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1982 EUROPEAN POPULATION CONFERENCE

In Strasbourg on 21-24 September 1982, demographers and policymakers will meet to discuss 'Demographic Trends and Policy Responses', under the auspices of the Council of Europe. (Member-states include 14 IPPF Europe member-countries: Austria, Belgium, Denmark, Federal Republic of Germany, France, Ireland, Italy, Luxembourg, Netherlands, Norway, Portugal, Sweden, Turkey and UK.)

Discussion papers (in English and French) will be circulated to participants before the conference on the following topics:

1 General review of the population situation and trends in Europe

2 More detailed examination of certain fields of particular importance:

- a changes in age structure
- b patterns of fertility regulation
- c participation in economic activity and the changing role of women
- d family formation and dissolution; family structures
- e size and growth of immigrant populations

3 Future prospects:

- a attempts to interpret past and current demographic changes
- b possible future demographic developments

Likely major consequences:

- c economic (labour market, social security system, the economy, etc)
- d non-economic (sociological, psychological, cultural, political, etc)

4 Policy responses:

- a - adaptation to changing patterns
  - attempts to influence demographic trends (legitimacy and limits; main fields of action; efficacy)
- b survey of country reports on policy objectives and measures relevant to population trends; attitudes of the public on demographic matters

5 Possibilities for future European cooperation on population questions

The conference will be open to the public. Further details are available from the Deputy Director of Economic and Social Affairs at the following address:

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67006 STRASBOURG Cedex
France

One old man said to another: "My dear friend, do you remember the good old days, when the air was clean and sex was dirty?" I fear that this question does not reflect the real situation. Sex is still dirty in the eyes of many. Nearer to reality came a ten year-old boy, whose mother asked his opinion of a children's book of sexual information, which he had just read. He replied: "It is very good, but dirty".

This Swedish child had evidently been influenced by the idea that sex is dirty. Parents and teachers are now more able to answer questions about the facts of life, but they often experience an inner resistance to telling young people of their own experiences and opinions concerning sexuality and its role in personal relations between men and women.

There is a quite different domain, which signifies that sex is dirty, and that is pornography. Its effect owes much to depicting sex as shameful and forbidden.

The opposite characterises literature and art of quality. In the novels of D H Lawrence, sexuality is a strong positive force with a heavy element of mysticism. The deep experience of sexuality and mental nearness is connected with the good forces of life. Accordingly, Lawrence strongly abhorred pornography. That some of his novels were censored in some countries was a tragic reaction of a depraved culture. George Bernard Shaw was right when he said that *Lady Chatterley's Lover* should be compulsory reading in all girls' schools; except that such reading is at least as necessary for boys.

The same distinction between pornography and nonpornographic sexual openness is made in the official Swedish guidelines for sex education. They say that art and literature can give a deeper understanding of sexuality than any other materials, whereas pornography is a strong negative force, *not because of its openness about sex,* but because pornography handles women as impersonal or despised instruments for men's sexual gratification. Pornography strongly undermines the common feeling of the value and dignity of all human beings.

The long story of the struggle for and against sex education in Sweden is fascinating. The first initiative was taken in 1900 by the first Swedish woman physician. The most important contributions came in the 1920s and 1930s from another woman, the Swedish sex education pioneer, Elise Ottesen-Jensen. In 1942, the Government recommended the official introduction of sex education throughout the school system, beginning in the first year at seven years old. In 1956, sex education became compulsory for all school ages.

In 1970, a large investigation was made to determine the real incidence of sex education. It found that nearly all children received some sex education at school, but that its quality and quantity varied considerably.

We have hardly evaluated sex education. The idea of <u>not</u> informing children and young people about the facts of life is beyond discussion. It is only established that those who received sex education have more knowledge than those who did not; and that sex education is more appreciated if the teacher is able to provoke class discussions.

We also believe that the recent decrease in teenage legal abortions has resulted from improved public contraceptive services, and intensified information and discussion in schools.

In 1969, a sample of 18-30 year-olds in Sweden were asked if they had used a contraceptive at their first coitus. 56% answered yes, which is much higher than in France (5%) several years later. This big difference must depend on the facts that contraceptives had for a long time been banned in France, and that France at that time had no sex education.

During the years 1965-70, Sweden experienced a rapid increase in gonorrhoea, especially in the ages 18-24 years. During the years 1970-76, we had on the contrary a rapid reduction in gonorrhoea, unlike other countries. The reason was a massive information campaign, and intensified information in schools.

