POSTCOITAL CONTRACEPTION
A REPORT FROM THE LONDON BROOK
ADVISORY CENTRES, UNITED KINGDOM

Postcoital contraception is a valuable addition to other methods of birth control. It is best described as "interception" in that it may not prevent the fertilization of an egg, but acts by preventing the implantation of a fertilized ovum in the endometrium, if one exists. It is not an abortion because it does not interfere with an embryo that has already been implanted, if the recommended criteria for defining an abortion are strictly followed.

In the United Kingdom, postcoital contraception has become an increasingly acceptable and available method, to be used if there has been unprotected intercourse or if a method of contraception has failed. At the London Brook Advisory Centres, the number of cases treated has more than doubled each year from 96 in 1980 to 1089 in 1983.

There are two methods available—a hormonal method, commonly referred to as the "morning-after-pill", which is most frequently used (1026 cases in 1983), and the insertion of an intrauterine device or IUD (63 cases).

The "morning-after-pill"

In the early hormonal treatments, large doses of Ethinylestradiol were used, up to 25 mg over a five-day period. The pregnancy rate was low, but the side effects of nausea and vomiting, headaches and breast tenderness were serious, and made this a treatment reserved for cases where the risk of a pregnancy was considered to be high, and the consequences unacceptable.

The procedure has been completely changed since Dr Albert Yuzpe, a Canadian gynaecologist, made his work known in the 1970s. Following the regime advised, two tablets of a combined oestrogen-progestogen pill are taken. Twelve hours later another dose of two tablets is taken. Each dose of two tablets contains 0.1 mg Ethinylestradiol and 1.0 mg Norgestrel, which is conveniently supplied by using Eugynon 50 or Ovran 50 pills. The shorter regime is easy to complete.

There have been fewer side-effects with this method. Nausea is the most commonly reported, by 1 in 4 women. Vomiting may occur in 1 in 8. Both effects are probably caused by absorbing the oestrogen in the pills. We have not found an increased risk of pregnancy in the women who vomit, and unless they vomit within half an hour of taking the tablets, we do not suggest further treatment.

Other side-effects include headache, fatigue, tender breasts or depression in a small number of cases. Side-effects have not proved serious or incapacitating, and only last 6-12 hours.

Outcome of hormonal treatment

The risk of a pregnancy following a single act of unprotected intercourse has been calculated to be 5% at any time of the cycle, and 20-30% at midcycle. Failure of postcoital contraception has been reported as ranging from 1.6% to 3.5%. This is considerably less than the expected rate of pregnancy if no treatment were provided. Patients should always be warned, however, that the method is not 100% effective and they should consider what they would do if a pregnancy continued. In practice, most would opt for an abortion.

We have not had sufficient numbers of women continuing a pregnancy to know whether the medication has an increased teratogenic effect. Evidence from women who have continued taking oral contraceptives in the early weeks of pregnancy suggests this is unlikely.

For maximum success of the "morning-after-pill" the following criteria should be met:

- treatment begun within 72 hours of exposure to unprotected intercourse;
- only one incident of unprotected intercourse in the menstrual cycle;
- agreement of the woman to abstain or use additional contraceptive methods until the next period;
- agreement to return for follow-up in 2-3 weeks' time, to make sure there is no continuing pregnancy.

Postcoital IUD insertion

This method of postcoital contraception may be used later, up to five days after exposure, and so it may be the only choice when patients delay seeking treatment after unprotected intercourse.

Few pregnancies have been reported with this method, less than 1 in 1300. The IUD may be left in situ if acceptable, for long-term contraception.

But it is usually undesirable to fit an IUD on a nulliparous woman because of the risk of pelvic inflammatory disease. This could be an added risk if infection is apparent, or after a rape. The technique of fitting may also be more difficult and cause pain. Where the IUD method is the only alternative available, it is possible to remove the IUD when the first period arrives, to reduce the risk of infection.

