should be collected and analysed.

- Audrey Simpson (United Kingdom) commented that this chapter refers to employment policy more than sexual and reproductive health.

- Bojana Pinter (Slovenia) asked that the fertility rates should be analysed more carefully, e.g. the decline in the 1960s and 1970s and the decline in the 1990s in the Central and Eastern European countries.

- Janos Annus (Hungary) asked from Natalie Bajos, what factors explain the high fertility rate in France. She replied that it is caused by different factors, many of them related to gender equality. In addition, the French rate was never that low than for example in Hungary.

4. Contraception (Philip Hannaford)

For the Report, information on contraceptive prevalence rate in women aged 15-49 years as well as gatekeepers and reimbursement policies to selected contraceptives were collected. The data was taken from UN Reports on contraceptive use, national surveys and studies and provided by project participants with a separate questionnaire. The data covered different age groups and came from different years (oldest from the early 1990s). Also different sets of contraceptives were asked from the respondents. Data was not available from Cyprus, Greece, Ireland, Lithuania and Luxembourg.
The use patterns for contraceptives vary substantially between countries. Some countries have very high proportions of non-effective methods. The sterilisation rates differed between genders. In most countries, however, female sterilisation was much more common than male sterilisation. In most countries, physicians or GPs are gatekeepers for contraceptives. In some countries, nurses and midwives can administrate IUDs or write prescriptions. Countries have adopted different reimbursement policies. In most countries, contraceptives are not given free of charge for adults.

The first conclusion is that the current data is not detailed enough for international comparisons. Also more detailed information needed by age, socioeconomic groups, ethnic background and so on. The rationale of current reimbursement policies should be reviewed. The role of gatekeepers in contraceptive service delivery should be reviewed. Information on new contraceptive methods should be disseminated. Access to widest possible range of safe, effective, acceptable and affordable contraception methods should be guaranteed in Europe.

Discussion:

- Paul Van Look (Switzerland) asked about some country-specific information, which seemed to be incorrect. The effectiveness should be measured with standardised methods. Philip Hannaford (United Kingdom) urged all participants to correct the factual errors in the Report. For the project, the prevalence rates were more important than effectiveness rates.

- Gunta Lazdane (WHO) reminded that contraceptive rate is one of the Millennium Development Goal indicators. All countries have to report the data latest in 2015, when the MDG goals are globally evaluated. She also told that e.g. Spain has a very recent survey on sexual health. Anyhow, EU should have a common sexual and reproductive health survey.

- Jørn Olsen (Denmark) asked, if sales data can be used. Philip Hannaford (United Kingdom) told that they are not very reliable due to cross-border sales and the lacking information on the user.

- Janos Annus (Hungary) told that countries will report something for their MDG and other international data collections. Their quality may be questioned.

- Christian Fiala (Austria) commended that the columns of contraceptives should include also the new contraceptives. Philip Hannaford (United Kingdom) agreed. The other question was related to time the prescription is valid. The Netherlands replied that oral contraceptives be prescribed for more than one year.

- Natalie Bajos (France) asked to include the respondents’ age groups in the Report. The contraceptive rates should be given by socioeconomic background. Also information on teenagers’ possibilities to get contraceptive should be collected. Also the use of contraceptives when unwanted pregnancy started should be studied.

- Kristina Gemzell (Sweden) requested that the remaining barriers for the use of contraceptives should be evaluated.

- Kai Part (Estonia) asked, if women with no need of contraceptive are included in the statistics or not. Philip Hannaford (United Kingdom) told that this remains unknown.
- Mika Gissler (Finland) reminded that also information on men’s use of contraceptive should be collected.

- Alli Kubba (United Kingdom) asked, if we are talking about clinical effectiveness or effectiveness in real life. For public health reporting, clinical effectiveness is less important.

- Ausrute Armonaviciene (Lithuania) and Evangelos Makrakis (Greece) notified that their national data was not included in the data. They will be added.

- Serana Donoti (Italy) reminded that it is important to highlight for the reader the great variation of data sources, data collection methods and years covered.

