

Teenage Pregnancy in Developed Countries: Determinants and Policy Implications

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Introduction

This article summarizes the results of a comparative study of adolescent pregnancy and childbearing in developed countries, undertaken by The Alan Guttmacher Institute (AGI). The study's main purpose was to gain some insight into the determinants of teenage reproductive behavior, especially factors that might be subject to policy changes.

A 1983 article by Charles F. Westoff, Gérard Calot and Andrew D. Foster reported that although adolescent fertility rates have been declining in the United States, as they have in virtually all the countries of Western and northern Europe, teenage fertility is still considerably higher in the United States than in the great majority of other developed countries.¹ There is a large differential within the United States between the rates of white and black teenagers. However, even if only whites are considered, the rates in the United States are still much higher than those in most of the other countries. The gap between the United States and the other countries is greater among younger adolescents (for whom the great majority of births are out of wedlock and, presumably, unintended) than it is among older teenagers. Abortion rates are also higher among U.S. teenagers than among adolescents in the dozen or so countries for which there are data.²

Two major questions were suggested by these comparisons: Why are teenage fertility and abortion rates so much higher in the United States than in other developed coun-

"[U.S.] teenagers . . . have inherited the worst of all possible worlds. . . . Movies, music, radio and TV tell them that sex is romantic, exciting, titillating. . . . Yet, at the same time, young people get the message that good girls should say no."

tries? And, since most teenage pregnancies in the United States are unintended,³ and their consequences often adverse,⁴ what can be learned from the experience of countries with lower adolescent pregnancy rates that might be useful for reducing the number of teenage conceptions in the United States?

The AGI study involved two distinct undertakings: quantitative bivariate and multivariate analyses of the factors associated with adolescent fertility in 37 developed countries, and case studies of teenage pregnancy and its antecedents in five selected countries and the United States.

The 37-Country Analysis

The two dependent variables selected for the 37-country* study were cumulative age-specific birthrates for girls under age 18 and those for women 18-19. The rates are explained in the appendix (page 61). Birthrates rather than pregnancy rates were chosen because abortion data were available for only 13 of the 37 countries. However, it was found that abortion rates and birthrates were highly correlated, so that it seemed reasonable to assume that birthrates are an acceptable proxy for pregnancy rates. Measures for 42 independent variables selected for the quantitative analysis were obtained from published data and from a country-level survey conducted by the AGI designed to supplement inadequately documented areas of information, such as the prevalence of sex education within each country, the availability of contraceptive services for minors and social attitudes that might have a bearing on adolescent sexual activity. The questionnaire was sent to the public affairs officer of the American embassy in each foreign country

included in the study, to the embassy of each of these countries in Washington, D.C., and to the family planning organization or other agency responsible for family planning services in each country.

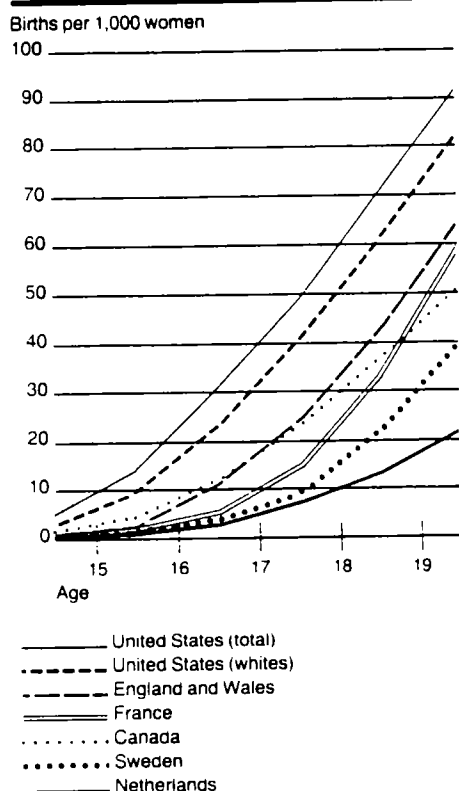
Scatter plots and pairwise relationships between each independent variable and the two dependent variables were examined initially, and on the basis of these results, a multivariate analysis was attempted. Descriptions of the methodology and of the major results of the bivariate analysis are carried in the appendix. The results of the multivariate analysis presented here have to be taken as suggestive rather than conclusive, and they are described only in broad terms.

- The analysis found a positive association between teenage childbearing and the proportion of the labor force employed in agriculture (a variable interpreted as indicating level of socioeconomic development).
- There is a positive relationship between levels of maternity leaves and benefits and the teenage birthrate. (Because the United States does not have a uniform national policy, it was not represented on this variable. In fact, U.S. maternity benefit policies tend to be less liberal than those in most European countries,⁵ and, thus, the United States would not have fit this pattern.)
- Analysis of the relationship between fertil-

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*Australia, Austria, Belgium, Bulgaria, Canada, Chile, Cuba, Czechoslovakia, Denmark, the Federal Republic of Germany, Finland, France, the German Democratic Republic, Great Britain (England and Wales; and, considered separately, Scotland), Greece, Hong Kong, Hungary, Ireland, Israel, Italy, Japan, the Netherlands, New Zealand, Norway, Poland, Portugal, Puerto Rico, Romania, Singapore, Spain, Sweden, Switzerland, Taiwan, the USSR, the United States, and Yugoslavia.

Figure 1. Births per 1,000 women under age 20, by woman's age, case-study countries, 1981



ity and openness about sex (defined on the basis of four items: media presentation of female nudity, the extent of nudity on public beaches, sales of sexually explicit literature and media advertising of condoms) in a given society reveals low birthrates in countries found to exemplify the most liberal views.

- More equitable distribution of income (i.e., a greater proportion of a country's total household income received by the poorest 20 percent of the population) is negatively related to the cumulative birthrate for girls under 18. Of the 19 countries for which this information was available, Canada, the United States and New Zealand have the least equitable distribution of income. Of these three countries, the United States has by far the highest teenage birthrate.

- The birthrate for older teenagers is lower where the minimum age for marriage is higher. (Again, the United States was not represented on this variable because the legal age at marriage varies from state to state, although in most states women can marry on their own consent by age 18.)

- Finally, the rate for older teenagers is also somewhat responsive to government policies to increase fertility.

It is notable that the United States differs from most of the countries with comparably

high adolescent fertility on four factors. The position of the United States is anomalous with regard to socioeconomic development, one of the most important factors associated with low teenage fertility. Although it is one of the most highly developed countries examined, the United States has a teenage fertility rate much higher than those observed in countries that are comparably modernized; and the U.S. rates are considerably higher than those found in a number of much less developed countries. The inconsonance applies particularly to fertility among younger teenagers, where the U.S. rate falls between those of Romania and Hungary. The relatively high adolescent birthrate in the United States would also suggest, if the experience of the United States were consistent with that of other countries, that the country has a pronatalist fertility policy, high levels of maternity leaves and benefits and a low minimum age at marriage. In fact, the United States has none of these.

The United States fits the general pattern for high teenage fertility in that it is less open about sexual matters than most countries with low teenage birthrates, and a relatively small proportion of its income is distributed to families on the bottom rungs of the economic ladder.

Had better or more complete information been available, it is likely that at least some of the additional variables found to be associated with adolescent fertility in the bivariate analysis would have retained their importance in the multivariate analysis. Certain of them deserve mention because of their policy significance and because they figure prominently in the individual country case studies that follow, for which more detailed information was available. These include restrictions placed on teenagers' access to contraception, the level of religiosity in the country (both associated with high birthrates) and teaching about contraceptives in the schools (associated with low birthrates). It is noteworthy that government subsidy of abortions is *not* associated with teenage fertility.

In the 37-country study, the United States does not appear to be more restrictive than low-fertility countries in the provision of contraceptive services to teenagers; however, comparable data could not be obtained on the provision of contraceptives free of charge or at very low cost—a factor that, as we shall see, appears to be very important in terms of accessibility in the country case studies. Teenagers are much less likely to get free or very low-cost contraceptive services in the United States than in the other five countries studied in detail—all of which have much lower adolescent birthrates and abortion

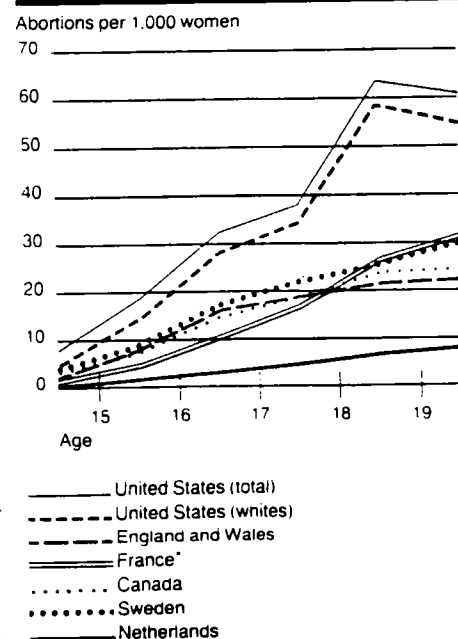
rates than the United States. The very high level of religiosity reported for the United States (the highest of any of the 13 countries for which there are data) is probably one factor underlying the low rating of the United States on openness about sex. It is also notable that the United States scores relatively low among the 37 countries on the measures of availability of contraceptive education in the schools.

Country Case Studies

The five countries selected for the case studies in addition to the United States—Canada, England and Wales, France, the Netherlands and Sweden—were chosen on the basis of three considerations: Their rates of adolescent pregnancy are considerably lower than that of the United States, and it was believed that sexual activity among young people is not very different; the countries are similar to the United States in general cultural background and stage of economic development; finally, from the investigators' experience with the first phase of the project, it was apparent that for these countries, some crucial data related to adolescent pregnancy were available.

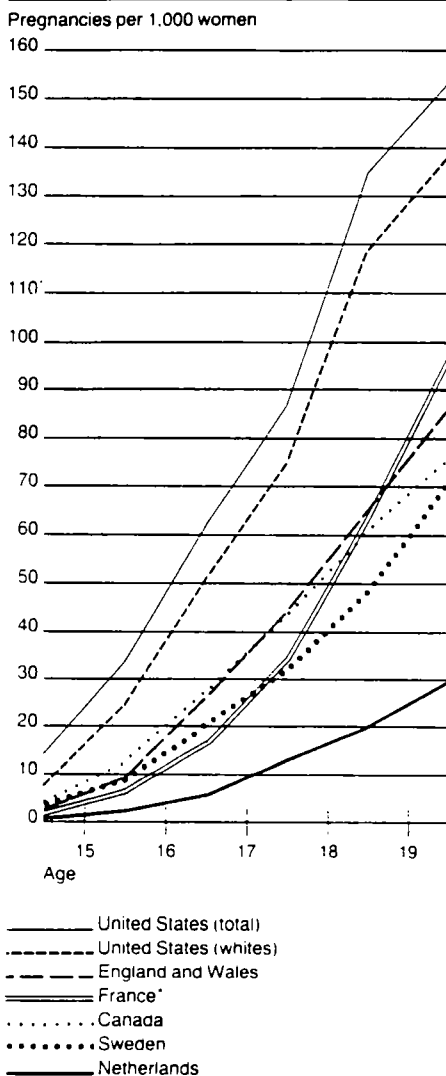
Figures 1, 2 and 3 present, for the United States and each of the five countries, 1981 birthrates, abortion rates and pregnancy rates by single year of age. The exceptional position of the United States is immediately apparent. The U.S. teenage birthrates, as Figure 1 shows, are much higher than those

Figure 2. Abortions per 1,000 women, by woman's age, 1981



*1980 data.

Figure 3. Pregnancy rates per 1,000 women by woman's age, 1981



*1980 data.

Note: Pregnancies are defined here as births plus abortions; age is the age at outcome.

of each of the five countries at every age, by a considerable margin. The contrast is particularly striking for younger teenagers. In fact, the maximum relative difference in the birthrate between the United States and other countries occurs at ages under 15. With more than five births per 1,000 girls aged 14, the U.S. rate is around four times that of Canada, the only other country with as much as one birth per 1,000 girls of comparable age.

Teenagers from the Netherlands clearly have the lowest birthrate at every age. In 1981, Dutch women aged 19 were about as likely to bear a child as were American women aged 15-16. The birthrates are also very low in Sweden, especially among the youngest teenagers. Canada, England and Wales, and France compose an intermediate group. Birthrates are relatively high for Canadian

girls aged 14-16, and rise gradually with age. The French rates are low among women up to age 18, but increase very sharply among older teenagers.

In 1981, as Figure 2 shows, the relative positions of the countries with respect to abortion are surprisingly close to the pattern observed for births. The United States has by far the highest rate, and the Netherlands, very much the lowest, at each age. French teenage abortion rates climb steeply with age,* while the Canadian curve is somewhat flatter. The rate for England and Wales rises relatively little after age 17. The chief difference between the patterns for births and abortions involves Sweden, which has age-specific abortion rates as high as, or higher than, those of any of the other countries except the United States.

The teenage pregnancy rates† necessarily follow the same pattern, as Figure 3 reveals. The U.S. rates are distinctly higher than those of the other five countries; the Dutch rates are clearly lower. The French teenage pregnancy rates appear to be low among teenagers 16 and younger, and after that age, to be high. The reverse is true of Canada.

Thus, the six countries represent a rather varied experience. At one extreme is the United States, which has the highest rates of teenage birth, abortion and pregnancy. At the other stands the Netherlands, with very low levels on all three measures. Canada, France, and England and Wales are quite similar to one another. Sweden is notable for its low adolescent birthrates, although its teenage abortion rates are generally higher than those reported for any country except the United States. It is noteworthy that the United States is the only country where the incidence of teenage pregnancy has been increasing in recent years. The increase reflects a rise in the abortion rate that has not been completely offset by a decline in the birthrate. For both younger and older teenagers, the disparity between the U.S. pregnancy rates and those for other countries increased somewhat between 1976 and 1981.

In the United States, the pregnancy rates among black teenagers are sufficiently higher than those among whites to influence the rates for the total adolescent population, even though in 1980, black teenagers represented only 14 percent of all 15-19-year-olds. Restriction of the international comparisons to pregnancy rates among white U.S. teenagers reduces the difference between the United States and other countries by about one-fifth. However, the pregnancy rate for white U.S. adolescents remains much higher than the rates for the teenage populations in the other countries, as shown in the table in the next column.

Pregnancy rate	15-19	15-17	18-19
U.S. total	96	62	144
U.S. white	83	51	129
England & Wales	45	27	75
France	43	19	79
Canada	44	28	68
Sweden	35	20	59
Netherlands	14	7	25

Denmark 25
What is more, some of the other countries studied also have minority populations that appear to have higher-than-average teenage reproductive rates (e.g., Caribbean and Asian women in England), so that it would not be appropriate to compare white U.S. rates with rates for the total adolescent population in those countries.

A common approach was established for the study of the six countries selected for close examination. Detailed information on teenage births and abortions was collected, and a systematic effort was made to assemble quantitative data on the proximate determinants of pregnancy—specifically, the proportion of teenagers cohabiting, rates of sexual activity among those not living together and levels of contraceptive practice. In addition, the investigators sought descriptive material on a number of related topics: policies and practices regarding teenage access to contraceptive and abortion services, the delivery of those services, and the formal and informal provision of sex education. Several aspects of teenage life were explored to try to enhance understanding of certain social and economic considerations that might influence the desire to bear children and contraceptive practice. These include the proportions of young people in school, employment and unemployment patterns, the move away from the family home, and government assistance programs for young people and, particularly, for young unmarried mothers.

Teams of two investigators each visited Canada, England, France, the Netherlands and Sweden for one week and conducted interviews with government officials, statisticians, demographers and other researchers, and family planning, abortion and adolescent health service providers. These interviews provided the opportunity to discuss attitudes and other less tangible factors that might not otherwise have been possible to document, and helped the investigators to identify other sources of data.

The five countries that were visited and the United States have much in common. All

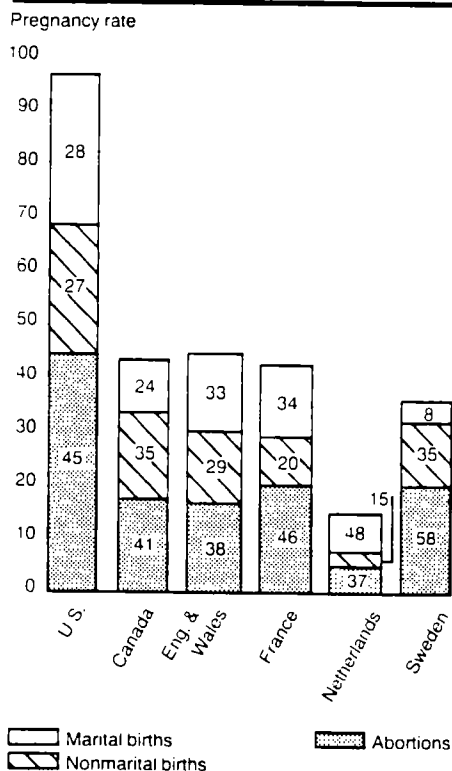
*The relatively low rates among younger teenagers may be due to underreporting at those ages in France.

†Calculated as the sum of births and abortions experienced by women of a given age divided by the midyear estimate of the female population of that age.

are highly developed nations, sharing the benefits and problems of industrialized modern societies. All belong essentially to the cultural tradition of northwestern Europe. All have reached an advanced stage in the process of demographic transition. Life expectancy is over 70 years for men and women of all the countries. Finally, all have fertility levels below that required for replacement. Yet, as Figure 3 demonstrates, teenage pregnancy rates in the six countries are quite diverse. However, the consistency of the six countries' positions in Figures 1 and 2 points to an immediate and important conclusion: The reason that adolescent birthrates are lower in the five other countries than they are in the United States is not more frequent resort to abortion in those countries. Where the birthrate is lower, the abortion rate also tends to be lower. Thus, the explanation of intercountry differences can focus on the determinants of pregnancy as the antecedent of both births and abortions.

• *The desire for pregnancy.* Are the differences in adolescent birthrates due to the fact that in some countries, higher proportions of young women choose to become pregnant? The number of marital births per 1,000 teen-

Figure 4. Percentage distribution of pregnancies, and pregnancy rates, by outcome,* for women aged 15-19, 1980/1981

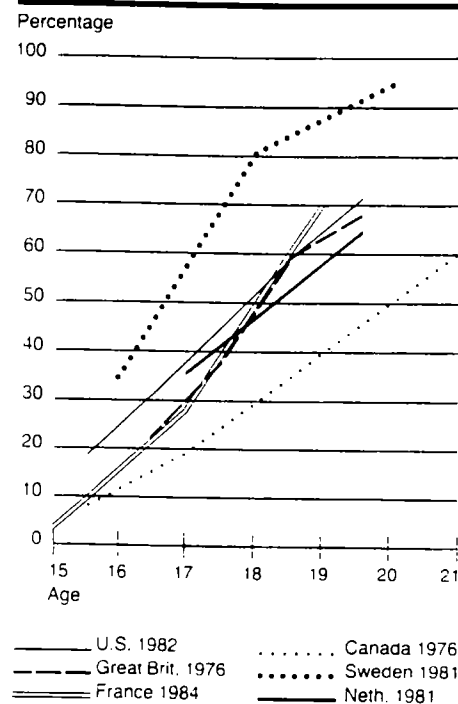


*The rates can be estimated by measuring the height of the bars against the vertical axis. The numbers inside the bars represent the percentage distributions.

agers is higher in the United States than in any other of the countries studied, and the proportion of teenagers who are married is at least twice as high in the United States as in the other countries (not shown). Data on teenagers' pregnancy intentions are available only for the United States. In 1980, 76 percent of marital teenage pregnancies and only nine percent of nonmarital teenage pregnancies were intended. On the assumption that all pregnancies ending in abortions are unintended, and that a large majority of nonmarital births are the result of unintended pregnancies (except in Sweden, where nonmarital childbearing has traditionally been free of social stigma), the distribution of pregnancy outcomes illustrated in Figure 4 sheds some light on the contribution of unintended pregnancy to the differences among the six countries. The combined fraction of all pregnancies accounted for by abortions and nonmarital births is approximately three-quarters in the United States and Canada, close to two-thirds in England and Wales and France, and only about one-half in the Netherlands. Thus, in England and Wales, France and the Netherlands, unintended pregnancy appears to constitute a smaller part of adolescent pregnancy than it does in the United States. Even more striking is the fact that the abortion rate alone in the United States is about as high as, or higher than, the overall teenage pregnancy rate in any of the other countries.

• *Exposure to the risk of pregnancy.* Figure 5 illustrates some recent findings on levels of sexual activity (defined here as the proportion who have ever had intercourse) among teenagers in the six countries. The data should be interpreted cautiously, however, as there are numerous problems of comparability and quality. (Two potentially important aspects of sexual activity among adolescents—the number of sexual partners and frequency of intercourse—could not be examined because data on them were not available for most countries.) The most striking observation from the figure is that the differences in sexual activity among teenagers in the six countries do not appear to be nearly as great as the differences in pregnancy rates. Sexual activity is initiated considerably earlier in Sweden than elsewhere. By age 16, around one-third of all Swedish girls have had intercourse, and by age 18, four-fifths have done so. In Canada, by comparison, women may have had their first sexual experience later than the average for all six countries. At ages 16-17, only one out of five girls are sexually active. Smaller proportions of women are reported as having initiated sexual intercourse before the age of 18 in both Great Britain (England, Wales and

Figure 5. Percentage of women ever having had intercourse, by age



Scotland) and France than in the United States. However, a rapid catch-up seems to take place, and in France the proportion of young women who have had intercourse by the time they are 19 appears to be higher than that found in the United States. The median age at first intercourse is very similar for the United States, France, Great Britain and the Netherlands—something under age 18—and is about a year younger in Sweden, and may be about a year higher in Canada.

These data indicate that the variation in adolescent pregnancy rates shown in Figure 3 cannot, by and large, be explained by differences in levels of sexual experience. The examples of the Netherlands and Sweden make it clear that the postponement of first intercourse is not a prerequisite for the avoidance of early pregnancy. It does seem possible that reduced sexual exposure among younger Canadian teenagers is partly responsible for keeping their pregnancy rates relatively low. The difference in pregnancy rates between the Netherlands and Sweden may also be partly attributable to the older age at sexual initiation in the Netherlands.

• *Contraceptive use.* The data on contraceptive practice, represented schematically in Figure 6, were, likewise, derived from surveys that differed widely in their design and approach to the issue.⁶ Nevertheless, it is possible to make some estimates of proportions using any contraceptive method, and proportions using the pill, at various ages.

Contraceptive use among French teenagers is probably underestimated because condom use was not included in the published results of the survey. It is likely, therefore, that the United States has the lowest level of contraceptive practice among teenagers of all six countries.

In particular, pill use appears to be less widespread among U.S. teenagers than among those in the other countries. This difference suggests that American adolescents use less effective contraceptives to avoid accidental pregnancy, even if they are using a birth control method.

• *Access to contraceptive and abortion services.* Contraceptive services appear to be most accessible to teenagers in England and Wales, the Netherlands and Sweden. In England and Wales and the Netherlands, those seeking care may choose to go either to a general practitioner (limited to their own family doctor in the Netherlands) or to one of a reasonably dense network of clinics. The Dutch clinic system is less extensive than the British one, but it is directed largely toward meeting the special needs of youth, whereas in England and Wales, there are relatively few clinics specially designed for young people. In Sweden, there are two parallel clinic systems, one consisting of the primary health care centers that serve every community, and the other consisting of a less complete network providing contraceptive care and related services to the school-age population.

Canada, France and the United States also have clinic systems, but these appear to be less accessible than those found in the other countries. (In France, however, the clinic system has expanded considerably since 1981.) The Canadian clinic system is uneven, with fairly complete coverage for adolescents in Ontario and Quebec, and scattered services elsewhere. The U.S. clinic network is reasonably accessible in a strictly geographic sense. Moreover, all family planning clinics receiving federal funds are required to serve adolescents. A basic drawback of the U.S. clinic system, however, is that it was developed as a service for the poor, and is often avoided by teenagers who consider clinics places where only welfare clients go.⁷

Condoms are widely available in England and Wales, the Netherlands and Sweden. They not only are available from family planning clinics and pharmacies, but also are sold in supermarkets and other shops and in vending machines. In France and in many parts of Canada and the United States, condoms are less freely available.

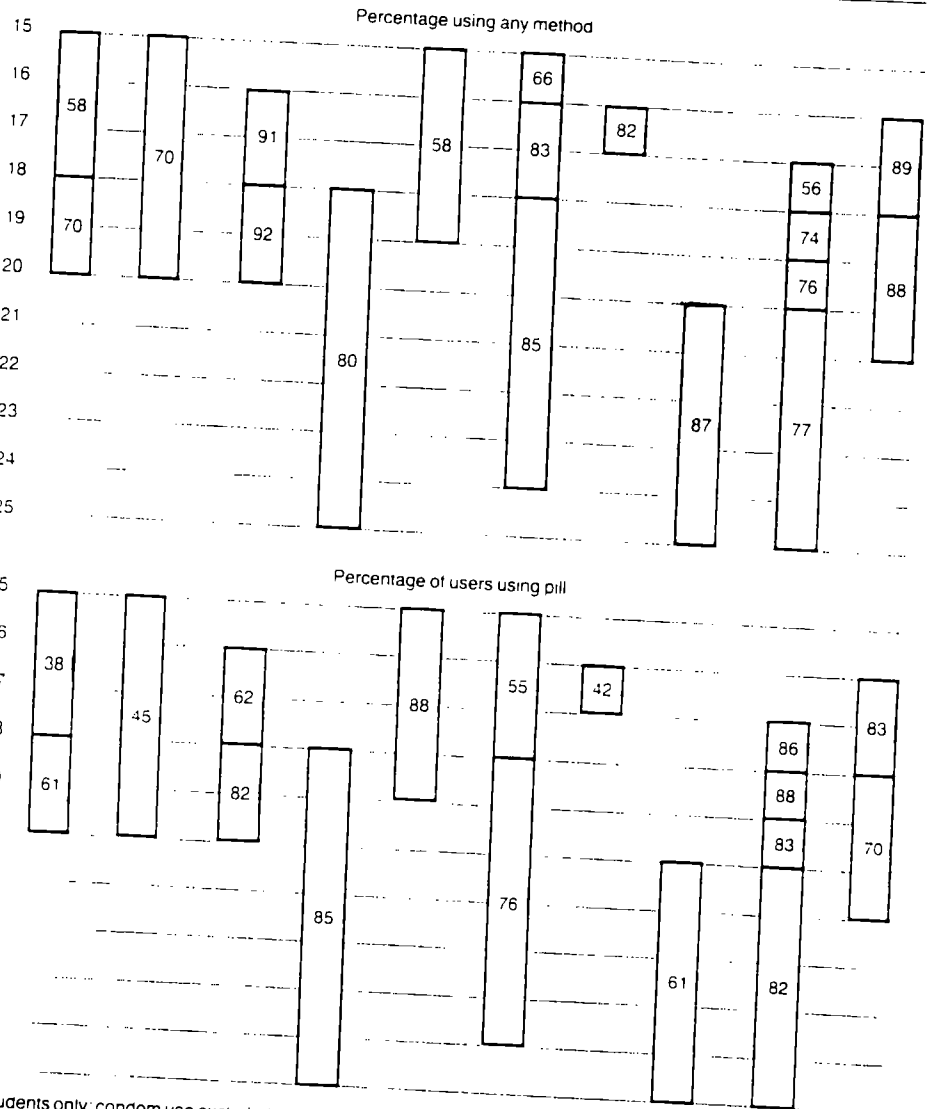
Confidentiality was found to be an important issue in every country. Even where attitudes about sex are very open, as in the Netherlands and Sweden, the research

teams were told that young people wish to keep their personal sex lives private. The need for confidential services is probably best met in Sweden, where doctors are specifically forbidden to inform parents about an adolescent's request for contraceptive services. Dutch doctors also are required to keep the visit confidential if the teenager

requests it; and the services in Dutch clinics are entirely confidential. French official policy stipulates that clinic services for women under age 18 be absolutely confidential. Although the prescription of contraceptives to girls younger than 16 without a requirement that the parents be informed is now being legally contested in Britain, the practice was

Figure 6. Percentage of sexually experienced women using any contraceptive method and, among users, percentage using the pill, by age and marital status of woman and occasion of contraceptive use

Age	United States		Great Brit.	France*		Canada	Sweden		Netherlands	
	1976	1979	1976	1979	1980	1976	1978†	1981	1979/1980	1981
	NM‡	NM‡	NM‡	T‡	T‡	T‡	T‡	T‡	T‡	NM‡
	Used at last coitus	Used at last coitus	Use currently	Use regularly	Use regularly	Use currently	Used at last coitus	Used in last 4 wks.	Used in last 6 mos.	Used at last coitus



*Students only; condom use excluded.

†Students in one city.

‡T = all women; NM = never-married women.

Notes: The data should be interpreted cautiously because of problems in their comparability and quality. As an example of how to read this figure, the data for Canada indicate that among all sexually active women, 66 percent of 15-year-olds, 83 percent of 16-17-year-olds and 85 percent of 18-23-year-olds were using some method in 1976.

followed through the period covered by this study, and the British government is seeking to preserve confidentiality for young teenagers. In Canada and the United States, many individual doctors insist on parental consent before they will provide contraceptives to minors. However, most family planning clinics in Canada and the United States provide services to young women without any such restriction.

Like all medical care, contraceptive services, including supplies, are provided free of charge to young people in England and Wales and Sweden. Free services and supplies are available from clinics to French women under age 18; and for older teenagers, most of these expenses are reimbursable under social security. Contraceptive services provided by Dutch family doctors are covered under the national health insurance scheme, but the clinics charge a small fee. Until very recently, no charge was made to have a prescription filled at a pharmacy. In Canada, doctors' services are likewise covered by national medical insurance, and clinic services are free; but all patients except those on welfare have to pay for supplies obtained from pharmacies. The potential expense of obtaining contraceptive services in the United States varies considerably. Indigent teenagers from eligible families are able to get free care through Medicaid, and others do not have to pay anything because of individual clinic policy; otherwise, clinic fees are likely to be modest. On the other hand, consulting a private doctor usually entails appreciable expense, as does purchase of supplies at pharmacies.

An additional observation concerns the central role of the pill everywhere outside the United States. In each country, the research teams were told that the medical profession accepts the pill as a highly appropriate, usually the most appropriate, method for adolescents. Moreover, a pelvic examination is not necessarily required before the pill can be prescribed in some of these countries. The emphasis on pill use emerged more clearly from the interviews than from the incomplete statistics on contraceptive use summarized in Figure 6. By contrast, in the United States, there seems to be a good deal of ambivalence about pill use, both on the part of the medical profession and among potential young users. In the United States, medical protocol requires that a pelvic examination be performed before the pill can be prescribed, a procedure some young people find daunting.⁵ Whether justified or not, this requirement undoubtedly influences method selection among young women.

Postcoital contraceptive pills have been available at many family planning clinics in

the United Kingdom for a number of years. Postcoital IUD insertion and oral contraceptives are available in the clinics run by both the Dutch and the French family planning associations. However, it is unlikely that these methods are sufficiently widely utilized to influence the birthrate appreciably. In Sweden, the morning-after pill is not yet permitted for general use. The federal Food and Drug Administration has not approved postcoital use of pills in the United States, and no plan exists to market them, but they are available in some college health clinics and rape treatment centers.

Geographically, abortion services are most easily accessible in the Netherlands and Sweden. Although services are theoretically in place throughout England and Wales and France, wide differences in the abortion rates by area are believed to be attributable to variation in the availability of abortion facilities. In all three countries, as in Canada and the United States, services are likely to be found in cities. In Canada, England and Wales, and France, abortions typically involve at least an overnight hospital stay.

In Sweden, there is no charge for abortion; Canadian women usually pay only a small portion of the cost; and abortions obtained under the national health service in Britain are also free. However, because of bureaucratic delays in the national health service, almost half of British women choose to pay for an abortion in the private sector. In the Netherlands, the cost of an abortion is borne by the patient but is not high. The same was true in France up until 1982, when the service became free. Most U.S. women must pay for the abortion procedure themselves. For a second-trimester abortion, in particular, the cost may be substantial.

• *Sex education.* Sweden has the distinction of being the first country in the world to have established an official sex education curriculum in its schools. The curriculum, which is compulsory and extends to all grade levels, gives special attention to contraception and the discussion of human and sexual relationships. Perhaps most important, there is a close, carefully established link in Sweden between the schools and contraceptive clinic services for adolescents. None of the other countries comes close to the Swedish model. Sweden established this link in 1975, following liberalization of the abortion law, because of concern that liberalized abortion access might otherwise result in a sharp rise in teenage abortion rates. In fact, adolescent abortion rates have declined dramatically since 1975, whereas the rates for adults have not changed much. (In the other countries studied, teenage abortion rates have not fallen during this period.) The Swedish authorities

credit the combination of sex education with the adolescent clinic program for the decline.

In Canada, England and Wales, and the United States, school sex education is a community option, and it is essentially up to the local authorities, school principals or individual teachers to determine how much is taught and at what age. In England and Wales, however, there is a national policy favoring the inclusion of topics related to sex and family life in the curriculum, whereas there is no such national policy in Canada and the United States. French policy now mandates broad coverage of sexuality for all adolescents, although in practice, interpretation of this provision similarly devolves on local decision-makers.

The Netherlands is a case apart. Coverage of sex in the school curriculum is limited on the whole to the facts of reproduction in natural science classes. The Dutch government, nevertheless, encourages the teaching of contraception indirectly by subsidizing mobile educational teams that operate under the auspices of the private family planning association. At the same time, in recent years there has been an explosion of materials on contraception and other sex-related topics in the media, much of which is of a responsible and informative nature. Youth surveys show that knowledge of how to avoid pregnancy appears to be virtually universal.

In Sweden, sex education is completely accepted by the vast majority of parents, most of whom themselves had sex education while they were in school. Objections are confined to the immigrant community, for some of whom sex education represents a direct challenge to their own traditions. British law requires schools offering sex education to notify the parents. In the United States, many of the school districts that provide sex education give parents the option of excusing their children from such courses.

The Wider Context

Consideration was given to a number of other social, economic and political factors that appear to be related to the phenomenon of adolescent pregnancy. The investigators who visited the four European countries were struck by the fact that in those countries, the government, as the main provider of preventive and basic health services, perceives its responsibility in the area of adolescent pregnancy to be the provision of contraceptive services to sexually active teenagers. This commitment to action and the enunciation of an unambiguous social policy appear to be associated with a positive public climate surrounding the issue. Teenage childbearing is viewed, in general, to be undesirable, and broad agreement exists that teenagers re-

quire help in avoiding pregnancies and births.

Another aspect of government involvement in and commitment to contraceptive services for teenagers has to do with the rationale for such programs. In France, the Netherlands and Sweden, the decision to develop such services was strongly linked to the desire to minimize abortions among young people. In France and the Netherlands, for example, conservative medical groups had shown some reluctance to endorse the provision of contraceptives to young, unmarried women. Apparently, the alternative of rising abortion rates among teenagers helped to persuade them that such services were justified. In Sweden, the connection was made explicit by the government, and the 1975 law that liberalized abortion also laid the groundwork for the development of contraceptive services for young people, with the specific understanding that prevention of the need for abortion could best be achieved by putting safe, effective, confidential services within the reach of all teenagers. In the United States, in contrast, some powerful public figures reflect the view that the availability of contraceptive services acts as an incitement to premarital sexual activity and claim, therefore, that such services actually cause an increase in abortions.

The use of contraceptive services is obviously made simpler in the European countries, as in Canada, by the fact that medical services of all kinds are easily accessible through national health programs, and teenagers, in particular, grow up accustomed to using public health facilities or to visiting their local general practitioner as a matter of course. This combination of ease of accessibility and familiarity with the health care system probably serves to remove many of the social, psychological and financial barriers to contraceptive services experienced by young people in the United States.

There seems to be more tolerance of teenage sexual activity in the European countries visited than there is in most of the United States and in parts of Canada. Such acceptance of adolescent sexuality is unremarkable in a country like Sweden, with its long history of support for sexual freedom, and the absence there of taboos against premarital sex. However, such acceptance represents a considerable break with traditional standards in the Netherlands, France and, in Canada, Quebec. One reason for the more successful experience of the European countries may be that public attention was generally not directly focused on the morality of early sexual activity but, rather, was directed at a search for solutions to prevent increased teenage pregnancy and childbearing.

In the United States, sex tends to be treated as a special topic, and there is much ambivalence: Sex is romantic but also sinful and dirty; it is flaunted but also something to be hidden. This is less true in several European countries, where matter-of-fact attitudes seem to be more prevalent. Again, Sweden is the outstanding example, but the contrast with the United States was evident in most of the countries visited. Survey results tend to bear out this impression, although the questions asked are not directly comparable from country to country. For instance, in 1981, 76 percent of Dutch adults agreed with the statement that "sex is natural—even outside marriage," whereas in 1978, only 39 percent of Americans thought premarital sex was "not wrong at all."⁹ These observations tend to confirm the findings of the 37-country study, which found that openness about sex may be an especially important factor in lowering adolescent fertility.

While the association between sexual conservatism and religiosity is not automatic, in the case of the United States the relationship appears to be relatively close. The proportion of the population who attend religious services and feel that God is important in their lives is higher in the United States than in the other case-study countries.¹⁰ Although England and Wales and Sweden have an established church, both countries are more secular in outlook than the United States. Moreover, in the Netherlands, France and Quebec Province, increasing secularization is believed to be an important aspect of recent broad social changes. Fundamentalist groups in America are prominent and highly vocal. Such groups often hold extremely conservative views on sexual behavior, of a sort rarely encountered in most of Western Europe. Both the nature and the intensity of religious feeling in the United States serve to inject an emotional quality into public debate dealing with adolescent sexual behavior that seems to be generally lacking in the other countries. It is notable that religiosity was found to correlate highly with adolescent fertility in the 37-country study, although the number of country observations was small.

Although all six countries included in the survey are parliamentary democracies, the nature of each country's political institutions differs, and there is considerable variation in the way in which public issues are developed and public policies formulated. The U.S. political system appears to foster divisiveness and confrontation at many levels of society, while these elements seem less salient a part of political life in the other countries. In addition, the United States is distinguished by the widespread use of private funds to mount political campaigns and create myriad pres-

sure groups. While the American confrontational style may have its political uses, it makes the resolution of certain emotionally charged issues hard to achieve. Positions tend to become polarized, and the possibilities for creative compromise are narrowed. The most interesting country to contrast with the United States, in terms of political style, is probably the Netherlands. It has strong and diverse religious and political groups, but a complex range of formal and informal conventions exists to defuse and resolve ideological conflicts before these emerge into the open. As a result, through accommodation and negotiation, the Dutch administrations of all political tendencies have, in the past 15 years or so, been able to make birth control services available to teenagers without exacerbating divisions in the society.

Directly related to this issue is the fact that with the exception of Canada, the United States is a much larger country than any of the others, in terms of both its geographic and its population size. In smaller, more compact countries, where lines of communication are more direct, it is easier than in the United States to engage in a national debate that includes all the appropriate parties to the discussion. For example, in the early 1960s, debate within the Dutch medical community over the advisability of prescribing the pill to teenagers quickly resulted in a broad consensus. A similar process would be much harder to implement in the United States. As a result, informing concerned professionals about the terms of a debate may be as hard as keeping the general population up to date on any issue.

Another closely related facet of national life is the extent to which political and administrative power is concentrated in the national government. France is often cited as the epitome of a centralized state, and even the existence of two "nations" within England and Wales is a simple arrangement compared with the federal systems of Canada and the United States. Both countries have two-tiered government structures, with some powers delegated to the central government and some reserved to the provinces or states. This structure has two main consequences: First, major differences can develop within the country in policy-making. Second, the task of giving shape to social change, in terms of public policies and programs, becomes enormously complicated because of the many bureaucracies that must be dealt with and the sometimes indeterminate boundaries of their separate jurisdictions.

Many observers from different backgrounds have suggested that early teenage childbearing in the United States is a response to social anomie and to a sense of

hopelessness about the future on the part of large numbers of young people growing up in poverty. In the course of the country visits, the investigators collected information on teenage education and employment patterns, in order to explore further the possible association between career and life opportunities for young people and their attitudes toward reproductive planning. The finding was that educational opportunities in the United States appear to be as great as, or greater than, those in other countries, except, possibly, Sweden. In Sweden, about 85 percent of young people aged 18-19 are pursuing academic or vocational schooling. In Canada and France, most young people leave school at around 18, as they do in the United States, although a higher proportion of U.S. students go on to college. However, in the Netherlands, only about half of girls are still in school at age 18, while in England and Wales, the majority of young people end their full-time schooling at age 16.

The employment situation is difficult to compare or assess, since definitions of labor-force participation and unemployment differ from country to country. The most that can be concluded is that unemployment among the young is considered a very serious problem everywhere, and young people themselves are universally uneasy on this score. The chances of getting and keeping a satisfying or well-paying job do not appear to be worse in the United States than in other countries. To a greater extent than in the United States, however, all the other countries offer assistance to ease the problem, in the form of youth training, unemployment benefits and other kinds of support.

It is often suggested that in the United States the availability of public assistance for unmarried mothers creates a financial incentive for poor women, especially the young, to bear children outside of marriage. Yet, all the countries studied provide extensive benefits to poor mothers that usually include medical care, food supplements, housing and family allowances. In most cases, the overall level of support appears to be more generous than that provided under the Aid to Families with Dependent Children program in the United States. Benefits in the other countries tend to be available regardless of women's marital or reproductive status, although in England and Wales and in France, at least, special supplementary benefit programs for poor single mothers also exist. In those countries, however, the existence of considerable financial support for out-of-wedlock childbearing does not appear to stimulate adolescent birthrates or explain the differences between their rates and the U.S. rates.

The final difference between the United

States and the other countries that may be relevant to teenage pregnancy concerns the overall extent and nature of poverty. Poverty to the degree that exists in the United States is essentially unknown in Europe. Regardless of which way the political winds are blowing, Western European governments are committed to the philosophy of the welfare state. The Dutch and the Swedes have been especially successful in achieving reasonably egalitarian societies, but even in England and Wales and France, the contrast between those who are better off and those who are less well off is not so great as it is in the United States. In every country, when respondents were pressed to describe the kind of young woman who would be most likely to bear a child, the answer was the same: adolescents who have been deprived, emotionally as well as economically, and who unrealistically seek gratification and fulfillment in a child of their own. Such explanations are also given in the United States, but they tend to apply to a much larger proportion of people growing up in a culture of poverty. No data are available that would have made it possible to examine adolescent pregnancy in terms of teenagers' family income. However, as noted earlier, the 37-country study found that more equitable distribution of household income is associated with lower teenage fertility—at least among the younger teenagers.

Policy Implications

The 37-country study and the individual country studies provide convincing evidence that many widely held beliefs about teenage pregnancy cannot explain the large differences in adolescent pregnancy rates found between the United States and other developed countries: Teenagers in these other countries apparently are *not* too immature to use contraceptives consistently and effectively; the level and availability of welfare services does *not* seem correlated with higher adolescent fertility; teenage pregnancy rates are *lower* in countries where there is *greater* availability of contraceptive services and of sex education; levels of adolescent sexual activity in the United States are not very different from those in countries with much *lower* teenage pregnancy rates; although the teenage pregnancy rate of American blacks is much higher than that of whites, this difference does not explain the gap between the pregnancy rates in the United States and the other countries; teenage unemployment appears to be at least as serious a problem in all the countries studied as it is in the United States; and American teenagers have more, or at least as much, schooling as those in most of the countries studied.

The other case-study countries have more extensive public health and welfare benefit systems, and they do not have so extensive and economically deprived an underclass as does the United States.

Clearly, then, it is possible to achieve lower teenage pregnancy rates even in the presence of high rates of sexual activity, and a number of countries have done so. Although no single factor has been found to be responsible for the differences in adolescent pregnancy rates between the United States and the other five countries, is there anything to be learned from these countries' experience that can be applied to improve the situation in the United States?

A number of factors that have been discussed here, of course, are not easily transferable, or are not exportable at all, to the United States: Each of the other five case-study countries is considerably smaller, and all but Canada are more compact than the United States—making rapid dissemination of innovations easier; their populations are less heterogeneous ethnically (though not so homogenous as is commonly assumed—most have substantial minority nonwhite populations, usually with higher-than-average fertility); religion, and the influence of conservative religious bodies, is less pervasive in the other countries than it is in the United States; their governments tend to be more centralized; the provision of wide-ranging social and welfare benefits is firmly established, whether the country is led by parties labeled conservative or liberal; income distribution is less unequal than it is in the United States; and constituencies that oppose contraception, sex education and legal abortion are not so powerful or well funded as they are in the United States.

Some factors associated with low pregnancy rates that *are*, at least theoretically, transferable receive varying levels of emphasis in each country. For example, school sex education appears to be a much more important factor in Sweden than it is in the other countries; a high level of exposure to contraceptive information and sex-related topics through the media is prominent in the Netherlands; condoms are more widely available in England, the Netherlands and Sweden. Access to the pill by teenagers is probably easiest in the Netherlands.

On the other hand, although initiation of sexual activity may begin slightly earlier in the United States than in the other countries (except for Sweden), none of the others have developed official programs designed to discourage teenagers from having sexual relations—a program intervention that is now advocated and subsidized by the U.S. government. The other countries have tended to

leave such matters to parents and churches or to teenagers' informed judgments.

By and large, of all the countries studied, Sweden has been the most active in developing programs and policies to reduce teenage pregnancy. These efforts include universal education in sexuality and contraception; development of special clinics—closely associated with the schools—where young people receive contraceptive services and counseling; free, widely available and confidential contraceptive and abortion services; widespread advertising of contraceptives in all media; frank treatment of sex; and availability of condoms from a variety of sources. It is notable that Sweden has *lower* teenage pregnancy rates than have all of the countries examined, except for the Netherlands, although teenagers begin intercourse at earlier ages in Sweden. It is also noteworthy that Sweden is the only one of the countries observed to have shown a rapid decline in teenage abortion rates in recent years, even after its abortion law was liberalized.

The study findings point to several approaches observed in countries other than Sweden that also might help reduce teenage pregnancy rates in the United States. These include upgrading the family planning clinic system to provide free or low-cost contraceptive services to *all* teenagers who want them, and publicizing the fact that these services are not limited to the poor; establishment of special adolescent clinics, including clinics associated with schools, to provide confidential contraceptive services as part of general health care; encouraging local school districts to provide comprehensive sex education programs, where possible, closely integrated with family planning clinic services; relaxation of restrictions on distribution and advertising of nonprescription contraceptives, especially the condom; dissemination of more realistic information about the health benefits, as well as the health risks, of the pill; and approval of the use of postcoital methods.

In sum, increasing the legitimacy and availability of contraception and sex education (in its broadest sense) is likely to result in declining teenage pregnancy rates. That has been the experience of many countries of

Western Europe, and there is no reason to think that such an approach would not also be successful in the United States.

Admittedly, application of any of the program and policy measures that appear to have been effective in other countries is more difficult in the United States nationally, where government authority is far more diffused. But their application may, in fact, be as easy or easier in some states and communities. Efforts need to be directed not just to the federal executive branch of government, but to Congress, the courts, state legislatures, local authorities and school superintendents and principals—as well as to families and such private-sector and charitable enterprises as insurance companies, broadcast and publishing executives, church groups and youth-serving agencies.

Among the most striking of the observations common to the four European countries included in the six-country study is the degree to which the governments of those countries, whatever their political persuasion, have demonstrated the clear-cut will to reduce levels of teenage pregnancy. Pregnancy, rather than adolescent sexual activity itself, is identified as the major problem. Through a number of routes, with varying emphasis on types of effort, the governments of those countries have made a concerted, public effort to help sexually active young people to avoid unintended pregnancy and childbearing. In the United States, in contrast, there has been no well-defined expression of political will. Political and religious leaders, particularly, appear divided over what their primary mission should be: the eradication or discouragement of sexual activity among young unmarried people, or the reduction of teenage pregnancy through promotion of contraceptive use.

American teenagers seem to have inherited the worst of all possible worlds regarding their exposure to messages about sex: Movies, music, radio and TV tell them that sex is romantic, exciting, titillating; premarital sex and cohabitation are visible ways of life among the adults they see and hear about; their own parents or their parents' friends are likely to be divorced or separated but involved in sexual relationships. Yet, at the same time, young people get the message good girls should say no. Almost nothing that they see or hear about sex informs them about contraception or the importance of avoiding pregnancy. For example, they are more likely to hear about abortions than about contraception on the daily TV soap opera. Such messages lead to an ambivalence about sex that stifles communication and exposes young people to increased risk of pregnancy, out-of-wedlock births and abortions.

Appendix

Two criteria were applied in defining "developed" countries for the statistical analysis in the 37-country study: a total fertility rate of less than 3.5 children per woman, and a per capita income level of over \$2,000 a year. A population size boundary of at least one million was also imposed. Three of the 40 countries that qualified for inclusion—Argentina, Trinidad and Tobago, and Uruguay—were dropped from the analysis because they had no recent data on teenage fertility. Cuba was included despite the fact that no per capita income data were available. Where possible, England and Wales were treated as a separate country from Scotland. It should be stressed that the final group of 37 countries constitute a universe rather than a sample, so that statistical inferences based on sampling theory cannot be made from the findings.

Initially, eight dependent variables* involving teenage birthrates and pregnancy rates were selected for consideration, allowing for the varying coverage and precision of the data. Since the correlation coefficients† among these eight variables suggested that the relationship between birthrates and pregnancy rates was quite close—and pregnancy rates were available for fewer than two-fifths of the countries—cumulative birthrates for girls under 18 and for women 18–19 were finally chosen as dependent variables. These were formed by summing the single-year age-specific birthrates across each of the two age spans.

Almost 100 independent variables were initially considered for inclusion in the 37-country study. However, high-quality data for sufficient numbers of countries were not always available, making it necessary to reduce the final number to 42.

A few caveats about the quality of the data used in the bivariate analysis are also in order. It is not possible to tell whether a low correlation indicates the absence of a relationship or is due to shortcomings in the data. In many instances, the measures available are only rough approximations of the concept they were intended to represent, and even though a number of other potential variables were excluded because the data were not comparable from country to country, more subtle forms of noncomparability no doubt remain. In addition, the variables derived from the AGI country survey must be regarded as subject to a considerable margin of error, since they represent informed observation rather than quantitative fact.

It was decided to exclude from the multivariate analysis variables for which 18 or fewer country observations were available and those having a correlation coefficient of less than 0.3 with both dependent variables.

*These were the birthrate for women aged 15–19; cumulative birthrates for women under 20, for women less than 18, and for women 18–19; the pregnancy rate for women aged 15–19; and cumulative pregnancy rates for women 15–19, for women under 20, for women less than 18 and for women 18–19.

†The calculation was made only for the countries for which data on adolescent abortion rates were available: Canada, Czechoslovakia, Denmark, England and Wales, Finland, France, Hungary, the Netherlands, New Zealand, Norway, Scotland, Sweden and the United States.

Appendix Table 1. Zero-order correlations between the independent variables and the cumulative birthrates for women under age 18 and women aged 18-19

Variable	Cumulative birthrate		N
	Women < 18	Women 18-19	
Marriage			
Proportion of females married at ages 15-19	0.83	0.84	37
Minimum age for marriage without parental consent	-0.33	-0.39	24
Childbearing			
Five-year total fertility rate for ages ≥20	0.06	0.13	37
Policy to raise fertility	0.25	0.36	35
Liberal policy on maternity leaves and benefits	0.45	0.58	28
Proportion of gov't expenditure on income maintenance and family allowances	-0.19	0.09	17
Paternal financial support (Q)	0.07	0.21	31
Contraception			
Proportion of all currently married using the pill	-0.18	-0.17	20
Proportion of all currently married using condoms	-0.63	-0.58	13
Policy to provide contraceptives for young, unmarried women (Q)	-0.46	-0.44	36
Favorable policy on teaching contraception (Q)	-0.21	-0.06	37
Proportion of female students taught about contraception (Q)	-0.31	-0.17	36
Age at which contraception is taught (Q)	0.12	0.17	28
Abortion			
Abortions per woman 15-44*	0.67	0.77	24
Parental consent for abortion not required (Q)	0.01	-0.04	33
Public funding of abortions (Q)	0.05	0.26	29
Sex			
Open about sex (Q)	-0.50	-0.51	37
Minimum age for consensual intercourse† (Q)	0.30	0.24	34
Proportion of female students in coeducational schools (Q)	-0.00	0.04	36
Health			
Population per physician	0.12	0.05	34
Maternal mortality	0.43	0.51	35
Per capita gov't expenditure on health care	-0.13	-0.11	19
Education			
Proportion of secondary-school-age females attending school	-0.13	-0.27	31
Proportion of females 15-19 attending school	-0.20	-0.12	14
Per capita gov't expenditure on education	-0.44	-0.38	18
Social integration			
Total marital divorce rate	-0.26	-0.27	19
Mortality rate from liver cirrhosis	0.34	0.35	34
Incidence of suicide at ages 15-24	-0.17	-0.15	30
Proportion foreign-born	-0.35	-0.28	19
General social conditions			
Log of population density	-0.18	-0.13	35
Proportion in cities with populations ≥500,000	-0.12	-0.32	34
Proportion of labor force in agriculture	0.60	0.66	34
Religiosity	0.66	0.67	13
Employment			
Labor-force participation rate for females 15-19	0.28	0.11	15
Labor-force participation rate for males 15-19	0.11	0.02	15
Proportion of labor force female	0.22	0.39	33
Labor-force participation rate for females 35-44	0.35	0.42	18
Overall unemployment rate†	0.15	0.16	27
General economic conditions			
Gross national product per capita	-0.51	-0.61	33
Average annual growth in gross domestic product	-0.16	-0.11	28
Proportion of total household income distributed to top 10% of population	0.06	0.00	14
Proportion of total household income distributed to bottom 20% of population	-0.41	-0.14	19

*Excluding Japan.

†Excluding Puerto Rico.

Note: Q=comes from the AGI country questionnaire.

Appendix Table 1 shows the correlations between the two dependent and 42 independent variables. The latter are grouped under headings intended to indicate in a general way the nature of their possible link to adolescent fertility. The variables associated with low adolescent birthrates (ranked according to degree of correlation) are GNP per capita; openness about sex; a government policy to provide contraceptives to young, unmarried women; a high proportion of household income distributed to the bottom 20 percent of the population; a high proportion of the population foreign-born (the last two for younger teenagers only); a high minimum age at marriage without parental consent; a high percentage of women taught about contraception in the schools (for younger teenagers only); and a high percentage of the population living in large cities (for older teenagers only).

Associated with high teenage birthrates are a high percentage of the labor force engaged in agriculture; a generous policy of maternity leaves and benefits; high levels of maternal mortality; a government policy to raise fertility; a high proportion of the labor force composed of women (the last two for older teens only); a high rate of mortality from liver cirrhosis—a proxy for alcoholism; and a high minimum age for consensual intercourse (for younger teenagers only).

Two variables with high correlation coefficients and for which 19 or more country observations were available were not used for the multivariate analysis because of their special status as intermediate variables closely correlated with birthrates. These were the proportion of females married at ages 15-19 and the abortion rate for women aged 15-44.

High correlation coefficients were obtained for the variables proportion of married women whose partner used condoms (negative) and the level of religiosity in the country (positive), but too few countries had this information to meet the requirement for inclusion in the multivariate analysis.

The multivariate analysis was based primarily on ordinary least-squares regression. The approach taken was determined by the need to minimize the problems associated with very small sample size and the substantial amount of missing data. First, step-wise procedures were used to identify the three independent variables having the greatest impact on each dependent variable, and then the remaining independent variables were added one at a time to assess how much variation each of them could explain over and above that accounted for by the initial three. A brief discussion of the results of the multivariate analysis can be found in the text (see pages 53-54).

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The Availability of Reproductive Health Services From U.S. Private Physicians

By Margaret Terry Orr and Jacqueline Darroch Forrest

Summary

Data on the provision of seven types of reproductive health care were collected from private physicians in four specialties: general/family practitioners (GP/FPs), general surgeons, obstetrician-gynecologists and urologists. All ob-gyns, and eight in 10 GP/FPs, provide the pill, IUD or diaphragm. Over nine in 10 ob-gyns provide infertility and obstetric care and prenatal genetic screening; but only one-third or fewer of GP/FPs do so. Ob-gyns and urologists are far more likely to perform sterilizations than are GP/FPs and surgeons (nine in 10, compared with one-fifth to one-half). Although ob-gyns are the most likely to perform abortions, only four in 10 do so.

Among ob-gyns who do not perform tubal sterilizations or abortions, and among urologists who do not perform vasectomies, the primary reason is moral or religious objections (reported by 59-71 percent). For GP/

Nine in 10 of the doctors surveyed provide contraceptive services; about half deliver babies and offer help to the infertile; four in 10 perform sterilizations; but only one in 10 of these physicians perform any abortions.

FPs and surgeons who do not perform the three procedures, the leading reason is that they do not perform surgery or that type of surgery; however, 34 percent of nonproviders in these specialties report moral or religious opposition to abortion.

Eight in 10 ob-gyns will provide contraceptives to minors without parental consent, but only six in 10 GP/FPs will do so. One-half of doctors who perform female sterilizations, and eight in 10 of those who do vasectomies, require spousal consent. Among those who perform abortions, half require parental consent for minors.

Access to private reproductive health care is quite limited for the poor, because many physicians will not accept Medicaid reimbursements or reduce their fees for low-income patients. Only 50 percent of physicians in the relevant specialties offer contraceptive services to Medicaid patients, and 29 percent or fewer offer other types of services. Only 1-15 percent will serve the poor at reduced fees.

Introduction

Like other medical services in the United States, reproductive health care services are delivered primarily through the private sector rather than through publicly subsidized facilities. An estimated 67 percent of women who use medically prescribed contraceptives (oral contraceptives, IUDs and diaphragms) rely for those services on physicians in private practice,¹ as do 96 percent of men and 90 percent of women who undergo sterilization.² Ninety-seven percent of abortions are performed in private facilities.³ Private physicians undoubtedly deliver most of the babies born in this country (though precise data are not available),⁴ and provide most of the care for infertility problems.⁵

Nevertheless, little is known about the extent to which private physicians provide specific reproductive health services, and about the conditions under which they provide them. Research and public policy have focused primarily on the funding and delivery of contraceptive services through the public

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United States and Denmark: Different Approaches to Health Care and Family Planning

Henry P. David, Janine M. Morgall, Mogens Osler, Niels K. Rasmussen,
and Birgitte Jensen

The findings of this study suggest that, compared to the United States, Danish health care policies and family planning services delivery systems are, in the aggregate, more conducive to the promotion of effective contraceptive practice, more instrumental in conveying information to high-risk groups, and more successful in reducing the incidence of unintended pregnancies and induced abortions. One of the major reasons for this difference may stem from the positive and nonambivalent climate of public opinion about sexuality in Denmark and the manner in which health care and family planning services are delivered to all segments of the population regardless of age, income, or location of residence. Research in reproductive behavior is greatly facilitated by the existence of automated population registers. (STUDIES IN FAMILY PLANNING 1990: 21, 1: 1-19)

Unwanted pregnancy is a particularly serious social and public health problem in the United States. Despite declining birth rates since 1970, adolescent pregnancy, abortion, and childbearing have remained considerably higher in the United States than in the majority of other developed countries, even though age of sexual debut and rates of early sexual activity are comparable (see, for example, Westoff et al., 1983; Hayes, 1987; United Nations, 1988, Westoff, 1988). The legal abortion rate among US teenagers is also higher than that of any other developed country reporting such data (see Tietze and Henshaw, 1986). Data from the 1983 National Survey of Unmarried Women indicate that among sexually active never-married American women aged 20-29, 85

percent of first pregnancies were unwanted at time of conception. Less educated women and those living in poorer socioeconomic circumstances were least vigilant in their contraceptive practice (Tanfer and Horn, 1985). In terms of public health policy perspectives, it may well be timely to note comparisons between experience from the United States and Denmark, a culturally comparable country with a quite different public perception of and policy approach to sexuality, health care, and family planning services delivery.

Why Denmark?

Social scientists have long held that trends in Northern Europe tend to foreshadow developments in the United States (see, for example, Rossi and Sitaraman, 1988). Denmark was selected as a suitable country for comparison because Danish policy on reproduction and family planning has evolved on the basis of adapting legislation to the perceived needs of the population without promoting either growth or reduction (DANIDA, 1984). If there is a central focus, it is on the prevention of unwanted pregnancies and on the provision of accessible contraceptive services to all residents regardless of age or income. Women can obtain contraceptive services from family practitioners, who are generally more accessible than specialists in obstetrics/

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gynecology. Costs of family planning services and abortion are covered under national health insurance. Information and education programs consistently promote responsible sexual behavior, the practice of effective contraception, and prevention of unwanted pregnancies (Osler et al., 1990).

As in any transnational study, questions about generalizability and transferability of experience arise. The US population dwarfs the more ethnically homogeneous population of 5.1 million Danes (with a small minority of immigrants from non-Nordic countries). An independent kingdom with about 1,000 years of recorded history, Denmark, like the United States, is a parliamentary democracy, an economically highly advanced, consumer-oriented society, and a NATO member (Andersen, 1987; Manniche, 1989b). The compactness of the country facilitates rapid information dissemination. With social and welfare benefits more firmly established, and a much higher taxation rate, income distribution is not as inequitable as in the United States. In both countries, the educational process extends through the teen years, the status of women has steadily advanced, and the population is increasingly urbanized. In Denmark, however, secularization is further advanced and there is no government program designed to promote abstinence among adolescents. Fundamentalist and orthodox religious beliefs, often puritanical in nature, play a minor role in Danish public policy formation and private life.

Differential patterns of fertility are similar, with increasing postponement of first births, low adult fertility, and a decrease in families with three or more children (Hansen, 1988; Matthiesen, 1988; Monnier, 1988). The long decline in marriages bottomed in the early 1980s. Marriage-like cohabitation continues to increase gradually (18 percent of all unions in 1985) (Manniche, 1989b). One consequence has been the social acceptability of births to unmarried women (Manniche, 1986a, 1989b). Although almost 44 percent of all live births in 1986 were nonmarital, 93 percent were delivered by women who had the same address as the child's father; only 1 percent of married mothers and 10 percent of unmarried mothers said they did not live with the father (Sundhedsstyrelsen, 1986c). In the United States, it was estimated that in 1982 about 6 percent of all unmarried women 15-44 were cohabiting. They were more likely to practice contraception than noncohabitants (Bachrach, 1987), a situation similar to that believed to prevail in Denmark.

Research on reproductive behavior in Denmark is greatly facilitated by the existence of an automated population registration system (Lunde, 1980; Verhoef and van de Kaa, 1987). "Person numbers" are assigned

at birth or within five days when entering Denmark on a visa other than a tourist visa. Danes are used to providing their individual number for multiple purposes, especially in relation to health and social services, all of which are free but must be recorded. Research data derived from computer linkages are usually available only in the form of aggregate statistical reports carefully designed to protect individual privacy and confidentiality. Examples of register-based research include reports on repeated abortion (Somers, 1977), post-abortion, and postpartum admissions to psychiatric hospitals (David et al., 1981), and the ongoing longitudinal study of the fertility careers of all Danish women born in 1959 and in 1964 (David et al., 1990).

Climate of Public Opinion

United States

The US mass media reflect, as well as form, an ambivalent climate of public opinion about sexuality and its expression. Frequent allusions to sexual intercourse occur in entertainment programming, and sexual innuendo is often used to attract attention in advertising. While the amount of explicit sexual content in television programs has increased since the late 1970s (Harris, 1987a), and young people receive numerous clues about how to be sexually attractive, little information is provided about how to be sexually responsible or cope with an unwanted pregnancy. Contraception is almost never mentioned, in part because media executives believe such references will be perceived as offensive by the public (Harris, 1987b).

Prescription drugs generally cannot be advertised in the media. Although advertisements for nonprescription barrier methods have appeared in print and on independent radio stations, attempts to place advertisements for contraceptives on network radio or commercial television have been consistently rejected by national broadcasters. Even when mentioned in relation to AIDS, the focus has been more on disease prevention than on preventing unintended conceptions. The federal government and states have few active programs to inform and educate the public about family planning and contraception (Forrest, 1988). Recent efforts to publish and disseminate an AIDS-education pamphlet, explaining how to use condoms, were blocked by the chief public affairs officer of the Department of Health and Human Services (Specter, 1989). Instead of a national policy consensus, strongly held conflicting views prevail (Koop, 1989). In sum, "Americans are often confused and ambivalent about their sexual behavior; apparently many people, especially the young, have

intercourse but do not prepare in advance by obtaining contraceptives because they feel guilty about having sex" (Forrest, 1988).

Denmark

In Denmark, as in other Nordic countries, the approach to sex is pragmatic, not moralistic. Most Danes deem sexuality as a natural and normal component of a healthy life, similar to eating and sleeping, for which individuals must assume personal responsibility through effective contraception to prevent unintended pregnancies. Sexuality and contraception are openly discussed in the media and the location of contraceptive counseling centers is advertised. Information is provided to children at an early age. There is an entrenched national consensus to limit childbearing to wanted pregnancies. Danish attitudes about sexuality, contraception, and abortion evolved gradually within a context of cultural change in which tradition and loyalty to an established authority (such as the church) shifted toward an increasingly accepted ideology and practice of personal self-determination and individualism (Manniche, 1989b). There has been no public backlash to threaten these evolving views. Thus, while no one advocates abortion as a method of family planning, there is a broad consensus that abortion is a necessary backup procedure and should be available to women without charge under national health insurance. The evidence is persuasive that public law conforms to popular norms and practices (Manniche, 1989b).

One of the policy questions most often asked about Denmark concerns the ready availability of pornography. After the Pornography Act was liberalized in 1967, porn shops flourished—but only for a few years. Since 1973, sales have been flagging. Porn stores have mostly disappeared from the major shopping areas. Those that remain seem to cater primarily to tourists from abroad (Carlsen, 1980). When asked in 1989, most Danes seemed perplexed by the ambivalence that continues to surround sexuality in the United States.

Health Care Policies and Delivery Systems

United States

The health care system in the United States is based on the private practice of medicine. Three-fourths of the population rely on an office-based private physician or a private clinic as their regular source of medical care (Aday and Anderson, 1984). The majority of US physicians are specialists; only 16 percent are general practitioners (GPs) or family practitioners (NCHS, 1986).

Since patients have direct access to specialists as well as to general practitioners, they often see only the physician they believe is needed for a particular service. Not uncommonly, doctors are being asked to treat a specific problem without knowing more of the medical history than what the patient reports (Ries, 1987). Access to private physicians varies widely according to ability to pay fees for services, eligibility for lower-cost or free public health services, and geographic location. There is no national health insurance.