Reasons for requesting postcoital contraception

Among the 1089 women treated with postcoital contraception at the London Brook Advisory Centres in 1983, 49% did not use any contraceptive on the occasion of this intercourse; 30% had a known failure of contraception; 14% failed to use available contraception, such as the Pill, sheath or cap, or the sheath broke or came off, or the diaphragm was found to be torn; in 4% the contraceptive method was used incorrectly (cap incorrectly placed, oral contraceptive taken incorrectly); and other reasons (failed coitus interruptus, rape) accounted for 3%.

Guidelines for postcoitus interruptus

1. Counselling the patient

Because the considerable amount of information that should be given to the patient cannot all be absorbed or retained, it is helpful to have a printed sheet that sets out the information clearly and simply, to give to patients to refer to. Counselling the patient and helping her to make a decision should be considerate and unhurried - which is not always easy in a busy clinic or practice. Suitably trained nurses should be able to take on this role.

Future contraception should always be discussed when postcoital contraception is being used and the reasons for failure of previous methods should be considered. An acceptable method should be decided on and initiated.

In May 1983 the Family Planning Association (FPA) launched a publicity campaign on postcoital contraception and made a special appeal to general practitioners and family planning doctors to respond to the growing demand for "morning-after" contraception. The FPA distributed free posters for clinics and general practitioners' surgeries and free leaflets for the public.\(^a\)

In the view of the FPA Medical Advisory Panel, postcoital contraception is a method of "emergency" contraception for use in cases of unprotected intercourse, rape and failure of barrier methods such as the condom. It is not recommended as a routine method of birth control.

3. Professional awareness

Unless doctors are aware of the method, confident to use it, and prepared to see patients at short notice within the 72-hour time limit, and adjust their practice accordingly, availability will be limited, and full advantage will not be taken of the method.

In summary, if the likelihood of an unwanted pregnancy that might lead to an abortion can be reduced from 30% to 3%, I believe that most doctors and their patients will appreciate this as a valuable method. And if the consultation can also be used to help provide future reliable birth control, this is an added benefit.\(^b\)

[From: Dr Fay Hutchinson, Brook Advisory Centres, Central Office, 153a East Street, London SE17 2SD, United Kingdom]

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\(^a\) The FPA has developed information materials for the public and for the health professions. For samples of the materials write to: FPA, Family Planning Information Service, 27/35 Mortimer Street, London W1N 7RJ, United Kingdom.
POSTCOITAL CONTRACEPTION IN OTHER EUROPEAN COUNTRIES

The Autumn 1984 issue of Planned Parenthood in Europe includes the proceedings of a one-day discussion by the IPPF Europe Regional Council on postcoital contraception. In a lead article, Philip Meredith reviews the role of postcoital contraception in family planning practice in Europe. Three country experiences are discussed: the Federal Republic of Germany by Dr K.O. Hoffmann; the Netherlands by Dr M. Van Santen; and Hungary by Dr Artur Bernard. The provision of postcoital contraception in 17 other countries is briefly summarized.

[The bi-annual information bulletin is available free on request (in English or French) from IPPF, 18-20 Lower Regent Street, London SW1Y 4FW, United Kingdom]

COUNTRY REPORTS

A LEGAL FRAMEWORK FOR SEX EDUCATION IN PORTUGAL: TWO CONSIDERATIONS

On 24 March 1984, a bill on sex education and family planning came into effect in Portugal.

The bill defines sex education as a fundamental right to be guaranteed by the State and to be introduced in the school curricula through the training of teachers and through support to parent education. It further defines the responsibility of the State to promote information on family planning methods and to establish the required legal and technical organizational structure to enable the free exercise of responsible parenthood.

In addition, the bill of March 1984 guarantees to adolescents under 18 years free access to contraceptive services which, since 1976, have been set up under the impulse of Dr Arosio Ramos, as part of Maternal and Child Health Care.

