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Family Planning

With Focus on Contraception as Seen by Health Centre Physicians and Population

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ACADEMIC DISSERTATION

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ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
EC	emergency contraception
FP	family planning
GP	general practitioner
HIV	Human Immunodeficiency Virus
IUD	intrauterine device
OCs	oral contraceptives
STDs	sexually transmitted diseases
WHO	World Health Organization

LIST OF ORIGINAL PUBLICATIONS

The thesis is based on the following original publications.

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III. Kirkkola A-L, Virjo I, Isokoski M, Mattila K (1999). Contraceptive methods used and preferred by men and women. Advances in Contraception 15:363-374.

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V. Kirkkola A-L, Virjo I, Isokoski M, Mattila K (2001). Primary health care physicians and population have realistic views on IUD contraception. European Journal of General Practice 7:59-61.

VI. Kirkkola A-L, Virjo I, Isokoski M, Mattila K (2002). Oral contraceptives: Views among primary health care physicians and population. European Journal of Contraception and Reproductive Health Care 7:1-5.

VII. Kirkkola A-L (2003). In the jungle of information. European Journal of General Practice 9:97-98.

INTRODUCTION

Population conferences have established the position of family planning as one of the most important issues in all societies. Overpopulation, lack of nutrition and mothers´ and infants´ health conditions especially in developed countries are items which have revealed the necessity of family planning.

The right to family planning was established in 1968 in the United Nations International Conference on Human Rights in Teheran (Marshall 1997). The World Population Conference in Bucharest in 1974 emphasized the individual's right to freely decide the number and spacing of children. The United Nations World Conference on Human Rights in Vienna in 1993 formally accepted the right to control one's own body (Lottes 2000). Family planning was confirmed as one of the basic elements among sexual and reproductive rights by the International Planned Parenthood Federation (IPPF) in 1994 (Cook and Fathalla 1996) (Appendix 1). The International Conference on Population and Development in Cairo in 1994 (Appendix 2) and the fourth World Conference on Women in Beijing in 1995 extended the meaning of reproductive health from maternal health and family planning to health problems and rights related to sexuality (Lottes 2000).

Concerted efforts have been made in Finland for decades to ensure that pregnancies be desired and propitiously determined. The Finnish abortion rate has long been among the lowest in the world (Rasimus 1999), and remains so in spite of a rise in figures after the mid-nineties (Vikat et al. 1999). No precise data are available to explain the change, but one possible reason has been held to be the reductions in sexual education in school health and cuts in health care finances (Kosunen et al. 2002).

The role of men in family planning has been emphasized especially in recent years. In order to be able to counsel men and their partners and provide optimal guidance in family planning and matters of sexual health, it is vital to know what men and women think in these issues and where they obtain their knowledge. Extensive studies of sexual life have been carried out in Finland, the study cohorts including both men and women (Sievers et al. 1974, Kontula and Haavio-Mannila 1993, Haavio-Mannila and Kontula 2001). Less research has however been done on experiences of modes of contraception, as also on the various sources of information men and women use and the amount of information they receive in these matters. Prerequisite to high-quality and appropriate family planning and sexual health services is also knowledge of the experiences and the views of physicians providing these services.

During recent decades there have been a number of attempts to define the terms sexual and reproductive health, and the emergence of divergent schools of thought bespeaks the complexity of the issue. In Finland the term "family planning" has been used since the 1980s (Sihvo and Koponen 1998), while the term "reproductive health" came into use in the latter 1990s. When this study was originally undertaken the terms sexual and reproductive health were not particularly widely used in Finland. The main focus here is on family planning, more specifically contraception.

1 REVIEW OF THE LITERATURE

1.1 From family planning to sexual health

Family planning is seen as a component in reproductive and sexual health (IPPF 1995, Marshall 1997), and contraception and prevention of induced abortions and unwanted pregnancies constitute an aspect of this sector; one Finnish definition of family planning indeed embraces contraception, induced abortion services, infertility therapy and promotion of sexual health (Rimpelä and Ritamo 1995).

As defined at the International Conference on Population and Development (ICPD) in 1994, *reproductive health* is a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. This conception thus implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide whether, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice in the regulation of fertility which are not against the law, and the right of access to appropriate health-care services which will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having healthy infants (IPPF 1995, Koivusalo and Ollila 1996, Marshall 1997). According to another definition, reproductive health is related to the reproductive organs, fertility, clinical services and illness (Klouda 1996).

According to the World Health Organization (WHO) definition *sexual health* is the integration of the physical, emotional, intellectual and social aspects of sexual being in ways which are positively enriching, and enhance personality, communication and love (http://www.siecus.org. 2001). A Finnish definition, again, refers to sexual health as the ability of women and men to enjoy and express their sexuality and to do so free from risk of sexually transmitted diseases, unwanted pregnancy, coercion, violence and discrimination (Lottes 2000).

1.2 History of contraceptives

Divergence in the practice of limiting the numbers of children can only be understood if placed in the context of both the economic and the social conditions prevailing in a given society. It should be borne in mind that religious, medical, social and philosophical trends have an impact on the way people accept and have the possibility to use contraception (McLaren 1994). Nor in discussing family planning must we overlook the individual's and couples´ attitudes to contraception and their current knowledge of family planning. Awareness of these aspects is more important than the contraceptive technology made available (Sievers et al. 1974).

It is difficult to pinpoint the time when mankind first realized the connection between coitus and procreation. It is also difficult to say when fertility was first controlled; perhaps it was always controlled (McLaren 1994). In ancient times population limitation was widespread among pre-literate people; infanticide and abortion were common practices among primitive societies, whereas birth-limiting practices were rare (Schenker and Rabenou 1993). The Greeks were the first to give deliberate thought to problems of population. Contraceptive knowledge is recorded in a wide range of Greek and Roman medical writings (Schenker and Rabenou 1993). In the medieval period the dispersion of medical and scientific knowledge, including conception control, was a contribution of Arabic physicians (Schenker and Rabenou 1993). The role of human sperm in reproduction was established only in the middle of the 19th century (Bartfai 2000). The relationship between menstruation and ovulation was not perceived until the endocrine function of the ovary was recognized and the corpus luteum was linked with the menstrual cycle in the early 20th century (Schenker and Rabenou 1993).

Anti-conception techniques require no more than a vague notion of a relation between coitus and pregnancy, and at some time in the distant past populations attempted to control conception on the basis of this relationship (Schenker and Rabenou 1993). The Bible contains a chapter in which a man called Onan is mentioned as letting his seed be wasted; this can be interpreted as withdrawal (McLaren 1994). Coitus interruptus, as a method of birth control, is still in contemporary use worldwide (Rogow and Horowitz 1995). It is used especially in developing countries (Rogow and Horowitz 1995) but, for example in France and the former Czhecoslovakia, withdrawal was in fact the most widely employed means of birth control in the 1970s (Van de Kaa 1987, Heitlinger 1987). The use remained high also in the 1990s in the Czech and Slovak Federal Republic (Ketting et al. 1993) and in Romania (Serbanescu et al. 1995).

The forerunner of the modern condom existed after the mid-1500s (Schenker and Rabenou 1993, McLaren 1994). From the sixteenth to the nineteenth century the device was used mainly to avoid venereal diseases. With the vulcanization of rubber in the 1840s condom production became widespread (Turpeinen 1967, Oakley and Bogue 1995); in Finland the first condoms were manufactured by Suomen Gummitehdas in 1937 (Palo-Oja and Willberg 1998). In addition to their traditional role, condoms have moved to a crucial and central position in the strategy for prevention of sexual transmission of the human immunodeficiency virus (HIV) and other sexually transmitted diseases.

Since ancient times there have been descriptions of contraceptive methods (e.g. textile pieces lubricated with olive oil) which may be regarded as pre-stages of a diaphragm (Turpeinen 1967). The sponge was a forerunner of the modern diaphragm developed in the 1880s (McLaren 1994).

At the turn of the 18th century commercial houses began to develop acidic powders and jellies to kill sperm (McLaren 1994), and by 1880 spermicides were in mass production (Schenker and Rabenou 1993).

Surgical sterilization of men and women became possible in the 1890s, but was usually carried out for eugenic reasons on the mentally ill (McLaren 1994). The latter half of the 20th century saw the introduction of sterilization as a contraceptive method (Geljins and Pannenborg 1993).

The forerunners of the modern intrauterine devices appeared at the beginning of the 1900s (Piotrow et al. 1979, Petta et al. 1996). Subsequent to the development of biologically safe plastics in the 1960s several IUDs were designed incorporating this material. A first-generation copper-releasing IUD was designed at the end of the same decade, and hormone-releasing devices came on to the market in the 1970s. In Finland copper-releasing IUDs were introduced in 1972 (Hirvonen and Idänpään-Heikkilä 1990) and the levonorgestrel (LNG) IUD in 1990 (Petta et al. 1996).

Oral contraceptive (OC) pills were developed in the mid-1950s (Hatcher 1984, Tyrer 1999); they comprised combined oral contraceptive pills (COC). The first to be marketed in the United States contained 150ug estrogen and 9.85mg progestin (Mishell Jr 1991, Thorogood and Villard-Mackintosh 1993). By 1970, the estrogen dose was lowered to 50ug and in 1974 formulations with 20,30 and 35ug ethinyl estradiol were marketed (Mishell Jr 1991). Mini-pills containing only a progestational agent became available in the 1970s. The 1980s witnessed the introduction of biphasic and triphasic COCs, where the dose of ethinyl estradiol and more importantly of progestogen changed during the pill cycle (Kubba and Guillebaud 1993). On the Finnish market OCs were introduced in 1962 (Kosunen 1996); progestin-only pills were registered in 1971, low-estrogen oral contraceptives in 1974 and triphasic OCs and a combination of ethinyl estradiol/desogestrel in 1981 (Hirvonen and Idänpään-Heikkilä 1990).

Subcutaneous contraceptive capsules were developed during the 1960s. The first system consisted in six capsules each containing levonorgestrel. In Finland these capsules were registered as Norplant® and were available from 1984 (Holma 1989) until the year 1999 (personal communication, University Drugstore, Helsinki). Nowadays two- or one- capsule-containing systems are available.

Depo Provera® is a medroxyprogesterone acetate (DMPA) injection introduced in 1963 (Biggrig et al. 1999). In Finland this method came on the market in 1974, indications being adjuvant and/or palliative care for patients with endometrial or breast carcinomas. For contraceptive purposes it has been used since 1995 (Pharmacia product manager, personal communication). However, the mode was used with special permission for contraception in some areas in the northern part of Finland at the end of 1960s (Docent J. Puolakka, personal communication).

Post-coital methods have been employed since ancient times (McLaren 1994). For example women would made vehement movements to expel the seminal fluid from the vagina (Bartfai 2000, Schenker and Rabenou 1993), or relied on douches and disinfectants (Zieblad 1999). In 1995 emergency contraceptives included regular combined ethinyl estradiol/levonorgestrel pills (the Yuzpe regimen) and the copper IUD (Consensus statement on emergency contraception 1995). Modern post-coital hormonal contraception using high-dose estrogen or ethinyl estradiol was first applied for rape victims in the 1960s (Bartfai 2000). The IUD was administered as an EC as early as 1976. Post-coital pills containing levonorgestrel alone were introduced in the early 1980s (Bartfai 2000) and mifepristone (RU486), an antiprogestin, has been used as a method of induced abortion (Cadepond et al. 1997). It has also proved highly effective as an emergency contraceptive after unprotected intercourse (Glasier et al. 1992, Haspels 1994, Glasier 1997, Task Force on Postovulatory Methods of Fertility Regulation 1999). The Yuzpe regimen came on the Finnish market in 1986 (Lähteenmäki et al. 1995, Kosunen et al. 1997a). Levonorgestrel-only pills have been

shown in a large-scale clinical trial to be better tolerated and at least as effective as the Yuzpe regimen (Task Force on Postovulatory Methods of Fertility Regulation 1998). In Finland levonorgestrel-only pills with 750ug levonorgestrel have been available on prescription since June 2000 (Tokola 2000) and as a non-prescription drug to women of 15 years and older since 1.5.2002.

The natural family planning approach (NPF) comprises the calendar or rhythm method, the basal body temperature method, symptothermal methods and the Billings method (Tuimala 1987). The calendar or rhythm method is based on the idea that the first six or last ten days of the menstrual cycle are so-called safe days to have intercourse (Tuimala 1987). The basal body temperature method is based on the changes in basal body temperature after ovulation, and symptothermal methods comprise a range of approaches applying basal body temperature measurement and monitoring symptoms related to the menstrual cycle such as painful breasts and pain in the lower abdomen (Tuimala 1987). The Billings method is based on observation of changes in the cervical mucus during the menstrual cycle (Tuimala 1987). These techniques became feasible consequent upon understanding of the hormonal cycle and changes in it, this mostly in the mid-20th century (Klaus 1982). Persona® is a new step in NPF. This is personal hormone-monitoring system (Bonnar et al. 1999). Persona consists of a hand-held monitor and disposable test sticks which measure changes in urinary hormone concentrations. The monitor indicates fertile unsafe days and infertile safe days by displaying red and green lights (Trussell 2001).

The NuvaRing®is a combined contraceptive vaginal ring designed for three weeks´ continuous use followed by a 1-week ring-free period (Sarkar 2003).

The newest contraceptive method is a norelgestromin- and ethinylestradiole-releasing depot pad (Toivonen 2002). Its contraceptive efficacy is similar to that of combined oral contraceptives (Toivonen 2002).

Testosterone-progesterone hormone combinations in male contraception have been studied since the 1970s, but only since 1996 has progesterone use been examined systematically (Pöllänen 2000). The first mode was injectable, but this is not convenient for wider use, and improved dosage methods are under development (Pöllänen 2000).

1.3 Atmosphere in Finland with special reference to family planning

Every individual represents her/his own era, and clearly society and family must have an impact on the atmosphere in which one lives. Family planning is indubitably one issue which depends on atmosphere. In this study, the age of the study population ranged from 18 to 50 years, which in turn means that older respondents were born in the 1940s and their parents in the first two decades of the century. The survey of atmosphere thus mainly spans a period from 1900 to the present day.

Lutheran Christianity has for centuries had an impact on Finnish culture, living and customs (Turpeinen 1991). Sexual pleasure and sexual intercourse even in marriage were perceived as sinful during the 1700s and 1800s; sexual morality was absolute, with the requirement of

monogamy and no extra-marital relationships (Nieminen 1951); and the Church represented the main educator in sexual life among the population (Turpeinen 1991).

According to a study made by Sysiharju it is possible to distinguish four different periods in the history of Finnish sexual counseling and education: 1) the period before the Second World War, when sexual matters were private; 2) the period immediately after the war, when sexual and moral education were to the fore; 3) the years 1955-1965, the phase of family education and 4) the period after the mid-1960s, when the main concern was with systematic sexual education (Sievers et al. 1974).

At the beginning of the 20th century industrialization and the rise in the population's educational level promoted the spread of relative sexual morality based on the facts of sensuality (Nieminen 1951, Sievers et al. 1974). Women's participation in work outside the home as part of the industrialization process gave them greater economic independence and also opportunities to meet men other than their husbands, this again tending to relative sexual morality (Nieminen 1951). The year 1905 brought the General Strike, where after society lived in a turbulent state. The doors were open to new thoughts and ideas (Nieminen 1951). Finnish women were the first in the Europe to receive the right to vote in national election in 1906, which could only further enhance their independence. Though the sexual drive was seen in Christian circles as of God's creation and as such holy, this did not mean that eroticism and sexual pleasure were accepted as positive values (Nieminen 1951). The Church maintained its role as a powerful sexual educator by publishing books concerning sex education addressed especially to young people (Turpeinen 1991). Sexual education and sexuality were likewise topics in the medical field. The most notable Finnish sexual educators were the physicians Konrad Relander (later ReijoWaara) and Max Oker-Blom (Turpeinen 1991). The health journal Terveydenhoitolehti (founded in 1898) emphasized the value of health and chastity and enlightened readers regarding the threat of syphilis (Turpeinen 1991).

By the eve of the First World War the hedonistic view of sexuality and relative sexual morality had developed further than ever (Nieminen 1951). There emerged a strong antagonistic movement among people fighting for absolute sexual morality, which in turn brought an enormous increase in the number of publications related to education in chastity (Nieminen 19951). Civil marriage was permitted in 1917; nonetheless among the population at large it did not gain as much support as was expected (Nieminen 1951). The Civil War left wounds which remained open for decades.

In the 1920s social turmoil continued after the war, likewise the process of popular enlightenment. The ecclesiastic authorities began to see the use of contraceptives in marriage as partly acceptable, though the suspicious and cautious attitude persisted (Nieminen 1951).

The early 1930s saw a profound worldwide economic depression, and 1939 brought the outbreak of the Second World War. Simultaneously the Great Depression set in, bringing shortages of nutrients, energy and almost all necessities. Rationing was imposed and was maintained on the average for 15 years (Valvanne 1991). In Finland sterilization was prohibited by criminal law up to 1935, being permitted only for women's health, this being a decision between a physician and woman (Hemminki et al. 1997a). Gonorrhea and syphilis were the most common sexually transmitted diseases (STDs) in this period (Hiltunen-Back

and Ranki 2000). The first domestic condoms were manufactured by Suomen Gummitehdas in 1937 (Palo-Oja and Willberg 1998), not however available to everyone, as they were sold in pharmacies. Eugenic reasons for sterilization were accepted in a law introduced in 1935 (Hemminki et al. 1997a). The law allowed both sterilization and castration by the National Board of Health without a person´s or custodian´s consent. People had the possibility to request sterilization if they expected to have handicapped children (Hemminki et al. 1997a).

