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POSTCOITAL CONTRACEPTION IN EUROPE

Introduction

At the 1984 IPPF Europe Regional Council Meeting, delegates from the 20 member planned parenthood associations devoted one day of lectures and group discussion to the subject of postcoital contraception. It had been recognised that, although existing contraceptive methods can be used postcoitally, in few countries has there been a concerted effort to bring this fact to the attention either of professionals involved in contraceptive provision or the public.

The following papers were presented at or resulted from this discussion day.

THE ROLE OF POSTCOITAL CONTRACEPTION IN EUROPEAN FAMILY PLANNING PRACTICE

Introduction

In contrast with the legal and other problems which have inhibited the widespread adoption of postcoital contraception in the United States (1), evidence suggests that the majority of Eastern and Western European countries are rapidly adding this method to their contraceptive services - even in countries where not all existing methods are widely available (2). This paper attempts, firstly, to present an hypothesis to explain the paradox that greatest demand for this 'emergency' measure will occur in those populations where the use of the most modern, effective contraceptive methods is greatest; and secondly, to review the current status of service provision in Europe.

In the medical sense, the recent arrival of postcoital contraception on the planned parenthood scene is of little significance compared with the variety of existing contraceptive options and services. For neither are the techniques of after-sex pregnancy prevention (oral steroids or IUD) additions to exisiting contraception methods, nor does the provision of a postcoital contraceptive option entail any revision of existing services.

Nevertheless, the minor changes which the addition of this facility would make to the workloads of family planning personnel should be contrasted with the enormous significance it could have for many contraceptors. The reasons for this stem from the dramatic changes most European countries have experienced in the use of modern methods of contraception over the last 20 years.

It is proposed here that changes in contraceptive method use over the last two decades have led to accompanying changes in social-psychological attitudes to pregnancy. And it is through an appreciation of these attitudes that changes in abortion rates, the ratio of planned and unwanted pregnancies, and ultimately, the present and future importance of postcoital contraception, can be understood.

Table 1 displays the distribution of method use with survey data from the 1960s and early 1970s. What this distribution conceals is a drift throughout Europe from the so-called traditional, to modern medical or technical methods as these are made available.

In more recent years the apparently inexorable drift towards modern medical/technical methods (which offer the highest theoretical efficacy rates) has been stemmed. Persistent anxieties over the consequences to health of these methods have led to a reaction against them among some women, and a return to more simple (eg. cap and condom), if in some respects more refined, techniques (eg. muco-thermal and sponge-spermicidal methods).

TABLE 1: Current uses: extent of modernisation of methods used (figures show percentages of all current users)

Country	Modern methods (sterilisation pill, IUD) (1)	Trad.methods (safe period, withdrawal) (2)
Netherlands	78	7
USA	68	8
Great Britain	66	7
Norway	66	9
Finland	56	4
Denmark	49	3
Hungary	65	28
France	52	38
Belgium	48	42
Czechoslovakia	40	38
Spain	27	56
Italy	22	57
Poland	12	66
Yugoslavia	12	73
Bulgaria	5	84
Romania	1	83

Source: Berent J Comparative Studies: Family Planning in Europe and USA in the 1970s. No 20, October 1982, World Fertility Survey.

Nevertheless, the argument remains that the generations of women passing through the medical contraceptive revolution, whether they ultimately decide upon sterilisation or a return to the techniques described above, are likely to develop a different attitude to the threat of accidental pregnancy than those preceding generations who had at their disposal traditional methods only.

As examples of the 'contraceptive revolution' significant changes in method use took place in England and Wales, and Hungary over the years 1966-76. In the former, the use of the pill, IUD and sterilisation (increasing from 21 to 66 per cent) almost eliminated the use of withdrawal and safe period, though since the 'pill scare' of the mid-1970s, in the UK, the popularity of the condom has returned.

In Hungary, while the incidence of sterilisation remains negligible, the use of modern methods rose from nil in 1966 to as much as 65 per cent in 1977, and the use of traditional methods declined from about two-thirds to about one-quarter of all users(3). France and to a lesser extent Yugoslavia show a similar pattern of change. In Eastern and Southern Europe (with differences existing between urban and rural dwellers)(4) the departure from traditional methods has been less rapid, though most countries in Europe display an increased use of modern methods among young marrieds.

In sum, older marriage cohorts in all European countries rely more upon traditional methods than younger groups, indicating an overall trend towards modern methods which is likely to continue. Traditional method use is most widespread in Bulgaria, Romania and Yugoslavia, where three-quarters or more of current users rely upon withdrawal or safe period as the principal method of contraception.

Unplanned and unwanted pregnancies

A number of studies have investigated family size, hopes for further children, past and present contraceptive use, and attitudes to pregnancy. The following conclusions have implications for postcoital contraception.

In spite of an overall reduction in the number of unplanned pregnancies following the take-up of modern methods, European women using such methods appear everywhere to have more unplanned pregnancies than those using traditional methods(5). A most striking case is Spain, where general contraceptive use is low with a high reliance on traditional methods. Yet here only 9 per cent of pregnancies are reported as unplanned. Secondly, among women using modern methods of contraception, the rate of pregnancies reported as unwanted is higher than that among women using traditional methods. In contrast to unplanned pregnancies, the percentage of such pregnancies reported as unwanted increases with the age of the woman. Berent reports that unplanned pregnancies are particularly frequent among couples with three or more children and among less educated women, and that, for most countries, the incidence of unwanted pregnancy is between one-half and one-third of all unplanned pregnancies (6).

Research in Britain conducted over a ten year period suggests that the ratio of unwanted against unplanned conception has increased due to the existence of modern methods (7). The implications of this finding, if they can be generalised to their countries in Europe, are contentious. For the anti-family planning movement has, at least in the UK, used such conclusions uncritically, to argue that state assistance in provision of modern contraceptives has done nothing to eliminate the problem of abortion, and has increased the problems faced by women through its contribution to STD rates, divorce, etc.

From a social psychological perspective, it may be argued that exposure to modern methods will create expectations of greater effectiveness in pregnancy prevention than traditional methods. This is likely, in turn, to influence womens' willingness or ability to tolerate the prospect of contraceptive failure or accidental pregnancy.

A changing 'contraceptive consciousness' may be displayed in a number of ways: those accustomed to long-term reliance on traditional methods are likely to be more skilled in preventing accidental pregnancies than those modern method users who occasionally resort to withdrawal or safe period. Also, the occurrence of a pregnancy to a traditional method user prepared for such a possibility, is unlikely to have the same psychological impact as the pregnancy to the woman who has organised her reproductive future around the oral contraceptive.

Social researchers are faced with potentially different perceptions of the term 'unplanned' according to contraceptive lifestyle, when comparing trends cross-nationally.

It is therefore argued that the demand for a postcoital 'emergency' contraceptive option is most likely to be highest among women faced with the occasional failure of the most effective modern methods. Of significance here is the continuing rate of unplanned conceptions among modern method users, and the proportion of these conceptions which are subsequently defined as unwanted. This is an expression of expectations of ability to totally control fertility which have accompanied the arrival of modern contraceptive technology. Unfortunately, such technology has brought its own problems, not least because this technology can not yet live up to users' expectations of it. The contraceptive consciousness which has followed the development of modern methods is less willing to accept contraceptive failure.

The recent publicising of postcoital contraceptive services has highlighted the user failure factor particularly of the 'modern' condom, although a smaller number of requests for PCC are the result of forgetting pills, problems with the cap, etc. Whether tearing condoms or forgetting the occasional pill is a 'user' or 'method' failure is largely irrelevant; the reaction of women using modern methods to the possibility of accidental pregnancy is important. The high level of anxiety which the recent existence of postcoital services has uncovered is some measure of this reaction.

An additional factor which further distances the 'modern' from the traditional method user is method change. In contrast to lifelong use of withdrawal or safe period methods, the typical modern contraceptive user is likely to have moved to or from the oral contraceptive, with periods of condom or IUD use before or after. As a characteristic of modern method use, method change brings with it risk of contraceptive failure as new competences (eg, the skill of fitting a cap or the need to remember to take pills) are acquired.

Contemporary social factors may also add to the statistical possibility of modern method/user failure (or occasional use of no method). In a more liberal sexual environment characterised by increased divorce/partner change, the consequent increased number of sexual initiations in a lifetime increase the likelihood of haphazard use of contraception and occasional non-use (the sexually active young are notorious non-users on first intercourse). Roberts notes:

> 'Oral contraception has been sold to the public as the easiest, safest method of contraception there is, yet it actually imposes a routine which cannot be varied and many factors have to be taken into account which affect its efficiency. It is, in effect, as intrusive as a mechanical method, but it intrudes into everyday life, not sexual activity' (8).

Luker considers a further influence on the reaction to the threat of pregnancy accompanying modern method use:

> 'Until quite recently, child-bearing, and especially the beginning of child bearing, hs been something over which little control has been exercised ..... it is only with the advent of widely-distributed, effective contraception in the form of the pill that couples have had to consciously decide to stop contraception and engage in child-bearing; such a conscious thought-out decision is an abrupt and sometimes difficult one to make. Contraceptive risk-taking within marriage may be a way of side-stepping the greater commitment needed to 'cold-bloodedly' plan the stopping of contraception and the beginning of child-bearing.' (9)

Who needs Postcoital Contraception (PCC)?

No postcoital contraceptive service has operated on a large enough scale, or for long enough, to reliably estimate long-term demand. Nevertheless, pilot schemes indicate that potential demand is 'enormous' (10). A small pilot service in the UK required no advertising, but simply word-of-mouth knowledge to produce rapidly increasing demand. Nevertheless, it has been argued that greater publicity is required for this new method before all women who fear a possible accidental pregnancy can take advantage of it

In addition to methods problems, PCC may be used in the following circumstances:

1 Rape
2 Inebriation: intercourse when under the influence of alcohol
3 Incest
4 Extramarital affairs
5 Mental handicap
6 Teratogens: recent use of drugs such as cytotoxics or live vaccines (Rubella)
7 First time intercourse: notorious for lack of contraceptive protection (11)

It is already apparent that general practitioners or family planning clinic staff themselves may present an obstacle to the rapid establishment of PCC services. While all GPs (and trained midwives where possible) are able to provide this service, many may yet be prevented through their ignorance (some believe that PCC is still at the research stage) or inability to discover prescribing /administration details (the pills and devices now employed were not originally used for PCC and, for example in the UK, do not have this indication on their product licences). So, although manufacturers do not or cannot yet promote their steriodal contraceptives as suitable for postcoital use, physicians are free to use them for this purpose.

Many general practitioners remain ignorant of this method; some others believe that it constitutes abortion and/or is in contravention of abortion laws. It has been reported that, in the FRG, the majority of physicians are unaware that under German abortion law: 'all methods of birth control used before implantation of the ovum is completed arenot defined as termination of pregnancy'. The law does not mention any time restriction. As a result PCC is falsely associated with abortion (12). However, physicians must be both willing and able to provide appropriate counselling on this aspect, particularly if they suspect that the woman has moral/religious objections to abortion (13).

Other reasons for GPs resistance to offering PCC include: a lack of sympathy for women who have emergencies of this kind; and a concern that if it was offered, women would abuse the service by using it a sole method of contraception, particularly if they are having intercourse only occasionally. (Evidence suggests that this apprehension is unfounded). It may also be of some concern that a significant number of women will not attend for follow-up consultations.

Technical Problems in Providing Services

Problems of providing PCC services when they are urgently needed must be overcome. Demand may occur at weekends, when surgeries and clinics are closed. Furthermore, many practices operate an appointments system and receptionists may not be aware of the urgency of a call. Such problems may be overcome through the advertising of a 24 hour telephone service offering a referral address. The question whether the demand that clients return for further consultation as a medical safeguard may have a deterrent effect must also be considered.