The bill on sex education and family planning expresses an intention concerning the development of sex education. It does not provide a specific framework for implementation.

During 1984, the Portuguese Family Planning Association organized several activities for teachers, parents and youngsters. In April 1984, for example, the Association introduced a seminar on sex education for 800 teachers. Other schools requested help to organize sessions on sex education for adolescents and parents. In the urban area, about 200 teachers, 2000 youngsters and 300 parents participated. In March 1985 a second teacher training seminar on sex education was conducted.

As a result of these activities as well as from contacts with various officials on how to implement the law on sex education, the Portuguese Family Planning Association proposes two major guidelines.

1. Sex education requires a global view of sexuality including physical, emotional, social and partnership aspects. Whether sex education succeeds depends on the quality of the relationship between teacher and students and on the participation of the students in the educational process. The different aspects of sex education should be part of existing programmes at school including various cultural activities.

2. Sex education is a dynamic, education process involving all members of the school. A way to start this process at school is to have teachers from different fields form a core group responsible for the introduction and support of sex education at school. Such a group should not only try to reach the student but also other teachers and especially parents.

[From: Mr Duarte Vilar, Associação para o planeamento da Família (APF), Delegação regional de Lisboa, Rua Artilharia Um, 38, 2º Dto., 1200 Lisbon, Portugal]
FERTILITY BEHAVIOUR IN FLANDERS:
TWO DECADES OF RESEARCH

Fertility has been investigated in the last two decades by the Population and Family Study Centre. The Centre was established in 1962 and most research is carried out in collaboration with research units at different universities. In 1982, the national Centre was replaced by two regional study centres, one for the Flemish Community (CBGS) and one for the Francophone community. This report covers research conducted in part still by the national Centre and later by the CBGS, and it concerns four fertility surveys carried out in 1966, 1971, 1975-1976 and 1982-1983 on the Flemish population in Flanders.

Data from these surveys show a decrease in the fertility achieved by women aged 30-34 years from 1966 to 1983, with at the same time a lowering of the variance around the average number of children they have.

<table>
<thead>
<tr>
<th>Survey period</th>
<th>Average no. of children</th>
<th>Variance</th>
</tr>
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<tbody>
<tr>
<td>1966</td>
<td>2.57</td>
<td>(1.92)</td>
</tr>
<tr>
<td>1971</td>
<td>2.41</td>
<td>(1.19)</td>
</tr>
<tr>
<td>1975-1976</td>
<td>2.19</td>
<td>(1.06)</td>
</tr>
<tr>
<td>1982-1983</td>
<td>2.07</td>
<td>(0.82)</td>
</tr>
</tbody>
</table>

Throughout this period, the proportion of women with one and two children remained stable and the change in average fertility was due to a considerable decline in the number of women with four or more children.

Modern couples cherish an ideal family size of 2.2 children which perfectly fits the demographic replacement norm for Flanders. The ideal family size, however, is not achieved in practice. Families with 3 and more children do not compensate for childless and one child families.

The last survey, 1982-1983, indicates a possible increase in "voluntary" childless couples. Among younger couples, 3% report they want to remain childless compared with 1% in the 1975-1976 survey. Cohabitation is also reportedly increasing. Half the adolescents in 1983 wished to live with their partner before marriage.

Family size is influenced by many factors, for example contraceptive practices. Family planning practices in the 1960s were very traditional. In the early 1980s, however, contraception predominantly involved the use of modern methods. The high frequency of Pill use among younger women and the strong increase in surgical sterilization with progressing age are striking features when survey data from 1966 and 1983 are compared.

In analysing fertility, female employment is the most important factor among all socioeconomic and cultural variables. Its influence can be summarized as follows: (a) job and career ambitions have a birth-limiting effect, (b) with increasing family size female employment decreases and (c) sub-fecundity leads more easily to continued employment.