At the beginning of the 1940s the Second World War cast its shadow over the country; the nation had a heavy burden to bear. After the war the number of marriages and births increased, producing the so-called baby boom (Auvinen 1991). The Great Depression continued. Rebuilding began at the end of the 1940s. The spread of gonorrhea and syphilis was substantial (Leinikki and Rostila 1994), and the use of condoms was promoted. The Family Federation was established in 1941 (Taskinen 1991, Nieminen 1993), the aim being to promote children's´, mothers´ and families´ well - being (Taskinen 1991). In 1948 the Ministry of Education established an expert team, drawn from the educational and medical fields, the outcome of whose planning work was Finland's first general scheme for sexual and moral education (Sievers et al. 1974). A state-financed guidebook "Perhekasvatusta tehostamaan" was distributed for example to various schools and youth organizations (Sievers et al. 1974).

A process of rapid urbanization was seen in the 1950s. The proportion of people who made their living from agriculture decreased rapidly (Riihinen 1980). Owing to the numbers of "hasty" marriages during the postwar period, the divorce rate increased (Auvinen 1991). In the same period Professor Alfred Kinsey made his extensive survey of women's and men's sexual behavior. The Kinsey report dealt with sexuality more openly than ever before, and provided a basis for sexual research in the coming decades in Finland as elsewhere (Sievers et al. 1974). The Family Federation of Finland commenced publication of the journal Avioliitto ja Lääkäri in 1950, its focus being on gynecology and social medicine (Auvinen 1991).

In the 1950 sterilization law women's health reasons were included, which in turn gave a possibility to use sterilization as a contraceptive method; otherwise the law had the same principles as those given in 1935 (Hemminki et al. 1997a). The first Abortion Act was adopted in 1950. The indications for induced abortion were medical, eugenic and ethical (Aborttilaki 1950). The Family Federation implemented sexual counseling and gave support to women and couples struggling with unwanted pregnancies (Auvinen 1991). At beginning of the 1950s the elementary school curriculum included items touching upon sexual education albeit in the "birds and bees" spirit (Sievers et al. 1974). Textbooks for the higher grades were slightly better, but confined nevertheless to a presentation of the sexual organs (Siever et. al. 1974). After the mid 1950s ideas were expressed concerning the need for sexual education in a variety of spheres (Sievers et al. 1974). However, the sexual education provided in schools remained very limited.

The appearance of the Pill in 1960 can be seen as a turning-point in woman's life. In Finland it was registered in 1962 (Kosunen 1996). For the first time women had at their disposal an effective contraceptive method and were simultaneously freed from the fear of unwanted pregnancies and forced marriages. Condom slot-machines were placed in public areas, for example in restaurant toilets. Attitudes became more liberal, sexuality was no longer a matter confined to marriage and for the purpose of producing children (Auvinen 1991). Thanks to new birth control methods sexuality was seen as a means to pleasure (Auvinen

1991). In spite of the liberalized atmosphere, however, negative attitudes against birth control emerged in the public sector (Sievers et al. 1974). The spring of 1965 came to be called the ”sexual spring ”. Debate arose relating to sexual questions (Sievers et al. 1974). Issues of undergraduates´ and medical students´ magazines were devoted to sexual matters. The Lutheran Church's representatives were ready to consider sexual questions for discussion in 1966 (Sievers et al. 1974). Emigration to Sweden was lively; the number of emigrants was about 40000 around 1969-70 (Strömmer 1991). The long-term impact of this development was reflected in the birthrates at the time (Riihinen et al.1980). For example in Sweden in 1970 the number of deliveries among Finnish fertile-age female emigrants was 5756. If they had delivered in Finland, the number of births there would have been raised by 9% (Riihinen 1980). The first abortion law failed to solve the problem of illegal abortions. According to the Abortion Committee about 19000 illegal abortions were performed in 1966 (Aborttilakikomitean mietintö 1969). The preparation of a new liberal abortion law was under way. In a variety of sectors the importance of sexual enlightenment was acknowledged, but actual measures remained sporadic and sexual instruction in schools remained particularly scant (Sievers et al. 1974).

Many legal reforms and lively debate concerning sexual matters took place during the seventies. The media were also involved (Nurmi 1993). Co-habitation became more common and relationships were seen as private matters (Nieminen 1993). In this decade Sievers and co-workers made their exhaustive study of Finnish people's sexual life (Sievers et a. 1974). Copper-releasing IUDs were introduced in 1972 (Hirvonen and Idänpään-Heikkilä 1990). The Family Federation of Finland commenced sale of contraceptives (barrier methods) by mail (Auvinen 1991).

The Sterilization Law was renewed in 1970, contraception and social considerations now being introduced as new reasons for sterilization (Sterilisaatiolaki 1970). Other aims were to eliminate forced sterilizations, to reduce sterilizations conducted in connection with abortions, and to promote male sterilization (Hemminki et al. 1997a). The Abortion Act was renewed in 1970, social grounds being accepted as sufficient reason for an induced abortion (Aborttilaki 1970). The law emphasized the essentiality of contraceptive counseling for those who had undergone induced abortion. There was vigorous debate on induced abortions at the end of the 60s prior to the new law and at the beginning of the 70s after its introduction (Sievers et al. 1974, Nurmi 1993).

The Primary Health Care Act in 1972 legislatively established family planning as a part of health centre duties (Kansanterveyslaki 1972). In 1972 the National Board of Health issued national guidelines on contraceptive counseling (Lääkintöhallitus 1972). Ninety per cent of municipal health centres had commenced family planning counseling by the year 1976 (Sukupuolikasvatustyöryhmän mietintö 1979). The Abortion Act was revised once more in 1979 (Lääkintöhallitus 1979). The time limit for pregnancy termination changed from 16 gestation weeks to 12 in cases involving social reasons. Simultaneously Parliament undertook to ensure that family counseling be easily available to the population. Debate on sexual education in the schools commenced on a substantial scale following the spring of 1965 (Sievers et al. 1974). The matter was taken up in the 1970 report of the comprehensive education planning committee, whereby sexual education was included as a part of the subject termed civic skills (Sievers et al. 1974). Though in itself no more than indicative, the report nonetheless evinced official awareness of the importance and the general precepts of sexual education (Sievers et al. 1974). In 1972 a working committee appointed by the

Ministry of Education set about outlining a syllabus for sexual education in the comprehensive schools (Sievers at al. 1974).

The National Board of Health issued guidelines on human relations and sexual education in 1980 (Lääkintöhallitus 1980) and new guidelines on contraceptive counseling in 1982 (Lääkintöhallitus 1982). Family planning services were developed and put into practice purposefully during the 80s (Rimpelä et. al. 1996). Contraceptive counseling was conducted in family planning clinics located in health centres or during consulting hours, in the schools or in student health care. First-time contraceptive users received pills and IUDs free of charge (Liinamo et al. 1999). The number of abortions fell especially among teenagers during the 1980s (Kosunen and Rimpelä 1996, Mandelin 1997). The incidence of sexually transmitted diseases such as Chlamydia, human papilloma virus (HPV) and herpes increased while the number of syphilis and gonorrhea cases declined (Kontula and Haavio-Mannila 1993, Hiltunen-Back and Ranki 2000). Contraceptive counseling faced new challenges in the 1980s with the appearance of the Acquired Immune Deficiency Syndrome (AIDS) (Kosunen 1996). In Finland the first AIDS cases were diagnosed in a research project in 1983 (Valle et al. 1983). The sterilization law was altered in 1985 to allow sterilization upon request if the recipient was 30 years old or had three children (Hemminki et al. 1997a). The 1989 health and eroticism report published by the Terveyskasvatuksen neuvottelukunta included e.g. data on the impact of sex on health and future views on eroticism (Nurmi 1993). This report provoked lively discussions both nationally and internationally (Nurmi 1993).

1.4 Family planning in Finland in the 1990s

The Primary Health Care Act is still in force and the municipalities have the same responsibilities to take care e.g. of the arrangement of family planning services. A population-based responsibility system was tried out in certain areas of the country at the end of the 1980s (Aro et al. 1993). According to the national plan all municipalities should have a primary health care population-based responsibility system by the end of the year 1996 (Valtakunnallinen suunnitelma 1991). In 1995 62% of municipalities had adopted such a system (Kangas 1998). Population-based responsibility for primary health care seems to have accelerated access to care at health centres, and to have improved the continuity of care (Guidelines on health care in Finland 1999).

The law on state subsidization was revised in 1993 (Laki sosiaali –ja terveydenhuollon suunnittelusta ja valtionosuudesta 1992). The main objectives of the reform were to enhance municipal autonomy and to promote economy and efficiency in their operation (Public Health Report 1996). It offered the municipalities a new possibility to organize their social welfare and health services as they saw fit (Public Health Report 1996). Since, however, the reform coincided with a moment in the economic cycle in which the municipal economies were in considerable imbalance, it is difficult to evaluate its impact (Public Health Report 1996).

In 1990 a study was made in ten health centres belonging to the population-based responsibility project (VPK) (Koponen et al. 1992). One cohort of respondents comprised health centre physicians. They were asked e.g. which part of health centre work they had taken part in before the population based-system project and their current workfield. It

emerged that the amount of e.g. mother, child and contraceptive counseling work had increased during the survey period.

In 1994 study was made of , among other things, use of healthcare services in the context of contraception in a random sample (n=3000) of women aged 18-44 years (Hemminki et al. 1997b, Hemminki et al. 1998). They were asked about their latest contraceptive visit to a care provider and care site. Of those who had visited a public health unit 46% had seen a general practitioner (Hemminki et al. 1997b). The use of private gynaecological services was more common among women who had higher education and lived in the capital area (Hemminki et al.1998).

In 1995 a survey was carried out on the municipal service structure, the sample comprising municipalities with more than 5000 inhabitants (n=185) (Kokko 1997). From this material it emerged that 27% of the municipalities arranged contraceptive counseling as a part of population-based responsibility or under a broader work scheme, in 31% contraceptive counseling was carried out totally separately, while in other municipalities these services came partly under population-based responsibility (Koponen et al. 1998). It was found that contraceptive counseling services were implemented separately more often compared to other health promotion services in health centres implementing population-based responsibility (Koponen et al. 1998). Moreover, FP services were implemented separately more often in municipalities below 10000 inhabitants than in larger municipalities (Koponen et al. 1998).

In 1995 Myllykangas and his co-workers studied attitudes to cuts and increased fees in health care in various Finnish population groups (Myllykangas et al. 1997). The material comprised: 1) a population sample of 2000 subjects aged 18-70 years derived randomly from the Finnish National Population Register; 2) a random sample of 1500 physicians derived from the register of the Finnish Medical Association; 3) a random sample of 1000 nurses derived from the register of the Finnish Nursing Association, and 4) a sample of 2200 politicians involved in health and social administration. The list of politicians was obtained from the Finnish Community Association. Respondents were asked e.g. which of the 18 specified medical activities at the primary health care level could be cut without causing severe harm to the population. Most respondents in all groups were most willing to cut expenditure on health education, occupational health services, hygiene inspection, substance abuse care, rehabilitation services for war veterans and family planning. Of the physicians 11%, of the nurses 12%, of politicians 17% and of the general public 18% would accept cuts in expenditure on family planning.

Nowadays schools also have the possibility to decide whether or not their curriculum should include sexual education and contraceptive counseling (Rimpelä and Ritamo 1995). In a school health study during 1996 and 1997 made among 8th and 9th class comprehensive school students it was found that the amount of sex education was lower than ten years previously, and that contraceptive counseling given by school nurse and physician had been reduced (Liinamo et al. 1999).

The National Research and Development Centre for Welfare and Health launched a development project Family Planning 2000 in 1994, the objective being to develop family planning (Ritamo and Kautto 2000). A common goal has been to improve the service system and to test new innovative models in addition to providing information. Promoting

professional training has also been considered important. The achievements of the project were notable.

Family planning services have been determinedly developed over a number of decades and not without success (Kosunen 1993, Rimpelä M et al. 1996). Internationally compared the Finnish abortion rate has been one of the lowest (Mandelin 1997, Rasimus 1999), although in 1995 the declining trend in the total number of abortions ceased and begin to reverse, the increase being 10% between the years 1995 and 1998 (Vikat et al. 1999). The number of abortions per thousand women aged 15 to 49 was 7.8 in 1995 and 8.6 in 1998 (Vikat et al. 1999). Major changes in abortion rates were noted in the following age groups: 15-19 years, 18-19 years and 30-34 years (Vikat et al. 1999).

Family planning counseling has met new challenges since the mid-1990s. The incidence of Chlamydia began to increase after 1995 (Paavonen 2002). In the former Soviet Union, particularly in Russia and Estonia, rates of STDs increased dramatically in the 1990s (Lottes and Kontula 2000), this in turn meaning that an increasing number of Finns, especially men, are contracting STD due to increased travel and mixing with populations of Russia and Estonia (Lottes and Kontula 2000). Subsequently such men pass the diseases to their partners (Lottes and Kontula 2000). The number of syphilis infections also doubled in 1995 due to prostitution in Russia (Reunala and Hiltunen-Back 2002). Efficient information campaigns concerning AIDS have continued, with the result that the number of people infected with HIV has remained internationally compared low (Nurmi 2000). The route of transmission of HIV via intravenous drug use is a new concern for health personnel (Lottes and Kontula 2000).

1.5 Changes in marital status, live births and fertility rates

The structure of the marital status has changed over the years. According to Murdock marriage is a central social institution which has internationally the following tasks: control of sexual life, procreation, care and rearing of children and a function as a consumer unit (Murdock 1949). Due to changes in society, e.g. industrialization and urbanization, the impact of marriage and family has changed (Sievers et al. 1974). The number of consensual unions increased from the 1960s onwards (Nieminen 1993). Thus in the 1950s the annual mean number of marriages was 32191 while in 1995 the figure was 24317 (Miettinen 2002). According to a Finnish study made in 1971 the number of consensual unions was 0.7% (Sievers et al. 1974), the figure being 17.9% of all unions in 1994 (Miettinen 2002).

Finland's formerly high birth and mortality rates fell permanently from the 1870s on (Riihinen et al. 1980). The alteration in population structure began with a decline in the death-rate, but lowering of the birth-rate gradually became the more prominent factor (Riihinen et al. 1980). The annual mean for live births has declined markedly from 1910 to 2000 (Table 1). In 2000 the number of live births was 56742 (Miettinen 2002) In the light of figures for total fertility a woman prior to 1910 would bear 4-5 children as against about 1-3 to 1960 (Table 1). The total fertility rate was 1.73 in 2000 (Miettinen 2002). The pattern of fertility trends over the last 35 years- a rapid and sizeable decline followed by a period of smaller fluctuations, has been accompanied by an increase in the median age of mothers at first birth (Vikat 2002). For example between 1961 and 1965 the median age of mothers at first birth was 23.25 years, while in 2000 it was 27.30 (Miettinen 2002).

Table 1. The total fertility rate for women and the annual mean live births in Finland from 1901 to 2000. Figures calculated from the statistics of Statistics Finland updated/published by Miettinen.

Year	Total fertility rate per woman	Live births (annual mean)
1901-1910	4.68	90292
1911-1920	3.81	83045
1921-1930	3.10	78184
1931-1940	2.39	70584
1941-1950	2.99	92613
1951-1960	2.88	88024
1961-1970	2.37	76466
1971-1980	1.65	62789
1981-1990	1.69	62534
1991-2000	1.75	61673

1.6 Contraceptive practices

During the study various kinds of literature turned up from international databases and it was difficult to discern what kind of information the literature actually gives. This led to the need to analyze the databases more thoroughly, and to study their applicability for a contraceptive practice researcher.

1.6.1 Databases (VII)

Medline is seen among medical researchers as a reliable source of scientific information, and this database was thus chosen in this work. Popline and Sociological Abstract databases were used to widen the search, since contraceptive use is not solely a medical issue. Moreover, discussions with the University Information Specialist confirmed that these databases yield most references on contraceptive practices.

Medline is produced by the U.S. National Library of Medicine and contains all records published in the Index Medicus, providing unparalleled access to worldwide biomedical literature from 1966 to the present day. The database contains a broad range of medical topics relating to research, clinical practice, administration, policy issues and health care services (National Library of Medicine, USA, 2001).

Popline (population information online) is produced by the Population Information Program at the Johns Hopkins University Center for Communication Programs. The system covers primarily English-language items but is international in scope, holding publications from 1970 to the present with selected citations dating back to 1886. Popline provides worldwide coverage of population, family planning and related health issues, including family planning technology and programs, fertility and population law and policy (Population Information Program, Johns Hopkins University Center, 2001).

The Sociological Abstracts database provides abstracts of journal articles and citations of book reviews, abstracts of books, book chapters, dissertations and conference papers from 1963 to the present. It is supplied by Sociological Abstracts, San Diego, USA.

To find contraceptive practice studies via the international databases the first phase was to decide on the kind of search terms used. The help of a trained librarian proved invaluable.

