Family matters

As the end of the century draws near, Entre Nous takes a look at how people's attitudes are changing towards that most intimate social group, the family. In general, European couples are having fewer children than their parents, and more divorces. They gladly set up home together, but are more cautious about when to marry and when to have their first child. The family itself has become an animal of many disguises. In one household there may be either one or two parents, children of one or more unions, or any number of permutations on the theme. Also, in less than 20 years there will be more Europeans aged over 65 than under 15. Both sexes in this new power group can expect to live for several years longer than their forbears, so more of them will do so in company with a partner.

East Europeans still tend to marry early and to have their first child while quite young. Yet some have begun to live together, to the detriment of marriage. As in the west, couples in the east are having fewer children. But one distinct area of difference remains, and that lies in the use of contraceptive methods.

Diana Gibson

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In the west people can choose from a range of methods, one of which, the pill, is not only safe and effective but protects against cancer and cardiovascular diseases. Had the pill not suffered from a bad press, even more western women might have used it. On the other side of the iron curtain, meanwhile, some governments had their own reasons for blackening the pill's reputation. Yet even in cases where both the pill and the intrauterine device were available, women in several parts of eastern Europe in the Seventies and Eighties - for whatever motives - showed themselves inclined to prefer abortion to contraception. In Yugoslawia and Romania, abortion was tending to become the only method of birth control.

Hungarian and east German women are now moving away from abortion towards contraception. If this trend spreads, it could soon become difficult, as in the case of the composition of the family, to tell the two ends of Europe apart.

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Diana Gibson

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GUEST EDITORIAL

Two routes, same destination
by Chantal Blayo

All over Europe, the large family has been disappearing gradually since 1950. It began with a narrowing of the spread of family size at a time when efforts to bring down the number of high-parity births were being counterbalanced by an increase in the number of first- and second-born children. Sterility, single-child families and larger-size families were also becoming more rare. All this resulted in an astonishing convergence towards increasingly uniform family size in all the European countries, with two-child families coming to predominate.

When the number of births of first and second children stopped increasing, the counterbalance vanished and the marital fertility rate declined rapidly. It dropped again after 1970 due to an increase in intervals between births and a decrease in first births.

As the European fertility rate declined, marriages also became less frequent, but with a very large degree of divergence in annual marriage rates in the different countries. This divergence will persist so long as there is still a European country that can follow that route: the latest statistics confirm that the eastern countries are doing just this. Divergence is thus about to give way to a convergence of the marriage rates.

The effect on fertility of this drop in marriage has been neutralised, to varying degrees, by an increase in births outside marriage. In some countries the movement towards a fall in the birth rate has been due partly to a rejection, at least for the time being, of illegitimacy. Here again, however, the diversity between the rates results from differences in the speed with which nations adopt new types of behaviour.

Today, the disappearance of large families is being accompanied in some countries by an increase in the number of childless families, the two phenomena uniting to produce very low fertility rates. Contemporary women of 35, whose completed family size can be estimated without too great a risk of error, will have an average — depending on the country — of between 1.4 and 2.1 children. This is far from the fertility rate of women born twenty years earlier, who had between 2.0 and 3.0 children on average, and even many more in Albania and Ireland, which at that time were atypical, but now are aligning themselves with the others.

It is known that progress in contraceptive techniques and the liberalisation of abortion laws (in virtually all of Europe) are not the causes of this slump in fertility. Motivation is much more significant than technique in this sphere; but this said, one might well wonder about abortion's place in couples' choice of preventive methods. Is abortion only a method of correcting contraceptive failures for less experienced women, or is it a chosen method of limiting births in its own right?

The answer depends on the country. Whatever characteristics are taken into account, women in eastern Europe who have abortions can be clearly distinguished from those having abortions in the west (Italians excepted). Generally speaking, in the west abortion is more frequently resorted to by young women, unmarried women, childless women and women who have not had an abortion before. Conversely, in eastern Europe the majority of abortions are performed for married women, women over 25, women with at least one child and women for whom this abortion is not the first.

Many of these eastern European married women with one child or more who have abortions will do so several times in the course of their fertile life. Moreover, the average frequency of abortion remains relatively high (even in countries where it has dropped considerably), being higher than 1 abortion per woman everywhere and in Romania, 6 abortions per woman.

Hungary is apparently the only country in eastern Europe where there has been a distinct change in behaviour with regard to contraception, resulting in a reduction in the average number of abortions from 2.8 in 1969 to 1.2 in 1989. In eastern Germany contraception improved later, but abortion was even more widespread than in Hungary, as it was also in Czechoslovakia, though it seems to have fallen in recent years. In Yugoslavia abortion is increasingly taking the place of contraception, but has not yet reached the Romanian level. In Romania the million abortions carried out in 1990 probably prevented at least 500,000 births. By adding those to the 367,000 registered births, one obtains a total of 867,000 births or a gross birth rate of 38 per 1,000. Such a figure can only be found in a population where contraception is virtually non-existent.

Hungary and east Germany are the only countries in eastern Europe where abortion is now tending to be replaced by contraception. In neighbouring countries such as Yugoslavia and Romania, on the other hand, the trend is for abortion to become the only method of birth control. And judging by the behaviour of women in Yugoslavia (in Serbia in particular), where the pill and IUD are available, it seems that the choice of abortion...
UK Health Secretary launches family planning initiatives

British Health Secretary Virginia Bottomley and FPA President Anna Ford recently announced a series of new initiatives to promote wider use of family planning and contraception which will be carried out by the FPA with a special £200,000 grant from the Department of Health.

The grant will finance three FPA projects targeted at both the general public and professionals:

• the Growing Up project: a series of three booklets providing information for parents, young people and children.

• a project to provide information on family planning an sexual health for women and men in their place of work.

• a primary health care project to support doctors and nurses in general practice in their efforts to improve their own family planning services.

FPA director Doreen Massey said: 'One in three pregnancies is unplanned and teenage pregnancy rates are rising. Family planning services alone cannot solve this problem. They must be backed up by sex education and public information. The FPA already plays a vital role promoting family planning, raising professional awareness and providing public information. The new grant will allow us to develop this work into new areas.'

The FPA chose 14 February (St Valentine’s Day) to launch — complete with pop band — How Your Body Changes, its new pamphlet for teenagers. (For details of this and the two other booklets in the Growing Up series, see Resources, page 18).

Dr Guy Ah-Moye adds:

In the UK family planning services are provided mainly by: family doctors (over 85% of services) and by special community FP clinics (15% or less).

The health authorities argue that as GPs are now doing more family planning work, more special clinics will have to close. But others argue against further closures pointing out that the special clinics provide:

• an anonymous service for younger women, especially those aged 16 or under

• a wider choice of methods, as some GPs do not offer methods such as the IUD or the diaphragm and do not yet offer free condoms

• a better service, as most GPs tend to be too busy to give the patients enough time, and many have had no training in family planning since qualifying

• postgraduate training for nurses and doctors, which means that FP education will suffer if more clinics are closed.

Family doctors are given financial incentives to do family planning. They receive P12.75 per year for each woman to whom they prescribe the pill, injections, the diaphragm, etc, and even get paid for only giving advice. If they fit an IUD, they get P42.75, and after each ensuing twelve months can claim the yearly P12.75, so long as the woman keeps the IUD and the GP checks it once a year. Discussions are in progress on the supply of condoms by GPs.

The 180,000 or more legal abortions occurring each year in the UK points to the need for more and better family planning education, especially in the age group 12-16.

A GP chatting with schoolgirls. Special clinics in the UK provide post-graduate education in family planning for doctors and nurses. Photo Margot Bourlet©/Brook Advisory Centres

Continued from page 3

is not only dependent on the non-availability of modern methods.

Although European women are behaving in an increasingly homogeneous way as regards their level of fertility, there are notable differences in their ways of attaining it, and especially in their use of preventive methods. West and east are still quite distinct in this respect, but the western countries themselves are far from being uniform.

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New FPA founded in Prague

A rather high number of induced abortions, an unsatisfactory level of contraception and almost no sex education have led a group of Czechoslovak specialists to found the Society for Family Planning and Sex Education in Prague.

Like the other 125 non-governmental FPAs around the world, the Czechoslovak association defends women’s right to make free decisions on motherhood, including the right to abortion. It gives priority to sex education and responsible parenthood.

FPA Chairman Dr Radim Uzel said: ‘Instead of warning, it is preferable to offer a helping hand; this has also been the experience of the countries with more liberal abortion laws, which also have the lowest abortion rates.’

The Society’s members are not only gynaecologists and sexologists, but also teachers, sociologists, psychologists, marriage counsellors and other specialists interested in family planning as a human right.

Dr Uzel said that the Society will also keep its members informed about developments in other countries, using as a source Entre Nous, ‘already highly appreciated in Czechoslovakia’.