Another factor that influences family size and that we want to underline is the observed relationship between an unsatisfying partner relationship (lack of communication with partner, problems with sexual intercourse) and the fact that these couples have more children than they desire.

In addition to conducting fertility surveys, the CBGS Centre analyses demographic trends, changes in family condition and welfare, and the problem of aging. Study results are published in Dutch and in two yearly English documents: Population and family in the Low Countries and CBGS progress report. From time to time important study results on contraception are made available to the public through the media.

[From: Professor R.L. Cliquet, Director a.i., Population and Family Study Centre (CBGS), Ministerie van de Vlaamse Gemeenschap, Nijverheidstraat 35/37, 1040 Brussels, Belgium]
FAMILY PLANNING AND SEX EDUCATION
IN AUSTRIA

Adolescent sexuality poses a problem for adults as well as adolescents. The adult frequently deplores adolescent sexuality on moral and practical grounds. The adolescent is frightened because of the new emotional and social experiences that sexual activity entails.

Adults in Austria do not in general accept sexual activity among adolescents. Adolescent sexuality will be recognized when there is a pregnancy, but until that point sexuality will not be discussed but in some way forbidden. The fact that sexual experiences in adolescence may help the young person to choose the right partner and to raise a family is not considered acceptable in our society. Furthermore, although adolescents learn useful things for later work or social life, learning about sexuality is mostly omitted from this general process of learning.

In 1970 a sex education curriculum was introduced in Austrian schools as parents and teachers are considered the most suitable people to teach knowledge, norms and values. Unfortunately, the teaching of sexuality is hardly put into practice. Children are taught the biological "facts of life" to some extent, and sexuality is covered in religious education. Teaching biological facts, however, is considered superfluous because teachers feel the young already know the basic facts of life through biology courses. Religious education more often fills a gap in learning about sexual relationships but the number of children attending these courses is declining and not all youngsters who attend religious classes find the norms and values taught acceptable to them.

While teachers generally agree that schools should provide sex education, they are often unwilling to give sex education themselves. Explaining the sexual act seems very difficult to them. Research by Graf in 1975 shows that only 25% of the teachers interviewed answered questions correctly about the sexual act and about the genital areas.\(^a\) There is hope but no evidence that this situation might have changed in the last ten years.

Adolescent sexuality is largely a problem of communication between generations. Adolescents know more about sexuality and have more experience than their teachers and parents believe. According to research by Mechler, 33-40% of all 16-year-old adolescents in Austria have already had sexual experience.\(^b\) At 19, 75% of them have been sexually active. Parents do not talk about sexuality with their children fearing that this will make them sexually active. Youngsters do not dare ask their parents for fear they might know they are already sexually active. This "conspiracy of silence" may result in an unwanted pregnancy.


Adolescents here as elsewhere in Europe have developed new sexual morals. They want stable relationships based on mutual love and fidelity. As long as this is acceptable to both partners, the relationship continues. Sometimes the relationship grows into marriage. More often, a number of relationships with different partners precede marriage.

Studies on abortion in Austria show that 25% of abortions are performed on adolescent girls. This certainly indicates a need to improve sex education in and out of school.

A year ago, the Ministry for Family, Youth and Consumer Affairs started to develop a "media case" for teachers that will contain material on sex education for 10- to 15-year-olds such as a film, slides, posters, and a booklet with background information for teachers and educators. The Ministry will provide the case to all schools early in 1986. The material will be used in teacher training courses as well, and for out of school youths.

The materials are being developed with the Ministry of Education and parent associations have been invited to join the working group in preparing the materials.

[From: Dr Elisabeth Jandl-Jager, Scientific Secretary of Österreichische Gesellschaft für Familienplanung, II. Univ. Frauenklinik, Spitalgasse 23, 1090 Vienna, Austria]

SEXUAL COUNSELLING FOR DISABLED PEOPLE:
A PERSONAL VIEW

This paper raises some points in the training of sexual counsellors and other professionals working with disabled people. In the next issue of ENTRE NOUS, I will look at the questions asked by the disabled and discuss how to deal with them.