Search terms used in Medline were *"contraception behaviour"* (Mesh term), which is described; behaviour patterns of those practising contraception. This includes contraceptive usage, contraceptive methods chosen and contraceptive method switching. *"Contraception"* (Mesh term) is defined as use of agents, devices, methods or procedures which diminish the likelihood of or prevent conception. Contraception was used by focusing on methods, utilization and trends. *"Contraceptive practice"* was searched from titles and abstracts. In Popline the search term was"*contraception behaviour".* In Sociological Abstracts *"contraceptive use", "contraceptive method", "contraceptive practice"*, and the search was made from titles of publications.

After the search there was a list of references, part of them including an abstract. The author studied the material received, the aim being to find good-quality epidemiological studies on

adults´ contraceptive practices. After a preliminary perusal references which contained information on contraceptive use were ordered via the library or interlibrary loan for proper scrutiny.

The author studied the publications received. Part of them proved to describe material and sampling processes insufficiently. To find out the kind of information publications gave the author developed a classification system whereby it was demanded that the following facts be included in the study: survey year, country, survey method, number of respondents and response rate or size of a sample, and number of respondents or refusals. The studies were then classified: *Nationally representative* meant that the sample was derived from a national source (e.g., national population register) which is reliably and adequately described. *Regionally representative* were those in which the region (tract of land or smaller area such as a city) and the source of the sample were reliably and adequately described. *Representing specified groups* were those which reliably described what the group represented. *Not sufficiently defined* were all other contraceptive studies which did not meet the above requirements.

1.6.2 References and abstracts (VII)

Medline produced 366, Popline 144 and Sociological Abstracts 28 references concerning the above-mentioned topics (Figure 1). In the search process, references might emerge from a number of bases, and these were naturally included only once in the find summation. Medline and Popline yielded 25 identical references, Medline and Sociological Abstracts 9, and Popline and Sociological Abstracts 1. The number of references to be found in all three databases was zero. The number of references for further process was: Medline 366, Popline 120 and Sociological Abstracts 18. A detailed list of references is available from the author.

Fifty-seven of the references lacked an abstract, five of them were books; these references were omitted from further study. The number of abstracts in English was 319 in Medline, 119 in Popline and 9 in Sociological Abstracts (Figure 1).

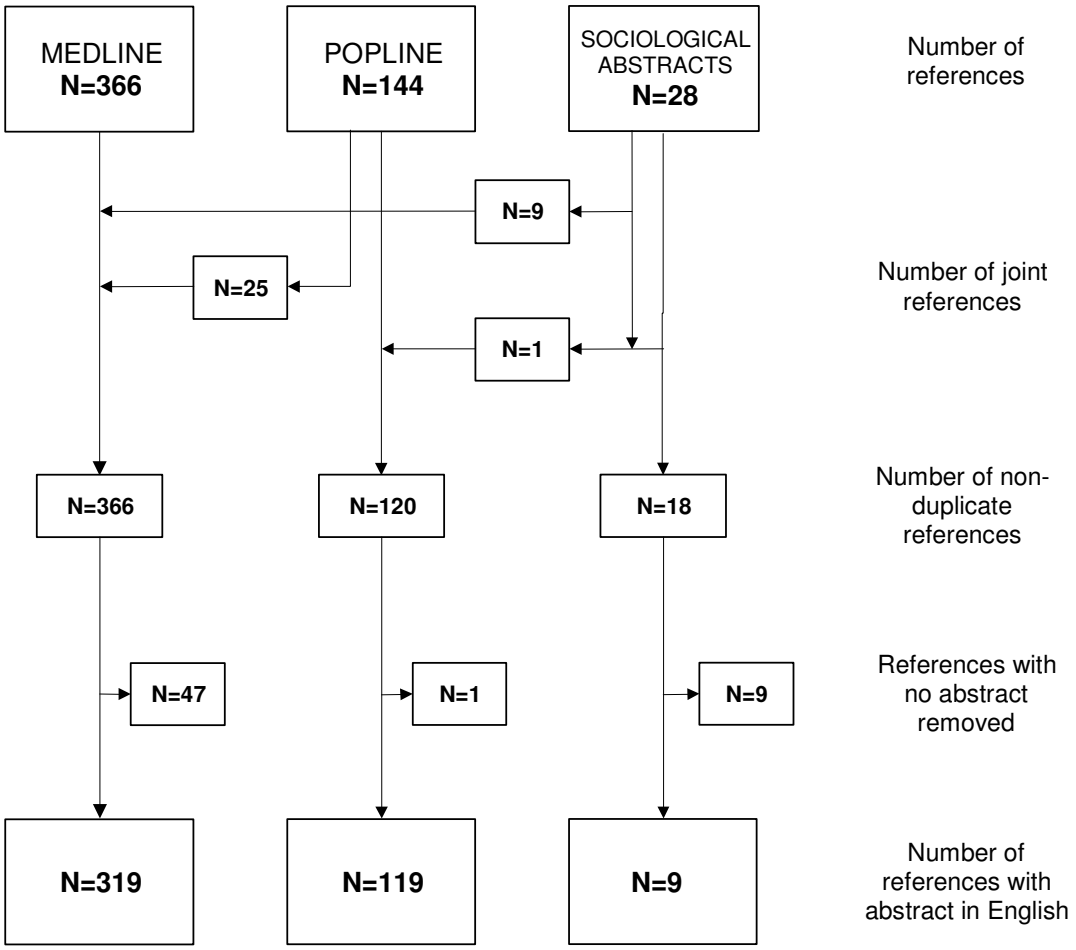

Figure 1. Process of gathering epidemiological contraceptive practice abstracts using Medline, Popline and Social Abstracts databases from 1990 to 2000.

Of all publications, 59 were in ten other languages, although the abstract was in English (Figure 2). Languages ranged from Thai to Russian. There were a total of 165 abstracts which did not deal with contraceptive practices and these publications were omitted from further study.

The aim here was to concentrate on adult contraceptive practices. Studies in which the study population comprised only adolescents (∠18 years), altogether 42, were omitted. In many studies a part of the respondents were adolescents, and their results could not be separated. These studies were included in the analysis. Based on this selection the numbers of publications ordered were 110 in Medline, 57 in Popline and 6 in Social Abstracts (Figure 2).

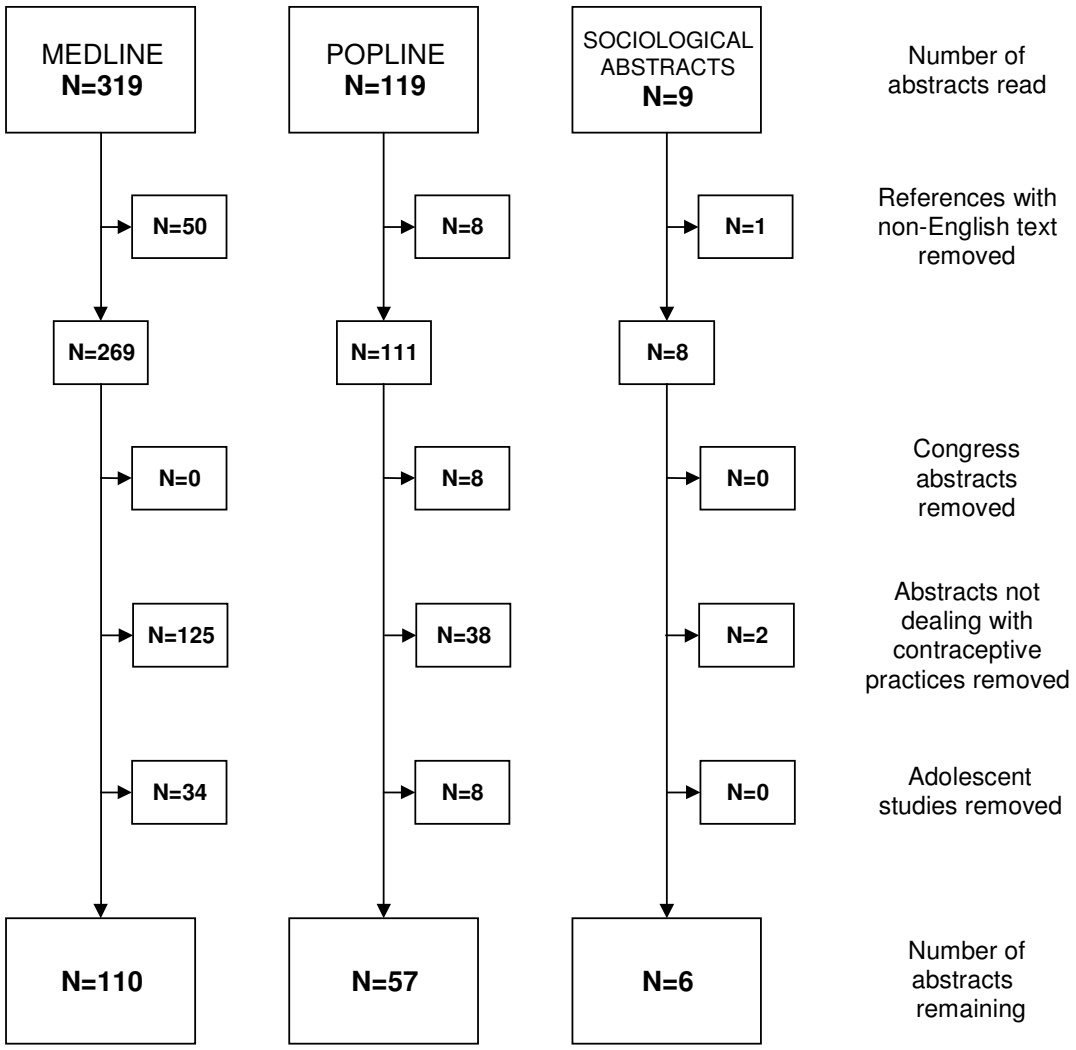

Figure 2. Process of evaluating epidemiological contraceptive practice abstracts from Medline, Popline and Sociological Abstracts databases from 1990 to 2000.

1.6.3 Publications (VII)

Six of the publications, however, proved to deal with adolescent's contraceptive practices; the target group was simply not brought out in the abstract, and these studies were omitted in this phase (Figure 3). Also, studies (n=69) which did not include precise or original data on contraceptive use were excluded as miscellaneous. Of these, 51 did not include original data; 13 did not include precise data and 5 presented only tables on contraceptive use without proper text. These studies were descriptions of data from various studies made by different researchers. Five publications proved unobtainable even via interlibrary loan. The numbers of publications which dealt with adult contraceptive use for the final categorization were 62 in Medline, 28 in Popline and 3 in Sociological Abstracts.

Classification was made according to the system described in chapter 1.6.1. Medline yielded 3 publications for the first class, 1 for the second, 13 for the third and 45 for the fourth class (Figure 3). Popline and Sociological Abstract Databases did not include any publications in the first class. Most publications were in the fourth class in Popline.

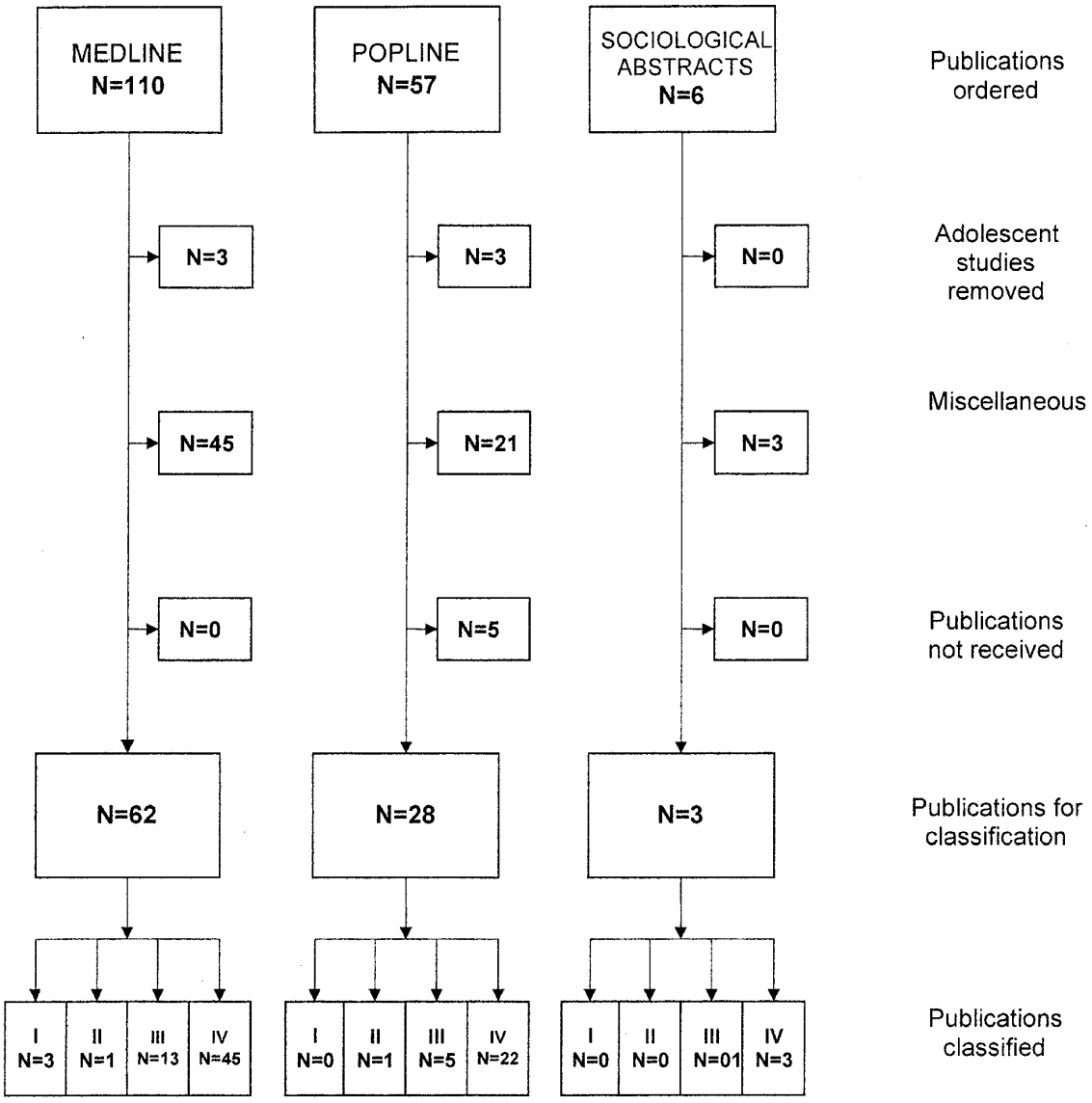

Figure 3. Process of evaluating publications dealing with epidemiological contraceptive practices from Medline, Popline and Sociological Abstracts databases from 1999 to 2000.I=nationally representative, II= regionally representative, III= representing specified groups and IV= not sufficiently defined.

1.6.4 Usefulness of Medline, Popline and Sociological Abstract databases in contraceptive research (VII)

In the present work the time period ranged from 1990 to the end of 2000 in respect of international contraceptive practice studies.

The number of references and the diversity of abstracts and publications was a surprise. The keyword “contraception” alone produced nearly 15,000 references. Mesh terms used in the present study produced a crop of over 500 references, yielding a final total of 93 publications for evaluation. For comparison a search was made by Google and Altavista search engines. Google produced 40700 references and Altavista 14355 references with the keyword “contraceptive practices”. These search systems produce an enormous number of references which do not include scientifically evaluated information.

Various weaknesses were noted in the publications; e.g. publications without abstract turned up in significant numbers. Using an abstract the author/s can give an insight into the publication and increase its attractiveness. Both good and inadequate abstracts were noted. One should not forget that a good study may forfeit attention if the abstract is inaccurate.

It is difficult to understand why international databases contain items where the only information provided consists in names of author/s, title and source of publication. In more extensive data collection, one cannot, for financial if for no other reasons, undertake to order literature solely on the basis of titles.

There were 59 publications in other languages than English. As mentioned above, the languages ranged from Russian to Thai. The present writer would surmise that the business of having, for example, one Thai article translated would have involved considerably more difficulty and expense than the information ultimately yielded would warrant. Here it must of course be conceded that were the majority of available material in languages other than English, translation would be essential to avoid research bias.

Furthermore, if a study description is very complicated, e.g., contains numerous abbreviations or acronyms without explanation, it will sometimes be extremely difficult to understand the process. Nor should one forget that the study process should be so clearly presented that anybody can repeat the study by following the procedure as described.

It has been noted that even well-prepared database searches find only 50-70% of relevant publications (Dickersin et al. 1994). When a researcher makes a systematic literature review, other sources have to be taken into account (Mäkelä et al. 1996). A systematic approach also entails a follow-up of the references appended to articles found (Mäkelä et al. 1996). On the basis of this yield between 3 and 6 most important publications may be selected in which the survey topics are discussed. Searching through the annual issues of these the researcher may then come upon publications in which the indexing of keywords diverges from the established format (Mäkelä et al. 1996). Useful accounts may also be found in the records of for example symposiums and in the so-called "grey literature", for example material published by various authorities and in the industrial sector (Mäkelä et al. 1996).

The present study revealed Medline, Popline and Sociological Abstract databases to be of but limited value to a researcher and the researcher must be alert and critical throughout and use various other information sources such as those mentioned above.

1.6.5 International studies

This review concentrates solely on contraceptive practices in European countries (http://www.who.org). Comparison between Finland and countries nearby was the most reasonable; a study of practices worldwide would have constituted an excessively broad context. In article VII, which deals with the use of international databases, countries outside Europe were, however, included.