We know from large-scale enquiries that sexual satisfaction has increased, especially among women. The reason for that must be the broad change of attitudes towards sexuality during this century. We believe that sex education has played a role in this change. The feeling among children and young people that sexuality is a positive aspect of life has probably helped them to accept their own sexuality and escape old taboos.

Some months ago, a middle-aged woman told me about her experience of sex education when she was a young teenager. In her class they had a woman biology teacher, whom they liked very much. One day she sat down on the teacher's desk and said to the class: "Now we will have sex education". Then she told the class very openly and finely about her own first sexual experiences - what was pleasurable and what hurt during this period of trial and error. Then she told them about her marriage, the happy experience of a developing sexual relationship, and the experience of being pregnant and living with children. Then she answered the many questions from the class. The woman said that it had decisively influenced her own attitude to sexuality and relationships.

I think this story has something important to say about the relationship between the older and younger generations. It is often said that teenagers live in their own world, and that it is difficult or impossible to contact them. A Swedish sociologist investigated this assertion and found that the most important obstacle to communication was not the attitude of the young but the shyness of parents and teachers to speak openly of their deeper experiences of life. Naturally you can never insist that a teacher should discuss personal experiences. But if possible in a natural atmosphere, it can be very helpful to the young and also a good starting-point for further discussion.

Let us now consider the dark side of the situation. The effect of education about life depends on the social conditions of children and young people. In Sweden, some young people vandalize schools and railway trains. At school many are indifferent, hopeless or aggressive, dominated by the feeling that neither home nor society has given them something to live for. Consequently they have no confidence in teaching about human relations, or in any education.

A condition for creating a positive interest in education is to change their whole situation while growing up. A German professor of education visited Sweden and was asked why young people were so aggressive against school. He replied that, if society vandalizes the young, they naturally answer by vandalizing society where they meet it, that is at school.

These young people are unwilling to listen to any teaching about life until the reasons for their aggression have been removed. But the aggression has today reached unprecedented proportions.

In the Western world, there are also severe problems in school of lack of discipline and inability to concentrate. In young people's sexual life, there are relationships which provide mutual support in the complicated world of teenagers today. On the other hand, you have types of sexual life which are utterly self-destructive.

During the last 10 years in Sweden, the median age at first coitus has decreased from 17.6 to 16.5 years for men, and from 18.2 to 16.2 for women. Interviews with teenagers have shown that very early sexual activities are often unsatisfactory for the young, especially for girls, but not necessarily destructive of their later sexuality.

In Sweden, there is a growing feeling that our philosophy of upbringing has been partly wrong. The wrong development was the idea that pupils must have the freedom to find their own way, their own values and norms, and that it harms their development if you try to influence them. Teaching must be neutral, taking no standpoint on ethical questions. That was the philosophy.

In the Swedish State Commission of sex education around 1970, we were already convinced that this philosophy was wrong. In the new teachers' handbook of sex education we introduced therefore a long chapter on ethical teaching. It states that our society is founded on certain basic democratic and human values, which have definite implications for relationships between men and women. The handbook presents some ethical rules, and invites the teachers to sustain them. The pupils retain *the right to argue for other standpoints*. This change of philosophy should not reduce sexual openness and the positive attitude to sexuality.

In 1980, the new school curriculum included such guidelines, absent from the 1969 curriculum.

In the teachers' sex education handbook in Denmark, the approach is clearly different. There the school must take no position on sexual ethics. In Sweden, we have become convinced that such a pluralistic and passive attitude deprives children of the emotional experience of values indispensable for a good society and for a good individual life.

I am convinced that Elise Ottesen-Jensen would agree. In the early 1970s, I was asked to come to the Swedish Association for Sex Education (RFSU) to present the ideas of the state commission for the new sex education handbook. I mentioned the need for active ethical education, taking clear positions on some points. Among the listeners was Elise Ottesen-Jensen, shortly before her death. After the presentation she got up with some difficulty from her chair, embraced me in her usual warm and spontaneous manner, and said: "Now I feel that at last Swedish sex education has found its right way".

Carl Gustaf Boëthius
RFSU
Stockholm

According to a recent study of teenage sexual experience and attitudes, by the age of 19 years, 70% of unmarried teenagers are sexually experienced. Every year in the UK, about 33 000 teenagers have an abortion, 24 000 give birth, and 18 000 marry while pregnant.