A competent counsellor is someone who internalizes a belief in the client's rights and opportunities to have a satisfactory sexual life, despite the disability. What should they know and feel to become sensitive, competent counsellors?

From my own counselling experience, I know that you struggle sometimes with hostility from others. People look at you as a very strange person because of your work. You are also working for a very distant goal. Therefore, people who work in this field need continuous support and encouragement. Interestingly, counsellors working with disabled people are very much alike all over the world: they have similar difficulties, share the same hopes and recognize each other's ways of dealing with the problem. In many ways, we have to be more careful, more patient and less threatening in discussing sexuality with disabled clients than do sexual counsellors for the non-disabled. Why is this so?

Our greatest challenge is to fight against two strong attitudinal forces: attitudes towards sex and attitudes towards the disabled. These attitudes are mixed in an incredible way. We cannot just question negative attitudes towards sex but have to develop confidence in ourselves and between ourselves and the disabled, so the disabled will feel they can always turn to us on this question.

From experience and the training courses I have conducted, I feel that the attitude of personnel poses the greatest problem and threat to counselling the disabled about sexuality.

\[a\] Wimmer-Puchinger, B. Motive zum Schwangerschaftsabbruch (unpublished manuscript, 1982)

\[b\] In view of the cost of the "media case", free sample copies will not be available. Interested readers may wish to contact Dr Jandl-Jager at the above address to arrange for a review of the material.
For example, personnel who take care of the disabled may often avoid or refuse to answer questions out of fear of getting themselves into an uncomfortable situation. Their voice or bodily movement shows anxiety or an inability to discuss sexual questions. Unconsciously, disabled people will stop asking questions and afterwards they will say: "No one ever asked me anything. There is no need."

Professionals tend to forget that they are in a superior position because they are not in need of counselling or of care themselves. The client with a disability is. In addition, professionals perpetuate myths about sexuality. For example, the only correct sexual expression is sexual intercourse; and orgasm should occur at the same time for both male and female partners. But sexuality is much more. It is body signals, eye contact, touching, variations in bodily contact, oral and manual sex, exploring of erogenous zones, etc. This is my definition of sexuality in the broadest sense. If you, however, define sexuality as sexual intercourse only, you condemn yourself and others to a very dull life.

There are other common myths, such as: sexuality and feelings of love are for young and beautiful people; and disabled people are "sacred sufferers" for the rest of mankind and should therefore not be involved in activities that are pleasurable, such as drinking, smoking and sex. Not to mention the myth of the disabled woman's passive role in bed, whether she enjoys it or not. Recent research on the disabled woman's sexuality has shown the need to define sexual inadequacy in women more clearly. Is it lack of lubrication, lack of sensation, pain in intercourse or the wrong partner?

Other myths are spread by people working "for" disabled people (which is different from working "with" disabled people) such as: "Will disabled people not want to prove their normality by producing children?" or "How can we teach disabled adolescents about pregnancy and childbearing, when we don't believe in them having children?"

These are some of the myths affecting the environment of disabled people. We should first deal with them and discuss them openly. I want to make clear that it is not threatening for disabled people if you discuss sexual questions and inform them how to enjoy their sex life. You don't stir things up. The anxious questions are already there as well as the misconceptions.

References:


[From: Ms Inger Nordqvist, Coordinator and Project Leader in Sexuality and Disability, Handikappinstitutet, Department of Information and Education, Box 303, 161 26 Brome, Sweden]

YOUTH AND HEALTH

The World Health Organization goal of health for all by the year 2000 and the theme of the 1985 International Youth Year, "Participation, development, peace" are intertwined. The purpose of this article is to draw attention to the relationship between youth and health, particularly in terms of sexual and reproductive health. In the past the health problems of youth have not been given much attention because, by and large, the young are a healthier segment of the population. In contrast children, the elderly and the disabled are more vulnerable to the ravages of disease.
However, in recent times the following factors have focused attention on health issues of the young.