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THE SHRINKING FAMILY

Waltz of the couples: change partners, please

The marriage 'dance' is still all the rage, but many couples cohabit beforehand — and some permanently. Divorce, on the other hand, although increasing, seems to make older people more reluctant to take the floor a second time, writes John Haskey.

Characteristics of couples — including the formation and dissolution of their unions are of fundamental interest to those working in family planning, sex education and health education. For the start of a union (whether legal or consensual) marks the beginning of a period of potential child-bearing. The partners' characteristics also reflect the anthropological aspects of partner selection, helping us to understand variations in couples socio-sexual behaviour. The type of union is important, too, because there is plenty of evidence that the timing and level of fertility of married couples differs from that of couples who cohabit.

Traditionally, in virtually every European country, marriage signalled the start of sexual relations and subsequent family-building. More recently, however, the link between marriage and child-bearing has become weakened as births outside marriage to both single and cohabiting women have grown in number. Marriage as an institution has also come under pressure from increasing divorce; in most European countries, marriage rates have fallen whilst those of cohabitation and divorce have risen.

Decline of marriage

The pattern of marriage changed fundamentally around the late 1960s or early 1970s, depending on the country. Marriage rates fell, and first marriages increasingly occurred at older ages. These trends started in northern Europe — with Sweden and Denmark in the vanguard — then spread west, south, and finally, but to a more limited extent, to the east.

Some young adults were deciding not to marry at all — choosing either to live alone or in consensual unions — whilst others were delaying marriage. The early decline in marriage rates in Sweden and Denmark was undoubtedly associated with the long-standing social acceptance of cohabitation and an early growth in its prevalence. At the other end of the spectrum, the fall in marriage rates was later and generally smaller in southern and eastern Europe - Italy and Czecho-

slovakia, for example — where levels of cohabitation are believed to be comparatively low.

In general, the average age of women at first marriage rose during the 1970s and 1980s, by about four years in Sweden and Denmark and by two to three years in England and Wales, Switzerland, France and West Germany. In countries such as Romania, Hungary, Greece and Spain, the average age of brides at first marriage increased by up to one year, whilst in others, such as Poland and Portugal, it actually fell slightly. Information from surveys in France, the Netherlands, Austria, and Great Britain shows that the proportion of first marriages preceded by cohabitation has grown steadily, indeed linearly, over the last two decades, reaching levels of between 40% and 80% for recent marriages. The proportion is believed to be almost 100% in Sweden (see page 7).

Divorce rising

Since the mid-1960s, divorce has increased substantially in all of northern Europe, a large increase in the west, but only a continuing, moderate, increase in the East. Divorce rates have consistently been very low in southern Europe; Italy, Spain and Portugal only introduced divorce during the late 1960s/early 1970s. If the late-1980s divorce rates were to persist, about 4 in every 10 marriages would eventually end in divorce in northern Europe, about 3 in western Europe, and between 1 and 4 in eastern Europe.

Divorced men and women usually remarry; especially the younger ones, although rates of remarriage after divorce have declined sharply for both sexes in most of Europe in the last 20 years. There is evidence from a few northern and western countries that the prevalence of cohabitation is highest amongst the divorced and separated, and lowest amongst the single and widowed. Apparently the growth in cohabitation amongst the divorced has contributed to their remarriage rates being depressed.

The highest proportions of women cohabiting are almost invariably found in the early twenties age-group: between 3 and 4 in every 10 in Norway, Denmark and Sweden; and between 1 and 2 in every 10 in Switzerland, Great Britain, France and the Netherlands. In other places, such as Ireland, Italy and Belgium, the proportions are comparatively low, which suggests a wide variation between European countries.

Although marriage everywhere remains very popular, marriages have been delayed by the growth of pre-marital cohabitation, marriage rates depressed by the rise permanent consensual unions, and the patterns of remarriage and cohabitation have been affected by the growth in divorce. These trends have been most pronounced in the north of Europe, followed by the west, and least pronounced in the east and the south. It seems likely that they will continue in the immediate future, although divorce rates may be stabilising — at relatively high levels — in some northern European countries.

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Born in Scandinavia: either side of the blanket will do

Scandinavian population statistics are to a large extent based on central population registers, containing basis demographic information on individuals. These registers include marital status, but in some countries very little — or no — information on cohabitation outside marriage. Demographic events such as births, marriages, divorces and so on are well covered. The registers do not, however, contain information on conceptions that end in spontaneous or induced abortion. This is why Lars Ostby focuses here on births.

In the years following World War II, the percentage of births to unmarried parents in Scandinavia again fell to a level at or under the long-term trend, that is 4-5% in Finland and Norway, twice as much in Sweden, and in Denmark something in-between. As the diagram shows, however, beginning in Denmark and Sweden in the early 1960s, this percentage has been steadily increasing. By the end of the 1980s, the majority of the births in Sweden were actually occurring outside marriage. The more recent Swedish decline in 1989-1990 was the result of certain changes in the social security system, which caused an enormous number of marriages in late 1989.

Although published statistics on conceptions and marital status vary very much in both content and detail, it seems that everywhere the percentage of extramarital births varies with the age of the mother, and with her parity. In Sweden for 1990, two thirds of first births were outside marriage, declining to one in five among women of parity four and higher. The extra-marital fertility shows greater dependency on parity than on age. The age gradient in Norway is steeper than in Sweden, probably indicating that extramarital fertility in Norway is still likely to increase. Judging by the low Finnish age gradient, however, I would not expect an immediate large increase there.

When an unmarried woman becomes pregnant, the probability that she will have an induced abortion is much higher than for a married woman of the same age and parity. As the abortion statistics are much less detailed than birth statistics, it is not possible to make any exact comparisons, however. When extramarital fertility was at its lowest, an unmarried woman who became pregnant normally married before the birth. For Norway, the percentage of pregnant brides was estimated to be around 50% at that time. This percentage is much lower at the moment, but the probability of marriage is still influenced by a pregnancy.

The content of the concept of marriage has been gradually changing in the last decades, more profoundly in Sweden and Denmark than in Norway and Finland. As an indicator of 'single mothers', statistics on extramarital births are useless. Basing ourselves on a Norwegian fertility survey at the Central Bureau of Statistics, we have shown that almost all increase in extramarital fertility is due to births to cohabiting couples. From Norway and from other countries, we have indications that around or less that 10% of the births are to single mothers. Mothers who are single at the time of a birth cannot be expected to remain permanently single. A retrospective study of children's family histories in Norway shows that a great — and increasing — majority of single mothers will enter a union sooner or later.

In societies where extramarital births are more the rule than an exception, the reactions against them will be very modest, or non-existent. Very often, the neighbours of new parents will not be aware of their marital status. There are, however, some regional differences, and some areas where this still matters.

In the Norwegian fertility survey, women were asked whether they were willing to have a child without living in a relationship. Less than 20% of the women were positive to the idea.

My conclusion is that even in the most 'advanced' countries in Scandinavia, marital status has some influence on fertility behaviour. Everywhere, the fertility among married people is higher than among the unmarried. In a few cases, as in Sweden for 1986, it is possible to calculate separately the fertility for married women, women cohabiting outside marriage and single women. In the highest reproductive age groups, single women have a fertility equal to 10-30% of the rest, increasing with age. Married women have higher fertility than cohabitants below the age of 30, and it is also higher at higher ages. So the main difference in fertility in Scandinavia is between cohabiting and non-cohabiting women.
More power to the third age

Europe's elderly people — soon to make up one fifth of the population — are already demanding better conditions. Jenny de Jong Gierveld and Harry Bron sema suggest that society is responding too slowly.

As predicted by demographers, the proportion of over-65s in Europe has risen from 8.7% in 1950 to 13.4% in 1990, and could reach 20.1% by 2025. From 2010 onwards their number will shoot up as the children of the post-war "baby boom" reach 65.

In a converse process called dejuvenation, the number of under-15s, who in 1950 accounted for a quarter of the population, had fallen by 1990 to only 19.6%, and by 2025 could drop to 16.5%. Soon — probably between 2010 and 2015 — older Europeans will form a larger group than the young.

This aging of the population is explained by the continuing increase in life expectancy and by sustained low fertility, which produces fewer young people.

Longer life and fewer children

Life expectancy at birth will go on rising, though at a slower rate. For women it will climb from 77.7 years (1990-95) to 82.2 (2020-25), and for men from 71.1 to 76.6. Data from all 12 European Community countries confirm this trend. In 1990 Dutch women’s life expectancy at birth was 6.5 years longer than men’s, similar to the figures in most of western Europe. But in France, Finland and most of the east European countries the difference has reached 8.0 years and is expected to continue at about the same level.

Life expectancy at higher ages has also risen. For example, in 1985 a 65-year-old Italian woman could expect to live on average another 17.7 years, and a 65-year-old man about 13.9 years. More and more of the older age group will be very old (75 and over), particularly in western Europe. This aging within the older group is especially likely to cause problems in the near future.