Compare the sexual influences on the young, and opportunities open to them, now and 20 years ago. In 1960, few teenagers had motor-cars for back-seat petting. Teenagers were effectively controlled by their parents. Magazines for teenagers concentrated on hobbies and romantic stories, culminating in a date or perhaps a first kiss.

Nowadays, we have highly sophisticated commercial television, which sells almost anything. Advertisers appeal to us in two ways: through the family, and through sexuality. They sell products by presenting them as part of a desirable life-style. Having bought the image, people buy the product.

However, selling goods by sex-appeal also sells sexuality as normal, acceptable behaviour. What sense do young people make of it all?

Teenagers are economically and politically immature, but capable of reproduction, and emotionally vulnerable. To this child/adult conflict is added newly acquired disposable income. Teenagers form a considerable market, as advertisers have been quick to realise.

What are teenagers' attitudes to sexuality? While sexuality has entered their lives as something pleasurable and guilt-free, contraception remains unacceptable. Coitus must be romantic, that is essentially unplanned, passionate, mindless. Contraception is *negative*.

20 years ago, a young man would not have used a condom. The pharmacist would probably have sold it with a moral lecture. The young man would be too embarassed to use it and, if the girl became pregnant, he would marry her.

Nowadays, the young man drives a motor-car and enjoys other sexual opportunities. Pharmacies now display condoms openly. But one glaring aspect remains unchanged: the condom still suffers from a dirty, unfashionable image.

Condoms are relatively easy and cheap to procure in the UK and, unlike most other contraceptives, have no side-effects, and imply no long-term commitment. Used properly, the condom is as effective as an IUD in place. Considering the ups and downs of teenage love, and the tendency of young girls to cease oral contraception if their relationship becomes uncertain, a coitally related method is often more effective. So why don't teenagers use condoms?

Over half the teenagers who have intercourse try a method of contraception. Most are more-or-less aware of the risk of pregnancy. What prevents them from acting on this perceived need for contraception is the image of condoms. The young are most anxious to act correctly; we should exploit this sensitivity.

In order to change the habits of sexually active teenagers, we must exploit the impact of advertising. (Current sex education at school is either too biological, or too concerned with love, marriage and family planning.) Young people are not only committed to romantic love as unpremeditated; girls are also committed to romantic maternity.

Some women become pregnant in order to trap men, to punish their parents, or to escape from intolerable domestic situations. Others do so because they believe what the mass media tell them: mothers have loving babies and husbands, live in lovely homes, and enjoy high status.

This cannot be changed merely by offering the hard facts of early motherhood, but by offering another, more desirable image, as tempting as motherhood. You sell the concept of contraception, the image of a fun-loving and happy contraceptor.

Resistance to contraceptive advertising is based on a fear that selling contraceptives promotes irresponsible sexuality. US studies suggest that sexual activity is unaffected by the availability of contraceptives; the greater the awareness of sexual matters (including contraceptives), the later the age at first coitus.

Another criticism of contraceptive advertising is that it may corrupt the very young. But sexual information cannot corrupt an immature youngster. Contraceptive advertising should be aimed at those of an age to understand the concept of contraception, rather than of contraceptives.

If teenagers model their behaviour on that presented by the mass media, which sells sexuality, then we must also sell them the means to prevent the consequences of such behaviour. I do not favour sophisticated marketing to manipulate people, but selling contraceptives seems the only ethical use of such techniques.

Suzie Hayman
Brook Advisory Centres
London

FRENCH CAMPAIGN OF INFORMATION ON CONTRACEPTION

At the initiative of the Ministry for Women's Rights, the Government announced in June 1981 a wide campaign of information on contraception during the last quarter of 1981 and 1982.

The first phase of the proposed campaign aimed to make women aware of their right to information. It was presented as publicity spots on television, with the slogan "Today, every woman should be able to choose". At the same time, the addresses of centres approved to give information were listed in all town halls and post offices.

This television campaign has allowed some programmes to be broadcast at times when women were able to watch them, and partially enabled the press to fulfil its proper role.

The Mouvement Français pour le Planning Familial (MFPF) voiced certain reservations over the means chosen by the Government to implement this information campaign, i.e. a publicity spot among other advertisements. Moreover, while it is important to acquaint women with the reception facilities available, they remain largely insufficient and even absent from some regions. The Government hopes to promote the establishment of such facilities in the near future.