Menarche appears to be occurring earlier, possibly because of improved nutrition, and the age of marriage is rising. As a result there is more risk of unprotected sexual intercourse with an increase in the problem of unwanted pregnancies, sexually transmitted diseases, induced abortion, premature parenthood and its associated social, educational, and economic burdens.

Regional urbanization means a transition from a traditional rural society, in which the young have the support of the extended family, to urban or peri-urban settings where they often migrate alone and are exposed to new and alien ideas from the mass media, tourists, and migrant workers returning from other countries. Commercial interests stoke their aspirations for things that society often cannot provide. To this we should add unemployment, underemployment and the threat of nuclear catastrophe which puts today’s young people under considerable strain.

Sexual and reproductive health issues

Young people worry about their sexuality and whether they can function normally. Lack of information and misinformation from peers, adults and professionals account for the larger portion of such distress.

Unprotected sexual intercourse outside marriage occurs more frequently. It can lead to sexually transmitted diseases, and pregnancy in early adolescence with attendant higher risks of morbidity and mortality to mother and fetus.

Premature parenthood has devastating effects on the young woman but also on the child. It may mean the end of the educational, economic and social development of the young woman. It breeds poverty with consequent physical and often emotional deprivation for the child whose parents are too immature to rear it adequately.

The range of effective contraception for young women and their partners is limited. The IUD is not recommended for nulliparous women and because of the irregularity of the menstrual period in young women, natural methods are not likely to be effective. Sterilization is inappropriate and barrier methods require some skill and forethought.
The Pill is not always easily accessible to the young unmarried person. Perhaps the condom is the most useful method for unplanned sexual activity, but it depends largely on the responsibility of the young male, and his reliability remains an open question in most societies.

Promoting health for and by the young

Most problems of adolescent sexual and reproductive health are preventable in two ways: by promoting health for and promoting health by the young.

Promotion of sexual and reproductive health for the young includes services adapted and accessible to the young and in which they have a say. The most needed services are: sexual education for young people both in and out of school and counselling by people (sometimes peers) who are selected for their natural sensitivity to others; contraceptive services; preparation for parenthood; and accessible screening and treatment services for sexually transmitted diseases.

The biggest challenge to the International Youth Year is to search for and find ways and means for the young themselves to contribute to their own health. Young people are a great resource for health promotion.

"It's our future"

There is a pool of willing and talented young people whose skills might be used, for example:
- to promote their own health and that of their families through better knowledge of hygiene, fitness, and healthy living;
- to provide education, information and counselling to other young people and to children;
- to help in oral rehydration and immunization programmes, and in the improvement of sanitation or the construction of health facilities in the community;
- to act as messengers, communicators and transporters to health professionals, for example in delivering medical supplies to isolated communities;
- to participate in community health studies.

These are some of the possible ways in which the resources of the young can be used. The ideas will come from the young themselves, the opportunities should be provided by us.


MEETINGS REVIEWED

A FORUM ON SEXUALITY IN BARCELONA

A four-day forum on sexuality in Barcelona, 17-20 April 1985, was organized by the Institute for Women's Affairs of the Ministry of Culture in collaboration with the Ministries of Health, Education and Justice and with the technical and organizational support of the City of Barcelona and was attended by a representative from the family planning unit of the WHO Regional Office for Europe.

This national meeting was to plan a global coordinated project on sexuality involving central, local and autonomous
levels of administration in the areas of education, information and services and to specify how this project could be implemented, specifically how the different levels of the administration would coordinate their efforts.

Some 50 participants from different levels of administration and various professional groups achieved through lively discussions a remarkable exercise in national policy-making. The commitment and vision of those present helped overcome professional and political boundaries. At the end of the meeting a comprehensive list of recommendations was drawn up concerning sexuality in the three key areas of education, health and the community.