Problems in Advertising the Service

It is generally agreed that, of all contraceptive services, PCC requires the most intensive, continuous publicity. When a woman is in such a position that PCC can help her, she must know where to go and why she must obtain treatment within a short period of time. However, because of the cost and the opposition to advertising authorities, many countries will face difficulties common to family planning in general (14). Hoffmann reports that some Pro Familia clinics (the FPA of the FRG) are about to cooperate with other advisory centres, including GPs, gynaecologists in private practice and in hospitals with out-patient departments, pharmacists and others, in channelling information about PCC(12).

Conclusion

It has been argued that the greater the reliance on the so-called 'modern' compared with 'traditional' contraceptives the more important postcoital contraception will become to the psychic and physical health of women. This has been explained by reference, firstly, to the problems particular to modern methods use in conjunction with partner changes and method changes during the contracepting lifetime; and secondly, to 'expectations' of total pregnancy planning with modern methods, and reduced tolerance of accidental pregnancy.

Subject to medical confirmation of long-term safety and refinement of existing postcoital methods, the hypothesis above appears to be supported by the evidence available from European countries at different stages of modern versus traditional method use.

REFERENCES

1 'Postcoital Contraception: A Delicate Political Issue' Contraceptive Technology Update, April 1984 vol 5

2 This data is taken from evidence supplied by the 20 member Planned Parenthood Associations of the Europe Region of the IPPF

3 Berent, J op cit pg 26

4 Regional differences within European countries can be highly significant. Thus, while the educational level of the woman appears to have little influence on the prevalence of modern methods in the USA and Northern Europe, the reverse applies to Belgium, France, Italy, Poland and Spain. In Spain, the use of modern methods among women with post-secondary education is among the highest in Europe, at 74%.

5 Berent, J op cit pg 29

6 Ibid pg 29. Cartwright discovered that, in the UK, 44% of all known conceptions to married women with two or more children are regretted. Cartwright, A Recent Trends in Family Building and Contraception OPCS 1978

7 Cartwright, A op cit

8 Roberts, C 'Providing a Service to Meet Women's Needs' in Postcoital Contraception: Methods, Services and Prospects Pregnancy Advisory Service 1983 London pg 31

9 The complexities of oral contraceptive use and the possiblities of failure are graphically illustrated by Fraser and Jansen who discuss the effect of errors of Pill taking and other external factors of contraceptive efficacy. They note that very little precise information exists to guide the practising clinician in his counselling of Pill-takers about a) individual variation of minimum dose required for effective contraception; b) the risks of missed Pills, and c) interaction of the Pill with other drugs. Ian S Fraser and Robert Jansen,'Why do inadvertant pregnancies occur in oral contraceptive users?',Contraception, June 1983, vol 27 pp531-551).

10 Luker, K Taking Chances: Abortion and the Decision not to Contracept 1975 University of California Press pg 102

11 See Parsons, A 'The Provision of a Postcoital Contraception Service' in: PAS op cit pg. 9

12 Hoffmann, K in PAS op cit pg 17

13 Remarkably, inspite of this issue (Catholic) religious authorities in Europe have, as yet, failed to single out this method for special condemnation.

14 Johnson, T in PAS op cit pg 53

15 Hoffmann, K op cit

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FOUR YEARS' EXPERIENCE OF POSTCOITAL CONTRACEPTION IN PRO FAMILIA* CLINICS

In May 1976 the government of the Federal Republic of Germany introduced an important Penal Law Amendment which incorporated a change in the existing abortion law. On the whole it became more liberal. Furthermore, the new law confirms that: 'All methods of birth control used before implantation of the ovum is completed, are not defined as 'termination of pregnancy'.

From the legal point of view, all sorts of implantation-interfering methods could be used during the first four weeks following a menstrual period. This law gave the legal basis for an official approach to using postcoital methods in the Federal Republic of Germany.

Eight years after the introduction of this law, the majority of physicians are still unaware of the legal position. It is not surprising therefore that the application of morning-after methods is often associated with early abortion and closely linked to physicians' moral and personal convictions. This timidity to act possibly illegally may be one of the principal reasons why knowledge of postcoital birth control is still not sufficiently implemented and is even widely opposed.

Many publications on the subject of postcoital techniques can be found in the scientific literature of the last ten years. But they have yet to play a major role in family planning. Family planning services face the challenge of identifying the means to best deliver this method to those in the fertile age range whom it can best benefit.

These considerations influenced the FRG Association for Family Planning and Sexual Counselling, Pro Familia, to initiate a morning-after service programme at the end of 1979. It was part of a more comprehensive project concerned with the needs and problems of specific target groups in the society, especially young couples and the different categories of single people.

After reviewing the scientific literature we found the combined estrogen/progestagen method as described by Yuzpe in Canada to be the best available means of pregnancy prevention in these circumstances. This method did not have the discouraging side-effects of the concentrated estrogen application which contributed to the predominantly bad image of 'morning-after-vomiting' in the past.

Approximately 1,200 applications in 35 of the 120 Pro Familia Counselling centres were registered during the last 4 years. Two thirds of the clients used the combined steroid method, described by Yuzpe; one third used a modified scheme with a gestational drug (levonorgestrel) up to 12 hours postcoitally (KESSERÜ, mod).

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*The family planning association of the Federal Republic of Germany

The results were presented at various congresses in Europe: London 1983, Paris 1983, Heidelberg 1983 and Dublin 1983 (XIth World Congress on Fertility and Sterility). Various publications appeared in the medical as well as the lay press to coincide with this Congress. From this time interest has steadily increased. The results from 725 applications are as follows:

1 The vast majority of users are between the ages of 13-26 years (75%) with a significant tendency toward the younger age group.

2 Approximately 50% of the clients had not used any contraceptive. Approximately 35% of applications were necessary after having 'troubles' with condom use.

3 For 95% of the (well informed) clients it was possible to administer the necessary hormone regime before a 48 hour period had elapsed.

4 The efficacy rate for the combined method was 98.1%, The gestagen-only method was calculated to be 97.1%.

5 During this time there was a significant improvement of up to 99% because the counselling physicians had learned to identify specific needs and indications by noting their patients' history more precisely. (It is important to realise, that the application of this emergency method is related to one single unprotected intercourse per cycle.)

With financial support from the Federal government (Ministry of Health) Pro Familia began an information campaign in conjunction with university hospitals, gynecological societies and the regional Pro Familia branches in various cities, including local press conferences and an evening lecture with open discussion for medical doctors and students (Frankfurt, Mainz, Munich, Stuttgart, Cologne, Freiburg).
The aim of this project was to inform the medical profession using the usual channels (teaching hospitals), medical opinion leaders, as well as information to the lay public by press campaigns, because general awareness is still very poor. Furthermore we were demonstrating the role of a client-oreintated family planning organisation as a pacesetter in spreading a new method of birth control for the benefit of couples in the fertile age.

In conjunction with lectures about mechanical and chemical barrier methods of family planning, Pro Familia's approach to postcoital contraception has been presented to pharmacists: they should be able to give correct information about this method to potential users, when they ask for the 'morning-after pill' in the pharmacy.

Various Pro Familia counselling offices arranged meetings with GPs, gynecologists, hospital doctors and ambulance services with the aim of building up a coordinated 'morning after service'. With respect to this method, Pro Familia doctors are familiar with the: pharmacology, working principle, mode of application, taking patients' history and documentation (with the kind support and assistance of Dr Maarten van Santen from the Netherlands).

As long as a specific pill for postcoital use remains unmarketed, we have decided to manage with our own questionnaire and follow-up scheme for detecting side-effects and possible contraindications. The preliminary results were handed over to the Federal Office of Health (Bundesgesundheitsamt). In the meantime a pharmaceutical firm (Schering, Berlin) applied for registration of a drug according to the YUZPE scheme which may be marketed by May 1985 in the Federal Republic of Germany.

Since 1979 no serious side-effects have been seen with the application of the two different schemes of postcoital birth control (combined estrogen/progestagen and progestagen only), particularly no tubal pregnancy. The main complaints are sickness and nausea which are comparable with the known symptoms in pill-starters. The side-effects could be lowered by additional use of antiemetics or the simple advice not to take the pills on an empty stomach (one should bear in mind the eating habits of teenagers).

Conclusions and remaining questions

1 As long as most 'condom troubles' are due to inappropriate usage, especially by inexperienced teenagers, we should discuss a new and realistic approach to condom counselling; we should consider the advice we are giving on this method in comparison with the time-consuming procedure of instruction on the use of the diaphragm.

Furthermore, we should discuss the traditional 'law' in family planning of always using the condom in combination with a spermicidal preparation'. The questionable higher effectiveness has to be compared with the undoubtedly decreased motivation in being obliged to use both methods. In advertising the availability of reliable postcoital methods as an emergency method in cases of a broken or slipped condom, it is feasible that condom use without spermicide might be recommended in the light of problems of motivation and acceptability. It must be realised, tha the counsellor's own family planning practice stands often in sharp contrast to their advice to clients.

2 In future we will give up the use of the progestagen-only method; in our hands we found a lower efficacy and no significant advantages in comparison to Yuzpe's method;

3 We do not have clear cut experiences in using postcoital steroids in the case of one or two forgotten pills during an OC cycle;

4 The only contraindication encountered up to now has been one ectopic pregnancy.

5 Only the collection and publication of well-documented records in the biomedical press will help to persuade the medical profession to use the less contraindicated and simple postcoital method (Yuzpe) for the benefit of their patients.

Psychologists and sociologists should help to clarify the role of postcoital birth control in family planning work:

a Is PCC another compromise among available methods of contraception?

b Is PCC a step toward achieving the 'ideal' contraceptive?

c Is the use of PCC as an emergency method a means of better motivation in the use of and higher acceptability of other family planning methods, eg. as 'back-up' method for the use of barrier or natural family planning methods?

Further literature is available on request from the author.

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DEVELOPMENTS IN POSTCOITAL CONTRACEPTION IN THE NETHERLANDS

In the Netherlands postcoital contraception was first made available generally by the family planning clinics of the Dr J Rutgers Foundation, an organisation similar to the Family Planning Association in the UK.

Since 1964, high dosage estrogens have increasingly been used, reaching a peak in 1974 when 46,000 prescriptions were dispensed in a population of 13 million.

As shown in table 1, its use has decreased since then:

Table 1

Frequency of use of the morning after pill in the Dutch population

1972	52 per 10,000 women	35,000	extrapolated to the
1973	59	40,000	population
1974	68	46,000	
1975	60	41,000	
1976	60	41,000	
1977	49	34,000	
1978	50	35,000	
1979	50	35,000	
1980	50	35,000	
1981	35	25,000	
1982	35	25,000	
1983	30	20,000	

Contraception has been widely available in this country for many years and the subject has been part of secondary school sex education for some time. Medical students are trained in this subject, and general practitioners do counsel patients when providing contraception. However, since some GPs are not familiar with the techniques required for fitting diaphragms and IUDs, they refer their clients to obstetricians/gynaecologists. In the Netherlands, such specialists work within hospitals only. Therefore, women who do not want to use the impersonal official health services prefer the clinics of the Dr J Rutgers Foundation.

Contraceptive services through GPs (including referral to specialists) are free, since they are included in the compulsory national health insurance scheme for low and average income groups. However, most adolescents prefer the low budget clinics of the Rutgers Foundation. Government grants make such low budget services possible, and grants are given because of their pioneering sexological counselling. Economic recession is now threatening its continuation, due to restrictions in funding.

Different aspects of postcoital methods

High dosage estrogens are most effective if taken between 24 and up to 48 hours after a single unprotected sexual intercourse. Through women's weekly magazines, brochures, radio broadcasts, this became widely known, and weekend services were made available. On Saturdays and Sundays house officers on duty in the major hospitals and the GPs on duty in the smaller towns are available to prescribe postcoital medication and give some contraceptive counselling. At the pharmacy on duty these medications can be obtained at all times.

This has resulted in a high rate of contraceptive take-up in the Netherlands, resulting in the lowest request rate (from resident women) for termination of pregnancy in the western world. Sweden stands in contrast where postcoital hormonal treatment is not accepted generally and the pregnancy termination rates are high.