Overall, in 1984, 74 percent of women of reproductive age were covered by private health insurance, usually linked to their own employment or their partners'. Half of employees covered by group health plans through their workplace must pay part or all of their health insurance costs (USBC, 1986). Of all women of reproductive age, 10 percent with low incomes qualified for Medicaid but 17 percent had no health insurance at all (Gold and Kenney, 1985). Those with no coverage included one-fourth of women under age 25, one-third of those with incomes below 150 percent of the federal poverty level, and one-fourth of unmarried women; coverage was lowest among unemployed single women (AGI, 1984). Only 56 percent of physicians who provide reversible contraception accept Medicaid reimbursement, and only 17 percent will reduce their fees for women who cannot pay the full amount (AGI, 1984). Since physicians are not evenly distributed and generally prefer to practice in more economically advantaged areas, women living in economically depressed inner-city areas or in sparsely populated or poor rural areas are often deemed "underserved."

The only policy-mandated groups for whom family planning services are regularly provided at little or no cost are low-income women and adolescents. In addition, a few local programs have been developed for immigrants. Only limited resources exist to meet the specialized needs of drug addicts, the mentally disordered, the mentally retarded, or the physically handicapped, who are also considered "underserved" since they generally do not reach out to service providers (see, for example, David and Lindner 1975; David and Morgall, 1990).

Denmark

In contrast to the United States, Denmark has national health insurance (NHI) that includes family planning and provides for everyone regardless of income (Sondergaard and Krasnik, 1984). Primary health care services are centered on the general practitioner, whose main source of income is NHI. The GP is the NHI gatekeeper. Nearly everyone in the country has a local

GP who provides family planning services or, when indicated, refers a patient to a specialist, such as an obstetrician/gynecologist, whose services are in most cases also covered by NHI.

Secondary health services include hospitals operated by public authorities. Most are publicly owned. The few nonprofit private hospitals are almost 100 percent subsidized by local authorities, and are subject to the same legislation and standards applied to public hospitals. Under NHI, medical services including family planning, counseling, and pre- and post-pregnancy services are provided without charge to the person. Every Dane is covered by NHI and services are readily available and accessible throughout the country.

Until 1987, the Danish health care system was almost entirely the responsibility of the Ministry of the Interior. Although at that time some functions were transferred to the newly organized Ministry of Health, responsibility for implementing local services remains with the counties and municipalities (NOMESKO, 1987). The Ministry of Education is responsible for the education of academic health personnel and for legislation regarding sex education in the public schools (Paludan, 1986).

The concept of "underserved" groups (as used in the United States) is less appropriate for Denmark, where the focus is less on specific population subgroups and more on programs for individuals perceived to be at increased risk, including women after delivery or abortion, or those experimenting with different contraceptive methods or needing some special assistance because they are reluctant to take the initiative in seeking services (Knudsen and Asnaes, 1985; Osler and David, 1987; Osler et al., 1990).

Acceptance of sexuality as a healthy and normal part of life involves for many Danes an obligation to assist mentally disordered, intellectually retarded, and/or physically handicapped persons in achieving a satisfying quality of sexual life. Such a goal requires reinforcement of parental and staff awareness of patients' needs, a willingness to meet such needs, and judicious sensitivity by policymakers and service providers in implementing existing legislation (Osler and David, 1987; David and Morgall, 1990).

Under consideration in Denmark is a bill proposing to provide guidance about sex education to the staff of institutions caring for persons with physical and/or mental handicaps. Already, some staff have taught residents how to masturbate, usually after obtaining parental consent; women teach women and men instruct men. Sexual aids have also been provided. In a Copenhagen home for young mentally retarded persons, residents can utilize the services of a visiting

surrogate sex partner who is a trained nurse. Since existing legal prohibitions on the provision of sexual services have never been enforced in the social-pedagogical therapeutic area, it has been recommended to make changes in the Penal Code commensurate with the rights of handicapped persons to a private sexual life (Buttenschøn, 1987; Løt, 1987).

Family Planning Services Delivery Systems

United States

Policies related to the delivery pattern of family planning services in the United States mirror the way health care in general is organized. Most, but not all reproductive health services are provided by private practitioners. Physicians are more likely to serve higher-income women (77 percent of those with family incomes over 150 percent of the federal poverty level compared to 53 percent of poorer women). They also provide services to 73 percent of women aged 20 and older compared to 48 percent of teens (Forrest, 1987). Almost all tubal sterilizations and vasectomies are performed by private physicians (Forrest and Henshaw, 1983). The provider of reproductive health services is usually a specialist, typically an obstetrician/gynecologist, not the physician consulted for general health care (Orr and Forrest, 1985).

The first birth control clinic in the United States opened its doors in 1916 in New York City; it was shut down ten years later by local authorities as a violation of obscenity laws (Dryfoos, 1988). Beginning in 1918, court decisions and administrative rulings gradually made it possible to disseminate information on and provide methods of birth control. By 1923, Planned Parenthood volunteers launched privately funded family planning clinics in more than 100 communities to provide women with contraceptive information and diaphragms at a time when most physicians were unwilling to do so (Reed, 1978). As private practitioners began to offer contraceptive advice and services, the nonprofit private clinics increasingly served poor women who could not obtain contraceptive services from public health clinics.

The struggle to make family planning available to all socioeconomic groups did not end until the Supreme Court ruled in 1965 that the constitutional right to privacy includes the right to use contraceptives (Griswold, 1965). In the late 1960s, the federal government began to fund family planning services in both public and private clinics. The initial goal was to provide for poor women who could not afford to consult private practitioners. Eventually, the mandate was broadened

to include adolescents and other special groups, such as immigrants (Forrest, 1988). However, due to political conflicts, threats of boycott, and costs of liability insurance, American women have fewer birth control choices in 1990 than do women in other industrialized Western countries (Potts, 1988).

Almost all family planning clinic patients in the United States are women, mostly poor: 83 percent have incomes below 150 percent of the poverty line and 13 percent receive welfare; 32 percent are under age 20 and 14 percent under 18. Clinics are located in every state, frequently in lower-income areas. Most are administered by public health departments (57 percent) with Planned Parenthood the next most common provider (Torres and Forrest, 1985). The single largest source of funding is the federal government, whose guidelines mandate that low-income persons and teenagers be given priority in service provision (Torres, 1984; Gold and Macias, 1986).

Family planning clinics usually do not provide a full range of reproductive health services, are open an average of 30 hours a week, and often have a waiting period between the time of making an appointment and the actual clinic visit. Two-thirds of clinic patients received pill prescriptions in 1983 (Torres and Forrest, 1985). Fewer than 25 percent of clinics provide either male or female sterilization; most refer patients to specialists. More than 90 percent provide pregnancy testing and counseling (Torres, 1984). Besides offering contraceptive-related medical examinations free or at low cost, all clinics provide supplies free or at less-than-market prices. Charges for visits vary from none for any patient with a family income under 100 percent of poverty to modest fees based on verified income. In 1983, two-thirds of all clinic patients received free services, including 79 percent of adults and 61 percent of older women (Torres, 1984; Forrest, 1988). Although supervised by physicians, family planning services are generally provided by nurse practitioners (Silverman et al., 1987; Winter and Goldy, 1987).

Data from the 1982 National Survey of Family Growth indicate that among sexually active women aged 15 to 24, friends are the leading referral source for women attending clinics and parents for those who go to private physicians. Black women, Hispanic women, low-income women, and younger women are considerably more likely than their counterparts to use a clinic at first family planning visit. Only 17 percent of women who have ever had intercourse made their first family planning visit before sexual debut, and 10 percent made their first visit in the same month. For the other 73 percent of women, the median delay between sexual debut and the first family planning consultation is 23

months, or nearly two years. Even women whose second intercourse occurs within one month of sexual debut experience a median delay of 19 months from sexual debut to family planning visit (Mosher and Horn, 1988).

Clinics are generally considered complementary to, not competitive with, services provided by private physicians, who prefer patients able to pay their fees. Women with special problems are referred to other private practitioners. "Because of the need to maneuver through the health care system to find a private physician who provides the service sought or to find a lower price alternative, the task of obtaining contraceptives can be difficult in the United States" (Forrest, 1988). Rates of nonuse of contraceptives are 80 percent higher among poor women than they are among women with higher incomes (AGI, 1987). And, with the erosion of budgetary support, the federal family planning program was, at the beginning of fiscal year 1989, operating at less than half the level of fiscal year 1981 (Children's Defense Fund, 1988).

Denmark

In contrast to the United States, national policy placed family planning services delivery systems in Denmark within the national health insurance system, and made them available without charge to all residents regardless of income. Already in the 1960s, family planning was incorporated into state and medical institutions in diverse ways. From 1961, the Mothers' Aid Association introduced contraceptive counseling as a means of reducing abortion, at its offices throughout the country. And, by a revision of the Pregnancy Hygiene Act of 8 June 1966, family planning was incorporated into national health legislation. Under this law, a woman was entitled to receive free health care during pregnancy. During her final postnatal examination, the physician was obliged to discuss family planning with her.

Law No. 236 of May 1984, further amending the 1975 law on health measures during pregnancy, mandates the provision of guidance on contraceptive methods (IDHL, 1985). All persons born or resident in Denmark are entitled to free contraceptive counseling from a physician or a clinic established for this purpose. Communities are authorized to enter into an agreement with a private institution—such as the Danish Family Planning Association (DFPA)—for the operation of contraceptive guidance clinics. Such guidance may be provided to persons who are under 18 years of age, or unmarried, or have been declared incapable of managing their own affairs without the consent of a parent or guardian. Modern contraceptives are readily available

and accessible for purchase at pharmacies almost anywhere in Denmark on prescription from GPs or the clinics (which are considered an alternative source of service).

As discussed below, abortion is available on request in the first trimester of pregnancy. Until 1973, voluntary sterilization could be obtained only with the authorization of a committee (IDHL, 1968; Koch-Nielsen et al., 1975). Law No. 318 of 13 June 1973 made sterilization available on request to all Danes over 25 years of age (IDHL, 1973b, 1975). Spousal consent is not required. Persons incapable of giving informed consent may be sterilized on the basis of an application submitted by a guardian specially designated for the purpose. Procedures are performed without charge in approved hospitals. Vasectomies may be performed by specially licensed physicians through national health insurance (IDHL, 1977). Since 1974–75, more men than women have sought sterilization procedures, with the proportion of men increasing with higher socioeconomic status (Manniche, 1985, 1989b; Sundhedsstyrelsen, 1986a, 1986b).

Contraceptive Practice

United States

Despite reported increases in use of the pill, sterilization, and condoms during 1982–87, nonuse of contraceptives remains a matter of concern in the United States (Henshaw and Silverman, 1988). In 1987, some 71 percent of all women of reproductive age at risk of pregnancy relied on sterilization, the pill, or an IUD. However, all of the net increase in the use of the most effective methods occurred among married women. Among unmarried women at risk of unintended pregnancy, the proportion using the most effective methods remained stable at 64 percent. Moreover, 8 percent of all women aged 15–44 at risk of unintended pregnancy were using no contraceptive method, with the level even higher (13 percent) among unmarried women at risk (Forrest and Fordyce, 1988).

Private obstetricians/gynecologists remain the main providers of contraceptive services. They may charge substantial fees (which are seldom reimbursable under health insurance coverage), may not always be easily accessible for economically disadvantaged women, and are less likely to have a long-term relationship with such patients. The family planning clinic system exists primarily to serve the low-income population. Young people frequently find these facilities unattractive because they are perceived as services for the poor and as conveyers of a lower standard of medical care. US

clinics are more likely to refer clients to private physicians for special assistance than the reverse. Thus, in the United States, selection of service source is determined chiefly by a person's socioeconomic characteristics and financial resources rather than by the nature and extent of the service needed (Jones et al., 1988).

Denmark

Danish women have a lower proportion of unplanned pregnancies and a lower abortion rate than American women (Jones et al., 1988). One reason may be that the determination to limit childbearing to wanted pregnancies is more deeply entrenched in Denmark (Rasmussen et al., 1983). Use of effective contraceptive methods is linked to their ready availability through GPs, who are usually located in close proximity to their patients, often know them for longer periods of time, and have their costs covered by national health insurance. The pill is the predominant method. GPs prescribe low-dosage formulations and are available when needed for consultation on possible side effects. GPs are occasionally criticized for spending a minimum amount of time with their patients or for not providing counseling about alternative methods of contraception. GPs may and do refer patients to clinics offering alternative methods, evening or weekend consultation, female staff, and educational programs, all of which are subsidized by public funds. It is recognized that socioeconomic differences still persist in the practice of effective contraception (Manniche, 1986a, 1986b). Reducing these differentials is a major public policy objective.

Abortion

United States

From 1607 to 1828, common law in the American colonies and the United States allowed women to have abortions at will (Means, 1970, 1971; Mohr, 1978). Much has been written about the changing tenor of the times that resulted in abortion becoming illegal by 1900 in all American jurisdictions except when a continuing pregnancy was perceived to be a threat to the woman's life or health (Means, 1968, 1970; Gordon, 1976; David, 1980).

Reform of restrictive abortion legislation was stimulated largely by medical concerns for the health consequences of illegal abortion (Rossi and Sitaraman, 1988). While supported by health professionals, it was not on the agenda of major American political parties in the 1960s, as it had been among the socialist parties in much of Europe since the turn of the century (Bebel,

1910; David et al., 1988).

Although the US Supreme Court ruled in January 1973 in *Roe v. Wade* that during the first trimester of pregnancy the abortion decision rests solely with the pregnant woman and her physician, abortion has remained a highly controversial issue. While the 1989 Supreme Court ruling in *Webster v. Reproductive Health Services* did not exclude abortion from the constitutionally protected right to privacy, it signalled that a myriad of state-enacted restrictions on abortion, which had previously been overturned by the Court, might now be permitted (US Supreme Court, 1989; *Newsweek*, 1989; *Washington Memo*, 1989; AGI, 1990). Perhaps no other elective medical procedure has evoked as much debate or generated such ethical and moral controversy, often intruding on the accumulation of scientific data (Koop, 1989).

In 1984 and 1985, the number of US abortions, the abortion rate, and the abortion ratio stayed at approximately the same levels as in the previous three years, after having risen steadily since the 1973 Supreme Court decision. Just under 1.6 million abortions were performed, and about 30 percent of pregnancies (excluding those ending in stillbirths and miscarriages) were terminated. More than four in ten pregnancies to either teenagers or women over 40 end in abortion, compared with about two in ten pregnancies to women in their twenties. More than half of all abortions are performed by the eighth week of gestation, more than 90 percent by the twelfth week, and less than 1 percent at 21 or more weeks of gestation. Delays tend to be due to late recognition of pregnancy, medical reasons, and/or geographic, financial, or administrative barriers (Henshaw et al., 1987; Ellerbrock et al., 1987; Lawson et al., 1989; AGI, 1990).

In 1987, as in prior years, the majority of abortions in the United States were obtained by young women (26 percent under age 20; 59 percent under age 25), mostly unmarried (81 percent), and without a previous birth (52 percent). The proportion of repeat abortions among total abortions continued to rise, reaching 39 percent in 1983 and 43 percent in 1987 (Henshaw, 1987; Henshaw and Silverman, 1988).

The abortion rate of 28 per 1,000 women aged 15–44 in 1985 suggests that almost 3 percent of women of childbearing age had an abortion during the year. The rate declined from a peak of 29 in 1981, which corresponds to a decreasing proportion of 15–24-year-old women within the population of women of reproductive age. The highest abortion rate was among 18- and 19-year-olds (60 per 1,000). After rising during the 1970s, the pregnancy rate for adolescents aged 15–19 years peaked in 1981 at 128 per 1,000 at age of concep-

tion, declining to 126 in 1983 (Henshaw, 1987).

Since 1979, the abortion ratio has fluctuated between 297 and 304 per 1,000 live births. The ratio of 298 in 1985 suggests that 30 percent of pregnancies not ending in miscarriage or stillbirth were terminated by abortion, or 25 percent when estimated miscarriages and stillbirths were considered (Henshaw et al., 1987). The highest abortion ratios were found among women 40 and older (51 percent) and teenagers (42 percent).

Most respondents to a 1987 survey of abortion patients said that several factors had contributed to their pregnancy termination decision (Torres and Forrest, 1988). Three-fourths mentioned that having a baby would interfere with work, school, or other responsibilities; two-thirds indicated they could not afford to have a child; and half said they did not want to be a single parent or had partner relationship problems. Of women who had a procedure at 16 or more weeks gestation, 71 percent attributed their delay to not having realized they were pregnant; almost half indicated that the delay was due to difficulties (mostly financial) in arranging the abortion.

The number of abortion providers in the United States declined by 5 percent between 1982 and 1985, and the geographic distribution of abortion services continued to be markedly uneven. Some 82 percent of all US counties (50 percent of those classified as metropolitan and 91 percent of those classified as nonmetropolitan) lacked an abortion provider in 1985. In that year, 87 percent of abortions were performed in nonhospital facilities, an increase from 82 percent in 1982. Although free-standing abortion clinics constituted only 15 percent of all providers, they were responsible for 60 percent of procedures in 1985. As of mid-1986, charges for first-trimester nonhospital abortions ranged from \$75 to nearly \$900. The average amount paid was \$213. In 1985, only 39 percent of nonhospital abortion facilities accepted state reimbursement for abortions provided to low-income women, and only 55 percent of facilities offered some reduction in charges to such women (Henshaw, 1987; Henshaw et al., 1987). Moreover, harassment of abortion service providers increased (Forrest and Henshaw, 1987).

While no legislation defining criteria for abortion has been passed by Congress, restrictions on financial reimbursements abound, as do limitations on the provision of services by federal grantees. Whereas the federal government provided 94 percent of federal and state subsidies for sterilization in 1985, the federal government's share of abortion subsidies was less than 1 percent of the funds used (Gold and Macias, 1986). Yet, for every tax dollar spent to pay for abortions for poor women, about \$4 is saved in public medical and welfare

expenditures while helping to ensure that such women have control over resolving their unwanted pregnancies (Torres et al., 1986).

Although the dynamics of intended and unintended conceptions have been much discussed, as have been the short- and longer-term medical and psychological effects of abortion, US-based research has been greatly handicapped by the lack of a national abortion reporting system and adequate follow-up monitoring. Thus far, it has not been possible to conduct large-scale, longer-term studies, or to compare deliveries and abortions in carefully matched representative populations over time (David, 1989; Adler et al., 1990). Presently, very little federal money is devoted to abortion-related research, and none to the improvement of abortion techniques such as RU 486 (Klitsch, 1989).

Denmark

The first mention of induced abortion in Danish law is found in King Christian V's Code of 1863, but court-imposed sentences appear to have been punishments for infanticide rather than for terminating an unwanted pregnancy (Manniche, 1989a, 1989b). The law of 1863 remained in force until a new Criminal Code was enacted in 1866 permitting induced abortion if the continuing pregnancy would threaten the mother's life.

The 1920s and the 1930s marked the beginning of a public debate on contraception and abortion in Denmark, stemming mainly from a quest for equal social rights for women and the absence of specific legislation regulating medical practice in relation to abortion (Gille, 1952; Gebhard et al., 1958; Skalts and Nørgaard, 1967). When the first Danish law specifically dealing with abortion was adopted on 18 May 1937 (coming into effect on 1 October 1939), it promulgated that unwanted pregnancy could be terminated during the first three months of pregnancy on the basis of defined medical, ethical, and eugenic indications. The medical indication was expanded by stating that "serious risk" to the woman could be due to causes other than actual disease, thereby implicitly introducing the concept of a sociomedical indication (WHO, 1971). Examples of socioeconomic situations were included in the administrative circular to the medical community (Sundhedsstyrelsen, 1939; Heisterberg, 1988).

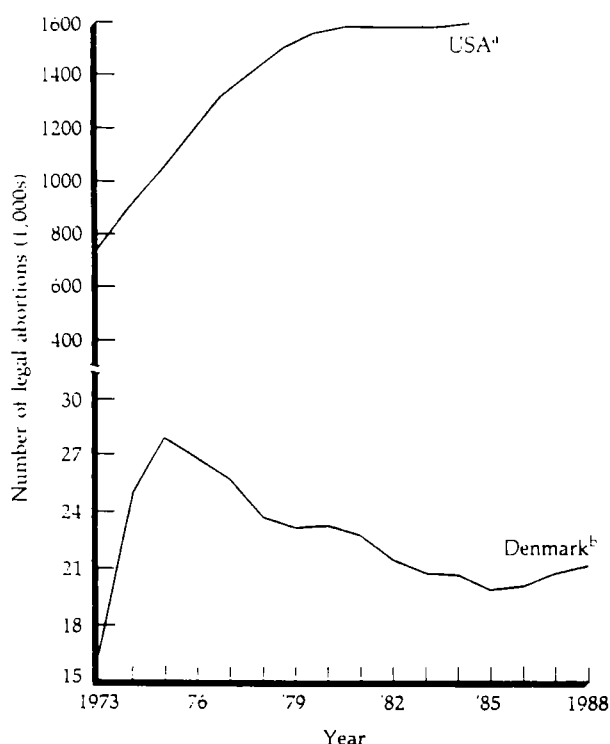
The subsequent 50 years were characterized by trends favoring decriminalization of abortion, widening indications for legal procedures, additional social support services for pregnant women, and establishing contraceptive counseling services as complementary components of abortion facilities (for example, Kjerkegaard et al., 1989). Parliament approved increas-

ingly liberal legislation in 1956, 1970, and 1973 (IDHL, 1957, 1970, 1973a). The 1973 law became effective on 1 October 1973 (eight months after the January 1973 US Supreme Court decision). Henceforth, a woman resident in Denmark could, at no cost to herself, have her pregnancy terminated as an elective right provided only that the procedure could be performed before the end of the twelfth week of pregnancy. Her husband's consent, if she is married, is not necessary. The decision to obtain an abortion must be solely that of the pregnant woman, who has to go to her GP and request it. After the twelfth week, a request for abortion must be reviewed and approved by a three-member joint council. If the woman is under 18 years of age, one of her parents or guardians must consent, but this requirement may be waived in certain circumstances when a special committee is empowered to provide permission. The Danish legislation became the first Western European law permitting abortion on request during the first trimester. Subsequently, illegal abortion disappeared almost completely. The provision that physicians may decline to perform the procedure (but must then refer the woman to another facility) has not created difficulties (Manniche, 1986a; Pedersen, 1983). Facilities are available and accessible throughout Denmark.

Following liberalization of the law regarding abortion in 1973, the abortion rate increased sharply in all age groups. At the same time, sales of oral contraceptives declined but those of IUDs increased (Somers and Gammeltoft, 1976a, 1976b; Matthiesen, 1979). Since 1975, the sale of pills has again increased, a trend that is consistent with the decline in the adolescent pregnancy rate. As shown in Figure 1, the number of annual abortions peaked earlier in Denmark (1975) than in the United States (1985), and declined fairly steadily until 1987. Abortions represent between one-fourth and one-third of all pregnancies. The total abortion rate, that is, the average number of abortions a woman would have, assuming a continuation of current age-specific rates over her reproductive life span, stood at 0.52 in 1986, compared to 0.76 in the United States in the same year. Nearly all procedures (97 percent) are performed before the twelfth week of gestation (Knudsen and Tanska, 1987), which lessens the risk of morbidity, reduces anxiety and stress, and is more economic. Pre-abortion counseling is mandatory. Post-abortion follow-up and counseling are frequently provided.

Considerable interest has been expressed about the role and potential influence of the GP in the abortion decision-making process. In individual interviews with 67 Copenhagen GPs, conducted by a female physician in 1976 (three years after abortion on request became legal), 91 percent indicated that women seeking an

Figure 1 Number of legal abortions in the USA (1973–85) and Denmark (1974–88)



^aUSA data reported by the Alan Guttmacher Institute (AGI). No abortion statistics are yet available for the US for 1986–88; an AGI survey is in progress. Author's estimate for 1988 is 1.6 million. ^bDenmark data reported by Sundhedsstyrelsen.

abortion usually have made their decision before coming to the GP (Gammeltoft and Somers, 1976). Interviews with a representative sample of women in Copenhagen in the late 1970s found that more than half the women terminating unwanted pregnancies made their decision immediately upon discovering their condition. Better than three-fourths did so within the first week. Over 80 percent of those more than 25 years of age made their decision about pregnancy resolution before consulting their GP (David and Rasmussen, 1980). Subsequent informal discussions with service providers, conducted in 1986–87, again suggested that more than 90 percent of women requesting an abortion made their decision before approaching a GP.

Our previous cooperative studies in Denmark (David and Rasmussen, 1980; Rasmussen, 1983) and others (Wohlert and Møller-Larsen, 1979) suggest that women terminating unwanted pregnancies used a greater variety of contraceptives, that unintended conceptions occurred during shifts from one method to another, and that only a tiny proportion practiced no

contraception of any kind. Women requesting abortion did not constitute a specific risk group but happened to be in a life situation where their pregnancy was unwanted at that time. Among 230 women individually interviewed six months after having an abortion, reliance on effective modern contraceptives was found to have increased substantially. The use of condoms, diaphragms, and spermicides declined from 69 percent to 19 percent, while use of pills, IUDs, and sterilization increased from 29 percent before abortion to 73 percent six months later (Sidenius et al., 1983).

One of the few studies comparing serious psychological sequelae post-abortion and postpartum was also conducted in Denmark. Utilizing computer linkages among Danish national registers, admissions to psychiatric hospitals (an operational definition of a very adverse reaction) were tracked three months post-abortion and postpartum for all women under age 50 resident in Denmark. Data were obtained on 27,234 women terminating pregnancies, on 71,378 women carrying to term, and on the population of 1,169,819 women aged 15 to 49 years. To determine incidence rates, only first admissions to psychiatric hospitals were recorded. While women with an admission 15 months prior to abortion or delivery were excluded, it was not possible to control for psychiatric frailty (Andersen and Rasmussen, 1986). It was noted that for never-married and currently married women the post-pregnancy risk of admission to a psychiatric hospital was roughly the same, about 12 per 10,000 abortions or deliveries, compared to about 7 per 10,000 for all women of reproductive age. However, separated, divorced, and widowed women who decided on abortion experienced a four-fold higher admissions rate (64 per 10,000) than women in similar situations carrying to term (17 per 10,000). Women seeking to abort pregnancies that may have been very much wanted at the time of conception seem to be in particular need of counseling (David et al., 1981; David, 1985).

It has been suggested (Rasmussen, 1983) that the decline in Danish births was a consequence of a reduction in planned pregnancies without a corresponding decline in the number of unplanned pregnancies. Women requesting an abortion to terminate an unwanted pregnancy do not differ from other women regarding their motivation for birth control. Most abortions are performed for women whose life situation is not conducive to rearing a child. They either have the number of children they want (usually two), or are over 35 years of age, or do not live in a stable partner relationship. For the remaining minority of women having abortions, their choice is largely determined by conflicting demands of education, employment or lack of work,

employment does not usually influence the decision to seek an abortion or carry to term. The availability of legal abortion has made it easier for women to decide in favor of postponement when confronted with changes that might result from an increase in family size. The relatively stable number of abortions compared with the rising number of births in the years 1983–88 further suggests that most deliveries stem from wanted pregnancies (Manniche, 1986b; Osler et al., 1990).

Adolescents: Needs and Services

United States

Adolescent sexuality is not a new phenomenon in the United States (see, for example, Hofferth et al., 1987). For the past 15 years, more than one million, or one of every ten women aged 15–19, has become pregnant annually (Trussell, 1988). Risks of unintended premartial pregnancy are rising as more adolescents become sexually active at earlier ages while the proportion of sexually active teenagers increases with age (Hofferth et al., 1987; NCHS, 1987). Although contraceptive use has risen, only one in three sexually active adolescents practices contraception all the time, and a sizable proportion does not begin contraceptive practice for a year or more after sexual debut (Mosher and Bachrach, 1987). To the extent that such sexual activity is not limited to mutually monogamous relationships, there is an increased risk of exposure to AIDS and other sexually transmitted diseases (Bachrach and Horn, 1988).

To review the situation and make recommendations for reducing the large proportion of unintended adolescent pregnancies, the Committee on Child Development Research and Public Policy, within the National Research Council of the National Academy of Sciences, established in 1984 a Panel on Adolescent Pregnancy and Childbearing. Its two-volume report (Hayes, 1987; Hofferth and Hayes, 1987) includes comprehensive reviews of trends in and determinants of adolescent sexual behavior, decision-making, contraceptive practice, and pregnancy resolution. Except where otherwise indicated, the following observations are based on the Panel Report.

In 1985, pregnancy outcomes included 477,000 live births, 416,000 induced abortions, and 138,000 miscarriages or stillbirths (Henshaw and Van Vort, 1989). Women under age 20 accounted for 26 percent of all abortions and 13 percent of all births. Over three-fourths of births resulted from unintended pregnancies among mostly unmarried women, nearly half of whom had not yet reached their eighteenth birthday (Hen-

Calculations from NCHS data suggest that at 1985 rates of birth and abortion, 9 percent of teenage women will have had at least one abortion by their eighteenth birthday and an equal proportion will have had one or more births. By age 29, the figures are likely to be 18 percent and 20 percent, respectively. Because some of the women will have had more than one abortion or birth, a cohort of 1,000 adolescents may be expected to have had 227 abortions and 261 births by age 20 (Henshaw and Van Vort, 1989).

The 1985 pregnancy rate among nonwhite teens aged 15–19 was twice as high as that among similarly aged white adolescents. About 42 percent of both white and nonwhite teenagers terminated unwanted pregnancies by abortion. However, among girls under age 15, the abortion rate among nonwhites was 5.4 times that of whites, while the birth rate was 6.5 times as high (Henshaw and Van Vort, 1989).

In the period 1976–80, the abortion rate for women aged 15 to 19 rose by 24 percent (Ventura et al., 1988). In actual numbers, conceptions increased but abortions accelerated even faster, resulting in a declining number of births. Both the number of abortions and the abortion rate (per 1,000 women aged 15 to 19) increased by 50 percent between 1974 and 1980. Between 1980 and 1985, the abortion rate remained stable at 43–44 per 1,000 women aged 15–19. The birth rate fell slightly from 53 percent in 1980 to 51 percent in 1985. (See Table 1.)

While falling adolescent fertility rates have been a characteristic of most developed countries, the US decline is one of the smallest (United Nations, 1988). The most striking contrast is among the youngest teens: US girls under age 15 are at least five times more likely to give birth than are young adults in any other developed country for which data are available (Jones et al., 1986). Among older sexually active teens at risk for unintended pregnancy, nonuse of contraceptives is more than twice the level of women in their early twenties (AGI, 1987).

Teenage families with children are disproportionately fatherless, and most are poor. Teen marriages, when they occur, are characterized by a high degree of instability. In addition, teenage parents, both mother and father, suffer the negative impact that untimely parenting has on their education and the related limitation of career opportunities. Teen parents are more likely than those who delay childbearing to experience chronic unemployment and inadequate income. Because these young people often fare poorly in the workplace, they and their children are highly likely to become dependent on public assistance and to remain dependent longer than those who delay child-

Table 1 Abortion, birth, and conception rates per 1,000 women aged 15–19, United States and Denmark, 1977–85

Rate	Rate per 1,000 (by year)								
	1977	1978	1979	1980	1981	1982	1983	1984	1985
Abortion rate									
US	37.5	39.7	42.4	42.9	43.3	42.9	43.5	43.2	43.8
Denmark	25.5	24.3	22.5	22.7	20.4	18.2	17.6	17.4	16.3
Birth rate									
US	52.8	51.5	52.3	53.3	52.7	52.6	51.7	50.9	51.3
Denmark	22.1	20.3	18.1	16.8	14.3	12.4	10.6	10.1	9.1
Conception rates									
US ^a	104.6	105.6	109.4	111.2	110.8	110.3	109.9	108.6	109.8
US ^b	119.3	122.5	127.2	127.6	128.5	127.4	125.9	126.9	127.5
US ^c	90.3	91.2	94.7	96.2	96.0	95.5	95.2	94.1	95.1
Denmark	47.6	44.6	40.6	38.9	34.7	30.6	28.2	27.5	25.4

^aHenshaw and Van Vort (1989): Pregnancy rate by age at outcome.

^bAccording to Henshaw and Van Vort (1989), by age at conception

^cAbortion rate plus birth rate, to compare with Denmark.

Source: S.K. Henshaw and J. Van Vort, "Teenage abortion, birth and pregnancy statistics: An update," *Family Planning Perspectives* 21 (1989): 85–88; Sundhedsstyrelsen (Danish National Board of Health).

bearing until their twenties. That unrealistic attitudes and motivations may have encouraged young adolescents to carry to term and keep their babies rather than opt for abortion or adoption is apparent from the finding that such teenagers are more likely to end a subsequent pregnancy by abortion (Joyce, 1988).

On the basis of two years of review, analysis, and debate, the Panel on Adolescent Pregnancy and Childbearing concluded that prevention should have the highest priority. Sexually active teenagers of both sexes need the ability to avoid pregnancy and the motivation to do so. Making contraceptive methods available and accessible to those who are sexually active and encouraging them to use these methods effectively is the surest strategy for pregnancy prevention.

To achieve the highest priority recommendation, reducing the rate and incidence of unintended pregnancy among adolescents of school age, the Panel urged continued public support for contraceptive services to adolescents at low or no cost; sex education programs providing information on contraceptive methods and how to use and obtain them; greater and more effective outreach endeavors by service providers; further development and refinement of comprehensive school-based clinic models for implementation in schools with large high-risk populations; and the development, implementation, and evaluation of condom distribution programs and the use of paid promotional messages for contraceptives aimed at sexually active adolescents.

The Panel further concluded that there is no scientific basis for restricting the availability of abortion for adolescents. Research evidence shows that to require teenage minors to seek parental consent often causes them to delay abortions, with attendant health risks. Adolescent minors should be encouraged, but not required, to involve their parents and partners in the decision-making process.

Denmark

In Denmark, as in the United States, age at menarche has steadily decreased since the mid-1800s (Manniche, 1983). Although age of sexual debut and levels of early sexual activity are comparable in the United States and Denmark (Wielandt and Bolsen, 1989), conception rates in Denmark are less than half those reported from the United States. As shown in Table 1, the gap has been widening from 1977 to 1985 (Rasmussen and David, 1981; David et al., 1982). While conception rates increased in both countries after liberalization of the law on abortion in 1973, rates for Danish adolescent women aged 15–19 peaked in 1975 at 51.8 per 1,000 women. They declined subsequently year by year to lows of 25.4 in 1985 and 25.1 in 1987. Birth rates decreased even more sharply from 32.4 per 1,000 women aged 15–19 in 1970 to 22.1 in 1977 and to 9.1 in 1985 before rising again to 9.4 in 1987. Abortion rates stood at 25.5 per 1,000 women aged 15–19 in 1977, dropping steadily thereafter to 16.3 in 1985 and 15.7 in 1987. Abortion rates have exceeded birth rates since 1976.

Particularly noteworthy in Denmark is the high abortion ratio per 1,000 live births among 15–17-year-old girls, who are far more likely than 18–19-year-olds to terminate an unwanted pregnancy than to carry to term. Overall, the vast majority of pregnancies among Danish adolescents are resolved by abortion, reflecting a more general and perhaps cultural negative perception of childbearing at adolescent ages. While consistent practice of contraception starts earlier and is more widespread in Denmark than in the United States, the Danish adolescent abortion rate and ratio are deemed too high and have stimulated the Danish Family Planning Association to launch fresh initiatives designed to improve effective contraceptive practice.

Several policy recommendations of the US Panel

were implemented in Denmark some years ago. For example, an amendment to Act 312 of June 1972 reduced the age of majority from 20 to 18 years. Unless married, minors under age 18 are legally in the custody of their parents or guardians. However, the Social Welfare Act of April 1976 authorized GPs to provide contraceptive counseling, prescribe pills, or fit diaphragms or IUDs for minors without charge and without parental consent. Minors become independent national health insurance members at age 16 when they attain the right to select a GP of their choice within their area of residence; until age 16, however, they must, technically, have parental permission to use their card for a consultation with their GP (Paludan, 1986). Abortion for minors is considered a medical procedure and, when needed, is available and accessible without charge under the same conditions as for adult women.

Under Article 282 of the Social Welfare Act of 1 April 1976, each county is responsible for providing access to contraceptive counseling without charge for minors under the age of 18. The Ministry of the Interior, which administers the program, prepared guidelines for the counties' health and social welfare administrators but did not stipulate how the counseling should be provided, except that each clinic must employ an experienced physician, preferably an obstetrician/gynecologist. In actual practice, many school classes from age 14 and up visit the clinics during the year for explanations of contraceptive methods presented by a nurse (Knudsen and Osler, 1987).

Particularly striking in Denmark is the use of contraception at "sexual debut," a term first suggested by Auken (1953) as an improvement on "first sexual intercourse." In a study of 15-16-year-old pupils (N=518) in a rural Jutland community, 80 percent used some form of contraception at sexual debut (Rasmussen and Munk, 1986). In a representative study of 286 young women and 336 young men, aged 16-20 years, 80 percent of those who reported sexual activity had used contraceptives at sexual debut; the proportion rose to 89 percent among young women and 83 percent among young men if it was the first time for both partners (Wielandt et al., 1987). Condoms were employed most frequently, followed by pills. Average age of sexual debut was 16.8 years for both men and women, reasonably similar to the 17 years reported in an earlier representative study (Hertoft, 1968, 1980).

An example of sexual activity and contraceptive practice among ninth graders (aged 15-16) in the school year 1985-86 was reported from Viborg, a community of 39,000 people in the rural area of Jutland (Rasmussen and Munk, 1987). Among a total of 518 pupils, every third one (178), regardless of sex, had had sexual ex-

perience, including 81 of 227 boys (35 percent) and 146 of 291 girls (32 percent). Of the 178 who had sexual experiences, most had their sexual debut around age 15 and 80 percent had used some form of contraception at that time. Of 82 boys, 33 (40 percent) reported having had sex in the immediately preceding four weeks, compared to 51 of 93 girls (55 percent). Again, 80 percent had practiced contraception the last time. The relationship between sex, sexual experience, and contraceptive knowledge was investigated by means of six test questions. Knowledge was derived mostly from friends, books, and school. For those pupils who had not experienced sexual debut, school was of greater significance than friends in obtaining knowledge. Parental transmission of information had practically no significance for boys but communication with the mother was very significant for girls.

In an ongoing study, two entire cohorts of Danish women, born in 1959 and 1964, respectively, have been tracked through the Danish registers to age 21. Initial data show that, of those born in 1959, every fourth woman had experienced a birth and every fifth an induced abortion. Of those born in 1964, every sixth woman had experienced a birth and an equal proportion had experienced an induced abortion (David et al., 1990). These data suggest further improvement of conception control and the effect of public policies attuned to private needs.

In sum, available information on Danish adolescents suggests that high levels of adolescent sexual activity do not necessarily result in high conception rates. Moreover, low birth rates do not necessarily imply high abortion rates; they reflect low conception rates. The Danish experience demonstrates that low abortion rates and low birth rates are compatible.

Sex Education and Information

United States

Although it is widely believed in the US that parents should be the primary transmitters of sexual information and values to their children, it is equally widely recognized that many parents are uncomfortable about their ability to discuss sex-related matters adequately with their children. Public opinion polls have repeatedly shown support for sex education courses that provide birth control information for 12-year-olds (Rosoff, 1989). While all but a few US states require sex education, the decision whether to teach the subject or how to teach it is usually left to the discretion of local school districts (Orr, 1982; Sonenstein and Pittman, 1984; Marsiglio and Mott, 1986). In the absence of national guide-

lines, no national data are available on the content or quality of sex education programs. State and local guidelines are often purposely vague to assure maximum community flexibility. The result is that considerable variation occurs in what passes for sex education, practically no guidance is given for innovation, and little support is provided for assisting teachers in coping with pressures from reluctant parents or anxious school administrators. Policies and curricula addressing AIDS are frequently far more specific than those designed to prevent unwanted pregnancy (Dawson, 1986; Rosoff, 1989). The overall impact of sex education in the United States, however defined, is difficult to assess. Some observers have described the current situation of conflicting views and practices as another example of "American puritanical resistance" to recognizing the sexual realities of modern life (Westoff, 1988).

Denmark

Sex education in public schools in Denmark was practiced for many years before Parliament passed a law in 1970 making it a compulsory primary school subject throughout the country (Risør, 1985, 1988). Law No. 313 of 26 June 1975, the Public School Act, mandated obligatory sex education as an integrated subject, beginning no later than third grade at age nine. The school must provide information regarding genital anatomy, conception, contraception, and venereal disease as part of teaching other subjects and during the homeroom class. More comprehensive teaching may be offered in the sixth and seventh grades, and again in ninth grade. In practice, individual teachers are often left to determine the extent and content of their teaching (Paludan, 1986). It is, however, unusual to find students who have not been exposed to some sex education (Hessellund, 1977, 1978). A 1971 effort by a Danish couple to have their ten-year-old daughter excused from sex education was rejected by the authorities (Søgaard, 1983).

The stated legislative goal of sex education is for pupils "to acquire knowledge of sexual matters so as to learn to take responsibility for their own lives and to demonstrate consideration for others" (Ministry of Education, 1972). Each Danish county and each school principal is, however, left alone to administer the teaching program and fulfill the requirements stipulated by the Act. Some teachers encourage students to write their questions on a slip of paper and deposit them in a bag, from which questions can then be drawn at random. In this way, confidentiality is preserved and openness fostered.

In Denmark, as in the United States, sex education has been a sensitive topic in the parent-child communi-

cation process. Of 225 women who were 40 years old when individually interviewed by two Danish female psychiatrists in 1976-77, 93 percent reported no discussion of sexual matters in their home during childhood; 75 percent never received any information from their parents. As mothers of teenagers at the time of interview, these women strongly supported sex education. Twenty percent thought it should be solely a parental responsibility, 3 percent suggested the school accept full responsibility, and 77 percent favored shared responsibility between parents and schools (Søgaard, 1983).

Several studies among school-age youngsters in Denmark suggest that lack of knowledge about how to obtain and/or use modern contraceptives plays only a minor role in explaining their nonuse or ineffective practice (Bernsted and Krasnik, 1978). Young women under age 21 obtaining terminations of unwanted pregnancies were no more dissatisfied with the sex education they received in school than were nonpregnant women of similar age in a representative sample (Wer-muth et al., 1987; Wielandt et al., 1988).

In a study conducted in greater depth, Paludan (1985) noted that self-acceptance as a sexual being is part of the maturation process in which youths strongly adhere to the mores of their peer group. Those who have a steady partner utilize effective contraceptive methods, whereas those who are unattached are reluctant to carry a diaphragm or condom for fear that this would give the appearance of "looking for it."

Interviews with eighth and ninth grade teachers and pupils elicited the view that students had learned about technical aspects of sexuality in earlier grades and now wanted to discuss the radical changes in their bodies and emotional lives. Among the problems identified were the difficulty some teachers experienced in attempts to establish rapport with their students, divergences in levels of maturity and knowledge among students, and differences in attitudes and values about sex education between pupils' families and teachers (Shore-Paludan, 1984).

As Paludan (1986) observed, the Danish history of social consciousness and informal openness provides many opportunities for young people to make responsible decisions as they mature. Some of the pedagogic and psychological barriers to implementing available knowledge and utilizing available services may be a factor of being at an age where reason and responsibility are at times overwhelmed by the need to cope with anatomical and physiological changes. Sex education and counseling need to account for these issues if they are to be effective in reaching young minors. Thus, following an experiment to supplement sex education for ninth graders in Copenhagen with visits to clinics of

the Danish Family Planning Association, the number of abortions performed on women under age 20 declined from 459 in 1986 to 357 in 1987 (Jacobsen, 1989).

In response to student criticisms of the sex education program (Wermuth et al., 1987), and to assess lessons learned from Danish experience, a Working Group was convened and drafted recommendations for improvements that were submitted to a Ministry of Education Commission considering the promulgation of new guidelines for sex education (Rasmussen, 1987). The Working Group reaffirmed that obligatory sex education should begin no later than third grade. In view of the interpersonal difficulties that some parents and teachers experience in communicating knowledge about sexual matters, it was recommended that more responsibility in sex education be assumed by persons who are perceived to be "neutral," that is, individuals not having an established role relationship with adolescents. Such neutral persons as, for example, the general practitioner, the school nurse, and family planning clinic staff, would complement the sex education efforts of parents and teachers, who, being involved in adolescents' daily lives, are more likely to be targets of teenage rebellion. Emphasis in sex education will focus more on the importance sexuality plays in family life. Within that context, knowledge, motivation, and attitudes are to be oriented toward strengthening character development, encouraging acceptance of responsibility for sexual behavior, and avoiding unintended pregnancies.

The Working Group also recommended that more emphasis be placed on psychological aspects, including body awareness and acceptance, together with the realization that it is quite normal to be unsure and shy in intimate situations with another person. Young people need to become aware of the real or imagined pressures for sexual debut and learn how to cope with them. While sex is a natural and normal part of life, society has a right to expect that pregnancy be avoided in circumstances where couples are not prepared to assume parental obligations. Contraception is the responsibility of both partners, not solely a woman's problem.

Additional recommendations suggested that courses in sex education be part of the basic education and postgraduate training of professional groups, especially teachers and GPs. Guidelines need to be updated regularly with instructions and teaching materials oriented to the requirements of students at different ages. In addition, GPs and midwives are encouraged to offer contraceptive advice to all women giving birth.

In the opinion of the Working Group, sex education is an ongoing and continuing life-long process.

Attitudes about pregnancy, relationships, and life situations change over time, calling for changes in prevention practices and propitious advice. To facilitate the process, media and public facilities (libraries, pharmacies, and so forth) are to be enlisted in a constant effort to provide adults with a flow of information on new developments, reinforcing the concept of personal responsibility for sexual behavior. Many of these recommendations are being gradually implemented.

The Danish AIDS educational campaign is directed toward adolescents, who are perceived as being in the process of forming sexual habits, being in potential danger because of more frequent changes of sexual partners, and representing a good investment in the sense of preventing infection and/or reducing future unintended conceptions. There is an awareness that knowledge and attitudes are not always translated into practice, and that special efforts are necessary (Sundhedsstyrelsen, 1988; Kjoller et al., 1989).

Denmark's openness to sex and sexuality has made it easier to talk about AIDS, to use clear and direct language, and to show explicit pictures, cartoons, and videos. The national campaign conveys the message that sex is good, healthy, and beautiful, but requires responsible behavior expressed through safe sex practices.

More than 200 well-known Danes participated in a television and radio spot campaign, presenting different brief messages brought together under the slogan "Think Twice." Posters portraying a loving couple were printed and have become popular among young people. To make condoms less mysterious and facilitate wider acceptance, 20-foot-long posters were placed on the sides of city buses displaying condoms with the message "Protect The One You Love." Six different languages were used, not to titillate tourists but to attract the attention of Danes. Pamphlets showing how to use condoms properly were distributed with six different covers in supermarkets, gas stations, newspaper kiosks, and pharmacies. Specially equipped and staffed mobile education centers visited schools and answered questions. There were few negative reactions (de Neergard, 1988).

AIDS is no longer viewed as something that endangers only homosexuals or drug users. With the spread to women and children, AIDS information is directed specifically toward adolescents with the objective to:

- make education life-oriented, not death-oriented;
- minimize fear and discrimination;
- integrate AIDS education with other sex and health education;

- make AIDS education open and direct;
- include face-to-face contacts, not only written materials;
- make education multisectorial by including schools, clubs, sports, the arts, and so on;
- desensitize condoms by displaying them, placing them on thumbs, or blowing them up like balloons;
- make sure condoms are easily available and accessible; and
- foster the concept that "safe sex" is the high-status thing to do.

Danish experience suggests that the best approach to developing educational materials for youth is to work with young people and let them be creative. For example, all 14–15-year-old school children in Copenhagen were invited to participate in a competition, writing their thoughts about AIDS. Many productive ideas resulted. Teachers generally cooperated very well, but some found it difficult to discuss sex, a view that was respected. As previously noted, teachers make good sex educators only when they are personally comfortable with the topic. Thus, the AIDS campaign has made sex education even more publicly accepted than before and youths are becoming actively involved in the effort to prevent sexually transmitted disease as well as unwanted pregnancies (de Neergard, 1988).

Of particular importance in building and enhancing a public and professional consensus is the Danish Family Planning Association, formed in 1956 by the Women's Medical Society, the Danish Medical Society, and the Association of Danish Pharmacists. Soon thereafter, DFPA began selling contraceptives, initiated an information service emphasizing the importance of family planning to somatic, psychological, social, and sexual functioning, opened several clinics for contraceptive guidance, and prepared materials for educating school teachers, other service providers, and interested lay persons (Risør, 1985, 1987, 1988, 1989). Subsequently, membership in DFPA was opened to associations whose members were professionally trained in relevant fields. Among the early studies conducted by DFPA were the practice of contraception by young mothers in Copenhagen and teenage pregnancies in Denmark, 1940–71 (Braestrup, 1971, 1974).

Located in Hellerup, a suburb of Copenhagen, the DFPA continues to extend its many services and educational and coordinating activities. Its two Copenhagen clinics, supported in part by the Municipality and the County, are actively providing services to the public and the schools. Particularly noteworthy in 1987 was a

national family planning poster contest for students from the sixth through the tenth grades that elicited numerous imaginative and humorous entries (DFPA, 1988). The DFPA also publishes newsletters and a journal, sponsors symposia and seminars, and disseminates monographs (DFPA, 1980, 1983; Osler and David, 1987). Most recently, the DFPA participated in the Working Group formulating recommendations for improving sex education and teacher training; advocated the continued operation of at least one family planning clinic in every county of the country for patients desiring alternatives to their GPs and for women preferring a female physician; and continued its educational campaign designed to reduce the incidence of abortion. It also warned against an overreliance on condoms due to AIDS prevention efforts, cautioning that the abandonment of more effective contraceptive methods might trigger a rise in unintended pregnancies.

Summary and Conclusions

While exposure to the risk of unwanted pregnancy is no less in Denmark than in the United States, the Danish birth rate declined further and the abortion rate peaked earlier. The number of abortions and the abortion rate have remained fairly constant since 1983 but the number of births and the birth rate per 1,000 women aged 15–49 and per 1,000 population reversed their trend (Knudsen, 1988). Similarly, total abortion rates and ratios have continued to decline since 1983, while total conception and fertility rates rose since 1985. A recent analysis suggests that this pattern does not reflect an increase in the delivery of unplanned conceptions but rather resulted from a larger proportion of older women wanting to have a child (Knudsen and Jensen, 1989).

Research in reproductive behavior in Denmark is greatly facilitated by the existence of automated population registers. Overall, the findings of this study suggest that, compared to the United States, Danish health care policies and family planning services delivery systems are, in the aggregate, more conducive to the promotion of effective contraceptive practice, more instrumental in conveying information to high-risk groups, and more successful in reducing the incidence of unintended pregnancies and abortions. One of the major reasons for this difference may be the positive and nonambivalent climate of public opinion about sexuality in Denmark and the manner in which health care and family planning services are delivered to all segments of the population regardless of income, age, or location of residence. The Danish system reflects well prevailing public attitudes and adheres to private expectations.

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In this issue

Although Europe today is characterized by the lowest fertility ever witnessed, there are many different reasons behind it.

In this issue of *Entre Nous* Dr Chantal Blayo reviews in depth ways and means of regulating fertility in Europe.

In some countries there is a great deal of contraception, not too many abortions and only few sterilizations. In another group of countries sterilizations are more widespread and therefore abortions are less frequent. In a group of central and eastern European countries abortion appears to be a favoured means of contraception for various reasons.

We were all wrong when we thought that the eastern European countries would pass smoothly from abortion to contraception, from withdrawal to modern contraception, writes D. Pierotti in his article "Padlocked societies". A drastic re-thinking is necessary for specialized family planning and population organizations working in the area. Think big is the key term of a new strategy that might work.

Abortion for social reasons is no longer consistent with the law in Poland. The Senate passed a new abortion law at the end of 1992. Several articles deal with this subject in *Entre Nous*, but in Hungary, at about the same time, a different and much more liberal law was passed.

In this issue of *Entre Nous* you will find other articles on family planning projects in Eastern Europe.

Recently new research has shown an increased risk of prostate cancer following vasectomy. Other studies have not been able to confirm these findings and the impact of all the research is discussed in Dr Van Look's article.

The next issue of *Entre Nous* will focus more on male responsibility and involvement in family planning.

Because of many substantial articles for this issue, *Entre Nous* was made a double issue. Hopefully you will enjoy and agree with us that the articles should all be published.

Contents

EDITORIAL

Family planning in Europe,
by Chantal Blayo.....3

FEATURES

Fertility regulation in Europe

The access to contraception and sterilization, by Chantal Blayo and Amélia Esparteiro Leitao 4

A system of registration and statistics,
by Chantal Blayo.....5

Abortions in Europe,
by Chantal Blayo.....6

Padlocked societies, by D. Pierotti.....10

Adolescents and contraceptive advice,
by Marianne Søndergaard 12

WHO FILE

WHO in the new independent states ...12

Pilot projects in St Petersburg,
by France Donnay 13

Contraceptive or abortifacient.....13

EUROPEAN NEWS

IPPF in Eastern and Central Europe,
by Lynn Thomas.....14

Private involvement in Turkish family
planning, by Yaşar Yaşar 15

"Berdel" 15

Poland turning against the stream 16

Abortion law in Poland,
by Jolanta Sabbat 16

Two forms of argument,
by Mikolaj Kozakiewicz 17

New abortion law in Hungary,
by Dr István Batár 17

RESEARCH

Vasectomy and risk of
prostate cancer.....18

WORLD NEWS

Control of fertility in the People's
Republic of China, by Yves Blayo.....19

MANAGEMENT

The scheduler, the register and the
report card, by Gaston Legrain and
Pierre Delvoe.....20

UNFPA FILE

Two decades in population politics 21

RESOURCES

Books 22
Documents 22
Magazines/Newsletters.....23
General 23
Training opportunities.....

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ENTRE NOUS 22-23, June 1993

GUEST EDITORIAL

Family planning in Europe

by Chantal Blayo

Today Europe is characterized by the lowest fertility ever witnessed. Women on the average have very few children and even the countries which resisted the declining trend for the longest time (Albania, Ireland) today are recording less than three children per woman. To judge by these results, family planning is hardly a problem in Europe. But is it as simple as that? Do couples everywhere in Europe today have a choice of birth control methods?

By simplifying slightly, we can divide Europe into three groups of countries:

1) Countries in which women rely for the most part on medical contraception, where recourse to abortion is only used to correct contraceptive failures, and where irreversible methods are still only used to a limited degree. A great deal of contraception, not too many abortions, few sterilizations.

2) In a second group of countries, the recourse to abortion is less frequent (UK, the Netherlands especially), not because the control of conception is greater but because sterilization is much more widespread.

3) Finally, in the countries of the former Communist bloc, abortion frequently takes the place of contraception and the number of sterilizations is negligible.

In theory, couples have free access to methods of birth control but in practice legal restrictions, administrative conditions, poor reception systems and distribution of information discriminate against those groups of the population who are the least integrated (adolescents, ethnic minorities, migrants, etc.), particularly in certain countries. There remains in fact in Europe a certain inequality with regard to access to the means of birth control.

Administrators of social services are no longer opposed to controlling fertility, they are even rather inclined to be in favour of it, but the legislators occasionally resist, as has been the case in Ireland, or even reverse direction, as in Poland. Furthermore, society does not always allow individuals a real choice of contraception. In some countries, as we have seen, where there is little opposition to abortion, as in many eastern European countries, there is a resistance towards the widespread distribution of modern contraceptive methods; other countries less favourable to abortion place more emphasis on sterilization than on greater strictness in the practice of contraception. And finally we note that numerous systems of reimbursement

tend to favour abortion rather than medical contraception, and the latter rather than the use of condoms.

The proportion of couples protected by the voluntary sterilization of one of the partners has in no European country reached the 40 or 50% level which was recorded in the US and Canada at the end of the 1980s, but has exceeded 20% in the UK and the Netherlands, which are trendsetting countries in this regard. The recourse to sterilization is a recent phenomenon in Europe and the reasons have not yet been studied, nor has an attempt been made to assess the consequences of its slow but progressive diffusion in European countries where the risks of unplanned pregnancy are no longer great.

This issue is concentrating mostly on a review of fertility regulations. This review is the first step of a project initiated in 1990. The project consisted of generalized, simple and easy to handle indicators to assess and monitor family planning services on a routine basis.

Two meetings took place in 1991 and 1992, letters were sent to all the ministries in Europe and to counterparts to get information on their programmes.

The results of this investigation are published here and, unfortunately, will put an end to this project. It was a collective effort spearheaded by Dr Blayo, Research Director at the National Institute of Demographic Studies. She was assisted by the following consultants: Dr A. Leitao, Ministry of Health of Portugal, Ms L. Knudsen, Ministry of Health of Denmark, Ms M. Shabanah and Ms R. Sadana, WHO Regional Office for Europe.

D. Pierotti

Europe has made considerable progress in matters of public health with legislation on the recourse to abortion. Conversely, all prohibitions have had catastrophic consequences on public health; the level of maternal mortality in Albania and Romania (before the most recent change in the political regime), testifies to this. One fears that the legal restrictions recently introduced in Poland will result in a deterioration of the health of women.

Much is said and much is written about the use of contraception, on the recourse

to abortion, on the needs of women, on the resistance to the spread of modern methods of prevention, but the plenitude of the discussion appears to be in inverse proportion to the wealth of the information gathered, of statistical information in particular.

It is, however, impossible to comprehend a phenomenon properly without an analysis of statistical data regarding its frequency. This would appear evident and yet, even in Europe, a continent with a long-standing statistical tradition, the literature in the field of birth control is rife with analyses based on approximations, biased indexes, and partial statistics. The assessment phase is often avoided because of the numerous political and economic interests which are involved in this area and also because everyone suffers from the illusion that he or she knows these questions well, and their a priori ideas are reassured by reading superficial analyses which do not call for costly verifications in this regard.

The evaluation of a phenomenon which is of concern for public health must not be disregarded. If we wish to comprehend the resistance to the spread of contraception, the reasons for the sociocultural choice of abortion, sterilization, or contraception, we must adopt permanent provisions for the recording of these events, in particular of abortions and sterilizations. We must think about the most suitable indicators of family planning, which can inform us of its spread and of the characteristics of the persons concerned in their various capacities, and adopt provisions on recording which will permit us to evaluate these indicators. These provisions must also be adapted to the specific characteristics of European prevention services, the majority of which depend, as we have seen, on private medicine. However ambitious this objective may be, it is in keeping with the interests at stake and its results will determine the choice of actions to be taken.

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Country by country check-
down of sterilization
availability.

Country

FERTILITY REGULATION IN EUROPE

The access to contraception and sterilization

by Chantal Blayo and Amélia Esparteiro Leitão

The various countries of Europe exhibit more similarities than differences as far as conditions of access to contraceptive methods are concerned. Those of eastern Europe, however, are still in a class by themselves in this regard.

The provision of contraceptive pills, coils, spermicidal products, and condoms does not pose problems in the north, west, and south of Europe (excluding Albania), but the supply is less than the demand in the other countries (with the exception of Hungary and the Czech and Slovak republics); this is particularly noticeable in Poland, in the countries of the former Soviet Union, and in Romania. The shortage has been temporarily rectified in Albania and Bulgaria, thanks to the furnishing of significant quantities of these products by international organizations, but their dissemination is hampered by numerous problems of distribution.

As a general rule, only a physician can prescribe an oral contraceptive, and only a physician can insert an intrauterine device (IUD). The services of a specialist are even required in some countries of eastern Europe. Sweden and Turkey, however, have authorised midwives to prescribe contraceptive pills or to insert coils. Actual practice is in accordance with the regulations in the great majority of cases, but in Turkey, Bulgaria, Romania, and perhaps in the countries of the former Soviet Union, the dispensing of pills without prescription, when they are available, is tolerated. Paradoxically Romania, which demands in theory that the prescribing physician should be a specialist, in practice allows the dispensing of pills without prescription in pharmacies, when they are available.

The regulations on spermicidal products are less strict, and they can generally be dispensed in pharmacies without it being necessary to obtain a prescription. Some products, however, are only dispensed on medical prescription in some countries (e.g. Switzerland and France).

Today, condoms are sold in both pharmacies and elsewhere, even in Ireland. This is, however, still not the case in all the countries of the former Communist

bloc, more often due to economic reasons than to a political decision.

The conditions of access to contraceptive products are regulated within the legal framework and differ greatly in nature according to the country. One must distinguish between countries controlled by very restrictive laws in this area (France, Ireland, eastern European countries especially), which have legislated to abolish these prohibitions, and the more tolerant countries that have not had to make any laws authorizing the distribution of contraceptives (which had never been forbidden), but that later adopted legislation confirming the right to family planning and the right to information in this area. This right is even incorporated in the Portuguese constitution of 1976.

Some countries, such as France, refuse to allow the advertising of contraceptives outside of journals intended for physicians, while on the other hand, some countries, e.g. Denmark, encourage this advertising.

For a long time the sterilizations carried out in Europe have only been on medical grounds. Sterilization for purposes of contraception was an absolute exception and liable to be punished, if it was considered as a violation of the physical integrity of the individual, which was under penalty of law.

Today a certain number of European countries have expressly anticipated in their regulations the possibility of a woman or a man submitting to a surgical operation for the purpose of contraception and defined the conditions under which this operation is to be permitted. The obligation of residence in the country is mentioned in many laws; in Finland a minimum number of children (3) is demanded, and age conditions are set (over 18 years in Turkey, with consent of the spouse, over 25 years in Austria, Denmark, Iceland, Norway, Portugal, and Sweden, over 30 years in Finland and over 35 years in Croatia and Slovenia).

There are still many countries in which a legal vacuum exists in this area, where sterilizations for contraceptive purposes are still in danger of constitu-

ting a statutory offence of mutilation. This is the case in France, in all the countries that share a common border with France, in Ireland, Austria, Greece, Malta, and Poland. It is a practice, however, which is tolerated to varying degrees. It is less and less so in Poland, and more and more so in western Germany. Sterilization is still carried out in Spain and Italy, even less in Ireland and Malta, but one can observe a slow progression in this area in Belgium and France.

Voluntary sterilization is legally possible in Hungary and Romania, practised on a small scale in Albania without there being a legal basis for it, and prohibited in Bulgaria.

Finally, we point out that it is in the Netherlands that the proportion of couples protected by the sterilization of one or both partners is the most numerous, without any legislation existing on the subject. As is the case with abortion, we must make a distinction between law and practice.

Family planning services as such have been set up by the governments of several countries, but most often the public family planning services are integrated in other services, such as community clinics, hospitals, pre- and postnatal clinics, which, by definition fulfil many other functions.

Whatever the importance of these services may be, which vary depending upon the country, what characterizes Europe as compared to the world of the developing countries, is the very large share of the private sector, in particular of the private practitioner, in the responsibility for informing and prescribing.

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A system of registration and statistics

by Chantal Blayo

In 1971 the World Health Organization recommended to countries preparing to legalise the recourse to induced abortion that they make provision in their law for an obligatory reporting of all interventions; there remains, however, no permanent registration of abortions in Austria, Greece, Luxembourg and Portugal. There is obviously none in existence in Northern Ireland, Ireland and Malta, where abortion is prohibited, or in Switzerland, where the conditions for legal

recourse are very limited, except in certain cantons. Albania is preparing to institute such a provision.

Registration is, moreover, not always complete where it does exist. This is the case in the former Federal Republic of Germany, France, Italy, Poland, and Spain, and in all likelihood in the republics of the former USSR, particularly Lithuania.

And finally, the information gathered at the time of registration is not always

suitable for providing a good analysis of the phenomenon and not always comparable from one country to another. The data gathered is often further impoverished at the stage of the publication of the statistics: it would not require much effort to provide more extensive, more useable, and more comparable data.

Certain estimations, or even results of surveys, make up for these shortcomings, but by no means completely. To survey those who practice abortions is only possible if one has a register of them. A retrospective survey of a sample representing all women of age 15 years or older would theoretically allow us to reconstruct the statistics on abortions of past years, but at the same time the size of the sample would depend on the women who were prepared to respond, and the fact that it would rely on the statements of the women, whereas forgetting and the desire to dissimulate are obstacles which cannot be disregarded.

The magical quality of the survey is often illusory; few surveys, in fact, offer information on the practice of abortion in the countries of Europe.

Nothing can replace systematic registration accompanied by the publication of a well conceived statistical record. As abortion is always carried out in a hospital environment in Europe, the adoption of such a provision is relatively easy and its coverage depends upon the true willingness of the authorities to achieve this.

Sterilization

It is striking to realize that this phenomenon, which appears to be spreading in Europe, is only very rarely the object of

Europe at War

For the past three years, there has been armed conflict in several countries of central and eastern Europe, especially the former Yugoslavia, and some of the Russian republics. The information we have gathered on activities in family planning pre-date the period of conflict. No member of our team has visited these countries, and we have not met those responsible for preventive programmes.

The lack of recent information, together with a certain reserve in face of the sufferings of these people, has led us to postpone, until a more peaceful time, a discussion of the problems of fertility.

Editorial Notes

Assessing the practice of contraception poses many problems. Photo Lars Bahl/2maj



abortion restrictions
country by country

ABORTIONS IN EUROPE

Access to abortion: The legal context, practice and frequency of recourse

by Chantal Blayo

For a long time various types of legislation concerning abortion have only been adopted in order to set the conditions for prohibiting it. Russia was the first country to authorize, in 1920, the recourse to abortion simply on the demand of the woman concerned. The other republics of the Soviet Union adopted an analogous law in 1921. The USSR subsequently prohibited this recourse (in 1936), only to authorize it once again in 1955. A comparable liberalizing trend then immediately spread to neighbouring countries: in 1956 Bulgaria, Hungary, Poland, and Romania adopted laws legalizing abortion, followed by Czechoslovakia in 1957 and Yugoslavia in 1960. The countries of western Europe did not follow suit until 10 to 20 years later, if one excludes the modest extension of the legal grounds for recourse in the countries of northern Europe during the years preceding the second world war. The liberalization of abortion in eastern Europe, however, was followed 12 to 17 years later by restrictions more or less significant depending upon the individual country: the most remarkable instance is that of Romania, where the ruthless limitation in 1966 of the grounds for authorization put an end to a very extensive liberal tradition. These limitations were further reinforced in 1985, while, on the other hand, in Czechoslovakia in 1986 and in Hungary in 1988 new legislation on abortion abolished the

requirement of obtaining the permission of a special committee. In 1989 and 1990 Romania and Bulgaria respectively reinstated the legal possibility of abortion exclusively on the demand of the woman concerned.

The right to abortion was incorporated into the Yugoslavian constitution of 1974 and between 1977 and 1979 the various republics adopted more liberal legislation than had previously been in effect. The legal conditions for recourse to abortion remained very restrictive in Albania right up until 1989, and were greatly expanded in 1991. Poland, on the other hand, is today proceeding in the direction of repression and voices have been raised in protest against the liberal laws in Hungary and in the Czech and Slovak republics.