Several United Nations publications in fact contain reviews of contraceptive use worldwide (e.g. United Nations 1996a, United Nations 1996b). Their material is presented in reference tables of national surveys concerning current contraceptive use by method for all available countries and dates. Since however the original papers are not available, these studies have been omitted from the present review of the literature.

In Norway data were collected as a part of a Norwegian fertility study conducted in 1988. The sample comprised 4933 women aged 20-43 years selected at random from the Central Population Register (response rate 81%); the women were personally interviewed. Those selected were fecund, sexually active and not pregnant. Respondents were asked about the contraceptive methods they had used during the month prior to the interview. Of the total respondents 30% used IUDs, 21% OCs, 15% condoms, 14% female sterilization, 5% male sterilization and 6% coitus-dependent methods, e.g. withdrawal, safe periods, foam and sponge (Skjeldestad 1994).

An extensive survey of sexual behaviour was carried out in Britain between May 1990 and November 1991 (Wellings et al. 1994) among women and men aged 16-59 years. The aims were to obtain information helpful in assessing and preventing the spread of HIV, to collect data which would increase the understanding of the transmission patterns of HIV and other sexually transmitted infections, and would aid in the selection of appropriate and effective health education strategies for epidemic control. A random sample (n=50010) was picked from the small-user Postcode Address File. After removing out-of-scope (i.e. non-residential institutions, not yet built residencies or residential but vacant) and ineligible addresses (persons not belonging to the age group 16-59 years) there were 29802 potentially eligible addresses, constituting the basic response-rate dominator. Interviews were completed with 18876 respondents, giving an overall response rate of 63.3%. Interviewed respondents were asked to list all contraceptive methods they had used in the past year. Twenty-nine per cent reported the use of OCs, the corresponding figure for the men's partners being 30%. A condom was used with partners by 26% of the women and 37% of the men. Among women and men 13% reported the use of male sterilization, the figures for female sterilization being 11% among the women and 9% among the men´s partners. An IUD was used by 7% of the women and 5% of the men's partners, and withdrawal by 4% of the women and 7% of the men. Two per cent of the women and the men's partners had used a diaphragm. Of the women 2% and of the men 3% reported using the safe period with their partner. The use of sponge and douche was below one per cent among both the women and men's partners.

In 1991 a national survey of knowledge, attitudes and practice with regard to contraception was carried out in the Czech and Slovak Federal Republic (Ketting et al. 1993). More detailed information on the sampling process was not given in the article cited here. The sample size was 1175 women aged 15-44 years; the response rate was 91.2%. Respondents filled out a questionnaire at home in the presence of an interviewer. The number of women

who were in need of contraception was 838 (78.2%). The current use of contraceptives was as follows: natural methods 32%, condom 29%, IUD 17%, pill 7% and sterilization 3%.

Oddens and associates made a survey of contraceptive use and attitudes in Great Britain in 1992 among women aged 15-45 years (Oddens et al. 1994a). All the women who took part in a consumer survey carried out by the National Opinion Poll Services (London) and who were aged 15-45 were invited to participate in the study. These women had been selected according to a two-stage stratified design. A systematic sample of 180 constituencies had been drawn from 631 parliamentary constituencies in the United Kingdom (with the exception of Northern Ireland), on the basis of the size of the electorate in each constituency. Subsequently the respondent's names were randomly drawn from the Electoral Registers for the selected constituencies. The women concerned were contacted in their homes by specially trained fieldworkers. If the subjects were not at home, call-back visits were made, mainly during the evening, on up to a maximum of four occasions. Women aged 15-17 (who were not on the Electoral Registers) were invited to take part by selection from within the households visited. Where more than one of these appeared to belong to the household their first names were listed in alphabetical order and one of them was invited to take part according to ranking numbers indicated on the questionnaires. A self-administrative questionnaire with a return envelope was mailed to the sample. The eventual sample size was 1753 women, the response rate being 55.2%. The items covered current contraceptive use by exposed women, i.e. those women who were sexually active, not pregnant or wishing to get pregnant and not infertile. The percentage of exposed respondents was 67.1% (649). Of these 36% used OCs, 21% barrier methods, 16% male sterilization, 10% female sterilization, 7% IUDs, 3% OCs plus barrier methods and 1% withdrawal.

In reunified Germany a survey was made of women (n= 1265) aged 15-45 on contraceptive use in 1992 (Oddens et al. 1994b). The sample was obtained by random-walk approach, whereby fieldworkers from a survey agency collaborating in the study followed designated routes throughout the country, starting from 275 predetermined locations. They identified suitable subjects by visiting their homes and inviting the woman in each household whose birthday fell first to participate. A questionnaire was handed over for self-administration and picked up approximately 1 week later. The response rate was 84, 1%. Of all respondents 52% had used OCs, 12% IUDs, 10% condoms, 8% female sterilization, 3% male sterilization and 1% withdrawal.

In Italy in 1993 a survey was conducted of current contraceptive use and attitudes among women aged 15-45 years (Oddens 1996). The sample (n=2000) was obtained by random-walk as described above (Oddens et al. 1994b), covering the entire country, including Sicily but excluding Sardinia, starting from predetermined locations selected on the basis of regional quotas and the degree of urbanization. Female fieldworkers identified suitable subjects by visiting their homes and inviting them to participate. Recruitment took place both during the day and in the evening. A questionnaire was handed over for self-completion and picked up by appointment approximately 1 week later. The response rate was 77.1%. Contraceptive use was studied among exposed women (n=1542), i.e. those women who were sexually active, not pregnant or wishing to get pregnant. Of all respondents 31% used barrier methods (condoms, diaphragms and/or spermicides), 30% used OCs, 18% withdrawal, 8% IUD and 1% sterilization.

In 1993 a survey was carried out in Romania covering reproductive health issues among women (n=5283) (Serbanescu et al. 1995). The population from which the respondents were

selected included all women between the ages 15 and 44, regardless of marital status, who were living in Romania between July and December 1993. The 1992 census was used as the sampling frame. The response rate was 92%. Of those responding 35% currently used withdrawal, 8.4% rhythm, 4.3% IUD, 4.1% condom, 3.2% oral contraceptives, 1.4% tubal ligation and 0.8% spermicides.

In France 2944 women and 1941 men aged 20-49 were interviewed on their current contraceptive practices in 1994 in a Fertility and Family Survey (Toulemon and Leridon 1998). A total of 5900 households were selected from among 75000 households approached in an annual study of employment. The survey selected the respondents after considering the number of adults aged 20-49 years living in each household and the structure of the household. The response rate was for women 84% and for men 79%. Of the women 36% used OCs, the figure for men's partners being 34%; 16% of women reported using an IUD, the percentage for men's partners being 14. Of the women 5% and of men 8% reported the using condoms with their partners. Female sterilization was used by 4% of women and 3% of men's partners. Male sterilization was very seldom used, the figures for the women's partners being 0.2% and for the men 0.3%. Withdrawal was used by 2% among both women and men.

In 1994 a random sample of Swedish women aged 15-45 years were interviewed on contraceptive practices (Oddens and Milsom 1996). The sample was obtained by a random stratified telephone approach. Household telephone numbers were drawn from the 28 telephone directories which cover Sweden, in proportion to the number of listings in each directory. Fieldworkers from the survey agency which conducted the study contacted women in the selected households in a maximum of three attempts. Telephone recruitment took place both during the day and in the evening. A self-administered questionnaire with return envelope was mailed to selected persons. The response rate was 61%. Contraceptive use among respondents was as follows: 23% used OCs, 21% condoms, 17% IUDs, 3% female sterilization, 2% male sterilization, 3% OCs + barrier method and 2% withdrawal.

In 1996 the Swedish National Institute of Public Health made a survey of sexuality and health among women and men aged 18-74 years in (Lewin et al. 2000). The material comprised a random sample derived from the national population and address files. The net sample was 4781, the response rate being 59%. Respondents were asked about contraceptive methods used during the latest intercourse (Lalos 2000). Of the women 20% and of the men's partners 21% had used OCs, stick or spray; 14% of the women and 15% of the men reported use of condom with their partners and 15% of the women and 12% of the men's partners had used an IUD. Twelve per cent of the women and 14% of the men had used withdrawal with their partners, 8% of the women and 3% of the men reported being sterilized and 4% of the women and 3% of the men reported use of rhythm.

In St Petersburg a survey was carried out among women and men aged 18-74 years on their life habits, one part dealing with contraception (Haavio-Mannila and Kontula 2001). The sample was randomly derived from the electoral list. The net sample was 3419, the total response rate being 61%. Respondents were asked about the contraceptive method used during the latest intercourse within one year. Results are presented among respondents between 18 to 54 years. Altogether 23% of the women and 32% of the men had used a condom with their partners; an IUD was used by 18% of the women and 7% of the men's partners. Oral contraceptives, foam or emergency contraceptives were used by 13% of the

women and 8% of men's partners. Rhythm was used by 17% of the women and by 14% of the men; 12% of both women and men had used withdrawal.

In Estonia in 2000 the Emor Research Institute made a survey of sexual habits among women and men aged 18-74 years (Haavio-Mannila and Kontula 2001). This was one of the Institute's regular monthly Omnibus studies. The net sample was 2500, the total response rate 41.2%. Respondents were asked about the contraceptive method used during the latest intercourse. Of the women 35% and of the men's partners 21% had used an IUD. Oral contraceptives, foam or emergency contraception was used by 11% of women and by 13% of men's partners; 19% of both women and men had used withdrawal, 14% of the women and 8% of the men rhythm with their partners. Of the women 12% and of the men 26% had used a condom with their partners.

Summary of international contraceptive practice studies: the spectrum of the sampling processes in the studies varied considerably. In some works the mode of proceeding was difficult to understand by reason of excessively complicated explanations. Reporting, especially concerning the sampling process, was inadequately conducted. Oral contraceptives, condom and IUD proved to be the most popular methods in most of the countries where contraception was studied. Withdrawal and rhythm were used fairly widely in the Czech and Slovak Federal Republic (Ketting et al. 1993), in Italy (Oddens 1996), in Romania (Serbanescu et al. 1995), in Russia (Haavio-Mannila and Kontula 2001) and in Estonia (Haavio-Mannila and Kontula 2001).

1.6.6 Finnish studies

It can be said that apart from a couple of smaller studies on contraceptive use, research on a larger scale commenced at the beginning of the 1970s. In view of respondents´ age range it is logical to start the review of studies from 1970.

In 1971 a survey was made among 18-54 years women (n=1590) and men (n=902) on sexual life (Sievers at al. 1974). The cohort was a random sample drawn from the National Population Register. Respondents were personally interviewed by trained interviewers. The total response rate was 91.4%; for women 92.7% and for men 89.2%. Respondents were asked about their current and past contraception practices. The percentages of ever use of contraceptives among all respondents were: condom 71%, withdrawal 56%, oral contraceptives 38%, rhythm 22%, foam 15%, IUD 5%, diaphragm 4% and douche 4%. Leppo made his academic dissertation in 1978 using the material from this 1971 survey conducted by Sievers and co-workers (Leppo 1978). The work described and analyzed contraceptive practices in the light of social, psychological and medical factors, with special reference to the implementation of findings for public health and policy-making (Leppo 1978).

In 1977 the Population Research Institute arranged a survey on fertility, which was a part of a World Fertility Survey (Riihinen et al. 1980). The sample comprised 6200 married women aged 18 to 44 years. It was derived from the Central Population Register. Women who were divorced, living apart, widowed, in a new marriage, mentally ill, deaf, blind or had lived a long time abroad were excluded from the study. Participants were personally interviewed by experienced interviewers. The response rate was 90.6%. Respondents were asked to name their contraceptive methods during their marriage. Of the total respondents 49% reported the use of condoms during the marriage, the figures being 31% for OCs and 31% for IUDs. Other female contraceptives (not defined) were used by 4% of respondents, withdrawal by 4%, female contraceptives plus condom by 3% and rhythm by 2%.

Since 1978 the National Public Health Institute has annually studied the health habits of people aged 15 to 64 years by postal questionnaire. Respondents are asked e.g. about the use of OCs. The percentage of OC users among fertile-age women (15-44 years) was e.g. in 1979 13% in the South of Finland and 10% in other parts (Puska and Airaksinen 1979), in 1989 22% (Berg et al. 1990) and in 1999 23% (Helakorpi et al. 1999). Percentages were calculated from the samples.

In 1987 and 1988 a random stratified sample of 1000 Finnish women aged 18 to 44 years living in the province Uusimaa was surveyed on contraceptive use (Makkonen et al. 1993). The sample was drawn from the Central Population Register, and respondents received a postal questionnaire. The response rate was 84%. The figures for ever use of various contraceptives were as follows: 87% had used barrier methods (condom 86% and diaphragm 1%), 81% OCs, 48% IUD, 31% withdrawal, 19% chemical methods (foams, jellies and vagitories 18% and contraceptive sponge 1%), 12% natural methods (thermal, symptothermal and ovulation), 7% douche, 5% female sterilization, 4% subcutaneous implants and 1% male sterilization (Makkonen et al. 1991).

In 1989 Statistics Finland made a survey on Finnish women's life course and family formation (Nikander 1992). A random sample (n=5141) of women born in 1938-1967 (age at the time of the study 22-51 years) was drawn from the National Population Register. Women selected were personally interviewed. The response rate was 81.4%. The use of various contraceptives at the time of interview was: IUD 20%, oral contraceptive pills 15%, condom 14%, female sterilization 8%, condom together with some other method 4% (foam, cream, suppository, sponge or diaphragm), male sterilization 1%, contraceptive capsules 1%, rhythm 1%, withdrawal 1%, contraceptive foam, cream, suppository, sponge or diaphragm below 1%.

A National Population Register-based survey of Finnish people's sexual life was carried out in 1991/1992 among 18-74-years women and men (n=2964) (Kontula and Haavio-Mannila 1993). The total response rate was 75.9%, for women 77.7% and for men 74.2%. The use of contraceptives during the latest intercourse among those respondents who were in need of contraception (number not given) was: 28% of women had used OCs or subcutaneous implants, the corresponding figure for men being 22%. Of the women 27% and 40% of men had used condom contraception; 21% of women reported the use of IUD, the figure being 21% among the men's partners. Of the women 11% and of men 8% reported the use of sterilization together with their partner. Withdrawal or rhythm was used by 3% of women and 3% of men, and 4% of women and 3 % of men reported the use of double contraception.

A study of a random sample of women aged 18 to 44 (n=3000) and of men aged 20 to 24 (n=200) and men aged 40 to 44 (n=200) was carried out in 1994 by The National Research and Development Centre for Welfare and Health (Sihvo and Koponen 1998). The sample was again derived from the National Population Register. Selected persons received a postal questionnaire. The response rate for women was 74% and for men 53%. Of the female respondents 25% used OCs at the time of the study, 20% condom (condom alone or with chemical/natural contraception), 18% IUD, 9% sterilization, 5% double contraception (condom + OC, or condom + IUD or condom + contraceptive capsules), 1% contraceptive capsules and 1% chemical contraception (Sihvo and Kosunen 1998). Of the men aged 20-24 years 53% reported that their partner had used OC during the last year, 24% reported the use of condoms. Of men in the age group 40-44 years 29% reported that their partner had used an IUD, the figure for condoms being 22% (Viisainen and Sihvo 1998).

In 1998 and 1999 a study was carried out by Statistics Finland on people's sex trends (Haavio-Mannila and Kontula 2001). The material comprised a random sample (n=3300) derived from the National Population Register, age range 18 to 74 years. Participants received a postal questionnaire. The total response rate was 45.8%. Of the women 52.9% (n=872) and of the men 38.4% (n=634) replied. The contraceptive methods used during the latest intercourse among those who had had intercourse within the last year were as follows: of the women 31% had used OCs, the figure for men's partners being 33%. Of the women 28% reported the use of a condom with their partners and of the men 27%. IUD contraception was used by 24% of women and 22% of men's partners. Of the women 6% reported the use of withdrawal and 7% of men. Rhythm was used by 2% of women and 1% of men with their partners.

In 2000 a national student health survey was carried out among Finnish university students (Kunttu et al. 2001). The target group consisted of Finnish undergraduates aged 19-35 years. The population size was 5030 students; 53.9% were women and 46.1% men. They received

a postal questionnaire. Female respondents were asked e.g. about the use of OCs. The total response rate was 63, 1%. Of the women 50.9% reported of the use of OCs.

Summary of Finnish contraceptive practice studies: sampling processes were properly illustrated and reported. The source of the samples was in most cases the National Population Register. Response rates dropped markedly from the 1970s compared to the 1990s. The use of condoms decreased from the 1970s to the 1990s and oral contraceptives became more popular during the 1980s and 1990s. In the 1990s IUD contraception was used much less than in the 1970s.

1.7 Physicians´ participation in family planning work and prescription practices

In 1988 a survey was made of 318 general practitioners in the three northernmost counties of Norway concerning the frequency of consultations on contraception and the kind of contraception they usually recommended (Halvorsen et al. 1990, Karlsen et al. 1990). The response rate was 75%. Of female physicians 85.6% had consultations for birth control more than twice a week, the figure for male physicians being 55.9% (Halvorsen et al. 1990). Of all respondents 85% had informed the clients about at least three different alternatives: oral contraceptives, intrauterine devices and condoms (Karlsen et al. 1990).

In 1990 Osler and colleagues reported that in Denmark in 1988 95% of OC prescriptions were made by GPs, 4% by gynaecologists and 1% by a family planning clinic (Osler and Riphagen 1990).