In most European countries the average number of children per woman has long been below the replacement level of 2.1. Twenty-five years ago, the average was 2.77 children in the EC countries. By 1989 it had dropped in all these countries, except Federal Germany, to 1.57.

The drop is still gradual in most European countries. Only France and Sweden maintain relatively stable rates which are near, but also below, replacement level.

Work and status

Population aging will inevitably lead to changes in elderly people’s social status. As a group, they will be better educated and more assertive in demanding their rights. It will be important for them to stay in the labour force as long as they want, because of the link between income and status. Much will depend on economic growth, employment policy, official pensionable age, and the way in which early retirement and disability schemes are applied.

Rising life expectancy for both sexes means an increase in the percentage of elderly married couples, and thus a drop in the percentages of elderly widow(er)’s, never-marrieds and divorcees. Most older people live with a (marital) partner, usually without children. In Sweden, 58.3% of very elderly men (aged 75 and over) were married in 1985, in the Netherlands 63.6% (1988), in Italy 65.8% (1989), and in France 64% (1988). Due to the difference in life expectancy, the corresponding figures for women were much lower: Sweden 22.4%, Netherlands 22.1%, Italy 20.6% and France 21%. This means that more than three quarters of very old women live without a partner. Most are widows, a much smaller percentage being never-marrieds or divorcees.

Today, elderly people without a partner increasingly form one-person households, especially women. This trend, visible across Europe, implies a greater need for — among other things — care facilities.

Finally, an aging population affects consumption patterns. Generally speaking, dejuvenation reduces the demand for anything to do with raising children, but aging increases the demand for specific types of accommodation, domestic services, food, health and medical care. Elderly people who are better educated may also develop a greater interest in training courses and many types of leisure activities, including travel.

How old is old?

Sixty-five, the pensionable age in many countries, is often thought of as the lower limit of the older age group. This statistical cut-off may be as low as 55 or 60, but is arbitrary and has little to do with how old a person feels or looks to others. Fewer and fewer of the 'young elderly' (up to age 74) show the physical and psychological effects stereotypically associated with getting older. Yet they are increasingly being shut out of the production process. In Europe, only half of 60 year-olds still work, in some countries only 30%, and this trend is not expected to change. Because of the prestige attached to economic activity in Europe, leaving the workforce will for many individuals mean even greater social isolation.

The population will go on aging for at least the next 30 years. Europe should be thinking about changing its attitudes towards older people, and about how to tackle the socio-economic consequences of an aging society.

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"C Team" in revolt: Danes who lived through the poverty of the 1930s have formed a national movement, led largely by women, to improve the "wretched" living conditions of about 5% of elderly people. Photo Thomas Sjørup/Nordfoto
Tomorrow may be too late

Childlessness by choice is today very rare in any part of Europe. But unintentional infertility can result from the postponement effect seen in western countries, which has not yet spread east, writes France Prioux.

Practically everywhere in western Europe, voluntary childlessness seems to have peaked around 1970. In several countries, such as Denmark, France and Norway, the proportion of women born between 1940 and 1945 who have had no children is less than 10%, which denotes practically non-existent voluntary infertility, bearing in mind the number who have never married (between 5% and 10%) and the low fertility outside marriage. In many other countries (West Germany, England and Wales, Spain, Italy, Netherlands, Portugal and Sweden, for example), the proportion of childless women today lies between 10% and 12%.

This low infertility follows a long period of decline. Indeed, it was formerly not uncommon for 20% of women to remain childless; celibacy was more widespread and childless married couples more common. After the last war, however, fewer and fewer women remained single, with couples getting married much younger, while the interval between marriage and the first birth grew shorter and infertility in marriages declined. Hence at that time the proportion of childless women probably reached an all-time low.

Parenthood postponed

Around 1970 everything changed: first married couples postponed the birth of their first child, then marriages themselves occurred later and later and grew less and less frequent. Fertility outside marriage may have become widespread (though this varied widely from one country to another), but it was generally not enough to offset the decline in the marriage rate, since cohabiting couples hesitate even more than married people before having their first child. So a more or less general rise in infertility was observed, and in a few countries (West Germany, Austria, Finland, Netherlands and Switzerland) it is estimated that the proportion of women without children rose to about 20% in the 1958-60 generations. However, almost everywhere else (except in England and Wales), infertility in women of that age group never exceeded 15% and remained as low as around 10% in Spain, France and Portugal.

This increase in infertility is not always the result of a clear choice; more often it is the result of a process of "putting off till later" in the expectation of a better moment. Indeed, in surveys the proportion of women stating that they do not want any children is always extremely small and does not increase significantly as fertility rises.

This process of postponing the first child, made possible by effective modern contraception, is bound up with changes in society and the spread of new lifestyles: more protracted studies, delay in couple-formation, increasing solitariness, greater marital instability, the rejection of marriage (which may result in a fairly strong refusal to have a child when a society condemns fertility outside marriage), and the increase in female employment, which may prove more or less incompatible with motherhood in certain countries where, because young working mothers are not an accepted thing, social legislation and welfare structures are lacking.

Older mothers in western Europe

This delay in first pregnancies has radically altered the timing of first births, which have become very rare among young women and more and more common at more advanced ages (25-35 years). But at 30 or 35 sterility is more common than at 20, so not all the births desired will become a reality.

This trend, which is common to all western countries — with here and there a small discrepancy of 5 to 10 years, in southern Europe, for instance — has not so far affected the countries of the former eastern bloc (including East Germany). There, infertility continues to be low (still under 10%), while women marrying early, seldom remain unmarried and have their first child very young. So in the east, voluntary infertility is still virtually non-existent.

Physical impediment

The tendency to postpone the first birth automatically increases not only a couple's use of contraception but also the risk that they will be physically unable to have children. To reduce the number of childless women, therefore, it would perhaps be better to use birth control to limit the number of births rather than to space them. Countries where the number of childless women is particularly high would need to find ways of making it easier to combine work and motherhood.

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Most women want children, but if they put it off until after age 25, for physiological reasons they may be unlucky. Photo Heine Pedersen/Billedhuset
Blurred edges to population policies

Fertility is now below replacement level in most European countries, especially the industrialized ones. In the last 20 years, several countries have developed or improved pronatalist programmes containing incentives that are designed to motivate couples to have a second and especially a third child, to maintain a stable population.

The WHO Sexuality and Family Planning Unit called a short consultation on this subject last October. What actually constitutes a pronatalist population programme and the connections between public policies and private reproductive behaviour were not very clear. Nor is it easy to assess the longer-term demographic effects of pronatalist policies or what influences their effectiveness. The outcome usually reflects the country’s history, cultural and religious traditions, changes in lifestyle, and the value given to the family and children.

Incentives are defined as monetary or non-monetary inducements to voluntary reproductive behaviour that conform to specified population policies. They may be small or large, in cash or kind, parity-specific or income-linked, immediate or delayed, one-time or incremental, or any combination of these. Disincentives are negative sanctions that are either incurred or thought likely as a result of violating the policy. But both incentives and disincentives are difficult to define.

Pronatalist policies designed to encourage early marriage and larger families, thereby raising the future total fertility rate, should not be confused with traditional social welfare policies designed simply to ease the burden of childbearing. Some policies have both demographic and social welfare aims. Strong pronatalist policies may be linked with restrictions on contraceptive availability and legal abortion. Moreover, other public policies affecting social security, education, employment, housing, regional planning and the emancipation of women may unintentionally influence demographic behaviour.

Population policies are the product of politics. Often written in ambiguous language and intended to affect society as a whole, they still depend for their outcome on micro-level changes in a couple’s perceptions of the costs and benefits of having children. In theory, they can be carried out in many ways but in practice such policies are severely limited by administrative, political, technological, economic and ethical constraints. One difficulty is that governments rarely enunciate precise goals. Their approach may range from non-interference in private reproductive behaviour to total coercion using controls ranging from traditional cultural influences to imposition of fertility regulations.

In some countries, fertility rates have increased briefly (in terms of period rates) following introduction of pronatalist policies. However, it is not clear how the rates were influenced, particularly in the case of parities one, two and three. A forthcoming report will describe experiences in Bulgaria, France, Germany, Sweden and Norway.

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1891-1991 — same battle

Strolling one evening in the old quarter of Bucharest, I turned up a wonderful find at a secondhand bookshop: fifty bound issues running from July 1890 to June 1891 of the Journal des Voyages, an illustrated weekly full of adventures on land and sea.

Now defunct, the Journal des Voyages told tales of geography, ethnography and anthropology, with a dash of colonial exoticism, and here and there a few thoughts on the problems of old Europe.

In the issue of 18 January 1891, an article by the Editor Léon Dewez tells us that the present-day concerns of French politicians — the depopulation of France and the declining influence of the French language — were already burring issues 101 years ago.