If, in northern and western Europe following the last war, legalized abortion was very rare, a general prohibition against abortion is in fact the exception today. If one excludes the very small countries such as Malta and Monaco, where recourse to abortion is completely prohibited, only Ireland retains legislation so restrictive that abortion is not only illegal but also unconstitutional. Northern Ireland has not benefited from the Abortion Act of 1967 which liberalized abortion in England, Scotland and Wales; it has remained subject to a severe statute dating from 1861. In Switzerland, the legal grounds for recourse are

still restricted to medical reasons.

To sum up, recourse to abortion is only prohibited in Ireland and Poland; it is permitted *de jure* during the first three months of pregnancy in the large majority of European nations exclusively at the request of the woman. In those countries where the woman must justify her request by obtaining the authorization of a medical official (England, Scotland and Wales, the former Federal Republic of Germany, Spain, Hungary, Ireland, Italy, Luxembourg, the Netherlands, and Portugal), almost all women desiring an abortion attain one, at least during the first ten weeks of pregnancy.

No European country has, however, actually authorized recourse to abortion without restriction. Furthermore, abortion remains a criminal offence if the prescribed conditions are not respected. Only in Denmark, Norway, Sweden, Bulgaria, the Netherlands, the Czech and Slovak republics, the former Yugoslavian republics, and in the European republics of the former USSR has it been removed from the criminal code.

The recourse to legal abortion is accompanied by various restrictive conditions depending on the individual country (to a limited period of gestation if not on grounds of health, to a minimum length of residence in the country if the woman is a foreign national, with parental consent if she is a minor, etc.) and requirements regarding its administration (the

Continued from page 5

registration, whereas it would be very easy to systematically keep count of the operations carried out in a hospital environment and to gather information on the persons who undergo such an operation. We are thus deprived of precious information. The proportion of couples protected by such an intervention is sometimes obtained by surveys but there is hardly any information on the characteristics of this group.

Contraception

Assessing the practice of contraception

poses more problems, as this practice does not depend upon a single action and in the majority of countries dispensing of contraceptives is made through many different channels (pharmacies, public family planning centres, private practitioners). Moreover, certain methods of contraception require no medical aids.

The activities of family planning centres, where they exist, are sometimes a source of statistical data.

In some countries producers' associations make statistics available on the sale of contraceptive pharmaceuticals or

other means.

Exact surveys enable us to draw portraits of the users and to get to know the methods they employ. Many countries carried out such surveys at the end of the 1970s, within the framework of the world survey of fertility. Today we are a long way from knowing, in all the countries of Europe, the proportion of women who utilise each of the methods of contraception and even farther from being able to fill in the details of the portrait.

It is urgent that we invest in the search for data essential for studying these phenomena.

quality of the practitioner, the type of establishment, procedure to be followed, etc.). England and Wales and the Netherlands are the only countries in which abortion is permitted as long as the fetus is non-viable (whether performed on grounds of health or not) and which do not impose conditions of residence for foreign nationals; however, abortion on demand is not practised.

By a decision of the Ministry of Health, abortion on demand has been possible in Albania since June 1991 without condition if the woman is unmarried and with her husband's consent if she is married.

One must, however, distinguish between legislation and practice. In countries with liberal legislation a woman may, in practice, come up against numerous obstacles to obtaining an abortion. This is, in fact, the case in the west in Austria, in certain Länder of the former Federal Republic of Germany, and in certain regions of Spain where there is still a distinct opposition to abortion. In Portugal the statutes covering the application of the law of 1984 are not always made widely known.

Conversely, liberal practices may become established in countries with a restrictive legislation in this area: the most striking case is that of the Netherlands prior to 1982 and France to a somewhat lesser degree before 1975, and of Belgium prior to 1990, where one could observe frequent violations of the law which went unpenalized.

Moreover, restrictive laws may be interpreted in a more or less liberal manner: the concept of "dangerous to health" required by Swiss law varies appreciably from one canton to another. Similarly, abortion was tolerated in Greece on numerous grounds well before it was liberalized in 1986.

In northern and western Europe simplified techniques are much more in use than elsewhere in the continent. Due to a lack of the necessary equipment (suction curettes especially), many abortions in Europe are still practiced by curettage. The abortion pill, mifegyne (or RU 486 as it is called, after the initials of the laboratory which produced it) is only available in France, Great Britain, and Sweden.

Frequency of recourse

It is in Romania that recourse to abortion is the most frequent (an average of 6 abortions per woman in 1990). Romanian women alone will undergo, during the course of this year, almost half of the abortions carried out in the part of central Europe consisting of Albania, Bulgaria, Hungary, Poland, Romania, the Czech and Slovak republics, and the territories of former Yugoslavia. The practice is also very widespread in Belarus, Serbia, and Russia (more than 3 abortions per woman, almost 4 in Russia). Serbia is the only country outside of the former Soviet Union, with the exception of Romania, to have such a high frequency.



In western and northern Europe women have an average of less than one abortion each. Photo Sonja Iskov/2maj

Between 2 and 3 abortions are recorded per woman in the majority of the European republics of the USSR and in Poland. The frequency is the lowest in Lithuania, if one is to believe the reported statistics (an average of 1.72 abortions per woman). It appears that the social disapproval which has led to the rise of clandestine operations in Poland, a neighbouring country which is also Catholic, may well exist in Lithuania and have the same consequences. A frequency of recourse in Lithuania equivalent to that observed in Latvia and Estonia (an average of 2.6 abortions per woman) would appear to be more credible. The same phenomenon can be observed in the more Catholic countries of western Europe: the recourse to abortion is no less frequent there, quite the contrary, but clandestine practices are more widespread. Thus in Italy under-registration is considerable and, according to the estimates of the Istituto

Superiore di Sanita in Rome, indicates that Italy is the western European country in which women have the greatest number of abortions (an average of 0.7 per woman).

In Albania, Bulgaria, Hungary, the Slovak and Czech republics, and the majority of the territories of former Yugoslavia women undergo an average of from 1.1 to 1.8 abortions.

In summary, the frequency of recourse to abortions remains at a fairly high level in central and eastern Europe, even in Hungary, where it has dropped markedly, since it is slightly higher than one per woman on an average, and has in Russia (and even more so in Romania), soared to record levels. In western and northern Europe, on the other hand, women everywhere have an average of less than one abortion each (0.15 to 0.63 according to the country). Abortion thus appears to be a favoured means of contraception in central and eastern Europe.

RECOURSE TO ABORTION: LEGAL CONDITIONS, PRACTICES AND FREQUENCY

Country and date of most recent legislation	Conditions for legal recourse and practice	Statistics on abortion		
		Year	Absolute number	Average number of abortions (per woman) ⁽¹⁾
Albania 1991 ^(a)	On demand	1991	20 269 ⁽³⁾	1.12***
Austria 1974	On demand (12 weeks) Health reasons (24 weeks)	1986	16 800 ⁽³⁾	0.28***
Belgium 1990	On demand (12 weeks) Health reasons (unlimited)	1989	16 406- 22 144 ⁽⁴⁾	0.21-0.29***
Bulgaria 1990	On demand (10 weeks) Health reasons, rape, incest (22 weeks)	1989	111 042	1.79**
Czech Republic Slovak Republic 1986	On demand (12 weeks) Health reasons (24 weeks)	1990 1990	109 361 47 901	1.56* 1.23*
Denmark 1973	On demand (12 weeks) Health reasons (24 weeks)	1988	21 199	0.56*
Finland 1970	Socioeconomic reasons (12 weeks) Eugenic reasons (23 weeks) Health reasons (unlimited)	1990	12 232	0.356*
France 1979	On demand (10 weeks) Health reasons (unlimited)	1988	216 000 ⁽³⁾	0.51*
Germany, former Democratic Republic 1972	On demand (12 weeks) Health reasons (24 weeks)	1989	75 297	0.63**
Germany, former Federal Republic 1976	Psychological and social reasons (12 weeks) Health reasons (22 weeks or unlimited)	1986	220 000 ⁽⁴⁾	0.47***
Greece 1986	On demand (12 weeks) Health reasons (20 weeks)		n.d.	n.d.
Hungary 1988	Socioeconomic reasons difficulties, extramarital birth, older than 35 years, two children living (12 weeks; 16 weeks for minors) Health reasons (24 weeks) Malformation of fetus (unlimited)	1990	90 394	1.24*
Iceland 1975	Socioeconomic reasons, rape, incest (12 weeks) Health reasons (unlimited)	1987	700	
Ireland 1861	Abortion was declared unconstitutional in 1983	1989	3 721 ⁽⁷⁾	0.15***

Notes

Weeks = weeks of gestation following conception. The definition of the length of gestation is not always precise; it is possible that the periods referred to in the table are actually the number of weeks which have elapsed since the last menstrual period. We note that the authorization to perform an abortion on grounds of health after the first trimester of a pregnancy is subject to stricter procedural restrictions than we have descri-

bed here.

- (a) Ministerial regulation; legislation is in preparation
- (b) Northern Ireland is still subject to the statute of 1861 which forbids the performance of an abortion regardless of the grounds on which it is requested.

(1) Average number of abortions per woman, calculated

* according to the cumulative rate of abortion by age;

** by using the method of weighed

mean;

*** by multiplying the proportion of abortions to live births by the total birth rate.

Despite the fact that the distribution of abortions according to age differs from the distribution of births according to age, this approximation gives a good indication of the magnitude of the frequency with which abortion is performed. (2) Abortions conducted in hospital and abortions done without hospitalization. It is probable that abortions were not yet fully reported in 1990.

ENTRE NOUS 22-23, June 1993

Country and date of most recent legislation	Conditions for legal recourse and practice	Statistics on abortion		
		Year	Absolute number	Average number of abortions (per woman) ⁽¹⁾
Italy 1978	Socioeconomic reasons (90 days) Health reasons (viability of fetus)	1988	280 000 ⁽⁸⁾	0.65*
Luxembourg 1978	Socioeconomic reasons (10 weeks) Health reasons, rape (22 weeks)		n.d.	n.d.
Netherlands 1981	Risk to the life or mental health of the woman (very liberally interpreted) (viability of fetus)	1988	18 000	0.15*
Norway 1975	On demand (12 weeks) Health reasons, rape (24 weeks)	1988	15 852	0.51*
Poland 1992	Risk to the life of the woman (unlimited)	1989	400 000-600 000 ⁽⁹⁾	1.50***-2.20
Portugal 1984	Risk to the physical or mental health of the woman, rape (12 weeks), eugenic reasons (16 weeks) Regulation on application not yet adopted as of January 1993		n.d.	n.d.
Romania 1989	On demand (12 weeks) Health reasons (24 weeks)	1990	992 265	6.00***
Spain 1985	Rape (10 weeks) Eugenic reasons (22 weeks) Risk to the physical or mental health of the woman (unlimited)	1987	63 900 ⁽¹⁰⁾	0.23*
Sweden 1974	On demand (18 weeks) Health reasons (24 weeks)	1988	37 585	0.65*
Switzerland 1937	Medical reasons (viability of fetus) (interpretation of "mental health" varies from one canton to another)	1981	13 000 ⁽¹¹⁾	0.28***
United Kingdom England & Wales ⁽⁸⁾ Scotland	Risk to the life of the woman, her physical or mental health, the physical or mental health of the children in her family, risk of malformation of the child to be born (viability of the fetus)	1989 1989	179 463 10 209	0.42* 0.26*
European republics of the former USSR	On demand	1989	5 769 709 ⁽¹²⁾	3.70***
Republics of former Yugoslavia 1977-1979 Serbia 1991 Slovenia 1991	On demand (10 weeks) (Serbia: 8 weeks) Health reasons, rape, incest (unlimited)	1986	359 567	2.00*

(3) This figure does not include legal abortions performed outside hospital and is an underestimate of the number of abortions performed in Austria.

(4) 16 406 corresponds to the number of abortions reported in the investigation of B. Tissot et al. and abortions performed on Belgian women in the Netherlands and the United Kingdom; 22 144 corresponds to the maximum number of abortions performed on Belgian women in 1989, according to the estimates of the authors.

(5) Estimate by INED. The total rate of abortions has been corrected by the same proportion as the absolute figure.

(6) Statistics reported by Social Security, presumably more reliable than the number of registered abortions.

(7) Abortions on Irish women performed in England and Wales.

(8) Estimate by l'Istituto superiore di Sanita in Rome. The total rate of abortions has been corrected by the same proportion as the absolute figure.

(9) Estimate quoted by M. Kozakiewicz.

(10) Estimates by Spanish family planning; the ratio between this number and the number of abortions reported gives us a corrective factor to be applied to the total rate of abortions calculated on the basis of reported numbers of abortions.

(11) As estimated by P.A. Gloor et al.

(12) Number of abortions performed on women in hospital, of women hospitalized after abortion and of women undergoing suction curettage in a mobile care unit.

Pad locked societies

by Daniel Pierotti

A drastic rethink is necessary for specialized family planning and population organizations working in eastern Europe.

Revolutionary events in eastern Europe have not only transformed the political face of Europe and changed the way of life of millions of people. They have also made a drastic rethink necessary for specialized aid organizations. These countries have benefited from a flood of sympathy, emanating especially from western Europe. They are European, Caucasian, they share our religious and cultural roots: only their political choices, sometimes imposed from outside, differentiates them a little from us.

Family planning, a little dot drowned in the massive expanse of programmes of economic restructuring and institutional development, benefited particularly from the favourable context. Family planning was a familiar concept, and there were no preconceptions regarding particular forms of contraception. A contraceptive industry had been created and exported. Density of medical services was good, there was only a lack of suitable medical equipment, modern contraceptives and the concomitant training. Over five years, western contraception was to become the norm, a way of life. These brother nations would pass smoothly from abortion to contraception, from withdrawal to oral contraception.

We were all wrong

Little by little, disillusionment and discouragement have replaced the feverish enthusiasm of the first few years. What has happened? Where have we gone astray?

Social phenomena that were underestimated at the start had completely invalidated the data. One does not wipe out two generations of enclosure by a few months of good advice.

Certainly, the contacts appear excellent, and there are liaison personnel who are both articulate and brilliant, but with the exception of a few national variants, the unwritten rule remains immutable: those decisions which are made are, without exception, restrictive in nature. The reflex to close up is universal. It is relatively easy to cite a series of facts to illustrate our theme, in the form of a patchwork, drawn from here and there on our visits to various countries.

Those who have been granted fellowships abroad to be trained in the practice of modern contraceptive techniques are reluctant to accept the idea of sharing their new expertise with their colleagues who have remained at home.

Distribution of contraceptives supplied by agencies is carried out stealthily in a

random mixture: a few pills here, a few condoms there. As to the juiciest titbit, the IUD, only a handful of privileged pharmacies have the right to it. Women receive no information on the types of contraception available, where they can acquire what they need, or at what price. This enables certain unscrupulous practitioners to re-sell these luxury products clandestinely.

Family planning services sometimes remain in the abstract, while maternity clinics are only half-open, guarded by an arrogant warder to whom the reasons for the visit must be explained in public view; there is no indication of where and when consultations take place.

Specialist consultations have not yet been introduced, and this reinforces the obscurity and the vague, magical aspect of contraception. As for policy on training of staff, it remains restrictive and obscure.

The address of the family planning centre is passed on from friend to friend, among initiates who pay for the privilege. Information is conspicuous by its absence from the programmes. Nursing and midwifery staff, even when trained, are only used very exceptionally in this capacity. Contraceptive education given to women is carried out in difficult conditions by overworked staff, such as in the pre-abortion or post-abortion ward.

Audiovisual equipment is under-utilised, and is more likely to be covered with dust in a store room than covered with fingerprints in a classroom. It is occasionally lent to projects of this kind when necessary, and after lengthy negotiations.

Medical equipment is distributed without being checked, without written instructions (or instructions in a foreign language), and is to be found either dispersed indiscriminately through the service, or religiously exhibited, still in the original packaging, unused, or jealously guarded by the director's midwives.

Doctors prescribe without written reference such as specifications, books and manuals: so they cannot verify their knowledge or correct their prescriptions.

There is no machinery to monitor the quality of action. The very word seemed to strike our colleagues as obscene. Each one is dug into his or her own territory, jealously defending their own expertise.

We need not discuss here the "waltz" of those liaison personnel trained for the project who simply disappear or are mysteriously transferred.

The most symbolic element came to light by chance during a routine ground visit to a maternity facility of average size. In one of the consulting rooms, a sterilizer took pride of place, on a table and in working order, but closed with an

enormous brass padlock. Only a chosen few within the service were privileged to possess a key. This piece of equipment, muzzled, on public display, exemplifies the beautiful yet useless gesture.

These few examples could easily be repeated ten times over. Obviously, some will retort (and it is true, as we have also said) that there are great variations, and there are even a few rare places where the quality of service leaves nothing to be desired. But in general, the interests of women simply do not figure in the priorities of health professionals. Initiatives and user-friendliness are not the order of the day, but hesitancy and reluctance have become so.

Our liaison personnel were a dream. *Mea Culpa*. We must wake up. We must totally rethink our strategy, and relocate it in a new context, by downgrading our initial aims.

Opening up to the outside world, making contraception a part of everyday life, the creation of counter-measures, common language and partnership: these are the key words on which our actions must be based.

Opening-up to the world

Study trips are essential. How could one imagine that professionals and managers within the health service, who have never left their own country, could work in any way other than the restrictive one they have always known?

Learning to take contraception for granted

Contraceptives should be everywhere. They should be as readily available in the pharmacy as an antibiotic or an aspirin compound. At the beginning of a programme, one must be generous. One must think big. The common modern methods - IUD, oral contraceptives, condoms should be available in all pharmacies. If local conditions permit, we should introduce injectables and implants, put contraceptives on sale in grocery stores, but always with a generous hand. It is worse for a programme to be faced with a shortage than to throw away some date expired contraceptives.

The cost of contraceptives must be reasonable even for those who are short of money. Recommended prices for contraceptive products should be publicized, on TV or in print, by the national authorities, in order to avoid opening the floodgates for predatory opportunists.

Information on consultation hours must be clearly displayed and familiar, and consultations must be carried out in a manner which ensures confidentiality and attains public respect.

In order to accept contraception properly, women must be receptive. This is

not the case at the time of an abortion. Faced with the medical establishment, groups of consumers must be stimulated to act as defenders of the public interest, in order to avoid possible excesses. We should finance specialized associations and women's groups and train them to make and run their own information services.

We must educate pharmacists for their role of advisers to women. We must distribute posters and pamphlets. Let us not forget the representatives of the specialist media with an interest in the problems of reproductive health: we must put across to them the appropriate message, facilitate their communication with colleagues in other countries, create a network, which will be supported by documentation sent out regularly in the form of updates.

Common language

All those who prescribe must have access to technical information and reference books on contraception, in the language of the country.

There must be no elitism in the knowledge of contraception. All concerned personnel - gynaecologists, obstetricians, general practitioners, midwives - would benefit from reference works in their native language.

For the population in general, informa-

tion must be made available in popularized form: information leaflets in the local language should be produced and distributed at consultations. Posters of all kinds should brighten the countryside. TV should play a dynamic informative and educative role. International agencies need to develop their networks without any preconceptions, so as to avoid the surprise of overlapping, or of fundamental differences of viewpoint. The experience brought to the project by both sides would contribute to its success.

Developing a real partnership

Midwives and nurses are the only health service professionals who are able to give adequate information to women in gynaecological or obstetric care. They are in contact with the women, and they are available. They alone must be entrusted with the responsibility for contraceptive information within the service. These professionals must be regarded as full partners. They should have the benefit of national responsibilities, study trips, and grants, with an equal entitlement to that of doctors. They must have the equipment and the reading matter they need in instructing the women.

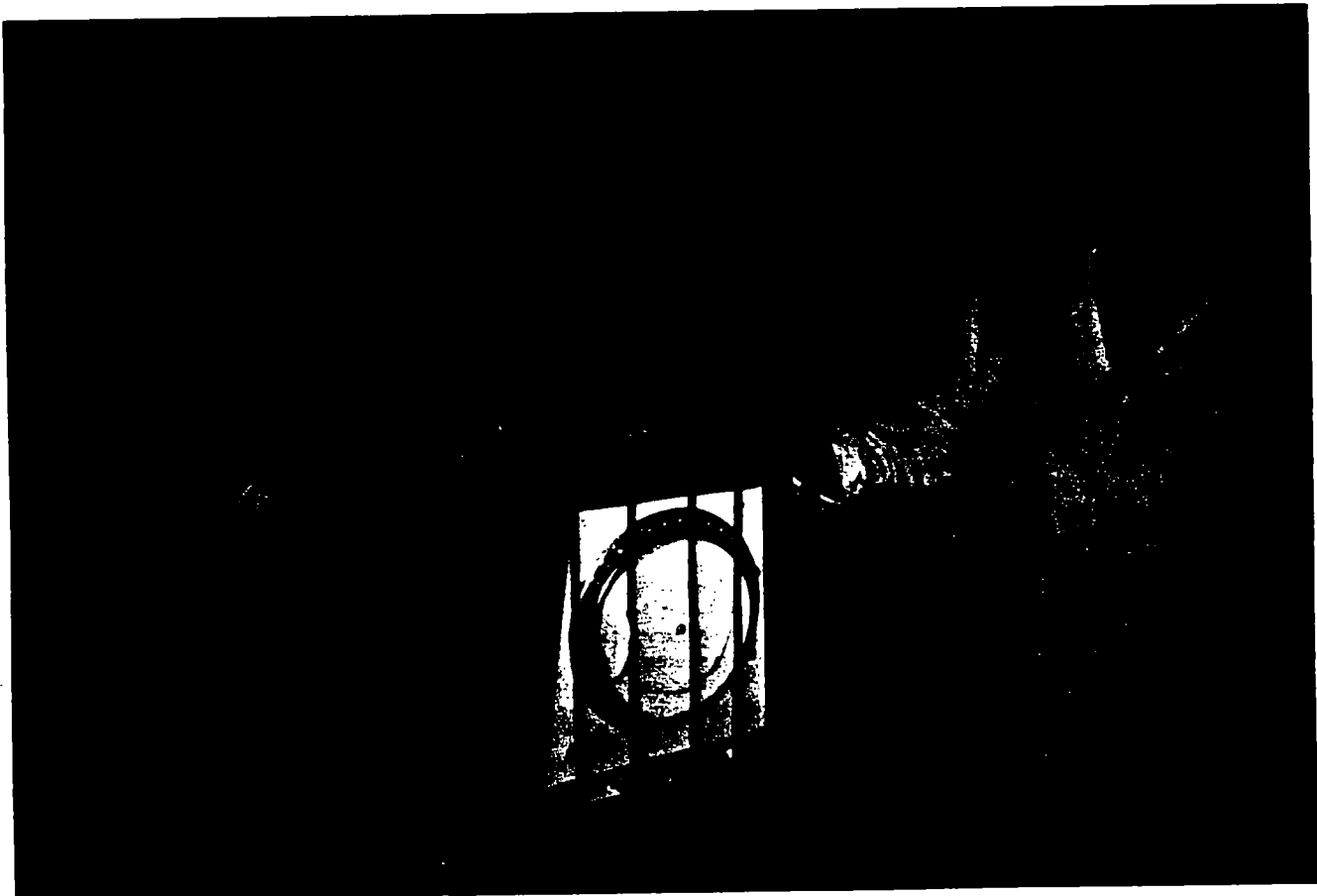
When a project is put into practice, we should ensure a more intensive presence. Every two or three months, we should

visit for two weeks, instead of making lightning visits once or twice a year, which are more diplomatic than efficacious. We should lay down quarterly plans of action, detailing different activities to be accomplished. Let us act with vigilance and goodwill. Let us reawaken supervision: there can be no harmonious project without objectives, and no coordinated development without supervision. If some find the word distasteful, we may call it "guidance", but let us retain its essential nature: to keep the project on the rails.

These proposals are not original. They cannot take the place of grants, local training, provision of equipment, schemes of evaluation. They deal solely with the public service centres, because that was our brief. The proposals highlight a certain number of indispensable measures, which are sometimes neglected or allowed to fade into the background, but which, in the case of eastern Europe, because of their cumulative effects, are essential to the success of the programme.

Dr. D. Pierotti

A sterilizer closed with a padlock illustrates that rethink is necessary in eastern Europe. Photo D. Pierotti



Adolescents and contraceptive advice

by Marianne Søndergaard

In the Scandinavian countries there is no lower age limit for adolescents' access to contraceptive advice

Denmark attaches great importance to avoiding barriers which prevent young girls from seeking contraceptive advice. It is preferable to offer easy access to this information and counselling to adolescent girls having unwanted pregnancies.

There is, in Denmark, no lower age limit for adolescent girls' access to seeing their general practitioner (GP) for instruction in the use of contraceptive methods. That means that all - irrespective of age and without parental consent - can receive this guidance.

In addition to this, the GP is bound to observe professional secrecy at this counselling which means that parents cannot request any information at all from the GP in this matter. And there must be specially weighty reasons to break this professional secrecy. It is thus stressed that a young woman should not refrain from seeking advice out of fear

that her parents will know about her intimate life, and that she protects herself against unwanted pregnancy resulting in a subsequent induced abortion.

It is not desirable to fix any age limit for adolescents' right to seek this advice because it concerns the adolescents' actual sex life and not the parents' - or others', for that matter - ideas or opinions of how they wish this should be. After the introduction of free abortion, many quite young abortion-seeking girls turned up.

Free of charge

It is the wish to strengthen the development that all children receive the necessary sex education at school, as well as to ensure that there is easy access to information on contraceptive methods. It is likewise important that the GP's counselling is provided free of charge so that a young woman does not refrain from seeking contraceptive advice for economic reasons.

Finally, it is stressed that there should be an alternative contraceptive counsel-

ling service in case a young woman for some reason or other does not want to consult her GP on this matter. The girl may be too shy and prefer a more neutral place to go to, maybe because the GP is the family doctor and has known her since she was a baby. A number of contraceptive clinics are thus available all over the country.

It is characteristic of Denmark as well as of the other Scandinavian countries that the access to information and counselling on contraceptive methods is given a high priority in view of promotion and improvement. This is done by avoiding all barriers of an economical, geographical, ethical or emotional character.

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WHO FILE

WHO in the New Independent States

WHO will act as clearinghouse for information on health assistance to the New Independent States (NIS).

An information newsletter entitled "NIS Health News" is published in English, French and Russian and serves as a diffusion channel for information on all aspects of the health situation, including its evolution and assistance received and cooperation established in the NIS. The first issue was distributed in October 1992.

Besides the existing database and country profiles that together provide some information of the health situation country-by-country, additional material, such as gaps and overlaps in support, is being added.

In order to obtain this information, close collaboration is maintained with the different permanent missions in Geneva to keep track of activities being carried out by countries as well as donati-

ons of vaccines, pharmaceuticals and medical supplies in terms of technical assistance and training. The missions are requested to provide information on the nature of assistance, quantities, costing, dates and place of delivery, etc. This should permit an identification of the needs which are not yet met by the donor community.

The main functions of the clearinghouse are: identification, collation, analysis and dissemination of information on priority health care needs; informing the international community on the health situation including analysis of needs and support received; establishment of communication mechanisms through comprehensive databases drawing on multiple information sources; monitoring the evolving health situation in each republic, and maintaining country profiles.

The clearinghouse is assisting Kyrgyzstan in collaboration with the Minister of Health, in the formulation of its health budget for 1993. Three principal categories were highlighted: quick disbursement of drugs, vaccines and medical supplies; technical assistance in the

medical field; and long-term investment such as hospital to hospital partnerships, pharmaceutical production, etc.

WHO is working with the OECD in Paris to use its data register and has also intensified its coordination with the Moscow office of the International Federation of the Red Cross, especially in relation to the clearinghouse function. At their request, a technical consultation on pharmaceutical kits for essential drugs for children's hospitals was organized in October 1992. Collaboration with the European Commission, the World Bank and the European Bank for Reconstruction and Development, and other UN agencies, has increased.



Pilot projects in St Petersburg

by France Donnay

Within the framework of the Healthy Cities project of the World Health Organization's European Regional Office, quite an ambitious programme has been undertaken in St Petersburg: renovation of maternity hospitals, ante- and postnatal services, and family planning centres. The project is supported by the communities of Hamburg, Milan, Rotterdam, Stockholm and Turku, and by the School of Public Health in Nottingham. Four pilot projects have already been launched.

Advice centre for adolescents

Contraceptive advice and prescription, termination of pregnancy, screening and treatment for sexually transmitted diseases (also for boys), psychological advice, groups for young mothers, and teaching of the young at sessions of audiovisual instruction.

The centre is already much visited. During my visit I was struck by the enthusiasm of the staff for an active new dialogue with the young. But I was also struck by the gaps in knowledge, due to the lack of recent medical information, for instance contra-indications against prescribing the pill to young women. On the other hand, the old techniques of physiotherapeutic treatment, forgotten in western Europe, seemed to have a real role to play here. Following an abortion, for instance, why not enjoy the benefit of a massage, a course of ultrasound or infra-red. Why not a face-mask for acne, for a few at a time, in a small, warm room where it is easy to talk.

Home for Single Mothers

A maternity clinic or "lying-in" home, serving young women in very poor circumstances. It offers them material security, clothing, medication, meals provided before and after the birth, as



An advice centre for adolescents on contraceptives, sexually transmitted diseases, etc., has been set up in St Petersburg. Photo Anders Petersen/MIRA/2maj

well as an approach to maternity stay which is entirely new to the city: rooming-in, fathers present (not a success), feeding on demand.

Rehabilitation centre for high-risk patients

A residential facility for 125 pregnant women at risk, in a building located outside the city and away from its pollution.

Family Planning Centre

Located in a large hospital in the heart of the city, the centre already covers all aspects of family planning: contraception, terminations, sterilization, investigation of infertility, amniocentesis, laparoscopic surgery, reception and instruction of patients. The balance between the various activities has not yet stabilized. There are too many abortions, too little

contraception and treatment of sterility.

A "Consensus Conference" was held from 9 to 11 December 1992, with the participation of representatives of the towns concerned, and delegates from the maternal and infant health services of all the districts of St Petersburg. Resolutions were made, but many new ideas, more concerned with the patient/client relationship than with technique as such, were also discussed.

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Contraceptive or abortifacient

In the Maltese islands (in the Mediterranean), a controversy about the IUD functions as an abortifacient or a contraceptive has been going on since February.

More than 98% of the little more than 300 000 of the Maltese are Catholics and for the most part practise their faith. Thus the church plays a major role in the culture of the island. Induced abortion for any reason is prohibited. If the IUD can be classified an abortifacient, the IUD will be prohibited too. The controversy got started by a letter to the editor in one of the main papers, written

by Dr. J. L. Bonnici, USA. He argues that the IUD is an abortifacient and he supports this argument partly by quotations from Dr Van Look, Acting Director, Human Reproduction, WHO, who writes: "there is no doubt that there is a higher spontaneous abortion rate in women who become pregnant with the device in situ."

Dr Bonnici and others think this statement strongly support the IUD as an abortifacient. They do not discuss or consider the fact that the increased risk of spontaneous abortions are only increased if the IUD is left in place in the event of an accidental pregnancy. If the device is removed, the subsequent risk of spontaneous abortion is no greater than normal. It is therefore good medical

practice to remove the device if an intra-uterine pregnancy is diagnosed. Dr Patrick Rowe, Medical Officer, Human Reproduction, WHO, concludes on the scientific data on the IUD. It is a contraceptive: "There is no scientific evidence that the mode of action of intra-uterine devices is abortifacient in nature or that the device disrupts implantation. All available evidence including research that has confirmed the conclusions reached by the WHO Scientific Group indicate that the IUD interferes with sperm migration in the upper female genital tract and/or ovum transport."

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EUROPEAN NEWS

IPPF in central and eastern Europe

by Lyn Thomas

IPPF's attention has lately been focused on establishing and supporting non-governmental family planning organizations.

IPPF had member associations in Bulgaria, the former German Democratic Republic, Hungary, Poland and Yugoslavia for many years. Since the political changes that have taken place in these countries the PPAs have been able to review their roles and they can now play an important part, not only in the provision of high quality family planning services, but also in providing training to health professionals and information to the general public.

In addition, contacts in other countries: the Czech Republic, Albania, Romania, the Slovak Republic, and Russia are leading to an increasing number of associations being established.

IPPF has been able to provide seed money for many of these newly formed organizations, enabling them to set up, at the very least headquarters with basic equipment and to employ a coordinator/director.

Each association is in a different phase of development, and each is in the process of planning their future activities. The Regional Bureau organized a workshop on strategic planning in 1992 for these countries, which provided some guidelines on how a strategic plan could be developed, including the need for the associations to look closely at their country situations, to identify other players in the family planning field and to ensure that they were "doing the right things" and not simply "doing things right".

Governments should be the main providers of family planning services and these services should be integrated into the national health systems. The role of the NGOs is to work in parallel, to sometimes do the things that governments might find politically difficult - such as services for adolescents - and to advocate for sexual and reproductive rights. NGOs are able to act as pressure groups, encouraging governments to take seriously the problems of women who are faced with abortion as their only means of fertility control and to monitor the quality of such services that do exist.

Impressive speed

The speed with which NGOs can become well established has been impressive. Whilst Ministers of Health are rapidly coming and going and national programmes to introduce comprehensive family planning services are constantly delayed, a PPA can be up and running within months of its conception. The associations in Romania, Society for Education on Contraception and Sexuality (SECS), and the Family Planning Association of Russia are examples of this. SECS was established in March 1990, it now has representation in 26 of the 40 judets, provides training for general practitioners, is training trainers in FP and is currently developing programmes on sex education for teachers. In 1993, SECS will open its thirteenth clinic, with joint IPPF/European Community funding.

The Russian Family Planning Association (RFPA), established in December 1991 will be opening its second clinic, which will also be a training centre, in the North West Region of Moscow within the next few weeks. In addition, the RFPA has set up more than 25 branches during the year. If sufficient funding can be found, the association will divide the country into eight geographic Regions and each will have a model clinic and training centre. The association has also produced videos, translated several IPPF medical Publications into Russian and is in the process of producing five television programmes on different methods of contraception and on abortion.

With joint IPPF/European Community funding, programmes are also being developed in Albania, Czech Republic, Hungary, Poland and the Slovak Republic. Each programme includes training, development of information and education materials and clinic services, on varying scales.

IPPF is hoping to organize a meeting for our contacts in the Baltic States to discuss future collaboration. In January this year I had the opportunity of meeting people from each of the Central Asian Republics during a meeting on Maternal and Child Health in Alma-Ata organized by USAID, and IPPF is now discussing what kind of support they

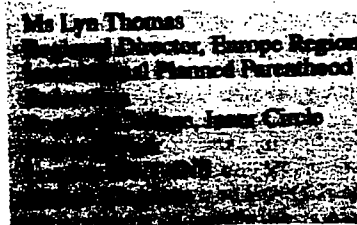
need. To date our limited resources have kept us from being active in other states of the former Soviet Union, but we anticipate increased activity during 1993 and beyond.

Women's organizations

An important component of Regional work has been developing and maintaining contacts with different women's organizations working in the area of reproductive rights, these include the Women's Global Network for Reproductive Rights, European Network for Women's Right to Abortion and Contraception, Catholics for a Free Choice, International Women's Rights Action Watch and many others. The changing political situation in central and eastern Europe is, in many cases, having a negative impact on women's health, status and reproductive choices and this networking is enabling us to keep abreast of the changes and to work together to help minimize the difficulties they can cause.

More recently we have been collaborating with groups concerned about the torture and rape of women in former Yugoslavia, hoping to provide some practical assistance where possible.

It is a very exciting and challenging time to be working on reproductive rights and health issues in Europe. In the IPPF Europe Region we are optimistic that by responding to needs expressed by our colleagues in central and eastern Europe and being sensitive to their difficult and changing circumstances, much can be achieved in a short space of time by the nongovernmental sector.



Private involvement in Turkish family planning

Involvement of the private sector is considered a must in the Turkish Family Health and Planning Foundation

Turkey is characterized by a wide range of population problems. In addition to excessive population growth with limited resources, which remains one of the most pressing problems, an unbalanced population distribution within the country, unplanned urbanization and explosive growth of cities and poor distribution of human resources all contribute to the urgency of the situation. Furthermore, the pressure to provide for the health, housing and educational needs of the growing population; the burden on urban infrastructure; and the economic and social imbalance associated with internal and international migration pose serious problems for the Government and the economy.

The population in Turkey was 56.4 million in the 1990 Census and with the present growth rate of 2.2%, it will double in 31 years.

The Turkish Family Health and Planning Foundation (TFHPF) was established in order to provide alternative and

innovative solutions to the economic and social problems caused by this fast population growth. It is a private non-profit organization that was legalized by a Council of Ministers decree on 14 September 1985 and a civil court decision on 14 November 1985. The purpose of the Foundation is to improve and expand family planning and health services in Turkey.

All goals of the Foundation are to be achieved through the involvement of the private sector. The leaders and creators of the organization are prominent businesspeople, university professors and heads of trade and employers' confederations.

A strong commitment to the issues of family planning by the private sector is a must. Our supporters are people who view global population growth as an issue that affects our collective capacity to wrestle effectively with virtually every other issue of human need: health care, literacy, food supply, environmental protection and economic justice.

The goal of the Foundation is to encourage the private sector to be actively involved in improving the quality of life

of families in Turkey by expanding and increasing the efficiency of family planning services.

The scope of work for the Foundation includes:

- Public education, information and motivation in family planning;
- National and international training and seminars;
- Publication and dissemination of health information;
- Establishment and operation of health and family planning clinics;
- Management and distribution of contraceptives;
- Activities related to nutrition, maternal and child health;
- Research, evaluation, demonstration and pilot projects;
- International and national collaborative activities.

We believe that the final outcome of all our activities is to have healthy mothers, healthy children and consequently healthy and happy families.

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Berdel

The Turkish movie "Berdel" can only be highly recommended for everybody

involved in family planning. The importance of the movie goes way beyond the borders of Turkey.



The movie "Berdel" tells the story of Hanim and Omer who were deeply in love with each other until they came into conflict after the birth of their sixth daughter. The birth disappointed Omer, because he wanted a baby boy and he blamed his wife for his lack of a male offspring. Given local custom he took a second wife, hoping she would bear a son.

The first wife Hanim, the second wife, the daughter exchanged by Omer in order to marry the Kuma under the "Berdel" all became the victims of tradition.

"Berdel" is directed by Atif Yilmaz and produced by Gülseven G. Yaşar. It is made for the Turkish Family Health and Planning Foundation (TFHPF).

TFHPF Board decided that the motto of the Foundation, which is "Have as many children as you can afford and make happy", could most effectively be spread by mass media, that is cinema, radio and television and a family planning campaign, to increase awareness, should be started.

To this end, in March of 1987 a scenario competition was started by the Foundation. "Berdel" was chosen as the best scenario out of 96.

Contact: The Turkish Family Health and Planning Foundation.

Poland turning against the stream

A law on the protection of the fetus was passed by one vote in the upper chamber of the Polish parliament in early 1993. This extremely restrictive law led to heated debates in both houses of parliament. Many people who wish to be heard on this subject have been in touch with *Entre Nous*, but we lack space for all they have written. Poland is the first country in Europe to turn against the stream, in reversing an arrangement of abortion on demand.

In Romania and Albania, in contrast, the alteration in the abortion law has proved a real case study, and has produced spectacular effects.

Legalization of abortion, and its practice in a secure surgical environment, has led to an immediate and massive drop in the maternal mortality rate - over 50% in Romania and Albania, in under two years.

Once abortion is legal, women do not die of it. It should be noted that the conditions prevailing are far from offering the comforts of western countries: limited availability of instruments, obsolete technique (dilation and curettage), shortage of anaesthesia and pain control, and lack of post-abortion contraceptive advice.

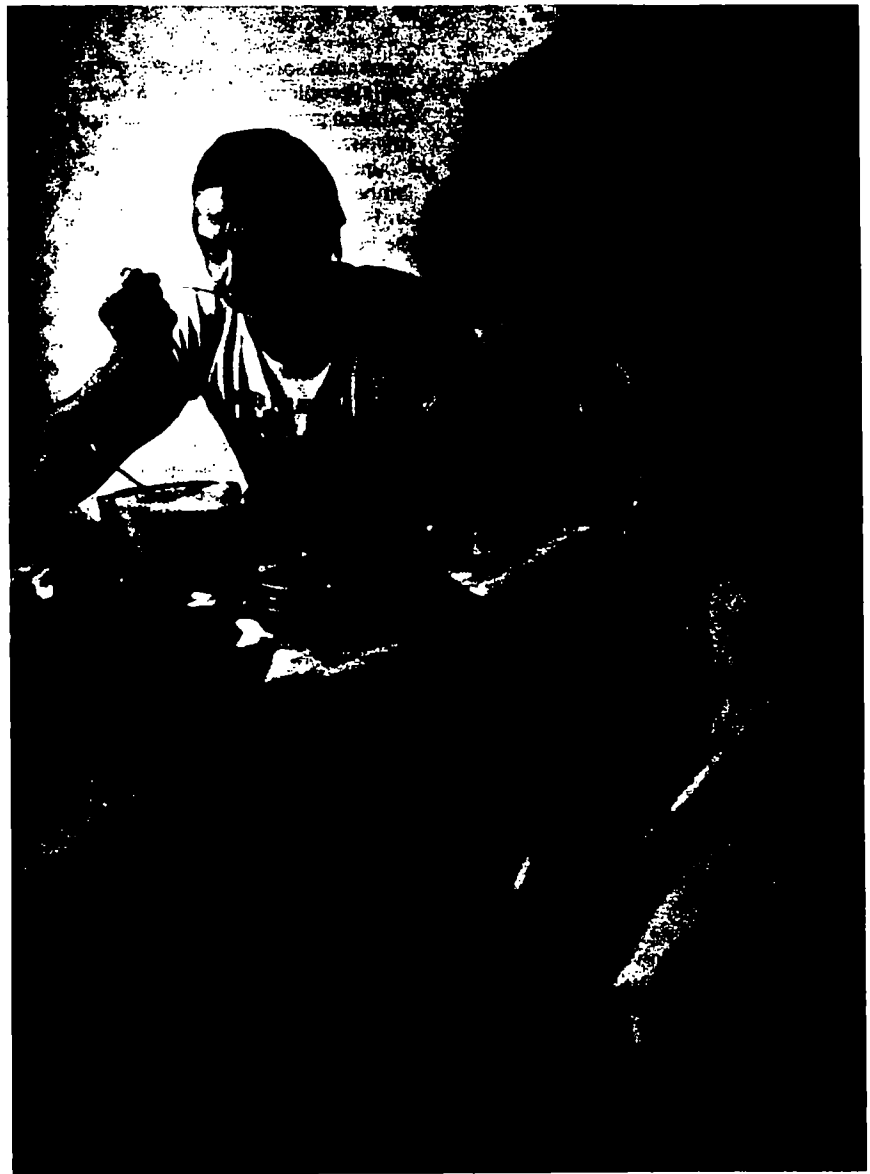
Legalized abortion in these two countries is still practised, albeit now legally, as a method of controlling fertility, specifically due to the fact that the environment is hostile, or at least indifferent, to contraception.

While the major result of the legalization of abortion is a drop in the rate of maternal mortality, the changeover from abortion to contraception, in a hostile context, is clearly more difficult, and slow to take root. The introduction of contraception in a hostile environment is similar to the introduction of modern agricultural technology into a traditional rural society.

Poland will constitute a reverse case study to that of Romania and Albania, i.e. the maternal mortality rate could rise again among the poorest women, who would resort to the services of untrained abortionists. Thus economic discrimination will emerge, as the more wealthy women travel abroad for abortions.

Without taking sides in any way, one must recommend, at the very least, an active and broadly-based policy on modern contraception which would include: public information, training of personnel, arrangements for modern contraceptive methods to be available, easily accessible, inexpensive, and for them to be distributed without discrimination by age, marital status or sex.

Dr. D. Pieroni



A law protecting the fetus, banning abortion was passed by one vote in the Polish Parliament. Photo Hakan Pieniowski/MIRA/2 Maj

Abortion law in Poland

The Senate has passed the Abortion Law without modification and by one vote. This means that indications for legal termination of pregnancy include threat to life and health of the mother, pregnancy resulting from criminal activity and congenital disorder of the fetus. Social indications will no longer be consistent with the law.

Concerning sex education and family planning, Article 2, point 2 of the law states that the local authorities according to their terms of reference, defined elsewhere, are obliged to ensure unhindered access to methods and articles used in

informed parenthood. In Article 4 sex education, information concerning informed and responsible parenthood, family values, life in-utero and methods of informed procreation will be introduced into the school curriculum. The responsibility for the details of the curriculum will rest with the Minister of Education.

The Law requires the President's signature before its contents can be implemented.

Two forms of argument

Professor M. Kozakiewicz, a member of the Polish Diet, has served as president of the parliament, president of the Polish Association for Family Planning, and vice president of the IPPF. To some he is an eminent and respected person, while to others he is the enemy. Professor Kozakiewicz has sent us the contents of his two speeches in the Polish Diet, made respectively on 30 June and 30 December, 1992. Due to lack of space, we are not able to publish them in their entirety, but we highlight here the principal ideas. Two forms of argument are developed: on the one hand juridicopolitical, on the other hand arguments on public health, justice and equality.

Juridicopolitical arguments

The law on voluntary termination of pregnancy concerns all Poles.

Instead of a vote in parliament where only eight members are women, would it not be preferable to hold a referendum, which would be far more representative?

Professor Kozakiewicz asks himself what the profound motives can be of

certain groups of members: is it possible that a group of members want to impose their view of voluntary termination of pregnancy on everyone? Is it possible that the members are proposing the transformation of a moral standard into a constitutional law which is also binding on non-Christians? Is a juridical precedent being created whereby constitutional law will be submitted to the church's moral authority? Is it possible that certain people wish to make Poland into a model state where all legislation will conform to the church's moral standards?

Each member of parliament will make his or her decision, not from profound conviction, but on the basis of assessment of the chance of reelection, depending on whether he or she supports or opposes the law on abortion.

Arguments of public health, justice and equality

Professor Kozakiewicz reasserts that voluntary termination of pregnancy is an evil, but a necessary evil. It should not

be a means of birth control, but an emergency exit. To campaign against VTP is to propagate sexual education and knowledge of contraceptive methods.

The law will discriminate. It will affect women in poor circumstances, while those who are wealthier will travel abroad, as Spanish, French and German women did in 1970. This is demonstrated by the fact that when legislation on voluntary termination of pregnancy was liberalized in those three countries, the flood of mass migrations for abortion slowed down, and then ceased. The law as it stands makes no mention of sex education, but demands the inculcation of "respect for human life from the moment of conception".

For Professor Kozakiewicz, the law in its present form does not correspond to the real sexual lives of men and women at the end of the 20th century. One clause of the law discusses homicide. Professor Kozakiewicz wonders, if voluntary termination of pregnancy is homicide, why is the doctor condemned, but not the woman.

The Editor

New abortion law in Hungary

by Dr. István Batár

In December 1992, the Hungarian Parliament revised the abortion law.

The new law is in some ways more liberal than the former one. A woman can now have an abortion on demand within the first 12 weeks of pregnancy, if she is in a "crisis situation". A compulsory consultation has also been introduced with a nurse who informs the woman on issues of contraception, maternity allowance, etc.

Under certain circumstances abortion is legal beyond the first trimester. These include for example misdiagnoses of the pregnancy, if the woman is under 18 years, or in case of genetical or teratogenic risks.

Abortion performed for medical reasons is free of charge. In other cases the fee is HUF 5000, the equivalent of US \$60, which can be reduced according to the economical status of the family. In one way the new law can be considered more restrictive: previously, an abortion was free of charge for women who became pregnant with an IUD, whereas now the woman has to pay the abortion fee.

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The Parliament, Hungary. Pol photo



ical risk factors during the current pregnancy, being under age 18 and being black were strong predictors of low birth weight (odds ratios of 2.14, 1.29 and 1.66, respectively). After controlling for these risk factors, as well as for marital status, education, previous infant death or stillbirth, smoking, adequacy of prenatal care, and receipt of prenatal care somewhere other than a public health clinic, the researchers found that women who did not receive care coordination were 20% more likely to have had a low-birth-weight infant, 50% more likely to have a very low birth weight infant, and 20% more likely to have had an infant death as were women who received the services.

The women who received care coordination were at somewhat higher risk for certain maternal characteristics associated with low birth weight than were those who did not: They were more likely to be black (61% vs. 58%), to be unmarried (66% vs. 61%), to be under age 18 (16% vs. 13%) and to have less than 12 years of education (49% vs. 44%). The researchers point out that these women could have had higher risk levels because some health departments targeted coordination to high-risk groups. They also note that a selection bias in the other direction could have existed because women who would have had better birth outcomes in any case may have been inclined to choose care coordination.

Women receiving care coordination were then divided into those who began participating three or more months before giving birth and those who received the services for a shorter time. Among the 7,846 women receiving the services for less than three months, 10.5% had a low-birth-weight infant, compared with 6.5% among the 7,680 who received the services for three or more months. The proportion of women receiving services for less than three months that had a very low birth weight infant was 1.7% compared with less than 1% of the women who participated longer. In the group with the shorter service period, there were 11.6 infant deaths per 1,000 live births, compared with 8.7 per 1,000 in the other group. The average amount paid by Medicaid for newborn care beginning within 60 days of birth was \$1,879 in the group receiving services for less than three months and \$1,483 in the group receiving services for longer. Comparing only full-term births, women with care coordination for three or more months had a rate of low birth weight of 3.8%, compared with a rate of 5.1% among those receiving care coordination for less than three months.

The researchers also compared outcomes by the proportion of the pregnancy covered by maternity care coordination. Women who received services for more than half of their pregnancy had rates of low birth weight and very low birth weight of 6.4% and less than 1%, respectively. Comparable proportions were 9.9% and 1.4%, respectively, among women who were covered for less than 26% of their pregnancy. Among women who received services for more than half of their pregnancy, there were 8.0 infant deaths per 1,000 live births, while among those who were covered for less than 26% of their pregnancy, there were 10.2 infant deaths per 1,000 births.

The investigators added that women who participated in the Baby Love Program were more likely than those who did not to have had a postpartum family planning examination (68% vs. 39%) and to have obtained well-baby care for their newborn (65% vs. 25%). The researchers also note that their study "must be placed in the context of an early evaluation," as many providers had not yet developed all the resources necessary for the program, and only 31% of Medicaid-eligible women in the state received care-coordination services during the time of the study.—R. Turner

Reference

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Replacement-Level Fertility Has Now Become the Rule In Most of Eastern Europe

Fertility in Eastern Europe fell rapidly after restrictions on abortion were relaxed in the 1950s; according to a recent study, it had reached replacement level in three of seven countries by the mid-1960s.¹ In the late 1980s, Eastern European women could expect to have between 1.8 and 2.3 lifetime births. In most countries, abortion remains the most frequently used method of preventing births: The results of a second study show that total abortion rates* in the late 1980s ranged from 0.6 in East Germany to 2.0 in Yugoslavia; in Poland and Romania, for which reliable figures are not available, estimates place those rates at 2.2 and more than 6.0, respectively.²

Effects of Policy on Fertility

An investigation focusing on seven Eastern European countries used vital statistics data to analyze trends in fertility and

trace their correlation with laws influencing childbearing. In six of the seven countries considered (the exception was East Germany), cross-sectional fertility rates revealed two general phases in fertility trends. From the end of World War II until the mid-1960s, fertility declined throughout Eastern Europe: In 1950, the total fertility rate (TFR) was above 3.7 births per woman in Yugoslavia and Poland, about 3.0 in Bulgaria, Romania and Czechoslovakia and about 2.5 in Hungary; by 1965, the TFR had fallen to around two births per woman in Bulgaria, Hungary and Romania, and hovered around 2.5 births per woman in Czechoslovakia and Poland. Although Yugoslavia's TFR had decreased by more than one birth per woman over the 15-year period, it remained the highest in Eastern Europe (2.7). In East Germany, the TFR remained at about 2.4–2.5 births per woman.

After 1965, fertility in each country fluctuated around a level of equilibrium (lowest in Hungary and highest in Romania) that ranged from 2.0 to 2.5 births per woman. The fluctuations varied in timing and magnitude across countries: They were large in Romania but hardly perceptible in Poland. Only in Yugoslavia did fertility continue to decrease throughout the following 25 years, dropping below 2.0 births per woman by the end of the 1980s.

In many cases, these variations were caused by the introduction of fertility-related laws and policies. Abortion laws were liberalized in most of Eastern Europe during the 1950s; after 1965, pronatalist measures, often accompanied by restrictions on abortion (and sometimes on contraception), produced chaotic changes in fertility levels throughout the region.

During the 1950s, the countries with the most abrupt and sweeping changes in abortion laws experienced the largest decreases in fertility. Romania's TFR fell rapidly after the sudden, radical liberalization of abortion laws in 1956. In Hungary, where liberalization in 1956 followed strong pronatalist measures instituted three years earlier, fertility declined from 2.6 births to 2.0 births per woman by the end of the decade. However, in countries where restrictions on abortion were relaxed only slightly or were loosened gradually over time (Bulgaria, Poland and Yugoslavia), fertility declined more slowly and sporadically. A still different pattern emerged in Czechoslovakia, where a sud-

*The total abortion rate is the sum of age-specific abortion rates in a given year, or the average number of abortions a woman could expect to have during her lifetime at current rates.

den relaxation of restrictions on abortion in 1956 was followed closely by the introduction of childbearing incentives: Fertility rapidly increased immediately after these measures were instituted, but soon returned to its preincentive level.

Romania provides the best illustration of the effects of government intervention: In 1966, abortion was restricted and contraceptives were prohibited; in the following year, the TFR rose from 1.9 births to 3.7 births per woman. In contrast, the lack of substantial political intervention in Poland and Yugoslavia allowed fertility to decrease slowly and steadily. In both countries, the TFR was above 3.7 births per woman in 1950, approaching 2.0 births per woman only in the late 1980s.

In East Germany, changes in the TFR also corresponded to government action. Fertility decreased from 2.4 births to 2.2 births per woman between 1950 and 1958, but then rose steadily until abortion laws were liberalized in 1965. Between 1965 and 1976, the TFR fell from 2.5 births to 1.6 births per woman; then pronatalist interventions again increased the birthrate for a short time. Despite childbearing incentives, the TFR has remained below 2.0 births per woman since 1971.

Thus, as the investigator observes, trends in fertility in Eastern Europe during the four decades following World War II reflected the chronology of changes in demographic policies. In general, abortion laws were liberalized only when fertility was relatively elevated, and pronatalist measures were introduced when fertility dropped to around two births per woman.

Completed Cohort Fertility

Unlike changes in the TFR, trends in completed cohort fertility show only vague associations with shifts in demographic policy. At the end of World War II, completed fertility in Eastern European countries ranged from fewer than two lifetime births per woman in East Germany to almost four births per woman in Yugoslavia. Generally, completed fertility was lower in central Europe (less than 2.5 births per woman in Czechoslovakia, East Germany and Hungary) than in southeastern Europe (2.9 births per woman in Bulgaria, 3.4 in Romania and 3.8 in Yugoslavia). The two exceptions to this pattern were Albania and Poland: In Albania, women had an average of nearly six lifetime births, the highest level of completed fertility in Europe, while in Poland, a central European country, women had almost as many births as women in Romania.

The liberalization of abortion laws in the

mid-1950s did not perceptibly affect these figures. Likewise, pronatalist measures introduced after 1965 were not generally followed by a noticeable increase in completed fertility: In East Germany, for example, fertility increased by only 0.1 birth per woman after incentives for childbearing were introduced, and in Romania, the average number of births per woman rose from 2.3 to 2.5 after abortion and contraception were restricted. In the other Eastern European countries, completed fertility stabilized at around 2.0 births per woman in the cohorts born after 1945. In Bulgaria, however, stabilization had occurred during the reproductive years of women born around 1930, and cannot be associated with the pronatalist legislation passed in that country in 1968 and 1973.

Mean Age at Childbearing

The weak effect of legislative measures on completed fertility, despite their strong influence on annual birthrates, implies that modifications in the timing of childbearing were important. Throughout Eastern Europe, the mean age at childbearing decreased measurably during the decade following World War II: In Czechoslovakia, for example, the mean age fell by about two years between 1950 and 1960. The liberalization of abortion laws slowed this movement, and at times stopped it entirely. This pattern was repeated in East Germany a decade later. In Bulgaria, where access to abortion had gradually been increased during the early and middle 1950s, the decline in mean age at childbearing was, by contrast, almost imperceptible.

The pronatalist measures adopted after 1965 were followed by a further decrease in the mean age at childbearing in Romania, Hungary and Czechoslovakia. In Hungary and Czechoslovakia, where large year-to-year fluctuations in the fertility curve obscured period patterns, completed fertility declined and stabilized over the long term, and mean age at childbearing decreased, but both of these trends were interrupted in the cohorts born between 1930 and 1945.

Cohort Fertility by Birth Order

The investigator points out that two aspects of demographic policies in Eastern Europe may confound the correlation between legislative changes and variations in fertility rates. First, laws with intrinsically contradictory goals were adopted in succession, and their effects tend to cancel each other out in longitudinal measures such as completed fertility. Second, some of these laws were aimed at small

families and others at large families, and their effects are reflected imperfectly in rates that mix first births, in which policymakers had little interest, with second or third births, the augmentation of which was a basic goal of pronatalist measures.

To examine differences in cohort fertility by birth order, the researcher distinguished between couples with one or two births and those with three or more (higher order) births. (Romania was not included because the available data were insufficient.) Throughout Eastern Europe, higher-order fertility decreased in the cohorts born between 1935 and 1950: For example, the average number of higher order births per woman fell from 0.66 to 0.23 in East Germany and from 0.90 to 0.58 in Poland. This trend has slowed and sometimes reversed itself in the most recent cohorts: Among women born around 1960, the number of higher order births has stabilized at about 0.34 per woman in Hungary, and has risen to almost 0.26 among women in East Germany. In these cohorts, higher-order fertility in Poland, Yugoslavia and Czechoslovakia is about double that in Bulgaria, East Germany and Hungary.

In contrast, the average number of first and second births per woman increased, particularly in the countries in which the average number of higher order births per woman was lowest. For example, the average number of first and second births in Bulgaria rose from 1.66 among women born in 1935 to 1.76 among those born in 1955. Elsewhere, there is no clear pattern: In Poland, the average number of first and second births decreased from 1.72 among women born in 1935 to 1.59 among those born in 1945, then remained relatively stable, while the average number of such births remained between 1.67 and 1.72 per woman in the corresponding cohorts in Czechoslovakia. The earlier differences between countries narrowed between 1935 and 1955: For example, Czechoslovakia and East Germany differed by about 0.1 birth per woman in cohorts born around 1955, about half of the difference that existed 20 years earlier.

The author of the study concludes that the pronatalist policies of many Eastern European countries have met with both relative success (an increase in the average number of first and second births per woman) and relative failure (stabilization of higher-order births at a low level). Fertility has fallen in countries where it was highest, and has recently begun to rise in countries where it was lowest. The great diversity in fertility that characterized

Eastern Europe immediately after World War II has given way to similarity as the political ties that have bound these countries for the last 40 years dissolve.

Abortion and Contraception

A second study examined the incidence of abortion in Eastern Europe since World War II. Laws easing or removing restrictions on abortion were adopted in Bulgaria, Hungary, Poland and Romania in 1956, in Czechoslovakia in 1957 and in Yugoslavia in 1960. In the mid-1960s, however, several of these countries began to reintroduce restrictions. In contrast, East Germany loosened restrictions on abortion in 1965 and removed them entirely in 1972.

The investigator used national registry statistics to examine trends in recourse to abortion from 1960 to the late 1980s in six countries (and from 1972 in East Germany). Because of underregistration of abortions performed at private clinics in Poland and nonregistration of clandestine procedures in Romania, the official statistics underrepresent the number of procedures performed in those countries. The investigator estimates the total abortion rate in 1988 at 1.5–2.2 per woman in Poland and at more than 6.0 per woman in Romania.

In the countries with relatively reliable statistics—Bulgaria, Hungary, East Germany, Czechoslovakia and Yugoslavia—neither levels of abortion nor changes in total abortion rates conformed to a single pattern. Figures on the average number of abortions per woman in 1960 were

available for only three countries—Yugoslavia (0.3), Czechoslovakia (0.9) and Hungary (2.1). By 1972, the first year in which data for all five countries were available, the average number of abortions per woman ranged from 0.9 in Czechoslovakia to 2.3 in Hungary.

The total abortion rate decreased in Hungary and East Germany, but increased in Bulgaria, Czechoslovakia and Yugoslavia. In East Germany, the only country in which the average number of abortions per woman never exceeded 1.0, the rate declined from just below 1.0 in 1972 (the first year in which statistics were available) to 0.6 in 1989. In Hungary, the rate declined from 2.1 in 1960 to 1.2 in 1988.

Large year-to-year fluctuations characterized total abortion rates in Bulgaria and Czechoslovakia. Overall, however, the rate in Bulgaria increased from 1.6 to 1.8 between 1965 and 1988. In Czechoslovakia, the average number of abortions per woman decreased slightly between 1960 and 1975 (from 0.9 to 0.8), then increased to 1.4 in 1989. In Yugoslavia, the rate rose steadily from 0.3 in 1960 to 2.0 in 1986.

In general, the characteristics of women in Eastern Europe who have abortions are different from those of their counterparts in the West. In 1986, 68–91% of women who had abortions in Bulgaria, Czechoslovakia, Hungary and Yugoslavia were married, compared with 26% of those in Great Britain and 44% of those in France. Of women having abortions in Czechoslovakia, Hungary and Yugoslavia, 42–70% had already had an abortion, com-

pared with 17% in Great Britain and 20% in France. In Bulgaria, Hungary, Czechoslovakia and Yugoslavia, 12–19% of women having an abortion were childless, compared with 59% in Great Britain.

Since World War II, abortion has been the most frequently used method of preventing unwanted births in most of Eastern Europe, particularly in Yugoslavia and Romania. However, in East Germany and Hungary, access to modern contraceptives has reduced the total abortion rate. In 1966, 67% of Hungarian women were using a contraceptive method, but the most prevalent method was withdrawal (42%). By 1986, contraceptive prevalence was approaching 74%, with more than 58% of women using the pill or the IUD and only 2% relying on withdrawal. The investigator points out that in 1988, similar proportions of French women were using a contraceptive method (76%) and relying on the pill or the IUD (59%); the proportion relying on withdrawal, however, was larger than that in Hungary (6%). According to other sources cited by the investigator, 57% of East German women and 25% of Czech women currently use the pill or the IUD.³—F. Althaus

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Sexually Active Adolescents Have Less Knowledge And Less Fear of HIV than Their Abstinent Peers

Compared with peers who are not sexually active, seventh-grade and eighth-grade males who are sexually active tend to be less knowledgeable about the human immunodeficiency virus (HIV), less fearful of contracting HIV, less tolerant of people who have AIDS and more likely to engage in risky behaviors.¹ A similar but less extreme pattern is found among sexually active female students of the same ages.

Researchers selected a sample of 1,379 students, with a mean age of 13.2, from junior high schools (seventh and eighth grades) in four districts of Rhode Island. The students represented 63% of all junior high school students in these districts, which were chosen to reflect ethnicity, socioeconomic status and place of residence. The sample was 78% white, had a family income ranging from \$14,948 to \$23,133

(mean income of \$19,078) and represented rural, urban and suburban areas. Most of the students (72%) were college-bound.

All students had received state-mandated education about HIV beginning in seventh grade and averaging 4.7 hours. (After parental notification, 1% of parents elected not to have their children participate in the program.) Approximately 6–12 weeks after the conclusion of the HIV education, the students completed a questionnaire that contained seven demographic items, 20 questions of knowledge, 26 attitude statements and 10 questions concerning past behavior.

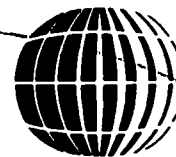
The investigators constructed six scales and computed scores for each student on the following topics: HIV knowledge, tolerance of people with AIDS, fear of HIV, behaviors intended to prevent HIV trans-

mission, general (non-HIV) risk attitudes and past risk behaviors. A three-way analysis of variance was performed to determine the influence of and interactions between grade level, gender and occurrence of sexual activity on the scale items.

Of 1,379 students, 341 (25%) were sexually active. Nearly three times as many male students (35%) as female students (13%) reported being sexually active. Among those who were sexually active, 53% of the males and 40% of the females had had sex more than five times. Grade level was significantly related to knowledge of HIV and intention to practice behaviors that prevent HIV transmission: Eighth-grade students had more knowledge of HIV and indicated stronger intention to practice safe behaviors in the future—including abstinence, condom use

Statistics on women
in E. Eur contrasted
w/ W. Eur.

PLANNED PARENTHOOD IN EUROPE

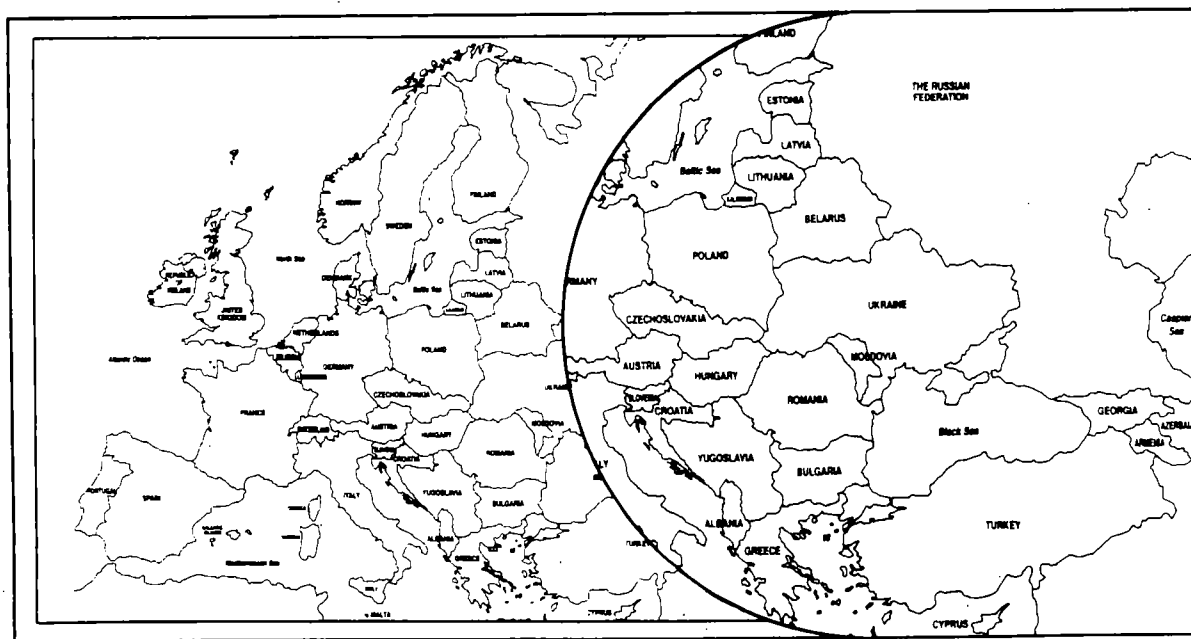


Vol 21, No 2

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Central and Eastern Europe

Editorial	1	Contraceptive Practices and Attitudes of Women in the CSFR	14
Culture and Sexuality in the former USSR	2	The Church's Heavy Hand in Poland	18
Family Planning Needs in the Commonwealth of Independent States (CIS) and Baltic States	5	Current Contraceptive Use in Romania	20
* Family Planning in the Russian Federation	7	The Family Planning Project of the Swiss Red Cross in Romania	23
* Abortion and the Problems of Family Planning in Russia	8	On the Value of Moral Support	25
Contraception in the former USSR: recent survey results on women's behaviour and attitudes	9	European Parliamentarian's Conference	27
Youth Work Initiatives in Moscow	12	News Items/Meetings	29
Sexual Education in Transition in Bulgaria	13	Book Review: The Right to Choose	35
		PPA Profile: Denmark	36
		A Personal View: Elisabeth Jandl-Jager, departing President, IPPF Europe Region	38



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**We would like to thank
everyone who contributed
to this issue.**

Editorial

Evert Ketting*



Transition: for better or for worse?