Since the side-effects of the traditional high dosage estrogens, which needed to be taken daily for 5 days, were great (nausea and vomiting) there was a recognised need for some alternative. The Canadian research group of Dr Yuzpe introduced a one-day treatment with a low-dose estrogen-progestagen combination. Published experience with this method in over 2,000 cases led to its use in the Netherlands.

Moreover a comparative study of these methods by the author displayed a similar degree of efficacy against pregnancy after one unprotected intercourse. In the Netherlands by 1983 only 33% still used the classic high dosage estrogen treatment, while in 66% of cases a prescription of the low-dose combination method was given.

Though the low dose combination can be used up to 72 hours after intercourse, which is a day or two more compared to the classic high dosage estrogen treatment, cases arriving later for interceptive help were given the choice between insertion of an IUD as a highly effective postcoital interceptive procedure, or to wait and see. Postcoital IUDs have the set-back of discomfort during insertion, especially for the unprepared patient, and the potential risk of inducing an upper genital tract infection.

In the Netherlands the age distribution shows the postcoital methods to be mainly used by adolescents (see table 2), though initially more women in the age group 25-34 years requested the morning-after-pill (1972).

Adolescents rarely use contraceptives during their first intercourse. Of those who do, some reject the idea of taking pills, preferring instead the diaphragm or the condom. Postcoital methods serve as a back-up in these circumstances and when mechanical contraception fails.

Table 2

Percentage distribution of different age groups using postcoital steroids

Age group	10-14	15-19	20-24	25-34	35-44	45-54
1972	0.4	30	30	24	14	1
1973	1	33	33	16	12	3
1974	0.3	40	26	16	12	5
1975	0.9	34	31	19	11	4
1976	2	37	23	18	16	4
1977	1	32	30	19	12	5
1978	1	39	32	12	12	5
1979	0.4	30	37	18	11	3
1980	-	33	30	20	15	2
1981	0.6	31	34	18	13	3
1982	1	31	30	16	12	1
1983	2	35	30	16	13	3

Recently an anti-progesterone compound, developed in Paris, has been used in clinical research for those women who request the postcoital pill too late. This compound needs to be taken 2 up to 4 days in the premenstrual week of the menstrual cycle. It blocks the activity of progesterone produced in the corpus luteum, resulting in either onset of menses or disruption of possible implantation. In contrast to all other postcoital techniques mentioned before, this alone is a postimplantational method to prevent unwanted pregnancy, and is therefore an abortifacient.

In the Netherlands there are no legal obstacles to using any of these methods since women requesting them are regarded as pregnant. Only very few doctors reject these postcoital methods on the grounds that they must protect 'human life' under any circumstance. They do not take into account the feasibility of the life of the child to be born, nor the life the mother is going to live.

However, the new pregnancy-termination Act in the Netherlands is a compromise created by the coalition parliament, requiring a 5 day consideration period before treatment is allowed to take place. In practice we regard this time-lapse to have passed between the presumption of pregnancy by the mother and the request for help. Thus, in practice, the law does not conflict with our demand that the wish of the client is respected.

In the Netherlands, all modern types of pregnancy prevention are widely available and known to the public, and most physicians favour their availability. Ethical and legal conditions do not hamper their liberal use. Such medical care reduces the need for pregnancy termination and favours human welfare.

Literature for further reading:

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POSTCOITAL CONTRACEPTION IN HUNGARY

The IUD has never been used as a postcoital contraceptive method in Hungary. However, a postcoital hormonal method called 'Postinor' has been available in Hungary since 1981, produced by Gedeon Richter Ltd, Budapest.

The Postinor tablet contains: 0.75mg levonorgestrel/d-norgestrel, and taken immediately after intercourse is effective in preventing pregnancy (one dose). In the case of repeated intercourse, it is necessary to repeat the dosage 8 hours following the first act. The method is advisable only for women who rarely have sexual intercourse (on average, once a week or a maximum 4 times per month).

The side effects are nausea, withdrawal or spotting bleeding on the second or third day after taking the dose. Contraindications are diseases of the liver and biliary tract, cholestasis in previous history of pregnancy.

The method is obtained only by prescription from the age of 16 years from gynecologists or GPs. Follow-up medical supervision is required each month of use, or in case of irregular bleeding, immediately. One packet contains 10 tablets and costs 2 Forints. ($1=50 Forints).

The demand for this product since 1981 indicates that its consumption has increased. In 1981: 298,000; 1982: 280; and in 1983: 303,000 packets were sold. A multi-centre study has been conducted in 10 Hungarian institutes during August 1978 and Februrary 1981. This will determine the general efficacy and nature of side-effects of the drug, as well as the composition of users. The trial has been undertaken by the Department of Medical Science, Chemical Works of Gedeon Richter Ltd, Budapest. The product was used by 1,315 women for 8,815 cycles. The age range of these women is 14-40 years.

The mechanism of action of Postinor: the exact mechanism of its contraceptive action has not yet been clarified. The following are some possibilities:

- structural changes of the endometrium, induced by the drug which hinder implantation;
- changes in the crystallisation and viscosity of the cervical mucosa;
- an intra-uterine sperm immobilising effect;
- an effect on the pypothalmaic-pypophyseal-ovarian axis, and on tubal motility is also a probability.

During this period, 27,253 acts of coitus occurred. The monthly frequency of intercourse was about 4; the end values were 1-8. Among the women, 442 (33.6%) had not used any type of preventive measure previously; 837 (66.4%) had. The distribution of women by age, marital status and obstetric events in history are shown in Tables I, II and III.

Table I: Age of women

Age/Years	Number of Women	%
15-19	662	50.34
20-24	179	13.62
25-29	141	10.72
30-34	174	13.23
35-39	97	7.38
40-	62	4.71
Total	1315	100.00

Table II: Marital Status of Women

Marital Status	Number of Women		%
Married	321		24.41
Unmarried	822		(62.51
Divorced	119	75.59	(09.05
Widowed	41		(03.12
Living separately	12		(00.91
Total	1315		100.00

Table III: Obstetric events in the womens' history

History	Number of Women	%
Nulligravida	903	68.67
Primipara	289	21.98
Multipara	123	9.35
Total	1315	100.00

Source: G Seregély: Results of a Multicentre Trial of Postinor, Department of Medical Science, Chemical Works of Gedeon Richter Ltd, Budapest, RG: 23415

Pregnancy occurred in 23 cases, 6 were attributable to the ineffectiveness of the dose, and 17 to the fault of the user. The raw mean value of Pearl-index is 3.37 ± 0.99, the purified mean value 0.83 ± 0.44. By analysing the occurrence of side effects, it appears that the incidence of withdrawal bleeding (9.1%) and spotting bleeding (15.1%), nausea (5.7%) and temporary breast discomfort (4.3%) was only noticeable. The other complaints (headache, vomiting, abdominal discomfort, etc) are negligible. Only 39 women (2.9%) had discontinued use because of side-effects. A total of 120 women stopped taking the dose. Of the reasons for discontinuation, Table IV indicates that in the majority of cases a change in sexual life prompted the women to abandon Postinor.

This suggests that this method is useful for a certain social stratum of women at a certain period of life. These women are largely unmarried: 75.59% of the users were single (see Table II). One reason for the demand of this contraceptive method in Hungary is that the proportion of these women in the fertile age group (between (15-40 years) is increasing (28.48%). Because they are having intercourse infrequently they are reluctant to take oral contraceptives, or to use the IUD, because of side-effects. Thus, this population is most at risk of unplanned pregnancy and induced abortion in general. An analysis of the distribution of women having abortions in Hungary in 1983, displays that the abortion rate among those who are married is 2.9% and those unmarried is 8.6% (see Table V).

Table IV: Distribution of women discontinuing the use of Postinor and reason for doing so (9.1% of total observed cases)

Reason for discontinuation	Number of women	%
Became Pregnant	23	19.17
Wanted a Child	3	2.50
Regular sexual life	15	12.50
Changed to another method	32	26.67
Side effects	39	32.50
Fear, distrust	3	2.50
Cessation of sexual relations	3	2.50
Unknown reason	2	1.66
Total	120	100.00

Source: G Seregély: Results of Multicentre Trial of Postinor, Department of Medical Science, Chemical Works of Gedeon Richter Ltd

Table V

Marital status	No. of Women (aged 15-40 years)	No. of Abortions		%
Married	1 825 700	54 484		2.98
Unmarried	505 245	15 845	3.13)	
Divorced or living separately	167 067	6 451	3.86)	8.64
Widowed	54 651	902	1.65)	
1983 TOTAL	2 552 663	78 682		

Within the group of single women, special attention must be paid to the age group under 20 years. In a country such as Hungary, where an increase in the birth rate is desirable, it is very important to introduce a contraceptive method which will not endagner the future fertility of teenagers. It is well-known that resort to abortion is undesirable in this respect. The abortion rate among teenagers is rather high in Hungary and during the last 4 years, in spite of the introduction of the postcoital method has unfortunately not yet decreased (see Table VI).

Table VI

Year	No of Women	No of abortions	%
1980	313 160	8 182	2.61
1981	313 334	8 074	2.60
1982	314 776	8 187	2.60
1983	324 750	8 381	2.58

I believe that Postinor use will help to solve the contraceptive problems of teenagers and single women. With regular check-ups, it seems to be a reliable and harmless contraceptive. There is no moral or ethical objection to its use or distribution in Hungary. Postinor is recommended for use in the following cases:

1. Use over Several Months

- young women, 16 years and older, having sexual intercourse only occasionally
- unmarried women, rarely having intercourse
- women meeting their spouses, partners rarely (due to their professions, partners of servicemen, travellers, etc)
- if the women cannot take estrogen-containing tables and in addition rarely having intercourse

2. Use only Rarely

- if the normal contraceptive method was believed to have failed eg. condom
- if protection is required during the 'unsafe' period of the cycle
- under circumstances listed by Rowlands: rape, incest, etc

Since Postinor has been marketed in spite of side-effects, which initially were very common, the HSSFWW (Hungarian Family Planning Association) recommended reducing the hormone content of dose and to strictly specify an acceptable frequency of use within one menstrual cycle (up to 4 per month). The latter was accepted. In connection with the hormone content, the manufacturers are debating the fact that one postcoital pill called Postula (Schering) contains 1.0mg levonorgestrel, and another, used in the Peoples' Republic of China, has 0.75mg of levonorgestrel (i.e.the same as Postinor). However, there are no reported serious side-effects. Therefore, they challenge the necessity for the reduction of the hormone content of the Hungarian method.

References: G Seregély: Results of a Multicentre Trial of Postinor, Department of Medical Science, Chemical Works of Gedeon Richter Ltd, Budapest, RGD: 23415

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REGIONAL COUNCIL 1984 DISCUSSION ON POSTCOITAL CONTRACEPTION

i. Summary of Group Reports on the the Status of Provision in Europe

In Austria, postcoital contraception is widely available, almost exclusively in the form of IUD insertion because, with private medicine dominating the contraceptive services, this method brings greater financial return for gynecologists. There is also resistance to using oral preparations as the pharmaceutical industry has yet to market a postcoital oral contraceptive as such.

In Norway and Sweden, postcoital contraception can be obtained but is neither generally available or promoted (by the Planned Parenthood Associations there) because of a strong ideological emphasis on prophylactic contraception with the facility of abortion on request as backup. In Finland, as in the majority of countries, it is stressed that this will be made available only for emergency use, and for this reason is not widely publicised. By contrast, in Denmark, there is a high standard of public education about this method.

In the Federal Republic of Germany, United Kingdom, Ireland and the Netherlands, special efforts are being made to promote public (and professional) knowledge and use of the method - for emergencies only - and demand is increasing proportionately. Nine percent of clinic attenders in the Netherlands, and five percent in the Republic of Ireland, currently request postcoital contraception. In the latter country, although both orals and IUDs are offered by the Irish Family Planning Association clinics, some general practitioners refuse to deal with it due to a belief that it may be a form of abortion. In France, the method is well-known and offered by non-medical as well as medical personnel. No specific data was presented to the IPPF concerning Belgium and,Luxembourg, although it is known to be available in the former. In Italy it is available, though rarely requested.