For example, there was a common agreement that sex education should be available to people of all ages. The necessary conditions for implementation were spelled out. Existing family planning services should be made comprehensive and include opportunities for sexual counselling. Throughout all the recommendations, the need for training of staff involved in health and social service centres was emphasized, as well as the importance of coordination between various levels of services.

[For further information contact: Mrs Carlota Bustelo García del Real, Director, Institute of Women's Affairs, Ministry of Culture, Almagro 36, 28010 Madrid, Spain]

MANAGEMENT AND EVALUATION OF FAMILY PLANNING WITHIN THE FRAMEWORK OF PRIMARY HEALTH CARE

The National Centre for Human Reproduction and Family Planning in Rabat (which is also a WHO collaborating centre) and the Family Planning Unit of the WHO Regional Office for Europe have jointly organized, within the framework of primary health care, an interregional workshop on management and evaluation of family planning programmes. The workshop was held in Agadir from 4 to 15 February 1985. It was attended by 17 participants from eight countries from the WHO regions for Africa, the Eastern Mediterranean and Europe, in response to the wish of the organizers to improve the knowledge of national or regional staff in charge of the management process as applied to family planning.

Three main themes were dealt with at the workshop: population problems within the context of primary health care; assessment of health status; and the programming process within the framework of family planning. These subjects were surveyed in theory and in practice, and three studies were prepared by the health team of the Agadir Province. Technical background documentation drafted by the organizers was placed at the disposal of participants.

During field trips, participants were impressed by the work carried out by the health teams on primary health care in the provinces of Agadir and Taroudant. Both provinces are among the pilot areas for the development of primary health care. The WHO Regional Office for Europe has been collaborating with this project since 1982.

[Le gestion et évaluation des programmes de planification familiale dans le contexte des soins de santé primaires: Report on an interregional workshop, Agadir, 4-15 February 1985 (unpublished document ICP/MOH 502/c02, UNFPA/RM1/79/P05), French only]

THE TRAINING OF TEACHERS IN THE PSYCHOSOCIAL ASPECTS OF FAMILY PLANNING

A national workshop on teaching the psychosocial aspects of family planning was held in Lisbon, Portugal, at the Directorate-General of Primary Health Care, from 20 to 23 February 1985. It was organized by the Mother's Health Care and Family Planning Unit of the Directorate-General of Primary Health Care, jointly with the Family Planning Unit of the Regional Office for Europe of the World Health Organization.

Its scope was to give 22 participants from the nine regions in Portugal a chance of preparing and implementing a family planning training programme, integrating psychosocial aspects and adapted to the Portuguese situation.

The work was based on a draft guide for training in the psychosocial aspects of family planning, prepared by the WHO Regional Office for Europe and the International Children's Centre, Paris.
in cooperation with the training department in health sciences of the medical school in Bobigny, France, and the health education and family planning section of the National School for Public Health in Rennes, France.

The guide was translated into Portuguese by the organizers and was welcomed by the participants, who felt they would be able to use it for their work in Portugal, whether they are in charge of training or are directly involved in field work within a health team, participating in refresher courses for the staff.

The experience and the results of the workshop proved useful, as the guide was primarily drafted as a tool for training specialists in the countries of the European Region of WHO to help them prepare and implement the health personnel training programme in the field of family planning.


EDUCATIONAL AIDS

MARKETING CONTRACEPTIVE PRODUCTS

At first hand health and marketing seem at odds with each other. Aggressive marketing of cigarettes, alcoholic drinks and low quality foods has tended to show marketing people and their products as villains, eager to deceive or confuse the public to make a profit. However, marketing can be quite profitable from a health point of view. For a decade this strategy has been used with success in boosting sales of contraceptive products and more recently of oral rehydration salts. Such marketing is aptly called "social marketing". It uses the same marketing techniques to promote, distribute and sell products as commercial marketing, with the difference that commercial marketing aims at creating profit for the manufacturer while social marketing aims at creating a "health benefit" for the public.