Central and Eastern European countries have embarked on the difficult and cumbersome transition process from authoritarian communism to democracy and from centrally guided economies to open market systems. The short term results of this process are harsh in many respects. Unemployment rates are rapidly rising, the provision of elementary food and medical supplies is seriously disturbed in some regions, household incomes are falling, while at the same time consumer prices are rocketing. A press release issued on 18 March 1992, which summarises the conclusions of recent UNICEF-WHO missions to the former Soviet republics, mentions "a 'looming crisis' in many regions, particularly for vulnerable women and children, which demands an immediate response from the international community". It further says: "Urgent action can avert a human tragedy ...". Eric Palstra of UNFPA, who took part in one of these missions, reports in this issue of **Planned Parenthood in Europe** that urgent and priority needs in the fields of reproductive health and family planning require US \$20 million aid from the international community.

Under these hard economic and social circumstances it is absolutely essential that people can keep control over their own fertility, but even this fundamental human right is being threatened.

During the past decades this control has been exerted to a large extent by means of induced abortion. Millions of women in this part of Europe are still forced to rely on this method, as contraceptive supplies are inadequate, the few available contraceptives are often of poor quality and people lack the much needed sexual and contraceptive knowledge.

Of course there is a need for a transition from (mainly) abortion to (mainly) contraception in Central and Eastern Europe, but how can this transition take place when people are kept innocent regarding sexuality and contraception and when the necessary services and supplies are still so inadequate?

There is one 'solution' that definitely does not help in bringing about the transition from abortion to contraception; de-legalization of induced abortion. The 'Tbilisi Declaration', which resulted from the 1990 international conference 'From Abortion to Contraception', clearly states on the one hand, "abortion rates can be greatly reduced through universally available family planning programmes", but on the other hand it also concludes "restrictive (abortion) legislation does not affect the birth rate in the longer

term, but it is associated with high rates of unsafe abortion leading to ill health, infertility and death."

Nevertheless, there are very serious initiatives in Central and Eastern Europe that seek this impossible, repressive and health damaging non-solution.

In Poland the General Medical Council seems to hold the opinion that the parliament is too hesitant in banning abortion. After the Polish parliament blocked a proposal last summer to reverse the current liberal abortion law, the doctors drew up their own rules in December 1991. A new professional code regarding abortion, which came into effect on 3 May 1992, only allows abortion on extremely narrow grounds. This ethical code threatens doctors who break the code to have their licence to practice revoked. And of course it threatens women even more.

In the Czech and Slovak Federal Republic two new abortion laws seem to be emerging. A draft amendment to the existing abortion law prepared by the Ministry of Health of the Czech Republic allows for the termination of pregnancy on the woman's request up until the end of the twelfth week of pregnancy. The woman may have the abortion, in contravention of the present rules, outside her place of residence. One wonders whether this new rule is included to open up a future escape for Slovak women to have abortions in the Czech Republic, as the Slovak Ministry of Health is seriously working on cutting back women's free access to abortion. In its draft amendment "On Human Life Protection", the Slovak Health Ministry intends to re-introduce 'ethical councils' in hospitals to judge on individual requests for abortion. The amendment says abortion will only be allowed in limited cases.

Hungary's highest court ruled in December 1991 that the current liberal abortion regulations are unconstitutional. The Hungarian parliament has been given until the end of this year to change these regulations. Are the 90,000 Hungarian women who are in need of abortion each year supposed to travel to Austria for that reason, just like Austrian women travelled to Czechoslovakia until 20 years ago, and like the desperate Irish women who are still forced to travel secretly to England?

There is not only a great need for sexual and contraceptive education in Central and Eastern Europe. There is also a need for social historical education in the field of family planning. Millions of women all over the world have experienced that the forbidding of abortion is an absolute non-solution. The consequences of this non-solution have been perfectly documented, most dramatically in the case of Romania. Additional experiential learning would therefore be a shameful ostrich policy.

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Culture and Sexuality in the former USSR

Professor Igor S Kon*

"We have no sex"

Sexuality, erotica and sex research are very sensible social and political issues in the former USSR. For many years Soviet society hypocritically pretended to be absolutely sexless and even genderless. Ideological reasons for this are clear. As George Orwell wrote:

"It was not merely that the sex instinct created a world of its own that was outside the Party's control and which therefore had to be destroyed if possible. What was more important was the sexual privation induced hysteria, which was desirable because it could be transformed into war-fever and leader-worship"¹.

This repressive policy was also related to the old Russian cultural tradition. Medieval Russian Orthodox Church was no more and no less anti-sexual than the other Christian denominations but it was much more restrictive towards the visual representation of the human body and nudity - compare the Russian icons and the Western medieval religious art. Russian folk culture, language and behaviour have been always notorious for their outspoken sexuality, which had shocked Western observers, but it was impossible to transform this sexuality into a sophisticated and elegant high-culture eroticism. In the 19th century the emergent Russian erotic art and literature had to fight not only against joint forces of Church and State censorship but also against the radical revolutionary-democratic literary criticism which tried to subjugate all individual, personal and especially sensual values to the socio-political issues. These repressive intellectual attitudes delayed the development of Russian erotic art and made all sexual imagery appear low and dirty, thus making later Stalinist repressive policies morally justified and acceptable. Traditional attitudes of some non-Russian USSR nations have been even more conservative.

Since the early 1930s all kind of erotic art, sex research and even elementary sex education were absolutely forbidden, leaving the population sexually ignorant and mute. Now we are paying the price of that.

Glasnost and the price of ignorance

In spite of the official attitudes and policies, real Soviet sexual behavior was always as heterogeneous as anywhere else. Long-term developmental trends in sexual attitudes and behaviours are practically the same as in Western countries: earlier sexual maturation; earlier sexual initiation of boys and girls; social and moral acceptance of premarital sexuality and cohabitation; the weakening of the double standard for men and women; growing importance of sexual satisfaction for the stability of marriage; growing public interest in all kind of erotica; growing generation gap in sexual attitudes, values and behaviours - many things that were deviant and unacceptable for parents are normal for their children².

Glasnost did not generate these changes but it greatly accelerated them and made them visible. However - and this is very important - a Soviet "sexual revolution" is taking place in the context of a general social, political and moral crisis, and among the sexually ignorant, conservative

and fundamentally sexist population (in spite of the superficial level of egalitarian ideology). Long denied and exorcised, "Soviet sex" has broken its chains and has appeared as uncivilised, ugly and violent like almost every other aspect of Soviet social life, producing in society a state of shock and moral panic.

Current features of sexuality

What are the specifically sexological aspects of this difficult situation?

1. Terrible sexological ignorance as a result of the absence of any sex education in the family and the school. In a recent (February 1991) public opinion survey in the Russian Republic 87% said their parents had never spoken to them about sexuality. The students of the Soviet medical and pedagogical universities even today receive no systematic information about sexuality. It is the Government which is guilty. In the representative public opinion poll by the All-Union Public Opinion Research Centre (VCIOM) (March 1990) on the question, "What channels of information on sexual life do you believe to be the most acceptable and efficient?", 46% named special educational courses in schools; 42% - special educational literature; 29% - educational films and TV programmes; only 3% said there was no need for any sex education. In the Russian Federation poll (February 1991) on the question, "What would be your attitude to the introduction in schools, beginning at the fifth and sixth forms, of sex education lessons?", positive answers were given by 60% and 21% replied negatively³.
2. Extremely low contraceptive culture and high rate of induced abortions. This is partly the result of contraceptive shortages - even condoms are not always available - but in the first place it is the consequence of inadequate information and incompetence. In spite of some reduction in the last several years, the Soviet abortion rate, estimated at 7.4% (10 million a year), is still the highest in the world and it has desperate health and moral implications⁴.
3. Substantial growth of sexual violence, rape and child abuse as a result of a general social crisis, and adolescent delinquency and violence which is also motivated by traditional stereotypes of strong and aggressive masculinity. However, mass media and conservative public opinion attribute all this to the processes of democratization, liberalization of sexual morality and Western influence. There is no professional psychological help for rape victims or for sex offenders.

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4. Insufficient prophylactics to help reduce sexually transmitted diseases and AIDS. No professional sociologists or psychologists are employed in the medical AIDS prevention programmes and realistic analysis is often substituted by naïve and primitive moralization. The legal and social status of prostitution, which is very widespread, is also unclear.
5. The conditions of sexual minorities are quite tragic. Male homosexuality is still a serious criminal offence, gays and lesbians are systematically discriminated against, victimised and humiliated. The President of the (former) USSR Academy of Medical Sciences, Epidemiologist Valentin Pokrovsky recently sharply attacked the idea of decriminalization of homosexuality⁵. Homosexuals are the most hated social group in the country. In the representative VCIOM public opinion poll (November 1989) on the question, "What should be done with homosexuals?", 33% answered "liquidate", 30% replied "isolate", 10% replied "leave to themselves" and 6% answered "help them"⁶. This strong homophobia, which is rooted in a general social and cultural intolerance and in the sexual anxieties of the population, is further aggravated by irresponsible and provocative public statements of a small group of Moscow gay activists, supported by some American gay and lesbian organizations. These scandals are exploited by the reactionary mass media for their own political purposes.
6. The weakening of censorship and of social control over sexual information, in a situation of a permanent shortage of erotic literature, had stimulated the illegal production and distribution of low-level, pornographic and semi-pornographic publications and videos. As a challenge to traditional public morality it should have been somehow answered and regulated by central and local authorities, but conservative forces used this situation mainly as a pretext for a large scale campaign against glasnost, making a scape-goat of erotica as if it were the cause of all negative phenomena in society.

New calls for repression

As far as one can judge from the February 1991 VCIOM poll, this attempt has failed: people do want stronger social control over the distribution of erotica, especially among minors, but they do not believe erotica to be the main cause of the country's moral degradation. Just 28% believe that the open discussion of sexual problems in mass media has only negative moral effects. Total prohibition of erotica is supported only by 29% and there is great social and educational differentiation among respondents. Strong repressive measures are supported mainly by pensioners, Communist party members and military persons and not by the majority. Nevertheless, the decision of the (former) USSR Supreme Soviet "About the urgent measures against pornography, the cult of violence and cruelty" (April 1991) contains only restrictive suggestions and not a single word about the necessity of sex education and the development of a sexual culture as it had been suggested by professional experts, including several prominent psychologists and the Secretariat of the Sexological Association "Culture and Health". The independent experts believe that this parliamentary decision may have negative social and cultural effects.

Hopes for the future

In spite of the unfavourable social and financial situation and the lack of governmental support, family planning policies, including sex education, are now under consideration by the Russian government and substantial progress in sex research and education has been made in recent years.

In medical sexology (sexopathology), in addition to the already existing All-Union Research Centre at the Moscow Institute of Psychiatry, three chairs of sexopathology in the Kharkov, St. Petersburg and Moscow Institutes for Advanced Medical Training were organised in 1987/89. Sexopathology is formally acknowledged as an independent clinical sub-discipline. A few scholarly monographs and handbooks for physicians are published⁷ and some foreign books translated. Preparation of a course for medical students is in hand. Medico-psychological consulting centres are available in large cities.

Several centres of sex education for children and adolescents have opened and some popular books written or translated, including the French "Encyclopedie de la vie sexuelle" for children by Gilbert Tordjman and others, whose publication had provoked a noisy political scandal, "Sexual Happiness for Men" by Maurice Yaffe and Elisabeth Fenwich, and Alex Comfort's "The Joy of Sex" will be published soon. The first issue of a popular journal "Eros" is also being printed.

Some research on gender and sexuality is also being done within the social sciences and humanities field. At the Institute for Socio-economical Studies of Population there is a small Centre of Gender Studies. At the Institute of Ethnology and Anthropology, research on anthropology of the body, gender stereotypes and images of masculinity and femininity is in progress. At the Institute of Sociology questionnaires on sexual attitudes and behaviour of teenagers and university students are in preparation. In May 1990 the Institute of History of the Estonian Academy of Sciences organised an international conference on the social conditions of sexual minorities in twentieth century Europe, and comparative Finnish-Estonian-Soviet research on the situation of homosexuals is in progress.

The former Soviet State, with the exception of the Ministry of Health, has no sympathy or support for sexology. Because of this, voluntary funds and associations are crucial, for example: the Association for the Prevention of AIDS, which publishes a popular journal "SPID-info"; "Ogonjok-Anti-AIDS" Charity Fund; Association for the Prevention of Sexually Transmitted Diseases; Association of Psychologists, and especially the recently formed Sexological Association "Culture and Health", whose main tasks are the promotion and coordination of sex research and education, interdisciplinary expertise of socio-cultural, education and medical projects, organisation of medical and psychological help and consulting services and international cooperation.

The development of Soviet sexology faces the same two main difficulties as all other fields of research and practical activity: shortage of money and, what is even more important, shortage of professional personnel and education. Without massive help from our Western colleagues we cannot survive.

What kind of help do we need?

1. Sexological textbooks and journals - individual sexologists and even academic libraries have no convertible currency to buy them.

2. Western publishers to allow us copyright for Russian translation of sexological books, with payment in roubles, in order that we can have access to high quality information.
3. Participation of leading Western scholars in professional seminars and schools, sponsored by the Sexological Association and by other professional bodies.
4. Scholarships and grants for training and research, for young researchers and graduate students, including clinical psychology and social work.
5. A clear and firm professional and moral stand against the discrimination of sexual minorities and against homophobia, especially where repressive measures are advocated by the medical authorities as a means of AIDS prevention.

To help us is difficult. We ask not for something, as an American dictum says, but everything for nothing (except our wonderful future). Our means of communication are beyond any imagination. For some objective and subjective reasons we are inefficient and unreliable. We often promise more than we can really do, and we over-estimate your possibilities even more than our own. But you have no choice. We may not be as great as we have pretended before, but we are a very big country. Our problems are your problems and you have to accept us as we are.

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This article is a slightly adapted version of a presentation given in June 1991 at the World Association of Sexology Conference in Amsterdam.

Family Planning Needs in the Commonwealth of Independent States (CIS) and Baltic States

Eric Palstra*

United Nations' Mission

In response to appeals from the CIS Republics and Baltic States, and following discussions within the international donor community on humanitarian support to these countries, UNFPA participated in UNICEF/WHO collaborative missions which visited 14 states during February 1992.

An important finding of the missions was that all governments acknowledged the urgent need to strengthen family planning programmes. Current contraception throughout CIS and the Baltics is extremely low and lack of modern family planning services is reflected in the high numbers of induced abortions (the highest in the world), particularly in the western republics, and high population growth rates in other republics. For example, according to the data collected by the mission, many Russian women would have six to eight abortions during their reproductive lives.

Large unmet need for family planning

Governments are eager to enhance family planning services as a major health intervention to benefit mothers and children. The need to strengthen family planning is expli-



Hospital maternity ward in Dushanbe, Tajikistan



Health Minister Dr Dtschura (right),
at Dushanbe hospital

citly mentioned in the Tashkent Appeal for Partnership, signed by the four Central Asian Republics and Kazakhstan on 27 February 1992 at a joint meeting of representatives of the five governments and mission members. The mission noted, particularly in the Central Asian Republics, that many rural areas resemble or even surpass conditions found in developing countries with short birth intervals and high fertility. Many urban areas combine characteristics from developed countries with reasonably low fertility, but with an almost total neglect of contraception and reliance on induced abortion as a fertility regulating method. Available data on current contraceptive prevalence put the number of current users at 30%, but with an overwhelming majority practising more traditional, less reliable methods such as withdrawal and rhythm. Government services would normally include oral contraceptives, IUDs and condoms. However, concerns among both service-providers and clientele about oral pills (no low dose-pill available), the poor quality of locally produced condoms and IUDs, fur-

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ther jeopardise the family planning programme. In sum, family planning needs of all CIS and Baltic countries are enormous, particularly bearing in mind the substantial number of women in the reproductive age group (70 million), the almost total absence of safe, modern, reliable and quality contraceptives and, instead, a tradition of relying on abortions to control fertility.

Urgent needs

In terms of immediate needs, governments have already requested emergency shipments of IUDs which would be required to replace defective, locally manufactured ones and to meet the apparent unmet demand for quality IUDs. As immediate needs, regional and in-country training workshops on reproductive health and family planning, and on Islam and family planning for the predominantly Muslim republics, should take place soon to start bridging existing gaps in knowledge and skills. Demographic, health and socio-cultural surveys are needed in all countries to arrive at better data bases not only in terms of numbers but also for gaining more qualitative insights for supply and demand of family planning services. Moreover, the results of these surveys will be instrumental in preparing national contraception policies, and implementation strategies including comprehensive IEC campaigns. Technical assistance to the individual Republics would be required, and experience from other countries should be shared to assist CIS and Baltic countries to adopt a cafeteria style approach and to meet the demand for all safe, modern and reliable contraceptives.

Local production of contraceptives

Another major area requiring urgent assistance from the international community, would be the review and strengthening of national production of contraceptives. There is

an obvious demand for quality contraceptives and national production of IUDs, pills and condoms should be taken up on a priority basis. Technical assistance is required to review local production facilities, applied technology, international standards and marketing options. Following the planned privatisation of many public companies in CIS countries, privatisation of existing facilities and eventual joint ventures with existing private companies, should not be overlooked.

Financial implications

On the basis of the results of the missions, a draft budget covering the immediate reproductive health and family planning priorities in these countries was prepared. The total budget for urgent (six to eight months) and priority (18 months) needs amounts to almost US \$20 million which has been broken down per Republic and into basic components. All needs should be addressed immediately and can be absorbed by the recipient governments. While these most urgent needs are often life-saving and will spare needless human suffering, it is generally felt that they are temporary and should soon give way to the emergence of sustainable systems capable of meeting the needs of their populations in most of these countries.

UNFPA could assist the CIS Republics and the Baltic States in the above-mentioned areas provided, however, that external earmarked, multi-bilateral financial resources were made available to UNFPA, particularly since the present level of our financial resources and programme commitments do not permit us to address these needs. Donors can use UNFPA's technical capability in addressing the needs of the CIS Republics and the Baltic States, provided that all financial resources are met.



Clinic/pharmacy outside Bishkek, Kyrgyzstan

Family Planning in the Russian Federation

Natalia Komyssova*

The Russian Federation occupies an area of 17 million square kilometers. Its population is 148.5 million, with women numbering 78 million. There are over 40 million families in Russia with an average size of 3.2 persons. Small families (one or two children per family) are most common. Moreover, recent years have been characterised by a most significant birth rate decrease across Russia, which has unavoidably led to de-population, coupled with a spreading of small families.

At present the birth rate is below the replacement level of the population in 53 territories of the Russian Federation. This decreasing trend has been caused by the social and economic problems of society, especially the current economic crisis.

During the last decade the demographic changes that have occurred have affected all strata of Russian society. Changes in the family functions, increased significance of every newly born baby, and the decreased need for children explain these tendencies. Families are facing a necessity to balance both the number of deliveries and the intervals between them. People have a most realistic attitude towards demographic behaviour, unwanted pregnancies and family planning.

For a certain period of time the medical point of view prevailed over the social value of family planning. Absence of a systematic approach to the resolution of family problems as well as to family planning services have caused a widespread reliance on induced abortion as the major tool of birth control. In 1990 108.6 women out of 1,000 resorted to induced abortion. Nearly 190 thousand women annually interrupt their first pregnancies. This has affected women's reproductive health in a most dramatic way and has not reduced the mother and child death rates. The increase in gynaecological diseases has become a serious issue. The same is true of the increased number of childless families that make up 12%-15% of the population.

Post abortion pregnancy complications have increased three or four times. This situation is caused by the unsatisfactory family planning information system, the low level of sexual culture of the population, insufficient availability and diversity of contraceptives, lack of locally produced hormonal contraceptives, and a shortage of hard currency to buy contraceptives from abroad.

Doctors, auxiliary medical personnel and teachers display inadequate knowledge on family planning. Maternity consultations and other prophylactic clinics do not perform well as far as family planning is concerned, and at present as a result, only 15% of women in the Russian Federation are using IUDs and 1.5% use hormonal contraceptives. A doubling of these percentages would reduce the number of abortions by 40-50%. The shortage of modern medical equipment does not allow for the required level of medical care to enable women and men to restore their reproductive health.

The pressing problems of today are: the early beginning of sexual activity among the young, female and male genital diseases, AIDS, pregnancy prevention and induced abortion among young girls. The acceleration of youth pubescence with simultaneous relaxation of external social control provide the young with a freedom of action, including sexual behaviour. Research indicates that every fourth

schoolgirl aged 15-18 has sexual intercourse, and 65% of girls and 85% of boys at vocational schools begin their sexual life before the age of 18. The existing system of sexual education introduced as "The Ethics and Psychology of Family Life" has failed to increase students' knowledge in the areas of sexual and reproductive behaviour. It is estimated that 80% of young people use unreliable sources in their search for knowledge of the intimate side of life.

With this critical situation in mind, the Committee for the Family and Demographic Policies, under the Council of Ministers of the Russian Federation, with the help of prominent scientists, worked out the State programme on Family Planning for 1991-1995. The Programme is designed to radically change the attitude of every citizen, family and society as a whole to this issue, to make the population aware of their right to family planning, to create the conditions to regulate the birth rate by contraceptives, to preserve the reproductive health of people and to enable them to deliver only wanted and healthy children. The programme is a basis for developing regional programmes. It accommodates demographic, religious and national peculiarities and traditions by integrating the activities of various services, public organisations, cooperatives and other institutions.

An easily accessible information system is to be created with the participation of TV, radio and other media. A family planning service will be introduced, which will incorporate different establishments, centres, branches and consulting offices. Training of experts on family planning is to be reorganised. Training programmes will be enlarged and deepened in medical and teaching colleges, at doctors' and teachers' retraining faculties. The programme envisages the development of school curricula dealing with education, giving a sound approach to sexual and reproductive behaviour. Local production of contraceptives including IUDs is to be increased. The State budget will fund the Programme, with investment from enterprises and other sponsors.

The intended introduction of the above mentioned measures will make it possible to create a Family Planning Service in the Russian Federation. The objective is to help restore the reproductive health of the population and make social and medical services available to the people. The execution of the above mentioned measures should reduce the number of abortions by 15%-20% annually. Correspondingly, it will reduce the maternal mortality rate by 5%-6%.

The economic effect of reducing the number of abortions will create 165 million roubles annually. As well as the economic effect, the Programme is aimed at achieving a social effect, to increase spiritual and moral family values, responsibility of parents and the improvement of the demographic situation in Russia.

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Abortion and the Problems of Family Planning in Russia

Inga Grebesheva*

The health of women and children living in Russia is a cause for great alarm. Maternal and infantile death rates remain high (55.7 per 1000 live births and 17.0 per 1000 births respectively in 1991). Of all pregnant women, 50-70% suffer from various pathological conditions: anaemia, late toxicosis, kidney and cardiovascular diseases etc. The perinatal death rate, the number of pregnancies which do not run to full term and stillbirths are increasing. The sickness of the mother seriously affects the development of the foetus and the health of the newborn child. More than 50% of all babies have some kind of health problem. In the past few years there has been a significant increase in congenital abnormalities.

One of the main reasons for this alarming situation is the high number of abortions in Russia. On average every woman born in Russia has four or five abortions during her childbearing years. More than 10% of all abortions are illegal. Residents of rural areas and teenagers under the age of 17 are most likely to resort to illegal abortions and they suffer the highest level of complications and mortality. Of the total number of deaths from abortions, one quarter involve young women under 25 years. The most common cause of death from abortion is sepsis, followed by haemorrhaging. Most worrying is the number of abortions involving young teenage girls. Approximately 40,000 girls under 17 years of age have abortions every year.

The consequences of an abortion are truly alarming. Every woman who has an abortion, particularly her first, is running the risk of being made infertile. About 20% of married couples are unable to have children and, having had their first abortion with little idea of the consequences, they undergo lengthy and unsuccessful medical treatment in order to have the child they want.

The situation is aggravated by the frightening increase, particularly among young people, of venereal diseases and AIDS. Every fifth case of syphilis diagnosed is recorded in a teenager under 17 years of age and a third of new occurrences of gonorrhoea are in teenagers under 17.

To all intents and purposes our women are unable to make use of modern methods of contraception. Most women who have put off having a child, for whatever reason, will find it difficult to give birth to a wanted and healthy child because of the damage to their health caused by earlier abortions.

The sexual life of our women is dogged by a constant fear of unwanted pregnancy and its subsequent termination by abortion. Essentially, the people of Russia are being denied their right to safe sex and contraception although modern methods of contraception, and information on the subject, are available throughout the entire civilised world.

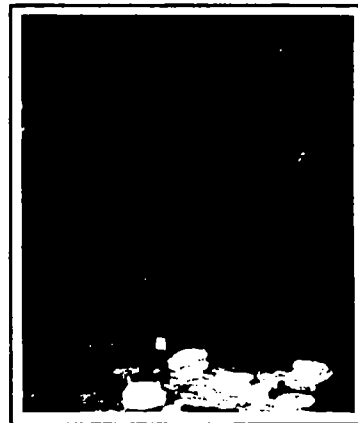
The absence of any professional, knowledgeable and, at the same time, sensitive information to explain the problems of sex and contraception to the different groups of our population, and particularly to young people, has led to the wide distribution of poor quality, inaccurate literature and video cassettes, which are often little more than pornography.

The main reasons for this unhappy situation are:

- an under-estimation of the depth and importance of the problems connected with women's health, with the production of healthy children, and the right to a safe sex life;
- lack of knowledge concerning contraception and the consequences of abortions, absence of training for doctors and family planning nurses, teachers, psychologists and other specialists;
- the low quality of most contraceptives made in this country and the lack of any industrial production of individual types of modern contraception, including widely known methods such as the Pill.

For many years, information on contraception was available only in women's clinics. Doctors were occupied mainly with helping pregnant women and treating gynaecological diseases, and no attention was paid to healthy women requiring contraception. Even now, young people and teenagers, particularly young men, are unable to obtain specialist help on sex and contraception. This problem used to be regarded as highly specialised and of medical interest only. Teachers, psychologists, social workers and others were not involved in trying to find the solution. It should be said that this year, for the first time in Russia, the training of social workers has started in the higher and middle educational establishments.

To help find a solution to the problems of family planning, the non-governmental Russian Family Planning Association was established in December 1991. Its establishment was supported by the Coordination Committee for matters concerning the Family, Motherhood and Childhood under the President of the Russian Federation and the Russian government. The work of the Association incorporates the efforts of various specialists: doctors, teachers, lawyers, psychologists, demographers, economists, etc. Its main aims are to enlighten and educate people, particularly teenagers and young people, while taking into account traditions, religious beliefs, the special circumstances of each family, to train teams of specialists, to publish material and set up branches of the Association in the various Russian territories. The Russian Association will attempt to guarantee the right of everyone to family planning and the protection of reproductive health.



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Contraception in the former USSR: recent survey results on women's behaviour and attitudes

Philippe Leheret,^(a) Irina Pavlenko,^(b)
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Introduction

The figures of the high abortion rates in the former USSR are well-known: at least 10-12 million per year. Far less information is available about the types of contraceptives used and the attitudes of the users towards them. The most recent figures, presented by Popov et al (1992) and Remennick et al (1990) are from the beginning of the eighties. These figures show a high use of traditional and unreliable methods. Modern contraceptive means like the IUD and the Pill are only used by 10% of women. This situation cannot only be explained by the abortion practice and the unavailability of modern contraceptives. Other factors may also play a role, such as lack of knowledge, fear of health consequences, unwillingness of the partner and negative attitudes towards modern contraception. The earlier studies seem to indicate that the traditional methods are judged to be more reliable than they really are, easy to use and safe for health. The IUD and the Pill are often judged as unreliable and inconvenient, and they are not accepted because of perceived health risks. These impressions are based on studies performed about 10 years ago, before Perestroika began. Many things have changed since that time. Has the development of an "open society" led to more openness about sexuality and has it changed contraceptive practices and attitudes? A recent study among women gives some answers to these questions.

The survey

The questionnaire was published in the monthly journal "Health", a popular magazine read by millions of women living in different republics of the former USSR. Readers could answer a questionnaire on personal background, family planning, use of contraception and attitudes towards it. A total of 8,059 women completed and returned the questionnaire, however the sample is not representative for the former USSR. Most of the women who completed the questionnaire were married (87%) with one child (49%); one third of the women had two children. The women were also rather young: 45% younger than 25 years; 52% between 25 and 39 years, and 4% were 40 years and older. The educational level of respondents was rather high: 52% attended primary and technical school; 13% attended high school and 35% had obtained a university degree. The women were from areas with different levels of urbanisation. They lived mainly in big cities in Western Russia, for example Moscow and St Petersburg (35%), in several parts of Siberia (42%) and in the Ukraine (22%).

Contraceptive failure

The majority of women in the survey had experienced induced abortion. Forty-one percent had one or two abortions; 19% underwent three or more abortions. The frequency of abortions is related to the number of unwanted pregnancies as a result of failing contraception. Approximately two thirds of respondents had one unwanted pregnancy and 30% experienced this more than twice. The first unwanted pregnancy was carried to term in 42% of the cases but more than half of the women (52%) had chosen an abortion. The second unwanted pregnancy, however, very frequently resulted in an abortion (73%); in 24% there was a spontaneous abortion and only 2% carried the pregnancy to term. These figures indicate a great need for reliable contraception.

Use of contraception

Most of the women indicated they used some form of contraception during the last five years; 18% did not use any contraception; 1% did not give an answer. The following groups of women were most likely not to have used contraception: women between 15-20 years (40%), unmarried (29%), poorly educated women (24%), and women living in the countryside (22%). The figures in Table 1 show the type of contraception used during the last five years.

Of all methods, the condom was most often reported to be used "sometimes". The IUD was the most steadily used contraceptive method, although the more traditional and natural methods (coitus interruptus and rhythm) were rather popular (31% reported "always" used). Ten percent of women had experience with vaginal douches as a contraceptive method. The Pill was less frequently used and only 10% always used it. The diaphragm was a very unpopular contraceptive method among former Soviet women. There was stable use of the main method of contraception; 39% used the main method for longer than three years; 28% used it for one or two years; one third had chosen their contraceptive method less than one year ago. The younger women (under 25 years) often used modern contraceptives. The natural barrier methods were more popular in the eastern parts of the former USSR (Siberia). In the western parts (Russia, Ukraine) highly educated women were more likely to choose modern contraceptives.

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Table 1

Contraceptive methods used during last 5 years
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	Always	Sometimes	Not Used
Condom	18%	51%	31%
Coitus interruptus	14	46	40
IUD	37	11	52
Rhythm	17	31	52
Vaginal douche	10	29	61
Pill	10	19	71
Chemical	2	14	84
Chemical + condom	1	4	95
Diaphragm	0	1	99

Preferred contraceptive method

The most preferred contraceptive method was the IUD; half of the women mentioned the IUD as their most favoured method; 25% of women gave this method as the second choice. The Pill is less popular; 18% mentioned the Pill as their first preference, and 25% rated it second. The condom took third place in the range of most preferred contraceptive method. Traditional methods were only chosen by a small proportion of women. These figures clearly indicate a gap between actual use and the preference of women.

Attitudes towards contraception

Regular use of contraception was more appreciated by these women respondents than the termination of an unwanted pregnancy through abortion. In answering the question: "What is more dangerous: regular use of contraception or abortion?", 89% judged termination of unwanted pregnancy to be more dangerous, 7% held the opinion that regular use of contraception is more dangerous, and 4% rejected both methods of family planning. In general, women between 45-50 years held the opinion that contraception is more dangerous than abortion (13%). Table 2 presents information about the perceived convenience (in terms of not interfering with sexuality), reliability and safety of different contraceptives. The IUD was perceived as the most convenient contraceptive method; however it was not rated as the safest in terms of health, which was the most striking perception regarding the condom. The attitude towards the Pill was not positive. Convenience and safety were negatively judged, and the reliability of the Pill was perceived as comparable to the condom and IUD. Even the rhythm method was not judged more negatively than oral contraception.

Sources of information

Although about half of the women (49%) asked their physician for advice on contraception, physicians were the main source of information in only 12% of cases. Written sources, i.e. books and magazines (45%), and friends (37%) were the most frequently used sources of information on contraception. The more highly educated women reported the use of written sources (50%), more poorly educated

women stressed the importance of their friends as information sources on contraception (40%). Parents in general were a rather irrelevant information source (4%) but they were slightly more important for women aged between 15-20 years (9%). These young women also used their peers as a source (43%).

Role of the partner

The partner was not an important source of information on contraception (1%). But this does not mean women perceive their partners as not being involved in the use of contraception; 59% described their partner as actively involved, 26% as indifferent, 11% as passive and only 3% of women indicated that their partner was against the use of contraception. So it is understandable that 76% of the respondents expressed the opinion that both the woman and her partner are responsible for preventing pregnancy. Twenty percent of women thought that only women are responsible for contraception, and 4% indicated that the male partner carried this responsibility. The women questioned thought that their partners had the same opinion.

Buying condoms

The shared responsibility of women and men in terms of contraception was made clear from the answers to the question, "Who buys the condoms?". It showed that 52% of women fulfil this role, while 48% of their partners bought condoms. Discussion about contraception with partners is always possible according to 54% of women, however 35% of them indicated that this is only sometimes possible and 8% stated "never".

Sexually transmitted diseases

The responsibility for preventing sexually transmitted diseases is shared by both partners. About 90% of women expressed this opinion; 7% stated that prevention of STDs is a matter for women, and 4% attributed this role to their partner. The figures were very similar concerning the perceived opinions of their partners. So, couples seem to agree about their common responsibility for STD prevention.

Table 2

Attitude towards the used contraceptive			
	Convenient	Reliable	Safe for Health
IUD	47%	30%	20%
Condom	14	28	43
Pill	17	20	7
Rhythm	11	7	19
Coitus interruptus	2	8	2
Chemical	2	1	1
Vaginal douche	5	3	7
Chemical + condom	1	2	1
Diaphragm	1	2	1

Conclusion

The results indicate that family planning behaviour in the former USSR is still dominated by the termination of pregnancy and widespread use of traditional contraceptive methods, despite the political changes during the past years. Although modern contraceptives like the Pill and the IUD are slightly more available and more frequently used, the survey revealed that there are still several objections to oral contraceptives and that the traditional methods are perceived to be more reliable than they really are. The IUD proved to be the most popular contraceptive.

Information supplied by physicians should be improved. There is still no data available on the opinions of physicians on modern contraceptives. This may be relevant because physicians may play an important part in reinforcing the negative attitudes of women towards modern contraception. In addition, the role of the press and media seems to be relevant. The interest shown by women concerning the survey in "Health" and the sources of information mentioned, highlights the important role of journals in modern family planning. The results are based on a non-representative sample with an over-representation of young and highly educated women. Furthermore, it is quite likely that women who are most interested in family planning have tended to cooperate with the survey. So it can be expected that actual practice and attitudes are more deceptive than the results show. The availability of reliable and safe contraceptives, combined with the education of providers and the dissemination of information, seem to be the basic fundamental conditions needed to modernise family planning and reduce reliance on induced abortion in this part of Europe.

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This article is based on the lecture at the opening of the Information Centre on Human Reproduction, Moscow (16 December 1991)

Youth Work Initiatives in Moscow

Valentina Popova*

The Moscow Centre for Forming Sexual Culture in Youth began its work in January 1990 and continues with its humanitarian activities in spite of considerable difficulties. It offers an anonymous consultative service for teenagers and is unique in offering such a service in Moscow and quite possible in the Commonwealth of Independent States (CIS). Our Centre works directly with the teenage audience and we meet more than 6,000 young people each year. The various experts at hand include psychologists, gynaecologists, sexologists, venereologists, narcotics experts and general practitioners.

Teenagers' problems

The problems of teenagers, which are closely associated with their self-dependence and entry into adult life, cannot be solved merely with the help of a telephone call. They come to our Centre, not only from Moscow but also from provincial towns and even other Republics. The most frequent reasons for teenagers coming to the Centre include rape, pregnancy, venereal diseases (sometimes as a result of rape), homosexuality, masturbation, transexuality and others. Usually the parents know nothing of their children's problems.

Sometimes girls who ask for advice on contraception are not having sexual intercourse but are apparently preparing themselves in advance. However, more often it happens that a girl has a regular sexual life and does not bother with contraception, or takes the advice of her friends on natural methods without being familiar with the rhythm of her menstrual cycle.

Our children, teenagers and even adults have little knowledge of their anatomy and physiology because the government pays insufficient attention to this aspect of the educational sphere. The absolute ignorance of teenagers regarding sexuality and sexual life might be illustrated by a recent example of a 15 year old girl who came to us as she was anxious about her periods having stopped. It was discovered that she had been meeting regularly with a 19 year old boy. She had not been taking any contraceptive measures and considered ovulation to be the safest period.

The Russian situation

A very difficult problem is that of helping under-age pregnant girls who do not wish to inform their parents of their situation. Legislation does not allow for a medical abortion before the age of 18 years without the parents' permission. Although a directive from the Moscow medical administration exists which authorises abortions in extraordinary circumstances, physicians are reluctant to shoulder this responsibility. Especially tragic are the situations when girls come to us for help, nearly full term in their pregnancy.

Up until now the possibility of contraception for our women has been an abstract subject - because of ignorance, lack of advertising, difficulties in obtaining consultations and shortages of contraceptives. As before, abortion is still the main method of regulating the birth rate and it remains a national tragedy.

This problem is especially aggravated now, in the present economic climate, when undernourishment is a serious problem and mothers do not know whether they will be able to feed their children tomorrow. If today one kilogram of butter costs a quarter of a physician's or a teacher's salary, what can we expect for our children tomorrow?

An appeal for help

One positive result of last year's work is the increase in the number of visits by young girls who are seeking advice on contraception, and this accounts for 20-25% of all consultations with gynaecologists. However, the Centre has no funds for advertising so teenagers become aware of our services from the rare newspaper articles or television broadcasts. Sadly we often receive letters from children, teenagers and adults when it is too late to give help. In addition, the anonymity of our service gives us no opportunity to monitor the fate of our clients.

Though several family planning associations and governmental structures have been formed to deal with these problems, practical organisations such as our Centre which work directly with young people do not have any financial and organisational support and their existence is dependent on pure enthusiasm. Our appeals to various organisations have not resulted in any concrete support. We need, free of charge, large supplies of contraceptives for demonstration, advertising and distribution to young people. We also need audio and video equipment, tapes and other materials.

Besides the work with teenagers, our Centre conducts training of specialists in the areas of child and teenage development and education, whose work will be invaluable in the years to come. We are certain that the more teenagers know about how to care for themselves and their children, the more valuable our efforts will be in the fight to save our people's lives and futures.

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Sexual Education in Transition in Bulgaria

Dr Roumen Bostandjiev*

The dominant approach to sex education, and every other ethical issue in Bulgaria, is still rooted in the socialist and collective ideology of previous decades. Attitudes to sexuality result from a tradition of patriarchal and authoritarian human relations, in which individuality was subordinated to the values and interests of the extended family and society. In this context sex education was primarily oriented to social control over individual behaviour.

The centralised hierarchical political system defined all needs of the various sectors of society. The prescribed task of school authorities and teachers with respect to sex education was to repress adolescent sexuality and to maintain institutional control over their personal behaviour. The justification for this approach was to reduce the high rate of induced abortions and divorces. Human sexuality was generally dealt with in a moralistic and "medicalised" way, while deviant behaviour was subject to sanctions.

A new humanistic approach

During the last decade the ineffectiveness of this approach became evident. The few specialists in the field attempted to introduce humanistically-oriented education programmes, aiming to show that misfortune in intimate life was not due to insufficient social control, but was a logical consequence of authoritarian control that handicapped the development of personal growth and responsibilities.

In 1988-89 we developed and tried to introduce into schools two new educational programmes: "Prevention of AIDS Depends on You and Me" and "In the World of Intimacy", aiming to increase students' abilities to make well-informed, individual decisions and to develop personal maturity. The pupils participated with great interest and pleasure, but reactions from the official school authorities were ambivalent. Even in the few cases where school official resistance was overcome and teacher training was organised, such initiatives remained marginal and alien to the repressive character of the educational system.

Resistance to change

The radical political changes of the last few years gave way to a slow and difficult process of social change, in which social groups at the bottom of society gradually started to express their needs. At the same time some key people in State institutions, especially those lacking real qualifications and abilities in sex education, began to feel insecure in their roles and so merely pretended to support change. In fact they protect their powerful positions by repressing any kind of independent activity, using their positions to maintain financial and administrative control.

Private initiatives

Being aware of the situation, a group of like-minded specialists (school psychologists and psychotherapists) with similar psycho-social convictions decided to create an independent professional organisation, called *Modus*. *Modus* aims to develop educational and training projects in schools

and universities, with family and sexuality education taking first priority.

To start with, our plan was to clarify the existing needs in the field of sexuality/family life education. In November 1990 we organised a national meeting to discuss these needs, inviting over 200 people from different social and professional groups involved in sex education: students, teachers, school officials, health workers, journalists, politicians, etc. On the first day, each group clarified their specific problems, needs and potential activities. Then the groups shared their results, made concrete agreements, and used this experience to draw up a plan for co-ordinated action. The main difficulties now in implementing this plan are the shortage of funds for social and cultural activities and the lack of complete independence of the schools.

Meanwhile, in March this year, several members of *Modus* formed the **Council for Sexual and Family Health** to deal predominantly with psycho-social aspects of sexuality, family life and parenthood. From our private office in Sofia, our work reaches in three main directions: psychosexual counselling - individual, marital, family and group therapy; the development and implementation of family life/sexuality education programmes in schools and for specific social groups (ie. parents, single people, physically disabled people, etc.); and the development of sex education programmes for university and post-graduate students of pedagogy, psychology, and medicine, with workshops and training courses for other specialists concerned with the problems of sexuality and family life. We try to create therapeutic teams, and have invited the most prominent psychotherapist in Bulgaria to supervise this work. In our educational projects we work with small groups, using group dynamics, a person-centered approach, psychoanalysis and other methods. We have recently signed our first contracts with three new universities in Bulgaria. In the curriculum for pedagogical students "sexual education" and "psychosexual counselling" are already included.

Future plans

The Council of Sexual and Family Health and *Modus* are the only private organisations involved in sex education in Bulgaria. We intend to organise a wider professional network, through which state institutions and new private organisations can collaborate. We believe that independent professional groups like ours are best situated to respond to the need for sex education. However, to develop our activities we need good office facilities (computers, telefax, video-systems, etc) and better information sources. As for us, the exchange of ideas and experience is extremely important, so we will be very grateful for any assistance.

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Contraceptive Practices and Attitudes of Women in the Czech and Slovak Federal Republic (CSFR)

Evert Ketting,^(a) Philippe Lehart,^(b)
Radim Uzel,^(c) Adriaan Visser^(d)

Introduction

In October/November 1991 a national representative survey on knowledge, attitudes and practice of contraception was carried out in the Czech and Slovak Federal Republic (CSFR). This first national study in the CSFR was organized by the Institute of Mother and Child Health Care in Prague, and supported by the CSFR Ministry of Health and the International Health Foundation (IHF). Some basic results of this study that are presented in this article have been discussed in a presentation by Dr Uzel at the 'Second Congress of the European Society of Contraception' in Athens, in May this year.

The general lack of adequate information on family planning in the CSFR was the primary reason for this study. This information is needed as a basis for future improvements to family planning services and to direct public education activities in this field. The outcome of this study indicates that a national policy is needed to facilitate the change from abortion to contraception, as the abortion rate in the CSFR is still quite high. Annually there are 47 abortions per 1000 women of fertile age - this rate varies in western Europe from five in the Netherlands to 20 in Sweden (Henshaw and Morrow 1990).

A questionnaire that had previously been used in studies in eight western European countries (Ketting 1990) was slightly adapted for the family planning situation in the CSFR. A random representative sample of 1175 women aged 15-44 was drawn and 1072 women agreed to participate in the study, rendering a satisfactory response rate of 91.2%. The women filled out the questionnaire at home in the presence of an interviewer. The sample was representative for age, level of urbanisation and region of the country. The data of the survey were analyzed and interpreted in close collaboration with the International Health Foundation in Brussels.

Women at risk of unplanned pregnancy

To assess the quality of contraceptive use, it is necessary first to define the group of women at risk of unplanned pregnancy. This group consists of those women who can become pregnant (sexually active and fertile), but who do not wish to. Table 1 presents the results of our survey at this point.

More than three-quarters of the women in the sample (78.2%) are at risk of unplanned pregnancy. The remaining 21.8% are either not having a sexual relationship, are known to be infertile, are currently pregnant or are trying to get pregnant. Most of the women at risk of unplanned pregnancy do not wish to become pregnant because they already have the number of children they want (62.8% of them); the remaining 37.2% only want to postpone childbearing. More than a third of all the women interviewed (35%) had experi-

Table 1

Women at risk of unplanned pregnancy		
	Absolute number	Percentage
1. Not at risk	233	21.8
No sexual relationship	121	11.3
Currently pregnant	33	3.1
Trying to get pregnant	37	3.5
Naturally infertile	42	3.9
2. At risk	838	78.2
Total number	1,071	100%

enced at least one unplanned pregnancy. Of this sub-group, 29% had experienced this more than once. Furthermore, in 37% of the cases the unplanned pregnancy occurred before marriage. This outcome is not very surprising in view of the poor contraceptive use, particularly among teenagers, that will be shown below. Only 20% of the unplanned pregnancies were carried to term, the remaining ones ended in induced abortions (71%) or spontaneous abortions (9%).

Use of contraception

The current contraceptive use of women at risk of unplanned pregnancy is shown in Table 2.

Natural methods of contraception (rhythm and withdrawal) appear to be the most widely used methods. Almost one third of the couples who are not seeking a pregnancy rely on these quite ineffective methods. The condom is frequently used as well, by more than a quarter of those in need of contraception. On the other hand, modern reliable methods of contraception are used by only a quarter of the women at risk. In particular, use of oral contraception is fairly low (7%). In western Europe about a third of the women who do not wish to become pregnant use this method. Similarly, contraceptive sterilization is rarely practised and male sterilization was not found at all. One in eight couples do not take any preventive measure at all, and therefore run a very high risk of unwanted pregnancy and induced abortion. These data indicate there is still a large unmet need for family planning education and services.

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Pattern of contraceptive
use in W. Europe

Table 2

Current contraceptive use among women at risk

Method	Absolute	Percentage
No method	103	12.3
Natural method	268	32.0
Barrier (condom)	240	28.6
IUD	142	16.9
Pill	60	7.2
Sterilisation	25	3.0
Total number	838	100%

Differences in contraceptive use

There are some significant differences in contraceptive use between the Czech and Slovak Republics (Table 3). In the Czech Republic use of the condom, IUD and the Pill is more prevalent than in the Slovak Republic. Furthermore, use of natural methods and no method at all were reported more frequently in the Slovak Republic.

The choice of contraceptive method is also dependent on the age of the woman (Table 4). The youngest and oldest women are most likely to use no contraceptive method at all. Particularly, teenagers seem to be at risk of unplanned pregnancy. On the other hand women aged around thirty are the most frequent users of modern methods of contraception. The condom seems to be most popular among adolescents. However, the data do not indicate how consistently this method is used.

Women without children are most likely to use no method at all, or a condom (Table 5). After having given birth to one or more children a substantial number of women start using the IUD. But they very rarely change from using natural methods to the Pill or sterilization.

The pattern of contraceptive use which is common in western Europe is not found in the CSFR. In most western European countries the youngest age group, which has not yet started having children, tends to use oral contraception or condoms. In western Europe, for the group of women aged around 30 with one or two children there is usually some increase in IUD use - the IUD is typically used for child spacing. Then, after completion of the family at around 35 years of age an increasing number of couples choose sterilization as a contraceptive method. In the CSFR however, use of the Pill is low in all age groups and is independent of the number of children. The IUD is not primarily used for child spacing, but instead to limit the number of children in the family, and sterilization does not seem to be a self-evident option after completion of the family. It is only the particularly high use of condoms amongst young couples without children which is similar to what is found in western Europe.

An important factor determining contraceptive use in the CSFR is religion. Women who occasionally or regularly go to church tend to use contraception less than women who do not attend church, and they are also more likely to use natural methods of contraception (Table 6).

Table 3

Current contraceptive use of women at risk by republic

Method	Czech	Slovak	Total
No method	11%	14%	12%
Natural method	29	37	32
Barrier (condom)	31	24	29
IUD	19	13	17
Pill	8	6	7
Sterilisation	2	5	3
Total (n=835)	100%	100%	100%

It would appear that use of the IUD and the Pill is inversely related to the degree of religious devotion - the church seems to affect reliable contraceptive use in a negative way.

Attitudes towards contraception

Acceptability of a contraceptive method is generally influenced by the way it is evaluated on four important criteria (Ketting 1990):

- Safety, in terms of health and side-effects
- Reliability (unintended pregnancy risk)
- Moral and religious acceptability
- Effects on sexual pleasure

All women in the sample (N=1072) were asked how they perceived the different contraceptive methods in terms of these four criteria.

In almost all countries safety (in terms of health) is the most important criterion for women. The results of the survey at this point are shown in Table 7.

The rhythm method and the condom are found to be by far the safest methods. Withdrawal scores slightly lower. But the modern medical methods are generally judged as being not very safe, particularly as one in every three women had severe doubts about the safety of oral contraception. The Pill scores lowest of all methods at this point and the diaphragm is practically unknown.

The perception of reliability of methods is rather surprising, as Table 8 shows. Most women correctly think sterilization is completely reliable, but the condom rates second. In all western European countries the Pill is known to be the most reliable method after sterilization. In the CSFR however, oral contraception scores as low as the withdrawal method. This low reliability estimate for the Pill is even more surprising, taking into account that only one in six women does not have an opinion on this point. So, women do actually have an image of the reliability of oral contraception, but it is a fairly negative and incorrect one. Conversely, the reliability of the withdrawal method seems to be over-estimated.

When it comes to the moral and religious aspects of contraceptive methods (Table 9), the traditional, unreliable methods and the condom score high or fairly high with about three-quarters of women questioned. The Pill and the IUD take a middle position on this criterion. Sterilization is least acceptable; only four in every ten women think this method is allowed and the remaining six do not think it is or do not know.

Finally, women in the sample were asked whether they felt contraception did or would negatively interfere with sexual intercourse (Table 10). A remarkable outcome here is most women do not know whether the Pill or sterilization would have a negative influence on their sexual relationship. Again this is rather different from western Europe, where most women appreciate the Pill for not interfering with sexuality. Another interesting outcome is that 61% of women do not know whether sterilization would influence the way they experience sexual contact. The opinions of Czech and Slovak women on the IUD, on the other hand, are quite positive in this respect. The opinions women have on the health risks and benefits of oral contraception and the perceived side-effects of this method have been investigated in more detail. The outcome of this study will be published in a separate article. Nevertheless, it should be mentioned here that there is a general lack of knowledge on oral contraception. About half of the women interviewed had to leave these questions unanswered. And as far as they had any ideas, their answers indicate that they are fairly suspicious of oral contraception.

Table 4

Current contraceptive use of women at risk by age							
Method	Age groups of women:						Total
	15-19	20-24	25-29	30-34	35-39	40-44	
No method	22	13	06	08	12	15	12
Natural method	27	33	36	35	27	31	32
Barrier (condom)	41	37	26	21	29	23	29
IUD	2	08	20	26	21	19	17
Pill	7	08	10	08	06	05	07
Sterilisation	-	01	02	02	05	06	03
Total %	100%	100%	100%	100%	100%	100%	100%
Total number of interviewees	(95)	(119)	(126)	(164)	(168)	(146)	(818)

Table 5

Current contraceptive use of women at risk by number of children (in %)				
Method	Number of Children			
	None	1	2 or more	Total
No method	15	12	11	12
Natural method	33	36	31	32
Barrier (condom)	36	26	26	29
IUD	06	19	22	17
Pill	08	06	07	07
Sterilisation	01	02	04	03
Total %	100%	100%	100%	100%
Total number of interviewees	(241)	(121)	(476)	(838)

Table 6

Current contraceptive use of women at risk by church attendance (in %)				
Method	Every Week	Occasionally	Never	Total
No method	15	13	11	12
Natural method	42	33	30	32
Barrier (condom)	26	31	28	29
IUD	08	14	20	17
Pill	05	06	08	07
Sterilisation	04	03	03	03
(Total %)	100%	100%	100%	100%
Total number of interviewees	(78)	(288)	(470)	(836)

Table 7

Contraceptive methods according to perceived safety (in %)				
Method	Completely Safe	Fairly Safe	Unsafe	Don't Know
Rhythm	61	21	02	16
Condom	59	23	02	16
Withdrawal	44	34	05	18
Sterilisation	17	24	20	39
IUD	08	42	29	21
Diaphragm	07	21	05	67
Pill	02	36	33	29

Table 8

Contraceptive methods according to perceived reliability (in %)				
Method	Completely reliable	Fairly reliable	Unreliable	Don't Know
Sterilisation	64	11	03	23
Condom	37	51	04	09
IUD	23	47	08	21
Withdrawal	10	45	33	12
Pill	09	53	22	17
Rhythm	05	36	40	19
Diaphragm	04	30	09	58

Table 9

Contraceptive methods according to moral/religious acceptability (in %)				
Method	Completely acceptable	Fairly acceptable	Unacceptable	Don't Know
Rhythm	56	21	02	21
Withdrawal	50	20	08	23
Condom	48	21	09	22
Pill	33	23	11	32
IUD	31	19	18	32
Diaphragm	24	13	13	49
Sterilisation	21	18	30	31

Table 10

Contraceptive methods according to interference with sex life (in %)				
Method	Very disturbing	Fairly disturbing	Not disturbing	Don't Know
IUD	01	13	54	32
Pill	02	08	36	55
Diaphragm	03	20	12	65
Sterilisation	08	18	13	61
Rhythm	08	38	36	18
Condom	08	44	31	16
Withdrawal	14	44	28	13

Question asked differently: does the pill lessen the desire for sex?

Conclusions

- The quality of family planning in the Czech and Slovak Republics is rather poor. More than a third of women of fertile age have already experienced at least one unplanned pregnancy. In most cases this results in a request for induced abortion. Consequently the abortion rate in the CSFR is fairly high, about four times as high as in western Europe.
- Only 28% of women at risk of unplanned pregnancy use modern reliable methods of contraception, most often an IUD. Compared to western Europe use of oral contraception and contraceptive sterilization are remarkably low.
- One in every eight women at risk does not use any method of contraception and one in three uses a traditional unreliable method.
- Many women in the CSFR do not have any idea about the relative advantages and disadvantages of different contraceptive methods. Likewise, many of them hold incorrect views at this point.
- The image of oral contraception is surprisingly negative. Most women incorrectly think this method is not safe for their health, or do not have an opinion at all; the reliability of the method is heavily under-estimated and the subjective acceptability is fairly low.
- All these results indicate there is a tremendous need among the general population for large scale family planning education.

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The Church's Heavy Hand in Poland

Frances Kissling*

Next time I lose patience with those who rail against church involvement in politics, I will remind myself of Poland in the 1990s. The Polish bishops have not simply blurred the line between Church and State, they have called for the line's erasure. Neither the joy of a Papal visit nor the loyalty Poles feel towards the Church compensates for the frustration they feel over the Church's colossal efforts to replace the totalitarian State with a theocracy.

The Polish experience erases any doubts about the importance of maintaining the wall of separation between Church and State. It also provides ample evidence that when the overstepping Church is the Roman Catholic Church, women will suffer most. The Polish bishops, in pushing their agenda in the public square, have established some of the industrial world's most punishing policies towards women. Not much political savvy is required to understand that Poland owes an enormous debt to the Roman Catholic Church or to see that the defeat of communism left a political void only those trained and organised through the Church were able to fill.

And fill it they did. The first act in the bishop's parade of horrors was their successful pursuit of government-supported religious education in the public schools. Regulations require that options be available for all children. In practice, only Catholic instruction is available. While participation is "voluntary", both peer and adult pressure is coercive. Indeed, a school principal blithely dismissed the recent beating of one non-participant, a Jehovah's Witness, by explaining that the boy had always been persecuted for his faith.

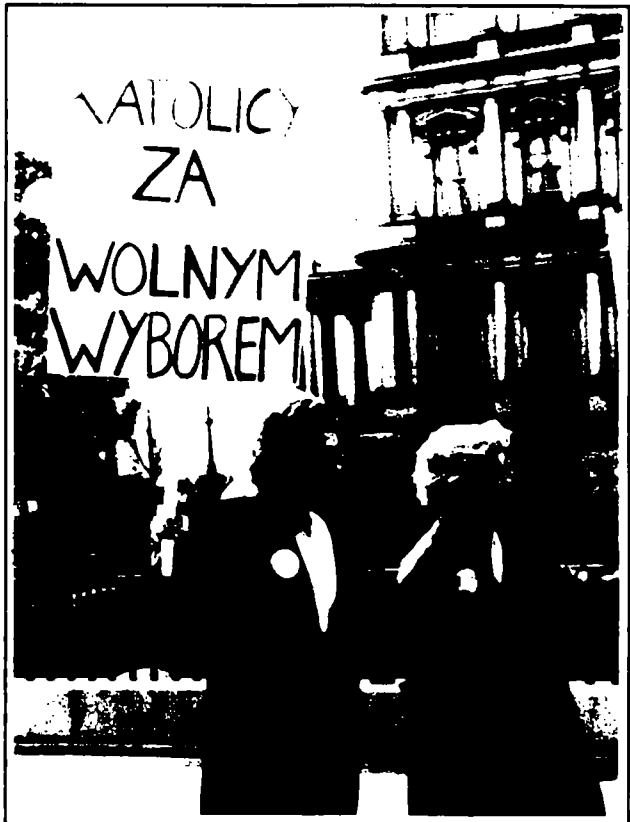
From the Ministry of Education, the bishops moved on to the Ministry of Justice, with a view to tightening up on divorce. Poles could once obtain a divorce by going to a local court; new regulations, conceived and pushed by churchmen, now require travel to the more distant and more crowded district courts.

Stiffer divorce laws, the bishops believe, will keep families together. Other measures are aimed at keeping women at home. When 60% of day care centres were closed in Poland, the bishops uttered not a single word in protest. The bishops also suggested that Poland's unemployment problem could be alleviated if women left the labour force, leaving men to be paid higher wages.

One prelate urged changes to school curricula so that girls would learn skills more suited to their roles as wives and mothers while boys would pursue traditional intellectual studies.

The success of many of the Church's proposals can be linked to the strong ties that bind Lech Walesa to the Polish Pope, John Paul II, and to conservative Catholicism. When Walesa had his opportunity as President to appoint a Minister of Women's Affairs, the Catholic bishops called the shots. They wanted, and got, a Minister who is Catholic, married, at least 40 years old, with two or more children. The bishops overlooked one thing. Minister Anna Popowicz* does not support a ban on abortion. Like many Poles, she believes that the country's inadequate housing, health services and employment opportunities do not help women to bear children with any assurance for their well-being.

It is in the area of family planning and abortion that the bishops have been most persistent. While a recent survey



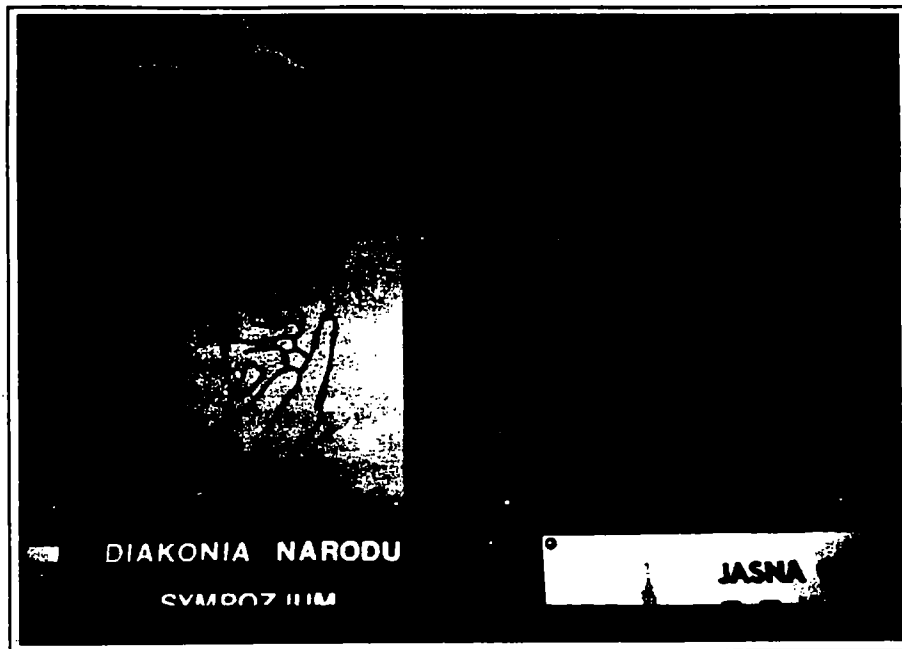
Taken in Washington, DC, USA, during Lech Walesa's meeting with President Bush in March, 1991. The placard says "Catholics for a Free Choice" in Polish.

(April 1992) shows that 61% of Poles favour the country's 35 year old law permitting abortion, the bishops have conducted a multifaceted campaign designed first to limit and then ban abortions, then limit and finally ban contraception.

The bishops successfully lobbied the Ministry of Health to require a woman seeking abortion to obtain the approval of two gynaecologists, her family doctor and a Church-approved psychologist. The expressed role of the psychologist is to dissuade the woman from terminating the pregnancy. But some women do not get that far. At least three women have died as a result of self-induced abortions since the regulations were put in place. One said she self-induced because she feared the psychologist would report her to her parish priest.

In the legislature, the bishops vigorously pursued an anti-abortion bill, personally endorsed by the Pope. The ban passed the Senate in October of 1990. However, the lower house, the Sejm, dropped the bill in May 1991 in the face of public opposition, handing the church its first political setback in a democratic Poland. But it may have been a

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Pro-life messages from a Catholic church in Warsaw, Poland

Pyrrhic victory for Polish women. In place of the original legislation, the Parliament approved a non-binding resolution calling on the government to ban abortions by private physicians. Church lobbying was intense, pervasive and even vicious. Catholics were threatened with denial of the sacraments if they refused to sign anti-abortion petitions. Pro-choice opinion is easily dismissed. Only communists and Jews favour legal abortion, Poles are told.

In December, opponents of abortion won a victory when the National Doctors' Guild drafted a new code of ethics that sharply restricts abortion, permitting it only in cases of rape or when the life of the mother is threatened. It also says the decision on whether a pregnant woman can undergo prenatal tests for genetic defects rests solely with her doctor. Sanctions include suspension of a doctor's license. This new medical ethics code has now taken effect from 3 May 1992.

New legislation was introduced in early 1992. Nearly half of the members of Parliament have pledged to support it even though it would permit abortion only in cases of rape or a threat to the woman's life. Violators would face prison sentences of up to two years.

The bishops have also called for new provisions in the Polish constitution declaring the foetus a person from the moment of conception, thereby making legal abortion impossible.

Most tragic is the Church's refusal to understand what is evident to almost everyone else. The best, least coercive way to reduce the incidence of abortion is through increased access to effective contraception. In May the Polish government announced a January decision made under intense pressure from the Church, to eliminate subsidies for birth control pills, putting them out of the economic reach of most Polish women.

At the urging of Pope John Paul II, Catholic pharmacists have organised "Pharmacists for Life". These druggists not only refuse to sell contraceptives but also strip pharmacies of contraceptives by buying up all the available stock.

Perhaps the only hopeful sign is that these actions have led to an erosion of Polish public support for the Church. The Church now ranks second, behind the army, as the most trusted institution. Legislators warn that the likely ef-

fect of the Church's obdurate opposition to women's and reproductive rights will benefit the communists in next October's election.

It was a scant 30 years ago, at the Second Vatican Council, that the Roman Catholic Church unequivocally acknowledged the validity of separating Church and State. The actions of the Polish bishops betray deeply ingrained remnants of the hierarchy's preference for theocracy over democracy.

Such sentiments are not confined to Poland. In our own backyard in the USA bishops press for changes. Recently Cardinal Bernard Law of Boston revealed a desire to import the Polish model. Opposing relaxation of a Massachusetts law restricting commercial activity on Sunday, the cardinal said, "It is ironic that as former Marxist and avowedly atheistic governments find room for religious expression Massachusetts erodes it".

Catholics, who historically have been both persecuted and persecutors, need to be especially sensitive to Church-State issues. Ironically, the Pope has said it best. On 1 January of this year, he urged world governments to allow individuals to pursue freely their beliefs and warned that when religious and civil law are synonymous, it "can stifle religious freedom, even going so far as to restrict or deny other inalienable human rights." The Polish bishops, who seek to honour the Pope, could do no better than heed these words.

**Since this article was written, Anna Popowicz has been removed from her post.*

Current Contraceptive Use in Romania

Dr Iulian Hopulea-Petri^(a) and Dr Pim de Graaf^(b)

Introduction

In Romania during the Ceausescu régime, due to the unavailability of family planning services, many children were born to parents who either did not want them or did not have the means to raise them. During 1990, the large number of orphanages and other child institutions in Romania, as well as their appallingly bad conditions, came to the world's attention. Very high maternal mortality during the pre-revolution years - 545 maternal deaths during the first 28 weeks of pregnancy in 1989¹ - mainly due to illegal abortions, became known as another consequence of the pro-natalist policies and the ban on family planning services.