In the German Democratic Republic, a postcoital contraceptive service is well established, with 2.5 percent of women in the fertile age range using this method (combined oral preparations). As with other contraceptives, although registered for use in Poland, it is unavailable due to the economic crisis in that country. By contrast, Hungary produces its own method (Postinor) though the IUD is not registered for postcoital use there. It is recommended that 'Postinor' is taken immediately after intercourse; in case of repeated intercourse, the dosage repeated after 8 hours up to a total of 4 times per month. Such directions have led to a large number of Hungarian women becoming accustomed to using this regularly as their principal method of contraception (available on prescription) causing considerable anxiety within the Hungarian Planned Parenthood Association that the public be re-educated to regard this as an emergency method only. During 1984, postcoital contraception has become available in Czechoslovakia and Bulgaria.

As yet, PCC is unavailable in Turkey (though IUDs have been given to women requesting abortion there), Portugal, and Malta (though there is evidence that certain medical practitioners use oral contraceptives for this purpose. In Yugoslavia, although unavailable at present, the Family Planning Council will be recommending its inclusion into existing family planning services during 1984.

ii. Group Comments and Recommendations

There is a reluctance on the part of many physicians to prescribe this method, for two reasons: Firstly, many are unaware that it is a viable means of contraception; or if they are, they are afraid of possible side-effects in the short or long term. Therefore, there is a need to encourage more research to provide reliable data which may either reassure the prescribers or warn them of specific contraindications.

Secondly, in countries where there is a legal prohibition of abortion, physicians fear that if they prescribe postcoital contraception they may be charged with attempting to procure an abortion. There are varied legal opinions on this but few case histories to learn from. In most cases, the law is a discouraging threat rather than something reflecting the actual situation. In those countries where abortion is defined as relating to the situation after implantation has taken place, there is no legal problem with PCC. However, Ireland, for example, is having difficulties in this area.

Adverse reactions are to be expected from conservative and church sources. However, this has not yet been forthcoming except in the Netherlands, where there was religious objection at the inception of their services. This has since disappeared. The question might be posed: are the Churches aware of this method as a 'moral problem' or are family planners simply ahead of them.? Do they think that it is just another oral method about which they have already spoken? Or are they currently distracted by the moral dilemmas posed by in-vitro fertilisation etc.?

There is a problem connected with the use of IUDs postcoitally in cases of rape, because an infection may also be transmitted. It was also recognised that it may be difficult to determine which groups of women are best suited to the different PCC options. The age of a woman may be a determinant here. It is also worth noting that PCC is yet another method of fertility regulation which places both the hazards and responsibilities on women. There needs to be some clarification on the relative risks to health from repeat abortions (most often occurring among the age group most using PCC) and the repeated use of PCC.

Postcoital contraception may be the best method of contraception for young people with only occasional exposure to risk of pregnancy, who appear to find the use of condoms objectionable, or because of the unreliability of poor quality condoms.

Oral and IUD postcoital methods should be available in every country represented in the Region as an emergency service. Where IUDs are chosen for PCC purposes, women should be encouraged to make a positive choice of this method on a more permanent basis.

It was felt that PCC should essentially be an emergency measure and not offered as a routine method of contraception. However, a definition of the term 'emergency' poses some problems. It was strongly felt that the consumer's voice should be heard, and that the physician should listen to how the client defined the emergency. There was also concern that the long-term effects of PCC were unknown, and that the method should be treated with some caution.

It was believed by some members of the groups that physicians were not automatically required to administer PCC (both orals and IUDs), though certain physicians in the groups contested this.

Pressure should be placed on the pharmaceutical industry to create a standard regimen dose - a pack containing only enough pills for one administration.

Recommendation of the Regional Council to the International Medical Advisory Panel (IMAP) of the IPPF:

'being aware of the possibilities that preparations used for postcoital contraception may affect long-term fertility and menstrual regularity, this Regional Council urges IMAP to encourage further research into the effects of postcoital contraceptive methods.'(23.5.84)

RFSU SEMINAR ON RAPE

A European seminar on the problem of rape was held in Tynningö Sweden, from the 3 to 7 June 1984. Entitled 'Rape - a drama from two perspectives' the seminar was organised by RFSU (the Swedish Society for Sex Education) and partly sponsored by IPPF.

Unlike in the USA, rape has only been a subject of debate in Europe since the mid-70s. The discussion about rape and sexual violence was and still is seen as a part of the struggle for liberation fought within the Women's Movement, imbued as it is with strong ideological features. Rape is considered to be an expression of women's oppression and part of a male-dominated culture. It is also considered to be one of the many manifestations of social, economic and political injustice suffered by women. RFSU's concern with sex roles and the theory and practice of sex education led it to examine the issues of sexual violence as an aspect of male socialisation.

A (second) Swedish Governmental Commission on Sexual Crimes, had been appointed by the Minister of Justice in 1977 to investigate laws relating to sexual crimes and to present proposals for updating the Penal Code. This led to the initiation of RFSU's rape project. In 1977, RFSU decided to set up a Rape Crisis Centre with the following scope of activity:

1 To offer aid to women who experienced fear and anxiety following sexual assault, as well as emotional difficulties resulting from the legal proceedings;

2 To gather experimental material which could contribute to the study of the Commission, and;

3 To set up a model of clinical counselling for societal institutions which, according to the guidelines for the Commission, would take over the task performed by RFSU.

RFSU obtained a grant from the Department of Justice to start the project at its clinic in Stockholm, believing that the experiences gained from such a centre could contribute knowledge about rape victims' needs to the work of the Commission.

There have been two publications reporting the findings of its project which included a survey of 60 convicted rapists to learn something of the motives of the assailant.

RFSU's intention in organising the rape meeting in Tynningö was to disseminate the findings of its work and research and hence to stimulate European-wide discussion of rape work experiences and areas for improvement and expansion.

The meeting involved 38 participants from 16 European countries and the USA. The quality of input from country representatives was very strong, perhaps due to the fact that RFSU had invited nominations and made a selection from among the respondents. Participants represented professions such as physicians, nurses, social workers, sociologists, psychologists, psychiatrists, lawyers, criminologists and demographers. Feminist groups were also represented.

The Seminar covered three major topics:

- the dimension of the problem in different countries and its recognition as a serious social concern;

- the direct impact of the crime on victims and their need for assistance in recovery;

- the characteristics of the offenders and their need for treatment.

The seminar was structured around the RFSU Rape Project and was introduced by background information on the rising problem of rape and international rape work from various professional perspectives. Rape in Sweden from a criminological point of view was discussed, followed by a detailed summary of RFSU's work with rape victims: different types of rape situation and how the victim reacts, rape crisis intervention and counselling; teenagers and rape; and the attitudes of victims' relatives and partners.

As well as papers given by RFSU staff and other Swedish experts working with various aspects of rape, two American researchers gave papers on their work. David Finkelhor's paper 'Myths and Social Attitudes to Rape' was an exploration of the factors leading to the social stigma surrounding the crime of rape and subsequent negative attitudes towards the victims themselves. One of Finkelhor's more surprising hypotheses being that such negative reactions actually stem from women themselves. He concluded that while men continue to control the world's major institutions, such as police, the legal system, the press, medicine and politics, an unvariably unsympathetic picture of rape victims will be presented to the public. Finkelhor's solution lies in changing attitudes through education, and this involves changes in legal and police systems, journalism and the media.

Finkelhor also presented a paper on rape in marriage.

A large part of the meeting was devoted to looking at offenders: how rapists look at the rape; results from RFSU's survey of rapists' attitudes, a profile of the offender, and guidelines for treatment. Nicholas Groth, who is working with 2 sex offenders rehabilitation schemes in the USA, noted that over 80% of rapists in the USA were themselves sexually abused as children and went on to discuss the rapist as a victim. A large proportion of men who rape, moreover, refuse to admit that a rape was committed. The idea of the rapist as a victim himself was for many participants a new and unwelcome idea, and gave rise to lengthy discussion on recidivism, education and treatment of offenders.

Finally, there was considerable discussion on experiences in services for victims of sexual violence: and future fields for rape work and extended research.

The Seminar's conclusions were given national press and radio coverage, and can be summarised thus:

- Rape is a complex problem with multiple causes which needs to be addressed from several perspectives: cultural, psychological, medical, legal and educational.The scale and nature of sexual assault is equally difficult to assess.

- Rape is primarily a crime of aggression rather than of desire, both in regard to the motivation of the offender and the impact on the victim.

- Every country needs to develop the knowledge and means necessary to treat the offender as well as the victim.

The seminar report will be published in 1985.

THE RAPE VICTIM'S PARTNER: A COUNSELLING PERSPECTIVE

Introduction

In 1977 the first rape crisis centre in Sweden was opened at an RFSU (the Swedish Association for Sex Education) clinic. The experiences from this rape crisis counselling centre have already been documented in books, reports and newspaper articles; they served as the foundation of new legislation covering the treatment of rape victims. The authors have worked in the rape crisis centre since its inception. In this paper we want to highlight a particular aspect of counselling: the rape victim's worry about her partner's reaction, and the rape as seen from the partner's perspective.

Many rape victims worry about their future relationships with men. Of those women who came to RFSU, 40% had a sexual relationship with a man at the time of the rape. Of these, 30% were worried that sexual problems might arise after the rape. Twenty percent feared that their trust of men would change in a negative direction, and 15% feared that their relationship as a couple would be ruined.

In rape crisis intervention, it is important to help the woman to clarify the nature of her worries, and to cope with the situation. In some cases this leads to her partner's participation in the counselling. In other cases the partner was so upset about what the woman had been through that he sought help for himself.

The woman's anxiety

The majority of women had wanted to tell the partner about the rape and most of them did so. Initially the women experienced understanding when they related the difficult and frightening experience. It is when the first shock and fright has been overcome that the anxiety arises: what consequences will the rape have on her and her partner's relationship?

It is common for the woman to fear that the husband or boyfried will think that 'she has herself to blame'. If the woman has been out on her own, or with a girlfriend, and been raped (eg. by a man she hitch-hiked with) then it is easy to imagine such thinking. She may also imagine such a reaction if, before she was raped, she had been drinking alcohol, or if the couple had had a row and gone their different ways, or if they were just going through a 'sticky patch'.

The woman's fears have, in these cases, been marked with guilt. In counselling it has proved important to find out if there are foundations for her anxiety that the man will attach blame to her, or whether she is punishing herself. Does she see the rape as a punishment for going out by herself? Does she think that she is punished because she started the row? Maybe she is putting feelings on to the partner that she is carrying herself but cannot cope with. Is the guilt experience of the rape so heavy that she has to divide the feelings between herself and the man, applying them to him as well?

Does she want to make her partner a judge, herself being unable to cope with her own self-criticism?

In cases where it is proved to be not solely the woman's fantasy that her partner has been apportioning blame and guilt, and therefore has had real reason to worry on this count, then the woman has needed help to assess her feelings about the partner's reactions. What does she believe to be the reasons for his rejection of her? Can it be sorted out? Can she accept his point of view, or is their relationship so frail that the rape becomes the decisive factor in whether she continues to consort or live with him?

Have I Changed?

Many women are worried that they have been changed by rape, or that they partner will think that they have been. The woman is, for example, worried that the partner will no longer find her sexually desirable. One way of overcoming this anxiety has been to take specific action. Often women have told us that very soon after the rape they tried to see if their sexual partnerships still worked. They have wanted to test both themselves and their partner. Is it possible to have sex? Can I receive him? Will I re-live the rape when I have intercourse with my fiancé? Can he, or does he, want to sex with me at all? However, most commonly women, wanted to delay sexual contact - in some cases for fear of their apprehension being confirmed.

Some women have expressed a fear that their partners will look on them as a whore after the rape. A strange man has penetrated them. In these cases women have believed men's view of rape to be strongly sexual in content, (which has in fact often turned out to be well-founded). Sometimes women themselves have shared what they believe to be men's views. She has felt wronged, devalued sullied by the degrading experience she has undergone and has come to look at herself with the same contempt which she feels for whores.