The television campaign lasted three weeks. It is too soon to make a serious evaluation of its popular impact.

The MFPF monitors ministerial decisions on the implementation of further action and, when asked, gives advice on work undertaken.

Otherwise, MFPF requirements and its specific way of approaching people remain unaltered. The information situation has hardly changed in France, although women's awareness has been raised as a result of the national decision to guarantee information on these matters.

THE FRENCH FAMILY PLANNING MOVEMENT CELEBRATES ITS 25TH ANNIVERSARY

On 13 November 1981, the Mouvement Français pour le Planning Familial (MFPF) organised a large public demonstration to celebrate its 25th anniversary.

It was a matter of recalling the history of the MFPF and the different struggles it had led, illustrated by display material recounting the peaks of its development and, in particular, to reaffirm every woman's right to information on contraception and abortion.

Following the election of François Mitterrand and the advent of a leftist parliamentary majority, it was important for the MFPF to recall commitments made during the election campaign. The MFPF sought to remind others of its unchanged requirements to abolish legislation restricting women's rights to their own bodies.

Besides MFPF militants from all over France (even from Réunion), this demonstration brought together many sympathisers. Among those invited, the President of the Republic was represented by Madame Jeanette Laot (Technical Adviser to François Mitterrand), and the Government by Madame Yvette Roudy (Minister for Women's Rights), accompanied by some advisers, notably Simone Iff, an MFPF militant of long standing, and by Madame Georgina Dufoix (Under Secretary of State for the Family).

The MFPF also received many telegrams of sympathy and support from prominent personalities and foreign organisations.

Before an audience of 1000, the MFPF pointed out that political change had not yet affected information on contraception and abortion. Government services, unchanged, continued to hinder the implementation of Government policy.

The MFPF declared itself in favour of the information campaign conducted by the Ministry for Women's Rights, which Madame Roudy outlined. However, the MFPF mentioned that information should be coupled with the means necessary to fulfil the basic right to contraception and that the decriminalisation of abortion was essential to achieve real equality for women.

After the official proceedings had concluded, a cabaret/circus and dancing went on till two in the morning.

CENTENARY CELEBRATIONS IN THE NETHERLANDS

On 7 November 1981, the Netherlands celebrated 100 years since the foundation of the Nieuw-Malthusiaanse Bond (Neo-Malthusian League), predecessor of the Nederlandse Vereniging voor Seksuele Hervorming (NVSH). For the occasion, the NVSH published a report describing past, present and future perspectives in the field of planned parenthood and sexual emancipation. (See also: '1881-1981 : A Century of Organised Family Planning in the Netherlands' : *Regional Information Bulletin Vol 10,1, 16*).

About 450 participants met to exchange experience. Several organisations were involved, including the NVSH and the Dr J Rutgers Stichting (the IPPF member-association in the Netherlands). The IPPF Europe Region was represented by a member of the Regional Executive Committee, Freddy Deven (Belgium).

POSTCOITAL FERTILITY REGULATION: A SIGNIFICANT ASPECT OF PLANNED PARENTHOOD

Women who 'take chances' feature in every published study of contraceptive usage. It is commonly assumed that they are ignorant, unwilling to use contraception, deterred by institutionalised contraceptive services, or just plain irresponsible.

Emerging evidence from a new postcoital fertility regulation service, set up by the Pregnancy Advisory Service (PAS) in London, suggests that this profile of women who risk unwanted pregnancy is misleading. Women using the PAS postcoital service confirm the findings of a recent survey*, that the number of women unwilling to use contraception is negligible. Neither ignorant nor unmotivated, they have problems and anxieties about current methods of contraception, accidents or method-failures, and sometimes bad luck. Perhaps a new and significant factor is the increased likelihood of changes in their lives or relationships which lead them to interrupt long-established contraceptive practice. Certainly the previous contraceptive usage of PAS clients, and the persistance needed to discover a source of emergency help within hours of unprotected intercourse, testify to their determination to avoid unwanted pregnancy.

Contemporary patterns of sexual activity, consequent on changing relationships inside and outside marriage, and mounting anxieties about the possibility of long-term health risks of systemic contraception and current economic deterrents to unwanted pregnancy, are likely to increase the need for measures to prevent pregnancy after unprotected coitus, and underline the long-term need for widespread access to postcoital facilities. Since morning-after treatment, of proven efficacy and acceptability, is already well-established and documented - and can be provided much more cheaply than abortion - it is unfortunate that so little has been done to make it widely available.