Since the revolution in Romania in December 1989, the government and Romanian and foreign NGOs have been trying to reduce both maternal morbidity and mortality and births of unwanted children by the introduction of family planning activities. Several authors have reported on the efforts made so far and on the obstacles in implementing sex education and contraception; the overview of Hord et al is the most comprehensive so far².

In this article, we give an estimate of the proportion of Women of Reproductive Age (WRA) who were, at the beginning of 1992, using contraception. The obstacles encountered in making such an estimation are discussed.

Data

One would suppose that, in Romania, the following kind of data could be used in order to assess the proportion of WRA who are protected against pregnancy by use of contraception:

- numbers of WRA using family planning services;
- figures on use of contraceptives;
- comparison, over time, of the number of pregnancies as indicated by the number of women who attend pre-natal clinics;
- comparison, over time, of the number of deliveries in combination with the number of abortions.

The first set of data would supply by far the most precise information. However, there is no system of data collection on family planning services. Although individual health services, like gynaecology departments and so-called "family planning cabinets" may very well have kept registers, notions of new acceptors, continuity rate, target population etc. are not yet well-known. Aggregates of data for district or national levels are not produced. Since family planning services are delivered in hospitals, private clinics and public dispensaries (in spite of legislation which limits most family planning activities to specialists) with a pattern that varies over time, we could not collect all the necessary data direct. Only isolated and indirect data could be used for our purpose. For this reason, we resorted to using indirect and global parameters: the number of contraceptives used per district. Additional data on numbers of abortions and deliveries are matched with the data on contraceptives, and checks are made on the comparability of these figures.

In March 1992, data were collected in three districts: Maramures, Sibiu and Caras Severin, all situated in Transylvania. The total population of these three districts forms 6.3% of the population of the country (see Table 1).

In 1990 and 1991, a high proportion of the German-speaking population of Transylvania, especially young people, emigrated to Germany, but not all districts were equally affected. As no precise data is available, our estimate is that the decrease in population in Sibiu district is less than 10%. The figures in Table 1 date from 1990, before the emigration process started.

These districts were chosen for data collection because our existing relationship with the health authorities would facilitate access to information that otherwise would be less accessible. Data were collected on the use of contraception; information on deliveries and abortions from the districts was compared with information on the same topics from the Ministry of Health (MOH).

Consumption of contraceptives

Registration of sales in the pharmaceutical distribution network is not computerised nor standardised in any way. The previous control over retailers has now ceased to exist and data on sales and stocks are no longer available. Donations from foreign organisations are not centrally registered as they are given to individual doctors or family planning services. However, we have reason to believe that in the three districts few of the donations of contraceptives escaped our attention. We collected information on the sales of contraceptives from the regional pharmacies to retailer pharmacies; the regional pharmacies, each one covering two or three districts, buy their supplies from national pharmacies and they sell to retailer pharmacies, most of which were privatised in 1991; per district there may be as many as 50 retailer pharmacies.

In 1990 and 1991, regional pharmacies received contraceptives from the MOH through the national pharmacies and from Médecins Sans Frontières (MSF). To this we added the contraceptives that had been made available directly to gynaecologists by different organisations.

Results

Between February 1990 and February 1992, in the three districts combined, 81,500 pill cycles were made available; hospitals and private clinics had a small stock left at the end of the period; public pharmacies had run out of stock for several months already, which put in jeopardy the continuity of pill use. For the purpose of our estimation we assume that virtually all pills have been used or prescribed. Since there is no way of telling how many women were actually using the Pill at the end of February 1992, we took a reasonable mean period of use: these pills would allow for the protection of 6,270 women during one year against pregnancy, this is 1.7% of all WRA in the three districts.

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^(b) Médecins Sans Frontières, Programme Manager, Netherlands

Table I	Total population and Women of Reproductive Age (WRA) in 3 districts and in all Romania	
	Total population	WRA
Caras Severin	403,000	99,300 (24.6%)
Sibiu	501,000	129,750 (25.9%)
Maramures	559,000	138,750 (24.8%)
total 3 districts	1,463,000	367,800 (25.1%)
Romania	23,206,000	5,600,000 (24.1%)

In 1990 and 1991, a total of 12,900 IUDs were made available to the three districts, the largest portion directly to gynaecological departments of the hospitals, the remainder through the regional pharmacies. Some stocks still exist in pharmacies. If we assume that 20% of these IUDs still have not been used, 12,430 IUDs have been inserted within two years, which means that 3.3% of WRA are presently protected against pregnancy by an IUD. IUD failures (spontaneous expulsion or extraction on the basis of complications, or reported pregnancy) only count for 1% of inserted IUDs.

Injectable contraceptives are hardly ever used, although initially a small number had been supplied to gynaecologists and regional pharmacies. Equally, pessaries do not enjoy popularity and the numbers used are negligible. Condoms have been made available in large numbers and are for sale in most pharmacies, in drug stores and tobacco stores; they are imported both by the national pharmacy and by private companies. According to the regular sales from the regional to the retailer pharmacies, they are much sought after. The nature of their use does not allow for an estimation of the protection they provide against pregnancies. We conclude that approximately 5% of WRA (1.7%

pills plus 3.3% IUDs) are using a contraceptive, acquired through the health services in the three districts.

A considerable number of women probably use contraceptives from abroad, for example from nearby Hungary or Germany. This phenomenon existed in the Ceausescu era, especially in Transylvania which historically has many links with these countries. A black market of contraceptives exists. We estimate, on the basis of information from several GPs and gynaecologists, that the supplies of contraceptives via this informal route is not more than 10% of the official circuit. So, we estimate that between 5% and 6% of WRA in the three districts concerned were using a contraceptive at the beginning of 1992.

Abortion and deliveries

Virtually all deliveries occur in health facilities, which give relatively accesible and complete data. Until the middle of 1991, abortions were performed exclusively in hospitals. Since then, however, private practices are being set up by gynaecologists and others. Abortions performed in these private practices are not declared or registered cen-

Table II Number of deliveries and abortions in 3 districts in 1990 and 1991

	District Maramures	District Sibiu	District Caras Severin
Total abortions			
1990	11,295	15,430	14,586
1991	10,335	13,276	13,375
Total deliveries			
1990	8,959	6,215	4,798
1991	8,162	5,441	4,269

Table III Pregnancy rates in the 3 districts (number of pregnant women per 100 WRA per year)

	District Maramures	District Sibiu	District Caras Severin
1990	14.6	16.7	19.5
1991	13.3	14.4	17.7

trally. The number of private practices varies from district to district, depending mainly on the socio-economic situation: in the district of Sibiu there are many more private practices than in Maramures. Therefore, since the middle of 1991, data on abortions performed in hospitals and registered by health authorities no longer represent the total number of abortions performed. When we compared data collected at district level and similar data from the MOH, the difference forced us to resort to just one of the sources. We have opted for data obtained from the MOH (see Table 2).

The total number of pregnancies (including abortions and deliveries) decreased in all three districts in 1991, compared to 1990. The decrease in the district of Sibiu may be explained, at least partially, by the emigration mentioned before. There has been little emigration from Maramures or Caras Severin.

Local health authorities suggest that the general decline of the total number of pregnancies from 1990 to 1991 is due to the impact of the use of contraception. However, the phenomenon cannot be explained solely by the 5% of WRA using contraception. We assume that it is the result of a combination of imprecise records, emigration, the impact of family planning services and non-registration of abortions.

Apart from the general decrease in pregnancies, there is considerable variation in pregnancy rates between the districts. The lowest rate of 13.3% of WRA has been noted in Maramures district in 1991, and the highest in Caras Severin (19.5%) in 1990 (see Table 3). Differences in the socio-economic situation might very well explain the variation.

The number of registered abortions remains very high: 55.8% of all registered pregnancies ended in an abortion in 1991 in Maramures, 71% in Sibiu and 75.2% in Caras Severin.

Discussion and Conclusion

In the three districts used for our estimation, since March 1990, Médecins Sans Frontières (Holland), with the assistance of other Dutch organisations, has given support to the development of family planning programmes by supplying contraceptives via gynaecologists (in 1990) and via regional pharmacies (in 1991); by organising workshops on family planning and sexual education for GPs and gynaecologists; by giving financial, logistical and organisational

support to local initiatives for workshops, lectures etc. on behalf of health professionals. In several other districts in the country and in Bucharest similar support of family planning activities has been given by other organisations, but in most districts no specific or sustained support in this area exists so far. So, these three districts might be expected to be among those in Romania which have a greater supply of family planning services.

At the beginning of 1992, probably between 5% and 6% of WRA used contraceptives in the districts of Maramures, Sibiu and Caras Severin. We assume that for Romania as a whole less than 5% of WRA use contraception, but this percentage could decrease rapidly if no new oral contraceptives are made available. However, this percentage may be called an achievement when compared with the less than 1% in 1990⁴.

One could say that the high abortion rate is an expression of a great unmet need for family planning, but not everyone perceives it in that way. Many people in Romania see no special reason to reduce the number of abortions. There is little debate on the moral dimension of abortion and the widespread ignorance concerning contraception certainly affects demand for it. If the need for family planning services has hardly been defined, a system of data collection does not exist either, and the introduction of private health services will render this task even more complicated. Until this system has been set up, calculations or estimates on the use and impact of family planning services throughout Romania will not be feasible.

With so many priorities in society in general, and in health in particular, family planning does not score high on the list. In the meantime, figures on the proportion of pregnancies that end in abortion may be used as an indicator of the impact of family planning services.

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The Family Planning Project of the Swiss Red Cross in Romania

Anke van Dam*

Since March 1991 I have been working as a delegate for the Swiss Red Cross in the districts of Brasov and Covasna, in Romania. In the two districts we have set up four family planning clinics. The clinics are situated in the hospitals of the different towns. Doctors and nurses have been instructed to work in the family planning field and contraceptive supplies have been provided by the Swiss Red Cross.

The day to day cases

To start I will present some day-to-day cases in the clinics in these different Romanian towns:

A woman comes to the Maternity Hospital with a high fever. She looks very ill. On her cheeks you can see signs of necrosis. She must have already been ill for a couple of days. In response to the question of what happened she answers that she had induced an abortion herself. She had used a twig of a tree, she put it in her cervix and waited for the contractions. She had done this three times before and nothing went wrong. So she decided to use this method again instead of going to the abortion clinic, where abortions are now legal. This time she had bad luck. The woman died from a sepsis of the self-provoked abortion.

After two years of sexual abstinence, while waiting for her errant husband to return home, a woman decided to have a short romance with another man. She trusted the man when he promised to withdraw his penis in time. However, she was unlucky, she got pregnant and had an abortion in the abortion clinic. During her ten years of marriage she had been so careful and had never had to have an abortion. Her first sexual adventure ended in a psycho-traumatic disaster.

Fortunately the next woman came to the family planning clinic of the Maternity Hospital in Brasov. She had heard about the clinic from a colleague in the factory. She wanted an IUD. She had three sons and she told us that she had induced an abortion herself 17 times, and because she was often up to six months pregnant she could tell the gender of her babies, and they were usually boys.

These three stories are not exceptional. Everyday in the clinic I meet women like these. We have all heard and read these things in the newspapers. Immediately after the revolution the world was shocked by the sad situation of Romanian women. However, even now, after working one year in this country, I am not used to the appalling experiences these women tell. And these things are still going on.

Fortunately there are indications that the number of self-provoked abortions has decreased considerably. However it still happens, and women still die because of this. On the other hand, the number of legal abortions remains very high. In 1990 there were approximately one million abortions in Romania and the Ministry of Health said that the number had decreased, although in Brasov the total number of abortions increased. There are reasons to believe that the Ministry of Health figures are unrealistically low, as many abortions are carried out in the booming private gynaecologists clinics and are not registered.

One may conclude that the need for information is urgent and vital. Women need to have information on the risks of self-induced abortions, as well as information on legal abortions. Most important, information on contraceptive methods and the prevention of abortions is crucial.

Information

The great need for information is illustrated by the behaviour of a gynaecologist and her assistant-doctor in a clinic in another town in the district of Brasov. These two female doctors know all the facts, advantages and disadvantages of the different contraceptive methods, and promote these methods very enthusiastically. However, they themselves do not trust the IUD or the Pill. Although they have read about the benefits of these methods they still think it will be harmful to their bodies. Statistics and articles from renowned medical magazines cannot change their minds. It is hard to trust arguments from the western world, when you have heard for decades from Ceausescu how bad contraception is for your health. We have seen the same thing in western Europe. The slightest rumour about an alleged disadvantage of a contraceptive method is enough to considerably undermine the entire method, and many women stop using it. It takes an enormous effort to dispel misconceptions and disinformation. And in spite of the large number of studies carried out on contraceptives in the western world, some Romanian doctors have started studies themselves on the risks and benefits of contraceptives. This will take much time and energy, but maybe these studies are necessary to convince the Romanian people that there are safe contraceptive methods, safer than abortion.

Collaboration

In the clinic where I work I collaborate with nurses, gynaecologists and general practitioners. In the hospital and clinic the "old" hierarchical system reigns. The gynaecologists are on the top of the ladder, the general practitioners follow and after them come the nurses. The nurses however do the counselling. They talk with the women and discuss the advantages and disadvantages of all the contraceptive methods. When the outcome of the counselling is different to the opinion of the gynaecologist, it is very hard for the specialist to listen to what the nurses say. The important role of the nurse is not yet recognised by all gynaecologists. The nurses realise that the gynaecologists are offended by their behaviour, but they also feel that they are not respected as clear thinking, professional, hard working assistants. They do not yet have the possibility to change this.

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Anke van Dam, with Brasov in the background

In the family planning clinic in Brasov we have started to have plenary meetings with gynaecologists, nurses and general practitioners (GPs). Together we try to find solutions to the problems we face in the clinic and we hope that this democratic process will be a good way to proceed.

In Romania we are trying to encourage general practitioners to work in the field of family planning, like in other countries such as Holland and the UK. We have started giving general practitioners theoretical and practical instruction and the gynaecologists are watching this very closely. As in most communist countries the salary of a doctor is not high - it only just compares to the salary of a labourer in a factory. By performing abortions gynaecologists earn extra money, and to compensate for any decrease in abortions they also receive payment for inserting IUDs. However when the GPs start to learn to insert IUDs, gynaecologists will lose this part of their income too.

The fragile situation in Romania makes people uncertain about their circumstances. Because of the high inflation rate life is difficult. Nobody is to blame when people want to make some extra money under these circumstances. Therefore we may not have the ability to introduce a ready-made solution from western Europe into a country like this.

Another problem in a society undergoing social and political change is that people are unsure of their position, especially those working in more responsible positions. Employees can be replaced over night, and this is not only a problem for Romanians but also for us. On several occasions I have discovered that the persons with whom I have been collaborating has been substituted or has left the country. All the cooperation that was built up and all the information shared is lost. And sometimes you have to start from the beginning again to achieve what you want.

Romanian women

The most difficult problem still remains "how to reach people who need family planning".

When you look at a Romanian family you see that they live in a traditional way. The Romanian man is seen as the head of the family. He loves his family and his wife, but he also must be looked after by his wife. He takes little responsibility for their reproductive health, this is a woman's responsibility. However women are very busy. In addition to their jobs in the factories from 8.00 am to 4.00 pm they have to do the shopping. They queue for hours for bread and milk. When they come home they have to do the housekeeping and they have to look after the children. They have no time to go to a family planning clinic or even think about contraception. It is a hard life for them.

With leaflets and posters on family planning we try to attract the attention of the women. We distribute leaflets in the abortion clinics and in towns as well as giving information about AIDS and family planning. We organise meetings in universities for the students. We visit schools and talk with pupils from 16 years and upwards. Sometimes I visit women's groups to discuss family planning with them. At present we are trying to give the Women's League of Brasov a new impulse to fight for reproductive rights.

During my work I see how eager women are to know more about family planning. They are interested and hungry for information, and they are very open-minded. It is so easy to discuss with them even the difficult subjects, such as sexual problems. After every meeting of this kind I feel content and satisfied and this gives me confidence. For me personally this is an important motivation for my work here.

Besides all this we try to do a good job in the family planning clinic. With a warm hearted welcome in the clinic and the provision of a good service we hope to convince women to come to us - and it works.

On the Value of Moral Support

Lyn Thomas*

Much has been written about the 'new market economies' and 'newly emerging democracies' in central and eastern Europe. There is technical expertise on 'how to set up your own business' or 'how to set up a stock exchange' and no doubt this is essential assistance. But what about a scheme to restore women's dignity and self-esteem?

Reproductive rights in jeopardy

In January 1990 there was a great deal of interest in Romania - people were shocked to read about the way women had been denied access to contraception and abortion and were horrified by the pictures of the 'orphans' in homes. How can it be that such a devastating story is forgotten so soon? How can it be that neighbouring governments are about to reintroduce Ceausescu's approach to family planning? Worse still, how can western European governments, so concerned about democracy and free market economies, stand by and let this happen?

In Croatia, Czech & Slovak Federal Republic, Hungary and Poland, laws which gave women the opportunity to make a decision about their fertility are being changed. Laws which either ban or restrict access to abortion are being introduced. To make matters worse, in some cases no attempts are being made to provide contraception either.

Poland has just been granted a loan in the region of US\$200 million by the World Bank. Nowhere in this proposal is family planning mentioned. Abortion is being restricted and contraceptives are not being provided. How is this different from what happened in Romania? Polish women have talked about exchanging their reproductive rights for democratic rights and exchanging the oppression of communism for the oppression of the church. How many will be exchanging their lives for legislation? When will policy makers learn that banning or restricting abortion does not make it 'go away'? When will they learn that banning abortion and not providing contraception will, in fact, increase the numbers of abortions? Of course they will not be legal, safe, medical abortions. They will be illegal, unsafe, performed in less than sanitary conditions and women will get infections. It is quite likely that some women will die.

Many of the governments in this part of Europe do want to provide comprehensive planned parenthood services, but the financial constraints are considerable. There is not a great deal of local manufacture of contraceptives, hence the majority of commodities would have to be imported. This requires 'hard' currency which is in short supply and if your country needs life saving drugs, contraceptives would hardly be high on a list of priorities. The will is there, but the money is not.

What IPPF has been doing

IPPF has been working with family planning organisations (PPAs) in central and eastern Europe for many years. Member associations existed in the German Democratic Republic, Bulgaria, Hungary, Poland and Yugoslavia. Some of these countries no longer exist but contacts have been maintained.

In some situations we are trying to build new contacts, with the hope of making the planned parenthood movement in this part of the Region stronger. What we attempt to do is to help establish and support a local national infrastructure that can evolve and develop in the way that is appropriate for each country. We provide support and training through our colleagues who work in PPAs in Europe and who are more than willing to share their expertise, often at no cost. This 'peer' approach to technical cooperation is well received, rather than theorists trying to preach how things should be done.

We try to build the infrastructure, providing funds for office equipment, rent and some salaries, which is not considered exciting for some donors. Donors like to fund projects, not core activities. Yet without core activities, the associations cannot get started and cannot undertake projects. How can people be encouraged to do things on a voluntary basis when after working for several hours, a few more hours of each day have to be spent in queues, waiting to buy food.

Whose needs are being met?

Some donors are interested in eastern and central Europe, but on their own terms. They feel the need to dictate what needs to be done, what is 'best' for the people in these countries. Attempts to introduce democratic processes into these new PPAs are being undermined by promises of money, and more money when that money is gone, if the 'projects' proposed by the donors are carried out. Is this what we in the West want to export?

Many donors send 'missions' to these countries. Colleagues in this part of the Region I have spoken to feel overwhelmed and occasionally insulted with the endless missions and reports telling them what they already know - that they have problems with abortion, and mother and child care, and no contraceptives. Some donors do not believe they can provide funding for this part of the world because it is not 'developing'. In many ways this is correct, but in terms of family planning provision it is not. Basic health infrastructures exist in all these countries. There are many physicians and other trained health personnel. Equipment is antiquated, facilities are less than ideal, but they do exist. Any financial assistance could be perceived as short term compared to 'developing' countries, because the basic infrastructure does exist.

Some donors restrict their funding for family planning so that it cannot be used for 'abortion activities'. This is quite difficult in a part of the world where abortion is the main method of fertility control, and where, in some cases, a woman could have had as many as eight abortions. Some donors do not believe that providing contraceptives is part of their responsibility, even though they may fund the setting up of a clinic. Some donors only want to support one method, often the introduction of sterilisation, regardless of cultural considerations.

Obviously there are a great many needs in these countries, in areas of health, economy and society. However,

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establishing comprehensive family planning services does not have to be costly when the infrastructure exists. Training, information/education and contraceptives are needed. Each country has differing levels of experience and knowledge. Each association, after some initial training is able to elaborate its own plans, and within a short space of time, can begin to implement them.

If women have the ability to control their fertility without resort to abortion, legal or otherwise, their contribution to rebuilding these societies could be greater and their health would certainly be better. Gynaecologists in some of these countries are spending as much as one third of their time performing abortions. This could so easily be reduced.

One country's experience

The IPPF first visited Romania in early February 1990. Not long after this, a small group of individuals formed the family planning association SECS (Society for Education on Contraception and Sexuality). One of these individuals gave evidence to a US Senate Hearing on what had been happening in Romania. This, together with the stories covered in the media, motivated the US government to donate \$1.6 million to Romania for family planning.

Throughout the rest of 1990, IPPF provided training for individuals and groups on contraception and sexuality, and suitable premises were sought for SECS' headquarters of the association. More and more individuals were deciding to join SECS, the network was growing. It is difficult to find people who are willing to give up what they perceive to be safe jobs, to start working for a new family planning organisation whose role is not yet entirely clear. Yet it is possible. It is difficult to find people to give up what little free time they have to work for such organisations on a voluntary basis. Yet it has proved possible.

SECS Board meetings were being held regularly and a democratic process was being established. However, towards the end of 1990, US money was arriving in Romania, in the form of consultants. Of course, in order to be able to accept the funding, SECS, as a non-governmental organisation, was obliged to sign the now infamous 'Mexico City Abortion Clause' declaring that they do not and will not 'perform or actively promote abortion as a method of family planning'. (It is regrettable that during the first discussions on the value of accepting this funding and the signing of the agreement, not all the Board members were present. The new democracy was already being threatened.)

The result is that in a country where one million abortions have been performed each year for the past two years, the family planning association is unable to advise a woman with an unwanted pregnancy where she can obtain an abortion, because of the restrictions of a donor government. I do not believe SECS wishes to 'actively promote abortion', but surely they should be free to provide advice to women seeking abortion? - especially in a country where historically information on abortion was illegal. If the government has decreed that safe, medical and legal abortions should be provided to all women, how can the family planning association exclude this information from its activities? This restriction is even more questionable when it is a well-known fact that abortion is still the major method of fertility control.

IPPF Europe Region's perspective

The IPPF is of the view that the first non-governmental family planning association in Romania should evolve from Romanians. It should not be something imposed by 'do-gooders' from the outside. The intention had been to slowly

build up an infrastructure that could last for many years. Time would be given for the volunteers and newly appointed staff to work out their priorities and plans and this time could be bought with IPPF funding in terms of rent, equipment and salaries.

The Minister of Health at the time the PPA was established was very supportive and was keen that the government should provide clinic services, with the PPA playing a complementary role in undertaking the information/education component of the family planning programme. In addition, SECS could train government physicians. This was the original plan. I believe that this plan has since been distorted by the introduction of money, potentially a large amount of money, which carries with it impositions, limitations, and a short life span as it must be spent within a certain timeframe.

This is a dilemma which needs to be addressed. IPPF Europe works in a way which is non-directive. It believes that by providing breathing space for new organisations, they will have the chance to decide on their national needs and priorities and not feel obliged to take up those areas of work that donors deem to be of importance, simply in order to obtain the funds. Dealing with donors is a relatively new experience for the Europe Region of IPPF. The Region has not, for obvious reasons, been an area of focus of international aid. Now that there is greater awareness of the needs in central and eastern Europe, it has in one sense become 'flavour of the month', although few donors have actually provided funding. The limited resources of the Region make it impossible to compete, in terms of time and money, with agencies which have access to large amounts of funding. It is impossible to send a staff member to Bucharest each month to meet with SECS colleagues. And do colleagues in SECS want this invasion every month?

If IPPF is non-directive in its approach it has to accept that associations in central and eastern Europe have the right to accept outside funding and whatever advantages/disadvantages this entails. However, I think that in its role as the largest non-governmental family planning organisation in the world, IPPF has an obligation to speak out about the constraints donors are putting on family planning associations in their efforts to develop a truly national plan that is appropriate for their situation, in their country, with their potential clients.

Where do we go from here?

The Europe Region declared some years ago that it wanted to have a non-governmental planned parenthood association in every European country. There were fewer countries then, but the principle holds. The process will be relatively slow because of the limited resources, but results will be achieved.

With small amounts of core funding, setting up offices in each country, sharing the planning systems that have been evolved over many years and sharing experiences (positive and negative) of other PPAs that have been existence for decades, it will be possible to build up a strong network. Sharing other PPAs' experiences of providing counselling services for adolescents, training teachers in sex education, helping women who have been victims of rape and sexual abuse, referring infertile couples for treatment, providing family planning services is as vital as providing the money to do it.

In our limited experience in the newly formed democracies, we know that moral support is as important as financial support. The IPPF Europe network can provide that moral support and we hope we can provide enough resources to give new PPAs the time to evolve at their own speed and to identify their own priorities.

European Parliamentarians' Conference

London, UK, 31 January/1 February 1992

The "European Agenda for Action on World Population" Parliamentarians' Conference was hosted by the British All-Party Parliamentary Group on Population and Development, in co-operation with IPPF Europe Region and the UNFPA, with the support of International Family Health, the British Birth Control Trust, Population Concern, the Simon Population Trust and the Global Committee of Parliamentarians on Population and Development. The conference was attended by 35 Parliamentarians from over 20 countries. The following is an abridged version of the Report, which will be available shortly.

The purpose of the conference was to:

- Provide an opportunity to develop contacts between European Members of Parliament interested in population issues;
- Clarify the role and responsibilities of European Parliamentarians concerning population issues in developing countries;
- Enable European Parliamentarians to suggest ways of increasing awareness and understanding of these issues, emphasising the importance of responding to the needs of developing countries, and ensuring that these issues are brought to the attention of their Governments and Parliaments.

Many of the world's leading experts in the subjects of population and the environment participated at the Conference. Keynote presentations were given by Dr Nafis Sadik (Executive Director of UNFPA), Dr Fred Sai (President, IPPF), Sir Crispin Tickell (Green College Oxford), Mr Joseph Wheeler (Director Programme Integration, UNCED) and Dr Halfdan Mahler (Secretary General, IPPF).

The conference began with Sir Charles Morrison, MP and Chairman of the British All-Party Parliamentary Group on Population and Development, welcoming colleagues from Parliaments all over Europe. Sir Charles expressed the hope that this conference would enable Parliamentarians to assess current population and environment trends, draw conclusions and develop networks throughout Europe, with the intention of ensuring that the conclusions of the conference are applied.

The Rt Hon Earl of Caithness, Minister of State, The Foreign Office, then followed with a welcome on behalf of the British Government, and he conveyed a message from Rt Hon Lynda Chalker, the Minister for Overseas Development, for the success of the conference.

Dr Nafis Sadik gave a presentation entitled "Population, Environment and Development: Social Development Perspectives". This focussed on four key areas; population and development; how population programmes work; meeting the population challenge and a new approach to development. She concluded by proposing four areas which required immediate action:

- a redirection of development efforts towards the social sectors;
- a direct and all-out attack on poverty;

- a shift to cleaner technologies, energy efficiency and resource conservation by all countries, but especially the richer quarter of the world's population;
- a decisive improvement in the status of girls and women.

Dr Fred Sai gave a presentation entitled "From Colonialism to Co-operation: a Political Overview of Population Issues". He looked at five major issues: family planning as a development priority; policy and public health aspects of abortion; the need for European leadership; a new look at population and the environment and emergence from colonialism to a new era of collaboration. He concluded by stressing that there must be equal access to planned parenthood services, and that European expertise and leadership in this field was crucial. He suggested that European Parliamentarians should be invited to visit countries in other regions, to see at first hand the realities of maternal and child health in many developing countries, and how family planning could make a real impact on improving people's lives. Dr Sai closed by saying that the negative perceptions of the colonial past were giving way to a new spirit of co-operation, and it was to be hoped that the issues of population and development would be tackled together, in a new era of collaboration based on mutual respect and trust.

Sir Crispin Tickell spoke on four aspects of "Environmental Dimension of Population Issues": biological imperatives, accelerating environmental change, the impact of the imbalance between population and resources and the role of Europe. He stressed that the earth had finite resources. It could well support a human population of 5.5 billion if they all lived on a vegetarian diet; 3.7 billion if they derived 15% of their diet from animal products; and only 2.8 billion if, as in North America today, they derived 25% of their diet from animal products. Furthermore, the prospect loomed not only of human population increase but also of accelerating environmental change. Sir Crispin concluded that it was a prime European interest to promote the concept of sustainable development as defined in the Brundtland Commission report, and that European support was needed for the proposal that 4% of official development assistance should be set aside for population activities. He ended with the following message, "This animal - you and I - cannot continue to multiply, consume more natural resources, and do more environmental damage indefinitely. Our long-suffering earth simply cannot take it."

In his contribution on "Population and UN Conference on Environment and Development (UNCED)", Mr Joseph Wheeler gave a brief summary of the Earth Summit conference to be held on 1 June in Rio de Janeiro; the interaction between environment and development; aspects of the conference follow-up recommendations which related to population; and other UNCED issues that touched on population growth. He stressed that UNCED was about human beings managing things so as to achieve a reasonably good life for everybody without destroying the life supporting environment. Joseph Wheeler then went on to talk about Agenda 21 and population issues. Chapter 4 of

the first section of Agenda 21 looked specifically at "Demographic Dynamics and Sustainability" and contained three programme areas: links between population dynamics and global environmental change; a call upon national governments to formulate integrated national policies for population and environment; a call upon countries to implement integrated population and environment programmes at the local level. Population growth and other demographic trends permeated the strategies in UNCED's Agenda 21. Direct and indirect measures to complete the demographic transition would immensely improve the prospects of success in the global effort to achieve sustainable development for all the peoples of this world in the coming century.

Dr Halfdan Mahler examined "The Human Right to Family Planning: the Role of European Governments in Population Assistance" in five key areas: an introduction to the universal acceptance of the concept of family planning as a basic human right, and the extent to which this contrasted with the reality; and essential "building blocks" for making the transition. He stressed that part of a thoughtful and provocative European Agenda for Action on World Population must be the political conviction that family planning is a human right - a human right as inalienable and indivisible as the right to life, to health, to education, to political and spiritual freedom, to personal and social economic growth. In order to secure this right there were four building blocks that must be put in place: consensus, choice, consciousness and conscience.

- Consensus, in terms of a thoughtful, yet provocative multi-party, multi-parliamentary understanding, was necessary to initiate action against the negative impact of rapid population growth.
- Choice was the basis of family planning. Not coercion, and not compulsion. The role of governments was to ensure that families were empowered to make enlightened decisions and then to act on those decisions.
- Consciousness: In the 1960s, only 10% of couples in developing countries used any form of contraception. Today, thanks to a worldwide programme of advocacy, information and education, that figure had risen to 50% and, as a result, population growth had slowed, albeit far too slowly. More than ever before in human history, knowledge was power. Not the power of governments over people - but the power of people over their own lives.
- Conscience: All the sacred books of the world - the Bible, the Koran, Hindu and Buddhist texts and many others - placed high value on the family. Without exception they all argued that no child should be brought into the world if it was not wanted, if it would not be loved, if it could not be cared for. The overriding consideration of the IPPF was the well-being of families and the children they produced. In the vast majority of cases, this implied the promotion of safe and reliable contraception available to all in need of it - family planning is an investment that Europe must make. Dr Mahler proposed that we provide continuous governmental and non-governmental support in each European country to a multi-party parliamentary group that would keep population and family planning issues on the political front burner.

Following the keynote presentations, Mrs Erica Terpstra MP, from the Netherlands, chaired the session during which the Human Right to Family Planning was discussed, and at which preliminary ideas for a European Agenda for Action on World Population were raised. This was followed by Baroness Lockwood, member of the British

All-Party Parliamentary Group on Population and Development, chairing the session at which the Agenda for Action was finalised. She invited Dr Imren Aykut MP, from Turkey, to open the session with some comments on the issues under discussion.

Dr Aykut briefly described how Turkey had responded to population problems, and focussed on migration as an example of a demographic phenomenon with the potential to increase friction between countries. She also focussed on how national parliaments, the donor community and NGOs each had different, but complementary roles to play in ensuring that population issues received the attention they deserve. Finally, Dr Aykut recommended that Parliamentarians continue to work together across international boundaries on population and related topics.

Participants then devoted much of the rest of the Conference to generating and refining ideas for inclusion in the European Agenda for Action on World Population. There were six broad areas which Parliamentarians identified as being especially worthy of attention, namely: women's perspectives on the human right to family planning; the European experience; obstacles to the advocacy of population work; lessons learned from aid programmes; abortion; and increasing resources for population activities. Each of these issues were incorporated into the Agenda for Action which was agreed by consensus at the end of the Conference, and appeared in full in the last issue of *Planned Parenthood in Europe* (Vol. 21 No. 1). The Agenda for Action was presented to Conference participants for final approval by International Family Health President Dr Malcolm Potts, who, together with Organization for Economic Co-operation and Development Aid Management Head Dr Carl Wahren had co-chaired the Agenda for Action Drafting Committee.

Baroness Lockwood closed the conference by saying that it had demonstrated the commitment of European Parliamentarians to tackling population problems. Baroness Lockwood concluded by identifying the challenge to Parliamentarians as being to transfer to others the sense of urgency, knowledge and awareness shared by Conference participants - this task would begin when each participant returned to their country, and asked of their Governments what they planned to do to improve on their present contribution to population and development work.

A copy of the full Report can be obtained from:

*The Chairman
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News Items

International Medical Advisory Panel (IMAP)

*Bombay, India
30-31 March 1992*

IPPF's International Medical Advisory Panel (IMAP) met in India recently and some of the highlights were as follows:

- At the request of the PPA of Finland, IMAP reviewed literature on the levonorgestrel-releasing IUD. The Panel commented that it is a very effective and safe IUD which may have advantages for women who have bleeding problems with the copper-bearing IUDs.
- At the request of the Supply Department of IPPF, IMAP reviewed literature on benzalkonium chloride as a spermicide, and noted that it has been accepted as a spermicide in many countries (mainly in Europe). After reviewing the medical literature, IMAP recommended that contraceptives containing benzalkonium chloride could be included in the IPPF commodities list.
- The IMAP statement on Abortion has been reviewed and a new section has been added on the medical termination of pregnancy with mifepristone and prostaglandin regime. It states that this method is as effective as vacuum aspiration, however, its availability is limited at present.
- The amended statement on Steroidal Oral Contraception recommends that one type of progestagen-only Pill be available in family planning programmes for lactating women who wish to use oral contraceptives and for whom the oestrogen component of the combined oral contraceptive is contra-indicated or not desirable.
- The statement on Norplant Subdermal Implant System emphasizes that Norplant is one of the most effective methods of reversible contraception and provides protection against pregnancy for five years. The importance of follow-up care is stressed and the necessity of attending a clinic where there are

trained staff when removal is required. The statement stresses that when a woman makes a firm request to have Norplant removed, this procedure should be carried out without unnecessary delay and irrespective of her ability to pay.

International Programme Advisory Panel (IPAP)

*Bombay, India
26-27 March 1992*

IPPF's International Programme Advisory Panel (IPAP) met in Bombay recently and some of the highlights were as follows:

Male Involvement: It was generally considered that male involvement strategies should now be integrated into overall family planning programmes and appropriate funding allocated to ensure the continuity of these activities.

Programme Sustainability through Cost Recovery: The panel recognised the need to further develop more rigorous criteria for programme sustainability and more adequate performance indicators in this area.

Quality of Care: A presentation was made on the IPPF Service Delivery Guidelines which will be introduced at the Regional and FPA levels during quality of care workshops.

Population and the Environment: It was considered that any statement on this subject must include development issues and the status of women. The panel then drafted a paper on 'Population, Development and the Environment' for the Secretary General's consideration.

Sexual Health: A background paper on 'Sexual Health: a Framework for IPPF' was circulated, and it was considered that the participatory 'problem-oriented' approach described in the paper should be encouraged at all levels, to allow for continuous evaluation of whether the services provided meet the needs of the community.

Services for Youth: The panel agreed that it was very important for IPPF to develop an appropriate strategy to ensure young people's access to information and services. IPAP endorsed the recommendation of the 1989 Members' Assembly on the establishment of an advisory programme panel on youth.

Sub-Panel on the Involvement of Women: This is currently focussing on the issue of management training for women. A training of trainers workshop was held in February and was considered to have been a successful first step in the process of facilitating women's participation at Members' Assembly. The wider objective is to facilitate the upward mobility of women in IPPF and the methodology for continuing this training process is now being addressed at regional level.

1992 IPPF PPA Staff Meeting

*Dublin, Ireland
8-13 March 1992*

This year the Europe Region PPA Staff Meeting took place in Dublin, Ireland, providing an opportunity for participants to hear first hand the problems faced by the Irish PPA (photo below). An afternoon was also spent



visiting the recently opened Family Planning Centre in Tallaght, Dublin.

The meeting began with each participant relating one positive and one negative aspect of their work during the last year, revealing that 70% of the negative aspects were connected to PPAs' financial problems. The issue of Funding/Structure of European PPAs was discussed in depth, and participants concluded that PPAs should develop fund-raising and business skills in order to develop financial security. Other issues discussed included Teenage Pregnancy, Twinning, Sexual Health and Advocacy.

A special welcome was given to David Andrews of Planned Parenthood Federation of America (PPFA), who gave a presentation of their work. He also gave an analysis of an "Anti-Abortion Plan" and a counteracting "Pro-Choice Plan", which participants found particularly interesting and relevant. A discussion then followed on ideas for a Pro-Choice Movement, and it was recommended that there should be a greater exchange of information and networking between countries in order to share strategies and reinforce campaigns.

Irish PPA staff members gave a presentation of their work; they spoke about the historical and political situation in Ireland in relation to family planning, the lack of formal sex education and the role of the IFPA in this area, and the financial difficulties the Association is facing. Participants were very moved by the problems faced by the IFPA and they offered to send a letter to organisations within their countries, requesting financial assistance for the Irish PPA.

Strategic Planning Workshops for PPAs

The Europe Regional Bureau has now held three of four workshops on Strategic Planning as part of the IPPF's Challenges Project. The fourth workshop will be held in London in June for Eastern European PPAs. All workshops are being facilitated by Marilyn Wilson, Head of IPPF's Policy and Planning Unit, and topics covered include an introduction to strategic planning, the planning process and constructing a goal structure. There is also time allowed for PPA representatives to discuss planning issues encountered in their own associations. Evaluations of these workshops have shown that they are enthusiastically received and of great value in introducing PPA representatives to this strategic planning concept.

IPPF Europe Regional Bureau News

Dilys Cossey, a former volunteer with the UK FPA and member of the IPPF Central Council and Europe Regional Executive Committee, joined the Europe Regional Bureau on 1 April 1992, as a Consultant. Dilys will be working primarily on the follow-up to the European Parliamentarians' Conference (see report on page 27) and the planning of a conference to be held in Frankfurt in December on the abortion pill.

Dilys will be working in this capacity for 1-2 days a week and we are happy to welcome her to the Bureau in her new role as a staff member.

We are delighted to announce another new addition to Europe Region - on 1 February 1992 IPPF Europe Regional Secretary, Philip Watson, and his wife Michelle became the proud parents of a baby girl, Abigail Mary, weighing 7lbs 7oz. Our best wishes go to Philip, Michelle and Abigail.



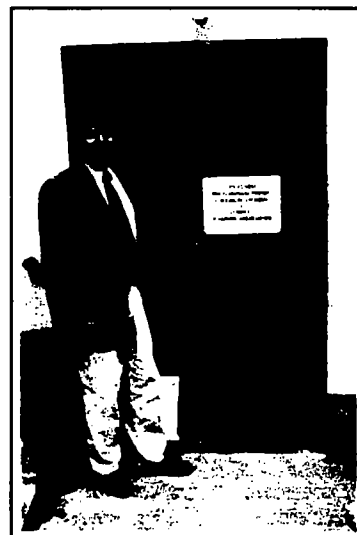
Czech PPA Opens Information Centre

The Prague-based Czech Society for Family Planning and Sex Education, chaired by Dr Radim Uzel, has just opened a family planning research and information centre. Located in the grounds of the Institute for Maternal and Child Health Care, the centre houses a collection of books, journals and other documentation on topics related to family planning, demography and fertility, and is the base from which the Society prepares its newsletter. The first edition of the newsletter is about to be distributed, and consists of a digest of all CSFR legislation affecting fertility, contraception, abortion etc., and summaries of recent

family planning literature received by the society.

In Bratislava, the Slovak Society for Family Planning and Parenthood Education, under the Chairmanship of Dr Michal Kliment, now has over 100 members, and is involved in mass media work promoting planned parenthood, and establishing contacts with various government ministries to discuss issues such as sex education.

At present, both societies have come together to form the Association for Family Planning of the Czech and Slovak Federal Republic (FPA CSFR), the Chairmanship of which alternates, and is currently held by Dr Radim Uzel.



Radim Uzel outside the Prague centre

Seminar on Modern Methods of Family Planning in Czechoslovakia

In the Autumn 1991 the Czech Association of Family Planning and Sex Education was established in Prague. One of their first achievements was a Seminar on Modern Methods of Family Planning, which was organised in Hradec Králové (East Bohemia) in co-operation with Gynaecological Society and the Faculty of Pharmacy of Charles University.

The Seminar was attended by over 300 participants, including health professionals and students. Papers discussed included: Demographic Aspects of Family Planning; Recent Developments in the Composition of the OC; IUD Contraception; Barrier Methods of Contraception.

The PPA will continue in this activity and other seminars are scheduled for May and October 1992.

Seminar on Sexual Health and Sex Education

*Athens, Greece
9-11 April 1992*

The Family Planning Association of Greece recently held its third seminar on Sexual Health and Sex Education in Athens, Greece. The seminar was attended by over 450 people, including teachers, health personnel, social workers and students, and was given wide publicity in the press, TV and radio.

The opening session was attended by various experts, including the former Minister of Health and the former Minister of Education. Among the presentations given were contributions by the PPAs of Portugal (Maria Alice Frade) and Germany (Gerhard Kothofer) on their experiences of sex education programmes in their countries. Other speakers included Katinka de Vries (WHO) who covered the training of trainers and the sensitisation of public opinion, and Gorm Wagner (WHO) who gave an enlightening presentation on "Sex Education in Europe: Trends and Perspectives".

National Conference of the Portuguese PPA

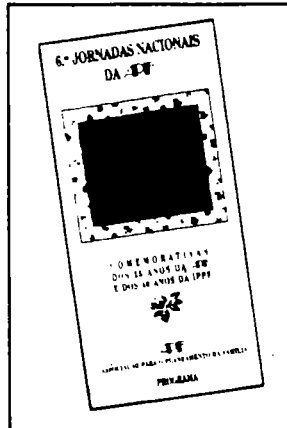
Every two years the Associação Para o Planeamento da Família (APF), organises a National Conference directed at professionals involved in family planning and sex education. This year APF is celebrating its 25th Anniversary as well as the 40th Anniversary of IPPF. "What has changed in society and in family planning during these years" was, therefore, the opening theme of the conference.

IPPF Secretary General, Dr Halfdan Mahler, gave a presentation on "Sexual Health and a Framework for IPPF". Other subjects discussed were: Sexual and Reproductive Rights in Portugal (with special emphasis on legal and illegal abortions); Recent Developments in Contraceptive Technology; Sexual Health; Adolescents, Experiences of Sex Education; Religion, Sexuality and Family Planning; Mass Media and Sexuality.

Several one-day symposiums were organised before the Conference including: Sexuality and Handicapped People; Psychodrama Sexuality and Therapy; Sexual Abuse and Violence;

Developing a Sex Education Programme.

More than 600 participants attended the conference, held in the city of Maia. President Mario Soares gave a message congratulating APF on its 25th Anniversary and recognising its positive contribution to family planning in Portugal.



Russian PPA Conference: Adolescent Sexual Behaviour and Contraceptive Use

13-14 April 1992

This conference was attended by delegates from Russia and the Commonwealth of Independent States (CIS), as well as three European PPA representatives. Jon O'Brien of the Irish PPA gave a presentation on 'Young People, Contraception and Sexuality', Barbro Lennér-Axelsson of the Swedish PPA spoke on 'Sex Education for Teenagers', and Monica Morganti from the Italian PPA gave a presentation on 'Counselling Centres in Italy'.

Other lectures and roundtable meetings included themes on sex education, rape, contraception, STDs and abortion, and each day there were video presentations which were a great success.

Abortion Controversy Rages in Ireland

On 27 February 1992 five judges in the Irish Supreme Court ruled by a margin of 4:1 that a 14 year old girl who became pregnant as a result of an alleged rape by the father of a friend could leave Ireland to obtain an abortion. Earlier the Irish High Court following application by law officers acting for the State had granted a legal injunction preventing the girl from

leaving the country and her parents from assisting her to obtain an abortion.

The Supreme Court judgment added chaos to the crisis and rekindled the abortion debate which has raged in Ireland ever since. Anti-choice activists have launched a major campaign to pressure the Government to hold a further referendum to amend the Irish constitution and copperfasten the ban on abortion as contained in the 8th Amendment to the Constitution. Anti-Choice activists claim that the Supreme Court judgment, which was based on the danger to the young girl's life because of the real threat of suicide, opens the gates to legalised abortion in Ireland. Pro-Choice activists fear the side judgment of the Supreme Court which ruled 3:2, that should for example a rape victim not have threatened suicide they would probably find that she must remain in Ireland and be forced to continue with the pregnancy. In a bizarre turn of events Irish Police reported that on 2 May a man presented himself and is seeking to restrain his former girlfriend using the anti-abortion clause in the Constitution from exercising her rights to choice and to travel.

Many Pro and Anti-Choice activists are campaigning against acceptance on the Maastricht Treaty for greater European Union unless the Prime Minister Albert Reynolds deals with the abortion controversy beforehand which to date he has refused to do.

Irish Frontline Organisations form Coalition for Freedom and Women's Lives

The Coalition for Freedom and Women's Lives (C.F.W.L) was launched in Ireland as the campaign platform of Frontline Organisations in the Irish Abortion Debate. Members of the Coalition include: Cherish, Doctors for Freedom of Information, Dublin Well Woman Centre, Irish Family Planning Association, Open line Counselling, and the Union of Students in Ireland. Affiliates include: The Campaign to Separate Church and State, Repeal the 8th Amendment and the Irish Council for Civil Liberties.

A spokesperson for the Coalition said that it was disgraceful that the question of Maastricht and European Union has been linked to the abortion issue by some politicians, through the protocol, without the consent or knowledge of the Irish people. The onus is now on politicians to separate the issues and urgently address the

rights and freedom of Irish women, now a cause of widespread concern.

Pledging their continued support for the efforts of politicians to solve the crisis, the Coalition expressed deep concern that the Maastricht Treaty would not be taken on its own merits and could be rejected because women will not risk further erosion of their basic rights.

The four point programme of the coalition focuses on the following issues:

1. Maastricht Treaty Protocol

The Coalition calls for the removal of the Anti-Choice Protocol to the Maastricht Treaty which relates to article 40.3.3 of the Irish Constitution.

2. Freedom of Information

a) The Coalition calls for constitutional and legislative protection for freedom of information, recognising that free communication of all relevant information is integral to the provision of professional pregnancy counselling services.

b) An end to the suppression of information vital to women's lives and health through the removal of certain books from the public libraries and the banning of books and magazines by the Irish Censorship Board.

3. The Right to Travel

The Coalition calls for legislative protection of the right of citizens to freely travel abroad for private purposes and an end to injunctions removing the right of women to travel.

4. National Programme of Action

The Coalition calls for a comprehensive Government programme to reduce unplanned pregnancies. Such a programme should include a properly resourced national programme of sex and relationships education in Irish schools; a serious commitment by Government to the provision and funding of comprehensive family planning services nationwide; the development of a national action programme to deal with the social and economic issues which contribute to crisis pregnancies and the belief by some women that abortion is their own option.

The Coalition will campaign and lobby over the coming months on this programme in the political and public arenas. Support for the Coalition is invited from interested organisations and individuals and details may be obtained by contacting:

*Jon O'Brien
Irish Family Planning Association
Halfpenny Court
36-37 Lower Ormond Quay
Dublin 1, Ireland
Tel: (353) 1 730 877*

National Family Planning Day in Albania

27 June 1992

Albania will be holding a National Family Planning Day on 27 June, which is being sponsored by the World Health Organisation and UNFPA. However, the country is without any information, posters or leaflets on family planning. If you are able to send any materials (to arrive before 27 June) they should be addressed to:

*Dr Agim Xhumari
Ministry of Health
Rr Qeunat Stafie No 251
Tirana No 22107
Albania*

March for Women's Lives

Washington, USA
5 April 1992

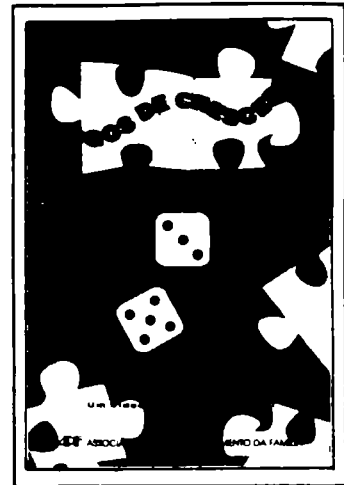
Over 500,000 people joined the March for Women's Lives recently in Washington, USA. The Planned Parenthood Federation of America (PPFA) was strongly represented. Speakers at the rally included former PPFA President, Faye Wattleton, and Kenneth C Edelin, MD, Chairperson of PPFA and of the Planned Parenthood Action Fund, who urged the marchers to embark on a "full-scale political offensive".

Marchers also included many members of PPFA's Board of Advocates, among them Jane Fonda, Maureen McGovern, Bella Abzug, Matthew Broderick, Jill Clayburgh, Geraldine Ferraro, Louise Fletcher, Cyndi Lauper, Mary Steenburgen, Joanne Woodward and Meredith Baxter.

During the march, PPFA launched their "Show Your Face, Pro-Choice America" campaign to mobilize support for abortion rights. This initiative was highly visible, with "Show Your Face" placards being carried by both Planned Parenthood and non-Planned Parenthood marchers alike.

Portuguese PPA produces new materials for Sex Education

In 1991, new opportunities emerged to increase sex education programmes in school curricula and in programmes directed at young people in the health service and in the Youth Institute. In response to this, the Portuguese PPA have recently produced several new materials to support the development of sex education activities.



1. Video: "Jogos de Crescer" ("Growing-up Games")

This is a 30 minute video (see above photo), directed at adolescents and youth to support activities on subjects such as growing up, relationships, sexual behaviour, unwanted pregnancy, contraception and sexual health. A handbook with suggestions for using this material was also produced.



2. Leaflet: "Passaporte para uma Sexualidade Saudável" ("Passport for a Healthy Sexuality")

This leaflet (see above photo) is directed at youth on sexuality, contraception and sexual health. It also contains useful information on the nearest family planning clinic, a calendar to check menstrual periods, and details of the law which allows youth to access to contraception and other services. The "Passports" will be used for "interdimensional travel" ("sexuality") in spatial ships commanded by "Captain Woman" and "Captain Man".

3. "School Sex Education - A Guide for Teachers and Educators"

This is a handbook on sex education produced by an APF team of volunteers and staff members. It is divided into four sections:

- a theoretical background on human sexuality, sex education (concept, values and objectives, techniques and programming);

- suggestions for sex education activities for young people aged 10 to 12 on: what is sexuality, our body, puberty, sexuality and our feelings, sexual roles, friendship and family, reproduction, pregnancy and birth;

- suggestions for sex education activities for young people aged 12 to 16 on the above topics, as well as contraception, STDs and sexual health, sexual abuse;

- suggestions for sex education activities for young people aged 14 to 19 on: sexuality and development, beauty and fashion, communication and sexuality, couple relationships, sex and the law, pregnancy and birth, contraception, AIDS and STDs, sexual exploitation.

Further information is available from:

Associação para o Planeamento da Família
Rua Artilharia um 38 2º Dto
1200 Lisbon, Portugal
Tel: (1) 653 993
Fax: (1) 687 379

UK FPA Publications

The UK FPA has produced two new publications on contraception. The booklet, 'Contraception: Your Choices', contains information on each different method of contraception including how it works, its reliability, advantages and disadvantages and where to get it. It also gives details of future methods of contraception such as the female condom and emergency after sex contraception. This booklet is available free from all UK pharmacists and from the UK FPA.

The booklet also compliments a new reference guide, the 'Contraceptive Handbook', specifically aimed at pharmacists on family planning methods and services. The 'Contraceptive Handbook' was developed as part of a project by the UK FPA and the Royal Pharmaceutical Society of Great Britain to explore and extend the role of the pharmacist in general health care and family planning. Each pharmacy in the UK, including hospital pharmacies, will receive one free copy of the Handbook under the Pharmacy Healthcare Scheme. Additional

copies are available from the UK FPA at a cost of £12.99 plus £2.50 p&p.

Further information on both publications is available from:

Press Office
Family Planning Association
27-35 Mortimer Street
London W1N 7RJ, UK
Tel: (44 71) 436 3288

Research Projects of the International Health Foundation (Brussels, Belgium) on Family Planning in Central and Eastern Europe

The International Health Foundation (IHF) is a non-profit research institute. One of the objectives concerns research on the menstrual cycle, fertility, infertility and contraception. Since 1982 several surveys on contraception in Western Europe have been carried out. The IHF is extending its research to several other Central and Eastern European countries.

- In 1991 a national survey was carried out in Czechoslovakia among women aged 15 to 45 years on several aspects of knowledge, attitudes and practice concerning contraception (see article on page 14 in this issue).
- With support of the WHO in Armenia an epidemiological study is being carried out on causes of infertility and use of contraception. Dr M Khachikian will present the results in her thesis at the University of Leiden.
- The results of a survey on abortion and contraception in the Russian women's journal 'Health' were presented in 1991 at the opening of the Information Centre on Human Reproduction in Moscow (see article on page 9 in this issue).
- A survey among several hundreds of doctors in the former USSR on their attitudes towards modern contraceptives is currently being carried out.
- The integrated results of several completed studies on family planning in the Eastern part of Germany were presented by Dr K Starke (Leipzig) in 1991 at the International Sexology Congress 'Sex Matters' in Amsterdam in 1991.
- Population surveys are being carried out on family planning in Hungary and Romania.

As a result of some of these studies the IHF and IPPF sponsored a workshop on 'Abortion and Contraception in Central Europe' (Amsterdam, June 1991). The paper on this workshop and results of other studies will be published in a book on 'Family Planning in Central Europe'.

Meetings

SECOND CONFERENCE ON MIGRATION AND HEALTH Brussels, Belgium 29 June - 1 July 1992

This conference, organised by the International Organisation for Migration (IOM), will serve as a forum for the discussion of migration and health by health professionals, policy planners and government officials involved in migrant and refugee health. Themes to be covered will include: disease prevention; health promotion; training of health professionals; mental health; infectious disease and health policy.

Further information is available from:

*Seminar Secretariat
IOM
PO Box 71
1211 Geneva 19, Switzerland*

LONDON SCHOOL OF HYGIENE FAMILY PLANNING COURSE London, UK 29 June - 31 July 1992

A five-week course in family planning impact evaluation will be held in London, UK, from 29 June to 31 July 1992, at the Centre for Population Studies of the London School of Hygiene and Tropical Medicine. The course will cover attitude measurement, basic demography applied family planning research, measurement of determinants of fertility, and measurement of birth prevention. Fee: £1,850.00

Further information is available from:

*The Short Courses Office
London School of Hygiene
and Tropical Medicine
Keppel Street
London WC1E 7HT, UK
Fax: (44 71) 388 3076*

GLOBAL SUMMIT OF WOMEN Dublin, Ireland July 1992

The Summit, with its unique focus on leadership, comes at a time when world attention is centered on "the new world order." Through exploration and innovative thinking, participants will create new paradigms for the future that will promote women's equal participation in all aspects of life.

More than 100 political, artistic, scientific, and community leaders

from every continent will form panels to discuss new strategies and models for women's leadership in the future. The panels will focus on the following issues:

- Redefining Political Leadership;
- Reclaiming Religious Freedom;
- Rethinking Food as a Macroeconomic Issue;
- Restructuring Work and Family;
- Valuing Women's Health;
- Women and Private Sector Leadership;
- Media and the Changing Image of Women;
- Women and the Arts;
- Formulating New Visions of Economic Leadership

Further information is available from:

*The 1992 Global Forum of Women
1000 16th Street NW
Suite 810
Washington DC 20036, USA
Tel: (1 202) 223 0267
Fax: (1 202) 659 3930*

INTERNATIONAL POPULATION CONFERENCE 1992: REVIVAL OF AGEING SOCIETIES Espoo, Finland 2-4 September 1992

The rapid demographic changes in the world have given rise to new and unexpected situations. Societies will have to solve the problems of arranging health care services, pensions and social security for the growing number of old people for decades to come. The International Population Conference 1992: Revival of Ageing Societies, will deal with the challenges posed by these issues. It will offer an opportunity for research workers and decision-makers to explore and discuss the consequences of population development with internationally recognised experts and to hear their opinions and experiences. Conference topics will include:

- Will society become more conservative as the elderly constitute a growing proportion of the population?
- Will society become bankrupt by an ageing population?
- Are pensioners prepared to return to work, and on what conditions?

- What ways are there of dealing with the growing number of migrants and refugees?

Speakers will include: Dr Nafis Sadik, Executive Director of the UN Population Fund, Professor Rita Süßmuth, President of the Deutscher Bundestag (Germany) and Professor Guillaume Wunsch, Secretary General of the European Association for Population Studies (Belgium).

Further information is available from:

*Ms Hilka Vuorenmaa
Secretary, International Affairs
Väestöliitto
Kalevankatu 16
00100 Helsinki, Finland
Tel: (358 0) 640 235
Fax: (358 0) 612 1211*

COURSE ON POPULATION AND DEVELOPMENT Cambridge, UK 7-18 September 1992

Organised jointly by IPPF and the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), this is an intensive two-week course for technical co-operation staff. Through lectures, discussions, audio-visual presentations, individual presentations and exercises, topics such as population theory, population and development, population and health, and the role of family planning will be explored.

The course will be taught in English by experienced specialists from the two organising agencies and by faculty members from Population Studies Centres. At the conclusion of the course a certificate of successful completion will be awarded.

Course themes are:

- Day 1: Population Theory
- Day 2: History of Population
- Day 3: Population & Development
- Day 4: Population & Environment
- Day 5: Population Sub-Groups
- Day 6: Population & Health
- Day 7: Role of Family Planning
- Day 8: Issues in Family Planning
- Day 9: Management in Family Planning
- Day 10: Role of Family Planning Organisations

The fee is £1,200. This fee covers tuition, room, breakfast and lunch. Accommodation will be in Corpus Christi College, Cambridge. Further information is available from:

*Med Bouzidi, Director
Programme Department, IPPF*

Book Review

Review by Joan Swingler*

The Right to Choose: Pioneers in Women's Health and Family Planning

Perdita Huston
Earthscan Publications Limited, London, UK, 1992

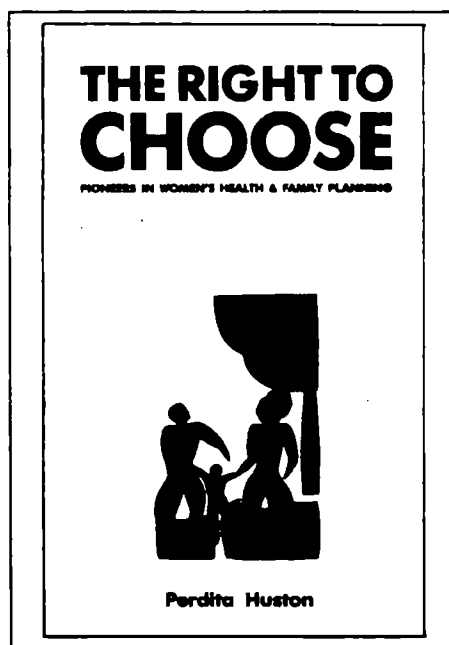
The family planning movement and the IPPF specifically traces its beginnings to those who perceived local and national needs to improve the poor state of women's health and to prevent the tragedy of unsafe abortion. Some realised that the benefits of development would not reach their people if the population doubled in size every 20 to 25 years. Others foresaw the impact of population growth on the natural environment.

Yet the main motivation remained the experience of witnessing the disastrous health consequences or deaths of women caused by unplanned pregnancies.

'The Right to Choose' was commissioned by IPPF as part of its 40th anniversary activities. It describes the lives of 12 women and men dedicated to the fight to provide family planning information and services to couples around the world. Through interviews with the surviving pioneers, families and former colleagues, its author, Perdita Huston, has created a welcome record of the motivation, local conditions, desperate personal needs which led them to fight as pioneers of the planned parenthood movement. The pioneers featured were chosen from more than 100 names submitted by national PPAs.

The book is not an organisational history, it is a series of recollections by and about individuals. The author rightly recognised that now, 40 years hence, it was timely to recollect and relate social change and attitudes towards the most intimate and fundamental aspects of life - that of self-determination in the act of procreation. By looking back to its origins, the IPPF is also aiming to inspire an ever increasing network of persons willing to challenge the status quo and to contribute their most effective support for the family planning movement.

The battle for information, accessibility and general family planning techniques remains one of the major socio-economic and philosophical challenges of this century. After 40 years of struggle and the continuing tradition of national PPA leadership and programme implementation, one must ask whether current world issues are understood clearly enough by the family planning movement and IPPF in particular, to accelerate the fight for reproductive rights and thus national responsibilities? Perdita Huston hopes that the book will encourage readers to take the fight for



such rights 'a little more seriously' but such will need greater frankness and clarity of strategies to be pursued. The book provides eloquent support for the introductory statement by IPPF President, Dr Fred T. Sai, in refuting the allegation that the provision of family planning information and services has been imposed on families and women in particular as a concept of the West - wherever. The pioneers' battles and achievements bear the proof.

'The Right to Choose' will stimulate its readers to explore the subject in depth and the pioneers' challenges are as real today as they were in their time. The health and socio-economic aspects which are vital components of family planning information and services in any local situation are demonstrated clearly by the author's interviews. They range from individual emotional motivations to a diversity of legal and political conditions, tradi-

tions and beliefs, notions for strategies - the spectrum is wide indeed. Readers will know from personal experiences which are the perimeters which have to be challenged for the freedom of choice of each individual to be expanded.

'Looking Forward', the author's epilogue, indicates clearly and ably the initiatives yet to be taken before the opposition to reproductive freedom in its broadest sense can be considered a matter of yester-year.

Who, if anyone, looking ahead to the 21st century, could deny that young people have the right to factual information on reproductive health as a means to make life's choices?

The pioneers were surely ahead of their time.

*Joan Swingler was Executive Secretary of IPPF from 1962 to 1986.

PPA Profile

DENMARK: Foreningen for Familieplanlaegning (FF)

Background

In 1947 the Danish Medical Women's Society put the problem of abortion on its agenda, ran an information campaign on contraception and opened pilot contraceptive clinics. The motto of the campaign was "Wished-for Children Create Good Homes". The clinics of the Medical Women's Society were not immediately accepted by the Medical Association and they were accused of breaking with professional etiquette before the clinics were accepted by the Danish medical establishment. Also, Danish Catholics reacted strongly against the information activities on contraception and the Catholic weekly newspaper attacked "the ladies" in a most offensive way.



Former PPA President, Agnete Braestrup, at the Danish PPA's 30th Anniversary in 1986

The Founder and first President of the Danish Family Planning Association, Dr Agnete Braestrup, was also one of the pioneers in the fight of the Danish Medical Women's Society. In 1955 the Association had been reconciled with the Medical Society and they established, together with The Danish Pharmacist Association and the Ministry of Justice a working party to prepare the founding of a Danish Family Planning Association.

The Danish PPA was founded on 4 February 1956. Its main objective was "to reduce the number of induced abortions and to promote information and research on family planning and responsible parenthood - including promotion of knowledge on safe contraception". The Danish PPA immediately joined IPPF and from 1969-71 Agnete Braestrup was the President of IPPF.

From 1958-65 FF opened four clinics in Copenhagen and the surrounding suburbs, offering individual counselling on family planning and contraception. The need for the

clinics proved to be big and soon they were very busy. The FF still runs services at two of the clinics.

From the very beginning, FF engaged itself in school sex education. Three members of the Board were appointed to the first sex education commission to draw up a curriculum for sex education, starting in primary schools in 1971. Since then FF has produced educational material - leaflets for pupils, books and teachers, videos, etc. - for sex education in schools.

Aims and objectives

Information, education and consciousness-raising on contraception, sexually transmitted diseases and on sexual problems have been the main core of activities of the Danish PPA and will continue to be important. The target groups of FF's activities have always been young people and groups with specific needs. In addition, easy access to good quality, reasonably priced contraceptives, through the sale of FF's contraceptive products PLAN in pharmacies, has had and will continue to have a high priority.

The Danish PPA has always been active internationally, both within IPPF Europe Region and in IPPF in general. Also the FF is represented in the governing bodies of the Danish Development Agency, Danida, and co-operates with Danida in organising seminars, workshops and other activities in developing countries.

The Danish PPA is presently in a period of transition (as are many other European PPAs), in terms of both its objectives and its organisational structure. Having been a medically orientated association, the orientation of FF has always been directed towards prevention of unwanted pregnancies, prevention of sexual transmitted diseases, prevention of abortion, etc. However, in recent years the membership base of FF has been widened so that Social Workers, Psychologists, Educationalists and other non-medical professionals are also present on the board of representatives and on the board of directors. This has opened up a discussion on sexuality, sexual well-being and health in a social context in Denmark.

Consequently the FF is presently working on a new set of objectives and statutes. According to the draft objectives the association in the future will work for promoting, advocating and providing services in relation to sexual well-being and autonomy in family planning. The FF wishes to promote a positive understanding and permissive attitude towards sexuality in society in general, and work for equality between the sexes, for the prevention of sexual exploitation and abuse, and other unwanted aspects of sexual activity. In this discussion the FF naturally has been much inspired by the sexual health discussion with IPPF Europe and not least our friends in RFSU.

Role and activities

Sex education in primary schools is, as mentioned, a long-standing project of high priority for the FF. In 1991 the Ministry of Education published the new curriculum for "Health and Sex Education" in which sexuality has been integrated as part of human health, implying that sexuality may be subordinated to life-style factors such as food, alcohol, drugs, etc. In order to give a higher priority to sex information, the FF has recently published a book "Sex Instruction in Primary School - a Guide for Teachers and Parents", which is being distributed to the local school boards.