Sometimes the woman's worry has been very concrete. A young woman who lived by herself in a ground floor flat was raped by a stranger who had climbed in through an open window. She immediately wanted to change her bed after the rape. Her reason was that her boyfried would not want to lie on it: '...everything would have been much easier if I had been raped on the stairs'.

Dare I talk about it?

Some women have delayed talking about the rape, unable to face the possible reactions of their partners, preferring to keep the experience to themselves. Often these women did not want to continue the counselling either. It is important to allow and encourage them to talk about how they think, and that people close to her are also reacting to the event.

The Male Partner's Perspective.

Among the people closest to the woman there is often a so-called 'hidden victim'. Often it is her partner or boyfriend. Our experience of meeting him or learning about his reactions from the woman is that the rape has a private significance for him as much as for her. The rape often brings to the surface hidden conflicts and problems within the man or his relationship with the woman. Often the man's feelings of inadequacy come to the surface. To understand the woman's partner's reaction to the rape it is important to remember that he is a victim of myths and prejudices as much as others: 'She has herself to blame' - 'only certain woman are raped'. This is a typical reaction to the sexual aspect of the event rather than to the effect on the woman of violence. The automatic significance of the sexual dimension ofthe event explains the anger and rage felt by the man which may be turned against the woman.

Understanding the Partner

The woman's immediate reaction to rape is one of fear and anxiety, while the man's is one of rage and anger. However, the conditions do not always exist for these two emotions to produce a positive outcome. In our material there are many examples of how the sexual aspects of rape feature prominently not only in the woman's imagination of how the partner should react, but also in the man's actual reaction. Such a reaction is not solely to be understood in terms of him being a victim of the myth-making that makes the woman wholly or partly repsonsible for the rape. A man who loves and desires his partner finds it difficult to imagine her as the subject of violence, whose life may be threatened by another man. On the other hand, the thought that another man might want her sexually may not be alien to him. This might explain his tendency to react to the sexual aspect of rape.

The man might also see the rape as aimed against him, and not primarily against the woman he loves and/or lives with. His reaction depends often on the type of rape to which the woman has been subjected. He will probably be less likely to react against the sexual aspect of the rape if the woman is assaulted by a stranger than if she is raped at a party where he is not present himself, or by a man that either or both know.

Experiences of the latter kind often produce feelings of jealousy in him - primitive reactions which can be seen as expressing feelings of sexual inadequacy aroused in him by the fact that another man has 'been to bed' with his woman. The man can get very angry, feel that this life is ruined and experience the rapist as a sexual rival. His anger becomes a strain for him because he has nobody to give it back to, on whom to take revenge. Some men have nightmares in which they might kill the rapist. Sometimes the man vents his anger on the woman, which can become very destructive, not only for their future relationship but also for her capacity to work herself through the crisis induced by the rape.

It can be difficult both for himself and her to see that the man's reactions stem from jealousy. He might assume an overprotective controlling attitude, ostensibly to protect and guard the woman so she will not be attacked again, but unconsciously to protect himself against entering into rivalry.

The partner's attitude can stimulate and sustain a regression, which is common during crises, and counteract the re-establishment of the woman's equilibrium. An overprotective attitude from the partner might also make it more difficult to solve the guilt problems which often appear in a rape victim. She might be prevented from expressing herself, herself assume responsibility for the rage she feels agains the rapist, and look upon herself with the man's eyes, eg. as a fragile doll. If the man is preoccupied with the feelings the rape has created in him, he will completely overlook the woman's need for support and understanding.

We have met women who have been very frightened of the partner's reactions of anger. They have feared that the man would go to extremes in his ambitions to try to get hold of the rapist. The partner's aggression have reminded them of the rapist.

Guilt or Shame in the Male Partner

Some men feel strong guilt at their not having been able to prevent the assault from occurring. They feel to blame for the fact that the woman was exposed to this degrading event. There are also men who feel the same degradation and shame as their partners, feeling deprived of their masculinity. A man who is overcome by strong feelings of guilt or shame will be able to offer no support to the woman. His powerlessness is as strong as hers.

Sex - An Acknowledgement that One Still Means Something

We mentioned earlier the woman's anxiety about the partner's reactions, and that some women want to attempt intercourse very soon after the rape in order to test whether the man is still sexually attracted to them. There are also men who seem to have the opposite need to be sexually reaffirmed by the woman - in order to obliterate the rape through sexual intercourse. If the man's wish to be reaffirmed coincides with the woman's, then sexual intercourse soon after the rape could be constructive. But if the woman cannot cope with sex and wants to delay then the man's needs can be experienced as trying and selfish. She might feel exploited and experience the man's needs and demands as a new assault.

Conclusion

Among the woman's close relations there may be so-called 'hidden victims' of the rape. Like the victim herself, they develop reactions to the assault which might be difficult to understand, and they try to cope both for themselves and for the woman. In giving advice to rape victims one should therefore pay attention to these reactions. Sometimes it is better if a counsellor other than the woman's counsellor advises the partner or other relations.

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THE IPPF REGIONAL ADOLESCENT SERVICES PROJECT: AN UPDATE

Introduction

In 1982, the Europe Regional Council approved a proposal for a project to help develop family planning and sexual counselling services specifically aimed at young people. A project coordinationg committee was established, made up of staff and volunteers from European family planning associations with some experience in this field.

The initiative for a project which could bring together individual FPA experiences in assisting adolescents stemmed from a request from the Italian FPA (UICEMP). A survey of adolescent opinion undertaken in Italy had illustrated that hardly any of the existing family planning services were geared to assisting or even welcoming younger members of society who desired some form of help with contraceptive or sexual problems. It had been discovered that very few teenagers were willing to attend the existing family advice centres, either public or private. Italy is not unique in recognising this failing in general contraceptive health care.

The project aims to provide a guide for FPA personnel to establishing contraceptive and/or counselling services specifically tailored to young people. This guide to establishing the necessary infrastructure of a service has been constructed from the core components of the more successful aspects of existing experiments in adolescent service provision in Europe. The task of the project participants has been to collect and collate data on the scale, operation and use made of these projects (see below) in an attempt to construct a 'model' service.

The substance of the report is based on information from 16 countries, and on more detailed accounts from 6 countries (Austria, Hungary, Italy, the Netherlands, Sweden and the UK).

Case studies of existing services in: the Netherlands, Italy, UK, Sweden, France and Poland provided a focus for a workshop for 13 FPA staff and volunteers, held in Innsbruck, Austria in 1984. The objective of this exercise was to devise projects to be implemented in selected countries (Austria, Ireland, Portugal) where no adolescent services currently exist. This was seen as the most practical way of testing the methodology contained within the report.

The Projects' Origins:

The longest established young people's advisory service is in the UK (Brook Advisory Services), which started in 1963. Other initiatives were taken in the 1970s (Hungary 1974; Sweden 1975: RFSU's 'Open House'; Netherlands 1976: Rutgershuizen; France 1977: MFPF's 'Mercredi Porte Ouverte aux Jeunes'; UKFPA 1972:'Grapevine'). The two most recently established are in Poland 1982: TRR's Warsaw Youth Clinic; and Italy 1983: UICEMP's 'Consultorio Teenager'.

While all of these projects have the common aim to attract young people in need who feel alienated from general family planning services, some have been more specific in identifying a target-group. For example, the UICEMP project in Italy is particularly designed to appeal to working-class young women in the 14-19 age range, who are least likely to contact the existing services. The Rutgershuizen, Brook Advisory Centres and the UK counseling projects, (New) Grapevine and 'Under 21' are all aimed at the unmotivated young, the disadvantaged and often unemployed young living in the more run-down urban areas.

Range of Services

Counselling is regarded as an essential element in young people's contraceptive services. All of the projects in this study offer counselling from a social worker usually on an individualistic basis. For example, the MFPF in France offers a combination of group counselling for all clients, followed by a medical consultation only if the client wishes it. With the exception of Grapevine in the UK and the Dioces of St Polten service in Austria, which offer counselling only on a trained volunteer basis, the other projects all offer a comprehensive range of facilities: contraceptive counselling and supply, pregnancy testing, abortion counselling and referral, smear and STD tests. Much attention is given to the atmosphere of these services in terms of decor, provision of music, plants, coffee, posters and magazines, and even games to occupy those who choose to call without appointment to wait for some service.

The kinds of problems which these services appear to generate include, at one extreme, the need to persuade long term clientele to graduate to the 'adult' services. There is some reluctance to give way to younger clients by those moving into their twenties because they have become so accustomed to the special facilities they have been offered and the staff who have served them for so long. At the other extreme is the outside opposition which young people's services attract. Such opposition (parental, church, political) generally challenges the right of the medical profession and related organisations to provide any assistance to young people to help them control their fertility or come to terms with their sexual development.

A Telephone Counselling Service for Ireland

Following participation in the Innsbruck workshop, the methodology has recently been put to test in the Irish Republic, where a telephone counselling service is about to be launched. During March/April 1984, a group of interested young people were selected from the Dublin area to give their opinions about the local needs of young people in this sphere, and how they might be assisted through the anonymity of the telephone. Several volunteers were selected from this group who, with the help of on the job training, are willing to run three telephone lines based in the Irish Family Planning Association Information centre.

Posters and cards have been designed to inform the community when and how they can make use of this service. Training for the volunteers has taken the form of lectures and discussion on sexual attitudes, andf factual information on pregnancy, contraception and sexual development. This training will continue once the phone service becomes operational in November 1984. It is hoped that one of the volunteers may begin to work full-time with governmental assistance for job creation. Initially the calls will be recorded for the purposes of a subsequent evaluation. It is hoped that local funding may be secured for a permanent service in the near future.

The report of the Regional Adolescent Services Project, designed as a guidebook, is essentially for individuals who have already had working knowledge of family planning services but wish to develop, in a separate or dependent form, a service specifically for adolescents, will be published in 1985.

VÄESTÖLIITTO SEMINAR ON INVOLUNTARY INFERTILITY

Väestöliitto, the Finnish Family Planning Association, hosted a seminar on the psycho-social aspects of involuntary infertility in Espoo, Helsinki, from September 18-21, 1984. The Association believes that in spite of the attention given to sophisticated medical diagnostic and therapeutic techniques, little attention has been paid to the psychological and social needs of the infertile couple. Helping infertile couples to solve their problems is regarded as an essential part of planned parenthood. Consequently, Väestöliitto hoped, by means of an international meeting, to:

- raise public awareness of PPAs' concern for the problems of infertile couples;

- emphasise the role of psychosocial counselling in infertility problems;

- support the role of the PPA as a means of referral (and basic fertility testing services where possible) for couples seeking infertility treatment.

Discussion revolved around the following topics:

- possibilities and limitations (finance, personnel etc.) of PPAs becoming more directly involved in the provision of infertility services;

- relationship between PPAs actual/potential involvement in this field vis-å-vis their customary preoccupation with contraception;

- ethical and legal aspects of artificial insemination techniques, and adoption.

In practice, it is the intention of the Finnish PPA to take on some of the initial testing and counselling procedures involved in infertility treatment as a step toward coordinating the treatment activities of the 5 major hospitals providing clinical; services in Finland. The size and population distribution in this country makes a streamlined counselling referral and treatment service, provided through the PPA, a practical possibility.

The forum provided the Finnish PPA with information on medical and legal developments relating to new techniques, and provided national publicity for Väestöliitto's endeavour. In addition to a large Finnish presence (from the PPA), invitees represented: Austria, Belgium, Bulgaria, Netherlands, Norway, Portugal, Sweden, Turkey, and Yugoslavia.

REPORT ON THE 1984 REGIONAL COUNCIL MEETING

The IPPF Europe Regional Council (RC), representing 20 IPPF member associations in Europe, met in Montisola (Italy) 23-26 May 1984. Observers from Czechoslovakia, Malta, and Spain, and staff from the associations of France, Italy, Portugal, Turkey and Yugoslavia, also attended the meeting. Two representatives of the Cyprus FPA also attended.

Formalities were handled on the first evening. The agenda was adopted, and the minutes of the 1983 Meeting agreed. The 1983 Regional Audited Accounts were approved.