A survey was made of 480 Finnish physicians in 1988 (Makkonen 1994). Their fields were gynaecology, specialist in general practice and no specialty. Their names were drawn from the register of the Finnish Medical Association. The actual sample consisted of 480 Finnish physicians, and was stratified into subgroups of equal size by speciality (gynaecology, speciality in general practice, no speciality), by gender, and by area of residence (Uusimaa province and other parts of Finland). The response rate was 74%. They were asked how often during the preceding year they had recommended or prescribed specified contraceptive methods. Altogether 68% had recommended OCs, the corresponding figures for IUDs being 53% and for condoms 41%. When the respondents were grouped by gender it emerged that equal proportions of women and men had prescribed contraceptive pills and intrauterine contraceptive devices (Mattila-Lindy et al. 1997). Of the female physicians 99% and of the males 98% had prescribed or recommended contraceptive pills, the figures for IUD being 85% among women and 79% among men. Of the women 91% had recommended or prescribed the condom, the figure for men being 80% ($p<0.05$) (Mattila-Lindy et al. 1997). They were also asked the number of IUDs inserted per month. The mean number inserted per month was 8.7 for gynaecologists, 1.8 for specialists in general practice and 1.1 for non-specialists (Makkonen 1994).

In 1993 a study was carried out of task profiles of European general practitioners in 30 countries (Boerma et al. 1997). The inquiry covered, e.g. primary care doctors´ involvement in family planning. Of Danish primary care doctors 99% were involved in FP; the figure for Iceland was 94%, 90% for Norway, 86% for Germany, 83% for Finland, 35% for Sweden,

33% for Latvia, 31% for Poland 31%, 23% for Estonia and 11% for Lithuania (Lember et al. 1999).

In an Irish survey in the North Eastern Health Board (NEHB) study was made of the range of family planning services provided by GPs in 1994 (Bonner et al. 2001). The sample comprised all GPs on the NEHB mailing list (n=165); the response rate was 66.1%. All except one of the respondents did family planning work. Of the total respondents 99% stated that they gave advice and prescribed OCs, the figure for injectable contraceptives being 99% and for hormonal emergency contraception 95%; 19% had given advice and fitted IUDs and 2% had performed vasectomies.

1.8 Sources of knowledge concerning contraception

1.8.1 Physicians

This item has been but very limitedly examined. Using database search by the term contraceptive knowledge, no articles concerning physicians´ sources of knowledge turned up. There emerged one publication by another search concerning contraceptive attitudes. The target group was gynaecologists in the former Czech and Slovak Federal Republic (Visser et al. 1993). The survey involved gynaecologists attending the National Gynaecological Congress at Karlovy Vary in 1992. A questionnaire was distributed among the participants (n=240) during a plenary session at the beginning of the congress. The total response rate was 64.6%. Respondents were asked e.g. their opinions on family planning for teenagers and their main sources of knowledge on contraceptives. Ninety-five per cent mentioned books and journals, 77% pharmaceutical firms, 41% colleagues, 12% training courses and 12% the media and advertisements as main sources of knowledge on contraceptives. Respondents had the possibility to choose various alternatives.

1.8.2 The population

Sievers and his co-workers studied how much knowledge concerning sex life respondents had obtained from their home and school (Sievers et al. 1974). The respondents were asked: 1) did you get any knowledge on sexual life in your home? And 2) Have you received sexual education at your school? The alternatives were: enough or excessively, too little, not at all although I'd like to have, not at all and I don't want to have. Of female respondents 14% and of males 10% reported that they had received adequate knowledge of sex life from their home, the corresponding figures concerning school among the women and 7% among the men.

In a 1988 Danish survey of women aged 15 to 44 years respondents were asked the main sources of advice on contraception (Osler and Riphagen 1990). The percentages of respondents seeking advice on contraception were respectively: general practitioner 38%, parents and relatives 19%, friends 18%, gynaecologist 11%, other source 8%, school and family planning clinic 3% of each. The publication did not make clear how many sources were permitted in responses.

In 1987 and 1988 a random stratified sample of 1000 Finnish women aged 18 to 44 years (response rate 84%) living in the province of Uusimaa was surveyed where participants were asked e.g. the information sources on IUDs (Makkonen et al. 1992). For women who had ever used IUDs physicians were the most important source of information, the figure being 48%; the next most important sources were nurses, and then magazines and newspapers (percentages not given in the publication cited).

In a comparison of results from eight countries on contraceptive behaviour the respondents were asked sources of information on contraception considered important and the main sources of advice on contraceptive use (Riphagen and Ketting 1990).

The doctor (not specified which doctor) was the most important source of information on contraception, mentioned by 46% of respondents in France, by 38% in Spain, by 37% in the Federal Republic of Germany, by 38% in Austria and by 43% in Sweden. In Italy the partner was the most important source, mentioned by 34% of respondents and in Denmark the media by 29%.

Gynaecologists were the main source of advice on contraception in Italy as mentioned by 64% of respondents, by 44% in France, by 56% in Spain, by 58% in the Federal Republic of Germany, by 55% in Austria and by 48% in Sweden. In Great Britain 51% of respondents and in Denmark 38% reported that the GP was the main source of advice.

Oddens and associates made a survey of contraceptive use and attitudes in Great Britain in 1992 among women aged 15-45 years (Oddens et al. 1994a). Respondents were asked the main sources of information on the contraceptive method in current use; more than one answer could be given. The GP was the most important source as mentioned by 47% of respondents, friends 26%, family planning clinic 23%, leaflets 19%, partner 17%, magazines 15%, school 12%, books 11%, parents 9%, gynaecologist 9%, newspapers 6%, television 5%, radio 1% and women's group 1%.

In a survey made in reunified Germany in 1992 respondents were asked where they had obtained information on contraception (Oddens et al. 1994b). It emerged that gynaecologists were the main information source, mentioned by 68% of respondents, and friends by 31% of respondents. Magazines, newspapers, television and/or radio constituted the main source of information for 18% of the sample.

Kontula and Haavio-Mannila studied how much knowledge concerning sex life respondents had obtained from their home and school (Kontula and Haavio-Mannila 1993). The respondents were asked: 1) did you receive any knowledge on sexual life in your home? And 2) Have you received sexual education at your school? The alternatives were: enough or excessively, too little, not at all although I'd like to have, not at all and I don't want to have. Of the female respondents 32% and of the males 25% reported that they had received adequate information on sex life from their home, the corresponding figures being 33% for the women and 28% for the men concerning school.

In an Italian survey made in 1993 respondents were asked to name their most important sources of knowledge on contraception; more than one answer could be given (Oddens 1996). The most important sources mentioned were gynaecologists in 52% of cases, where-after friends in 35%, followed by partners 34%, magazines 18%, newspapers 16% and books 14%.

In a Swedish survey conducted in 1994 respondents were asked to name the sources from which they had obtained information on contraception (Oddens and Milsom 1994). Of the total approached 68% had received their information from gynaecologists and/or midwives, 42% from friends, 26% from brochures and 23% from school. It was possible to give more than one alternative.

In a survey on family planning carried out in the EMOR Omnibus survey in Estonia in 1996 among women (n=421) and men (n=197) aged 18-50 years, respondents were asked how much knowledge connected with contraceptives they had received from various sources (Kalda et al. 1998). Female respondents stated that literature, doctors and journals were their most important sources, while male respondents stated literature, partners and television to be the main sources.

Summary of physicians´ and populations´ sources of knowledge concerning contraception: Physicians´ sources of knowledge seemed to be very little studied, while the populations´ sources of knowledge were more fully examined. In most studies respondents were only asked to name their sources of knowledge, and there was no information as to the amount of knowledge obtained from various sources.

1.9 Opinions concerning family planning

1.9.1 Physicians

There are only very limited data concerning this issue. Visser and colleagues reported on Czech and Slovak gynaecologists´ attitudes toward family planning in a 1992 survey (Visser et al. 1993). Respondents were asked for statements on teenagers´ family planning. Of the total respondents 10% were of the opinion that teenagers should not use contraception at all.

1.9.2 The population

In the 1971 study by Sievers and his co-workers of a random sample of the Finnish population 85% of the respondents were of the opinion that education on contraceptive use should be given at school (Sievers et al. 1974).

In 1994 a survey was made of Finnish men aged 20-24 and 40-44, who where asked on men's role in contraception (Sihvo and Viisainen 1998); 98% of the younger men and 86% of older men were of the opinion that the responsibility for contraception belongs equally to women and men. In a simultaneous inquiry among women (Sihvo and Koponen 1998) this question was not included.

Kalda and associates reported on a survey of the Estonian population where respondents were asked to evaluate various statements concerning sex education and family planning (Kalda et al. 1998). Almost all respondents expressed the opinion that men should be involved in family planning and that education on contraceptives should be given at school and would help to reduce the number of induced abortions. Respondents did not agree with

the statement”education on contraceptive methods encourages young children to start sexual activity too early”.

Summary of opinions concerning family planning: family planning issues have been studied by various types of questions. Respondents in different surveys were of the opinion that sex education should be given at school. Men’s role in family planning seemed also to be held important.

2 AIMS OF THE STUDY

The purpose of this study was to establish the opinions and experiences of Finnish health-centre physicians and Finnish men and women in matters relating to family planning, more specifically contraception.

The specific aims were:

1. To ascertain Finnish health centre physician´s participation in family planning work and the contraceptive methods Finnish health centre physicians´ have recommended to their patients.

2. To ascertain physicians´ sources of knowledge concerning contraceptive methods.

3. To study the Finnish population´s sources of knowledge concerning contraceptive methods.

4. To study the ever use of contraceptive methods among the Finnish population and the methods men and women prefer.

5. To compare physicians´ and the population´s experiences and opinions regarding family planning and sex education.

3 MATERIAL AND METHODS

3.1 Survey of Finnish health centre physicians

The study population here consisted of 351 randomly selected Finnish health centre doctors. Their names and addresses were drawn from the files of the Finnish Medical Association, where all Finnish physicians are registered. Every tenth physician listed was included in the study.

The questionnaire was devised jointly by Finnish and Estonian research groups. The items used here were modified so as to be applicable in both countries, and in consequence some questions may be strange to the Finnish reader and some aspect may be missing. Ten voluntary Finnish health centre physicians were asked to fill in the questionnaire and evaluate the intelligibility and clarity of the items. The questionnaire was further developed on the basis of their comments.

The survey questionnaire included structured, visual analogue scale (VAS)-based (Miller 1993) and open questions. On VAS-based questions respondents were asked to place a mark on the line at a point corresponding to their opinion. The scale ranged e.g. from strongly disagree (0) to strongly agree (100). The line lengths were transferred to the computer as numbers from 0 to 100 using a graphics tablet. The questionnaire inquired after respondents´ basic characteristics; gender, year of birth, phase of career, work place and work experience (Appendix 3). Respondents´ contraceptive recommendations were also asked. One part of the questionnaire concentrated on respondents´ knowledge sources concerning contraceptive methods. The last part of the questionnaire dealt with their views on contraceptives and family planning.

Numbered questionnaires with covering letters signed by one Finnish and one Estonian researcher and prepaid return envelopes were mailed to the physicians selected in June 1996. The questionnaire numbering was for follow-up of mailing. The first reminder with questionnaire sheet was mailed after a month to those who had not responded, the second with a new questionnaire and a one-page note stating reasons for not answering (Appendix 4) in August 1996 to those who had still not answered. These questionnaires were unnumbered.

After the first mailing 150 of the questionnaires were returned; after the first reminder 60 and after the second 33 questionnaires were received. After two reminder letters the response rate was 69%; 242 physicians returned the questionnaire. A further 18 physicians responded to the second reminder letter with a one-page sheet concerning reasons for non-response. Half of those who did not fill in the original questionnaire but returned the single sheet were female. The main reasons for not answering were: no family planning work, lack of time to answer or not usually answering any questionnaires.

Of all respondents 56% were women. The ages in the total cohort varied between 27 and 61 years, mean 41 years. Working experience ranged from 1 to 32 years, the mean being for women 13 years, for men 16 years and for all respondents 14 years. Of the total respondents 82 were specialists in general practice, the number of vocational trainees in general practice being 38, and 98 non-specialists. The number of specialists from other fields, for example gynaecologists, paediatricians and radiologists, was 15. The number of vocational trainees in other specialties was 7. The Finnish Medical Association collects every year in March data on licensed physicians, forming a continually updated register. The sample here was drawn in May 1996 and thus included a great deal of data based on the collection made in 1995. Respondents and all health centre physicians did not differ in terms of gender (p=0.093) and age (p=0.284) (Table 2). The comparison was made using STAT-SAK, the statistician's Swiss Army Knife (version 2.15. Malden, MA, USA), and test independency in two-dimensional contingency tables.

Table 2. Finnish health centre physicians in 1995 and physician respondents by gender and age group.

	Health centre physicians n=3323	Respondents n=239
	%	%
Women	57	56
Men	43	44
Total	100	100
Age group		
<30	8	5
30-39	39	35
40-49	39	42
50-63	14	12
Missing data		6
Total	100	100

3.2 Survey of Finnish women and men

The study population consisted of Finnish women and men aged 18 to 50 years. The random sample included 400 women and 400 men, whose names and addresses were obtained from the Finnish Population Register Centre. Due to twelve wrong addresses the sample in fact eventually comprised 393 women and 395 men.

The questionnaire was developed jointly by a Finnish-Estonian research group, with partly different questions for women and men. The postal questionnaire was new to the population in Estonia, which set limits to the modification and extent of the questionnaire. Five Finnish female and male volunteers were asked to evaluate the content of the questionnaire and the ease of dealing with it. The questionnaires were further developed and some questions removed according to their comments and observations.

The survey questionnaires (Appendix 5 and 6) included structured, visual analogue scale (VAS)-based and some open questions. The questionnaire inquired after basic characteristics such as year of birth, marital status, education and religion. To ascertain respondents´ contraceptive practices they were asked to name out of 14 contraceptive methods those they had ever used together with their partner/s. One part of the questionnaire concentrated on respondents´ sources of knowledge concerning contraceptive methods. The last part of the questionnaire dealt with views on contraceptives and family planning.

The questionnaires were numbered in the same way as for the physicians. The first mailing, including questionnaires, covering letters signed by one Finnish and one Estonian researcher and prepaid return envelopes took place in May 1997. The first reminder with a new questionnaire was sent in July 1997, and a second with a new questionnaire and a one-page note with reasons for not answering (Appendix 7) were mailed in August 1997.

After the first mailing 183 women and 104 men returned the questionnaires. After the first reminder a further 22 questionnaires were returned by women and 47 by men and after the second 26 were returned by women and 27 by men. After the two reminders the total response rate in the study population was 51% (n=399). Of women 56% (n=221) replied and of men 45% (n=178). Unfilled questionnaires were returned by three women and one man. The sheet concerning reasons for not answering was returned by 31 women and 22 men. The main reasons for non-response were: not usually answering any questionnaires (women n=20, men n=14), questions too intimate (women n=14, men n=5) or one gets too many different questionnaires to answer (women n=8, men n=9); respondents had chosen more than one alternatives given.

Half of the respondents were married (Table 3.). The majority had basic schooling or higher level education. By far the majority of respondents were Lutherans.

Table 3. Characteristics of population respondents by gender.N=number of respondents in various questions.

Characteristics	Women	Men	All
	N=208-221	N=172-178	N=380-399
	%	%	%
Age group (years)			
18-29	33	34	34
30-40	34	33	34
≥41	33	33	33
Marital status			
Single	25	26	25
Married	52	50	51
Cohabiting	16	18	17
Divorced	7	6	7
Widowed	1	0	0
Education			
Elementary or less	18	17	17
Intermediate or comprehensive	41	48	44
Matriculated	42	35	39
Professional education			
No professional education	20	12	16
Professional course/s	18	15	17
School level vocational	23	37	29
College level qualification	26	17	22
University degree	14	20	16
Religion			
Lutheran	85	83	84
Orthodox	1	1	1
Roman Catholic	1	0	1
Atheist	2	4	3
Other	4	3	4
Cannot say	1	1	1
No denomination	6	7	7

In further analysis marital status was classified as single, married, cohabiting and divorced/widowed. Educational level was classified according to the Unesco International Standard Classification of Education (ISCED) terms as lower secondary if nine years (= comprehensive school) or less, upper secondary when the subject had completed the matriculation examination or a vocational school, and third level when the person had completed an examination in a higher vocational institution or university (Haven 1998), this to render the results better understandable to international readers. This classification was so

new in Finland that no published national statistical information was available for comparison.

The percentages of Orthodox, Catholics and those who could not say whether they had a religion or not were small. In further analysis religion was classified as follows: Lutheran, atheist or no denomination and other. In our study the great majority were Lutheran. The group"atheist/no religion" was close to the group"not belonging to any religious community", but not necessarily quite identical. It is thus not possible to extract the proportions of atheists and respondents with no religion to make a comparison between respondents and the population.

Comparison of the respondents with the Finnish population in 1996 (Statistical Yearbook of Finland 1997) revealed no statistically significant differences in terms of age distribution (p=0.89 for women, p=0.66 for men) (Table 4), marital status (p=0.89 for women, p=0.56 for men) (Table 5) and completion of the matriculation examination (p=0.58 for women, p=0.19 for men) (Table 6) among either women or men. The comparison was made using STAT-SAK, the statistician's Swiss Army Knife (version 2.15. Malden, MA, USA) and independence test in two-dimensional contingency tables.