In January 1992 the FF opened the Sex Line - a new telephone counselling service for young people with young professional counsellors. It is a wide-spread venture which, through an anonymous telephone service, young people seek, and can be offered, individual personal counselling on their questions and problems in matters of sexuality and contraception. So far the Sex Line has proved to be greatly needed.



The FF has been concerned with the topic sexual abuse and has extended its information activities to include information on the issue. A leaflet for young people, aimed at breaking the taboos around sexual abuse and to inform them what to do, and where to go, if exposed to sexual abuse, was produced in 1991. The demand has been so great that 25,000 copies were distributed in six weeks - all copies given out on request only.

During the remainder of 1992, the Danish PPA will be concerned with promoting the association. Several methods are being employed. One is by the establishment of new collaborative relations and network with women's organisation and other relevant partners. In the autumn the FF has planned an IPPF 40th anniversary exhibition in four big cities on "Scandinavian women pioneers in international family planning - Elise Ottesen-Jensen and Agnete Braestrup" - and at the same time promoting the FF too. Public meetings on population policy and family planning will also take place in connection with the exhibition.

In 1993, the FF is planning to focus on the male role, male sexuality and male responsibility in family planning. A group of men have recently discussed how to address the issues and to prepare the campaign on male involvement and responsibility, and strategies on involving boys and men in sex education. The FF hopes that this activity may lead to a small European workshop for men within IPPF Europe on male sexuality and involvement in family planning.

Organisation and structure

The Danish PPA is composed of 17 member organisations, professional associations and unions, who send two representatives to the board of representatives. At present there are no individual members. The Board of Directors consists of nominees from the three founding organisations, The Danish Pharmaceutical Association, the Danish Medical Women's Society and the Danish Medical Society, a lawyer and nominees from three of the other member organisations. The FF office staff consists of the executive director, an information officer, a management consultant (for one year), and four secretaries.

The FF is aiming to change its organisational structure and membership within the next year. Besides including more professional organisations in its membership, the FF will recruit individual members (and organisations) as support members. The PPA is going to build local networks to expand its activities to the whole country and to draw younger, active people in to the work in the association. The number of board members will be increased from seven to nine people in order that the individual support members can nominate one or two new board members.

The future

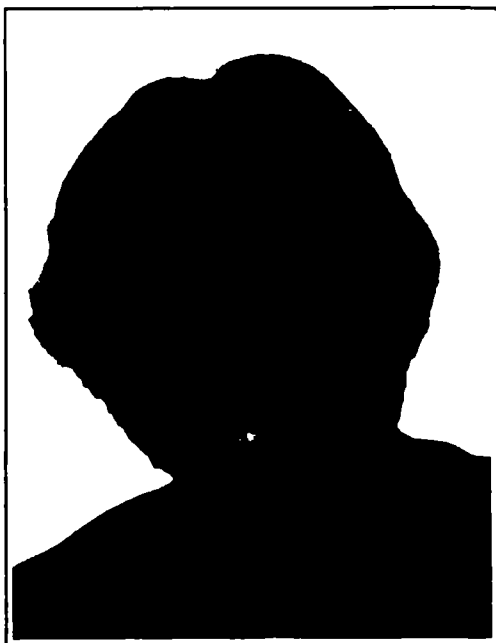
During the next year the PPA intends to finalise the new objectives for its work and to draw up new statutes. The association will develop a strategic plan on how to meet the new challenges in Danish/European society in the coming years. Thus Foreningen for Familieplanlægning hopes - and expects - to appear as a dynamic, rejuvenated 40 year old at its Anniversary in 1996.

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Blood, Sweat and Joy - what it means to be an IPPF Volunteer

Elisabeth Jandl-Jäger



Since I am coming to the end of my term of office as President of the Europe Region, I have mentioned my intention not to serve the IPPF in any other volunteer capacity. This decision, which was not made lightly, has aroused some surprise and questions among colleagues and friends, and I decided that I will outline not so much the reasons for a personal decision but what I believe to be structural and ethical considerations.

Every volunteer in IPPF ought, from time to time, to consider why he or she is volunteering. Family planning the world over is not so much a social movement - which we like to think - but a social service. The PPAs with the support of IPPF are very often delivering services which governments should actually provide. In order to have such public services, be they clinical, information and education or advocacy - what are needed are influential people who can give respectability and a certain power to the aims of the PPA.

The Blood and Sweat

It can be quite amusing when an illegal organisation is run by, or supported by, establishment people. I vividly remember my very first contact with members of the Irish PPA whose leading volunteers at the time were medical doctors, wives of university professors - very establishment people - supporting an illegal association. They were indeed brave and angry and they did what they believed was necessary to change the social and legal situation for couples in Ireland. This was 17 years ago and now we need the same type of brave and angry volunteers to perform the same tasks in

central and eastern Europe, creating a new family planning movement.

However in most western European countries those days are past. What remains are established organisations with more or less staff and a number of volunteers. Some of these volunteers are even interested in family planning in their own Region or worldwide. The volunteers we see in IPPF have already gone some way in the life cycle of a volunteer.

The traditional development of a volunteer begins at the local level, and goes on to national, regional and central levels. It is however a fact that the qualities a volunteer needs at regional or central level are not necessarily the same that are needed at local level. Therefore, very often the volunteer we meet at regional and international level has never participated at a local level. The kind of volunteers we see at IPPF are very establishment people, usually with a good education and language skills, who are outstanding personalities in their own countries. Then what makes them volunteer for endless meetings, endless journeys in what always seems to be the same hotel? As a volunteer you feel useful, wanted and powerful. You can imagine yourself as the boss of an international firm of importance - and it is important. These emotions can easily seduce the unwary volunteer into spending more and more years of her or his life in senior volunteer posts, getting a satisfaction out of it far beyond financial compensation. An IPPF volunteer is the envy of her or his colleagues at home because of the travel opportunities - they must be so important that someone else is actually paying for them to go to some of the most interesting places in the world.

Being a volunteer in IPPF teaches you a lot about international organisations - you can become a trained cosmopolitan even if you had a racist mind to start with. And there is the enormous joy of meeting like-minded people from different cultures. You can be one of those people to help bridge the gap of preconceived ideas about other races, nationalities or sex. There is a gap of misunderstanding which cannot be disputed but IPPF volunteers can make a very good show of overcoming it - even if 'those' in the 'other' Regions (of course, they are never in your own Region!) remain as patronising as ever.

The Joy

As a volunteer, you can enjoy the realisation of your dreams as we have seen over the last three years in central and eastern Europe. Even though the realisation of a united Europe of prosperous regions is a long way off, and will be difficult to achieve, volunteer organisations, with democratic rules of operation can have an important role to play, not only by providing family planning but showing in a small way how democracy can work and that it can work!

Elisabeth Jandl-Jäger, President of ÖGF (the Austrian PPA), has been an IPPF Europe Regional Council member since 1975, served as IPPF Eu Region President from 1986 to 1992.

During the past six years as Regional President, working with PPAs has been my greatest priority and the knowledge that I was, perhaps, able to encourage and support them in some small way has given me great joy and certainly motivated me to continue with the job.

A volunteer enjoys responsibilities because of the power which is theirs according to the IPPF Constitution. I would like to mention three responsibilities not clearly outlined in the Constitution:

1. Support your staff!

At every step of the volunteer ladder there are in all probability staff whose very existence depends on family planning and on volunteer decisions. This dependence must be recognised by the volunteers, and the staff must be recognised as the most valuable collaborators who are willing to give more than the volunteer - namely their economic existence to family planning. This commitment is certainly bigger than that of the volunteer. The bigger an organisation becomes the more the volunteers must depend on their staff to get the kind of support necessary for policy decisions.

2. Listen to your electorate!

Volunteers always know what is best - that is why they are volunteers. However, the volunteers who elect you to a certain post might wish you to make their opinion heard. This is a very important responsibility and do not tamper with the directives according to your own wishes. It can cost a lot of sweat to transmit the wishes of your electorate and at the same time help to maintain a good constructive working relationship with other volunteers and staff. To maintain a constructive equilibrium is your reason for being an IPPF volunteer.

3. Develop your successor!

Family planning needs a lot of people. Being in a decision-making position means power and enjoyment of it. However there is a life cycle - you can go on forever, or at least as long as you are elected, but there is a natural end. If you have not carefully developed your successor, the cause for which you have spent so much energy may slip. Compared to other things the life span of an IPPF volunteer is short, very short. A good volunteer will get as much enjoyment from the knowledge of having trained and supported one or more successors, as from his or her volunteer powers.

It cannot be expected that all the goals can be achieved, no matter how much time has passed. There is not a single goal which I feel we have fully achieved and can now turn to another issue. Many of our problems are here to stay for a long time. But, I am personally not at all discouraged because I feel the Europe Region is very much alive and good for a long fight. I should like to give younger people a chance to represent ÖGF. I will remain interested in what you are doing and I offer my experience and support if you should ever need it.

As you can see, I enjoyed my years with IPPF enormously and am very grateful indeed to all the people I met and from whom I learned so much, both on a professional and a personal level. Some will remain my friends even in after life. And believe me my dear volunteers - there is life after IPPF.



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The Delivery of Family Planning Services In the Netherlands

By Aida Torres and Elise F. Jones

Background

Of the five case-study areas, the Netherlands has the lowest fertility rate, the lowest abortion rate and appears to have the lowest ratio of unplanned to planned pregnancies. Use of effective methods of contraception is quite high: Fifty-six percent of Dutch women aged 15-44 are protected by sterilization, the pill or the IUD. This report explores some aspects of the provision of health care and family planning services in the Netherlands that may help to explain this impressive contraceptive behavior.

The Dutch health care system emphasizes preventive care, with the family physician, who is a general practitioner (GP), acting as the entry point into the system.¹ Almost all residents in the Netherlands are registered with a GP, the choice of GP being left to the individual. These physicians, the majority of whom are men, are consulted first for all medical problems; they provide all routine medical services, arrange for their patients' hospital stays and refer patients to specialists for sterilizations, abortions and other services they are unable to provide.

Nationally, there are 40 GPs per 100,000 population in the Netherlands, as compared with 31 per 100,000 in the United States.² GPs are fairly equally distributed throughout the 12 Dutch provinces. Over 60 percent of GPs are in solo practice, 33 percent are in a partnership or group practice and about seven percent work in health centers.³

Almost all family physicians participate in a government-sponsored health insurance plan administered by the Sickness Fund Council, a quasi-governmental body that determines health care standards and regulates the rates and fees charged by

The extensive use of reliable modern methods of contraception in the Netherlands has been stimulated by changes in social attitudes toward sexuality, by concern over the efficacy of traditional methods and by improved access to services.

service providers.⁴ Provincial and municipal authorities implement the council's policies and contract with local doctors, pharmacists, hospitals and other health care providers for their services. Family physicians who are affiliated with the national insurance plan are reimbursed according to the number of covered patients they serve; patients who are not covered by the plan pay the doctor for services rendered and are eligible for full or partial reimbursement by private insurance.⁵ Although there are some public health facilities, many hospitals and other health care facilities, including an important network of infant health centers, are operated by private organizations or foundations that are supported by government funds; in order to obtain these funds, institutions must comply with regulations established by the council.

Every resident in the Netherlands is covered to some extent by national health insurance plans financed by central government revenues and by employer and employee contributions. These plans differ according to the segment of the population included and the health services covered.⁶

The broadest scheme, the Exceptional Medical Expenses Fund, covers the medical costs of extensive illness for all residents of the Netherlands, regardless of their income. To finance the fund, employers are required to assume the costs for their employees, and self-employed residents pay a premium based on income. Those who are over the age of 65 do not have to pay for this insurance.

In addition to coverage for extensive illness, roughly two-thirds of the population

currently have Sickness Fund insurance, a government-sponsored plan that covers all basic medical expenses such as physician visits, medical supplies and hospital care for illnesses of short or moderate duration. Sickness Fund insurance is compulsory for everyone whose income is below \$19,600 (U.S.),* which is roughly equivalent to the average family income.⁷ The Sickness Fund is financed by both employer and employee contributions: A premium amounting to about 10 percent of each employee's wages is paid into the fund by employers, who deduct half from the employee's salary. The unemployed, including full-time students and the disabled, are covered by the insurance without having to pay a premium. Self-employed residents whose incomes do not exceed the cutoff may enroll in the plan on a voluntary basis. People with incomes exceeding the limit and under age 65 are expected to obtain private insurance.

Nearly everyone is covered by either public or private insurance. In 1982, about one-fifth of the population were covered by private insurance, and roughly four-fifths were covered by public insurance.⁸ However, since that time, the proportion of the population covered by public insurance appears to have declined as a result of a lowering of the income threshold for compulsory insurance.

In 1983, 70 percent of the total cost of health care in the country came from national health insurance funds—27 percent from the Exceptional Medical Expenses

Aida Torres and Elise F. Jones are senior research associates at The Alan Guttmacher Institute. The authors would like to thank those in the Netherlands who consented to be interviewed during the course of this study.

*Dutch guilders have been converted to U.S. dollars at a rate of 2.45 guilders to the dollar.

Fund and 43 percent from the Sickness Fund. About 25 percent of total health care costs were paid by individuals and private insurance, and five percent were financed through direct government subsidies to health service institutions.⁹

GPs and Family Planning Services

Most family planning patients obtain contraceptive services from their family physician. Doctors are not required to raise the subject of birth control with their patients but always provide information, services or referrals upon request. Contraceptive services are free to all patients enrolled in the Sickness Fund; some, but not all, private insurance plans also cover the costs of these services. The Sickness Fund has covered the cost of prescriptions for the pill, the IUD and the diaphragm since 1971, and has financed sterilizations since 1973.¹⁰ The morning-after pill is also offered under the publicly financed scheme. Nonprescription contraceptives are not covered by insurance; although the condom, foam, jellies, creams and suppositories are readily available, the sponge is not.

There is no law or public policy requiring parental consent or notification as a condition for adolescents' obtaining contraceptive services; doctors are required to respect all requests for confidentiality.¹¹ Nevertheless, some adolescents are reluctant to ask their family physician for contraceptives for fear that their parents will find out. Although bills for patients covered by private insurance are sent to the home, it is possible for teenage patients who do not want their parents to be billed for a visit to pay directly for the contraceptive services or supplies they receive. Patients who prefer to seek the services of another GP for contraception would have considerable difficulty finding a physician willing to see them unless their situation were urgent.

Because the Dutch public is quite sophisticated about birth control, most doctors assume that women who seek family planning services are well-informed about their contraceptive options. On average, contraceptive visits provided by family physicians last only 7-10 minutes.

The low-dose pill is the method most commonly prescribed by family physicians because it is considered to be effective, reliable and useful for maintaining cycle control. There seems to be general agreement among doctors that the long-term health risks associated with low-dose oral contraceptives are small; currently, there is growing support among doctors for making the pill available without prescription and for changing the duration of pill pre-

scriptions from six months to one year.

When a patient requests the pill, her doctor is likely to discuss its possible short-term side effects rather than its long-term health effects. Doctors are not required to discuss the latter, nor is a pelvic examination necessarily required before prescription of the pill. A protocol for family doctors reviewed by the Dutch Society of General Practitioners states that unwarranted medical advice or examination results in inefficient use of the doctor's time and causes undue anxiety and insecurity among patients, particularly young patients.¹² The protocol suggests that it is preferable for doctors to spend their time assessing and monitoring the suitability of the pill for the patient rather than discussing its possible long-term health effects.

Women who request the pill are usually given a six-month prescription and are counseled about method use. Patients are asked to come back for renewal of the prescription, and return visits are usually handled by the doctor's assistant.¹³ At return visits, before the doctor prescribes another six-month supply, the doctor's assistant will generally ask the patient if she has noticed any side effects related to pill use; however, the assistant is not required to review with the patient all of the possible side-effects pill users may experience.

Although the number of family physicians who provide the IUD is increasing, it is generally believed that more than 50 percent still refer patients who want an IUD to a gynecologist, most of whom are affiliated with hospitals or outpatient clinics. GPs who provide IUDs are likely to do fewer than 10 insertions a year. The physicians who offer IUDs generally assess the patient's health, perform a medical examination and counsel the patient on method use. Return visits for IUD checkups are handled by the doctor. (Patients referred to a specialist for IUD insertions are asked to return to the family doctor for follow-up visits.)

Doctors more or less actively discourage the use of other reversible contraceptive methods because they consider them to be much less reliable than the pill or the IUD. The diaphragm is rarely prescribed, condoms are advocated mainly for prevention of sexually transmitted diseases (STDs), and spermicides are usually prescribed only in conjunction with other methods, such as the condom, or with initial use of the IUD.

Clinics and Other Service Providers

Although most family planning patients obtain contraceptives from their own physicians, private family planning clinics

constitute a small but important network for the provision of contraceptive information and services. Clinics are viewed as places where services can be obtained anonymously, and where women clinicians provide the privacy and reassurance sought especially by teenagers and members of cultural minorities. Unlike the offices of family physicians, whose visiting hours are usually limited to weekdays, many clinics are open in the evenings and on weekends. In addition, although appointments are preferred, clinics accept drop-in visits from women seeking the morning-after pill, abortion referrals or other emergency services.

The largest network of family planning clinics in the Netherlands is run by the Rutgers Foundation (in Dutch, Rutgers Stichting), a private, nonprofit organization, which has 36 clinics throughout the country. The clinics provide a broad array of family planning services to all who seek them, but their primary focus is on the delivery of contraceptive services to immigrants (who make up six percent of the population) and young people—two groups that have been singled out by the government as needing special attention.

About 90,000 patient visits were made to Rutgers Foundation clinics in 1986.¹⁴ A majority of visits (about 60 percent) were made by women aged 18-25, and 12 percent were made by young teenagers. Sixty-six percent of patient visits were for the pill (including the morning-after pill), seven percent were for the IUD, six percent were for the diaphragm and one percent were for contraceptive injections. The remaining 20 percent of visits were made for other purposes, such as screening and treatment for STDs, pregnancy testing, and counseling and referral for sterilization and abortion.¹⁵

The foundation receives considerable support from the government, which provided 70 percent of its total budget in 1986; patient fees cover the rest of the clinics' expenses.¹⁶ The standard fee for a contraceptive visit is \$11. However, patients who have a written reference from their family physician are entitled to free services, and government subsidies partially cover the cost of visits made by adolescents under the age of 18, who need pay only \$5 a visit. Small municipal grants also help to subsidize visits made by women aged 18-20, and student insurance often covers the service fee. Although the cost of all prescription contraceptives dispensed at the clinics is covered by the Sickness Fund, women under age 20 who are not covered by the fund and who cannot afford to pay are given supplies for free.

The foundation also provides free family planning services to immigrant women who bring their infants and young children for medical checkups to the publicly funded infant health center in Amsterdam. (In the Netherlands, well-baby care is widely available, and parents are expected to utilize primary health services for their children—over 90 percent of all infants attend infant health clinics.¹⁷) Translators from the Amsterdam City Council's Interpreter Center participate in this program. Prior to visiting the infant health center, the mother has most likely heard about family planning from the midwife who delivered her baby or from a visiting nurse. During the family planning session, a Pap smear is taken and various methods of contraception are discussed. Immigrant women are most likely to choose the low-dose pill, in which case they are given a six-month supply and asked to return to the clinic or to a general practitioner in six months; those who request an IUD can have it inserted at the center or are referred to a hospital. Rarely do immigrant women request the diaphragm or condoms.

Rutgers Foundation clinics serve as the principal national source of information and counseling on problems related to sexuality and birth control. At 15 of the clinic sites, psychological and sexual counseling is offered to individuals who request such services. In addition, six centers send teams of nurses and social workers to conduct informal sex education sessions and discussion groups at schools and in community centers; the main job of these teams, however, is to train teachers, nurses and counselors in matters related to sexuality and birth control. Because educational and counseling services receive little government funding, the foundation charges small fees for such programs.

The clinics do not do any direct advertising but rely on outreach efforts to inform the public of their services. In 1986, the foundation launched a highly successful campaign that increased the clinic caseload two months later by about 10 percent. The campaign consisted of displaying posters and distributing brochures about birth control, abortion and "safe sex" in subway and railroad stations, at libraries, family doctors' offices and all branch clinics.

In addition to Rutgers Foundation clinics, several smaller organizations offer family planning services. MR'70 is an independent clinic in Amsterdam that provides birth control and abortion services. The organization receives municipal grants to subsidize its services for immigrant women. However, it relies on insurance reimburse-

ments for abortions and fees from private family planning patients to support its other clinic operations. The full fee for a contraceptive visit is \$10, but high school students are charged only \$2. The standard rates for IUD and diaphragm fittings are \$37 and \$25, respectively.

The Academic Hospital in Leiden, which receives government support, operates a variety of outpatient clinics, including a family planning clinic that serves about 2,000 patients a year.¹⁸ Clinic sessions are held one evening and one afternoon a week. During a woman's first visit to the clinic, she is counseled about various contraceptive methods and receives a complete checkup, including a gynecological examination, Pap smear and a breast examination—a standard practice that may have been dispensed with under new policy guidelines that were being formulated at the time of the site visit in February 1987. The initial visit concludes with instructions on method use and scheduling for follow-up visits. Once a week, the staff visits the hospital's maternity ward to provide birth control information to mothers interested in family planning.

Pharmacists also play an important role in the distribution of contraceptive supplies and the dissemination of birth control information. Pills and diaphragms can be obtained from pharmacies upon presentation of a doctor's prescription. IUD users obtain the device from a pharmacy and bring it back to the doctor for insertion; the same procedure is followed for patients who obtain injectable contraceptives. Clients who are insured by the Sickness Fund pay a basic prescription fee of \$1 for prescription drugs; those who are not insured by the fund pay \$17–\$21 for a six-month supply of pills. Condoms and spermicides are available at pharmacies without prescription but are not covered by insurance: Condoms cost \$2 for a packet of three, and spermicidal creams, jellies or foams cost \$6–\$9. Condoms and spermicides are also available in vending machines, supermarkets, newspaper shops and hair salons.

Pharmacists are required to tell patients how to use the methods they dispense. However, information about the possible health risks associated with a method are routinely included in package inserts. For example, the insert that accompanies the high-dose pill (50 mcg of estrogen) includes a list of medical conditions that contraindicate its use and warnings about reported adverse reactions related to taking hormonal contraceptives, ranging from such minor side effects as headaches, weight changes

and breakthrough bleeding to more serious complications, such as liver dysfunction and cardiovascular disease. The insert also cautions users not to take certain drugs while on the pill and warns of the increased risk of vascular disease, especially among smokers. On the other hand, the package insert for the low-dose pill (30 mcg of estrogen) emphasizes the method's benefits and downplays its possible side effects; nevertheless, it warns users against smoking cigarettes while on the pill.

Specialized Services

Patients who seek sterilizations, abortions or, in some cases, the IUD are referred by their family doctor to obstetrician-gynecologists. There are no restrictions on sterilizations regarding the age of the patient, the number of children she has or the need for special consent; in addition, sterilizations are free for patients covered by Sickness Fund insurance. In 1984, about 32,500 vasectomies and 28,500 female sterilizations were performed by specialists in outpatient clinics, hospitals and private family planning clinics that specialize in sterilizations.¹⁹ Although vasectomies are always performed on an outpatient basis, three-quarters of publicly financed female sterilizations are performed in hospitals, and patients usually require overnight inpatient care.²⁰

Eight private family planning clinics in five major cities specialize in sterilizations—five perform both male and female sterilizations and three perform vasectomies only. However, these clinics account for only a very small proportion of all sterilization procedures obtained by residents of the Netherlands. As more physicians affiliated with outpatient clinics or hospitals have begun performing sterilizations, specialized clinics have come to serve a smaller proportion of the national caseload. The full fee charged by specialized clinics to paying patients ranges from \$123–\$163 for a vasectomy and from \$204–\$327 for a laparoscopy.²¹

In the Netherlands, abortion is regarded as a backup service, not as a method of birth control. Although abortion was legalized in 1981, the regulations governing its practice were not formally adopted until three years later. However, even before the law was passed, abortion had been widely available in private, nonprofit clinics and in some hospitals.²² The law states that first- and second-trimester abortions may be performed in hospitals and nonprofit clinics after a five-day waiting period. Menstrual extractions, which have always been counted as abortions in the Netherlands,

not subject to the five-day waiting requirement.

Parental consent for abortions is theoretically required for women under age 21; but in practice, women aged 16 or over can obtain abortions without the consent of their parents. Since November 1984, residents may obtain abortions free of charge under the government-sponsored national health insurance system. The Exceptional Medical Expenses Fund covers the cost of abortions performed in clinics,²³ and the Sickness Fund or private insurance companies cover those performed in hospitals.²⁴ Payment by the Exceptional Medical Expenses Fund for clinic abortions has not caused a rise in rates; rather it has caused a shift in the balance of providers from hospitals to clinics.

In addition to MR' 70, which is a member of a voluntary, nonprofit group called Stimezo (the National Abortion Federation of the Netherlands), seven other Stimezo-affiliated clinics provide abortion services, as well as contraceptive services.

Contraceptive Use

The overwhelming preference of the Dutch for highly reliable methods of contraception is reflected in the patterns of method use among women of all ages. In the mid-1970s, just 10 years after the introduction of the pill, oral contraceptive use in the Netherlands reached by far the highest level reported anywhere in the world.²⁵ By 1975, 42 percent of Dutch women aged 15-49 either were using the pill or were protected by male or female sterilization (36 percent and six percent, respectively).²⁶ By 1981, 49 percent of such women were relying on the pill or sterilization (29 percent and 20 percent, respectively). As can be seen, these seven percentage point net increase in the use of these highly effective methods was due entirely to an increase in the use of sterilization; pill use actually declined by seven percentage points during this period, mainly because of widely publicized reports about the possible long-term health effects of this method.²⁷

A total of 2.3 million pill prescriptions were written in 1986.²⁸ Family physicians wrote about 90 percent of them, physicians working in family planning clinics wrote five percent and gynecologists accounted for the remaining five percent.²⁹ Among women who were using the pill, 18 percent were under 20 years of age, 53 percent were aged 20-29, 22 percent were aged 30-39 and eight percent were aged 40 or older.³⁰ Seventy-five percent of pill users belonged to the Sickness Fund, and were therefore entitled to free services and prescriptions.

Findings from the 1982 Netherlands Fertility Survey indicate that method reliability is the principal reason women switch from less-effective methods to sterilization or the pill. Among women who switched from the condom to the pill, 70 percent of those under age 30, and 63 percent of those over age 30, indicated that reliability was the main reason for changing methods. The next most frequently cited reason for switching from condoms to the pill was method convenience. On the other hand, medical and psychological reasons were the main reasons women gave for switching from the pill to the IUD, the condom or other less-effective methods.

Almost all the women who were using the pill or the IUD at the time of the survey intended to continue using the same method. Women who were using other reversible methods (the minority of total users) were more likely to want to change their method. Overall, only eight percent of all users intended to switch methods; most women who contemplated changing their method expected to adopt sterilization or the pill.

One issue that causes some concern among medical and health professionals in the Netherlands is that the wider acceptance of contraceptive sterilization may result in increased instances of sterilization regret. The most common cause for regret is "broken relationships," and the number of couples facing separation and divorce has been increasing.³¹ Furthermore, concern over the adverse long-term health effects of the pill is the principal reason for the rapid increase in the number of sterilizations, although resort to sterilization because of the drawbacks of reversible methods appears to increase the risk of subsequent regret.³²

Information and Education

Over the past 20 years, knowledge about reliable methods of contraception has improved greatly and social attitudes toward sexuality and birth control have changed dramatically. Government-sponsored information programs and the media, in particular, have played a major role in disseminating birth control information to the public. Information and interpreter centers, established specifically to assist young people and immigrants in gaining access to health services, are funded by the government. The Children's Telephone Assistance Service has set up a hot line that operates daily from 4 PM-8 PM for young people with problems. The hot line receives about 80,000 calls annually: 25-30 percent of the calls are related to sexual matters and

birth control, and another 15-20 percent are about relationships.

In 1976, the Ministry of Health and Environmental Protection established the Agency for Information on Health Care for Immigrants to help assimilate immigrants into the health care system. The agency is completely subsidized by the government and is supervised by a number of national health organizations whose main activity during the past 10 years has been to provide immigrants with translated, easily readable educational materials on all aspects of health care, including family planning. In addition, the agency sponsors a program that trains immigrant women to teach health education to their compatriots.

Although it has not been formally integrated into the curriculum, sex education is available in secondary schools to a limited extent; some teachers provide information about contraception, and some conduct informal group discussions about sexuality. In addition, a sex education course for high school biology teachers is taught at the University of Leiden with funds from the Ministry of Education. The university has also been involved in developing a high school biology textbook that includes information on contraception. In 1985, a law was passed opening the way for the introduction of health education into the primary schools, which may include information on sexuality and birth control.

Many people believe that the widespread use of reliable methods in the Netherlands has resulted mainly from open presentation and discussion in the media of matters related to sex and birth control. Radio, television and magazine coverage of sexual issues and contraception is geared toward educating the public, not toward sensationalizing sexual topics. A popular television show aimed at young people often covers topics related to sexuality, relationships and contraception. In addition, *Libelle*, the most widely read women's weekly magazine in the Netherlands, is a major source for birth control information. In the past few years, AIDS has been covered extensively by the press, radio and television and has focused public attention on the need for safe sex practices.

Additionally, a network of 80 counseling bureaus across the country (including the Rutgers Foundation clinics) serve as information centers, providing guidance and referrals to anyone in need of assistance with problems related to sexuality and birth control. These bureaus, which are all operated by private and charitable organizations, provide medical, psychological and social assistance as well as public informa-

tion and referral services. Each week, at least 6,000 people, three-quarters of whom are women, call or visit the centers for information or guidance.³³ More than half of all requests are for information about sexual problems and birth control, 35 percent are to make appointments for check-ups at family planning clinics or other facilities, five percent are for emergency referrals to doctors or family planning clinics, and the remaining seven percent are to purchase condoms or to obtain general information.

Brand-name advertising of prescription contraceptives is forbidden by law except in medical journals. However, the law requires that package inserts contain information on the long-term risks of the method and important facts about symptoms related to method use that the users themselves can detect. Once the authorities have approved the text of an insert, consumers may not bring product liability suits, as U.S. consumers have done in the case of the IUD, for example.

Conclusions

In the Netherlands, contraception is encouraged by the government, the medical profession and the media, and is widely accepted by the public. The extensive use of reliable modern methods has been stimulated by changes in social attitudes toward sexuality and birth control, by concern over the efficacy of traditional contraceptive methods and by improved access to services. The fact that primary health care is centered around family physicians who are likely to promote the pill may partially account for the pill's rapid acceptance and continuing widespread use. Nevertheless, a very high proportion of couples eventually turn to surgical sterilization, perhaps in part because of concerns about prolonging pill use into the later years of reproductive life.

The inclusion of contraception in the package of services covered by national health insurance has also contributed to the widespread use of effective methods of contraception. Contraceptive services and supplies provided by family physicians are free for most patients. In addition, contraceptive services offered at some family planning clinics are partially subsidized by the government and are consequently inexpensive.

Despite the overall high use of effective birth control methods and the low rates of abortion, compared with other developed countries, the Dutch themselves consider their situation far from ideal. Many adolescents do not use reliable methods, particu-

larly at first intercourse,³⁴ and women under age 20 constitute a significant proportion of abortion patients.³⁵ Fear of adverse parental reaction and lack of awareness that doctors are required to respect their right to confidentiality combine to dissuade some adolescents from approaching their family doctor for contraceptives. In addition, lack of information about clinic locations and the cost of clinic services, however small, may still present barriers to effective contraception among young people.

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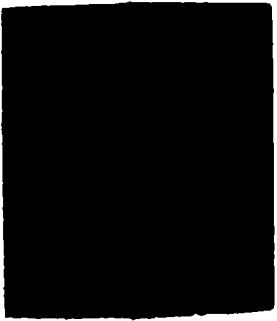
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National Events

DHS survey of contraceptive availability in Egypt

The health and family planning infrastructure in Egypt, barring private family planning clinics, is accessible (located within 30 kilometres) for all villages, according to the *Egypt Service Availability Survey 1989*. Two of three married rural women have a source of family planning in their village, and 96 per cent live within five kilometres of a source. Ninety per cent of women live within five kilometres of a pharmacy, 70 per cent within five kilometers of a government family planning clinic, 55 per cent live in villages covered by a community-based family planning worker and 66 per cent in villages with a family planning nurse. Availability of the Pill and condom is greater than that of the IUD, with 96 per cent of women living within five km of a source for the Pill, 95 per cent for the condom, and 61 per cent for the IUD. The study could not determine the reasons for the contraceptive use differential between Lower and Upper Egypt, but suggests that this may be due to general disapproval of family planning, and larger desired families by rural women in Upper Egypt, rather than lack of accessibility to services. The survey was conducted as part of the IRD/MACRO Demographic and Health Surveys Programme. Contact: IRD/MACRO, 8850 Stanford Boulevard, Suite 4000, Columbia, MD 21045, USA. (*Egypt Service Availability Survey 1989*, Cairo and Columbia, MD: Cairo Demographic Centre and IRD/MACRO, 1991)

EUROPE

Condom sales in Europe expected to increase

Condom sales in Europe should increase by 25 per cent from US \$492 million to US \$616 million over the next five years, according to a market research report. Italy remains the largest market with annual sales of US \$193 million, with rapid growth still occurring, mainly because of low usage of the Pill. West Germany is

the second largest European market, with sales at US \$111 million. In Spain, more than half of women between 15 and 45 do not use any form of contraceptive. The French condom market, worth US \$45 million, is poorly developed, according to the report by Frost and Sullivan. (*The Financial Times*, UK, 28 January 1992)

Testing for HIV in Europe

The Council of Ministers of the European Community, the committee of ministers of the Council of Europe, the general assembly of the World Health Organization, and the Standing Committee of Doctors of the European Community have issued statements on AIDS that underline the importance of voluntary testing and strict confidentiality. They emphasize that any discrimination against people who are HIV positive is an unacceptable infringement of human rights.

However, the *British Medical Journal* suggests that it is difficult to ensure full confidentiality when access to testing for HIV becomes more widespread. In Denmark a private firm has already advertised a 'do it yourself' test. They send out blood collecting devices and analyze the blood sent back. The amount of blood needed is small and there is no way of checking that the person requesting the test is the person whose blood is being tested, suggests the journal. (*British Medical Journal*, Vol 304, p435, 15 February 1992)

HIV and AIDS figures in the Czech Republic and France

Current estimates indicate that approximately 2,000 people have HIV in the Czech Republic, although only 116 people with HIV have been officially recorded. The regional health centre in Prague has established an anonymous helpline, providing information about prevention, and in a drop-in advice centre which was opened in November 1991.

By the end of September 1991, official estimates totalled 16,552 people with AIDS in France, with 8,560 AIDS-related deaths. The incidence is about 279 per one million inhabi-

tants, with a rate of 2,170 per million in Paris. Under-reporting is thought to be between 10 and 20 per cent, indicating that the actual number of people diagnosed since the beginning of the epidemic is nearer to 20,000 or 22,000. (*AIDS Newsletter*, Vol 6, No 17, 1991)

The consequences of Germany's falling birth rate

By the year 2030 there will be 20 million fewer Germans alive than there are today, reports the Institute of the German Economy. Couples have on average 1.19 children, fewer than Britain and France. Germany will need at least 300,000 immigrants annually just to fill the gap in its labour market. (*The Guardian*, UK, 4 February 1992)

Irish FPA opens new family planning centre

On St Valentine's Day, 14 February, the Irish FPA (IFPA) marked the opening of the country's first purpose-built and most modern family planning centre in a shopping centre in Dublin. IFPA spokesperson Catherine Forde commented that the IFPA had risen to the challenge of providing innovative educational and clinical services to the Irish population, "without the support of successive governments and in the face of restrictive and oppressive legislation". The opening of the new centre, she said, "reaffirms our on-going commitment to serve the health needs of Irish couples in the decades ahead". Attending the launch, television health presenter Ciana Campbell said that the IFPA plays a vital role in preventive health care for women and that IFPA's dedication and commitment should be "supported and matched by the relevant government departments". Other celebrities commented on the implications of condom laws in the age of AIDS, and the lack of adequate sex education in schools, which, said actor Mick Lally, "has a significant contribution to make towards improved, responsible and caring attitudes among men". (IFPA press release, 14 February 1992)

Sex Education in Swedish Schools: The Facts and the Fiction

By Carl Gustaf Boëthius

The popular American view of Swedish society tends to be based on a number of broad, often inaccurate, generalizations that over the years have assumed the force of myth. Sweden is frequently characterized as a clean, small, homogeneous, rather austere country, peopled by healthy, sexually athletic blondes. In no other area are the myths quite so strongly believed as in the domain of sexual activity and sex education. It appears that some Americans believe Sweden to be a country where from infancy, or at least from kindergarten on, children are supplied with a battery of clinical sexual information designed to encourage them to become precociously and incessantly sexually active. This process, it is claimed by uninformed critics, leads almost automatically to high rates of teenage suicide and venereal disease, and to increased levels of alcoholism, depression, divorce and breakdown among adults. Even social commentators who are more charitably disposed toward the country would probably argue that it was possible for Sweden to become the first country in the world to make sex education compulsory in schools only because of the unique tolerance and sexual openness of the Swedish people—qualities not found, they assert, in more conservative, more complex, more heterogeneous societies, such as the United States.

The first picture, of course, bears no resemblance to reality, and the second position lacks historical perspective. It is true that as early as 1942, in response to active pressure from women's associations, some doctors and the Swedish Association for Sexual Education (established in 1933 by Elise Ottesen-Jensen, who went on to become a founding

member of the International Planned Parenthood Federation), the Swedish government recommended the introduction of sex education into schools. Another significant influence at the time was the report of the 1935 Royal Population Commission. A year earlier, its most active commissioner, sociologist Gunnar Myrdal, and his wife, Alva, had published a book showing that poor Swedish families with a lot of children suffered from low standards of housing, nutrition and education. The Myrdals argued that improved living conditions and the reduction of unwanted pregnancies among such families could best be realized if, among other programs, more systematic information about birth control were made available, particularly as part of the school curriculum.¹

Most of the Myrdals' recommended reforms were eventually accepted (including repeal of a prohibition against contraceptive information). However, their views and those of Ottesen-Jensen and her colleagues were considered highly controversial at the time, and came under severe attack from conservatives, on both moral and political grounds. Many of the arguments made against sex education in Sweden in the 1930s and 1940s will probably sound familiar to Americans today. Opponents claimed, for example, that providing information about sexual functioning would arouse the sexual interest of boys at an abnormally early age and undermine the natural modesty of girls, and that most young people would interpret sex education as an open invitation to engage in sexual activity. These critics also argued that sexual information and the question of the proper timing of sexual initiation should be left to parents, and that sex education programs in public schools ran counter to Sweden's separate cultural traditions and to the rights of parents to convey to their children their own values on these matters.

In response to this criticism, the proponents of sex education in Sweden insisted that the goals of such a program were very

different from those portrayed by the movement's detractors. In fact, they argued, teaching children about the anatomy and physiology of reproduction took second place to the more positive goal of conveying to young people an understanding that sex education was really about good personal relationships characterized by a sense of responsibility and concern for others. At the core of the early Swedish sex education curriculum was the sense that the sexual life should be a source of joy and happiness shared with another person, and the awareness that sexuality as an integral part of human life is simply one part of broader personal and social development.

A Change of Approach

During the first couple of decades of Sweden's slowly growing sex education program, the dominant standard of behavior, stressed in a 1945 teachers' manual, was that of sexual abstinence throughout adolescence. However, as the custom of "going steady" (including, at times, a sexual relationship) became more common among Swedish teenagers (as indeed it did in most countries of Western Europe), adherence to this standard placed the teacher in an untenable position. If the teacher simply enunciated the standard of teenage abstinence, it meant that he or she was unable to bring up for discussion the real issues confronting a growing body of students. As a result, teaching became one-sided, emphasizing the biological aspects of sexual relationships and ignoring their ethical and psychological dimensions. In addition, a pedagogical concept had been introduced into Swedish teaching philosophy, which asserted that for democratic reasons, all teaching in the humanities should be morally neutral and value-free. The resulting sex education that students received tended not to be of great usefulness to them, and it provided them with little real guidance in their lives.

However, in a quite radical shift, and as a

Carl Gustaf Boëthius was secretary of the government commission that met from 1964 to 1974 to establish new guidelines for sex education in Sweden. He is vice-chairman of the Swedish Association for Sex Education. This comment is an adaptation of an article that originally appeared in the English-language review *Current Sweden*, No. 315, Mar. 1984, published by the Swedish Institute, Stockholm.

result of more than 10 years of consultation and research. In 1977, the Swedish National Board of Education issued a new teachers' manual for sex education that for the first time stressed the broad ethical dimensions and foundations of human and, particularly, sexual relationships.² The manual specifies a number of points on which it is considered both the right and the duty of the teacher to assert that a certain principle is ethically right and that its antithesis is wrong. Any teacher in the Swedish school system who holds a differing opinion in these areas is, of course, entitled to state that belief. However, he or she must present the value advocated by the Swedish education authority correctly. It is believed that in this way, disagreement can provide a good starting point for discussion. In addition, the manual states, the right of the student to voice his or her own opinion on ethical issues must be encouraged and respected.

The following ethical principles, among others, are enunciated in the 1977 teaching manual:

- Nobody is entitled to regard and treat another human being simply as a means of selfish gratification.
- Psychological pressure and the use of physical force in any context are violations of the personal freedom of others.
- Sexuality as part of a personal relationship involves more than casual sex. (This principle does not imply moral disapproval of people who are dependent on casual sexual relations during certain periods of their lives; but the deeper, more sustained relationship is what should be aspired to.)
- Schools should support the conviction held by nearly all young people that sexual fidelity in a permanent relationship is a duty.
- It is quite possible to teach the young to distinguish between pornographic and non-pornographic illustrations and texts. Complete frankness about sexual life in words and pictures is a goal toward which Swedish society has long striven. On the other hand, people should vigorously reject the kind of human degradation that normally permeates pornography.
- Men and women must be subject to identical standards of sexual morality. The old double standard, whereby men were entitled to complete sexual license while women were not, must be rejected. One further reason for rejecting traditional sex roles is that they tend to have an undesirable effect on sexual relationships.
- The old-fashioned notion that physically or mentally handicapped people or prisoners should be deprived of sexual relationships is no longer an acceptable viewpoint. Similarly, schools should help to discourage dispar-

aging views about sexual relationships among the aged.

- Schools should try to promote an atmosphere of tolerance. However, students should be made aware that such tolerance has limits, and that there is no reason why it should be extended to those who consider themselves entitled to commit physical or psychological assault on another person.

The Sex Education Curriculum

The recommended content of sex education in Swedish public schools is clearly outlined, by broad grade level, in the 1977 teachers' manual. The revised public school curriculum of 1980 states that sex education is an indispensable component at all grade levels.³ (Private schooling is almost nonexistent in Sweden.) Nevertheless, teachers are allowed a good deal of flexibility in deciding whether to expand or abbreviate the list of suggested subjects to be covered. At the youngest ages (6-9-year-olds), the psychological, ethical and social aspects of personal relationships are stressed first and foremost, as an introduction to discussing the physical differences between men and women, the structure and function of the reproductive organs, menstruation, sexual intercourse, masturbation, contraceptives, conception, pregnancy, childbirth, sterility, adoption, exhibitionism and child molestation.

The 1977 teachers' manual is based on the view that no information about sexual behavior is harmful to children if it is conveyed in a manner appropriate to their age. Menstruation, for example, is dealt with during the final year of the junior school, because for a number of girls, menarche occurs when they are about 10, and in some cases, parents have failed to prepare their daughters for this eventuality. Similarly, in today's world, even preschool children develop vivid ideas about sexual intercourse. Many of them ask questions that should be answered truthfully and in a manner that is both positive and friendly.

There is much to be gained from starting to provide information about contraception to six- and seven-year-olds. The discussion can be initiated through three basic ideas: First, all children have the right to be wanted at birth, so parents should wait until they can take care of a child before they decide to have a baby. (Small children very much like hearing this idea.) Second, the mother's health and the family's economic situation must be considered as part of the decision to have a child. (Young children have no difficulty in understanding these concepts.) Third, when the small child asks the teacher how it is possible for parents to decide when to have a baby, the teacher need only say that the mother will take a pill every day to prevent

getting pregnant, and that when she stops taking it, she will be able to conceive. This kind of approach to the issue of contraception stresses the responsibility of the parents and should not appear dangerous to those who might be shocked at the idea of talking about contraceptives with very young children. The aim is to make the idea of family planning self-evident to children. As a result, their awareness and motivation as adults will be the stronger. In the same context, the subject of sterility, which many children find puzzling, can also be raised.

In a somewhat more sensitive area, young children can be taught about infant masturbation. Although masturbation becomes less common between infancy and puberty, it is important to mention the subject in sex education classes to prevent children from developing the idea that the practice is harmful or reprehensible. It is also extremely helpful in school to address the topics of exhibitionism and child molestation in terms that are not frightening to the young. It has always been considered important to warn children not to go off with strangers.

At the intermediate level (10-12 years), many of the same topics are repeated, with the addition of some new items, including the physical and psychological changes of puberty, and some basic ideas about sexually transmitted diseases, nocturnal emissions and homosexuality. With respect to this last topic, students at this age should already be capable of understanding that the individual's sexual inclinations must be respected and accepted, so long as they do not involve violence toward others. The subject is dealt with more thoroughly at the senior level. (Sweden has long applied the principle that homosexual teachers should not be prohibited from teaching, so long as they agree to observe the same regulations as heterosexuals about relationships with students. Infringement of these rules is very uncommon in Sweden.)

At the junior high school level (13-15 years), the curriculum covers sex hormones, the anatomy of the reproductive organs, puberty, masturbation, petting, sexual intercourse, impotence, sexually transmitted diseases, sterility, contraception, sterilization, abortion, psychological changes in puberty, the sexual instincts, falling in love, love, companionship, family life, adoption, living alone, where to go for sexual and contraceptive advice or information, homosexuality, sexual deviation, sexual anthropology, the background factors influencing personal relations, attitudes toward sexuality in various non-Christian religions, the Christian view of marriage and the family, differing opinions about premarital sex, about teenage society,

sex roles, pornography and prostitution.

It is up to the individual teacher, in consultation with the students, to decide which topics to deal with in detail and which to treat in a more cursory manner. However, most classes involve a lengthy discussion of sexual intercourse, with emphasis on the importance of the personal relationship of which it is an expression. Discussions about the decision not to marry or to live alone should be concerned with counteracting a certain tendency on the part of teenagers to rate themselves and others in terms of how sexually "successful" they are. The teacher would probably remind the students that in the past, many individuals who chose to live alone made great contributions to society and, perhaps, developed rich personal relationships outside the purely sexual sphere.

In providing ethical guidelines on the issue of abortion, teachers are strongly encouraged to present thorough and impartial arguments reflecting opposing points of view. The teacher is entitled to espouse one position or the other, but may not criticize one block of opinion at the expense of the other. Teaching must also include a description of current legislation in Sweden governing the availability of abortion, as well as information about medical complications.

It is important that the community view sex education in the schools as an effective measure to prevent recourse to abortion. Children who are instilled with a serious sense of sexual responsibility at an early age are not likely to account for a large number of unwanted pregnancies and abortions. The curriculum, therefore, clearly stipulates that schools must inform students where they can go for contraceptive guidance and services.

At the upper secondary school levels (16-19 years), roughly the same topics are recommended as for junior high school students. However, the subjects are given appreciably different treatment, in keeping with the students' greater maturity and broader frame of reference, and teachers must not merely repeat factual material taught earlier.

Teenage Sexual Activity

It has been estimated that in the 1920s, one-half of Swedish teenagers had become sexually active by the time they were 20 years old. By 1967, this median had dropped to around 18, and by 1980, it was calculated to be just under 17. In the early days of the century, boys tended to have their first sexual experience at a younger age than girls. By around 1980, however, this pattern was reversed, and girls were becoming sexually active about six months before boys (at a median age of about 16 and one-half).⁴ It is important to present high school students with precise

information about these national averages, because many opinion surveys indicate that large numbers of young people grossly overestimate the proportion of their peers who have already had sexual intercourse. In this and other respects, sex education should help provide students with a sufficiently detailed picture of the complexities of real life for them to be able to base their own actions on rational considerations, rather than on peer pressure or spur-of-the-moment decisions.

A recent Swedish survey shows that the declining age at first intercourse has not entailed an increase in sexual promiscuity.⁵ The most common pattern is for young people to "go steady" and to be very strict about sexual fidelity while the relationship lasts (at that age, the relationship might be a brief one). Teachers' sex education manuals published in 1945 and 1956 both contained the recommendation that the "only thing schools can recommend with a clear conscience is sexual restraint during adolescence." The 1977 manual, in contrast, says that teachers and schools must treat both the sexually experienced and the sexually inexperienced teenager with respect and understanding, bearing in mind that the latter group includes many young people who have decided to wait before they become sexually involved. Sex education must be designed to be of interest and value to adolescents in both categories.

Conclusions

The allegation that sex education in schools encourages precocious sexual behavior is quite groundless. Schoolchildren take it for granted in every other area of their education that they will be taught subjects that will help them later in their lives. Why should they feel any different about sex education? Moreover, even in countries with little or no sex education in schools, teenagers have been starting to have sexual relations at ever earlier ages. This trend, as well as other significant changes in sexual behavior among adults, reflects profound and far-reaching social changes that have swept the industrialized world since the end of World War II. These changes are certainly not the result of introducing sex education into the schools.

In Sweden, the emphasis in the country's compulsory sex education program has shifted away from the neutral imparting of reproductive knowledge and toward increased stress on the emotional, ethical side of love-relationships. In keeping with that development, even the name of the school subject has been changed, from "sex education" or "sexual instruction" to the much broader "education about living together." Swedish sociologist Jan Trost has pointed out that the

word "sex" was not taken out of the title out of any sense of prudishness, or in an attempt at euphemism, but, rather, in order to stress the social and affective aspects of sexual relationships and to deemphasize the technical and physical aspects.⁶

Sex educators in Sweden are convinced that if young people see that sexual matters are surrounded by silence, secrecy, shame and fear, they will quickly come to believe that there is something wrong with their own feelings about sexuality. This belief will make it difficult for young people to understand that sexuality and personal intimacy are closely related and mutually supportive aspects of the same instinct. Parents and schools alike should talk to young people about the interdependence of sex and companionship, and they must do so in a truthful, positive, compassionate way. However, such a positive attitude does not mean that adolescents should be shielded from the more unpleasant forms that sex can take. Infidelity, promiscuity, pornography, prostitution and rape should not be concealed, but should be dealt with openly and critically. To be absolutely realistic with young people is the only possible way to win their confidence.

Parents and schools must help each other in this task. Parents who maintain honest and open contact with their children will be able to exert a much more profound moral influence on their children than the schools are generally able to do. Yet in the specific areas of biology, psychology, social ethics and other related disciplines, the major responsibility for teaching lies with the schools. This partnership between parents and schools is the very antithesis of the type of conflict anticipated by groups who are opposed to public sex education programs on the ground that they usurp the parental function.

Has the sex education program in Sweden's schools had any measurable effect on knowledge and behavior, especially that of young people? Very few attempts have been made to evaluate the program scientifically. Perhaps one reason for this is that the population gradually accepted the fact that young children and adolescents were entitled to sex education as a good thing in itself. The old belief that the way to inculcate sexual morality was through silence came to be seen for what it was—an insult to the intelligence and the needs of young people.

Some persuasive indicators of the program's impact on *knowledge* can be found, however. A survey carried out in 1967 found that students who had received sex education in schools had better information about the subject than those who had not.⁷ Such a survey would be impossible today, because there is no group of children in Sweden who

have not received sex education. Furthermore, a comparative survey of the sexual knowledge of U.S., Australian, British and Swedish schoolchildren between the ages of five and 15 found that Swedish children had better understanding and knowledge at earlier ages than children in the other three countries.⁸

Evidence of the program's effects on behavior can be seen in the fact that Sweden witnessed a disturbing increase in the incidence of gonorrhea among men aged 20-24 and women aged 15-24 between 1965 and 1970. The situation attracted a great deal of concern and publicity. In response, a vigorous information campaign about gonorrhea was conducted in the Swedish schools. After 1970, the rates of gonorrheal infection among young people in these age-groups declined by about 40 percent in five years, a reduction without parallel in any western country.⁹ Finally, an evaluation of the 1974 abortion act

carried out by an official government committee "found it particularly promising that the teenage pregnancy and abortion rates should have fallen so dramatically since the mid-1970s. The committee saw several reasons for this new trend: general social factors, . . . a more open attitude toward contraception, . . . heavy emphasis on an expansion of contraceptive services and the educational measures undertaken by schools and various other authorities on the subject of sexual and personal relations."¹⁰

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Books in Review

WFS: A Monumental Contribution

Reproductive Change In Developing Countries: Insights From the World Fertility Survey

ed. by John Cleland and John Hobcraft.
Oxford University Press, New York, 1985.
301 pp., \$24.95.

Reviewed by Charles F. Westoff

The World Fertility Survey (WFS), which was undoubtedly one of the most ambitious research projects in the history of social science, has come to an end after 13 very productive years. The contributors to this book take stock of the project's many achievements: edited by two prominent former members of the WFS professional staff, the book features thoughtful contributions by many researchers who were closely connected with the project.

The WFS was a project of monumental scope. Chris Scott and Vijay Verma trace its

origins in the book's opening chapter and describe the surveys, completed in 42 developing countries, involving interviews with nearly one-quarter million women of reproductive age. They also credit the WFS with an additional 19 surveys in developed countries, but in fact, the connection is only symbolic. The output has been enormous: country reports, standard data tapes that have greatly expedited intercountry analyses, substantive reports of a comparative nature, and analytical and technical studies that have led to substantial methodological advances. The goal of contributing to institutional development in Third World countries may have been less successfully achieved, but there were certainly a large number of professionals from these countries who became involved with the WFS project in various capacities.

There are some anomalies in the various authors' assessments. For example, Scott and the late V. C. Chidambaram strongly criticize the basic questionnaire as reflecting the Western bias that women have stable

attitudes toward the number of children they want. They state that this section of the questionnaire was the least fruitful, despite the fact that it was not even used in African countries, where responses might be expected to be less reliable. However, in other parts of the book, Robert E. Lightbourne, Amy Ong Tsui and John Cleland reach quite different conclusions, and, in my opinion, the correct ones, and attach a great deal of significance to the "wanted fertility" rate and to the usefulness of information obtained on whether additional children are desired.

Verma notes in his chapter on survey methods that the questionnaire took several years to develop and was modified periodically throughout the history of the WFS. This process of steadily improving the questionnaire has continued into the Demographic/Health Surveys (DHS) project, the successor to the WFS and the Contraceptive Prevalence Surveys; at present, the DHS core questionnaire, which built on the accumulated experience of these surveys, is in its

(Continued on page 282)

Charles F. Westoff is director of the Office of Population Research at Princeton University.

Fertility in the Netherlands

Looking at certain facets of fertility in what is possibly the "most perfectly birth-controlled nation"

For a few years now marriage has been losing its 'monopoly' as a living arrangement in the Netherlands. The decision to get married used to be one of the most important decisions to be made by young adults, but seems to be less important nowadays. For women marriage was a more frequent reason to leave their parental home than graduation or finding a job. Since 1971, however, women have been leaving home somewhat later than before. They stay in full-time education longer and their labor force participation rates are more pronounced. Fewer women than before get married, and moreover, if they marry they do so at a later age.

The latter tendencies also apply to childbearing (fewer children and later in life) (Figure 1).

Living arrangements

Until the age of 18 almost all 'children' live with their parent(s). After that girls leave the parental home quickly. At the age of 21 already half of all women live somewhere else. However, the rate of home-leaving has been slowing down since the early 1950s. At each age the percentage of women still living with their parents in 1988 exceeds that of 1982 (Figure 2). The age during which women born in 1960-1964 leave home is about half a year higher than that of women born in 1955-1959. Women from small families, women still studying and women with a full-time job stay with their parent(s) longer than others (Table 1).

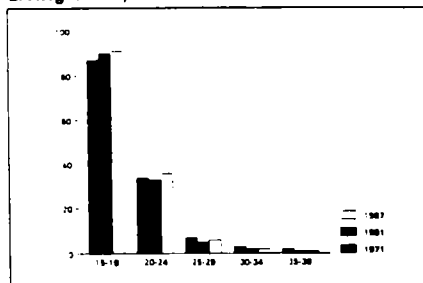
Fertility

Of the women who stop contraception to become pregnant for the first time—and a majority of all women opt for motherhood some day—half are successful within four months. For

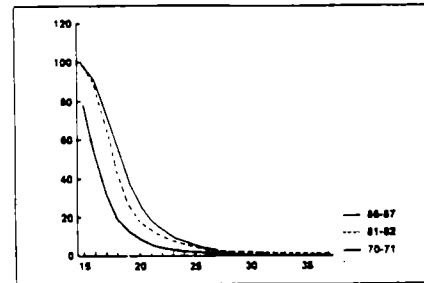
These are excerpts from the "Netherlands Fertility Survey 1988: Cohabitation, Marriage, Birth Control, Employment and Fertility." The paper was prepared by the Department of Population Statistics, Netherlands Central Bureau of Statistics. The original numbering of tables and figures have been retained in these excerpts.

Figure 1. Characteristics of Women (Percentages per Age).

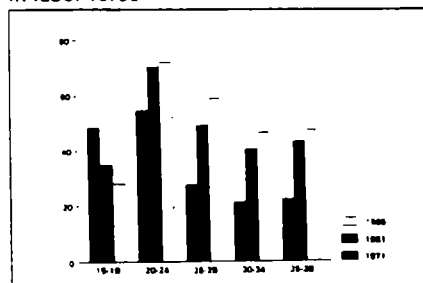
Living with parents



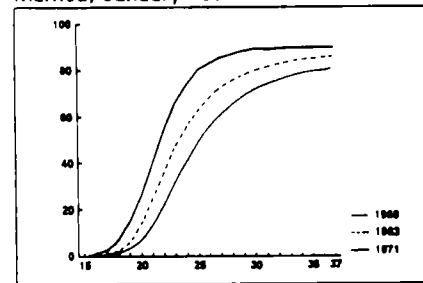
In full-time education



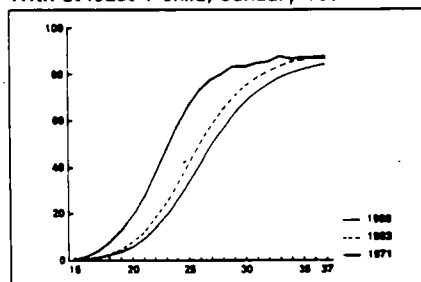
In labor force



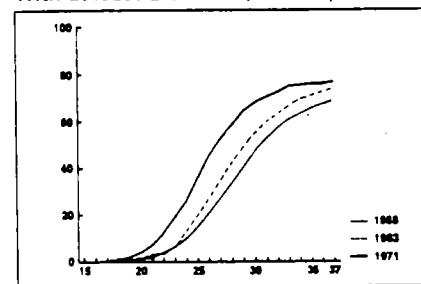
Married, January 1st



With at least 1 child, January 1st

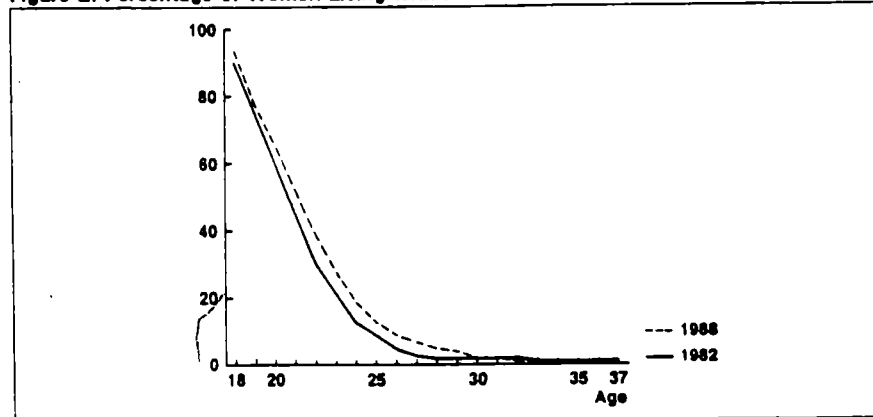


With at least 2 children, January 1st



Sources: Population Census 1971, Register Count 1987, population statistics, education statistics, Labor Force Sample Surveys 1981 and 1988.

Figure 2. Percentage of Women Living with Parents.



lower (Table 8). Of all attempts to become pregnant 11% (8% as shown in Table 8 plus 3% infecund women who are not included in this table) are still without success after 24 months. Among childless women this percentage amounts to nearly 20. This is partly due to infecundity. Of 30-35 year-old women 10% already know they are infecund. A majority of this 10% were fecund in the past and some had even given birth to a child.

Of 33-37 year-old women 19% ever had consulted a doctor at some time because they failed to become pregnant (Table 9). Almost half of childless women who ever tried to become pregnant consulted a doctor.

Not all pregnancies end with a live born child. Particularly due to miscarriages about one out of six pregnancies is lost (Table 10). If, instead of the number of pregnancies, the number of women is regarded (Table 11) over 20% of them turn out to have had at least one miscarriage, abortion or still birth before they were 33 years old. Un-

"Unwanted pregnancies (about 5 to 8% of all pregnancies of women born in 1950-1954) frequently end in induced abortion (about 3% of all women from this birth period has had such an experience)."

	18-19 years	20-24 years	25-29 years	30-35 years
All women	84	40	7	1
Parental family size				
1 or 2	85	46	8	2
3 or 4	87	37	7	2
5 or more	72	34	5	1
Inhabitants of municipality of residence when aged 6 to 16				
< 100,000	84	40	7	1
100,000-400,000	83	42	1	1
400,000 or more	78	34	10	1
Parents divorced				
Yes	71	21	3	0
No	85	42	7	1
Level of education				
Low	85	31	5	2
Medium	82	46	7	1
High	---	39	7	1
In full-time education				
Yes	90	47	6	0
No	77	39	7	1
Religious				
No	78	34	5	1
Yes	87	43	7	2
Hours work per week				
0	83	31	3	0
1-29	90	32	4	0
30 or more	81	48	12	6

--- < 10 respondents

Table 8. Time It Took to Become Pregnant.¹

	1 or 2 months	3 or 4 months	5 to 9 months	10 to 24 months	Not within 24 months	Total no. of respondents
	%					Abs. = 100 %
Total	40	20	16	17	8	1,134
No. of previous children ²						
0	30	19	14	20	18	336
1	42	21	17	16	5	584
2 or more	50	20	15	13	2	214
Age ²						
Younger than 25	41	18	12	18	11	415
25-29	37	23	19	14	7	541
30-35	42	17	15	21	4	178

¹Last attempt to become pregnant (up to 1985) of women born in 1950-1989.

²At the beginning of the attempt to become pregnant.

Table 9. Percentage of 33-37 Year Old Women or Women Born in 1950-1954, that Consulted a Doctor Because of Failing to Become Pregnant, 1988.

Number of previous children	Total	Among which: Ever experienced Pregnancy-stimulating treatment
0	14	7
Among which: Ever tried to become pregnant	45	21
1	29	9
2	20	7
3+	14	5
Total	19	7

Table 10. Pregnancies by Outcome.

Age at end of pregnancy	Year of birth	Miscarriage %	Abortion	Still birth	Live birth	Total no. of pregnancies
						Abs. = 100 %
Younger than 23 years	1950-1954	16	3	2	79	804
	1955-1959	15	4	0	82	395
	1960-1964	18	8	1	74	358
Younger than 28 years	1950-1954	13	2	2	83	1,755
	1955-1959	13	2	1	85	1,503
Younger than 33 years	1950-1954	13	2	1	84	2,687

Table 11. Number of Pregnancies per 100 Women.

Woman's age	Year of birth	Total	Among which at least 1 ending in:	Miscarriage	Abortion	Still birth	Live birth
Younger than 23 years	1950-1954	44		5	1	1	26
	1955-1959	27		4	1	0	17
	1960-1964	23		3	2	0	13
Younger than 28 years	1950-1954	127		12	2	2	61
	1955-1959	103		11	2	1	52
Younger than 33 years	1950-1954	193		17	3	2	79

Table 23. Women Aged 18-29 Years by Method of Birth Control, 1988.

	Living with male partner				Not living with male partner			
	Pill, injection %	IUD, condom	Never used any method	Total no. respondents Abs. = 100 %	Pill, injection %	IUD, condom	Never used any method	Total no. respondents Abs. = 100 %
All women	56	13	3	1,807	48	7	29	1,828
Inhabitants of municipality of residence								
< 100,000	55	13	3	1,345	47	5	33	1,233
100,000- < 400,000	54	13	1	264	47	9	26	325
400,000 or more	60	14	3	197	54	11	17	270
Level of education								
Low	56	8	3	785	49	6	30	700
Medium	56	17	2	820	46	6	31	930
High	56	16	1	199	53	9	20	198
Religious								
No	58	12	1	647	53	9	21	659
Yes	55	13	4	1,149	45	5	34	1,152
Church attendance								
Once a week	35	19	18	190	23	3	62	244
2 or 3 times a month	64	11	0	96	31	5	48	115
Once a month	57	12	1	283	52	5	27	284
Seldom or never	59	12	1	576	55	6	21	510
Political preference								
Christian Democrats	61	12	1	294	42	7	37	322
Socialists	58	12	1	501	55	6	22	398
Liberals	65	14	1	160	57	5	24	160
Democrats	49	20	1	97	50	9	21	138
Other left wing	55	24	0	77	43	14	30	118
Other Christian parties	27	15	29	67	7	0	83	69

that they do not need them (for example because they do not have a male partner) (Table 22). Non-use among women with a male partner is exceptional (Table 23). Methods of birth control are used, with some variations, in all layers of the population. Oppo-

"Birth control has become very normal in the Netherlands for almost everyone."

nents in principle of these methods can be found among confessionals who attend church very often.

Employment and Fertility

In the 1980s the percentage of economically active women increased. Among childless women a large majority have a job (Figure 24). The percentage of women who became mothers and kept their job after the first birth has also risen (Figure 25).

Especially among the higher educated and politically left-oriented women it is becoming more popular to go back to work immediately after maternity leave. Nevertheless these women are still a minority.

Most women who return to their jobs after their leave, however, work fewer hours a week (Figure 25 and Table 24).

Figure 24. Percentage of Women that is Employed.