In the UK, few physicians or clinics offer postcoital contraception. Interest in treatment declined during the 1960s, when the high estrogen doses caused unacceptable levels of nausea, vomiting and menstrual disturbances. The Brook Advisory Centres, whose young, single clients often have unpremeditated first intercourse, first offered high estrogen treatment.

In the late 1970s, studies in Canada and the USA showed that some combined oral contraceptives and copper IUDs would almost always prevent pregnancy if used within 72 hours of unprotected coitus. Since then, further investigations have confirmed their reliability, and clarified some of the criteria for treatment and management.

PAS opened a postcoital clinic in April 1981. The service offers to women, who have risked pregnancy around mid-cycle, a choice of techniques. To be effective, they must be administered during the five days between fertilisation and implantation. However, PAS restricts treatment to the first 72 hours after intercourse, as required by the Department of Health and Social Security.

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*Allen, I (1981): *Family Planning, Sterilization and Abortion Services.* Policy Studies Institute, London

Women seeking treatment are seen each weekday morning; they are told about the methods available, side-effects and the remote possibility of fetal damage or ectopic pregnancy if treatment fails. Careful assessment and medical examination establish the time of intercourse in the menstrual cycle, the likelihood of pregnancy, and identify contra-indications to treatment.

Most women choose the oral contraceptive (levonorgestrel 0.25 mg + ethinyl estradiol 0.05 mg): two tablets immediately, and two further tablets to be taken 12 hours later. The remainder have an IUD inserted. All the women seen are told that, in the unlikely event of the treatment failing, they will be offered help in obtaining legal abortion. They are urged to return to the clinic for a check-up four weeks later.

PAS started postcoital treatment conscious of its inability to provide an ideal, well-advertised service, open daily. But we believed, from the response to a short item in a women's magazine, that there was a widespread demand for postcoital methods.

We began with clear objectives: to assess the demand, acceptability and reliability of postcoital methods; to give women a choice of techniques, in the absence of contra-indications; and to provide information about the safety and effectiveness of postcoital methods of fertility regulation to the general public and health personnel. We hoped thereby to stimulate other physicians and clinics to offer postcoital treatment.

In the first nine months, 554 women have attended PAS postcoital sessions, and 516 were treated. Many women had travelled far, although 62% were treated within 48 hours of coitus, including 27% within 24 hours. 29% reached the clinic 49-72 hours after coitus, partly due to clinic closure over weekends.

80% of women chose the oral contraceptive. Relatively few women (11%) accepted an IUD, most having been advised that they had come too late to ensure pill effectiveness.

There have been seven definite pregnancies in this series; all had been treated with oral contraceptives. Three of these women were found at abortion to have been pregnant before seeking treatment; and four were method-failures.

Over 60% of the women returned to PAS for follow-up, while others have telephoned. Very few side-effects are reported: nausea and vomiting appear to be minimal; routine anti-emetics have proved unnecessary.

Although 53% had not been using contraception, the women were normally conscientious users. Most had used oral contraceptives, some for several years, and had stopped using them for various reasons. Others had had an IUD removed. Few of the women who had used the pill or IUD adapted easily to the alternative of barrier methods.

The other main reason for unprotected intercourse was the conclusion or interruption of sexual activity. Such women were notably unwilling to use contraception, which they feared might have long-term consequences. Unexpected reunions, chance encounters, new relationships, alcohol or romance frequently led to unpremeditated intercourse.

Surprisingly, few very young women used the PAS postcoital service. Only 16% were teenagers and 80% of women seen were over the age of 24 years;

13% of these were 35 and over. This latter group was most likely to have taken the pill for several years and express their own or partners' anxieties on this score. Equally, women approaching the menopause, and with adult families, were probably among the most determined to avoid this or any other possible pregnancy, even if it meant returning to the pill.

Indeed, another striking feature of the service is the opportunity it offers for fertility regulation counselling. There is little doubt that, despite their relief and satisfaction with 'morning-after' contraception, women find it distressing and traumatic to confront an unplanned pregnancy. The experience may well be a significant turning-point in their contraceptive practice.