Table 4. Women and men in the Finnish population in 1996 and respondents´ by age group.

	Finnish population	Respondents
Age group		
Women	n=1.095750	n=190
	%	%
<30	29	29
30-39	34	35
40-49	37	36
Men	n=1.139075	n=163
	%	%
<30	29	32
30-39	34	31
40-49	37	37

Table 5. Marital status in the Finnish population in 1996 and respondents by gender and age group.

	Finnish population		Respondents	
Age group				
Women	n	%	n	%
18-19			(18)	
20-29	315602		50	
Unmarried	229739	72.8	40	72.7
Married	78590	24.9	14	25.5
Divorced/widowed	7273	2.3	1	1.8
30-39	371257		67	
Unmarried	111332	30.0	19	27.4
Married	219755	59.2	42	62.7
Divorced/widowed	40170	10.8	6	8.9
40-49	408891		67	
Unmarried	58512	14.3	11	16.4
Married	271581	66.4	47	70.1
Divorced/widowed	78798	19.3	9	13.5
50-			(12)	
Men				
	n	%	n	%
18-19			(9)	
20-29	329596		50	
Unmarried	275166	83.5	39	78.0
Married	50706	15.4	11	22.0
Divorced/widowed	3724	1.1	0	0
30-39	386457		51	
Unmarried	161832	41.8	16	31.4
Married	194633	50.4	30	58.8
Divorced/widowed	29992	7.8	5	9.8
40-49	423022		59	
Unmarried	91483	21.6	13	22.1
Married	267995	63.4	41	69.5
Divorced/widowed	63544	15.0	5	8.5
50-				

Table 6. Women and men in the Finnish population in 1996 and respondents by age group and matriculation examination passed.

Matriculation examination passed	Finnish population	Respondents
Women	n=1095750	N=190
Age group	%	%
18-19		
20-24	53	52
25-29	51	54
30-34	46	51
35-39	38	39
40-44	30	50
45-50	21	22
50-		
Men	n=1139075	n=163
	%	%
18-19		
20-24	36	30
25-29	32	45
30-34	28	48
35-39	24	27
40-44	20	23
40-49	15	31

3.3 Statistical methods

The statistical approaches used were frequency distribution, variance analyses and cross-tabulations. Significance of differences was tested by chi-square test and the t-test for independent samples assuming unequal variances. A p-value less than 0.05 was considered statistically significant and values greater are marked in tables as non-significant (n.s.); 95% confidence intervals (CI) were counted. The software used was SPSS for Windows and STAT-SAK, the statistician's Swiss Army Knife, version 2.15. Malden, MA, USA.

4 RESULTS

4.1 Physicians

4.1.1 Participation in family planning work

Respondents were asked to define the proportion of family planning in their work as hours/month. Of the women 76% and of the men 52% reported that the share of family planning (FP) work was more than zero hours per month**.** Of women 7% reported that the share of FP work was zero, the corresponding figure among men being 28%. Sixteen per cent of the women and 20% of men did not answer this question.

The mean proportion of family planning work per month among those respondents who had answered the relevant question was 5 hours, among females 7 hours and 2 hours among males. Respondents were grouped according to family planning work in further analysis. Among those who did FP work the amount was 6 hours. Among the women who did FP work the amount was 8 hours per month, the corresponding figure for men who did FP work being 3 hours.

The percentages of gynaecological patients were also sought. The proportion was 10% among all respondents, 14% among females and 5% among males. Respondents were again grouped according to FP work. Of all respondents those who did FP work stated that the proportion of gynaecological patients was 13%, the figure being 3% for those who did not do it. Among the women the figures were 16% for those doing FP work and 3% for those not. Corresponding figures for men were 7% for those doing FP work and 3% for those not.

To study physicians´ possibilities to do family planning work respondents were also asked whether they had a couch for gynaecological examination and gynaecological instruments at their personal disposal. Of all respondents 93**%** had a gynaecological couch and 93% gynaecological instruments, of the women 96**%** had a couch and 96**%** instruments, the corresponding figures among men being 91**%** for both couch and instruments.

After grouping respondents by FP work the percentages among those who did FP work were: 98% for a couch and 99% for instruments. The proportions among those who did not do FP work were: 76% for a couch and 84% for instruments.

Respondents were also asked whether they had inserted IUDs and the number inserted. Of all respondents 86% had inserted IUDs. The median number inserted was 110 among all respondents, the figures being for females 110 and for males 50. When the respondents were grouped by FP work, the figures for those who did FP work were 338 and for those who did not do FP work 105; the difference was not statistically significant.

4.1.2 Perceptions on number of births and induced abortions

To establish how fully physicians are involved in matters related to family planning, respondents were asked to estimate the total number of births and induced abortions per year in Finland. According to the national statistics for 1995 the number of births was 63067 and for induced abortions 9884. Female physicians´ mean evaluation for births was 71108, the corresponding figure among male respondents 59193. The corresponding figures for induced abortions were 10437 among females and 9787 among males.

Respondents were again grouped by FP work. Those who were involved estimated the number of births at 68373, the figure being 58514 among those who did not do FP work. The figures concerning induced abortions were 9802 among FP workers and 12135 among those not involved in this field.

Respondent's´ evaluations were also studied by phase of career. Replies were considered correct if they did not diverge more than 5% from the statistics. Concerning the number of births 73% of other specialists had made the correct evaluation, the respective figures being 62% for specialists in general practice, 51% for doctors with basic training, 42% for vocational trainees in general practice and 33% for vocational trainees in other specialities.

Of vocational trainees in general practice 27% correctly estimated the number of induced abortions, corresponding figures being 27% for other specialists, 26% for physicians with basic training, 25% for the specialists in general practice, and 17% for vocational trainees in other specialties.

4.1.3 Contraceptive recommendation

Respondents were asked which of the various contraceptive methods they had recommended to their patients. Oral contraceptives, condoms, female sterilization, IUDs and female sterilization were the most commonly recommended modes among all respondents. Contraceptive recommendation was also analyzed by family planning work. A greater proportion of doctors doing FP work had recommended OCs, condoms and IUD than those not involved in this work (Table 7). No difference was seen between these two groups in the case of diaphragm, biological methods, Depo-Provera and withdrawal recommendations.

Table 7. Proportion of Finnish health centre physicians who had recommended contraceptives by family planning work and statistical significance of differences. N=number of respondents in various questions.

Contraceptive method recommendation	Family planning work		p-value
	Yes	No	
	N=146-159	N=36	
	%	%	
Oral contraceptives	100	89	0.001
Condom	99	86	0.007
Hormonal IUD	97	69	<0.001
Female sterilization	99	58	<0.001
Other IUD	98	81	0.003
Male sterilization	88	56	<0.001
Post-coital emergency pills	87	69	0.007
Norplant®	61	25	<0.001
Spermicidal foam	31	17	0.044
Post coital IUD	33	6	0.001
Biological methods	8	11	n.s.
Diaphragm	8	3	n.s.
Depo-Provera®	5	0	n.s.
Withdrawal	4	6	n.s.

4.1.4 The necessity of contraceptive methods

Respondents were asked to evaluate the necessity of various contraceptive methods in their work by visual analogue scale from totally unnecessary (0) to very necessary (100) (App. table 1). Both female and male physicians appreciated reliable and reversible contraceptive methods. Nonetheless statistically significant differences emerged.

The necessity of various contraceptive methods was also studied according to involvement in family planning work. Here it again emerged that those who did FP work evaluated the necessity of OCs and IUDs higher than those who were not involved (App. table 2).

4.1.5 Sources of knowledge concerning contraceptive methods

Physicians´ sources of knowledge on contraceptives were sought by asking them to evaluate on a VAS scale how much knowledge they had obtained from various sources. The scale ranged from"not at all" (0) to"very much" (100). The sources were basic medical education, vocational training, continuous medical education (CME) courses, colleagues, own patients, medical textbooks, medical journals, other journals, TV, radio, pharmaceutical companies and newspapers.

First an analysis was made to ascertain whether there were differences between female and male physicians. Both female and male respondents estimated that they had obtained a great deal of information from medical journals, but female physicians evaluated this source slightly higher than males (Figure 4). Pharmaceutical companies proved likewise to be an important source. Basic medical education and CME courses were rated among both genders as quite important sources, but vocational training seemed to be less important. Male physicians´ evaluations revealed that colleagues were a slightly more important source to them than was the case among female physicians.

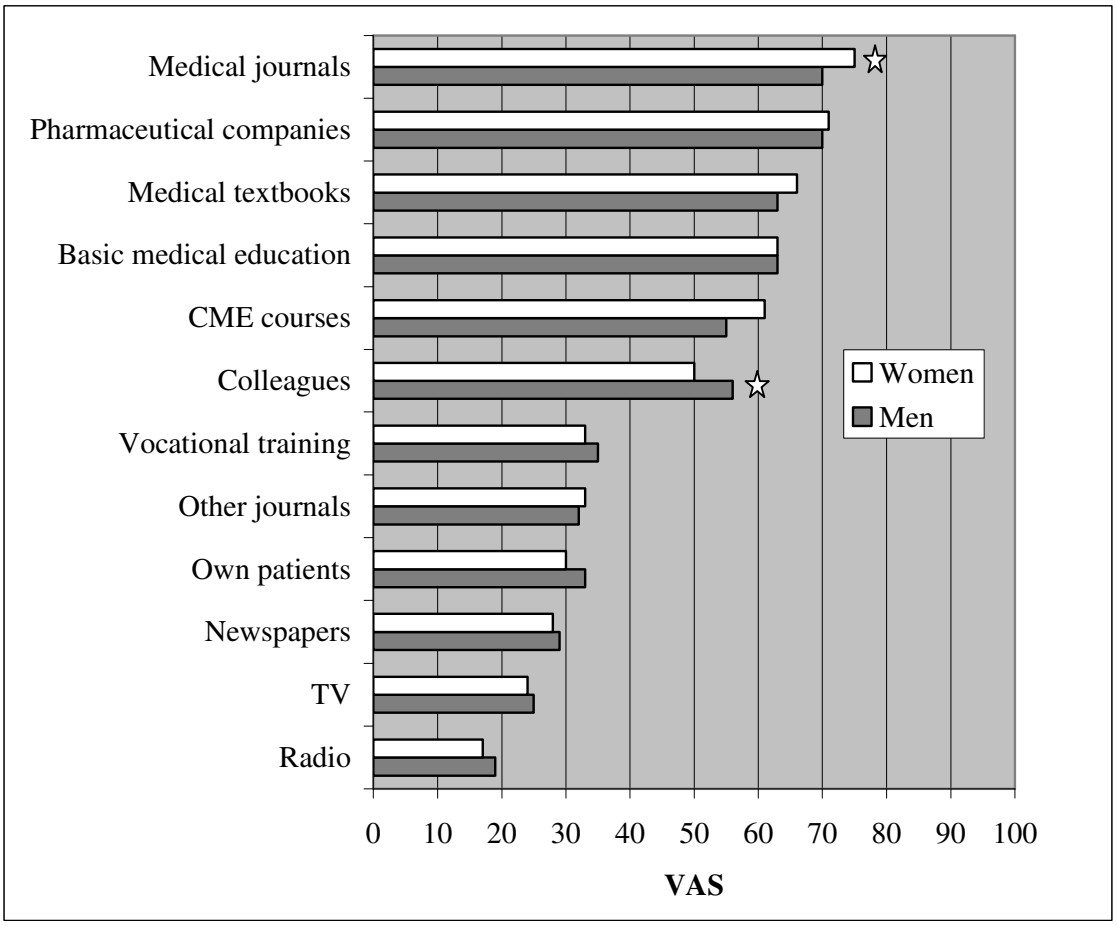

Figure 4. "How much knowledge connected with contraceptive methods have you obtained from the following sources" Answers of Finnish health centre physicians by gender on a VAS scale from not at all (0) to very much (100). Mean VAS value, statistical significance of difference marked: ☆ =p<0.05

In the following analysis evaluations concerning knowledge sources are presented by family planning work. Among both those who did FP work and those who did not, medical journals appeared to be the most important source of knowledge (Table 8). Those who did FP rated medical companies more important source than those did not. Statistically significant differences likewise emerged concerning CME courses. Vocational training was evaluated as rather poor knowledge source both among those who did and those who did not do FP work.

Table 8. "How much knowledge connected with contraceptive methods have you obtained from the following sources" Answers of Finnish health centre physicians´ on a VAS scale from not at all (0) to very much (100) by family planning work. Mean VAS value, 95% confidence interval and statistical significance of difference. N=number of respondents in various questions.

Source	Doctor´s family planning work				p-value
	Yes		No		
	n=116-158		n=31-36		
	mean VAS	95% CI	mean VAS	95% CI	
Medical journals	74	71-76	69	62-75	n.s.
Pharmaceutical companies	72	70-75	63	56-70	0.01
Medical textbooks	65	62-69	64	57-71	n.s.
Basic medical education	63	56-66	60	52-68	n.s.
CME courses	63	59-67	47	38-56	0.003
Colleagues	53	50-56	53	46-60	n.s.
Vocational training	37	32-42	29	20-38	n.s.
Other journals	33	29-37	31	24-37	n.s.
Own patients	32	29-35	30	22-38	n.s.
Newspapers	29	26-32	25	19-32	n.s.
TV	25	22-28	23	17-29	n.s.
Radio	19	16-21	16	11-20	n.s.

4.2 The population

4.2.1 Reproductive characteristics

Of the men 54% had children, the numbers being between one to nine. Of the women approached 64% had delivered, the number of labours ranging from one to five. Age at first pregnancy varied between 15 and 40 years. Of the women 18% had experienced induced abortion, the corresponding figure among men's partners being 16%.

When coital frequency was inquired after the alternatives were: many times a week, about once a week, 2-3 times a month, about once a month, 3-10 ten times per year, 1-2 times per year, less frequently or not at all. Of all respondents 28% had intercourse many times a week, 33% about once a week, 17% two or three times a month, 8% about once a month, 5% three to ten times per year, 2% one to two times per year, 3% less frequently and 5% had no intercourse at all.

In further analysis sexual activity was classified as high if the respondent had sexual intercourse at least once a week and low when she/he had intercourse less often. Sexual activity was high among about two-thirds of both men and women.

4.2.2 Sources of knowledge concerning contraceptive methods (I)

To establish where people obtained information on contraceptive methods respondents were asked to estimate how much knowledge connected with prevention of pregnancy they have derived from specified sources. The alternatives were: father, mother, brother, sister, boyfriend, girlfriend, spouse, physician, school health nurse, teacher, literature, men's journals, women's journals, TV and radio. In short, for men the most prominent sources were literature and spouse/partner (Figure 5). For the women the most important sources were literature, physician and women's journals. Father and mother were not seen as important sources among both women and men. There was no statistically significant difference concerning school nurse, TV and teacher as source of knowledge, otherwise the differences were statistically significant.

Study of the results by age revealed that both school nurse and teacher were rated more important sources of knowledge among both women and men in the two younger age groups than among the oldest respondents.

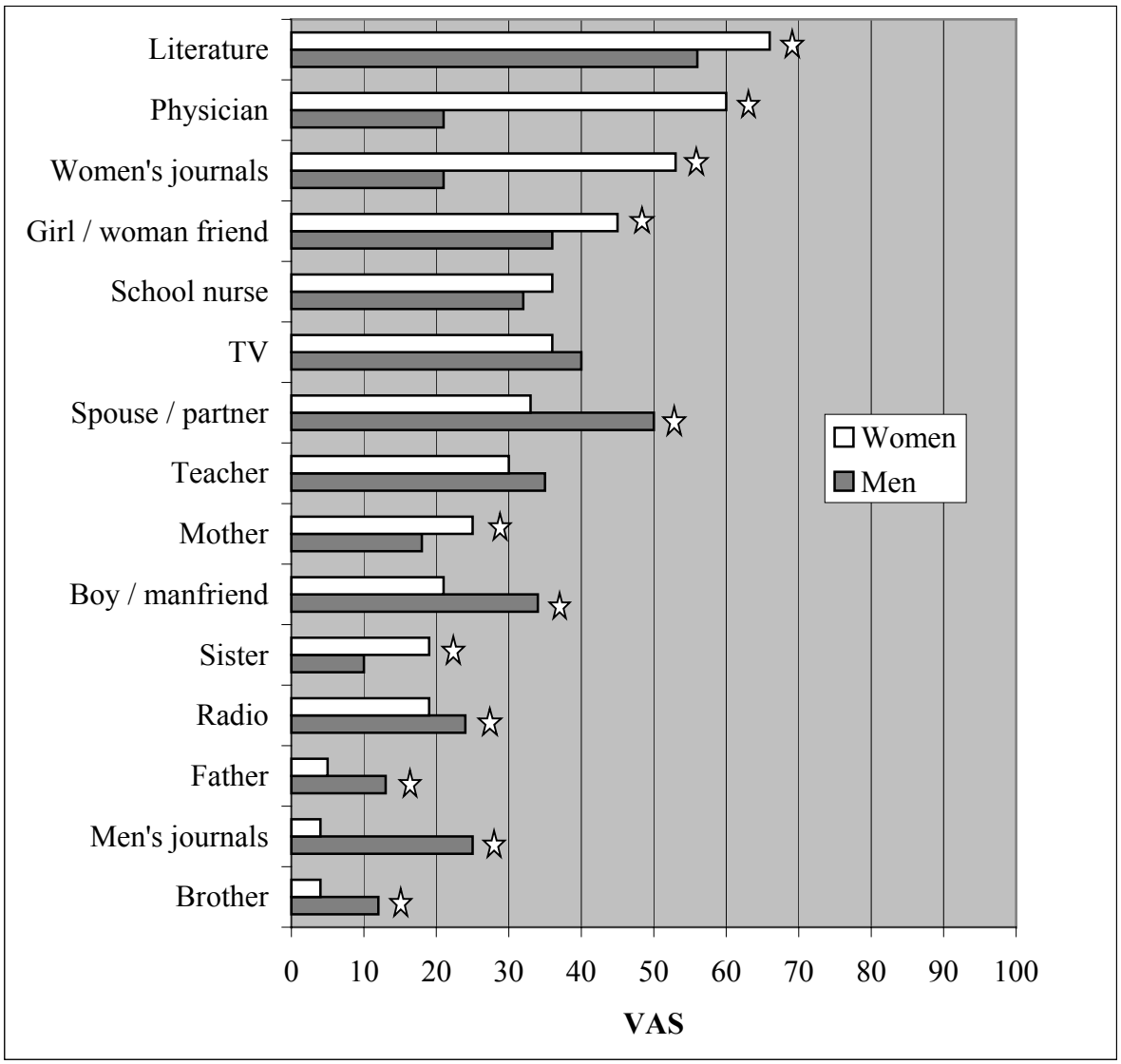

Figure 5. "How much knowledge connected with contraceptive methods have you obtained from the following sources" Answers of the Finnish population by gender on a VAS scale from not at all (0) to very much (100). Mean VAS value, statistical significance of difference marked: ☆ =p<0.05ö

4.2.3 Knowledge of hormonal emergency contraception (II) and intrauterine devices

To go deeper into respondents´ contraceptive knowledge level more specified questions were asked. They were asked ”if the condom breaks during intercourse and you wish to prevent an unwanted pregnancy the woman should take an emergency contraceptive pill”: The alternatives were: within 2 hours, within 24 hours, within 48 hours, within 72 hours and within one week. Answers within 2 to 72 hours were regarded as correct.