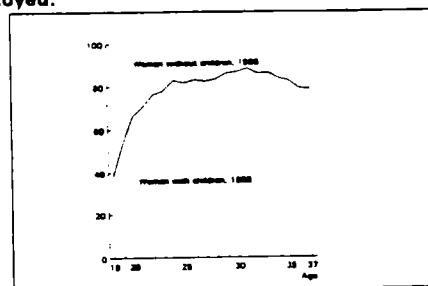
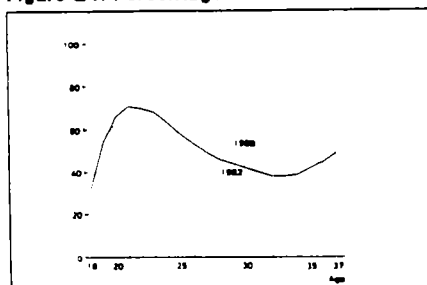


Figure 25. Percentage of Women that Resumed Work After the Birth of the First Child.

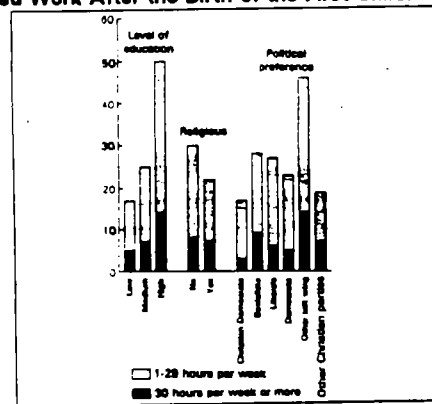
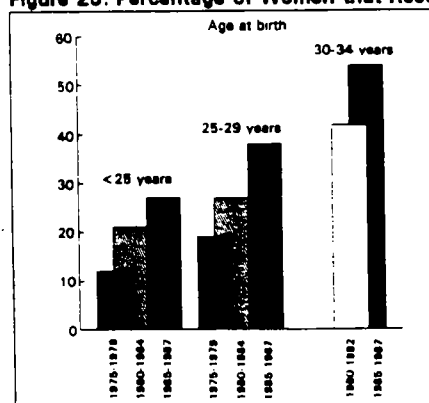


Table 24. Percentage of Women Employed Before and After the Birth of the First Child.

Birth of first child		At the beginning of pregnancy		After maternity leave	
Women's age	Year	Total	30 hours per week or more	Total	30 hours per week or more
Younger than 25 years	1970-1974	66	50	9	—
	1975-1979	67	51	8	2
	1980-1984	68	53	14	4
	1985-1987	60	40	18	4
25-29 years	1975-1979	78	48	15	—
	1980-1984	82	58	22	7
	1985-1987	80	55	30	7
30-34 years	1980-1982	73	50	31	—
	1985-1987	82	49	44	11

Table 21. Women by Method of Birth Control.

Table 21. Women by method of birth control.												
Age at date of interview		Fecund ¹ Pregnant	Contraceptive method					Infecund ² Sterilization		Other	Total no. of respondents	Family completed ⁴
			Pill, injection	IUD	Condom	Other ³	None ⁴	Woman	Partner			
		%									Abs. = 100%	%
18-19 years	1982	0	43	1	5	2	48	0	0	1	679	7
	1988	0	45	1	5	4	45	0	0	0	579	4
20-24 years	1982	4	56	5	5	2	25	0	0	1	1,727	9
	1988	3	59	2	5	6	24	0	0	1	1,533	8
25-29 years	1982	9	43	10	6	3	18	3	5	2	1,630	31
	1988	9	48	5	9	4	19	1	3	2	1,523	22
30-34 years	1982	3	27	12	7	4	16	11	14	7	1,626	67
	1988	6	31	9	9	5	16	6	12	6	1,427	54
35-37 years	1982	1	19	7	7	4	16	21	18	8	878	85
	1988	2	22	7	8	3	15	11	23	9	753	82
Total	1982	4	39	8	6	3	22	6	7	4	6,539	39
	1988	5	43	5	7	5	22	3	7	3	5,814	32

¹If living with a male partner: Both fecund. ²If living with a male partner: One or both partners fecund. ³Including method unknown. ⁴Mainly women without a male partner. ⁵Family completed = doesn't expect any more children.

Table 22. Fecund Women by Reason for Not Practicing Birth Control, 1988.

Never used any method					Used any method in the past				
Age	Opposed on principle	Never needed to	Other reasons, no answer	Total no. of respondents	Age	Is or wants to get pregnant	Relation ended	Other reasons, no answer	Total no. of respondents
	%			Abs. = 100 %		%			Abs. = 100 %
18-19 years	4	84	11	230	18-24 years	33	37		31 195
20-24 years	15	77	9	255	25-29 years	68	17		14 330
25-29 years	24	58	19	94	30-34 years	68	12		20 264
30-37 years	26	44	30	91	35-37 years	53	11		36 90
Total	14	72	14	668	Total	59	20	22	880

wanted pregnancies (about 5 to 8% of all pregnancies of women born in 1950-1954) frequently end in induced abortion (about 3% of all women from this birth period has had such an experience).

Birth Control

Nowadays birth control has become very normal in the Netherlands for almost everyone. The Netherlands may possibly be the 'most perfectly birth-controlled nation.' High frequencies of pill use at rather young ages (Table 21) coincide with very low frequencies of induced abortion. A recent development is the shift of sterilization to higher ages: of women born in 1950-1954, 8% were sterilized at age 33, whereas of those born in 1945-1949 this was 13% (Figure 22). This is partly due to comparable shifts in the ages at childbirth.

Another reason is that male partners more often undergo sterilization (Table 21), so the ultimate sterilization rates of males and females together have not changed very much (Figure 23).

Only a small minority of young women do not practise birth control because they are opposed to it in principle. For most young women who do not use contraceptives the reason is

Figure 22. Percentage of Women that Has Been Sterilized.

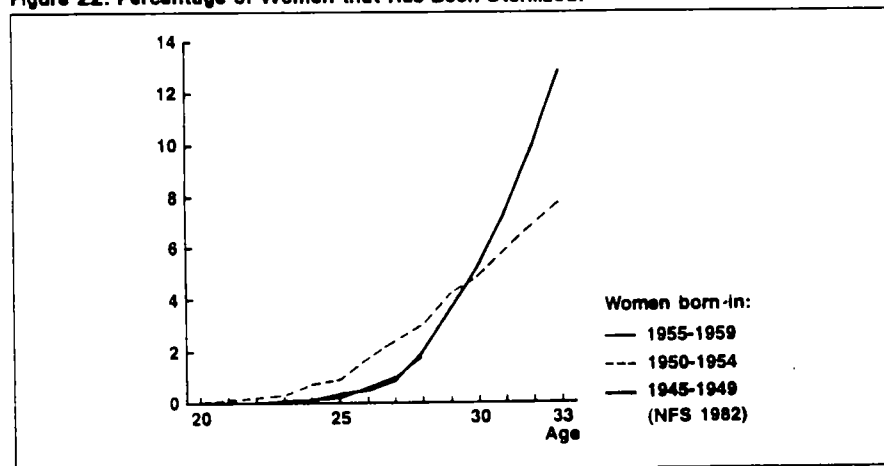
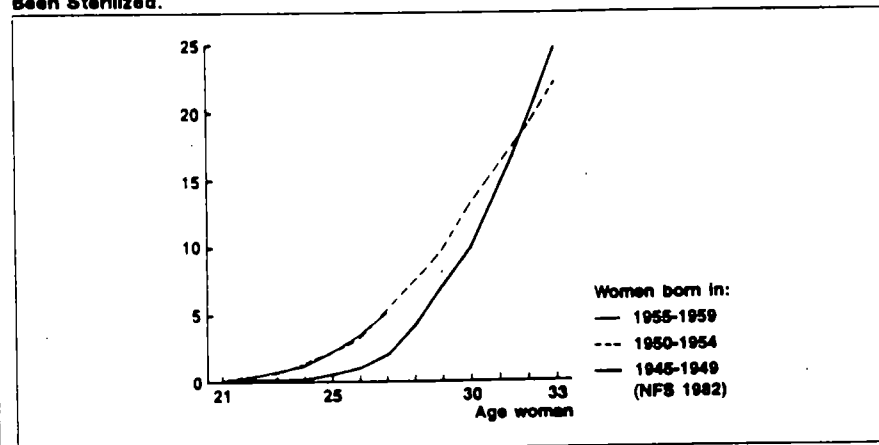


Figure 23. Percentage of Women that Has Been Sterilized or of Whom the Partner Has Been Sterilized.



Where have all the Europeans gone?

Some family planners say it's not their problem

In German, some family planners are calling it a birth strike. In Italy, local politicians are imploring women to reproduce at will. And in Luxembourg, the government is offering couples an extra \$200 a month if they will agree to add a third child to their family.

Throughout Europe, plummeting fertility rates have become a contentious topic as developed nations come to grips with an aging population, a graying work force and shriveling economic prosperity. But even as some European governments are actively encouraging women to repopulate their countries, many family planning experts do not view the European birth dearth as a problem they need to address.

"There are problems associated with every demographic picture, and they are nothing to be scoffed at," said Dr. Joseph Spiedel, president of Population Action International (PAI). "But this is something that we'll just have to endure."

Some other reproductive health groups,

'There are problems associated with every demographic picture,' noted PAI's president. But Europe's shrinking population 'is something that we'll just have to endure.'

however, suggest that European fertility is a subject that cannot be swept under the population carpet. While few fear a pro-natalist backlash against family planning services, officials from the International Planned Parenthood Federation (IPPF) have favored a preventive tactic. Deal with the situation now, they advise, before some government decides that the shrinking population is all the fault of family planning.

"It would be inappropriate for us to be complacent about this," said Karen Newborn, program advisor for IPPF's Europe bureau. "We have to start taking things like this seriously."

In some countries, the falling birth rates have already signaled serious alarm. As a whole, Europe averages 12.8 live births per 1,000 population, reports the World Health Organization. The number is a drastic contrast to the U.S.'s already low figure of about 16 live birth average.

Several nations have felt the fertility shortage most intensely. Italy has recorded a 1.3% total fertility rate, among the lowest

in the entire world. People over 65 make up 14% of the country's population.

Germany's total fertility rate is a mere 1.4%, prompting an emergency report by the Institute of the German Economy to reveal that there will be 20 million fewer Germans alive in 2030 than today and that at least 300,000 immigrants will be needed annually to fill the gap in its labor market.

While the reasons for the population decline range from healthy family planning programs to the growing public status and independence of European women, the effect of the region's economic condition on birth rates worries officials the most.

With over 10 million unemployed Europeans struggling through sluggish economies, according to the Population Reference Bureau (PRB), women have felt no great urgency to have more children. Yet many European government officials predict that the continent's fiscal health can hardly improve in the not-too-distant future with a shrinking work force.

"There's a birth strike going on," said Elke Thoss, director of the Profamilia family planning association in Germany. "Women — particularly East German women — have shown that they can be very rational and pragmatic about their sexuality."

Combined with what some consider a reluctance — if not a hostility — toward raising immigration rates, Europeans fear they are taking on the look of a dying culture. Experts disagree, however, whether self-preservation tactics could lead to reverberations against family planning.

"People don't take kindly to the idea that their own nationality may not exist 10 years down the line," said Carl Haub, PRB demographer. "Low fertility and how to compensate for it is definitely the hot topic in Europe these days."

Family planning tradition

If Europeans are searching for a solution to the birth problems, reproductive health officials are confident that the last place they'll look for blame are family planning clinics. Contraceptive availability in Europe has always been high, PRB notes, with many countries sporting liberal abortion policies. Tampering with reproductive freedom, many agree, is out of the question.

"It is too simple an explanation," said Germany's Thoss. "We have been a contraceptive society for years. We can't go back now."

If any area of the region is poised for a contraceptive backlash, observers suggest, it is likely to be Eastern Europe where pro-natalist policies have typically been backed by a high — but illegal — reliance on abor-

tions. Introducing birth control into the former communist cultures has been an uphill battle.

"They're worrying about falling birth rates so they can't understand why they should place a value on family planning," said IPPF's Newman. "A contraceptive mindset doesn't come automatically. The first reaction of most people is to restrict its access."

born in that country once they reach age 18.

"The Europeans will not use immigration as a solution," said PRB's Haub. "They don't see themselves as melting pots like the U.S. If a foreign-born population becomes truly visible — at, say, 5% — then they start to get worried."

If Europe further reduces its marginal immigration numbers, experts agree that a



Europe as a whole boasts only 12.8 live births per 1,000 population — a remarkably small figure that indicates a graying culture. Italy sports only a 1.3% total fertility rate. People over 65 make up 14% of that nation's population.

In Europe, the latest reaction has been to make childbearing a more attractive option to couples. Most nations offer cash allowances to families with two or three children. In Italy, two-child families receive U.S.\$14 per month while three-child families are given \$54 per month. In some countries, the sums increase even more significantly with the third child. French families' monthly allowances rise from \$77 for two children to \$175 for three. Before unification, West German families received \$62 for two children, \$153 for three. In Luxembourg, the allowance skyrockets from \$30 for two children to \$285 for three.

"If I'm thinking of having a child," Newman said, "I'd look at my country's housing, education, health care. I'd look to see if the infrastructure is favorable to having children. I certainly wouldn't shut down the family planning centers."

No immigration answer

While some have suggested encouraging immigration to solve the European population woes, many nations have gone in the opposite direction. Although 85% of Italy's growth is due to immigration, the nation allows fewer than 16,000 immigrants within its borders each year. Despite its work force shortage, Germany has tightened the reins on its immigration policy. France, meanwhile, has repealed a law that automatically awarded citizenship to people

rising black market immigration business could put pressure on governments to counter with a more pro-natalist policy.

"If you were running for office and you wanted to look like a populist and a tax-cutter, I could see talk of cutting family planning access," Newman said.

In some areas, a few politicians have already begun to play on the fertility fall. One candidate in Milan's recent mayoral election sent a letter to his constituents urging them to reverse the shrinking population trend. Blaming a recent accent on women's rights in Italy for the birth dearth, he wrote, "The smile on your children is worth a hundred times your desire to be free."

If that message hasn't scared family planners just yet, it has raised an eyebrow or two and begun the debate over whether family planning can lower a birth rate too far.

Although Romania's disastrous Ceausescu regime is the only European nation to ever curtailed contraceptive services in order to increase fertility, experts note that the idea — however far-fetched — is not unprecedented.

"We want to stimulate dialogue on the issue, but we don't want to actually stimulate a hostility to family planning," Newman said. "The thought here is that somebody eventually will make the connection if we don't take the problem seriously."

CONTRACEPTION IN WESTERN EUROPE

A CURRENT APPRAISAL

EDITED BY E. KETTING

An International Health Foundation Symposium

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Preface <i>E. Johannisson</i>	vii
List of participants	ix
Introduction by the Chairman <i>D. de Wied</i>	xi
1. Family Planning in Western Europe: An overview of major issues <i>E. Ketting</i>	1
2. Contraceptive behaviour in Western Europe: Some features of eight country surveys <i>F.E. Riphagen</i>	9
3. France: A change of policy <i>J. Cohen</i>	13
4. Denmark: Adapting legislation <i>M. Osler</i>	19
5. Sweden: Focus on sex education <i>B. von Schoultz</i>	23
6. Spain: Ten years of progress <i>J. Lohard</i>	29

Medical journalists from the eight countries were also invited. The role of the media as an important source of information is well established. Education of the public in matters of contraception has been a frequently pursued interest of the media. In view of the sometimes apparent lack of adequate information among the public and the sometimes unfavourable image of certain contraceptive methods, professional providers of contraception need the assistance of the press and other news media.

Finally, a number of representatives from pharmaceutical companies active in the field of contraception, notably oral contraceptives, participated in the meeting.

The development of new contraceptives and the improvement of existing ones require important commitments from the pharmaceutical industry, which justifies their interest in what takes place at the consumer level.

The International Health Foundation expects that this meeting, which brought researchers, health care professionals, policy makers, and representatives of the media and the pharmaceutical companies together, will promote successful family planning and contraception in the countries of Western Europe.

1

Family planning in Western Europe: An overview of major issues

E. Ketting

The objective of this chapter is to assess and discuss the major common issues and questions regarding family planning and contraceptive use that have been relevant in the past in Western Europe and to look for common trends in the development of family planning.

THE GENERAL ACCEPTANCE OF FAMILY PLANNING

During the past 25 years, European countries have witnessed a contraceptive revolution with two major characteristics. The first of these was that the idea that couples had a moral right to decide freely on the number and spacing of their children became generally accepted – individually, socially and politically. Secondly, a whole new generation of reliable and safe methods of contraception became available and was accepted.

This revolution has been so radical that the traditional question “Why do women or men use contraception?” has now become irrelevant. The relevant question nowadays is “Why do some people not use contraception?”. Contraceptive use has become a new social norm, and non-use has come to be considered as almost deviant behaviour, which people feel they must justify. Only when there is an explicit desire for pregnancy is the non-use of contraception considered acceptable.

Three factors have been of the utmost importance in the general acceptance of family planning. First of all, the fact that many pregnancies – and children – were not wanted gradually became accepted as a major individual, social and health problem. The fact of many children being unwanted has come to be recognized as a problem for these children themselves and for their parents, as well as being a general social problem.

Secondly, unwanted pregnancy came to be recognized as the cause of induced abortion, the latter being a major ethical, medical, social and psychological problem. Today it seems obvious that induced abortion results from inadequate contraceptive use, but until well after World War II induced abortion was almost exclusively defined as a criminal rather than a social and medical problem. As a result of that definition, family planning could not be seen as the correct solution to the problem of induced abortion. It was generally believed that the family planning philosophy was not the solution to, but rather the cause of induced abortion, because this philosophy taught people not to accept unwanted pregnancies, while at the same time adequate means of preventing these pregnancies were not available. Only after new, reliable contraceptive methods had become available could a preventive approach to the problem of induced abortion develop. A major breakthrough occurred only after the oral contraceptive pill had been introduced.

Finally, as the number of children desired by couples diminished, the need for effective methods which would enable people to separate sexuality from procreation grew. Sexuality is today related to the wish to become pregnant only during a relatively short period of people's fertile lifespan, but at the same time most people want to retain the possibility of having intercourse during the many years in which they are not seeking a pregnancy.

Seen in the context of these three basic reasons, which extend beyond family planning, contraception is not merely a method of preventing conception but is also a preventive health measure meant to prevent induced abortion, as well as a psychological measure, as its objective is to make possible sex without fear.

These three issues, taken together, render contraception a complicated issue. Contraception should be reliable, should have no adverse health effects and should facilitate rather than disturb sexual pleasure. What emphasis is put on each of these three elements will vary with time, and

among different countries and cultures and different social groups. This explains why discussion about the advantages and disadvantages of contraception is on-going and will probably continue into the future. Contraception is and will remain a multifaceted issue.

The relationship between induced abortion and contraception is also of great importance on a more practical level. Major changes in the fields of both contraception and abortion have taken place during the past 25 years in Western European countries, but these have not always coincided. In some countries, such as the United Kingdom, Denmark, Austria, France and Italy, abortion legislation and practice were changed before contraception became widely available and large-scale contraception campaigns were launched. As a result, these countries initially showed high abortion rates, which tended gradually to decrease after a few years. In some other countries, including Sweden, Germany and Spain, the contraceptive revolution coincided more or less with the liberalization of induced abortion. In a few countries, notably the Netherlands and Belgium (not included in the IHF survey; see later), contraception became widely available and contraceptive services accessible before abortion became legal. Probably partly as a result of this, the abortion rate in the Netherlands, and most likely also in Belgium, is comparatively low.

By the time abortion laws were being changed in Western Europe, it was generally felt, including on a political level, that contraceptive use should be improved in order to prevent abortion rates from rising. This line of thought still prevails, but a new element has entered the discussion: low birth rates. In several European countries, the question of what influence the legalization of induced abortion might have on the birth rate is currently a controversial subject.

Birth rates are increasingly felt to be too low in Western Europe and abortion rates are always felt to be unacceptably high. It thus seems sensible to try to reduce the abortion rate in order to raise the birth rate. This line of reasoning has been more or less accepted in some countries, notably in Germany. It is to be feared that as a consequence of this development, the political climate regarding contraception could worsen. If abortion is no longer viewed as a problem to be prevented by better contraceptive use, but rather as a cause of an unacceptably low birth rate, an important political motive for improving contraceptive behaviour will have been lost.

THE QUALITY OF FAMILY PLANNING

The quality of family planning and contraceptive use in a country depends primarily on three factors:

- (1) ample availability of contraceptives,
- (2) easy accessibility and good quality of services,
- (3) sufficient knowledge of contraception and motivation for use.

Availability is no longer a major problem in Western European countries, although there is still room for improvement. Availability should mean availability of a wide range of different contraceptives. During the past two decades, there has been some discussion as to whether or not 'the ideal method of contraception' could theoretically exist. This idea has more or less been left behind. The circumstances in which contraception is used differ too widely to make possible a single ideal solution.

The availability of a wide range of contraceptives is sometimes restricted by legal regulations. In Western Europe, almost all legal restrictions have been abolished, although contraceptive sterilization has not been fully legalized in some countries. Furthermore, there are still legal barriers to the availability of contraception for minors in a few countries.

Apart from legal restrictions, contraceptive availability is sometimes influenced by the position and role of service providers. Sweden is an interesting example in this respect. When the midwives in Sweden started to provide contraceptive services in the late 1960s, they were only allowed to insert IUDs but not to prescribe pills. Possibly as a consequence of that, IUD use in Sweden was much higher in the 1970s than in other, comparable countries.

In England or the Netherlands, the general practitioner (GP) or family doctor is the main provider of family planning services. In the Netherlands, the predominant role of the family doctor in this area has in fact largely limited the availability of contraceptive methods to oral contraception. The pill was almost the only method the family doctor could prescribe, as condoms were sold in pharmacies and drugstores, while gynaecologists and urologists were responsible for the IUD and sterilization, and other methods were thought to be too unreliable. As a consequence, the pill became the dominant method in family planning in the Netherlands. No other country has ever shown such a high pill use rate as did the

Netherlands in the mid-1970s. Institutional factors such as these still influence the availability of contraceptive methods in Europe at present.

In addition, the opinions of providers sometimes limit the availability of contraceptive methods. For instance, the availability of contraceptive sterilization varies widely among and within European countries according to whether gynaecologists and urologists regard this method as acceptable.

The *accessibility of services* is the second determining factor for the quality of contraceptive use. Here, a distinction should be made between formal and informal accessibility.

As regards the former, two aspects are of major importance: legal rules and financial barriers. In general, most legal barriers to the accessibility of contraceptive services have been removed in Europe in the past 20 years, but every now and then this situation is again threatened. The so-called Gillick case in England, which was an attempt severely to restrict the accessibility of services for minors, is a good example.

Financial accessibility differs widely among, and sometimes even within, European countries. In some countries services are free of charge: this is the case in England and, for the majority of the population, in the Netherlands. In other countries, such as Denmark and Austria, contraceptives must be paid for by the user. Together with differences in the cost of medical consultation and the price of contraceptives, this might be an important explanation for differences in consumption rates and, as a result, differences in abortion rates.

In this respect it is interesting to note that in several countries, for instance West Germany, abortion services are free of charge, whereas contraceptive services are not. From a financial point of view, this looks like an invitation to rely on induced abortion rather than contraceptive use as a means of birth control. As the costs of medical services continue to increase, causing politicians great concern, the financial availability of family planning services may be threatened in some European countries in the years to come.

Social and cultural barriers to the accessibility of services are at least as important as legal and financial ones. Discussing contraceptive use invariably involves talking about sexuality and the relationship with the sexual partner. Such topics being rather sensitive, accessibility in practice means that the service and the service provider should be trustworthy, not just professionally but also emotionally. The patient, or rather the contraceptive user, should feel safe and at ease, as well as being taken

seriously. Most importantly, particularly for minors, he or she should not feel ashamed of having sex or be afraid of being blamed for this.

Accessibility in this respect is mainly determined by the general cultural outlook regarding sexuality. Several studies have shown that in countries where sexuality is not a taboo subject, but is dealt with openly, people – particularly youngsters – tend to use contraceptive services most easily. Differences in cultural openness regarding sexuality seem to be the strongest determinant for contraceptive use among adolescents.

The third major determinant of the quality of family planning is *knowledge and attitudes towards contraceptive use*. During the past two decades, knowledge about contraception and its proper use has greatly increased in Europe. The level and accuracy of knowledge on contraception is primarily dependent on the amount and quality of the information the general public receives. The dissemination of this information is again largely dependent on the cultural atmosphere regarding sexuality and contraception, which varies widely among European countries.

If these areas are difficult to discuss openly because they are felt to be too sensitive, opportunities to discuss them in the popular media or to include them in school curricula will be rather limited. In this field, there are obvious differences between the rather open northern European and the more restrictive middle- and southern European countries.

Information is primarily disseminated in three ways. The first is by means of formal education in schools or through large-scale information campaigns, usually organized by central government. Only a few European countries have adopted formal sexual and contraceptive education. The Scandinavian countries are the furthest ahead in this respect. Some countries, such as France and West Germany, have launched large-scale public information campaigns. But in countries like Spain, Italy and Austria, the public at large has barely been educated in the field of sexuality and contraception.

Secondly, professional service providers are an important source of information. However, sometimes these professionals seem to be too professional, meaning that the information they convey is too technical to appear relevant to the average patient.

Finally, the popular media, radio, television, women's weeklies and newspapers, play an important role in this respect. The importance of this role can hardly be overestimated, although far too little is known about

the actual impact of the media in shaping popular knowledge about contraception.

The question of attitudes towards contraception is one of the most difficult to deal with, because these attitudes can hardly be separated from those concerning childbearing, women's roles, sexuality and partnership. This means that the choice of method cannot simply be understood in terms of objective advantages and disadvantages of different methods. Women and couples evaluate such advantages and disadvantages in terms of their personal situation and personal experience. When it comes to the more 'objective' criteria for choice, health, reliability, interference with sex life and ease of use are the most important factors.

In general, health has become a more important criterion in the past decade, whereas reliability seems to have become somewhat less important. It is possible that the gradual acceptance of induced abortion as a last resort method has influenced this development. However, it should be mentioned that women rarely are willing to accept a less reliable method because they can use abortion as a back-up possibility. It seems more likely that the medicalization of contraception in general (contraception being the competence of doctors) has caused a growing emphasis on medical, i.e. health aspects of contraception.

The trend towards medicalization is widely reflected in the way the media are dealing with contraception. This shift of emphasis has made contraceptive use more dependent on information concerning relative medical risks and benefits of contraception, and this will probably continue to be the case.

In spite of this, non-interference with sexual intercourse and ease of use have remained important criteria for the evaluation of contraceptive methods. Methods that strongly interfere with sexuality and that require scrupulous use, such as the diaphragm or the temperature method, have never become popular in Europe, although they might appear to be less damaging to health. Even condom use does not seem to have increased greatly, in spite of the AIDS threat.

Contraceptive behaviour in Western Europe: Some features of eight country surveys

F.E. Riphagen

Between 1984 and 1988, the International Health Foundation conducted surveys aimed at assessing contraceptive behaviour in women aged 15-44 in eight European countries. In chronological order, these were Italy, France, Great Britain, Spain, the Federal Republic of Germany, Austria and Sweden, for which full reports have been published elsewhere¹⁻³, and Denmark, the data for which are still to be published.

A comprehensive comparative analysis of the data from these surveys is presented in the Appendix to this report. Some of the major aspects of this analysis are discussed here.

There was considerable variation in overall contraceptive use from one country to another. The rate for overall use was high in Great Britain, Sweden and Denmark and low in Italy and Austria. Spain represented an anomalous case because of the relatively large proportion of women who were not (or claimed not to be) sexually active.

Differences in use rates also varied considerably from one method to another. The IUD, less popular than barrier methods, was more widely used in the southern European countries and the Scandinavian countries, while sterilization was frequent only in Great Britain and, to a lesser extent, Denmark.

Pill use was high in most countries surveyed. The only exceptions were Spain, where use was moderate, and Italy, where it was strikingly low. Correlations between use and age, number of children, and educational

level were similar in all eight countries. Oral contraceptives were widely used by young women for the purpose of child spacing.

Doctors were an important source of information in all the countries studied, in contrast to family planning clinics, which played a very insignificant role in providing information, especially in view of the fact that these institutions are often established precisely for the purpose of providing service to high-risk groups. In all eight countries, informal sources as a whole were at least as important as formal sources.

There was a shift of emphasis when it was advice that was sought, however. Here, the most important source was either the gynaecologist or the general practitioner: this varied from country to country according to the nature of the health care system. Informal sources played a much smaller role in providing advice. However, it was still the case that, with the exception of Great Britain, the role of the family planning clinic was minimal.

This pattern unfortunately provides considerable scope for the dissemination of less than accurate information concerning contraception, particularly among vulnerable groups of women such as those under the age of 20 and those who are less well educated. The impact of institutionalized sex education, found in Sweden and Denmark, was observed in those two countries only, and only to a limited degree.

Correct knowledge of fertility tended to correspond to educational level and to be low among 15–19 year olds. The level of knowledge generally was higher in the northern European countries than in the southern European states and Austria. Even when knowledge of fertility was adequate, however, practical knowledge was not necessarily at the same level: in Austria, for example, 40% of women taking the pill practised the 'Pillenpause', which was also common in Germany.

Distribution of oral contraceptives in Great Britain and Denmark is always through the general practitioner, as a result of the structure of the health care system in these two countries. In the other countries studied, gynaecologists are readily available through family planning clinics (Italy, Spain) or on an individual, private basis (Italy, France, Germany and Austria). The family planning clinic midwife is an exclusively Swedish phenomenon. These midwives are the main providers of IUDs and diaphragms. Female sterilization is always the responsibility of the hospital-based gynaecologist.

Family planning doctors, who work out of family planning clinics, are found only in Great Britain, where they are the first providers of IUDs, as well as providing pills and diaphragms.

In those countries where overall contraceptive use is the highest (Sweden, Denmark and Great Britain), reliable reversible methods are under the supervision of a general practitioner or are provided within the framework of a well-developed system of family planning clinics.

Of the eight countries surveyed, the highest overall use rates were found in Great Britain, Sweden and Denmark – the three countries offering the least expensive range of contraceptive methods, with primary health care comprising the key personnel involved in contraception and family planning.

Contraception was seen as a health issue in all eight countries. Health reasons were the principal motive for change of contraceptive method, and a high degree of concern was expressed about the safety of the IUD, sterilization and the pill in general, and about serious, irreversible health effects in connection with the latter in particular. These perceptions were quite consistent among all countries and all groups surveyed.

The number of women who had had experience with oral contraception was highest in Great Britain, Sweden and Denmark, as was the percentage of women with accurate knowledge of the pill's mode of action. Respondents in these three countries, as well as in Germany, widely acknowledged the advantages of the pill, but it was clear that they also saw the pill as a possible cause of serious health problems such as infertility, cancer and heart disease. Indeed, the proportion of women seeing these risks as inherent in oral contraception was high in all eight countries.

Similarly, the IUD was perceived as harmful by Swedish and Danish women. As a method, the IUD is less well known than the pill and has enjoyed less media attention.

In the case of the pill, these results confirm those found in the United States,⁴ and they were supported by an opinion poll conducted in a number of developing countries^{5a}. Explanations for this negative image have been suggested by Ketting⁷ and Riphagen⁸.

This is an issue that needs to be addressed more fully. The number of women risking an unplanned pregnancy still seemed unacceptably high in all countries other than Great Britain, Sweden and Denmark. Although a high percentage of women found the pill an attractive contraceptive despite its perceived disadvantages, it is clear that there is a need for the wider dissemination of practical, accurate information about oral contraception – particularly the newer formulations – by the media, doctors and health professionals in general.

It was also clear from the results of the surveys carried out in Great Britain, Sweden and Denmark that it is justifiable to draw a connection between a high use rate of reliable contraceptive methods and high levels of contraceptive awareness and integration, and systems with a tradition of family planning and sex education, where inexpensive contraception is made available under the supervision of primary health care personnel.

Our results show that during an interval spanning from four to eight years before the disappearance of formal borders between EEC Member States, considerable differences still existed between the countries involved in this study, six of which are Member States, concerning social issues such as family planning and contraception. Although some of these differences might reflect various stages along a single developmental path leading towards the same end point, national and cultural identities will persist, and there will probably never be a uniform pattern of European contraception.

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3

France: A change of policy

J. Cohen

Until recently, France has been a country quite strongly opposed to contraception. Legislation against contraception and abortion was introduced after World War I for demographic reasons. As late as 1944, a midwife was sentenced to death for performing an induced abortion. That was not so long ago.

In 1956, the *Mouvement Français pour le Planning Familial* was founded. It was completely illegal at the time. I was the representative of the medical students then, and we started a campaign in favour of contraception. Others involved in the movement were Marie André Lagard and Pierre Simon.

Three French Nobel Prize winners gave us strong support and then, in 1967, Lucien Lévy proposed legislation in favour of contraception. These proposals were accepted by Parliament in 1974; since then, contraception has been completely free in France.

Between 1967 and 1974, contraceptive pills were sold in France for medical purposes that were other than contraceptive. Thus, they were in fact technically available. In 1974, as well, induced abortion became legal in France.

I will present some data from studies done in France since 1965, most of them by Leridon of the Institute of National Studies on Demography (INED). Data from the most recent study, which was carried out in 1988, have been published in *Population*.

Introduction

While the exponential growth of the global population has been about 2% annually in the last century, it is well known that particularly in industrialised countries fertility rates have dropped dramatically in the past decades.¹ The trend towards declining birth rates is difficult to explain in countries like Bulgaria. Although the country's population is still increasing (from 8,862,000 in 1980 to 8,981,000 in 1988), the birth rate fell below replacement level in 1980^{2,3}. In recent years the population started to decrease. There seems to be a trend to 'compensate' for this decrease with an increase in teenage pregnancies. According to several investigators, this is an undesirable and problematic development in many respects^{4,5}. Until recently, this problem was not freely discussed in Bulgaria because of the political situation, but today the importance of the rise in these pregnancies for society, and the price that young mothers and their often unwanted children have to pay is a potential danger for the future development of the country. This 'emotional crash', 'partial bankruptcy of society' or 'social problem' as it is called by some experts⁶ is another part of the total crisis following the fall of communism. It will deepen the economic polarization in the country and between this country and the industrialised west.

Clinical experience

In our clinic in Pleven, in a three year period, 1191 babies were delivered by mothers under 18, 11.7% of all births in the clinic in that period. Out of these 1191 mothers, 271 (23%) had not even reached 16. At the same time 1781 teenage girls had induced abortions, 17.7% of all abortions performed in our clinic. In the last decade the number of teenage abortions went up by 3.5% and teenage births increased by 8.5%. Some textbooks and scientific papers point out that there are many more obstetrical complications among the elderly and teenage girls during pregnancy and delivery, while others insist (as our own experience indicates), that the problems especially of teenage mothers are not mainly obstetrical^{7,8}. The major problem is the difficult, usually unsuccessful integration of the girl-mother and her offspring into a hostile or indifferent society^{6,9}.

Teenage mothers under the age of 16

Marital status: Sixty-one point three percent of very young mothers are unmarried. In Bulgaria, one may marry at 18 years of age. Under that age written consent of the parents and special permission from the local court is required. Marriage is illegal if one of the partners is under 17. These obstacles to marriage may partly explain why 11.1% of teenage mothers left their newborn babies for adoption.

Parity: Thirty-nine girls from the investigated group became pregnant for a second time before reaching 16, and half of them delivered a second baby.

Education: Twenty girls were illiterate while 73 of them only had primary school education; 63 of the remainder left school between the age of 14 and 16 because of their pregnancy.

Employment: 155 (57%) of young mothers worked in factories, 44 (16%) were employed by State-owned farms as agricultural labourers. This means 73% of the teenage mothers under 16 had jobs although the law does not permit people under 16 to be hired workers. This violation of the law remains the only possibility for these girls to earn a living, but the financial burden also falls on their relatives.

Lack of sex education and family planning

In the Pleven region, the percentage of teenage births for girls under sixteen over three years was 2.7%, which is higher than in the USA, Poland and the former USSR. It is not possible to clarify all the reasons for this phenomenon, but it remains a major threat to the demographic structure and potential of society. Teenage pregnancy and teenage motherhood are not only linked to economic development, social structure or religion, although these factors are relevant to some degree - the lack of family planning and sex education programmes are major contributing factors. The democratization of the press led to an explosion of cheap and accessible pornographic literature. This filled the gap created by a lack of sex education and contraceptive programmes. At the same time there is little opposition from the Orthodox church to modern contraception and there are adequate supplies on the market, but they are unpopular because of high prices and lack of understanding. The price for an induced abortion equals that of one cycle of contraceptive pills. Abortion therefore remains the most popular and affordable method of fertility control and teenagers are nearly 20% of all abortion patients.

We believe that the data presented reveals the existing crisis in sexual education and family planning in Bulgaria, which causes a serious threat to the demographic structure of society and has a negative impact on all aspects of life, with quite dramatic long term consequences.

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Youth Work Initiatives in Moscow

Valentina Popova*

The Moscow Centre for Forming Sexual Culture in Youth began its work in January 1990 and continues with its humanitarian activities in spite of considerable difficulties. It offers an anonymous consultative service for teenagers and is unique in offering such a service in Moscow and quite possible in the Commonwealth of Independent States (CIS). Our Centre works directly with the teenage audience and we meet more than 6,000 young people each year. The various experts at hand include psychologists, gynaecologists, sexologists, venereologists, narcotics experts and general practitioners.

Teenagers' problems

The problems of teenagers, which are closely associated with their self-dependence and entry into adult life, cannot be solved merely with the help of a telephone call. They come to our Centre, not only from Moscow but also from provincial towns and even other Republics. The most frequent reasons for teenagers coming to the Centre include rape, pregnancy, venereal diseases (sometimes as a result of rape), homosexuality, masturbation, transsexuality and others. Usually the parents know nothing of their children's problems.

Sometimes girls who ask for advice on contraception are not having sexual intercourse but are apparently preparing themselves in advance. However, more often it happens that a girl has a regular sexual life and does not bother with contraception, or takes the advice of her friends on natural methods without being familiar with the rhythm of her menstrual cycle.

Our children, teenagers and even adults have little knowledge of their anatomy and physiology because the government pays insufficient attention to this aspect of the educational sphere. The absolute ignorance of teenagers regarding sexuality and sexual life might be illustrated by a recent example of a 15 year old girl who came to us as she was anxious about her periods having stopped. It was discovered that she had been meeting regularly with a 19 year old boy. She had not been taking any contraceptive measures and considered ovulation to be the safest period.

The Russian situation

A very difficult problem is that of helping under-age pregnant girls who do not wish to inform their parents of their situation. Legislation does not allow for a medical abortion before the age of 18 years without the parents' permission. Although a directive from the Moscow medical administration exists which authorises abortions in extraordinary circumstances, physicians are reluctant to shoulder this responsibility. Especially tragic are the situations when girls come to us for help, nearly full term in their pregnancy.

Up until now the possibility of contraception for our women has been an abstract subject - because of ignorance, lack of advertising, difficulties in obtaining consultations and shortages of contraceptives. As before, abortion is still the main method of regulating the birth rate and it remains a national tragedy.

This problem is especially aggravated now, in the present economic climate, when undernourishment is a serious problem and mothers do not know whether they will be able to feed their children tomorrow. If today one kilogram of butter costs a quarter of a physician's or a teacher's salary, what can we expect for our children tomorrow?

An appeal for help

One positive result of last year's work is the increase in the number of visits by young girls who are seeking advice on contraception, and this accounts for 20-25% of all consultations with gynaecologists. However, the Centre has no funds for advertising so teenagers become aware of our services from the rare newspaper articles or television broadcasts. Sadly we often receive letters from children, teenagers and adults when it is too late to give help. In addition, the anonymity of our service gives us no opportunity to monitor the fate of our clients.

Though several family planning associations and governmental structures have been formed to deal with these problems, practical organisations such as our Centre which work directly with young people do not have any financial and organisational support and their existence is dependent on pure enthusiasm. Our appeals to various organisations have not resulted in any concrete support. We need, free of charge, large supplies of contraceptives for demonstration, advertising and distribution to young people. We also need audio and video equipment, tapes and other materials.

Besides the work with teenagers, our Centre conducts training of specialists in the areas of child and teenage development and education, whose work will be invaluable in the years to come. We are certain that the more teenagers know about how to care for themselves and their children, the more valuable our efforts will be in the fight to save our people's lives and futures.

Valentina Popova can be contacted at:

*Center for Forming Sexual Culture in Youth
4 Marshal Sokolovsky Street
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Russia*

***Valentina Popova is Director of the Moscow Centre for Forming Sexual Culture in Youth.**

Sexual Education in Transition in Bulgaria

Dr Roumen Bostandjiev*

The dominant approach to sex education, and every other ethical issue in Bulgaria, is still rooted in the socialist and collective ideology of previous decades. Attitudes to sexuality result from a tradition of patriarchal and authoritarian human relations, in which individuality was subordinated to the values and interests of the extended family and society. In this context sex education was primarily oriented to social control over individual behaviour.

The centralised hierarchical political system defined all needs of the various sectors of society. The prescribed task of school authorities and teachers with respect to sex education was to repress adolescent sexuality and to maintain institutional control over their personal behaviour. The justification for this approach was to reduce the high rate of induced abortions and divorces. Human sexuality was generally dealt with in a moralistic and "medicalised" way, while deviant behaviour was subject to sanctions.

A new humanistic approach

During the last decade the ineffectiveness of this approach became evident. The few specialists in the field attempted to introduce humanistically-oriented education programmes, aiming to show that misfortune in intimate life was not due to insufficient social control, but was a logical consequence of authoritarian control that handicapped the development of personal growth and responsibilities.

In 1988-89 we developed and tried to introduce into schools two new educational programmes: "Prevention of AIDS Depends on You and Me" and "In the World of Intimacy", aiming to increase students' abilities to make well-informed, individual decisions and to develop personal maturity. The pupils participated with great interest and pleasure, but reactions from the official school authorities were ambivalent. Even in the few cases where school official resistance was overcome and teacher training was organised, such initiatives remained marginal and alien to the repressive character of the educational system.

Resistance to change

The radical political changes of the last few years gave way to a slow and difficult process of social change, in which social groups at the bottom of society gradually started to express their needs. At the same time some key people in State institutions, especially those lacking real qualifications and abilities in sex education, began to feel insecure in their roles and so merely pretended to support change. In fact they protect their powerful positions by repressing any kind of independent activity, using their positions to maintain financial and administrative control.

Private initiatives

Being aware of the situation, a group of like-minded specialists (school psychologists and psychotherapists) with similar psycho-social convictions decided to create an independent professional organisation, called **Modus**. Modus aims to develop educational and training projects in schools

and universities, with family and sexuality education taking first priority.

To start with, our plan was to clarify the existing needs in the field of sexuality/family life education. In November 1990 we organised a national meeting to discuss these needs, inviting over 200 people from different social and professional groups involved in sex education: students, teachers, school officials, health workers, journalists, politicians, etc. On the first day, each group clarified their specific problems, needs and potential activities. Then the groups shared their results, made concrete agreements, and used this experience to draw up a plan for co-ordinated action. The main difficulties now in implementing this plan are the shortage of funds for social and cultural activities and the lack of complete independence of the schools.

Meanwhile, in March this year, several members of Modus formed the **Council for Sexual and Family Health** to deal predominantly with psycho-social aspects of sexuality, family life and parenthood. From our private office in Sofia, our work reaches in three main directions: psycho-sexual counselling - individual, marital, family and group therapy; the development and implementation of family life/sexuality education programmes in schools and for specific social groups (ie. parents, single people, physically disabled people, etc.); and the development of sex education programmes for university and post-graduate students of pedagogy, psychology, and medicine, with workshops and training courses for other specialists concerned with the problems of sexuality and family life. We try to create therapeutic teams, and have invited the most prominent psychotherapist in Bulgaria to supervise this work. In our educational projects we work with small groups, using group dynamics, a person-centered approach, psychodrama and other methods. We have recently signed our first contracts with three new universities in Bulgaria. In the curriculum for pedagogical students "sexual education" and "psychosexual counselling" are already included.

Future plans

The Council of Sexual and Family Health and Modus are the only private organisations involved in sex education in Bulgaria. We intend to organise a wider professional network, through which state institutions and new private organisations can collaborate. We believe that independent professional groups like ours are best situated to respond to the need for sex education. However, to develop our activities we need good office facilities (computers, telefax, video-systems, etc) and better information sources. As for us, the exchange of ideas and experience is extremely important, so we will be very grateful for any assistance.

*Dr Bostandjiev may be contacted at:
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**Dr Bostandjiev is a member of the new, privately organised "Council for Sexual and Family Health" in Sofia, Bulgaria.*

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From: NEWSTAB

Delivered: Wed 17-Mar-93 13:52 EST

MANY POLISH TEENAGERS DO NOT USE CONTRACEPTION, POLL SHOWS
WARSAW, March 17, Reuter - Staunchly Roman Catholic Poland on Wednesday announced a campaign to make contraceptives more widely available after a survey showed many young people were not using them.

Family planning expert doctor Anna Firek told reporters a recent survey carried out among Warsaw students aged between 16 and 19 showed that half had had sex before they were 16 and 80 per cent of those used no form of contraception.

"When it comes to awareness among young people, the situation is as bad as it was many years ago. Young people are totally unprepared," she told the news conference, organised by the health ministry.

Contraception has come under the spotlight in Poland with the passing of a strict anti-abortion law after a long pro-life campaign by the powerful Roman Catholic church.

A clause of the law, which came into effect on Tuesday, obliges the government to provide sex education in schools and ensure that contraceptives are easily available.

"We will be carrying out checks on pharmacies to find out whether contraceptives are generally available," said deputy health minister Dr Marek Balicki.

A recent report by the U.S. foundation Population Action International put Poland near the top of a list of countries with the worst family planning programmes, along with Russia, Iran and Pakistan.

REUTER PSF JMM

(from IPPF)

Glamour ... Feb. 1994

Traditional views: Do they threaten young women's health?

 A NEW STUDY OF MORE THAN 1,600 TEENS, AGES 14 to 16, shows that girls who hold traditional beliefs about gender stereotypes are the most likely to lose their virginity at a younger age. The teens were first asked about their attitudes in sixth, seventh and eighth grade, then asked about their sexual activity two years later. By then, 32 percent of the girls had lost their virginity.

Girls who agreed with statements such as "Most women can't take care of themselves without help from a man" and "Most men want to go out with women just for sex" were more likely to be sexually active during the two years of the study than were those who had disagreed. One of the authors, Vangie Foshee, Ph.D., of the School of Public Health at the University of North Carolina in Chapel Hill, explains, "These young women may not *want* to have sex, but if they buy into traditional stereotypes, they may be more willing to be submissive and go along with what a man wants." That is consistent with findings from her current research: Teens who hold stereotypical gender views are more likely to be in abusive dating relationships. Other studies show that teenage girls with traditional views are less likely to use birth control; this new research adds to the evidence that they are more at risk for STDs and pregnancy.



*Population Action
International*

Formerly Population Crisis Committee

Nongovernmental Organizations In International Population and Family Planning

Today's awareness of world population problems owes much to the work of nongovernmental organizations. The private sector has traditionally taken the lead in this field, pressing governments of both developed and developing countries to adopt appropriate policies and to extend family planning services and education nationwide. The multiplicity of organizations in the population field is a sign of great interest, commitment, and vitality.

Population organizations worldwide now number in the hundreds. This listing is necessarily selective. It includes organizations with a minimum annual budget of \$500,000 and an international focus on funding or technical assistance for family planning programs, publications of influential materials, or extensive public outreach and political influence.

Africare, Inc.

Africare House 440 R Street N.W.
Washington, D.C. 20001

Telephone

(202) 462-3614

Telex 64239

Cable

Fax (202) 387-1034

Founded in 1971, Africare is a private nonprofit development assistance organization that supports rural African projects in water resource development, food production, health, relief, and refugee assistance. Funding is from individual contributors, foundations, corporations, the U.S. Agency for International Development (USAID), U.N. agencies, host governments, and other nations. Africare's population and family planning assistance is principally through the technical, material and financial support it provides to multi-year, self-help child survival and maternal health projects (currently operating in Burkina Faso, Mali, Niger and Nigeria). Africare has a yearly budget of \$14 to \$18 million, and 47 staff members at its headquarters, with an additional 295 staff members overseas. Africare has offices in 19 countries in Africa.

Executive Director: C. Payne Lucas; **Director/International Development:** Joseph C. Kennedy, Ph.D.; **Regional Directors:** East Africa: Alan C. Alemian, M.P.H.; Central Africa: Alameda E. Harper, M.P.H.; Southern Africa: Kevin G. Lowther; West Africa: Robert E. Wilson

Alan Guttmacher Institute

111 Fifth Avenue
New York, New York 10003

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(212) 254-5656

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Fax (212) 254-9891, 614-9203

The Alan Guttmacher Institute (AGI) is an independent nonprofit corporation for research and policy analysis, program evaluation, and public education in the fields of family planning, fertility, population dynamics, and broadly related areas of reproductive health and social policy. Although its major focus is on domestic U.S. programs and policies, AGI is also concerned with international population issues. Regular AGI publications include: *International Family Planning Perspectives*, *Family Planning Perspectives*, *Washington Memo*, and the *State Reproductive Health Monitor: Legislative Proposals and Action*. Annual editions of *International Family Planning Perspectives* are published in French and Spanish. Special publications include *Today's Adolescents*, *Tomorrow's Parents: A Portrait of the Americas* and *Induced Abortion: A World Review*. The 1993 budget of \$4.7 million is derived from foundation grants and other institutional support, USAID, the National Institute of Child Health and Human Development (NICHD), individual contributions, and publications revenues. AGI employs 57 full time staff. A Washington office maintains liaison with U.S. government agencies and monitors legislative and policy developments.

President: Jeannie I. Rosoff; **Chair:** Luella Klein, M.D.

Association for Voluntary Surgical Contraception

79 Madison Avenue
7th Floor
New York, New York 10016

Telephone

(212) 561-8000

Telex 425604 AVS UI

Cable (AVSC): IAFORVS NEWYORK

Fax (212) 779-9439

The Association for Voluntary Surgical Contraception (AVSC) works to make safe and voluntary surgical contraception a known and real choice for all women and men everywhere. Surgical contraception includes female sterilization, vasectomy, implants, intrauterine devices, and other methods that require medical procedures. In 1991-92, international activities accounted for the bulk of \$18 million in expenditures, including support for programs in over 40 countries. Programs stress medical quality insurance, counseling, information and education, client-centered management, service-based training, male involvement, postpartum and postabortion family planning, increased access, sustainability, and evaluation and research.

AVSC's international work is funded by USAID, UNFPA, the World Bank, foundations, and individuals. Four times a year, AVSC publishes the newsletter *AVSC News*; it also publishes a variety of print and audiovisual materials for family planning clients and professionals. AVSC employs some 120 full-time staff in New York and in field offices located in Dhaka, Bangladesh; Bogota, Colombia; Nairobi, Kenya; Lagos, Nigeria; Manila, Philippines; New Delhi, India; and Santo Domingo, Dominican Republic.

President, AVSC: Hugo Hoogenboom; **Director, Planning:** Terrence W. Jezowski; **Medical Director:** Amy Pollack, M.D.; **Director, Field Operations:** Lynn Bakamjian; **Director, Public Affairs:** Libby Antarah; **Director, Administration:** Sophia LaRusso; **Director, Communications:** Pamela B. Harper

Catholics for a Free Choice

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Washington, DC 20009

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(202) 986-6093

Telex

Cable

Fax (202) 332-7995

Catholics for a Free Choice (CFFC) is an educational organization established in 1973 to support the right to legal reproductive health care, especially family planning and abortion. CFFC also works to reduce the incidence of abortion and to increase women's choices in childbearing and childrearing. Through an extensive publications program, including the quarterly news journal *Conscience* and an independent Spanish-language news journal *Conciencia*, CFFC articulates the prochoice Catholic position in English, Spanish, and Portuguese, while exploring moral and ethical considerations relating to reproductive decisions and policy. With an annual budget of \$1.4 million (1993), including \$500,000 for work internationally, CFFC's network includes a regional office in Latin America, a representative in Mexico, and projects in Poland and Ireland.

President: Frances Kissling

Center for Population and Family Health, Columbia University

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Columbia University
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(212) 304-5201

Telex 971913

Cable POPHEALTH NEW YORK

Fax (212) 305-7024

The Center for Population and Family Health (CPFH) works to address some of the serious problems confronting disadvantaged women, children and families around the world. The Center focuses on issues related to reproductive, adolescent, and child and infant health, and is concerned with populations in the United States and in developing countries. Internationally, the Center supports projects that address family planning, primary health care, maternal mortality, AIDS, and other sexually transmitted diseases, and laws and policies as they affect women's status and reproductive rights. Center staff provide technical assistance in project development, training, and evaluation. The Center also offers a Master of Public Health degree, with a focus on population and family health in developing countries. The Center staff numbers approximately 120, and includes professionals from many disciplines. Annual funding is approximately \$10 million, with support provided by local, national and international public agencies and a number of private foundations. In addition to the main office in New York, Center staff are based in Accra, Ghana; Harare, Zimbabwe; Lome, Togo; Kampala, Uganda; and Cochabamba, Bolivia.

Director: James McCarthy, Ph.D.

Center for Population Options

1025 Vermont Avenue, N.W.

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Washington, D.C. 20005

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(202) 347-5700

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Cable

Fax (202) 347-2263

The Center for Population Options (CPO), established in 1980, seeks to educate adolescents about family planning and reproductive health, assure adolescents access to services, and decrease the incidence of adolescent pregnancy and sexually transmitted diseases, including HIV/AIDS, through media projects, materials development and training, school based health centers, and a variety of other efforts.

CPO operates the International Clearinghouse on Adolescent Fertility (ICAF) which provides technical and financial support to youth-serving professionals in developing countries. ICAF's Seed Grants program has provided over \$200,000 to launch 39 innovative programs in Latin America, Africa and Asia including research, peer training, IEC materials development and clinic services among others. ICAF also provides in-country training seminars on the management of adolescent reproductive health programs including use of CPO's widely acclaimed Life Planning Education program, which has also been adapted for use in Latin America as Como planejar mi vida and Adolescência: Época de Planejar a Vida. ICAF's publications include *Serving the Future: An Update on Adolescent Pregnancy Prevention Programs in Developing Countries*; and *Adolescents and Unsafe Abortion in Developing Countries*. Quarterly periodicals include *Passages*, available in English, French, and Spanish. CPO's fiscal year 1992 budget of \$1.88 million is derived from foundation grants and individual contributions. It has a full time staff of 32.

Executive Director: Margaret Pruitt Clark, Ph.D.; **Director of the International Center on Adolescent Fertility (ICAF):** Asha Mohamud, M.D., M.P.H.; **Chair of the Board of Directors:** Robert L. Johnson, M.D.

Centre for Development and Population Activities

1717 Massachusetts Avenue, N.W.

Suite 200

Washington, D.C. 20036

Telephone

(202) 667-1142

Telex 440384

Cable CEFPA

Fax (202) 332-4496

The Centre for Development and Population Activities (CEDPA) was founded in 1975 to provide management and supervisory training to family planning, health, and development professionals in developing countries. It also provides follow-up training and technical assistance in-country, and seed money to grassroots projects initiated or coordinated by CEDPA trained managers. Programs include a five year project to extend family planning services through women managers in developing countries and a project addressing the needs of young women aged 12-20 in areas ranging from family planning to income generation. CEDPA's 1992 budget of \$6.2 million is derived from workshop tuition fees and private, bilateral, and multilateral agency grants. It employs 48 full time staff.

President: Peggy M. Curtin; **Vice President:** Adrienne Allison; **Chair:** Yvonne Maddox, Ph.D.

Committee for International Cooperation in National Research in Demography

27, rue du Commandeur

75675 Paris Cedex 14

France

Telephone

(33-1) 43-20-13-45

Telex

Cable INEDEMO

Fax

Founded in 1972, the Committee for International Cooperation in National Research in Demography (CICRED) seeks to facilitate cooperative research among its 320 affiliated national population research centers. Its publications include: the quarterly *Review of Population Reviews* in English and French; a series of 56 country monographs; the *Directory of Demographic Research Centres*, and the *POPIN Thesaurus* in English, French, and Spanish. CICRED also organizes research conferences and publishes their proceedings. CICRED is funded chiefly by UNFPA and the French government.

Chair: Jean Bourgeois-Pichat; **Vice Chair:** Leon Tabah

Contraceptive Research and Development Program, Eastern Virginia Medical School

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The Contraceptive Research and Development Program (CONRAD) was established in October 1986 with a five year \$28 million grant from USAID to identify and develop new leads in contraceptive technology for use in developing countries through applied fundamental research, clinical studies, and product design and development. The original five year program was extended through December, 1993. In May 1992 it was renewed for another five years, until May 1997. CONRAD's professional and support staff work closely with a technical advisory committee of about 10 leading scientists to support sub-projects worldwide on improved methods of fertility regulation. Current projects in Chile, Mexico and Thailand involve the development of new contraceptive vaccines and injectables, improved barrier methods, including spermicides, and methods suitable for lactating women. Research on the heterosexual transmission of AIDS is also an important area with funding through USAID from MICH and CDC. CONRAD has a yearly operating budget of \$6 million, and 23 full time staff.

Principal Investigator and Director, CONRAD: Henry L. Gabelnick, Ph.D.

Development Associates

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Cable DAWASH

Fax (703) 276-0432

Development Associates is a for profit management and consulting firm with a number of domestic and international social and economic development projects funded by US government contracts. Internationally, the firm works in fields of health, family planning, education, training, environmental protection, drug abuse prevention, justice systems reform, business development and trade promotion. Under current USAID contracts, the firm provides training and technical assistance to family planning service delivery and training agencies in Asia, the Near East, North Africa, Latin America and the Caribbean. Additionally it operates a family planning services expansion project in the Dominican Republic, provides worldwide training for social marketing programs under the SOMARC III project, and implements the family planning and evaluation components of the worldwide PROFIT project. The family planning projects have a combined 1993 budget of \$6 million.

President: Peter B. Davis; Vice President/Director of International Health and Population Programs: Edward S. Dennison

DKT International

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DKT International provides family planning and AIDS-prevention services to improve the health and well-being of low-income families in developing countries. The organization supports and manages three types of family planning activities: abortion, sterilization, and social marketing, emphasizing projects showing promise of substantial demographic success. DKT International is funded by private donors and foundations, and has a budget of about \$2.5 million, and eight professional staff, plus local staff in Ethiopia, the Philippines, Malaysia, Nigeria, Brazil, India (Bombay), and Vietnam.

President: Phillip D. Harvey

E. Petrich and Associates, Inc.

1460 Higuera Street
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Fax (805) 541-2762

E. Petrich and Associates is a firm of development consultants in health care, family planning and population programs. Its two major international population projects are with the National Population Council and the Ministry of Health in Egypt funded by USAID and the government of Egypt for a total of \$5 million. Petrich's average annual budget is \$30 million provided by USAID, the World Bank, Pathfinder International, Family Health International and the Futures Group. It has a staff of 25 plus many independent contractor consultants. Its headquarters are in California and it has offices in Chapel Hill, North Carolina and in Cairo, Egypt.

President: Carol D. Brancich; Vice President, California: Ernest Petrich; Vice President, Cairo: Waleed Alkhateeb

Family Care International, Inc.

588 Broadway
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Cable

Fax (212) 941-5563

Family Care International (FCI) is a non-profit organization dedicated to improving women's health in the developing world, with a special focus on addressing the problems women face during pregnancy and childbirth. FCI fosters crucial networks—global, regional and national—that exchange information, share resources, and launch programs to improve women's health and expand family planning choices. FCI's special priority is working with local agencies in developing countries to design community-level programs that respond to women's needs. FCI operates with a small core staff in New York, field representatives in selected countries, and a roster of leading international consultants and advisors with experience in the development and management of health, family planning, and education projects. FCI's projected budget for 1993 is \$1.8 million. Funding and support for FCI's activities have been received from government agencies, multilateral organizations, private foundations and individual donors.

President: Jill W. Sheffield

Family Health International

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Research Triangle Park Branch
Durham, North Carolina 27709

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Telex 579442

Cable FAMHEALTH

Fax (919) 544-7261

Family Health International (FHI), established in 1971, has worked in more than 80 countries and has one of the largest international networks for evaluating new contraceptive techniques, studying the health consequences of contraception and conducting AIDS prevention programs. FHI assists ministries of health, hospitals and health centers in making more cost effective use of resources, improving access to contraceptive use, and strengthening the quality of care of family planning service delivery programs. Contraceptive introduction, reproductive epidemiology, maternal health and other family and reproductive health projects are supported through FHI's international network. FHI has an extensive AIDS prevention program and provides technical assistance and training to collaborating scientists and health care providers worldwide. Funded by A.I.D., other government organizations, private foundations, businesses and individuals, FHI's annual budget is over \$40 million. Its 300 member staff is divided between Durham, North Carolina; Arlington, Virginia; and 19 countries including Thailand, Kenya and Egypt.

President: Theodore King, M.D., Ph.D.; Chair: Torrey C. Brown, M.D.

Family Planning International Assistance

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Cable FAMLIPLAN NY

Fax (212) 247-6274

Established in 1971 as the International Division of the Planned Parenthood Federation of America, Family Planning International Assistance (FPIA) provides financial, commodity, and technical assistance to developing country organizations interested in initiating or expanding reproductive health service programs. To date, it has assisted more than 600 family planning projects, and shipped contraceptives and other family planning materials to more than 3,500 agencies in over 130 countries. FPIA-assisted projects are involved in: increasing the accessibility and quality of family planning service delivery; increasing contraceptive choice; and working hard to reach areas with high human suffering, low status of women and where little or no family planning services are available. The current program involves 25 selected countries. Program priorities include Southeast Asia, the former Soviet Union and Africa, with special emphasis on abortion. Principal support comes from foundations and individuals. FPIA has a staff of 35 working in its headquarters in New York City; and regional offices in Nairobi, Kenya (for Africa); Bangkok, Thailand (for Asia, Pacific and Eastern Europe); and Miami, Florida (for Latin America).

Vice President for International Programs: Dr. Daniel R. Weintraub

Futures Group

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(202) 775-9680

Telex 9102504173 FUTURES/WASH

Cable

Fax (202) 775-9694

The Futures Group, a for profit research and consulting firm, has three major USAID funded projects. RAPID IV (Resources for the Awareness of Population Impacts on Development) uses computer presentations to demonstrate the relationship between population growth and socioeconomic development to developing world policymakers. OPTIONS for Population Policy II helps public and private institutions in over 26 countries develop and implement national population policies. SOMARC (Social Marketing for Change) III provides technical and financial assistance to developing countries to develop, improve, or expand contraceptive marketing programs. During the next five years, the Futures Group expects to spend over \$60 million on population related projects. Sixty staff work in this area. In addition to its Washington office, the Futures Group has additional offices in Connecticut and North Carolina, and field offices in Mexico, Peru, the Philippines, Ghana, Niger, and Indonesia.

Director, RAPID IV project: Tom Goliber; Director, OPTIONS II project: Janet Smith; Director, SOMARC II project: Santiago Plata

Global Committee of Parliamentarians on Population and Development

336 East 45th Street
10th Floor
New York, New York 10017

Telephone

(212) 953-7947

Telex 4994118 GCPPD

Cable GLOCOMPAR

Fax (212) 557-2061

The Global Committee of Parliamentarians on Population and Development was established in 1982 to stimulate awareness among parliamentarians of population and development issues and to encourage them to promote appropriate national policies. The Committee encourages formation of national and regional parliamentary associations. It supports conferences and study groups, and publishes a quarterly newsletter, *Update*. Its annual budget is around \$1 million. It has a professional staff of three:

Executive Director: Aldo Matsumura

Institute for Reproductive Health, Georgetown University

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Fax (202) 687-6846

The Institute for Reproductive Health (IRH, formerly the Institute for International Studies in Natural Family Planning) was established in 1985 at the Georgetown University School of Medicine through a five-year, \$15 million grant from USAID to study and promote natural fertility regulation in collaboration with developing and developed country institutions. Now in its second five-year, \$17.5 million agreement with USAID, GU/IRH continues to be USAID's principal technical resource in Natural Family Planning (NFP) and Breastfeeding for Child Spacing, including the Lactational Amenorrhea Method (LAM) and breastfeeding as a proximate determinate of fertility. IRH's broad-based program consists of research, training, information, education, and communication, technical assistance, information dissemination, and policy development.

NFP service delivery is carried out largely by a subordinate agreement with the International Federation for Family Life Promotion (IFFLP), which supports services and related activities in affiliated NFP programs in selected countries. The NFP Division is focusing on improved fertility awareness and the knowledge, availability, acceptability, and effectiveness of NFP in developing countries.

Breastfeeding and LAM service delivery is primarily through technical assistance and support to existing developing country family planning and child survival programs. The Breastfeeding Division, recently named a WHO Collaborating Centre on Breastfeeding, is focusing on increasing the availability and acceptability of optimal breastfeeding with a focus on child spacing, through policy change, program support, and professional policymaker education. Many IRH/GU publications on NFP, breastfeeding, and reproductive health research are available in French and Spanish, as well as English. IRH/GU has an FY93 operating budget of nearly \$3 million, and a staff of 18.

Director of Breastfeeding and MCH: Miriam H. Labbok, M.D., M.P.H.; Director of NFP: Victoria Jennings, Ph.D.; Principal Investigator: John T. Queenan, M.D.

International Council on Management of Population Program

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The International Council on Management of Population Programmes (ICOMP) was established by the heads of population and family planning programs in developing countries to improve program management through dissemination of information, regional training workshops, membership conferences, and implementation of specific projects in developing countries. Funding sources are UNFPA, the governments of Norway, Canada, Sweden, Germany, the Netherlands, and the United States, the OPEC Fund, Commonwealth Secretariat, and private foundations. The 1993 budget is about \$1.5 million. ICOMP employs 4 senior professionals and 10 support staff.

Executive Director: Professor Jay Satia

International Federation for Family Life Promotion

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Fax (703) 516-0390

The International Federation for Family Life Promotion (IFFLP), founded in 1974, is a nonprofit association of about 100 national affiliate organizations supporting natural family planning research, education, and services. It conducts training programs, particularly in Africa, and publishes a semi-annual bulletin, monographs, manuals, and a program evaluation guide. Zone councils provide training and publish their own newsletters. IFFLP is supported by USAID, Canada, UNFPA, WHO, the Catholic church, and private contributions. Its annual budget is \$5 million to \$1 million.

Executive Director: Claude A. Lanctot, M.D.

International Planned Parenthood Federation

Regent's College
Inner Circle
London NW1 4NS
United Kingdom
Telephone (44-71) 486-0741
Telex 919573 IPE PEE G
Cable IPEPEE LONDON
Fax (44-71) 487-7950

The International Planned Parenthood Federation (IPPF), the world's largest private family planning organization, with member associations in 134 countries, was founded in India in 1952 to bring together diverse voluntary national family planning associations in a common cause. Its goal is to provide couples everywhere with access to family planning information and services.