Of course, the depopulation of France is a somewhat relative matter. I still recall my years in primary school, when we used to chant in unison: ‘There are 42 million French in France’. Today, 43 years later, the French have increased to 56 million.

UN statistics show that in 1990 France accounted for no more than 9% of the population of Europe, whereas 100 years earlier 13% of European had been French and in 1789, the year of the French Revolution, 27%.

And the decline in the influence of the French language is gaining momentum. In international bodies such as the UN French is still an official language, but its position is under threat. At the World Bank, English is the only official language; less than 10% of WHO meetings involve a language other than English; and for the poor soul who publishes in French, apart from a few intrepid readers, he or she soon sinks back into international obscurity.

This lingering death is part of an inexorable process that has put French into a species threatened with extinction. Paradoxically, only our former colonies can save it, by their sheer weight of numbers and by their deep attachment to the French language.

Dr D. Pierotti
TECHNOLOGY

Time to end bias against the pill

Women should be queueing up to take the pill - the only drug that actually prolongs life. Yet the public mistrusts it: only in the Netherlands is the pill widely accepted as safe. Dr Malcolm Potts of International Family Health, London, summarises the evidence, based on 30 years of pill use.

When Pincus and Rock first developed oral contraceptives in Boston in the late 1950s, abortion was unthinkable. Consequently they used a very high-dose of hormones in order to assure themselves that pregnancy failures would never occur. Unfortunately, we still live under the shadow of yesterday’s high-dose pills: today’s mothers are telling their daughters about the trouble they had with the pill without realising that contemporary women now have fundamentally new choices in oral contraception.

The facts

Low-dose pills have greatly reduced the risks of myocardial infarct and stroke over previous formulations. The US Food and Drug Administration, which has a reputation for conservatism, recently revised its guidelines on oral contraceptive use so that there should be no limitations on women over the age of 35 using the pill providing they do not smoke.

It was not until the 1980s that the first epidemiological studies appeared which were to demonstrate a marked protective effect of oral contraceptive use against ovarian and uterine cancer. All the studies conducted in this field have given the same results and there is a strong dose relationship — that is, the longer the pill is used the more powerful the effect.

Intellectually, it is interesting that the pill is the first therapy in the history of medicine that can actually prevent certain cancers and extend an individual’s expectation of life. In broad terms, all the changes observed with the pill are exceedingly small, and for the individual user and the individual prescriber the bottom line of computer risk-models is that oral contraceptive use brings about certain changes in the profile of diseases from which women suffer, and the risks and benefits more or less cancel one another out. Even the adverse effects on the cardiovascular system for older women with high-dose pills present a modest risk in relation to many other choices that individuals make daily. For example, high-dose pills in women over 40 reduce the expectation of life by several tens of days, but if a woman smokes one or two packs of cigarettes a day, then she will reduce her life expectancy by some four and a half years.

No doubt, if the pill was not associated with sex it would have been less controversial. Analysis of the media shows that many more adverse than beneficial stories about oral contraceptive use are published. Studies also show that most of us tend to underestimate risks in areas where we feel we are in control, such as the mortality associated with driving a car, while we overestimate risks that appear to be beyond our control and involve silent mechanisms that we do not understand, such as the risks of accidents in nuclear power stations (or the risk of adverse effects from taking the pill).

Loose ends

The one area where the data are confused and there are some reasons for concern is that of breast cancer. Nevertheless, if all cases of breast cancer in women up to the age of 60 are studied and the use of the pill in women with and without breast cancer is compared, then there is no difference whatsoever between the two groups. In other words, oral contraceptive use makes breast cancer neither more common nor less common.

Dr Susan Harlap of the Sloan-Kettering Institute in New York has done a meta-analysis of the published data on oral contraceptive use on breast cancer and suggests that there may be a slight rise in women in the 35-40 age group who develop breast cancer and then a slight deficit of cases in the following age cohort. If this is the case, then it may be that the pill brings forward cases which would have otherwise occurred, in much the same way as it is thought oral contraceptive use interacts with gall-bladder disease. Interestingly, the injectable contraceptive DepoProvera® may have a similar effect.

More information on oral contraceptive use and breast cancer is urgently needed but unfortunately no new large-scale studies are under way, although the National Institute of Health in the USA is planning a new set of investigations. It has recently been suggested that drug regulatory authorities ought to make it easier to market new formulations of the pill, at the same time devising ways in which the sale of the successful large-scale marketing of pills could help subsidise adequate post-marketing surveillance.

True or false?

Whether women live in Mexico, the US or Denmark, they believe that the pill causes infertility and weight gain and is associated with cancer. Many view contraceptive use as substantially more dangerous than pregnancy.

Myth

- The pill infertility
- The pill causes weight gain
- The pill causes cancer
- Taking the pill is more dangerous than a pregnancy

Reality

There is a very brief delay in the return of fertility following oral contraceptive use but no study has shown any adverse effect on fertility

Modern low-dose pills are associated with little or no weight gain

Oral contraceptives have a strong protective effect against two important cancers (ovarian and endometrial) and also protect against other conditions (ovarian cysts, ectopic pregnancy, pelvic inflammatory disease)

Taking the pill is less dangerous than pregnancy and childbirth

ENTRE NOUS 20, May 1992
Is the pill 'natural'? Breast, uterine and ovarian cancer are all influenced by lifelong patterns of fertility. The earlier a woman has her first period or the later she has the menopause, the greater the risk of these three reproductive cancers. The more children a woman has and the more she breastfeeds, the less the risk of ovarian and uterine cancer. The earlier a woman has her first full-term pregnancy in life, the less her risk of breast cancer. There are also some data indicating that breastfeeding reduces the risk of breast cancer.
To put it another way, modern living places numerous strains on the way in which women use their reproductive systems and is associated with an increased toll of malignancy. In a way, oral contraceptive use restores a woman's reproductive system to something that is nearer the natural pattern that evolution gave us. Unfortunately, currently available oral contraceptives do not have any protective effect against breast cancer but, in the long term, it may be possible to devise formulations which will have such an effect.
An important goal for the 21st century should be to devise a means of fertility regulation based on hormones which will not only permit a woman to choose how many children to have and when to have them, but will ensure that when she reaches the menopause she is a healthy woman without the increasingly high risks of breast, ovarian and uterine cancer that beset women today.

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The pill is good for you
Low estrogen-dosage pills protect women from several cancers as well as cardiovascular diseases. But old-fashioned ideas about the pill and scaremongering in the media have blackened the reputation of this safe, effective contraceptive

Henry David reports from Copenhagen:
A recent Danish FPA seminar on The Pill, the Media and Abortion attracted general practitioners from Denmark, Finland, Iceland, Norway, Sweden, the Faroe Islands and Greenland.
FPA President Professor Mogens Osler stressed the need to reduce risk-taking and introduce careful contraceptive use and sexual responsibility to further lower the incidence of abortion in Denmark. He said that life-long sex education should be promoted by all social levels, including health professionals and the media.

Safer than aspirin
Dr Malcolm Potts, Secretary of International Family Health (London), reviewed the history of the Pincus Pill, now over 30 years old. In his view, the pill has been widely misunderstood and 'mystified'. In many countries, including Denmark, a substantial proportion of women and even of health professionals believe that the pill represents a significant health risk; few people know that it confers protective advantages. In reality, said Dr Potts, who is a respected international authority, low estrogen-dosage pills are safer than aspirin, and reduce some cancers and cardiovascular risks. Even old high-dose pills were less dangerous than smoking even one cigarette a day.
Most pill failures — i.e. unwanted pregnancies — represent human error in pill-taking and failure on the woman's part to follow the instructions properly. For their part, manufacturers could improve the instructions. But the pill's most important disadvantage today, according to Dr Potts, is that, unlike the condom, it does not prevent AIDS.
Another problem is a matter of perception: people are conditioned to take a pill when they are ill, whereas they do not readily associate sexual behaviour with an illness.
Many people — including doctors — still base their attitudes to the pill on outdated information. For the vast majority of women a daily pill is not dangerous, will not contaminate or harm their bodies, and is a good preventive measure, but this notion has not been communicated effectively enough by either health professionals or the media. Jørgen Peder sen, a Copenhagen communications counsellor, voiced similar sentiments.