Almost every woman coming to PAS would have sought abortion if treatment had not been available and pregnancy was established. Postcoital techniques are simple, almost always effective, and less traumatic and expensive for women than abortion. If postcoital treatment were available through physicians and clinics, there would be a significant reduction in both abortions and unwanted births, and appreciable savings to the National Health Service.

Current ignorance about postcoital treatment is shared by women and health personnel alike. A major stimulus to medical interest is the recent IPPF decision to endorse postcoital treatment in emergency. PAS aims to accelerate the development of postcoital services by organising a symposium entitled 'Postcoital Birth Control: Methods, Services and Prospects' on 14 April 1982 in London.

Helen Grahame
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ABORTION TRIALS IN BELGIUM

In the *Regional Information Bulletin* (April 1981, pages 9-12), Dominique Chartier described the abortion situation in Belgium, and events since 1973. More recent events are summarised below.

In February 1981, the Brussels Public Prosecutor announced his intention of resuming legal proceedings on abortion. Since the Peers case in 1973, nobody under investigation had been tried.

This truce was made possible by a tacit agreement between the Minister of Justice and the Public Prosecutor, who had 'frozen' proceedings. The truce originated in the impossibility of implementing an outdated (1867) law; and from Parliament's inability to reform the law.

The trial opened on 2 September 1981. The accused were physicians having performed abortion, women having requested abortion, and their 'accomplices' (eg. parents authorising abortion for minors).

The defence counsel for the physicians first requested the tribunal to generalise all abortion cases, and to adjourn the trial indefinitely, to allow time for a Parliamentary initiative, or at least for two months, to allow the defence time to prepare its case thoroughly. The defence argument for generalisation was that it was unjust to prosecute only some physicians performing abortion, especially those working outside hospitals.

Moreover, Professor Hubinont, head of the gynecology department of the St Pierre Hospital of the Brussels Free University, asked to be indicted with the accused physicians, who had been trained in his department. Since 1973, Professor Hubinont's department had adopted the procedure of a multi-disciplinary team receiving women requesting abortion. The decision to perform abortion (up to 20 weeks) was taken collectively.

In non-hospital centres since 1975, the decision whether to perform abortion (up to 12 weeks) was ultimately the woman's. In evidence, Professor Lambotte (University of Liège) emphasied the quality of these services, and that hospitals alone could not meet the demand for abortion.

On 16 September 1981, the tribunal rejected the defence request. However, if only for practical reasons, some generalisation of the abortion issue is inevitable. The tribunal nonetheless agreed to adjourn the trial for one month. The coincidence between the trial and the election campaign influenced the tribunal in delaying the legal process, allowing the new Parliament time to review the position.

On 3 October 1981, a national demonstration, organised by the Coordinating Committee for Decriminalising Abortion, attracted 6000 people in Brussels. In the same month, Pro Vita and its Dutch-speaking equivalent attempted a civil suit against the physicians in the name of protecting life, which both the defence and the Public Prosecutor considered inadmissable. In November 1981, the tribunal confirmed this inadmissibility, ruling that these two organisations had no direct interest in the case, and that their aims were incompatible with the public interest, safeguarded by the Public Prosecutor.

On 9 December 1981, the accused physicians, from both the St Pierre Hospital and the non-hospital centres, and women having had abortion, gave evidence. On 13 December, defence witnesses gave evidence. Eminent professors from France, Netherlands and UK were heard first.

Public health considerations were emphasised. Abortion was a medical operation to protect women's health. It was proved that skilled abortion had greatly reduced unskilled abortion and its tragic consequences.

Also in December 1981, a bill was introduced in the Chamber of Deputies to suspend the abortion law for two years. The sponsors requested an immediate vote, but the bill was sent to committee for review.

On 3 February 1982, a mixed health/justice committee voted by 13 to 10 for such a suspension. However, on 4 March 1982, the Chamber of Deputies narrowly defeated (by 95 votes to 92, with 5 abstentions) the proposed suspension of the current abortion law.

The tribunal still refuses to hear other defence witnesses. These neglected witnesses were women who have had illegal abortion in Belgium or abroad, or who work in non-hospital centres. This medicalisation of the abortion question, at the expense of the women's viewpoint, raises the fear that repression of abortion, especially in non-hospital centres, may now be intensified in Belgium.

Belgische Federatie Geboortenregeling en Seksuele Opvoeding/
Fédération Belge pour le Planning Familial et l'Education Sexuelle
Brussel/Bruxelles

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