Women who had used EC pills knew better the right timing (within 72 hours) than those who had not. Of female EC-users, none answered that EC pills should be taken within 2 hours, 19% answered 24h, 58% 48h, and 23% 72h. The corresponding figures for female non-users were: 8%, 51%, 33% and 8%. For men there was no difference between those whose partners had used EC pill and non-users in knowing when to take the pills.

The respondents were also asked where the IUD is inserted. The alternatives were: at the bottom of the vagina, inside the uterus, in the ovary, in the peritoneum and intradermally. Of the all respondents 49% chose the alternative inside the uterus; 39% were of the opinion that the IUD is inserted at the bottom of the vagina, 6% chose alternative into the ovary and 1% subcutaneously. Of the women 59% knew that the IUD is inserted intrauterinely, the corresponding figure for men being 44% (p=<0,001). Among women age had no impact on the answer, while among men respondents from the oldest age group knew better than those in the younger age groups (p=0.031) (App.table 3). Among both women (p=0.0028) and men (p=0.013) those who were married or divorced knew better than those who were from other subgroups divided by marital status (App.table 4). Education and sexual activity had no impact on this issue among either women or men (App.tables 5, 6). The respondents were again grouped as IUD users and non-users. Of users 61% knew that the IUD is inserted intrauterinely, the corresponding figure being 44% for non-users (p=0.001). Of IUD users 37% were of the opinion that the IUD is inserted at the bottom of the vagina, the figure being 46% among non-users. Two per cent of IUD users chose the alternative in the ovary, the figure for non-users being 9%. Below one per cent among both IUD users and non-users were of the opinion that the IUD is inserted subcutaneously.

4.2.4 Contraceptive methods used by men and women (III, V, VI)

To ascertain the spectra of contraceptive methods respondents had ever used together with their partner(s) they were asked to choose from a list of contraceptive methods they had ever used (Figure 6). They were also asked to name the three best contraceptive methods.

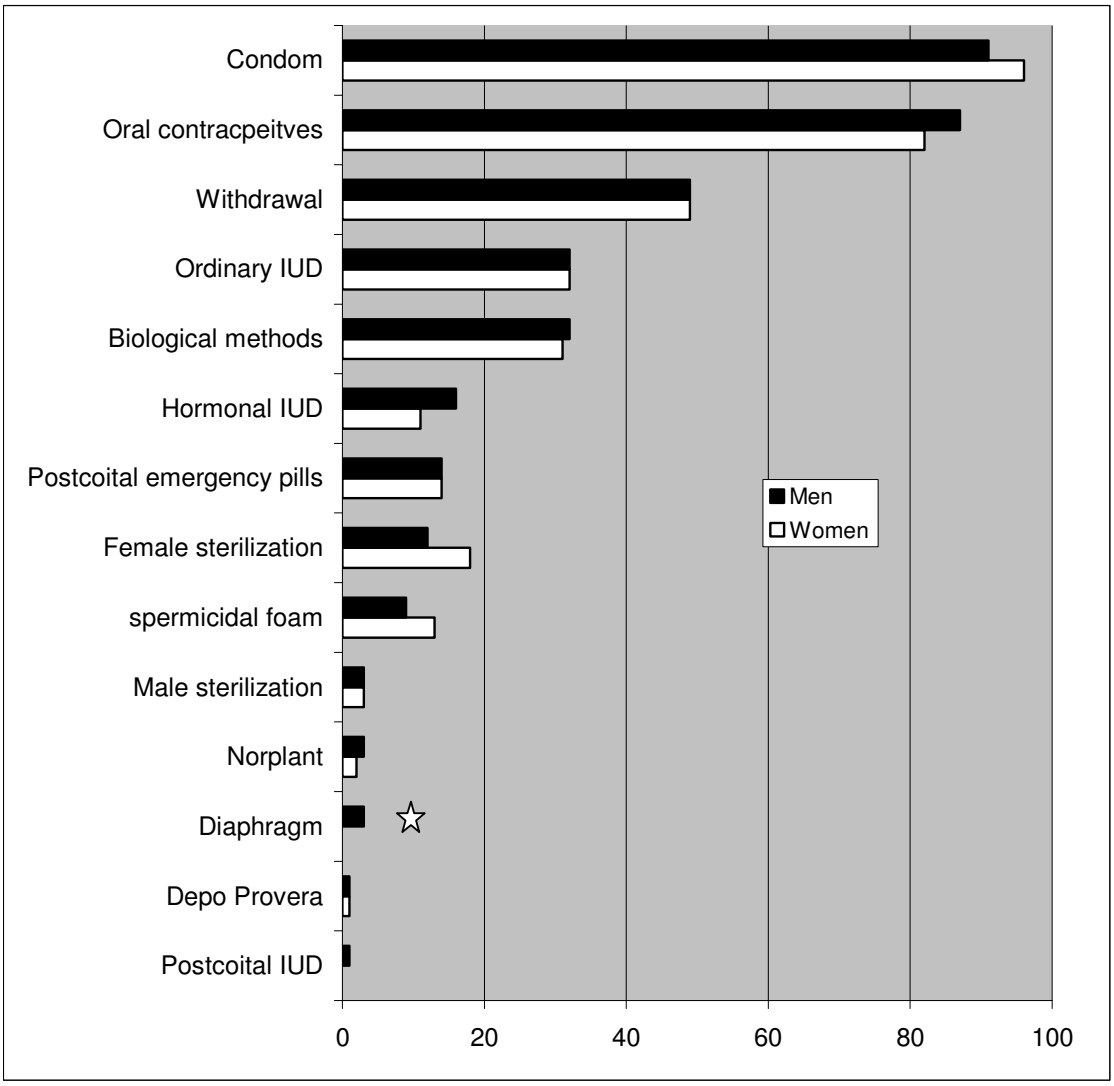

Figure 6. The proportion of Finnish men and women who have ever used with their partners various contraceptive methods. Statistical significance of difference marked: ☆ =p<0.05

Oral contraceptives

Concerning men's partner(s)´ and women´s OC use it was found that 87% of men´s partners and 82% of women had at some time used OCs (Figure 6). There were no statistically significant differences in OC use between the age groups either among men's partners or women (App.table 7). Among women 76% of single, 83% of married and 79% of cohabiting and 100% of divorced/widowed respondents reported use of OCs (App.table 8). Men's educational level had no connection with their partner(s)´ OC use (App.table 9). The proportion of OC users was higher among women with high educational level compared to respondents with low or medium levels (p=0.005). Among the men's partners the figures were 96% for induced abortion and 86% for those who had not undergone induced abortion (App.table 10). There was no statistically significant difference in partner's OC use between men who had children or not. The majority of both delivering and non-delivering women had sometimes used OCs (App.table 11); 77% of the women who had undergone induced

abortion and 83% of those who had not reported the use of OCs. Of the men with high sexual activity 90% reported that their partners had used OCs, the corresponding figure being 78% for those with low activity (p=0.006) (App.table 12). Of the women with high sexual activity 86% had at some time used OCs , the corresponding figure for women with low sexual activity being 74%, (p=0.034).

Ordinary and hormonal IUD

When men's partners´ and women´s IUD use was studied, 32% of men and 32% of women reported the use of an ordinary IUD together with their partner(s), the corresponding figure for hormonal IUD being 16% among men´s partner(s) and 11% among the women. The proportion of ordinary IUD users among the women was smaller among single and cohabiting respondents than among the married and divorced (p<0.001) (App.table 8). Concerning the use of hormonal IUD the result was similar (p<0.001).

There were no statistically significant differences in the use of ordinary or hormonal IUDs between men´s partner(s) among men with low education or with medium or high education level (App.table 9). The trend was similar among women.

More men with children reported that their partner(s) had used more ordinary and hormonal IUD than men who had no children (App.table 10). Of the women who had delivered 48% had used an ordinary IUD, but of those who had not given birth only three per cent had used this mode (p<0.001); none of those who had not delivered had used a hormonal IUD (App.table 11). Partner's induced abortions had no impact on IUD use. Sexual activity had no statistically significant impact on IUD use among either men's partners or women (App.table 12).

Female sterilization

Of the men 12% reported that their partner(s) were sterilized, the corresponding figure for women participants being 18%. Among both men's partner(s) and women older subjects were more often sterilized than younger ones (App.table 7). Married men more often reported that their partner(s) was sterilized than single, cohabiting or divorced/widowed (App. table 8). Among the women marital status had no impact on the use of the mode. Educational level had no impact on this item either among men's partner(s) or women (App.table 9).

Men who had children more often reported that their partner was sterilized than those who had no children (App.table 10). Of women who had delivered 25% reported that they were sterilized, the figure being 4% among those who had not delivered (p<0.001) (App.table 11). Of those women who had had abortions, 41% were sterilized, the proportion being 12% among those with no abortions, (p<0.001). Sexual activity (App.table 12) had no impact on the issue among either men's partners or women.

Male sterilization

The rate of male sterilization was 3% both among men and women's partner(s). Neither age, marital status, education, sexual activity nor religion had any impact on the use of male sterilization among either men or women's partner(s) (App.tables 7,8,9,12,and 13). Induced abortion had no statistically significant impact on the issue among either men's partner(s) or women (App.tables 10,11). There were no statistically significant differences between women who had delivered or not (App.table 11).

Condom

Of men 91% and of women 96% reported the use of condom with their partner(s) at some time. Of men about 90% in all age groups and of women over 90% in all three age groups reported the use of the mode (App.table 14). Among men single subjects had used condom contraception less than men in other groups (p=0.030) (App.table 15)., while among women marital status had no impact on condom use. There were no statistically significant differences between the educational level among either men or women (App.table 16). Of male participants those whose partner(s) had had an induced abortion more reported use of condoms (p=0.021) (App.table 17). The majority of women had used condom contraception whether they had delivered or not (App.table 18). Sexual activity had no impact on the use of condoms either among women or among men (App.table 19).

Withdrawal

Among both men and women 49% reported sometime using withdrawal. Among men age had no impact on the use concerning this item (App.table 14). Among women those in the age group 30-40 had used the method more than women in other age groups (p=0.013). Among women those in the groups divorced/widowed and married had used withdrawal more than single and cohabiting women (p=0.002) (App.table 15). Educational level had no impact on the use of withdrawal among either women or men (App.table 16). Men's partners´ induced abortions had no impact on the use of this mode (App.table 17). Women who had had induced abortions had used withdrawal more than those with no abortions (App.table 18). Among men those with high sexual activity reported more use of withdrawal than those with low sexual activity (App.table 19).

Biological methods

Among the men 32% and among women 31% had used biological methods for contraception. Age had no impact on the use of this method among either women or men (App.table 14). Women who were divorced/widowed had used biological methods more than other groups as divided by marital status (p=0.012) (App.table 15). Among the men whether they had children or not had no impact on the use of the method (App.table 17). Women who had deliveries reported more frequent use of biological methods than those who had not delivered (p=0.05) (App.table 18). Educational level and sexual activity revealed no statistically significant differences among either men or women (App.tables 16,19).

Post-coital emergency pills

Among both men and women 14% reported use of EC pills together with their partner(s). Among the youngest respondents both men and women reported more often the use of post-coital emergency pills ($p<0.001$) (App.table 14). Single and cohabiting women reported the use of post-coital emergency pills more often than married respondents, ($p<0.001$), (App.table 15). Educational level had no impact on the use of this technique among either women or men (App.table 16). Men who had children reported that their partner/s had used post-coital emergency pills less than men without children ($p=0.012$) (App.table 17). The proportion of post-coital emergency pill users was 26% among non-delivered, and 7% among delivered ($p<0.001$) (App.table 18). There were no statistically significant differences between those who had had abortions compared with the no-abortion group regarding the use of post-coital emergency pills. Of men with high sexual activity 19% stated that their partner/s had used emergency pills, the figure being 5% among those of low activity ($p=0.013$) (App.table 19).

4.3 Contraceptive methods preferred by men and women (III)

To study what contraceptives the population favoured most, respondents were asked to name the three best contraceptive methods. In analyzing the results first the theoretical maximum points for men/women were calculated as follows: the first-choice contraceptive method was given 3 points, the second 2 points and the third 1 point. The theoretical maximum points for men/women were 6 points x number of women/men participating in the study. The real maximum points were calculated as follows: 3, 2 and 1 were multiplied by the number of men/women who answered with the respective choices and the results were then added up. For each contraceptive method the points were counted by multiplying 3, 2 and 1 by the number of men/women who had chosen that alternative and summing the points.

Of the men about 41% placed condom first (Figure 7), of the women 39% placed OCs first (Figure 8). Other methods e.g. diaphragm, withdrawal, post-coital emergency pills, spermicidal foam and Depo Provera obtained only limited percentages each.

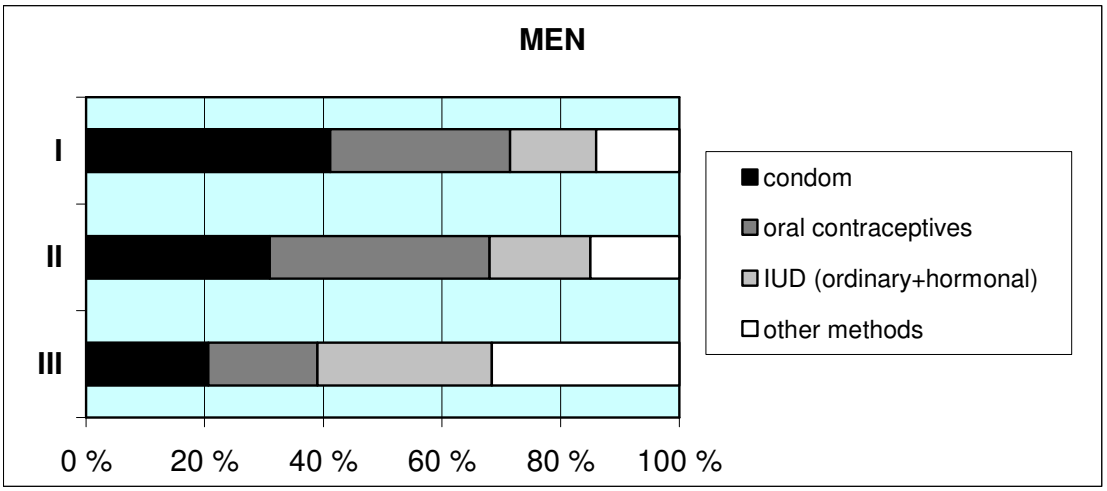

Figure 7. The three best contraceptive methods named by men; the proportional contribution of each method to the total score was calculated. Number of answers: I first choice (n=165), II second choice (n=150), III third choice (n=136).