Pill constantly improved
Dr Evert Ketting, Deputy Director of the Netherlands Institute of Social Sexological Research and Editor of Planned Parenthood in Europe (see page 19), cited developments in the Netherlands, which for some years has had the lowest abortion rate in Europe (5.1 abortions per 1,000 women aged 15-44 in 1988, about one-third of the Danish rate). Beginning in the mid-1960s, the Netherlands experienced considerable social and cultural change, led by the Dutch Association for Sexual Reform which, with the support of family practitioners, provided sex education in a non-moralistic way. The pill was officially registered in 1964; safe abortion services became widely available by 1972 thanks to a network of independent clinics tolerated by the government.
In an effort to reduce resort to abortion, the government joined other organizations in fostering acceptance of modern contraceptives. By 1971 family planning was included in the public health insurance system, and prevention of unwanted pregnancy was proclaimed a public duty for all mass communication media. Subsidies were provided for family planning clinics established by the Dutch FPA, and the concept of sexually responsible behaviour was actively encouraged. Today, few barriers to family planning exist for the Dutch. Recent surveys suggest that current pill use exceeds 80% in women of fertile age and that only 2% of pregnancies are unwanted at conception. Low estrogen-dosage pills are evaluated favourably by husbands and wives. Only about one Dutch woman in six experiences an abortion during her fertile years. Abortion is considered a woman's right — a method of last resort, readily available, but seldom used.

[The Danish Family Planning Association, Aurehøjvej 2, DK-2900 Hellerup, Denmark, will publish articles on the seminar (in Danish) in FP Information og Debatt.]
MANAGEMENT

Method selection made easy

A practical card simplifies the job of choosing the right family planning method to suit the client. Gaston Legrain, Pierre Delvoye and Latifou Salami explain how it works.

In 1989 the Togolese National Family Welfare Programme introduced a 'visit card' system for method selection, developed several years earlier in Burundi. Since then the card has proved equally successful when used by medical and paramedical health workers in Togo, and makes their work much easier.

The visit card is above all an aid to decision-making. It helps the health worker to identify the best contraceptive method or methods for each client on the basis of personal data, the medical history, and a general and gynaecological examination. The card is also used for follow-up and regular monitoring of the client.

On the first part of the card the health worker records details of the woman's gynaecological and obstetrical history, the number of children she wants, and socio-demographic data. The second part represents steps leading from the method the patient herself wants to the method or methods that can actually be recommended for her.

Matching method to client

During any family planning consultation, the essential problem confronting the health worker is the choice of a method. This choice must be an informed one, based on dialogue between counsellor and client. It is arrived at by matching the client's wishes (the demand) with the results of the health worker's investigations (the need) and the resources of the department concerned (the supply).

The health worker has to select one or several methods by taking into account all their contra-indications and considering them in conjunction with the client's individual profile. But there are several contra-indications — some absolute, some relative — for the different methods, and they are hard to systematize and memorize (see table).

First the counsellor must explain to the client the various methods available, how they work, what their advantages and drawbacks are, and how to use them. This initial contact is greatly facilitated by the use of visual aids.

The information on the first part of the card enables the health worker to take certain socio-cultural and medical variables into account with a view to reaching a tentative conclusion with the client - in other words, to ascertain whether she wants to limit or to space her pregnancies. The choice of method will also be influenced by how long the client says she wants the contraception to last.

Once she has made a choice, or at least expressed a preference, the next stage is to establish whether this choice fits in with her profile. It is at this stage that the innovative aspect of the visit card comes into its own, which is that the contra-indications are grouped together under three headings:

- Those identified by asking questions (e.g. a mother breastfeeding for less than six weeks)
- Those identified by looking at the client's history (e.g. a recent liver ailment)
- And those revealed by the general and gynaecological examination, including examination of the breasts (e.g. a blood pressure of more than 14/10).

Relative and absolute contra-indications

The second part of the card, on the extreme right of the table (third column), concerns the search for the recommended contraceptive method. It includes:

- A list of the methods: rhythm, barrier, IUD, combined pill, low-dose progestogen pill, injection;
- For each contra-indication and each method, a plus sign (+) to indicate that the method is recommended, a minus sign (−) to indicate that the method is not recommended, and a double minus sign (−−) to indicate that the method is relatively recommended.

One important point is that the relative contra-indications are not contra-indications when they stand alone. A relative contra-indication becomes an absolute contra-indication if associated with another relative contra-indication, if the symptom is a major one, or if local circumstances rule out monitoring.

<table>
<thead>
<tr>
<th>Method(s) souhaitée(s)</th>
<th>Methodes disponibles</th>
<th>MON DIU OUI PC PP INJ</th>
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<tbody>
<tr>
<td>A. ANORMESE</td>
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<tr>
<td>1. Nulliparese</td>
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<td>2. Donc enfant :</td>
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<tr>
<td>3. Parents multiples</td>
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<td>0</td>
</tr>
<tr>
<td>4. ANTECEDENTS</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>1. Génière récente</td>
<td></td>
<td>0</td>
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<tr>
<td>2. Maladie récente du fœtus</td>
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<tr>
<td>C. EXAMEN GENERAL ET GYNECOLOGIQUE</td>
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</tr>
<tr>
<td>1. Maladie du fœtus en cours</td>
<td></td>
<td>0</td>
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<tr>
<td>2. Tumeur mammaire</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>3. Plaque, varicé importantes</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>4. Infestation gynécie haute/laiss</td>
<td></td>
<td>0</td>
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<tr>
<td>CONCLUSION : METHODES RECOMMANDÉES</td>
<td></td>
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</tbody>
</table>

On the last line in the table comes the conclusion, in other words a recapitulation of the table listing the methods ultimately recommended for the client.

Once the method or methods that can be recommended in this particular visit have been decided upon, the health worker will look to see whether they coincide with the method the client herself wants. If not, a further discussion with the woman or the couple will be needed to explain in detail the advantages and drawbacks of the method selected.

Once the method has been agreed to, the health worker must prescribe it and talk to the client a third time to put her in the picture about the follow-up programme, any possible side-effects of the method (this information very often helps to increase perseverance with the method) and any 'warning signs' or alarm signals which should alert her to ask for another appointment without delay.

Lastly, the staff will arrange the client's next visit, and her card will be filed in the register under the appropriate month. The use and importance of the register will be dealt with in another article.

Dr Gaston Legrain, Ministry of Health and Population, and Dr Latifou Salami, University Hospital Centre, Lomé, Togo.

Dr Pierre Delvoye, Head, Department of Gynaecology and Obstetrics, B-7000 Ath, Belgium.

ENTRE NOUS 20, May 1992
Welcome visitors

First tried out in the 1950s, domiciliary visiting to give contraceptive advice and support to British women who could not or would not attend clinics proved remarkably successful, especially as in those days they had only the diaphragm, the condom and spermicides to choose from. Elphis Christopher describes one of the seventy remaining home-visiting services, in a mixed area of outer London.

Domiciliary family planning services are usually run by a female staff of one or two doctors and one to five nurses serving a population of around 200,000, mainly in deprived inner cities. The staff tend to be self-selected. They see a need that can only be met by home visiting, and can cope with frustration and occasional hostility. Their clients are referred to them by health visitors, midwives, social workers, and hospital and family doctors, although the more successful services, in terms of acceptability to the community, have a large proportion of self-referral clients.

In the home as at the clinic, all methods of contraception are discussed and provided. The woman herself chooses the method unless there are medical contra-indications; this is vital if she is to sustain her commitment to contraception. Pregnancy testing, vaginal examination (including smears), referral for termination of unwanted pregnancy and sterilization are all available. The visitor enquires particularly about psychosocial factors, to try to ascertain the woman’s or the couple’s lifestyle, the quality of their relationships, their level of maturity and self-esteem, and the amount of support they need. If appropriate, she liaises with the family doctor, health visitor and social worker, having first obtained the woman’s permission.

Haringey is an outer London borough with a population of around 200,000 and many inner-city features: homeless and socially deprived families, single parents, high unemployment. Its population is mainly of Asian, Cypriot and West Indian origin, with views and attitudes that are influenced by cultural and religious factors and have to be considered carefully when giving family planning advice. There are around 3,000 births and 2,000 terminations of pregnancy annually. The fertility rate is higher than for England as a whole.

Highly mobile population

Staffed by one medical officer and two nurses, the Haringey Domiciliary Family Planning Service has visited over 3,000 women since 1968; some 500 are being visited at present. Around one third of the clients are in the process of leaving Haringey at any given time. Nowadays the majority are young single mothers who refer themselves, via friends and relatives. Over one third are mainland British, 38% are of West Indian origin and the rest are African, Asian (mainly Bangladeshi), Cypriot and Irish. The average number of children per woman is 2.5 (but 6.6 for women from Bangla-

Critical reactions

Several writers have noted the positive contributory of domiciliary services to family planning, although others have been highly critical. For instance, home visiting is regarded as an expensive way of giving family planning advice, yet set against an expense such as receiving a child into care the cost is low. Some say that this service is not seeing the ‘right’ people; however the families not visited are those most likely to be involved with social workers, who as a group have shown reluctance to refer them. Allied to the latter criticism is what might be termed ‘eugenic fear’, that is that domiciliary services exist to stop poor people, the handicapped or certain ethnic groups from ‘breeding’. Others say that they create dependence, indirectly keeping the women away from the clinic.