Internationally, IPPF campaigns to heighten awareness of the issues, including the dangers of unwanted pregnancy and unsafe abortion, responsible parenthood, achievement of sustainable development, the unmet need for family planning and the need for increased funding. It lobbies for governments to recognize that family planning is a vital health measure, as well as a basic human right.

IPPF provides technical support and funding to the full-time professionals and volunteers who offer family planning services through their associations' clinics, mobile units and community-based distribution programs. Each family planning association endeavors to meet the needs of the local people, within the appropriate cultural and social setting. In addition to clinical services, activities include counseling, training, sex education, and AIDS awareness. Particular concerns for IPPF globally in the 1990s are the need to improve the status of women, promote responsible sex among young people, and the encouragement of more male involvement in family planning. Publications include *People* and *the Planet* (quarterly magazine), *Planned Parenthood Challenges* (twice yearly), and *Open File* (monthly news digest).

IPPF's budget for 1992 was \$83.4 million, made up of contributions from more than 30 governments as well as from private donors. IPPF has around 300 staff, located at regional and field offices in 12 countries, as well as at its International Office in London. The Western Hemisphere Regional Office (IPPF/WHR) is located at 902 Broadway, 10th Floor, New York, NY 10010; tel: (212) 995-8800; FAX: (212) 995-8853; Cable: WHIPPFE; Telex: 620661.

IPPF Secretary General: Halldan Mahler, M.D.; IPPF President: Frederick Sai, M.D.

International Projects Assistance Services

P.O. Box 100
Carrboro, North Carolina 27510

Telephone

(919) 967-7052

Telex 3799366 IPAS

Cable IPAS

Fax (919) 929-0258

International Projects Assistance Services (IPAS) is a private, nonprofit organization established in 1973. Its primary mission is to address the global problem of unsafe abortion through appropriate and timely treatment for abortion complications; options for safe, voluntary abortion; and comprehensive family planning counseling and services to reduce the need for abortion. Its major program emphasis at the present time is training health care workers in the manual vacuum aspiration (MVA) technique and establishing MVA services for treatment of incomplete and septic abortion with an emphasis on contraceptive follow-up. IPAS' focus on training for service delivery programs at teaching hospitals in developing countries has been expanded in recent years to include research and evaluation and more extensive development of curricula and educational materials. IPAS is also spearheading an international effort to focus attention on the need for post-abortion family planning counseling and services. To date, IPAS' staff, collaborators, and in-country colleagues have worked in more than 20 countries to increase awareness of the critical problems caused by unsafe abortion and to expand women's access to safe abortion care. IPAS' fiscal year 92-93 budget of \$2.4 million is derived primarily from private contributions and sales of medical devices; in addition, some funds are received under contract from bilateral and multilateral donors. (IPAS receives no U.S. government funds.) IPAS has a full-time staff of 34.

President: Forrest C. Greenslade, Ph.D.; **Executive Director:** Katie Early McLaurin; **Vice President for International Programs:** Ann Hogan Leonard, MSPH; **Vice President for Finance and Administration:** John W. Dorward; **Chair:** Louise Tyrer, M.D.

International Science and Technology Institute, Inc.

1129 20th Street N.W. - Suite 800
Washington, D.C. 20036

Telephone

(202) 785-0831

Telex 272785 ISTI UR

Cable

Fax (202) 223-3865

The International Science and Technology Institute (ISTI) is a consulting firm providing technical assistance in health, population, and nutrition; private enterprise development and economic analysis, and environment and natural resource development. It implements a family planning and health project in Senegal and provides overall administration for Nigeria's \$87 million USAID supported family planning project. The 1991-92 annual budget for population activities was approximately \$4 million. ISTI has a staff of 170.

President: Nihal Goonewardene; **Vice President for Health, Population and Nutrition:** Jean M. Shaikh

International Statistical Institute

428 Prinses Beatrixlaan - P.O. Box 950
2270 AZ Voorburg
The Netherlands

Telephone

(31-70) 3375737

Telex 32260 isi nl

Cable statist

Fax (31-70) 3860025

The International Statistical Institute (ISI), established in 1885, is an autonomous, non-profit, professional organization which seeks to develop and improve statistical methods and their application through international activities, with special emphasis on developing countries. In addition to conferences and publications, the Institute has research and statistical training programs and has pioneered projects that have subsequently been continued under government auspices. It has a staff of 8 people and an annual budget of \$700,000.

Director: Dr. Zoltan Kenezsey

International Women's Health Coalition

24 East 21st Street
Fifth Floor
New York, New York 10010

Telephone

(212) 979-8500

Telex

Cable

Fax (212) 979-9009

Founded in 1980, the International Women's Health Coalition (IWHC) is a private organization working in alliance with women's health advocates, women's organizations, health professionals and government officials in developing countries to enable women to manage their own fertility safely and effectively. IWHC supports women's organizations and health professionals who are working to promote reproductive rights and comprehensive high-quality reproductive health services; including safe abortion services. It undertakes advocacy in the United States and internationally for financial support and public policy recognition of women's reproductive health and rights. IWHC provides professional and financial support to colleagues in 8 countries of Asia, Africa and Latin America. It also convenes international conferences, collaborates with established organizations, and publishes issue papers. Funded by private U.S.-based foundations and some governments, IWHC has a budget of \$2.3 million and a staff of 20.
President Joan B. Dunlop; Vice President and Program Director: Adrienne G

Japanese Organization for International Cooperation in Family Planning, Inc.

Hoken Kaikan Bekkan
1-1 Sadohara-cho, Ichigaya
Shinjuku-ku, Tokyo-162
Japan

Telephone

(81-03) 268-5875

Telex 2324584 JOICFPJ

Cable JOICFP TOKYO

Fax (81-03) 235-7090

The Japanese Organization for International Cooperation in Family Planning (JOICFP) was established in 1968 to provide assistance for family planning programs in developing countries and to increase concern among the Japanese public about global population issues. JOICFP works closely with Japanese government ministries, the Japan International Cooperation Agency (JICA), and various international organizations (UNFPA, UNICEF, WHO, and IPPF) in program training and design. The Integrated Project on Family Planning, Nutrition and and Parasite Control (IP) operates in more than 20 countries in Asia, Latin America, and Africa. JOICFP promotes the use of video systems to spread family planning information and produces periodicals, monographs, books, and a documentary film series. Its 1992 budget was about \$7.2 million. It has a fulltime staff of 20.

Executive Director and Chair: Chojiro Kunii; President: Takeo Fukuda

JHPIEGO Corporation (A Johns Hopkins Program for International Education in Reproductive Health)

Brown's Wharf
1615 Thames Street
Suite 200
Baltimore, Maryland 21231

Telephone

(410) 955-8558

Telex 6849118 or 6849019 PIEGO UR

Cable JHPIEGO

Fax (410) 955-6199

Established in 1972 with support from USAID, JHPIEGO (A Johns Hopkins Program for International Education in Reproductive Health) is a major source of specialized training for developing country health professionals in medical and management skills for reproductive health care. More than 83,000 physicians, nurses, midwives, administrators, and medical and nursing students from over 120 countries have participated in JHPIEGO programs through 1992. Most training is conducted at national and regional centers and, in 1992, participants at JHPIEGO training programs came from 47 countries, including 20 African, 12 Near East and Asian, and 15 Latin American and Caribbean countries. Programs aim to strengthen clinical skills, improve reproductive health courses, and the training skills of those teaching reproductive health courses. JHPIEGO also works to institutionalize reproductive health training in medical and nursing school curricula by strengthening training systems (especially clinical training networks). JHPIEGO also provides funds, equipment, and educational materials, including manuals, course handbooks and audio-visual materials, to support training activities. JHPIEGO's training packets include reference manuals, course handbooks, slide sets, and anatomical models (when appropriate) for IUD insertion and removal, Norplant insertion and removal, sexually transmitted genital tract infections, infection prevention, training skills of reproductive health professionals and clinical training skills. JHPIEGO's 1993 budget of \$8.5 million is primarily from USAID. JHPIEGO's head office is in Baltimore, with field offices in Kenya and the Philippines, and offices planned for India and Turkey. JHPIEGO has about 70 employees.

President and Director: Noel McIntosh, M.D., Sc.D.

John Snow, Inc.

210 Lincoln Street

Boston, Massachusetts, 02111

Telephone

(617) 482-9485

Telex 272896 JSIW UR

Cable

Fax (617) 482-0617

John Snow, Inc.. (JSI) a corporation encompassing for profit and nonprofit entities, was founded in 1978 to provide technical and managerial consulting services to health and family planning programs domestically and internationally. JSI receives funding from USAID, multilateral agencies, state, local and federal governments. JSI's current portfolio of international family planning activities includes five USAID funded projects. JSI has a staff of 200. The five year \$33 million Family Planning Service Expansion and Technical Support (SEATS) project implements activities in 20 low prevalence countries in Africa, Asia, and the Near East. SEATS works with governmental, non-governmental and private sector organizations to make quality family planning services more widely available. The Family Planning Logistics Management project manages the supply of USAID donated contraceptives worldwide, provides technical assistance and training in contraceptive commodities logistics, and maintains the USAID Population Projects Database. In Kenya the Family Planning Private Sector Programme develops self-sustaining family planning schemes with commercial, industrial, agricultural, and other private sector organizations. In Nepal the Integrated Rural Health and Family Planning Services project integrates the work of government agencies involved in health and family planning activities. The Philippines NGO Strengthening Project is designed to improve the capacity of NGO's to deliver family planning service by enhancing abilities in service expansion, cost-recovery systems, and management. JSI also implements the Indonesia Norplant Surveillance Project, funded by the Asian Development Bank. The goal of the project is to monitor the effectiveness of the implant contraceptive method in five provinces on the island of Sumatra. JSI has an office at 1616 North Fort Meyer Drive, Arlington, Virginia (Tel: 703-528-7474 ; FAX: 703-528-7480) and maintains field offices in the Philippines; Bangladesh; Nepal; Indonesia; Cambodia; Papua New Guinea; Haiti; Zimbabwe; Senegal; Malawi; Uganda; Kenya; Burkino Faso; Cameroon; Rwanda; Tanzania; Cote d'Ivoire; Morocco; Bolivia; Columbia, and Turkey
President: Joel H. Lamstein; Vice President, International Division: Richard Moore; Director, SEATS Project: Nancy Harris; Director, Family Planning Logistics Management Project: Richard Owens

Johns Hopkins University, Population Communication Services and Population Information Program

The Johns Hopkins University
School of Hygiene and Public Health
Center for Communication Programs
527 St. Paul Place
Baltimore, Maryland 21202
(410) 659-6300

Telephone

Telex 240430 JHUPCS UR

Cable POPINFORM

Fax (410) 659-6266

The Center for Communication Programs, funded primarily by USAID, and also by UNFPA and private organizations and foundations, was established at the John's Hopkins University School of Public Health in 1988 to bring together resources, talents and new ideas on family planning and health communication. The Center's focus is on expanding international family planning and health communication projects through development and implementation of innovative approaches to mass media, interpersonal communication, and national campaigns and training workshops. An international staff of over 100, skilled in communication, family planning and IEC project management, provides training and technical assistance to more than 40 countries. The Center administers the Population Communication Services (PCS) project and the Population Information Program (PIP). The Center's annual budget of approximately \$20 million includes the funding for these projects.

Population Communication Services provides field support for family planning IEC activities in Africa, Asia, Latin America, and the Near East. These include: communication needs assessments; development of print, broadcast, and visual materials; technical assistance to national public and private sector information, education, communication programs; international meetings and training workshops; and a Media/Materials collection of over 20,000 family planning and health materials from around the world. PCS stresses audience research, regular monitoring, and use of entertainment to transmit health messages and recover costs. PCS is also active in USAID's Nigeria program through a separate Family Health Services contract and in Ghana through a Ghana Family Planning and Health Project contract.

The Population Information Program prepares and distributes comprehensive, technical *Population Reports* on fertility control methods, family planning programs, demographic issues, family planning research, and related health concerns. Each about four issues are published in English, French, Spanish, and Portuguese, with selected issues in other languages. PIP's international mailing list has over 100,000 names. PIP collects and abstracts materials for POPLINE, the computerized population information retrieval system available through the U.S. National Library of Medicine in the United States and 17 other countries. About 30 staff work on PIP activities.

Director, Center for Communication Programs (CCP), Principal Investigator, PCS, and Director, PIP: Phyllis Tilson Plotrow, Ph.D.; **Deputy Director, CCP and Project Director, PCS:** Jose G. Rimon II; **Deputy Director, PIP and Editor, *Population Reports*:** Ward Rinehart

Macro International, Inc.

8850 Stanford Boulevard
Suite 4000
Columbia, Maryland 21045

Telephone

(301) 290-2800

Telex 87775

Cable

Fax (301) 290-2999

Macro International Inc., a for profit consulting group, employs about 45 professional staff to supply technical assistance for the design, execution, anal and dissemination of surveys and their results under the USAID-funded Demographic and Health Surveys (DHS) Program. This 13 year, \$90 million project, which started in October 1984 and finishes in September 1997, provides financial and technical assistance for surveys on health and population in developing couni worldwide. Extensive publications result from the DHS program. Macro also provides assistance to a number of other donors in the areas of survey research and analysis. The yearly operating budget of the DHS division is close to \$10 million. Macro also has offices in Silver Spring, Maryland; Atlanta, Georgia; Burlington, Vermont; New York, New York; and Warsaw, Poland.

Director, Demographic and Health Surveys: Martin T. Vaessen; **Macro CEO:** Frank Quirk

Management Sciences for I
165 Allandale Road
Boston, Massachusetts 02130

Telephone

(617) 524-7799

Telex 4990154 MSHUI

Cable MANSHEALTH

Fax (617) 524-2825

Management Sciences for I is a private, nonprofit organization dedicated to closing the gap between what is known about public health problems and what is done to solve them. Through technical assistance, training, systems development, and applied research, MSH helps decision makers throughout the world use techniques of modern management to improve the delivery of primary health care and family planning services. MSH collaborates with public and private counterparts in maternal and child health, population, occupational and environmental health, management information systems, drug management, health care financing, and management training. Since its founding in 1971, MSH has provided assistance in these areas to over 70 countries in Africa, Asia, the Caribbean, Central and Eastern Europe, Latin America, the Near East, and the Pacific. MSH is lead contractor for the five year USAID Family Planning Management Development Project (FPMD) in which is currently working in 12 developing countries. MSH has a current yearly budget of around \$30 million. Its staff of 190 is based at its headquarters in Boston, Massachusetts, 23 field offices and 2 offices in Washington, DC
President: Ronald O'Connor, M.D.; Director, Population Program: Sara Seims, PH.D.; Director, FPMD: Catherine Crone Coburn

Margaret Sanger Center International
26 Bleecker Street
New York, New York 10012

Telephone

(212) 274-7200

Telex 4931221

Cable

Fax (212) 274-7299

In addition to its work in the New York area, the Margaret Sanger Center International (MSCI), a division of Planned Parenthood of New York City, provides education, reproductive health training, and technical assistance to reproductive and sex related health programs in middle and low income countries. It collaborates with both private and public sector agencies to improve accessibility to reproductive health through strengthened service delivery systems, formal and non-formal education in family life education, human sexuality and personal decision making, and expanded training and management of non-physician health personnel. MSCI also works actively in the integration of AIDS related programs into general reproductive health care. The Center currently has projects in 10 countries and an annual budget of over \$3.5 million for international population activities. Thirteen staff members work in this area. MSCI also has offices in Asia and Africa, and publications which include training manuals and project-related materials.
Director: Peter J. Purdy; Deputy Director: Joan Littlefield

Marie Stopes International (MSI)
62 Grafton Way
London W1P 5LD
United Kingdom

Telephone

(44-71) 388-3740

Telex 94016277 PPSE G

Cable

Fax (44-71) 388-1946

MSI (formerly Population Services Europe) is a nonprofit tax exempt charity registered in the United Kingdom. MSI is the largest non-governmental supplier of family planning and reproductive health services in Britain. MSI local affiliates provide a wide range of maternal health and family planning services in 21 developing countries and Romania as well as educational and contraceptive social marketing programs. A subsidiary, Marie Stopes Consultancy, provides population and reproductive expertise to the British Government, the World Bank, the European Economic Community. Overseas projects are funded by the British Overseas Development Administration (ODA), the European Economic Community (EEC), the World Bank, WHO, foundations, and private contributions, as well as fees for certain services. The current yearly budget is about \$17 million. It has a staff of about 350 in the United Kingdom.
Chief Executive: Timothy Black, M.D. Director, Overseas Programmes (MSI): Henrietta Search

Pathfinder International

9 Galen Street
Suite 217
Watertown, Massachusetts 02172-4501

Telephone (617) 924-7200
Telex 6817085 PFBOS
Cable
Fax (617) 924-3833

Pathfinder International, established in 1957 by Dr. Clarence Gamble, is a non-profit family planning organization whose mission is to increase the number of individuals in developing countries who have access to and voluntarily use high quality family planning services. Pathfinder provides funding and technical support to locally administered projects in over 30 developing countries in Africa, Asia and Latin America. Pathfinder supports direct service delivery projects, provides training, technical and managerial assistance and helps local institutions in both urban and rural areas move towards financial independence. Its 1992 \$21 million budget was provided by grants and contributions from individuals, foundations, and USAID. Pathfinder employs 145 staff at its headquarters in the United States and in its 11 field offices in the developing world. Pathfinder has a regional office for Latin America in Mexico City, one for the Near East in Istanbul and one for sub-Saharan Africa in Nairobi.

President: Daniel E. Pellegroni; **Vice President for Finance and Administration:** Carol L. Gibbs; **Vice President for Development:** Carol C. Wall; **Vice President for Technical Services and Programs:** Deirdre Strachan

Planned Parenthood Federation of America

810 Seventh Avenue
New York, New York 10019
(212) 541-7800

Telephone
Telex
Cable FAMLIPLAN NY
Fax (212) 247-6453

The Planned Parenthood Federation of America (PPFA), also known as Planned Parenthood/World Population, is a private, nonprofit U.S. organization providing national leadership in reproductive rights advocacy and family planning services. Established in 1916, PPFA operates more than 900 clinics in 49 states and the District of Columbia, and engages in the development/provision of family planning information; counseling; medical services; training, and public information. Since 1971, its international work has been carried out by a separate Division, Family Planning International Assistance (see separate listing). PPFA's 1991 budget was about \$407 million (\$363 million for affiliates; \$44 million for national headquarters), derived from private contributions, clinic fees and government contracts.

President: Pamela Maraldo, Ph.D.; **Chair:** Jacqueline S. Jackson, Ph.D.

Population Action International

1120 19th Street, N.W.
Suite 550
Washington, D.C. 20036

Telephone (202) 659-1833
Telex 440450
Cable CRISIS WASHINGTON
Fax (202) 293-1795

Population Action International is a nonprofit research and advocacy organization that works for universal access to high quality, voluntary family planning and reproductive health services and the empowerment of all people, especially women, to make their own reproductive choices. The goal of the organization, founded in 1965 as the Population 'Crisis Committee, is a better quality of life for present and future generations. It works with senior U.S. Government officials concerned with population issues; educates the U.S. Congress on the importance and urgency of the population problem; meets with developing country leaders in support of national population programs; educates and stimulates the U.S. media to enhance public understanding of population issues; and works to increase funding from the United States and other donor countries for international family planning programs. Its Special Projects Fund supports innovative cost effective and replicable family planning and women's reproductive health projects in selected major developing countries. Population Action publishes country studies, briefing papers and wall charts on topical family planning issues. Deriving its funding exclusively from private individuals and foundations, it has a staff of about 40 and a 1993 budget of \$3.4 million.

National Chair: Robin Chandler Duke; **President:** J. Joseph Speidel, M.D., M.P.H.; **Vice President and Director, Special Projects Fund:** Catherine Cameron

Population Communication

1489 East Colorado Boulevard
Suite 202
Pasadena, California 91106

Telephone

(818) 793-4750

Telex

Cable POPCOM

Fax (818) 793-4791

Population Communication was established as a non-governmental, non-profit institution in 1977 to communicate population messages to world leaders, develop television and motion picture screenplays with family planning and population themes, inform doctors about the latest contraceptive techniques and to obtain support for population stabilization policies from heads of government. Population Communication also develops child survival projects, studies the links between population and the environment and promotes programs that improve women's status. Activities are concentrated in Bangladesh, Brazil, Egypt, India, Indonesia, Mexico, Nigeria, Pakistan, the Philippines and Thailand. The organization, with a yearly budget of \$600,000, obtains funds from individuals, foundation grants, and endowment income, and has a staff of four.

President: Robert W. Gillespie; Director of Women's Programs: Rina Mardiana

Population Communications International

777 United Nations Plaza
New York, New York 10017-3521

Telephone

(212) 687-3366

Telex MCI 66560 UN

Cable

Fax (212) 661-4188

Population Communications International fosters technical cooperation among developing countries to strengthen population and development communications; provides technical assistance to media and population professionals in developing news coverage and entertainment programming to encourage acceptance of family planning throughout the world; works with environmental and scientific organizations to assist them in addressing the population issue; and serves as the secretariat for the Population Task Force of the Conference of Non-Governmental Organizations at United Nations Headquarters. The 1993 budget for Population Communications International is \$1.3 million, almost all of which is for international programs. Population Communications International has a staff of eight.

President: David O. Poindexter

Population Concern

231 Tottenham Court Road
London W1P 9AE
United Kingdom

Telephone

(44-71) 631-1546, 637-9582

Telex 919573

Cable POPCONCERN LONDON W1

Fax (44-71) 436-2143

Population Concern has been working since 1974 to raise funds for population and development programs worldwide and to raise awareness in the United Kingdom about global population issues. The charity, which became independent in 1991, has projects in Africa, Asia, Latin America and the Caribbean focusing on quality family planning within the context of basic health care and education. The U.K. awareness program produces resource material for schools, the media, parliamentarians, other development agencies and the public. Total income during 1992 was £971,819, which includes donations from the public, trusts, companies, the European Economic Community and the British government. Population Concern has a staff of 12.

Chair: Diana Brown; Director: Rajamani Rowley

Population Council

One Dag Hammarskjold Plaza
9th and 10th Floors
New York, New York 10017

Telephone

(212) 339-0500

Telex 9102900660 POPCO

Cable POPCOUNCIL NEW YORK

Fax (212) 755-6052

The Population Council, an international nonprofit organization established in 1952, applies science and technology to the solution of population problems in developing countries. The Council's work encompasses the social, health and biomedical sciences. In collaboration with governments, nongovernmental organizations and private agencies in developing countries, the Council undertakes programs and research on population policy, family planning and fertility, reproductive health and child survival, women's roles and status, contraceptive introduction, and development of human and institutional resources. The Council's Center for Biomedical Research investigates and develops contraceptive technology and studies male reproductive physiology. Two reversible, long-acting methods developed by the Council are NORPLANT implants and the family of copper-bearing T-shaped IUDs. The Council disseminates information on population issues through publications, conferences, seminars and workshops. It publishes two scholarly journals, *Population and Development Review* and *Studies in Family Planning* and supports advanced training for population specialists. Resources are allocated to projects throughout the world, but especially for the developing countries of Africa, Asia, and Latin America. Its 1992 expenditures of \$42 million were derived from foundation grants, individual donations, USAID, the World Bank, U.S. National Institutes of Health (NIH), UNFPA, UNICEF, the U.N. Development Fund for Women (UNIFEM), the African Development Bank, and the governments of Canada, Finland, Kenya, the Netherlands, Norway and Sweden. The staff of 300 (from 59 countries) work at headquarters in New York, at regional offices in Bangkok, Cairo, Dakar, Mexico City and Nairobi and at eleven additional country offices.

President: Margaret Catley-Carlson; **Vice President and Director, Programs Division:** George Brown; **Vice President and Director, Research Division:** John Bongaarts; **Vice President and Director, Center for Biomedical Research:** C. Wayne Bardin; **Chair:** McGeorge Bundy

Population Institute

107 Second Street, N.E.
Washington, D.C. 20002

Telephone

(202) 544-3300

Telex

Cable POPINST WASHINGTON DC

Fax (202) 544-0068

The Population Institute, an educational organization founded in 1969, creates awareness of international population issues among policymakers, media representatives, and the general public. Publications include POPLINE, a bimonthly newspaper with an international circulation of approximately 60,000, and TOWARD THE 21ST CENTURY, a series of issue papers. Ongoing activities include presentations before community, service and international organizations; briefings of national and international leaders, lectures to college and university audiences, coordination of World Population Awareness Week, presentation of Global Media Awards, coordination of family planning study tours, sponsorship of population fellowships overseas, operation of the International Visitors Center and management of the Contraceptive Endowment Fund. The 1993 budget of \$1.425 million is derived primarily from more than 30,000 individual donors, as well as from 49 foundations and international organizations. The Institute has a staff of 16.

President: Werner Fornos; **Chair:** Joyce W. Cramer;
Director of Information: Hal Burdett; **Public Policy Liaison:** Michael Murray

Population Reference Bureau

1875 Connecticut Avenue, N.W.
Suite 520
Washington, D.C. 20009-5728

Telephone

(202) 483-1100

Telex 4900010456 (PRB UI)

Cable

Fax (202) 328-3937

Founded in 1929, the Population Reference Bureau gathers, interprets, and disseminates information about population trends and their public policy implications. PRB produces publications and educational materials; organizes conferences, seminars and workshops; maintains an extensive reference library; and provides demographic information to policymakers, journalists, teachers and students and the concerned public. Publications include the monthly newsletter *Population Today*, the quarterly *Population Bulletin*, and the annual *World Population Data Sheet*. PRB's international programs provide technical assistance to organizations in developing countries to increase awareness and understanding of population issues among Third World policymakers. The annual budget of \$3.7 million comes from foundation grants, government contracts, private contributions, memberships and publication sales. PRB has a full time staff of 35.

President: Peter Donaldson (after January 1, 1994); **Director, International Programs:** Alene Gelbard, Ph.D.

Population Services International

1120 19th Street, N.W.

Suite 600

Washington, D.C. 20036

Telephone

(202) 785-0072

Telex 197885 PSIW-UT

Cable POPSERVICE WASHINGTON DC

Fax (202) 785-0120

Population Services International (PSI), established in 1970, designs, develops and operates maternal and child health, family planning and AIDS prevention social marketing and communication programs in developing countries. PSI fosters local industry and service capabilities related to health, and trains and provides technical assistance to local organizations and individuals. PSI presently has programs in 23 developing countries and one national demonstration project in the United States. Its 1992 operating budget of \$13 million includes government contracts and contributions from private foundations and individuals. PSI has a full time staff of 45, including overseas representatives.

President: Richard A. Frank

Population-Environment Balance, Inc.

1325 G Street, N.W. - Suite 1003

Washington, DC 20005-3104

Telephone

(202) 879-3000

Telex

Cable

Fax (202) 879-3019

Population-Environment Balance (BALANCE) is a grassroots membership organization dedicated to public education of the adverse effects of population growth on the environment. BALANCE advocates measures that would encourage population stabilization in the United States, encourages a responsible immigration policy for the United States, and promotes increased funding for contraceptive research and availability. Activities include public education, advocacy, media campaigns, and publications. The current annual budget of BALANCE is \$500,000. It has a staff of four.

Chair: Dr. Virginia Abernethy; Executive Director: Rose M. Hanes

Program for Appropriate Technology in Health

4 Nickerson Street

Seattle, Washington 98109-1699

Telephone

(206) 285-3500

Telex 4740049 PATH UI

Cable

Fax (206) 285 6619

The Program for Appropriate Technology in Health (PATH) seeks to improve health, especially the health of women and children in developing countries. PATH focuses on the effectiveness, safety, availability, and acceptance of technologies for health and family planning. PIACT (Program for the Introduction and Adaptation of Contraceptive Technology) is the arm of PATH responsible for reproductive health projects. Technical assistance is provided on new product introduction, local manufacturing, quality control, and logistics. The Fund for Technology Transfer assists developing countries in the transfer of health and contraceptive technology. Among its publications are *Outlook* in Chinese, French, English, Portuguese and Spanish, *Health Technology Directions*, and *Current Abstracts*. PATH's budget in 1992 was \$12 million derived from foundations, USAID, UNFPA, and WHO. It employs over 180 staff. In addition to its Seattle headquarters, it maintains offices in Washington, D.C., USA (at 1990 M Street, N. W. Suite 700, Washington, DC 20036; Tel: 202-822-0033; FAX: 202-822-1466); Bangkok, Thailand; Jakarta, Indonesia and Nairobi, Kenya.

President: Gordon W. Perdin, M.D.; Director, Washington Office: Carol Corso; Senior Program Advisor: Elaine Murphy; Chair: Mustari Khan

Program for International Training in Health (INTRAH), University of North Carolina

University of North Carolina

208 North Columbia Street

Chapel Hill, North Carolina 27514

Telephone

(919) 966-5636

Telex 3772242

Cable INTRAH CHAPEL HILL NC

Fax (919) 966-6816

The Program for International Training in Health, in the University of North Carolina School of Medicine, seeks to build national, regional and institutional capabilities to train, supervise, and support providers of family planning and MCH services. It gives technical, material, and financial support to improve curriculum planning; training and teaching; clinical and community based service provider skills; planning, management, and evaluation; and skills to design print and low cost visual materials. INTRAH produces training and reference materials for national capacity-building and for worldwide distribution. INTRAH has assisted in the training of over 65,000 persons from 36 countries since 1979. Current activities are funded by USAID and UNFPA. The fiscal year 1993 budget is \$3.9 million. INTRAH has regional offices in Nairobi, Kenya and Lomé, Togo.

Director: James W. Lea, Ph.D.

Program on Population, E Center

1777 East-West Road
Honolulu, Hawaii 96848

Telephone

(808) 944-7444

Telex 989171

Cable EASWESSEN

Fax (808) 944-7490

The Program on Population, formerly the Population Institute of the East-West Center, conducts research and training activities in the population field, with emphasis on social and economic aspects of population and their policy implications in the Asia-Pacific region. Founded in 1969, POP's activities are guided by the East-West Center's mission of promoting understanding and cooperation between the peoples of the East and West. USAID has been a major supporter of POP's programs over the years in the area of family planning program research and evaluation in India, the Philippines, Indonesia, Bangladesh, Pakistan and Thailand.

The operating budget for FY1993 is over \$4 million, of which more than half is funded by the U.S. government. POP also receives contributions from governments in Asia and the Pacific, corporations, and private foundations. POP publishes *Asian and Pacific Population Forum* and *Asia-Pacific Population and Policy*, as well as books, research and working papers.

POP employs 25 full-time professional staff, supports approximately 70 fellows, and trains some 20 research interns each year as part of the East-West Center, a national educational institution established by the U.S. Congress and incorporated by the State of Hawaii, based entirely in Honolulu, Hawaii.

Director: Andrew Mason, Ph.D.; **Assistant Director:** Minja Choe, Ph.D.; **Vice President for Program Development:** Lee-Jay Cho

Research Triangle Institute

3040 Cornwallis Road - P.O. Box 12194
Research Triangle Park
North Carolina 27709

Telephone

(919) 541-7218

Telex 802509 RTI PARK

Cable RESTRINS RALEIGH NC

Fax (919) 541-6621

The Research Triangle Institute (RTI), an independent, not-for-profit research organization founded in 1958, has over 1500 full time staff, including 25-30 who do research and provide technical assistance and training to developing countries in population and related human resource fields. During the past 15 years RTI has assisted over 50 governments through the USAID-funded RAPID (Resources for Awareness of Population Impacts on Development) and INPLAN (Integrated Population and Development Planning) projects. RTI's annual \$2 million population budget is funded by USAID, the World Bank and various U.N. agencies. RTI has an office in Washington, DC, at 1615 M Street, NW (Tel: 202-728-2080; FAX: 2092-728-2095) and program offices in Africa, Near East, Southeast Asia, Central America and Europe.

Director, Center for Development Policy: Thomas Wooten; **Program Director, Social Service and Human Resource Development:** James E. Kocher, Ph.D.

Tulane University, International Health Department Program

1501 Canal Street - Suite 1300
New Orleans, Louisiana 70112

Telephone

(504) 588-5399

Telex 1561043 PHTM UT

Cable

Fax (504) 584-3653

The Department of International Health and Development, through the Center for International Resource Development and the International Communications Enhancement Center, is assisting eleven African governments in eight major programs. Teams of long-term technical assistants, short-term technical support, and qualified home staff support have been provided for the field projects and offices. The Department provides long and short-term training at the certificate, masters and doctorate levels for students from more than 60 countries. Students have the opportunity to specialize in population and family planning. Tulane provides training and workshops for field staff and local counterparts to ensure fulfillment of project objectives. To further institution building, particularly in the fields of family planning, information and surveillance systems, intensive training courses have been conducted in participants' home countries, regionally in Africa and in New Orleans. The budget for these projects is \$11 million.

Department Chair: William Bertrand, Ph.D.

University Research Corporation

7200 Wisconsin Avenue

Suite 600

Bethesda, Maryland 20814

Telephone

(301) 654-8338

Telex 64693**Cable** URCINTER**Fax** (301) 654-5976

University Research Corporation (URC) is a for profit multidisciplinary consulting firm providing technical support in international and domestic health services. Internationally, URC's goal is to promote a better quality of life and work by improving health management and service delivery in population, family planning and other areas. The Center for Human Services (CHS) is a nonprofit affiliate sharing the same staff of approximately 160 people and the same corporate facilities. URC/CHS has carried out more than 650 projects for clients, including agencies of more than 60 developing country governments, the private sector, and US federal, state and local government entities. URC's headquarters are in Bethesda, Maryland. It has field offices in Haiti, Niger, Indonesia, the Dominican Republic, Ecuador, Egypt and Jordan. Its annual international project budget is approximately \$10 million. Among its 10 contracts are the Niger Family Health and Demography Project (1988-93), Indonesia Private Sector Family Planning Project (1990-95) and Indonesia BKKBN Management Information Systems (1992-94).

Chief Operating Officer: Richard Elder; Vice President and Director, International Division: David Nicholas, M.D. ; Chair of the Board: Melvyn Estrin

Supplemental Listings

Nongovernmental Organizations

This listing like the previous one is selective. It includes organizations involved in international population work with budgets of under \$500,000 which play a significant role as well as organizations which have a population component but whose major focus is not population.

Academy for Educational Development (AED) A private nonprofit organization seeking to improve educational systems throughout the world, including the expansion of health, nutrition, and family planning education. President: Stephen F. Moseley, 1255 23rd Street, N.W., Washington, D.C. 20037; Tel: (202) 862-1900; Telex: 197601; FAX: (202) 862-1947

American College of Nurse-Midwives Special Projects Section has programs in African countries to improve maternal and infant health and to better the lives of women through improved midwifery services and education, including family planning. Director, Special Projects Section: Cindy A. Kaufman; 1522 K Street, NW, Suite 1000, Washington, DC 20005; Tel: (202) 289-4005; FAX: (202) 289-4395

American Home Economics Association (AHEA) An educational and scientific organization founded in 1909 to improve the quality of family life through education, research, and public information. Executive Director: Mary Jane Kolar. 1555 King Street, Alexandria, Virginia 22314-2752; Tel: (703) 706-4600; FAX: (703) 706-HOME

American Public Health Association (APHA) Oldest and largest association of health professionals in the world; includes population, MCH, and international health among its special interest sections. Executive Director: William McBeath, M.D. 1015 15th Street, N.W., 3rd Floor, Washington, D.C. 20005; Tel: (202) 789-5600; FAX: (202) 789-5661

Association for Population/Family Planning Libraries and Information Centers - International (APLIC-International) Worldwide network of librarians and information specialists in the population and family planning fields. Contact: APLIC c/o Population Council Library, One Dag Hammarskjold Plaza, New York, New York 10017

Center for Reproductive Law and Policy An independent organization, set up in 1992, to secure effective and freely chosen reproductive health care for women worldwide. President: Janet Benshoof; Vice President: Kathryn Kolbert; 120 Wall Street, New York, New York 10005; Tel: (212) 514-5534; FAX: (212) 514-5538

Development Services International of Canada (DSI) A charitable organization which conducts, in concert with other organizations, family planning projects in 23 developing countries, with special emphasis on medical termination of pregnancy, treatment of incomplete abortion, and contraceptive counseling. Co-Directors: Edward B. Ratcliffe, Elinor Ratcliffe, Donna Snowdon; Treasurer: Annelie Brewer. Box 3190, 875 Speedsville Road, Cambridge, Ontario, Canada N3H 4S8; Tel: (519) 653-3275/4305; FAX: (519) 653-1337

Global Tomorrow Coalition, Inc. (GTC) Composed of over 100 organizations, GTC promotes public understanding and appropriate policy responses to the problems of rapid population growth, environmental degradation, and unsustainable trends in development and natural resource use. President: Donald R. Lesh. 1325 G Street, N.W., Suite 1010, Washington, D.C. 20005-3104; Tel: (202) 628-4016; FAX: (202) 628-4018

Health Services International, Inc. (HSI) Health care management consulting firm with international public health projects, including primary health care, MCH, and family planning. President and Chief Executive Officer: Juan Pozo-Olano, D. Sc., Ph.D. 3101 South Street, N.W., Washington, D.C. 20007; Tel: (202) 342-7866; FAX: (202) 342-7868

International Institute for Environment and Development (IIED) A policy research institute whose mission is to promote sustainable economic development in developing countries without jeopardizing the natural resource base. It covers the impact of population growth. IIED carries on research, prepares policy studies, does advocacy and provides public information. Executive Director: Richard Sanbrook. 3 Endsleigh Street, London WC1H 0DD, United Kingdom; Tel: (44-71) 388-2117; Telex: 261681 EASCANG; FAX: (44-71) 388-2826

International Union for the Scientific Study of Population (IUSSP) Professional membership organization stimulating research on population. Executive Secretary: Bruno Remiche. 34 rue des Augustins, 4000 Liege, Belgium; Tel: (62-41) 20-40-80; FAX: (62-41) 22-38-47

Los Angeles Regional Family Planning Council Inc. (LARFPC) Private, nonprofit, health systems management organization founded in 1968 to coordinate the delivery of family planning services throughout Los Angeles County. LARFPC provides reproductive health training and education to health care professionals, monitors client services through quality assurance department activities, and conducts contraceptive research. LARFPC is a USAID subcontractor to the Institute for Reproductive Health at Georgetown University. Director of Training and Education: Kimberly Aumack. 3600 Wilshire Boulevard, Suite 600, Los Angeles, California 90010; Tel: (213) 386-5614; FAX: (213) 386-4410/368-4411

National Abortion Federation (NAF) A professional association of abortion providers that establishes standards for quality care and provides professional training in provision of abortion services. Executive Director: Barbara Radford. 1436 U St., N.W., Washington, D.C. 20000; Tel: (202) 667-5881; FAX: (202) 667-5890

National Abortion Rights Action League (NARAL) U.S. membership organization that works through the political process at the national and community level to keep abortion legal; emphasizes grassroots organizing, public education, lobbying, and electoral work. Executive Director: Kate Michelman. 1156 15th Street, N.W., 7th Floor, Washington, D.C. 20005; Tel: (202) 973-3000; FAX: (202) 973-3096/3097/3098

National Academy of Sciences (NAS), Committee on Population Conducts scientific assessments of important population related issues, which are carried out by working groups and panels composed of Committee members and other distinguished scientists who serve on a volunteer basis. Study Director: Linda G. Martin, Ph.D. 2101 Constitution Avenue, N.W., Washington, D.C. 20418; Tel: (202) 334-3167; Telex: 248664; Cable: NARECO WASHINGTON; FAX: (202) 334-3768

National Audubon Society Develops policy, public education and advocacy on the linkages between human population growth and natural resource consumption. Conducts field-based projects in the U.S. matched with overseas sites to explore solutions to the problems of human pressures on wildlife and the habitat they both share. Director, Population: Patricia Waak. 666 Pennsylvania Avenue, S.E., Washington, D.C. 20003; Tel: (202) 547-9009; FAX: (202) 547-9022

National Council for International Health (NCIH) A private, nonprofit information, education and advocacy organization set up in 1971 to educate health professionals, policy makers, the media and the public on critical world health issues. President: Eliot T. Putnam, Jr. 1701 K Street, NW, Suite 600, Washington, DC 20006; Tel: (202) 833-5900; FAX: (202) 833-0075

National Family Planning and Reproductive Health Association, Inc. (NFPRHA) Public policy organization committed to expanding family planning programs, whose membership of nearly 1,000 service providers works to improve and enlarge services in the United States. Executive Director: Judith M. DeSamo. 122 C Street, N.W., Suite 380, Washington, D.C. 20001-2109; Tel: (202) 628-3535; FAX: (202) 737-2690

Pacific Institute for Women's Health A new organization set up in June 1993 in association with the Western Consortium for Public Health to promote research on women's health needs and to advocate for the improved health, wellbeing and status of women. Co-Directors: Francine Coeytaux and Joanne Leslie. Tel: (213) 934-1109; FAX: (213) 934-4736

Planned Parenthood Federation of Canada (PPFC) A national voluntary organization which promotes sexual and reproductive health throughout Canada, represented by 48 affiliates which provide education and clinical services. PPFC sponsors family planning projects through IPPF/WHR in Latin America and the Caribbean. Executive Director: Bonnie Johnson. 1 Nicholas Street, Suite 430, Ottawa, Ontario, K1N 7B7, Canada; Tel: (613) 238-4474; FAX: (613) 238-1162

Population Association of America (PAA) Scientific and educational membership organization, primarily of demographers. Secretary-Treasurer: Jeffrey Evans. 1722 N Street, N.W., Washington, D.C. 20036; Tel: (202) 429-0891; FAX: (202) 785-0146

Population Resource Center (PRC) Draws on U.S. experts in demography, economics, health, and related fields to provide authoritative briefings and analyses for policymakers in government, corporations, and the nonprofit sector. President: Jane S. De Lung. 15 Roszel Road, Princeton, New Jersey 08540; Tel: (609) 452-2822; FAX: (609) 452-0010

RAND Corporation Private nonprofit institution engaging in research and analysis of national security and public welfare issues, including a Labor and Population Program with an international component. Director, Labor and Population Program: James P. Smith. P.O. Box 2138, Santa Monica, California 90407-2138; Tel: (310) 393-0411; Telex: 9103436878; FAX: (310) 393-4818

Religious Coalition for Abortion Rights (RCAR) Coalition of 36 national religious agencies engaging in public outreach and advocacy to educate people about the diversity of religious perspectives on abortion and threats to religious liberty posed by legislation that restricts access to safe legal abortion. Executive Director: Ann Thompson Cook. 100 Maryland Avenue, N.E., Suite 307, Washington, D.C. 20002; Tel: (202) 543-7032; FAX: (202) 543-7820

Reproductive Freedom Project, American Civil Liberties Union Conducts litigation and public education to preserve and promote reproductive rights. Litigation Director: Catherine Weiss. 132 West 43rd Street, New York, New York 10036; Tel: (212) 944-9800, extension 515; FAX: (212) 869-4302

Sierra Club Volunteer environmental organization with a Population Program through which members apply grassroots pressure for legislative and administrative change on U.S. and international population issues. Washington Director, Population Program: Nancy Wallace. 408 C Street, N.E., Washington, D.C. 20002; Tel: (202) 547-1411; FAX: (202) 547-6009

Social Development Center Nonprofit center specializes in population research and family planning evaluation, including the use of microcomputers for international training in French, Spanish, and English. Director: Donald J. Bogue, Ph.D. 1313 East 60th Street, Chicago, Illinois 60637; Tel: (312) 947-2010; Cable: SOCDEV; FAX: (312) 947-2012

Transnational Family Research Institute (TFRI) Multidisciplinary, nongovernmental, nonprofit behavioral science research organization with a focus on reproductive behavior. Director: Henry P. David, Ph.D. 8307 Whitman Drive, Bethesda, Maryland 20817; Tel: (301) 469-6313; FAX: (301) 469-0461

Western Consortium for Public Health (WCPH) Consortium of the Schools of Public Health and University Extension Divisions of the University of California at Berkeley and Los Angeles. Affiliate members are San Diego State University School of Public Health and the Institute for Health and Policy Studies of the University of California, San Francisco. WCPH provides domestic and international technical assistance, training, and research in public health, population, and family planning. Executive Director: Joe Hafey. 2001 Addison Street, Suite 200, Berkeley, California 94720; Tel: (510) 644-9300; Telex: 6714622; FAX: (510) 644-9319

World Neighbors International nonsectarian grassroots organization working at the village level in 19 developing countries, 9 of which receive family planning assistance for clinic and mobile services, community based distribution, and information, training, and education. Contact: Denise Caudill. 4127 N.W. 122nd Street, Oklahoma City, Oklahoma 73120-8869; Tel: (405) 752-9700, (800) 242-6387; Cable: NEIGHBORS; FAX: (405) 752-9393

World Population Society Nonprofit organization provides professional and technical assistance to national planners, population program leaders, and parliamentarians on national policies and program planning. President: Philander P. Claxton, Jr.; Executive Director: Frank H. Oram. 1333 H Street N.W., Suite 106, Washington, D.C. 20005; Tel: (202) 898-1303; Telex: 283231 WPSA UR; FAX: (202) 775-9694

World Resources Institute (WRI) Policy research center created in 1982 by a grant from the MacArthur Foundation to help governments, international organizations, and the private sector determine how to meet basic human needs and nurture economic growth without undermining natural resources and the environment. President: Jonathan Lash. 1709 New York Avenue, N.W., Washington, D.C. 20006; Tel: (202) 638-6300; Telex: 64414 WRI WASH; FAX: (202) 638-0036

Worldwatch Institute Environmental policy research organization that brings global trends to the attention of the press and public through publications, particularly the annual State of the World report. President: Lester R. Brown. 1776 Massachusetts Avenue, N.W., Washington, D.C. 20036; Tel: (202) 452-1999; FAX: (202) 296-7365

Zero Population Growth (ZPG) Nonprofit membership organization, with commitment to international family planning, provides grassroots activism, public policy advocacy, school based population curricula, media campaigns, and publications. Executive Director: Susan Weber. 1400 16th Street, N.W., 3rd Floor, Washington, D.C. 20036; Tel: (202) 332-2200; FAX: (202) 332-2302

Training and Research Centers

Australian National University, International Population Dynamics Program Department of Demography, GPO Box 4, Canberra, ACT 2601, Australia; Tel: (61-62) 48-8805; Telex: 62694; FAX: (61-62) 57-1893

Brown University, Population Studies and Training Center Box 1916, Providence, Rhode Island 02912; Tel: (401) 863-2668; FAX: (401) 863-3213

Cornell University, Population and Development Program Warren Hall, Ithaca, New York 14853; Tel: (607) 255-1400; Telex: WUI 6713054 WUI; FAX: (607) 255-9984

Harvard University, Center for Population and Development Studies 9 Bow Street, Cambridge, Massachusetts 02138; Tel: (617) 495-2021; FAX: (617) 495-5418

Institut National d'Etudes Demographiques 27, rue de Commandeur, Paris 75675 Cedex 14, France; Tel: (33-1) 43-20-13-45

Institute for Development Training P.O.Box 2522, Chapel Hill, North Carolina 27514; Tel: (919) 967-0563; Telex: ITT 4943589 IDT CH

Johns Hopkins University, Department of Population Dynamics School of Hygiene and Public Health, the Johns Hopkins University, Baltimore, Maryland, 21231; Tel: (410) 659-6300

London School of Economics and Political Science, Population Investigation Committee Houghton Street, Aldwych, London WC2 2AE, United Kingdom; Tel: (44-71) 405-7686; Telex: 24655 LONDON G; FAX: (44-71) 242-0392

London School of Hygiene and Tropical Medicine Keppel Street, London, WC1E 7HT, United Kingdom; Tel: (44-71) 636-8636; FAX: (44-71) 436-5389

Pennsylvania State University, Population Research Institute 22 Burrowes, University Park, Pennsylvania 16802; Tel: (814) 865-0486; FAX: (814) 863-8342

Princeton University, Office of Population Research 21 Prospect Avenue, Princeton, New Jersey 08540; Tel: (609) 258-4870; Telex: 5106005694; Cable: POPULATION; FAX: (609) 258-1039

Stanford University, Morrison Institute for Population and Resource Studies Herrin Labs, Stanford University, Stanford, California 94305-5020; Tel: (415) 723-7518; Telex: 3722871; Cable: STANFUNIV; FAX: (415) 725-8244

Université Catholique de Louvain, Institut de Démographie 1, Place Montesquieu, 1348 Louvain-la-Neuve, Belgium; Tel: (32-10) 43-29-51; Telex: 59037 UCLP; FAX: (32-10) 47-29-52

University of California at Berkeley, Department of Demography, Program in Population Research 2232 Piedmont Avenue, Berkeley, California 94720; Tel: (510) 642-9800; Telex: 9103667114; FAX: (510) 643-8558

University of California at San Francisco, Institute for Health Policy Studies, Center for Reproductive Health Policy and Research 1388 Sutter Street, 11th Floor, San Francisco, California 94109; Tel: (415) 476-5254; FAX: (415) 476-0705

University of Chicago, Population Research Center 1155 East 60th Street, Chicago, Illinois 60637-2799; Tel: (312) 702-7372; FAX: (312) 702-3788

University of Michigan, Department of Population Planning and International Health: School of Public Health, University of Michigan, Ann Arbor, Michigan 48109-2029. Tel: (313) 764-7516; FAX: (313) 936-8199

University of Michigan, Population Studies Center 1225 South University Avenue, Ann Arbor, Michigan 48104-2590; Tel: (313) 763-7149

University of North Carolina, the Carolina Population Center University Square, West Franklin Street, Chapel Hill, North Carolina 27516-3997; Tel: (919) 966-2157; Telex: 650 152 9429; FAX: (919) 966-6638

University of Pennsylvania, Population Studies Center, Graduate Group in Demography 3718 Locust Walk, Philadelphia, Pennsylvania 19104-6298; Tel: (215) 898-6441; Telex: 7106700328; FAX: (215) 898-2124

University of Pittsburgh, Graduate School of Public Health, Division of Community Health Services, Population Program 130 DeSoto Street, Pittsburgh, Pennsylvania 15261; Tel: (412) 624-3128; Telex: 199126

University of Southern California, Population Research Laboratory 3716 South Hope Street, Los Angeles, California 90007; Tel: (213) 743-2950; Telex: 674803; FAX: (213) 743-7408

University of Texas at Austin, Population Research Center 1800 Main, Austin, Texas 78712; Tel: (512) 471-5514; FAX: (512) 471-4886

University of Western Ontario, Population Studies Centre Social Science Centre, Room 3227, London, Ontario N6A 5C2, Canada; Tel: (519) 661-3819; Telex: 0647134; FAX: (519) 661-3200

Selected Regional Organization with Population Activiti

African Development Bank (ADB) B.P. 1387, Abidjan 01, Ivory Coast

African Institute for Economic Development and Planning (IDEP) P.O. Box 3186, Dakar, Senegal

Asian and Pacific Development Centre (AFDC) Pesiaran Duta, P.O. Box 12224, 50770 Kuala Lumpur, Malaysia

Asian Centre for Population and Community Development 8 Sukhumvit 12, Bangkok 10110, Thailand

Asian Development Bank P.O. Box 789, Manila 2800, Philippines

Asian Institute of Management (AIM) M.C.C. P.O. Box 898, Makati, Metro Manila 3117, Philippines

Asian Population and Development Association (APDA) Nagatacho TBR Building, Room 710, 10-2, Nagatacho 2-chome, Chivoda-ku. Tokyo 100. Japan

Cairo Demographic Center 78 (4th Street) Hashaba-Eloya, Mokattam (11571), Cairo, Egypt

Caribbean Community (CARICOM) Bank of Guyana Building, P.O. Box 10827, Georgetown, Guyana

Center for African Family Studies (CAFS) P.O. Box 60054, Nairobi, Kenya

Center for the Development of Economic and Social Research in Africa (CODESRIA) B.P. 3304, Dakar, Senegal

Centre d'Etudes et de Recherche sur la Population pour le Developpement (CERPOD) Boite Postale 1530, Bamako, Mali

Centre Regional de Formation et de Recherche en Sante Familiale, World Health Organization Boite Postale 1324, Kigali, Rwanda

Institut pour la formation et la recherche en demographie (IFORD) BP 1556, Yaounde, Cameroon

Inter-African Committee on Traditional Practices Affecting the Health of Women and Children in Africa c/o ECA/ATRCW. Room 627. P.O. Box 3001. Addis Ababa. Ethiopia

Inter-American Planning Society (SIAP) Altata 51, oficina 403, Colonia Condesa (06140), Mexico-DF, Mexico

International Institute for Population Studies Gorandi Station Road, Deonar, Bombay 400088, India

Latin American Demographic Center (CELADE) Edificio Naciones Unidas, Avenida Dag Hammarskjold, Casilla 91, Santiago. Chile

Latin American Population Programme c/o Centro de Estudios de Población, Corrientes 2817, 7° piso, Casilla 4397, Correo Central. 1000 Buenos Aires. Argentina

League of Arab States, Population Research Unit 37 Kher Basha Street, Tunis, Tunisia

OPEC Fund for International Development P.O. Box 995, 1011 Vienna, Austria

Pan American Health Organization (PAHO) 525 23rd Street, N.W., Washington, D.C. 20037, USA

Regional Institute for Population Studies P.O. Box 96, Legon, Accra, Ghana

Regional Population Centre (CCRP) Apartado Aereo 24846, Bogota D.E., Colombia

Sahel Institute, Socio-Economic and Demographic Unit B.P. 1530, Bamako, Mali

South Pacific Commission (SPC) B.P. D5, Noumea Cedex, New Caledonia

Statistical Institute for Asia and the Pacific (SIAP) P.O. Box 13, Akasaka, Tokyo 107-91, Japan

World Population Foundation Der Kinderenlaan 14, 1251 EM Laren, the Netherlands

World View International Foundation Welhavensgate 1, 0166 Oslo 1, Norway

United Nations Organizations Providing Population Assistance

United Nations Bodies:

Food ^{and} Agriculture Organization (FAO) Coordinator, Population Program: Joop Alberts. Via delle Terme de Caracalla, 00100 Rome, Italy. Biennial budget 1988-89 for population activities, \$8.2 million, including \$6.7 million derived from UNFPA.

International Labor Organization (ILO) Chief, Employment Planning and Population Branch: Eddy Lee. 4 route des Morillons, CH 1211 Geneva 22, Switzerland. Biennial budget 1988-89 for population activities, \$24.3 million, including \$20.1 million derived from UNFPA.

Regional Commissions (Economic Commission for Africa, P.O. Box 3001, Addis Ababa, Ethiopia; Economic Commission for Europe, Palais des Nations, 1211 Geneva 10, Switzerland; Economic Commission for Latin America and the Caribbean, Edificio Naciones Unidas, Casilla 179-D, Santiago, Chile; Economic and Social Commission for Asia and the Pacific, United Nations Building, Rajdamnorn Avenue, Bangkok 10200, Thailand; Economic and Social Commission for Western Asia, P.O. Box 927115, Amman, Jordan) Total combined biennial budget 1988-89 for population activities, \$26.3 million, including \$18.7 million derived from UNFPA.

Specialized Agencies:

World Bank Senior Advisor, Population: Thomas W. Merrick; Director, Population, Health and Nutrition, Department, Human Resources and Operations vice-presidential unit; Janet de Merode. Four geographic vice-presidential units also have population and human resource (PHR) divisions in each of their 19 country departments and in each of the 4 regional technical departments. 1818 H Street, N. W., Washington, D.C. 20433, USA. Currently the Bank has over 50 ongoing projects with substantial population components, representing a total lending commitment of roughly \$963 million. In its 1991 fiscal year, the Bank committed a total of about \$351 million in new loans and credits for either discrete population projects or population components of combined health and population projects. The comparable figure for FY 1992 was \$103.5 million. Disbursement against these loans takes place over several years as projects are implemented.

United Nations Children's Fund (UNICEF) Senior Advisor, Health and Population: Dr. Ranjit Atapattu; Director, Program Division: Kul Gautam. 3 United Nations Plaza, New York, New York, 10017, USA. Biennial budget 1988-89 for population activities, \$0.2 million, derived from UNFPA.

United Nations Educational Scientific and Cultural Organization (UNESCO) Director of Population and Human Settlements and Coordinator of Population Programs: R. Urzua. 7 Place de Fontenoy, 75700 Paris, France. Biennial budget 1988-89 for population activities, \$20.9 million, including \$19.6 million derived from UNFPA.

United Nations Population Fund (UNFPA) Executive Director: Nafis Sadik, M.D.; Deputy Executive Director, Policy and Administration: Hirofumi Ando; Deputy Executive Director, Program: Joseph Van Arendonk; Director, Technical and Evaluation Division: Jyoti Singh; Address: 220 East 42nd Street, New York, New York 10017, USA; UNFPA is active in 140 countries and has field offices in 95; total biennial budget 1988-89, \$372.1 million, of which approximately \$196.8 million was allocated to UNFPA itself; the remainder was channeled through other U.N. organizations.

United Nations Secretariat:

Department of Economic and Social Information and Policy Analysis Under Secretary General: Jean-Claude Milleron.

Population Division Acting Director: Joseph Chamie; Address: 2 United Nations Plaza, Room DC2-1950, New York, New York 10017, USA; biennial budget 1988-89 for population activities, \$7.7 million, including \$1.8 million derived from UNFPA.

Statistical Office Director, William Seltzer; Address: 2 United Nations Plaza, Room DC2-1420, New York, New York 10017, USA; biennial budget 1988-89 for population activities, \$3.4 million, including \$1.3 million derived from UNFPA.

World Health Organization (WHO) Director, Division of Family Health: Angele Petros-Barvazian, M. D.; Director, Special Programme of Research, Development and Research Training in Human Reproduction: Giuseppe Benagiano, M. D. 20 Avenue Appia, 1211 Geneva 27, Switzerland. Biennial budget 1988-89 for population activities, \$276.9 million, including \$53.4 million derived from UNFPA.

United Nations Secretariat:

Department of Economic and Social Information and Policy Analysis Under Secretary General: Jean-Claude Milleron.

Population Division Acting Director: Joseph Chamie; Address: 2 United Nations Plaza, Room DC2-1950, New York, New York 10017, USA; biennial budget 1988-89 for population activities, \$7.7 million, including \$1.8 million derived from UNFPA.

Statistical Office Director, William Seltzer; Address: 2 United Nations Plaza, Room DC2-1420, New York, New York 10017, USA; biennial budget 1988-89 for population activities, \$3.4 million, including \$1.3 million derived from UNFPA.

Regional Commissions (Economic Commission for Africa, P.O. Box 3001, Addis Ababa, Ethiopia; Economic Commission for Europe, Palais des Nations, 1211 Geneva 10, Switzerland; Economic Commissions for Latin America and the Caribbean, Edificio Naciones Unidas, Casilla 179-D, Santiago, Chile; Economic and Social Commission for Asia and the Pacific, United Nations Building, Rajdamnern Avenue, Bangkok 10200, Thailand; Economic and Social Commission for Western Asia, P.O. Box 927115, Amman, Jordan) Total combined biennial budget 1988-89 for population activities, \$26.3 million, including \$18.7 million derived from UNFPA.

Specialized Agencies:

World Bank Senior Advisor, Population: Thomas W. Merrick; Director, Population, Health and Nutrition Department, Human Resources and Operations vice-presidential unit: Janet de Merode. Four geographic vice-presidential units also have population and human resource (PHR) divisions in each of their 19 country departments and in each of the 4 regional technical departments. 1818 H Street, N.W., Washington, D.C. 20433, USA. Currently the Bank has over 50 ongoing projects with substantial population components, representing a total lending commitment of roughly \$963 million. In its 1991 fiscal year, the Bank committed a total of about \$351 million in new loans and credits for either discrete population projects or population components of combined health and population projects. The comparable figure for FY 1992 was \$103.5 million. Disbursement against these loans take place over several years as projects are implemented.

World Health Organization (WHO) Director, Division of Family Health: Angele Petros-Barvazian, M.D.; Director, Special Programme of Research, Development and Research Training in Human Reproduction: Giuseppe Benagiano, M.D. 20 Avenue Appia, 1211 Geneva 27, Switzerland. Biennial budget 1988-89 for population activities, \$276.9 million, including \$53.4 million derived from UNFPA.

International Labor Organization (ILO) Chief, Employment Planning and Population Branch: Eddy Lee. 4 route des Morillons, CH 1211 Geneva 22, Switzerland. Biennial budget 1988-89 for population activities, \$24.3 million, including \$20.1 million derived from UNFPA.

United Nations Educational Scientific and Cultural Organization (UNESCO) Director of Population and Human Settlements and Coordinator of Population Programs: R. Urzua. 7 Place de Fontenoy, 75700 Paris, France. Biennial budget 1988-89 for population activities, \$20.9 million, including \$19.6 million derived from UNFPA.

Food and Agriculture Organization (FAO) Coordinator, Population Program: Joop Alberts. Via delle Terme de Caracalla, 00100 Rome, Italy. Biennial budget 1988-89 for population activities, \$8.2 million, including \$6.7 million derived from UNFPA.

Major National Governmental Agencies Providing International Population Assistance

United States of America:

Principal U.S. aid agency:

U.S. Agency for International Development. Office of Population, Research and Development Bureau, and geographic bureaus for Africa, Asia, Europe, Near East and Latin America, Washington, D.C. 20523. Total commitments for population assistance in fiscal year 1993 estimated at \$434 million. This includes \$350 million from the population assistance account in the foreign aid budget; \$67 million budgeted for population activities from the Development Fund for Africa; and \$17 million from the Economic Support Fund. Population funds are allocated bilaterally through 44 country programs (as of 1993) and through centrally-funded cooperative agreements and contracts with about 25 private cooperating agencies for their international programs.

Other U.S. governmental agencies with population activities:

Bureau of the Census Center for International Research (demographic analysis) and International Statistical Programs Center (training, consultation, and methodological materials). United States Department of Commerce, Scuderi Building, Washington, D.C. 20233; Tel: CIR, (301) 763-2870, ISPC, (301) 763-2832; Telex: 9102509167; FAX: (301) 763-7589

Centers for Disease Control (CDC) Division of Reproductive Health (assistance in management and evaluation of family planning programs). Center for Health Promotion and Education, 1600 Clifton Road, N.W., Atlanta, Georgia 30333; Tel: (404) 639-3056; FAX: (404) 639-3296, 639-3037

National Institute of Child Health and Human Development, Center for Population Research (biomedical research and research into methods of fertility regulation and social science aspects of population change) Executive Plaza North, 6130 Executive Boulevard, Room 604, Bethesda, Maryland 20892; Tel: (301) 496-1101; FAX: (301) 496-0962

Australia: Australian International Development Assistance Bureau (AIDAB), 62 North Boume Avenue, Canberra, ACT 2600, Australia. Population assistance in 1991, \$5.3 million.

Austria: Federal Ministry for Economic Affairs, Stubenring 1, A-1010, Vienna, Austria. Population assistance in 1992, \$0.56 million.

Belgium: Ministry of Foreign Affairs, Tour WTC 2, Boulevard Emile Jacqmain #162-44, Brussels, Belgium and Belgian Administration for Development Cooperation (AGCD) Marsveldplein 5 Bus 57, 1050 Brussels, Belgium. Population assistance in 1991, \$5.8 million.

Canada: Canadian International Development Agency (CIDA), Place de Centre, 200 Promenade du Portage, Hull, Quebec, K1A 0G4, Canada. Population assistance in 1991, \$28.9 million.

Denmark: Ministry of Foreign Affairs, Department of International Development Cooperation, 2 Asiatisk Plads, DK-1448 Copenhagen K, Denmark. Population assistance in 1991, \$24.2 million.

Finland: Ministry for Foreign Affairs, Department for International Development Cooperation, 15C Mannerheimintie, 00260 Helsinki, Finland and Finnish International Development Agency (FINNIDA), Katajanokanlaituri 3, SF-00160, Helsinki, Finland.. Population assistance in 1991, \$25.6 million.

France: Ministry of Cooperation and Development, Department of Health and Social Development, 20, rue Monsieur, 75007 Paris, France, and Caisse Centrale de Cooperation Economique, 8 Cité du Retiro, 3537 rue Boissy d'Anglas, 75379 Paris CEDEX 08, France. Population assistance in 1991, \$2.1 million.

Germany: Ministry for Economic Cooperation (BMZ), P.O. Box 120322, 5300 Bonn 1, Germany and the Agency for Technical Cooperation (GTZ), P.O. Box 5181, Dag Hammarskjold-Weg 1-2, 6236 Eschborn D6236, Germany. Population assistance in 1991, \$75 million.

Italy: Ministry of Foreign Affairs, Directorate General for Development Cooperation (DGDC), 1 Piazza della Farnesina, 00194 Rome, Italy. Population assistance in 1991, \$1.6 million.

Japan: Ministry of Foreign Affairs, Economic Cooperation Bureau, P.O. Box 216, Shinjuku Mitsui Building, 1-1, 2-chome, Nishi-Shinjuku, Shinjuku-ku, Tokyo, 163, Japan, and Japan International Cooperation Agency (JICA), 2-1-1 Nishi-Shinjuku, Shinjuku-ku, Tokyo, 163, Japan. Population assistance in 1991, \$63.1 million.

Netherlands: Ministry of Foreign Affairs, Directorate General for International Cooperation (DGIS), P.O. Box 20061, 2500 EB, The Hague, The Netherlands. Population assistance in 1991, \$39.6 million.

New Zealand: Ministry of External Relations and Trade, Private Bag, Wellington, New Zealand. Population assistance in 1991, \$0.42 million.

Norway: Ministry of Foreign Affairs, P.O. Box 8114 Dep., N-0032 Oslo, Norway, and Norwegian Agency for International Development (NORAD), P.O. Box 8340, 0030 Oslo 1, Norway. Population assistance in 1991, \$53.6 million.

Spain: Ministry of Foreign Affairs and Spanish Agency for International Cooperation (SAIC). Avda. Reyes Catolicosd, 4, 28071 Madrid, Spain. Population assistance in 1992, \$0.48 million.

Sweden: Ministry of Foreign Affairs, Department for International Development Cooperation and Swedish International Development Authority (SIDA), 61 Birger Jarlsgatan, S-10525, Stockholm, Sweden. Population assistance in 1991, \$42.2 million.

Switzerland: Federal Ministry of Foreign Affairs, Directorate for Development and Humanitarian Aid, 73 Eigerstrasse, 3003 Bern, Switzerland. Population assistance in 1991, \$6.8 million.

United Kingdom: Overseas Development Administration (ODA), Health and Population Division, 94 Victoria Street, London SW1E 5DH, United Kingdom. Population assistance in 1991, \$46.7 million.