- Carlo Alviggi (Italy) wondered why Italy has a low fertility, but also low use of contraceptives. Perhaps this relates to data quality.

5. Assisted reproductive technologies (Kitty Bloemenkamp)

It has been discussed, how much ART can affect fertility rates. One out of six couples reports infertility. Postponement of childbearing, increasing obesity rates, smoking rates and alcohol consumption declines fertility. It is estimated that 3.75 million ART babies have been born in the world so it is an important part of reproductive health.

The data come from the steering committee of bioethics of the Council of Europe (2005) and from ESHRE (European Society of Human Reproduction and Embryology) data collection on ART treatment (2007). The national counterparts provided the information on the reimbursement policies.

There are still seven EU member states without any legislation. In some countries the practice may not be according to the legislation. In some countries, some procedures are banned. Surrogacy is banned in most countries. There are different policies on the upper age limit for ART treatment (for women). Policies may differ between private and public clinics. Reimbursement policy varies by country.

Most ART children – calculated as a share of all live births – are born in Slovenia, Denmark, Belgium, Finland and Sweden according to ESHRE data from 2007. The multiple birth rates are 5% in Sweden, 10% in Finland, but up to 45% in Latvia. Also Turkey and Italy had many three embryo transfers. This related to the use of single embryo transfers, which are most common in Sweden, Belgium and Finland. The outcomes of ART children are still worse than that of other children, e.g. on perinatal mortality and low birth weight. This may also have long-term health consequences for the child.

ART discussion is related to childbearing policies. The data on legal and practical framework should be more updated. The benefits of earlier motherhood should be explained. The clinical results of ART should be disclosed. The status and outcomes of frozen human embryo should be discussed. The use of ART for non-medical purposes should be discussed.

Discussion:

- Todor Chernov (Bulgaria) reminded that ART tourism exists also nationally. The outcomes of private ART treatments may be treated in public hospitals. ESHRE data may be questioned since the data collection activities are funded by pharmaceutical companies.
- Paul Van Look (Switzerland) commented that ART has only a very minor effect on fertility rates, even if ART would be provided for all women without children.

- Jan-Steffer Krussel (Germany) supported the international data collection for providing benchmarking data for all countries. Abortion tourism is more seeking of cross-border reproductive health care services. In some cases, unserious information is given by private clinics may appeal customers from other countries. International data can be used to show, if this data is incorrect. Kitty Bloemenkamp (the Netherlands) told that different success rates can be used, e.g. taking account the number of transferred embryos.

- Kristina Gemzell (Sweden) stated that single embryo transfers should be recommended for all countries.

- Carlo Alviggi (Italy) told that the Italian legislation has been changed and three embryos are not transferred any longer. By personalised treatments the multiple rates can be lowered. The increased risk for adverse outcomes is more likely caused by infertility itself, not the treatment(s). ESHRE data is very old (currently only 2006 data has been published), and more updated data should be available.

- Medard Lech (Poland) told in some cases it is better to have no ART legislation than a very strict legislation. The Polish law is under planning, and it may ban all the treatments or allow them in a very few cases only.

- Bojana Pinter (Slovenia) told that there are no plans to standardise the medical vs. non-medical use of ART treatments. Opinions on donations and surrogacy vary greatly.

- György Bártfai (Hungary) promised that the Hungarian data will be completed. The government reimbursements up to five cycles. The percentage of ART children is 2%.

- Evangelos Makrakis (Greece) reminded that infertility is a health problem. Child outcomes should be studied for singletons to show, if the treatment have any deteriorating effect.

- Guntar Lazdane (WHO) told that WHO has developed a tool for sexual and reproductive health rights. This has been piloted in several countries. It would be interesting to pilot the tool for ART. Israel has already notified that they are interested in the ART pilot. Perhaps some EU country is interest to make the piloting?

- Ausrute Armonaviciene (Lithuania) suggested that exact legal regulations are listed in table 18.

- Albrecht Jahn (Germany) told that in some cases couples have to be protected from aggressive marketing from private business. A quality control is needed, but also equal access to services.

- Jørn Olsen (Denmark) notified that 5% effect on fertility is 5% influence, unless the women would not become pregnant otherwise.