Setting aside the obvious need of those who are too physically or mentally handicapped to go out or have language difficulties, these negative views ignore two significant points. First, there are women or couples who do have special problems with contraception, and the consequences of further pregnancies may well be disastrous both for them and their existing children. Second, the short-sighted view of family planning is to see it merely as writing out a prescription or fitting a device. However, much more is needed for those who are ambivalent about contraception, uncertain about themselves and their relationships, and feel they have limited future prospects. Adopting a method is an important part of family planning but it is the sustained use that is the vital part — the integration of contraception as an accepted part of a person’s life. It gives individuals the power to take more control, rather than regarding themselves as helpless victims, and this is where domiciliary family planning has a special role to play.

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Christmas time in Haringey. The domiciliary service visits about 500 women, including many of West Indian origin. Photo Henry Jacobs

FNTF NOUS 20, May 1992 13
RESEARCH

Female condom improves with use

Dr Nicholas Ford writes from Exeter, UK:

Despite the pressing need for increased use of contraceptives which protect against both pregnancy and sexually transmitted diseases, including HIV/AIDS, the male condom is the only product which fully meets these two criteria. A recent survey of the sexual lifestyles of over four thousand 16-24 year-olds in the South West of England revealed that only one third had used a condom during their last sexual intercourse (Entre Nous 19). There is therefore considerable interest in the potential of the new female condom or vaginal sheath (Entre Nous 16), due to be marketed as Femidom®.

But apart from its contraceptive and prophylactic qualities, will it be acceptable to potential users? The Institute of Population Studies at the University of Exeter, in collaboration with the UK Family Planning Research Network, is studying users' experience of the vaginal sheath. Couples who already accept barrier methods are of particular interest.

Each couple in this sub-study sample was given fifteen female condoms, and four sets of questionnaires to be completed separately by the man and the woman. The first (pre-use) questionnaire concerned sexual history and initial impressions; the others concerned impressions after the first, fifth and tenth use of the condom respectively. Of the 51 couples recruited, 36 returned the 'after first use' questionnaire and 29 the 'after tenth use' questionnaire.

Users often surprised

First impressions of the condom prior to use were perhaps the one aspect of the subjects' responses where there was a significant degree of consensus. The most common first impression is surprise (and a little concern) about its actual size.

It was interesting to note similarities in the first impressions of male and female partners, showing how crucial the partner's comments or responses are in shaping initial perceptions.

Although at first sight many respondents had felt somewhat daunted by the prospect of inserting the sheath, once they had actually tried it their anxiety was reduced.

An intriguing but as yet unresearched subject in the use of barrier methods is whether they pose any particular problems in specific sexual positions. Whilst three quarters of the respondents did not feel that the female condom was unsui-

Photo Charteex International Plc.©

table for any particular position, a small number did report that it did not stay in place during, for instance, penetration from behind, or came out on the penis during a change of position.

A few people commented on aesthetic and 'body-image' considerations, although again most reported no reactions of this kind. As noted, before using it most people were surprised by the condom's appearance, particularly its size. However, the most critical comments were reserved for its appearance when inserted. What a few women seemed to find objectionable was the fact that it was not hidden, but partly visible, in use.

Several others who were at first put off by the appearance of the outer ring and other points noted in the final questionnaire that their views had changed. Three tentative conclusions can be drawn.

Firstly, the idea that the female condom makes a woman unattractive can have a negative influence on sexual arousal. Secondly, such feelings may be influenced by the man's comments to the women. Thirdly, for most people the initially negative reaction to the appearance of an inserted condom declines with the familiarity of repeated use.

Acceptability rating

The finding that more than half of these couples who actually used the method once went on to use it at least ten times (returning the final questionnaire) is a fairly positive indication of its acceptability. Preliminary quantitative analysis also seems to indicate that users' experience of insertion and the condom's comfort in use improve with the number of times it is used.

With this potential acceptability allied to prophylactic qualities, it seems likely that the female condom will prove a valuable addition to the range of contracep-
tive products, and will increase consumer choice. Once it is launched on the market many couples will probably try it partly out of curiosity. Whether substantial numbers then go on to use it frequently may well depend upon whether they 'try it out' often enough for their initial inhibitions and misgivings to decline.

[The author would like to acknowledge the assistance in this research of Elspeth Mathie, Elizabeth Snowden and Elaine Davies.]

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Belgians prefer the pill

Dr Adrian P. Visser writes:

In Belgium the most popular contraceptives are the pill (used by 50% of women) and the IUD (used by 17%), according to a survey of 1006 women aged 15-45 carried out in 1989 by the Brussels-based International Health Foundation (IHF).

Use of the pill is more widespread among younger women, women without children, and those who appreciate its reliability and the lack of interference with their sex life. Religious practice
does not seem to play a role in the use of contraception in this originally Catholic country.

The women were on the whole well informed about several aspects of contraception, although only one third of them could answer some questions correctly. The least well informed proved to be girls aged 15-19 with a low educational level.

IHF concludes that younger people need more sex education relating specifically to their attitudes to contraceptives, and that physicians and schools should become more involved in sex education.


Careless or Reckless?

Bjarne Rasmussen writes from Frederiksberg, Denmark:

Frederiksberg Municipality’s AIDS Secretariat has recently made a study of ‘Young People’s Sexual Behaviour’. Some 2,300 pupils aged between 14 and 20 in Copenhagen were asked to reply to 164 questions on their age, education and social status, the content and value of sexual information received in school and at home, their sexual debut and behaviour, and their knowledge of sexual problems and HIV/AIDS. This article concerns one small part of the overall study. It describes the patterns of behaviour of sexually active city youth in Denmark; this particular sample consisted of 499 young people between the ages of 14 and 20 who stated that they had sexual intercourse often.

Determining factors

Comparing the sexual activity of young people who are in different classes but of the same age, one can see that it is not only age that determines sexual activity. The behaviour of their classmates is just as important.

All those interviewed were asked whether they received sexual guidance at home. A comparison between the two groups receiving ‘much’ and ‘no’ guidance reveals a marked difference in sexual activity. Among 17-year-olds receiving no guidance at home, only 13% are especially active, while among those receiving much guidance, 27% are especially sexually active. There are similar differences for the other age groups.

A difference also was revealed in regard to the sexual debut, and again there was a correlation with the amount of guidance received at home. From this correlation it can be deduced that young people who come from a family background where sexual subjects are discussed experience fewer barriers to sexual expression and are therefore more inclined to fulfil their sexual ‘needs’. These examples show that the sexual pattern of behaviour is quite clearly determined by cultural background, but this cultural background does not vary according to social group.

Of those asked how long they normally know their partner before having intercourse, almost one half answered that less than a week is enough. Here there is a visible gender difference. Thirteen per cent of the girls find a single evening to be enough, while 37% of the boys take this attitude. All were asked whether they would initiate a sexual relationship for a single evening. In this case 17% of the girls ‘occasionally’ or ‘often’ let a single evening’s acquaintance end with sexual intercourse, while 46% of the boys do so. Sixty-seven per cent of the boys say that they occasionally or often choose a new sexual partner whom they do not already know, whereas this applies to a little less than half of the girls.

Taking chances

While the necessity for using contraceptives and the choice of contraceptive has always formed an essential part of sex education for young people, the risk of HIV infection has accentuated its importance. The study shows that condoms and pills dominate, but coitus interruptus is the third most used method and in fact is considered as a type of contraceptive. Also ‘no contraceptive’ use is quite widespread. Those who have intercourse often do not use condoms nearly as much as their friends who seldom have intercourse. The use of pills increases markedly with sexual activity. Seventy-eight per cent of the girls who have intercourse often use the pill.

Do you use coitus interruptus ‘often’ or ‘occasionally’, and/or ‘often’ or ‘occasionally’ omit using contraceptives? Thirty-six per cent of the sexually active young are careless, according to this definition. A further 28% take chances once in a while (that is, they use coitus interruptus ‘seldom’ and/or ‘seldom’ omit contraceptives).

This is not only a phenomenon of puberty, and the investigation shows that experience is more important than age. To put it in another way: ‘carelessness’ and ‘chance-taking’ develop as young people become more and more sexually experienced. That means that the more their experience, the more ‘safe periods’, coitus interruptus and ‘no contraceptive’ are used.

Condoms have been especially recommended and advertised during recent years because of the risk of AIDS. About half say that they have good experience with condoms, but the ‘less good’ or ‘bad’ experiences increase with increasing frequency of intercourse.

Here again there is a gender difference: the experienced boys are more satisfied with condoms than the experienced girls.