The Regional President invited a representative of the Cyprus Family Planning Association to present an application to join the IPPF Europe Region, transfering from the Arab World Region. After discussion, the RC resolved to recommend to the Central Council and the Members' Assembly that the Cyprus FPA be admitted as a member in the Europe Region.

Representatives from the Cyprus FPA and observers from Czechoslovakia, Malta and Spain reported on recent planned parenthood developments in their respective countries (see page ** of this Bulletin).

The Regional Executive Committee (REC) report on major developments since the last RC meeting was approved.

Reports were presented on the implementation of Regional Work Programme activities since the last meeting:

- A Working Group on the project **Planned Parenthood as a Basic Human Right** had met to review implementation of decisions taken at its previous meeting regarding the timetabling of the different study chapters which would make up the final report, and to discuss details of the planned Regional seminar on the project's findings.

- The **Adolescent Services** Project Coordinating Committee reported on progress made in preparing a publication and described the Regional Workshop on the development of adolescent services held in Innsbruck, Austria, involving participants representing 13 countries.

- A special issue of the Regional Information Bulletin on **Feminism and the Health Movement** was discussed in the light of the wider interest and circulation this issue merited.

- Information Exchange Funding: The 1983 funding included 100 subscriptions to Sexualpädagogik und Familienplanung for the Austrian PPA; a visit by FRG Pro Familia counsellors to UICEMP, Milan; a visit by two Hungarian physicians to Belgium. The 1984 funding covered: a visit to UICEMP, Milan by member of the Irish FPA. A visit to Yugoslavia by 2 members of the Family Development Council of Bulgaria is planned for the end of 1984. A visit to the UKFPA by 3 GDR youth counsellors, following a visit from the UKFPA to Ehe und Familie is envisaged in 1984.

- RFSU Seminar: **Rape - A Drama from two perspectives** (Sweden, 3-7 June 1984). The first European seminar on rape, organised by the Swedish Association for Sex Education (RFSU) involved 38 participants from 16 European countries and the USA, with financial assistance from the Region. A publication based on the meeting will be available in 1985. (see page 26 for report)

- Väestöliitto seminar on **Infertility** (Finland, 19-21 September 1984): This seminar on involuntary infertility is intended to focus on psychosocial aspects in counselling of couples. PPA representatives from: Austria, Belgium, Bulgaria, Norway, Poland, Portugal, Sweden, Turkey, Yugoslavia and Finland attended. (see page 36 for report)
The following projects were reviewed and agreed by the RC for inclusion in the 1985 Work Programme:

- **PPA Responses to Opposition to Planned Parenthood** : The essence of this project is to gather from PPAs information on strategies employed by non-governmental opponents of planned parenthood, and counter-strategies employed by PPAs. An IFPA staff member and a volunteer have been delegated to analyse PPA experience and to prepare a seminar to be held in 1985.

- Follow-up Workshop on **Aspects of Adolescent Service Provision** : A member of the Regional Adolescent Services Project Coordinating Committee proposed that a further workshop be held to bring together people working in this field from countries which had not participated in the 1984 workshop.

- Programme Working Group Meeting to refine RC suggestions for projects to be initiated in 1986.

- Two issues of the Regional Information Bulletin in English, French and German.

- The RC re-adopted, without amendment, the Regional Policy Document adopted in 1984 for the 1985-7 Plan period.

- The RC then adopted the 1985 Regional Work Programme and Budget.

The RC discussed in groups the topic: **Postcoital Contraception** (see pages 23-25 of this issue).

Elections : The RC re-elected Jürgen Heinrichs (FRG) as Regional President, Mikolaj Kozakiewicz (Poland) as Regional Vice President, Antonietta Corradini (Italy) and Freddy Deven (Belgium) as REC members. Elisabeth Jandl Jager (Austria) was elected as a new REC member. The RC re-elected Lykke Aresin (GDR) as a Central Council representative and elected Dilys Cossey (UK) and Juhani Toivonen (Finland) as new CC representatives.

AUSTRIA - Österreichische Gesellschaft für Familienplanung (ÖGF)

Throughout Austria, there are presently about 170 clinics dealing with family and partner counselling, including contraception. All of these clinics are fully state-subsidised, but run by a number of different interest groups, ranging from the archdiocese on the right to feminist groups on the left. ÖGF runs 5 clinics in Viennese hospitals, specialising in problems of contraception and abortion. The number of clinics has slightly increased during the last year. Working relations with other governmental and non-governmental bodies depends on personal contacts. The national role of the ÖGF remains that of a watchdog of government activity.

Together with a pharmaceutical firm (CILAG), the ÖGF has prepared a publicity campaign to promote the diaphragm with physicians.

BELGIUM - Fédération Belge pour le Planning Familial et l'Education Sexuelle (FBPFES)
Belgische Federatie voor Gezinsplanning en Seksuele Opvoeding (BFGSO)

The Liberal-Social Christian democrat coalition remains in power. With respect to the Francophone region, efforts to simplify and rationalise the family planning situation has resulted in formal governmental recognition of family planning centres, and the FPBFES contributed significantly to the preparation of the necessary legislation. Within the Dutch-speaking region, new legislation is under review.

Certain subsidies have decreased. On the other hand, the opportunity of benefitting under the Government programme to combat unemployment has risen, permitting the Federation to recruit new workers with subsidies, leading to an extension of the work of the centres. The FBPFES comprises the Dutch-speaking CGSO, which has 12 centres, and the French-speaking branch, which has 36 centres, all subsidised by the Government for their counselling and educational work. The centres of the Francophone branch undertook around 29,000 gynecological consultations, and 23,000 psychosocial counselling consultations over the previous year, as well as providing sex education courses for schools.

The documentation centre of the CGSO handled around 400 requests for information, and there has been an increased demand for information from Belgian radio and television for several of their popular medical and social problems. During 1983, much energy was spent negotiating with the government concerning new regulations covering counselling centres. Lobbying work will remain an important part of future activities.

BULGARIA - Family Development Council of Bulgaria (FDCB)

In recent years, Bulgarian families have become increasingly sympathetic to family planning. The use of modern contraceptives has grown considerably during 1983, particularly IUDs. There is a nationwide supply network providing contraceptives (the pill and IUDs). Since 1984, postcoital contraception has been available. However, no sterilisation services exist. The first Bulgarian-made IUD is undergoing tests at present.

FPA activities co-exist with those of other agencies (demographic, sociological, medical, the Fatherland Front, the Movement of Bulgarian women etc.). In 1983, the Council expanded its activities in the regions - Plovdiv, Blagoevgrad, Petrich, etc. These branches provide family planning services, including information and education.

A number of national and regional conferences were held which dealt with questions of contraception and prevention of abortion. Members of the Council have lectured on a regular basis to public organisations, the mass media and young people. The Council is also represented in the BUL P02 Sterility project, financed by the Government and the UNFPA.

DENMARK - Foreningen for Familieplanlægning (FF)

In 1976, it was provided by Statute that women were entitled to seek advice on contraceptive methods in clinics in addition to receiving this guidance from GPs. Consequently, clinics were established in the various counties. The Government is now introducing a Bill with the objective of freeing the counties from this obligation, against the advice of the FF. It was argued that this would lead to a deterioration of the facilities for seeking advice, particularly as far as young people are concerned.

The Municipality of Copenhagen, which covers 90% of the expenses for the running of the FF's two clinics has reduced the 1984 FF budget for these centres by about 5%, advising the Association to rationalise procedures.

The FF is preparing to expand its information services, altering its Constitution to include '(the promotion of) information about and scientific research into family problems of a somatic, psychic, social and sexual nature'.

FINLAND - Väestöliitto

Väestöliitto is the only organisation in Finland dealing with population and family policy. In this respect the Federation acts as a pressure organisation and a provider of special services which supplement State health services. These include: family counselling clinics, medical genetics counselling and so on. In family education, the Federation's long term aim to establish a family education course was advanced with the Federation hiring a salaried employee to plan these courses for 1985.

The financial basis for this project was secured by the TV campaign 'Take Care of the Family', which was organised together with three other bodies and lasted throughout 1983. The family education course centre will train specialists from different occupations who work with families. Väestöliitto's awareness of the problem of involuntary infertility led to a decision to organise a workshop on this topic in collaboration with the IPPF in September 1984.

There were 10,300 visits to Väestöliitto's family counselling clinics in 1983, from 6,300 clients. An increase in the numbers attending for infertility treatment and family crisis counselling has prevented the organisation's involvement in research and publication activities.

FRANCE - Mouvement Français pour le Planning Familial (MFPF)

The new state policy of reducing expenditure has led to the postponement of social reforms and threatens the further development of existing services, including family planning. The government contribution to family planning has not decreased on the whole, notwithstanding sizeable discrepancies according to the kinds of projects and channel of funding - either national (confederation) or local (departmental associations).

Some projects mentioned in previous reports to IPPF Europe are still ongoing: the adolescent project; agit-prop type information, educational activities and training in the area of sexuality for people involved in different occupations - social workers, health workers, teachers, union organisers, association members, etc.

One project has been completed with the publication of the survey and proceedings of the 1982 Colloquium 'Contraception from the Woman's Perspective'.

Within the framework of a campaign for improved abortion facilities, it was disclosed at a press conference that 1900 illegal abortions had been documented, and information forwarded to relevant Ministers.

GERMAN DEMOCRATIC REPUBLIC - Ehe Und Familie (EFA)

The activities of existing centres for family planning and counselling (Ehe-und Sexualberatungsstellen) have been expanded. All these centres, subsidised by the Ministry of Health, are working together with local clinics in the field of legal abortion and special problems in contraception and psychotherapy. Contraceptives (free-of-charge) are mostly prescribed by gynaecologists and GPs in outpatient clinics. The staff of the family planning centres are nowadays especially interested in partnership problems.

Members of the EFA participated in the IXth Congress of Gynaecologists of the GDR in Berlin, where they demonstrated the results of a comparative study of different types of IUD. A new IUD was developed and clinically tested in the GDR, called 'Medusa'. In 1984 the device will be available for women. Two leading members of EFA published a scientific article of modern trends in the application of contraceptives in the "Zeitschrift für Ärztliche Fortbildung der DDR". EFA has developed a step-by-step-programme for qualification of counsellors in the field of partnership problems and sexuality ("Eheberater"). In the meantime, a training - course was held in Dresden in November 1983. Special co-operation activities exist between EFA and the Association for Psychology and Psychotherapy. The EFA has overseen the publication of the textbook of sexual medicine ("Lehrbuch der Sexualmedizin") by Aresin and Guenther.

FEDERAL REPUBLIC OF GERMANY - Pro Familia

The objective of the new government to give special importance to families and married couples will have an impact on its funding policy towards social service institutions. It is thought that PRO FAMILIA has been too priviledged financially in the past and that religious organisations have to be given a higher profile. This will mean that PRO FAMILIA will have to compete in the future much harder with other organisations for governmental funding. Furthermore, there are plans to encourage religious organisations to engage in family planning activities.

It is the opinion of the present conservative government that PRO FAMILIA's high profile must be reduced and this is happening. On the other hand PRO FAMILIA's role in the opposition movement,(opposition parties, women's movement, non-religious social welfare organisations) against the family and social policies of the government, is growing and its expertise in the field of family planning and sex education is acknowledged and demanded.

Although the political conditions have aggravated the work of PRO FAMILIA, it is at the same time a challenge to reconsider self-critically its past activities and to develop new perspectives and visions. The political impact PRO FAMILIA will have, will depend on its capacity not only to react to politics but to create new ideas and true alternatives to the conservative dream of "new motherhood".

Apart from continuation of usual activities, PRO FAMILIA has engaged in the following new activites in 1984:-creation of a brochure on all methods of "natural family planning" ; a brochure on the condom; a brochure for 6 migrant groups on all existing family planning services; training for group counselling; training on interprofessional cooperation within PRO FAMILIA clinics. In addition, an experimental training programme on female sexuality will be evaluated.