The social marketing of contraceptive products (pills, condoms, foams) proceeds in the belief that contraceptive sales -- and thus contraceptive use -- can be dramatically increased by the choice of appealing and culturally appropriate visual images, colours and product names.

Factors responsible for success in applying the social marketing approach have been succinctly summarized in a recent publication of the Population Communication Service (PCS) of the Johns Hopkins University. They include four guidelines: (1) the package must be acceptable to users (visual image, product name, colour and package size are points to look at); (2) the package must be appealing to retailers thus raising questions about appropriate display racks, dispensers, posters for shops; (3) the outer package can help

a PCS Packet No. 4: Packages for contraceptive products (10 pp).
to protect the contents against damage e.g. by using plastic and foil lining; and (4) the package should provide information on the proper use of the contraceptive, even in visual form if needed.

In addition to this publication, the PCS provides a larger poster with examples of tested and successful packages for contraceptive products in countries of Central America, Asia, Africa and the Mediterranean Region.

Market research and pretesting has led, for example, to the development of "Dhaal", a shield for condoms in Nepal, and of a "panther" for condoms in Jamaica and neighbouring Caribbean countries. Oral contraceptives are visualized in different ways: as a pearl on a shell (Caribbean countries), a flower in Ghana (Florii) and Nepal (Gulaf), or a delicate woman's portrait in Egypt and Bangladesh.

Even if you are not involved in product development, paying attention to the methods used in social marketing is helpful to sort out complex issues involved in health messages and materials. What do people need to know and what do they readily understand? What is considered offensive or appealing to the client's taste and customs? Answers to these and other questions is likely to lead to practical and sensitive communication between health workers and the public.

[For more information: Population Information Program, PCS, The Johns Hopkins University, 624 North Broadway, Baltimore, Maryland 21205, USA.
Note: PCS Packet No. 4 and other packets are free for people working in developing countries. In the US and other developed countries, enclose US$ 0.50 for each package]

What To Write For

In recent years the World Health Organization has supported one-day workshops that precede or follow international, regional or national meetings or conferences. This has proved to be an effective means of promoting ideas and approaches related to the attainment of health for all by the year 2000. A working document that was successfully used in such promotional workshops by the Division of Family Health, WHO, Geneva, is Risk approach in maternal and child health/family planning care: a one-day Workshop. WHO, Geneva (unpublished document FHE/MCH/85.4).
The risk approach is based on the hypothesis that a more accurate measurement of risk to health will lead to a better appreciation of the needs of the individual and of the community, and hence bring forward a more adequate response at all levels of health care, but especially at the primary health care level. So, the measure of risk is a proxy for need - need for promotive and preventive care - and invites a proportionate response.

The practical application of this approach can be more fully appreciated through participation in a one-day workshop that will lead to an understanding of the concept of risk and of how risk data can be used to reorganize maternal and child health including family planning care.

[If you are interested in organizing such a workshop or know people who are, write for a copy of the working document (29 pages, available in English now and in French soon) to the Division of Family Health, World Health Organization, 1211 Geneva 27, Switzerland]

FERTILITY, FEMALE EMPLOYMENT AND POLICY MEASURES IN HUNGARY


It is well known that fertility has decreased in Eastern European socialist countries in recent decades and that increasing numbers of women have become economically active. In an endeavour to halt the decline in birth rates, the governments of these countries have introduced major new policy measures aimed at encouraging fertility and at facilitating the combination of motherhood and work outside the home. This detailed study of Hungary not only gives demographic and employment data for the population as a whole but also provides interesting information on KAP (Knowledge, Attitude and Practice of Family Planning) surveys, panel surveys of marriage cohorts, and time budget studies.

[Order through major booksellers, or from ILO Publications, International Labour Office, CH-1211 Geneva 22, Switzerland, 15 Sw. frs.]