Despite the risk of HIV infection, sexually active teenagers neglect the condom. These jobless 16-18 year-olds, all receiving unemployment pay, visit schools to talk about AIDS. Photo Mogens Ladegaard/Nordfoto
WHO FILE

CIS faces AIDS inheritance

In 1987 the former USSR found its first AIDS case, a homosexual man who had caught the virus in Africa in 1982. Before diagnosis he infected five other men, and through them three women, one a blood donor. Another man also came back from Africa with the virus and passed it to his wife and child. This started a chain of nosocomial transmission, with more than 250 children contracting AIDS in Russian hospitals (Entre Nous 14/15, July 1990). By the time the old Soviet Union was dissolved at the end of 1991, screening had revealed 1,264 known seropositives, including 600 foreigners, and over 104 million people had been HIV-tested. Sixty-six people have now developed clinical AIDS.

Preventive network
The Soviet government started a prevention and control programme in 1987 with screening and mandatory reporting of infection. It introduced laws obliging certain groups of people — such as prostitutes, homosexuals, returning nationals and foreign students — to be tested, although WHO discourages such measures. All pregnant women, people with sexually transmitted diseases and hospital patients are still being tested obligatorily. During its last three years the former government committed vastly increased funds to AIDS, setting up a network of prevention and control centres and providing equipment, drugs and reagents for nearly 2,000 diagnostic laboratories. Information and education were also boosted.

At the same time the government made a big effort to protect confidentiality and the human rights of people infected with the virus, particularly their right to treatment.

Such was the situation inherited on 1 January 1992 by the 15 new republics of the Commonwealth of Independent States. But with the demise of the Union, centralised AIDS reporting and information collapsed. The main epidemiological centre will probably be absorbed by Russia where, like the other preventive services, the department responsible for AIDS has been placed directly under President Yeltsin’s control. Several of the republics have begun exchanging information directly with WHO. Despite the many tests done in the CIS, the real AIDS situation is not known. High-risk groups are believed to know little about prevention, though no sociological studies have been done. Community care and preservation of the infected people’s rights are badly needed. Under the old order, there was no training for either social workers or counsellors.

Salvation Army comforts families
In Volgograd and St Petersburg, the Salvation Army has stepped in to fill this yawning gap, bringing counselling, spiritual comfort, toys and clothing to the families of children with AIDS. There is considerable anger and guilt among parents and medical professionals alike over these children, some of whom have already died.

In February the Army’s technical assistance team mounted an AIDS training workshop in St Petersburg for 145 doctors, epidemiologists and disease controllers. Some of them were startled by the new experience, after a lifetime of communism, of beginning daily sessions with a prayer.

The need to see AIDS as more than a biomedical problem is now recognised, and volunteers are supporting the Army in its social work. It is vital for the CIS to adopt a community development approach to AIDS, says Captain Ian D. Campbell, Salvation Army Medical Adviser. He points out that the republics also need 3 billion syringes yearly, equipment, training, conferences, and help with the nursing and treatment of AIDS patients.

EUROPEAN NEWS

Sexology body seeks contacts

The All-Union Sexologists’ Association in the CIS is an independent organisation for sexologists, medical psychologists and others interested in sexology and family and marital relations. Its goal is to promote the development of sexology, to lay down legal foundations, and to improve services, with the long-term aim of strengthening relationships and disseminating information about healthy living and sexual life.

Founded in 1989, the ASA concentrates on post-graduate training, exchange of experience, and introduction of proved treatment methods into daily practice. It emphasises the need to develop a better attitude to sexology among the population, and to raise the level of the sexual culture through consistent sex education. The Association promotes research, organises conferences, and publishes papers, books, a journal and other materials. Members include foreign specialists as well as doctors from all the former republics. There are ASA offices in Moscow, Kiev, Minsk and many other cities.

The ASA is prepared to help develop guidelines on sex education, identify pornography, provide lecturers, help arrange programmes for teenagers, and so on. It welcomes cooperation with international and national societies, and is interested in developing scientific contacts and exchange programmes.

[For more details, contact: Professor Boris M. Vornik, Vice-President, Komsomolskaya 8, 252160 Kiev, Ukraine. Fax 7.44.543.84.21.]
TABLE TALK

A contraceptive community

Dr David Serfaty writes from Paris:
The free circulation of knowledge and methods of birth control within a homogeneous European Community of Contraception was called for at a meeting in Paris last November by the European Society of Contraception.

Experts from all 12 EEC countries, European organisations and the pharmaceutical industry attended this first ESC seminar on harmonisation of birth control methods in the Community, sponsored by the French Ministry for Women’s Rights and the Ministry for French-Speaking Communities.

The European Society of Contraception favours standardisation in three areas:
- contraceptive information and promotion, quality, prescription, nomenclature, cost and access
- application of abortion laws, decriminalisation, free circulation, liberty of choice
- legalisation of sterilisation, reimbursement, provision of alternatives.

The great frequency with which the pill is used is a common feature of the 12 Community countries. Nevertheless the ESC wishes to overcome a certain negative image of the pill in some countries, and to reduce abortions progressively through good-quality contraception.

Resistance against abortion by the medical profession resulting in variations in abortion practice even within countries is deplored by the Society, which says that the law should be applied by everybody in all cases.

The ESC believes that the choice of a method of termination should be the woman’s, after she has been duly informed. Experts at the meeting were keen to study the RU 486 method further.

The technology of contraceptive prescription — that is cervico-vaginal smears and metabolic tests, administered in some countries systematically prior to prescribing but in others not at all — will be the subject of the ESC’s second congress in May.

The answer lies in the tail

Dr Uri Wernik reports from Jerusalem:
A Chinese Emperor who died four and a half thousand years ago inspired the Israel Society of Sex Therapy to call its second Annual Convention (November 1991) Sexuality as a Metaphor: or a multidisciplinary investigation into the interrelations between the humanities, social and life sciences, sex study and therapy.

Huang-Ti (2697-2598 BC), the Yellow Emperor, who is regarded as the father of Chinese civilization, could also be considered as the first known sexologist. He was the author of ‘Ni Chiu Su Wen’, a treatise on sex that formed part of his studies in medicine and philosophy. Huang-Ti explained his preoccupation with sex by saying: ‘To understand the head, investigate well the tail!’

The investigation of sexuality, say the organisers, is relevant to the understanding of larger psychological, social, moral, metaphysical, and historical issues. Studying the representation of sexuality in the media and in the written and visual arts helps one to comprehend sexuality and the treatment of sexual functioning problems.

Some 180 sex-therapists, physicians, nurses, psychologists and social workers took part in the convention, held in Jerusalem. They heard speakers debate some less usual topics at an event of this kind such as Art and Culture, Spirituality and Love, and Revolution. Workshops included Sexuality and Zen Buddhism, Hypnosis, Humour and many others.

[Dr Uri Wernik President, ISST, Sex Therapy Clinic, Mgsav Ladach Hospital PO Box 90, Jerusalem 93190, Israel]

When she says no, she means NO!

Machos and sexual harassers come under attack in a new campaign to change male sexual behaviour

The Netherlands has become the first country to develop a national preventive campaign with youths and men as the target group.

‘Sex is natural, but not a matter of course’ is the theme of a joint campaign launched in autumn 1991 by four government ministries. Its aim is to change male sexual behaviour, and by doing so to prevent all forms of sexual abuse, from rape to verbal attacks.

Young men aged 15 to 35 are the targets of a series of TV spots and double-page magazine advertisements (see inset). Research shows that Dutch men still see women as one of two stereotypes: either they are ‘flighty’, experienced, and will find sexual harassment flattering, or they are ‘decent’ sorts, easy to taunt.

The government wants to broaden the concept of sexual abuse so that it includes not only assault, rape and incest but also whistling, sexist remarks and creeping hands. Youths and men, it says, must recognise that they have the primary responsibility here.

One in three Dutch women has experienced some kind of abuse. One fifth of all respondents reports having had experience with three or more episodes of sexual violence in the direct social environment. And 8 in 10 offenders are acquainted with their victims.

The campaign, which includes a brochure distributed through libraries and post-offices, will run until mid-1995. Regular research into its effects will be used to develop new initiatives as the campaign progresses.

Information is available from: Ms Marie José van Bavel, Ministry of Social Affairs and Employment, Postbus 90801, NL-2509 LV The Hague. Fax 31.70.333.40.30.

ENTRE NOUS 20, May 1992
American population leader and Ecuadorian NGO win 1991 award

Julia J. Henderson, a population and social development leader long associated with the UN and the International Planned Parenthood Federation, and CEPAR (Centre for Population and Responsible Parenthood Studies), which is a private, Ecuadorian non-governmental organization, will share the 1991 United Nations Population Award.

The award is presented annually for outstanding contributions to awareness of population problems and their solution. This year, each winner will receive a diploma, a gold medal and a prize of $12,500.

Ms Henderson was chosen because of her long involvement and leadership in world population issues. She sat on the original preparatory committees for the establishment of the UN in 1945, then headed various UN offices. In 1971, Ms Henderson became Secretary-General of IPPF, a position she held until her retirement in 1978. Since then, she has served as a volunteer in many population organizations, including the Population Crisis Committee and IPPF.