The cooperation within the IPPF Europe Region is satisfying especially on a bilateral basis. PRO FAMILIA counsellors have participated in the Regional information exchange and travelled to Vienna and Milan. the working relations with European organisations are close (e.g. WHO EUROPE).

Although scientific literature has reported postcoital research and techniques for more than 10 years, most doctors and other health professions are still not aware of or ignore the possibility of a back-up method for the morning after.Consequently, PRO FAMILIA organised, together with university clinics at a local level, information meetings for doctors in order to persuade them to participate in the programme.

In addition PRO FAMILIA has documented and analysed 1,239 postcoital cases.

HUNGARY - Hungarian Scientific Society for Family and Women's Welfare (HSSFWW)

The Presidium of the Society advocated prescription of oral contraception and postcoital contraception, forwarding recommendations to the National Institute of Obstetrics and Gynaecology. Following this the Society took part in the preparation of a major report: 'Birth Control in Hungary' for the Supreme Counselling Body of the Ministry of Health - the Scientific Health Council.

This material gave a survey of the situation of birth control in Hungary, noting deficiencies.

Meetings: debate on 'Instruments of the Socialist Law in the stabilisation of Family Life', Budapest, 9th March 1983; joint meeting of the Presidium of the Association of Hungarian Jurists; conference on 'Questions of Family Care', Budapest, May 1983; joint meeting of the Society, the Patriotic People's Front and the Hungarian Psychiatric Association; international symposium on 'Family Planning in Practice', Miskolc-Tapolca, May 1983. (with 2 Austrian, 1 Polish, 4 Czechoslovak, 3 West German and 11 East German specialists); a scientific session on 'Ten Years of our Population Policy' and the HSSFWW general assembly, Gyula, 20 - 21 October 1983.

Training programmes: members of the Society participated in the teaching of 'preparation for family life' in schools (for teachers, students and physicians). Members of the Society were also involved in the following courses organised at the Women's Clinic in Debrecen, and financed by the WHO and UNFPA: 'Training Courses on Methods of Family Planning' for Greek specialists; 'International Postgraduate Training Course on Methods of Family Planning' for specialists from developing countries.

IRELAND - Irish Family Planning Association (IFPA)

The persistent recession in the Irish economy, with increasing unemployment and a fall in spending power, continued to present financial problems to both the IFPA and its clients. In the absence of any grants or subsidy, the Association must ensure that its services pay for themselves and this has forced increases in charges (which may now be deterring the most needy cases despite a policy of waiving fees in the case of financial hardship), and a 12 month pay freeze for IFPA staff.

Moves by certain Area Health Boards to provide family planning services under public auspices met with some resistance from the organised medical profession, which, despite its poor record in this field, is now claiming that family planning should best be provided by family doctors. That represents a very significant change in attitude over the course of a decade. The Health Board continued its liaison with the IFPA, particularly in the Dublin area, which may lead to the creation of a limited public service provision during 1984.

Meanwhile, the IFPA has increased its service provision with the addition of Rubella immunisation and microbiological investigation of vaginal infections. No headway was made in the provision of female sterilisation, but vasectomy services were increased, and the demand for psycho-sexual counselling continued to grow.

The demand from doctors for training for a diploma in family planning now issued by a joint committee representing various family planning and medical interests (including the IFPA) grew further during the year, and special training courses for both doctors and nurses were and are being provided by the IFPA.

A total of ten tutors in sex education have been trained jointly between the IFPA and the Northern Ireland branch of the UKFPA. These will provide, during 1984 and thereafter, weekend and other courses for teachers, youth leaders and others, with continuing collaboration between Northern Ireland and the Republic. the demand for these and other courses continued to grow and the IFPA began to develop its own resource material by way of videotape presentations and draft curricula for use in schools. There has also been a significant request for sex education in the field of mental handicap.

During 1983 plans were formulated for the provision by late 1984, of special services for adolescents, including a telephone service manned by young people themselves, trained by the IFPA. Planning was also started on a European regional project to identify and counteract the organised opposition to family planning which has grown in recent years.

ITALY - Unione Italiana di Centri Educazione Matrimoniale e Prematrimoniale (UICEMP)

There have been some changes in 1983. The fall of the government and the consequent elections have heavily postponed important Bills of law eg. on sterilisation and on sex education in schools.

The quality of the services given by state clinics is deteriorating due to the indifference of politicians and the shortage of staff. In fact governmental cuts are severe in the health system, which means that retiring staff or staff absent for long periods are not replaced.

UICEMP is still largely dependent on IPPF funding. In 1983, the Health Ministry finally agreed to fund part of the association's programme. The branches have begun to finance the UICEMP Secretariat, but their contribution is still very small compared with the amount of activities to be undertaken.

1983 was a very important year for UICEMP which succeeded in organising 4 successful new activities:

1. Adolescent project: Five branches (Milan, Turin, Genoa, Rome, Palermo) opened weekly sessions for adolescents. In these sessions counselling and information on contraceptives and sexual matters are given free-of-charge, as are the contraceptives. Only gynaecological examinations require payment in 3 out of the 5 branches. Telephone counselling is available in all the 5 branches throughout the week. The activity was a complete success as far as attendance of youngsters is concerned with the demand overwhelming. A booklet on sexual matters was printed in March 1984 (20,000 copies).

2. National conference on "Resistance to Contraception": held in Milan in November 1983 and attended by about 200 participants (Mostly gynaecologists and psychologists). In 2 days work, anthropological, ethical, political, and psychological aspects of resistance to contraception were examined and discussed. A book containing the reports and the discussions will be published in 1984.

3. Southern Italy conference on "The Consultorio in a Changing Society": held in Palermo in December 1983. About 130 participants attended, mostly civil servants of the health local units which will have to organise the state clinics.

The round table discussion concerning the family planning situation in Southern Italy was particularly interesting. The initiative had an important impact in local press and TV.

4. Information and Education material: 5 new leaflets were prepared on the subjects of: pregnancy, abortion, smear and breast examination, hereditary diseases and STDs. These 5 new leaflets will accompany the

5 existing ones on contraceptives. They are intended to be a first information tool for our clients and for people attending our services. They are also meant to stimulate state family planning clinics to develop their own material.

LUXEMBOURG - Mouvement Luxembourgeois pour le Planning Familial et l'Education Sexuelle (MLPFES)

The MLPFES has four centres: Luxembourg/Ville, Esch/Alzette, Ettelbruck and Differdange. These centres have offered 10,000 consultations (of which 9,000 are offered by Luxembourg/Ville centres). The clientele are mainly young (65% under 25 years) but there has been an increase in women of menopausal age, who prefer to talk with our female physicians rather than male GPs.

Most of the young prefer oral contraceptives, although those between 25 - 35 years of age are increasingly requesting diaphragms and cervical caps with spermicide.

A not insignificant percentage of our clients prefer three or six-monthly injections of Depo Provera - 600 injections annually.

PPA activities include: sex education, contraception, infertility treatment (AIH-in house; AID conducted in Nancy, France), cervical smears, breast examinations, tests for and treatment of STDs, menopausal problems, marriage counselling, and counselling for sexual and psychosexual problems.

During 1981 - 82 a campaign against the procuring of women for prostitution resulted in arrests, prosecutions and sentences by the police, and stricter surveillance of the areas in which this was taking place - a more rigorous application of the law covering 'red-light districts'.

In 1982, an organisation was established (Info-Viol) for victims of rape. These victims are received by the family planning centres in the day-time, and by the state maternity hospital at night and over weekends. They receive the victims and assess the gravity of the assault. Postcoital contraception is available for women who are unprotected at the time of assault. Female volunteers are on call 24 hours a day to help women through the process of notification of rape, if they so wish.

Since February 1984, the MLPFES has had a physician at the disposal of male homosexuals to test for and treat STDs, and help clients with consequent identity problems if they require such counselling. No cases of AIDS have yet been notified.

For 5 years the Movement has given radio broadcasts every three weeks on different problems of family planning and activities wihin the family planning centres. These broadcasts are listened to by one-fifth of the population. the greatest success so far has been with a series of programmes on 'the first time' - a discussion of the problems raised by the first coitus. For her work in fighting to remove the taboo surrounding sexuality, the head physician of the Luxembourg centre,was named 'woman of the year' for 1983, which was very helpful to the image of the organisation.

NETHERLANDS - Rutgers Stichting (RS)

The bad economic situation persists. Like most of the health and social services, Rutgers Stichting remains rather uncertain about its future, but there are no longer any threatening political efforts to lower its subsidies. However, an ongoing discussion about the restructuring of both health work and social work may also consitute a threat.

Rutgers Stichting is the only nationwide institution offering medical, sexual and psycho-sexual services, in addition to sex education programmes. The organisation fills the gaps in public or government funded services in these areas. More than 100,000 people visited the Stichting's medical services last year, the therapists saw about 10,000 clients and 50,000 people were in contact with the educational services. Over 150,000 people asked for information by 'phone. The streamlining of the organisation, forced through the loss of government subsidies, did work in 1983. Some of the effects will be visible in the longer term. Further losses of subsidies were stemmed through the rigorous campaigning activities of the Rutgers Stichting.

The most visible activities of Rutgers Stichting were in the Autumn, when a big publicity campaign was launched, the theme of which was: "Make love always with .....a good contraceptive".

NORWAY - Norsk Forening for Familieplanlegging

Last year, the Parliament passed new law on health services in the community and from January 1984 every citizen has the right of access to the health services. This includes family planning, and the community has an obligation to inform the public about sexuality and family planning. The Association has already started with a series of meetings in secondary schools with pupils (14 - 16 years old), parents and teachers.

The financing of this new health service law is somewhat problematic, so the future will tell whether this right really will be realised.

The Association is funded from membership fees and grants from the Bureau or Health for special meetings and courses about family life, the role of the father, and for publications about family planning and handicapped people.

The Association has no service of its own as this is a governmental/ community obligation. However it is represented on committees discussing family planning and health service/health information together with other organisations appointed and financed by the Bureau of Health.

The NFF has produced in co-operation with Gyldendal (a well known publisher) a leaflet about handicapped people, and is working on a dictionary for young people and a leaflet for elderly people. It has held open meetings about parents and children in family life and about the role of the father and the changing role of the male. This has been part of an extensive debate in newspapers and among experts.

POLAND - Towarzystwo Rozwoju Rodziny (TRR)

The general political situation is stabilising, albeit with latent unsolved problems and conflicts. A shift in emphasis in the policy of the state away from the traditionally pronatalist policy is apparent even if only seldom expressed openly in public by officials. TRR began two years ago, and continued in 1983, patient but multiplex activities in favour of a neutral, instead of pronatalist, national policy, persuading the population through the use of mass media that very high fertility is a negative force in the process of overcoming Poland's socio-economic crisis. This activity is actively challenged by the Church, though without the aggression typical of earlier years.

A new phenomenon is the pressure group activity of some women's organisations aimed at the Ministry of Health to improve the availability of contraceptives (for example the Women's League and some young female journalists have produced sharp critical TV programmes and newspaper articles). These groups have established good working relationships with the TRR, and as a consequence of united activities the Ministry was compelled to increase the import of contraception from Hungary, Yugoslavia, Korea and the GDR, Unfortunately this has not solved the problem entirely.

The national role of the TRR, after some decline in prominence during 1982 - 83, is again high. While the Ministry is criticised in the mass media for the shortages in contraceptives, the Association is regarded as the sole body taking proper care of family planning and sex education. Three members of TRR have been appointed members of a Ministry of Education advisory body for family life education.

The general economic situation in the country remains grave, although there is a slight improvement during 1983 - the first time since 1977 (GNP growth of 5%). The situation of the TRR has also improved to a much greater degree, thanks to a donation from the Ministry of Health covering 57% of the TRR budget (1982 = 53%). This means that of the total TRR budget of zlo 58.7 million, 31.1 million came from the Ministry of Health, and 9.1 million from the local branches. The TRR received 3.3 million zlotys, net profit from the TRR subsidiary: Securitas, which manufactures contraceptives. A further 14.9 million was received in income from the central TRR agencies. As a result, income and expenditures are now well balanced.