- Jean-Jacques Amy (Belgium) reminded that there is no information on embryo reductions. This data should be collected in all countries. Mika Gissler notified that the data is collected by ESHRE.

- Bojana Pinter (Slovenia) seconded that the equal access to ART treatment should be emphasised.
- Jan-Steffan Krussel (Germany) told that the German ART register have information on all embryo reductions. In 2006, there were round 30 cases in 60 000 cycles.

6. Induced abortion (Mika Gissler)

Mika Gissler (Finland) presented that the task was to collect information on the legislation on induced abortions in the 27 EU member states and to analyse trends in reported induced abortion rates by using national and international statistics on induced abortions. Information on legislation was taken from previous literature and confirmed from the national counterparts.

Induced abortion is available in 25 EU member states, but illegal in two countries: Ireland (excluding cases to save woman’s life) and Malta (no exemptions). Access to induced abortion is very restricted in Poland (induced abortion for indications related to fetal abnormality, serious risk to maternal health and for the pregnancy initiated by reported rape or other act of violence). Four member states require a legal indication for induced abortion. Luxembourg requires an indication related to physical and mental health. Cyprus, Finland and the United Kingdom accept also indications related to socioeconomic circumstances. 21 member states allow induced abortion on woman’s request.

Time limits on abortions on request are usually 10-14 weeks, but higher in Sweden (18 weeks) and in the United Kingdom (24 weeks). For late abortions the limit is either between 20 and 24 weeks or according to the fetal viability. Several countries have no legal upper limit.

No EU member states require spousal authorisation, but 13 countries require parental authorisation for induced abortions among minors (15-18 years).

For abortion statistics, there are no registered induced abortions in Ireland and Malta. No data was available for Austria, Cyprus and Luxembourg.

EU member states report 1.2 million induced abortions per year equalling 10.3 abortion per 1000 women aged 15-49 years. This is lower for countries with abortion on request (11.0/1 000) than countries which require legal indication (25/1 000).

Northern European EU countries have the highest induced abortion rate among teenagers, which calls for action. Central and Eastern European countries have most repeated abortions and abortions among women aged 35 or more. Access to safe abortions may have deteriorated in these countries.

Data was based on official national statistics, and their quality remains unknown. Health Information System & Public Health Reporting should cover induced abortions both nationally and internationally.

Discussion (notes by Albrecht Jahn):

- Data on obligatory waiting period and counselling should be added. Mika Gissler (Finland) replied that is included in our paper (3-7 days).

- There are reports of underreporting in Greece: 100 000 registered; 200 000-300 000 unregistered in private offices. The same could be true in Poland and Cyprus. Evangelos Makrakis (Greece) commented that the official data include induced abortions in private and private hospitals and private clinics.
- It should be noted that abortion not allowed in Isle of Man and Northern Ireland (United Kingdom) and restricted in Faroe Islands (Denmark).

- Obligatory counselling is not appropriate wording. Neither is the term “consensious objection” an appropriate term.

- Do not use “chemical abortion” instead “medical abortion”.

- Highlight problems and costs abortion tourism (e.g. use of unsafe abortion).

- It can be discussed if the term “abortion on demand” should be used instead of “on request”.

- An asterisk could be added to countries with poor data quality.

- Example on the Greek/Bulgarian border: Greek women go over the border Bulgaria because it is cheaper.

- Illegal abortion is not automatically unsafe and vice versa. Study in Lancet on safe and unsafe abortion few years back raised the concern about the validity of data on drop of abortions in Eastern Europe.

- The legislation on Luxembourg now correctly classified.

- It remains unclear if menstrual regulations are included or not. This method is available e.g. in Poland to circumvent the illegality of abortion. This “underground mechanism” works quite well. The guesses stand at 150 000 per year, but the actual number remains unknown.

7. Summing up (Miguel Oliveira da Silva)

Miguel Oliveira da Silva ended the meeting to remind that the Report is of the Project, not of the participants. It is neither the Report of European Union, but a Report for European Union. All updated or corrected information should be sent to Miguel Oliveira da Silva latest 15 May 2011.