CEPAR was chosen for the high quality of its research on population, in particular its studies on the relationship between population and social and economic development, and its efforts to raise awareness of population issues in Ecuador.

The aim of CEPAR, which concentrates on the scientific study of population, is to promulgate its findings to governments, policy-makers, especially information on the relationship between population growth and economic and social development.

Books

Population pressure
Population, Resources and the Environment: The Critical Challenges assesses the prospects for remedying the impact of population and suggests the kinds of policies needed for sustainable development. From: UNFPA, 220 East 42nd Street, New York, NY 10017, USA. Price $24.75.

New UK series on sexual health
The British FPA’s Growing Up series is a response to demands from parents, teachers and young people for a resource that answers questions about sexual health and sexuality in a clear and frank style. The three booklets are: Answering Your Child’s Questions: information for parents; How Your Body Changes: Information for young people; and Sexuality: information for young adults. Through the booklets the FPA aims to encourage and equip parents to become better sex educators, promote education about adolescence and growing up, and help reduce the risk of unplanned pregnancy, HIV and STDs among young people. Available from: FPA, 27-35 Mortimer Street, GB-London WC1N 7RJ, UK. Price £1.50 each or £3 for the set (p & p included).

Abortion survey
Induced Abortion: A World Review, 1990 Supplement, by Stanley K. Henshaw and Evelyn Morrow, continues the international abortion factbook begun by the late Christopher Tietze. Published by: The Alan Guttmacher Institute, 11, Fifth Avenue, New York, NY 10003, USA. Price $25 plus $2.50 postage and handling.

Prepaid. Other political information appears in Dr Henshaw’s article in International Family Planning Perspectives, Vol. 16, No. 2, June 1990 ($8 plus $0.80, prepaid), from the same address.

New findings on the climacteric
Well-being and Sexuality in the Climacteric (1991) by Anna Oldenhave, containing the results of a third ten-yearly study of Dutch women supported by the International Health Foundation, disproves several previously held beliefs. Dr Oldenhave and co-workers found that the severity of vasomotor complaints (sweating and flushes) was linked to the severity of atypical complaints such as tiredness, tenseness, headaches and muscle/joint pain. Women had a high level of both kinds of complaints after hysterectomy, even if they still had one or both ovaries. The findings suggest that treatment to relieve vasomotor complaints may alleviate the atypical ones, which bother women much more, and that it is desirable to reduce the number of hysterectomies. They also explain why women with atypical complaints during pre- and post-menopause feel less well; this explanation in itself will relieve many women. Obtainable from: Dr A. Oldenhave, Dorpsstraat 268, NL-2391 CK Hazerswoude-Dorp, Netherlands. Tel 30.1728.74.86.
family, the spread of STDs and the creation of a fantasy world by the media. Discussing approaches, it points out that sex education is not just about biology but should stress emotional factors and instil a sense of responsibility. Science teachers, social scientists and religious authorities all need to be involved, says the report, which reflects a respect for the right to education and the right to freedom of opinion and religion.

Available from: Ministry of Education, Santiago, Chile.

AIDS materials in French
Le petit livre de la séropositivité et du sida, L'intervention sociale face au sida and Infection par le VIH et sida are information and training materials published by Arcat-Sida, the French agency formed to fight AIDS. Details and prices from: Arcat—Sida, 57, rue Saint-Louis-en-l’Ile, F-75004 Paris.
Tel. 33.1.43.54.67. Fax 33.1.46.33.11.42.

Reports

Counselling and prevention
HIV Counselling (1992) by Tim Bond is the report of a survey and consultation sponsored by the British National Association for Counselling and the Department of Health. Covers the meaning of counselling, principles, training, supervision and monitoring, with a directory of counselling-related agencies. Practice-related and particularly useful for counsellors and their managers. From: Daniels Publishing, Barton, GB-Cambridge CB3 7BB, UK. Tel. 44.223.26.48.80. Fax 44.223.26.48.88.

New WHO reports
Prices are 9 and 14 Swiss francs respectively.

Magazines/newsletters

The Women’s Global Network for Reproductive Rights publishes a regular Newsletter. Also available, the WGNRR Mortality and Morbidity Report 1991 and other materials. From: WGNRR, Voorburgwal 52, NL-1012 RZ Amsterdam, Netherlands.

Readers will be disappointed to learn that after nearly 20 years of continuous publication People, IPPF’s illustrated magazine, has ceased publication. In its place IPPF is issuing two new periodicals:

Planned Parenthood in Europe
Planned Parenthood in Europe (PPPE) is received by family planning associations, medical associations, universities, libraries, NGOs and other readers in over 120 countries, including Europe. PPPE is published three times a year by IPPF in London, and is free of charge. It carries articles on family planning and related issues in Europe, including education, resources, services and policy-making. For details, and a free subscription, contact: Dr Evert Ketting, Editor, or Ms Caroline Robinson, Desk Editor, Planned Parenthood in Europe, International Planned Parenthood Federation, Europe Region, Regent’s College, Inner Circle, Regent’s Park, London NW1 4NS, UK.

POSTAGE - WILL YOU HELP?
Entre Nous is free, but our handling costs are very high. If you can afford it, we should very much appreciate it if you could contribute 50 Danish kroner per year (or the same amount in another currency) as a handling fee. Please send your cheque—made payable to World Health Organization (documents)—to: Entre Nous, WHO Regional Office for Europe, Scherfigsvej 8, DK-2100 Copenhagen Ø, Denmark.

Portuguese materials
Planeamento Familiar—o que é? Como nasce uma criança and other materials for Portuguese-speaking African countries are available from: Comissão da Condição Feminina de Portugal, Av. da República 32-1.0, P-1093 Lisbon Codex, Portugal.
Training opportunities

FP programme management. Indonesia
BKKBN offers the following programme for 1992 based on the Indonesian experience: Planning and Managing Family Planning IEC (21 July-7 August); Women in Family Planning and Development (7-20 October); Planning and Managing a National Family Planning Programme (2-15 December). Other programmes available by prior arrangement. Details from: Programme Coordinator, International Training Programme, BKKBN, PO Box 1186, Jakarta 10011, Indonesia. Tel. 80.98.018. Fax 81.94.532.

Research and management, UK
The Institute of Population Studies, University of Exeter offers various short courses (7–11 weeks) in 1992 and four-week attachments between April and June on Needs Assessment, Data Collection, Information for Management and Evaluation. Two MA programmes in Applied Population Research and Family Planning Programme Management begin each October. A three-year PhD programme is also offered. Apply to: The Training Officer, Institute of Population Studies, University of Exeter, Hoopern House, 101 Pennsylvania Road, Exeter, Devon, EX4 6DT, UK.


4th International Berlin Conference for Sexology: Sexuality, the Law and Ethics (Berlin, 16-19 July 1992). Contact: Mr Rolf Gindor, DGGS, Gersheimer Str. 20, D-4000 Dusseldorf 1, Germany.


8th International Meeting of the Society for the Advancement of Contraception (Barcelona, 19-22 October 1992). Contact: SAC, Department of Obstetrics and Gynaecology, University Hospital of South Manchester, GB-Manchester M20 8LR. Tel 44.61.445.5113. Fax 44.61.445.1186.

IPPF Central Executive Committee Meeting, Central Council Meeting and Members’ Assembly (New Delhi, 19-28 October 1992). Contact: Information Services, IPPF, Regent’s College, Inner Circle, Regent’s Park, GB-London NW1 4NS. Tel: 44.71.486.0741; Fax 44.71.487.7950.

First European Biennial of Printed and Audiovisual Health Promotion Materials (Prague, 1-4 November 1992). Main themes will be AIDS, smoking, drug and alcohol abuse, physical activity and nutrition. Contact: Dr Z. Kucera, Director, National Centre for Health Promotion, Sokolska 54, CZ-121 39 Prague 2, Czechoslovakia. Tel: 42.22.206.341. Fax 42.2.432.172.

Smog and health

During smog episodes, major air pollutants can so far exceed guideline levels that they cause acute adverse effects on health. This can happen during stagnant weather in either summer or winter, the major pollutants differing according to the season. Various smog alert systems and abatement schemes have been devised. Different countries use different methods, although smog may spread across several countries at the same time.

This book assesses the risks to health during episodes of smog in winter and summer. In winter, the most significant pollutants are sulfur dioxide and suspended particulate matter, but they only indicate that a much more complex mixture is present in the atmosphere. In summer, photochemical reactions of nitrogen oxides and hydrocarbons lead to the formation of ozone and other harmful substances.

Available in English with French, German and Russian summaries from: Distribution and Sales World Health Organization CH-1211 Geneva 27 Order Switzerland

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