The TRR is composed of 42 branches, most with their own sub-structures from 2 to 12 per branch; the average number of sub-structures per branch is 6. However, there are 2 branches which stand alone (4 branches ceased to act after the 1980/82 crisis).

After a disastrous decline in membership during 1980-81, since 1982 TRR has recovered lost members and institutions. In comparison with 1982, TRR now has 2,270 new full members; 15,093 more supporting members, but a loss of 13 collective members. Total membership increased during 1983 by 12% to 144,000.

At present TRR operates 20 counselling centres, two of them particularly for young people (Warsaw, Cracow). These counselling centres served, together, 5,353 clients - an unsatisfactory number. The 2 youth counselling centres served 410 persons. Measures are recommended in order to increase the number of people which can be served by these centres, particularly in the provincial towns.

PORTUGAL - Associacao para o Planeamento da Família (APF)

General elections took place in April 1983. As a result a new government was formed by a coalition (Socialist Party/Social Democratic Party). Due to the economic crisis, the government is reducing its investment in health and education. The number of family planning clinic services in health centres and maternity hospitals has never been enough for the needs of the population. However, until 1979, new services were being established at a satisfactory rate. Since 1980, due to the policy of the Conservative government at that time, the national family planning services have been seriously depleted. In mid-1983, the Health Ministry integrated the clinic services into the health/social security system. This integration was, itself, important but it was implemented in such a rapid way that several gaps were left - particularly in the area of mother and child care and family planning services.

Recently, two laws have been approved by parliament: one concerns voluntary termination of pregnancy, and the other about sex education and family planning. Concerning the former, the law now states that abortions can be performed for therapeutic reasons, rape, or if the woman's health (physical or psychological) is in danger. The law on sex education states that the government supports such education as a human right, particularly for young people.

The APF has made a statement on: the abortion issue, legal barriers preventing adolescents' access to family planning, and the prohibition of voluntary sterilisation as a contraceptive method. This statement was sent to members of parliament, the Ministry of Health, the Ministry of Education, and the mass media, having great impact on public opinion.

SWEDEN - Riksförbundet för Sexuell Upplysning (RFSU)

Due to Sweden's economic situation RFSU received less government funding during 1983. RSFU was therefore forced to charge more for its services, courses, education activities, pamphlets, etc., which had earlier been supported by the state or had been self-financed.

RFSU engages in information and education activities to alter public opinion. Our clinics provide: advice, counselling, psychotherapy and help to victims of sexual assault.

The RFSU Sales Organisation retails barrier contraceptives and aids for handicapped people in order to finance other RFSU activities.

In 1983, RFSU celebrated its 50th anniversary. Instead of "birthday gifts" RFSU asked for financial contributions to a project which has preliminarily been called "Research about the Father". An "Open House" was arranged to which people close to RFSU were invited, among others the Minister of Social Affairs. A big jubilee poster, giving information about the activities of RFSU, was produced. In connection with the IPPF Europe Region Council Meeting in Stockholm in May and the RFSU Annual Meeting, a joint birthday party was arranged.

Courses: as usual, RFSU arranged courses on "Sexuality: Society Living Together" (3). As a consequence of the engagement in the male role, RFSU arranged a new type of course called "The Hollow Father", the aim of which is to encourage men to recognise more fully their responsibility as fathers. Three courses were arranged, based on the experiences gained at the clinic: "How to Meet and Work with the Problem of Rape" (2) and "How to Meet and Work with Sexual Counselling for Young People" (1). All RFSU courses utilise professional groups.

TURKEY - The Family Planning Association of Turkey (FPAT)

FPAT activities which started to regress in 1979 due to financial difficulties made great strides in 1983 when IPPF financial support was reinstated in 1982 and also due to good planning and programming to meet needs in this field.

Projects implemented gave gratifying results and the FPAT succeeded in getting the support and co-operation not only of the Ministry of Health, but the universities, hospitals, public and private companies and organisations. The moral and material support these institutions provided was highly instrumental in the degree of project success.

FPAT is expanding its services considerably this year both within existing branches in various parts of Turkey and by opening new branches.

There is much need for work in the field of family planning education and application in our country. FPAT activities are complementary to state activities in certain respects, or of a pioneering nature in others.

Although the use of modern contraceptives is increasing steadily, it is still not at the desired level. Activities geared to education and motivation have been emphasised to increase usage.

Links with government and decision makers: close contact was initiated and maintained particularly with members of parliament for the liberalisation of abortion and sterilisation. The purpose as well as benefits for the country were explained during meetings.

In order to have Family Life Education integrated into the secondary school curricula, representatives of related ministries were invited to the meeting organised within the scope of the project as were the representatives of other related organisations. The importance and necessity of the subject was emphasised during the meeting.

Training programme for student teachers: The "Family Planning" course which started in 1980 was given again this year on a voluntary basis by the FPAT executive Director.

Family Life Education project : This project is the fruit of FPAT efforts to incorporate Family Life Education in its activities since 1974.

UNITED KINGDOM - Family Planning Association (FPA)

Following the handover of the majority of its clinics to the NHS between 1974 and 1976, the U.K. FPA developed its role in the provision of information and education relating to family planning - a role which was further extended during 1983. The Family Planning Information Service handled a total of nearly 25,000 inquiries from lay and professional members of the public in its London Office, while those dealt with by Regional Offices brought the total to over 100,000.

In addition FPIS distributed more than 5 million leaflets and fact sheets nationally.

Consumer enquiries centred mainly on contraception, pregnancy and fertility problems though an increasing number of requests for information about sexually transmitted diseases and psycho-sexual counselling were received.

As well as everyday public service work, the work of FPIS involves a number of specific projects which last year included:

Pharmacists Project

The FPA/FPIS has been liaising with the Pharmaceutical Society of Great Britain since 1980 on a project with the long term aim of increasing the role and status of the pharmacist in health education, particularly family planning, and using the pharmacist as an economical and effective channel for distributing information and free literature to individuals. Following the publication of an investigation designed to assess the likely commitment of pharmacists to this idea, the project continued with a trial distribution of information materials to over 700 pharmacists; the reception of which by pharmacists and their clientele was to be examined for a fixed three-month period. The results of this trial, published in September 1984, confirm that a nationwide pharmacy based contraceptive information service is a realistic proposition, and should be developed accordingly.

In collaboration with London Weekend Television and the Brook Advisory Centres the FPA last year made a public service announcement with the objective of raising awareness of the need for contraceptive planning in young men. After initial conflict with the Independent Broadcasting Authority over the wording of the announcement, it was finally transmitted in December 1983. The 30 second feature focussed on a discussion in a hamburger bar between a group of young men during which the point was made that unintended pregnancy was not merely the responsibility of the girl involved. Following the transmission, FPA and Brook staff manned a TV "phone-in", giving advice on contraceptive provision for young people.

The FPA launched a campaign in May 1984, aimed at making post-coital contraception more widely available to the public. Pre-publicity over preceding months ensured that the campaign received maximum cover in all the media. A concise statement prepared by the Medical Advisory Panel was produced, to serve as a handy reference for doctors providing a post-coital contraceptive service.

YUGOSLAVIA - Family Planning Council of Yugoslavia (FPCY)

In the previous two years, there has been some shortage in the import of contraceptives as a result of economic difficulties. This situation has now been overcome. The FPCY collaborated with responsible government authorities on this matter.

During 1983, besides other activities, the FPCY organised a large conference on the theme "Results Obtained to Date on the Inclusion of the Humanisation of Relations between the Sexes at all Levels of Children and Youth Schooling into school curriculum'. The aim of this conference was to review the implementation of previously adopted conclusions and recommendations of the FPCY on this matter.

The results achieved in the Republics and Provinces were presented in nine papers. 38 participants represented social, political and professional organisations and relevant government bodies. After broad discussion on the theme, it was concluded that some positive results have been achieved in this work. These themes are more effectively integrated into the curricula of primary and secondary schools, not within one particular subject, but in all relevant subjects: biology, hygiene, literature, history, etc.

At the Conference, special attention was paid to the broader involvement of mass media in family planning education for youth and adults, through the specialised programmes already in existence for family, parents and children. It was pointed out that a team of experts had to be engaged to ensure the quality of such programmes and multidisciplinary approach to family planning. Equality of the sexes in society, family and marital life has to be tackled in these programmes also, considering it is one of the important issues for improvement in family planning behaviour.

During the past year, the FPCY was also engaged in the preparation of the Symposium on the theme "Population Policy in Yugoslav Socialist Self-Management of Society". With this aim, the Organisational board was formed of 26 members, representatives of corresponding organisations and government institutions, as well as scientists, well known in this field.

The aim of this Symposium is to explore problems in the population domain, the relationship between a population policy and family planning and to review results and experiences in the realisation of the constitutional right to family planning, and to decide upon future tasks in this field. The Symposium will be held in the first half of 1984.

NON-MEMBER COUNTRIES

CZECHOSLOVAKIA - Section for Family Planning and Parenthood Education of the Czechoslovak Sexology Society (SPRVR)

The members of SPRVR were very active during the year 1983 writing studies, papers and articles on the family planning and parenthood problems, which appeared in the main Czechoslovak papers and journals and have become very popular. In "Rude Právo" - the main Party paper - and in "Vlasta" official journal of the Union of the Czechoslovak women, articles on family planning, abortion law, and contraception were published. In "Mlady Svet" journal of the Union of the Czechoslovak Youth the panel discussion on the current problems of family planning and parenthood education appeared.

In 1983, an international comparison of 24 European countries covering the population development and population policy measures including comparative information on family planning and parenthood education legislation and practice was finished and published. For the chapter in question material from the IPPF, Europe Region was used.

In Olomouc (North Moravia) in September 1983 a seminar on parenthood education and its effectiveness was organised by the Palacky's University. The main papers were prepared by the members of SPRVR.

In 1985, 4th September, a seminar of socialist countries on adolescent sex and education for family life will take place in Czechoslovakia, prepared by SPRVR.

MALTA - Min-Naha-Tan-Nisa

The group Min-Naha Tan-Nisa was set up in February 1980: full membership is open to all who agree with the aims and policies of the group. The policy of the group has been to tackle issues of importance to women generally, so as to mobilise the broadest spectrum possible and so as to raise consciousness about women's general condition.

Quite early on, the need was felt to include male associate members in sub-groups working on issues that relate to both men and women. So, for example, both the on-going campaign for the reform of the Family Law and the introduction of divorce, as well as the group writing a book in Maltese on sex education are co-ordinated by women and men.

In its first meeting the group decided to campaign for the introduction of a government-run free family planning service. We gave priority to this issue because we felt that one of the major factors that prevented women from participating more actively in society was the fact that we had little control over our bodies. At the time the only organisation that gave family planning advice was run by the Catholic Church which, because of its ideology, only gave information about the so-called natural methods.

Our campaign included meeting women from different areas and sections of Maltese life, and a detailed report identifying the main areas and requirements of a comprehensive family planning service.

The campaign paid off in May 1981 when government announced the opening of three Family Welfare Clinics.

SPAIN - Comisión Gestora Nacional para la coordinación de Centros de PF (CGN)

Since 1983 the number of FP centres in Spain has increased from 160 to 200 in 1984. Most of those 40 new services are integrated with municipal primary health care centres. The Ministry of Health finally prepared several specific budgets for family planning which, after approval, aim to extend existing services.

This is a first step towards the integration of fp services into the network of social security primary health care services. A second initiative, under review, is to transfer contraceptive costs to the social security system. In the Ministry of health plan, in terms of personnel, a psychiatrist or psychologist (outside the mental health service) trained in sexology is foreseen.

At the beginning of 1984, Spain joined the UNFPA. In the near future, this may favour the promotion of family planning, particularly in the fields of information and training of health personnel. Contacts have been established with the UNFPA by the CGN.

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New unpublished paper:

Elise Ottesen-Jensen and the Emergence of the International Planned Parenthood Federation 1945-1953

Doris H Linder

Society for the Advancement of Scandinavian Studies 1984, University of Washington.

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