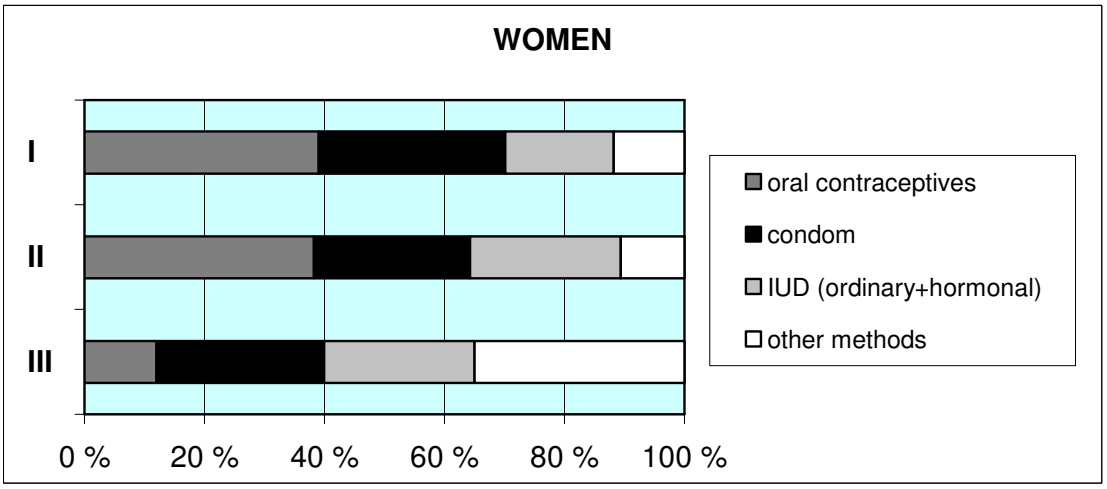

Figure 8. The three best contraceptive methods named by women; the proportional contribution of each method to the total score was calculated. Number of answers: I First choice(n=209), II second choice (n=207), III third choice (n=183).

4.4 Physicians´ and population's opinions on family planning and sex education (IV)

To ascertain physicians´ and the population's perceptions both groups were asked to evaluate statements concerning e.g. sex education and men's participation in family planning matters using a VAS scale from strongly disagree (0) to strongly agree (100).

Results concerning the statements are presented in greater detail in article IV. Both women and men among physicians and population were of the opinion that education on contraceptive methods should be given at school (Figures 9,10). Concerning the statement "Education on contraceptive methods encourages young people to start sexual life too early" both women and men disagreed among physicians and the population (Figures 11,12). When respondents opinion on men's participation in matters related to family planning was asked it came out that both women and men among both physicians and population agreed on the statement (Figures 13,14).

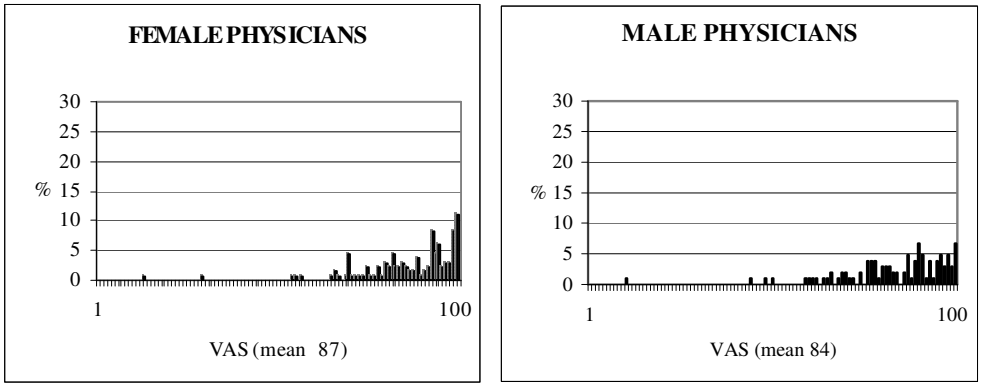

Figure 9. "Education on contraceptive methods should be given at school". Distribution (%) of opinions of female and male physicians on a VAS scale, strongly disagree (0), strongly agree (100).

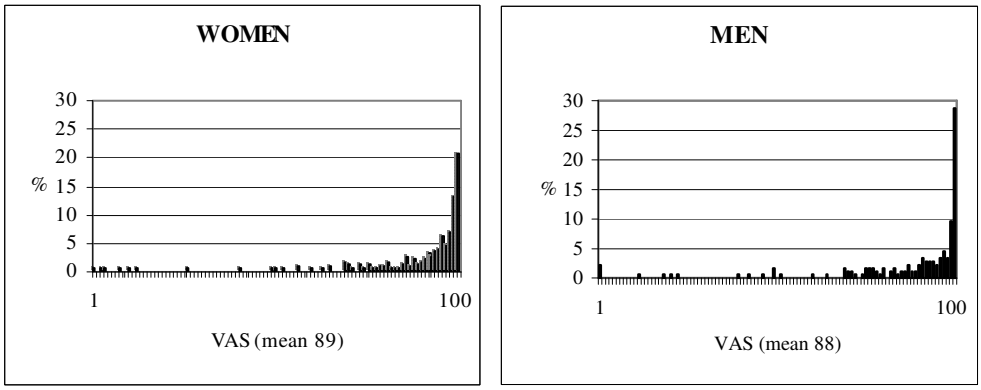

Figure 10. "Education on contraceptive methods should be given at school". Distribution (%) of opinions of women and men on a VAS scale, strongly disagree (0), strongly agree (100).

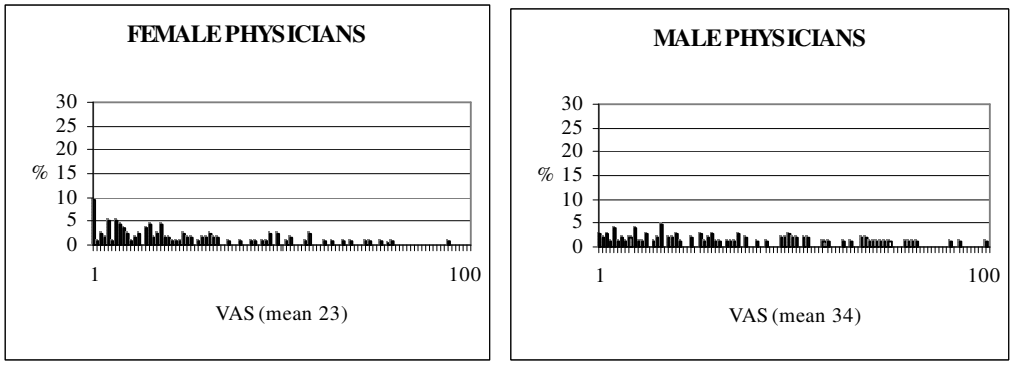

Figure 11. "Education on contraceptive methods encourages young people to start sexual life too early". Distribution (%) of opinions of female and male physicians on a VAS scale, strongly disagree (0), strongly agree (100).

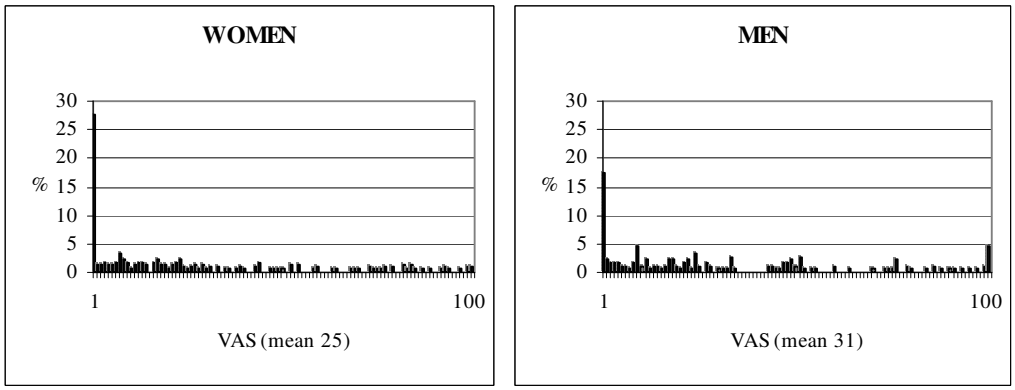

Figure 12. "Education on contraceptive methods encourages young people to start sexual life too early". Distribution (%) of opinions of women and men on a VAS scale, strongly disagree (0), strongly agree (100).

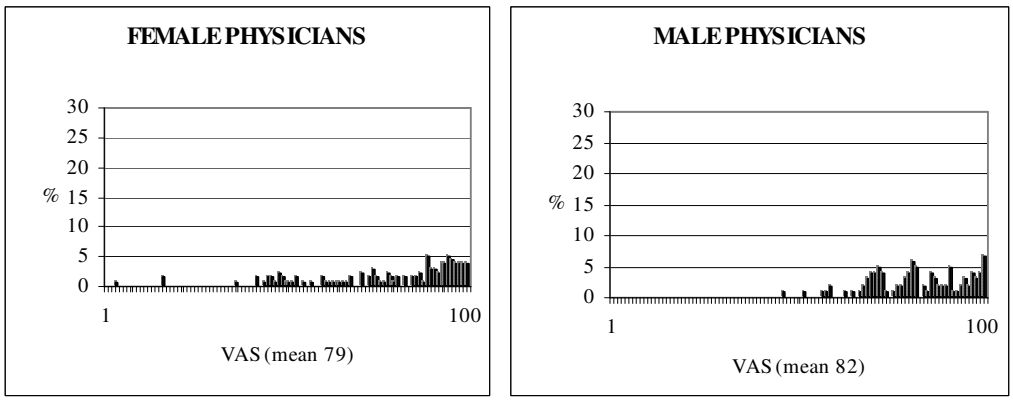

Figure 13. "Man shall participate in matters related to family planning". Distribution (%) of opinions of female and male physicians on a VAS scale, strongly disagree (0), strongly agree (100).

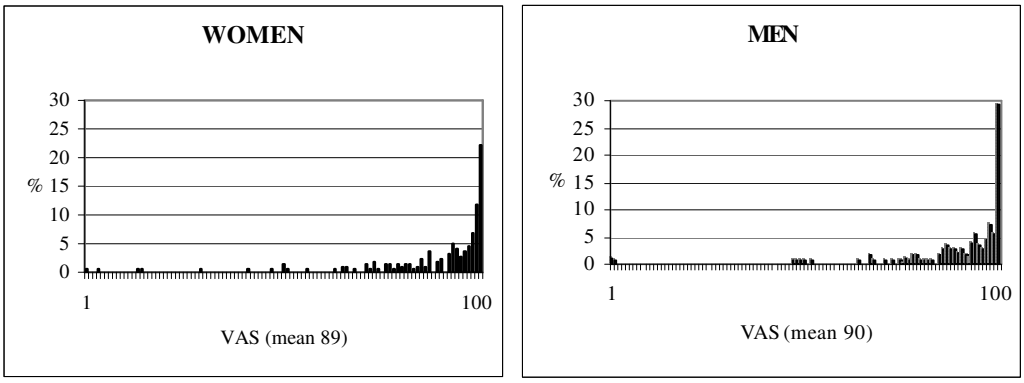

Figure 14. "Man shall participate in matters related to family planning". Distribution (%) of opinions of women and men on a VAS scale, strongly disagree (0), strongly agree (100).

5 DISCUSSION

In discussing family planning one must keep in mind that the meaning of this depends on the viewpoint. One should not forget changes in society such as industrialization, the increase in education, the widening of the social security system and women's working outside the home, all of which have substantially altered the position of the family (Sievers et al. 1974). Family planning can mean for the individual the freedom to enjoy sexual pleasure without being afraid of pregnancy, for a couple it can mean the timing of pregnancy and planning of family size, while in the community or among the population at large it can be seen as promotion or limitation of the birth rate taking into account medical, social and political aspects.

Although this study focused mainly on the use of contraceptive methods, it also covered other aspects such as knowledge and perceptions of family planning. For those who produce e.g. family planning services it is important to be aware of clients´ conceptions of the issue. Successful implementation of counselling work demands that both service producers and clients have realistic and common views.

Finland has been proud of its determined family planning counseling work. At the moment, however, it might be difficult to see the situation as a success story; according to Statistics Finland the number of live births has recently decreased and the number of abortions increased (Miettinen 2002). The increase in abortions started first among older teenagers, and gradually spread to younger girls (Kosunen et al. 2002). There has been debate as to what lies behind the changes. Possible explanations are the reduction in sex education in schools and cutbacks in health care and FP services in the first half of the 1990s (Kosunen et al. 2002). Moreover, the cost of oral contraceptives markedly increased during the 1990s (Klaukka 1994).

The Data 2005 project and the National Project designed to secure the future of health care underline the need to accrue a comprehensive hitherto unexploited corpus of information (Rintanen 2003). In the field of open care there is no system whereby solid and functional

data on this sector can be obtained (Rintanen 2003). In the case of family planning, for example, it would be to the purpose to codify clinic and family doctor visits made in this context. Equally useful from the standpoint of planning and financing these services would be statistical filing of IUD fittings and prescription of contraceptive pills.

Based on the results on physicians´ participation in family planning work established in the present study, it seems that family planning counselling work has faded into the background. It may be that more physicians in primary health care do FP work than could be brought out here. A different set of questions might have elicited a clearer picture of the extent of this activity. Registration of data concerning FP work is at present insufficient both nationally and locally (Rintanen 2003). It would thus be very important to take into consideration the development of proper registration systems in primary health care in the future. One reason for the obscurity of FP work might be the reforms made in primary health care during the 1990s. A study of the impact of the population-based responsibility system on FP work in this field is thus clearly warranted.

Men's role in contraception and reproductive health matters has been emphasized during recent years (Edwards 1994, Grady and Koray 1996, Drennan 1998). Nonetheless family planning continues to be considered a women's issue. A gender perspective requires taking into account the interplay between men's and women's roles, rather than a focus on women's situation alone (Helzner 1996). Gender analysis also includes encouraging men to be not only more frequent users of male-dependent contraceptives themselves, but also more supportive partners to the women in their lives who use female-dependent methods (Helzner 1996).

In Finland the importance of men's role in reproduction and related matters has long been acknowledged. One indicator of this is the three national surveys concerning sexual life made among both men and women conducted at the beginning of the 70s (Sievers 1974), in the 90s (Kontula and Haavio-Mannila 1993) and in the year 2000 (Haavio-Mannila and Kontula 2001). The sterilization Act passed in 1970, stipulating that couples should together decide which partner is sterilized, is also one indication of the awareness of men's role and responsibility in matters related to contraception. School and student health care has also promoted acceptance of men's role and responsibility in sex and reproductive health. In the light of this study men are actively involved and are interested in participating in matters related to family planning.

5.1 Methodological aspects

5.1.1 Representativeness

The response rate among physicians can be considered good and the sample representative (Table 1). The sample was taken from the files of the Finnish Medical Association. Facts on physicians are updated once a year in March. In this sample the majority of the data were from the sampling in March 1995. In Finnish health centres there are always vocational trainees from other fields doing their obligatory service, which is included in their specialization. There are also specialists like gynaecologists and paediatricians who are working permanently especially in larger health centres.

Concerning physicians´ smoking habits the results obtained in the present study are in line with those in a study made in 1997 on physicians´ working conditions by the Finnish Medical Association and the National Occupational Health Institute (Töyry et al. 2000). The sample comprised 4477 physicians derived from the Finnish Medical Association File, the response rate being 74%. They were also asked about their smoking habits. Of the men 8.4% smoked regularly and 15.7% occasionally, the corresponding figures for female physicians being 7,9% and 4.2%, while in the present study 23% of male physicians and 10% of female physicians were classified as smokers. In the present study smoking was asked differently. If the portions of regular and occasional smokers from the work of Töyry and associates are summed, the percentages are quite similar to those in the present study.

The response rate among the population left something to be desired. However, it did not differ from the response rates obtained by Haavio-Mannila and Kontula (2001) in the latter 1990s. The respondents can be seen to represent Finnish women and men in terms of age distribution, marital status and the share of those with matriculation examination passed (Tables 4,5,6). Caution should be nonetheless be exercised in interpreting the results.

A decrease in response rates was noticed from the 1970s to the 1990s (Kontula and Haavio-Mannila 1993). In a 1971 survey of Finnish people's sexual life the response rate was 92.9%, and correspondingly in a survey made by Kontula and associates in 1991/1992 the total response rate was 75.9% (Kontula and Haavio-Mannila 1993). In a 1998/1999 study by Kontula and his co-worker the total response rate was 45.8% (Haavio-Mannila and Kontula 2001). Similar observations have been made concerning the response rates in international studies (Riphagen and Lehert 1989, Riphagen and von Schoultz 1990, Oddens et al. 1994, Lewin et al. 2000).

Obviously there are a variety of reasons for this phenomenon. In a survey on sexual life carried out in Sweden in 1996 reasons for refusals were studied (Lewin et al. 2000). The main reasons were the subject, lack of time, principle or other. Reasons were similar to those found in the present study.

5.1.2 Methods and data collection

Structured questions are suitable for use with a large body of respondents. These kinds of questions facilitate data analyzing. The prerequisite is that the enquirer formulates the questions appropriately. Much may be missed when the respondent has the possibility to answer only "yes" , "no" or " I do not know". One point is that structured questions do not introduce new viewpoints and ideas as do e.g. open questions. Using qualitative methods it would be possible to widen the understanding of information. Qualitative data yield ideas for further issues.

One part of the questions comprised statements which the respondents were asked to, evaluate using the visual analogue scale (VAS). The VAS is a self-reporting device used to measure subjective phenomena such as patient symptoms, patient affect, function and quality of life (Miller 1993). This is one of a group of measurement and scaling techniques known collectively as graphic methods (Freyd 1929). Other techniques in this class include Likert scales, the semantic differential, and pictorial methods (Miller 1993). The analogue

scale has the important property of being continuous, at least theoretically, in contrast to digital scales, e.g. Likert scales (Aitken 1969). Several factors have been shown to affect VAS reliability; the duration between test and retest, length and position of line and availability of previous ratings (Miller 1993). VAS validity has been studied among other things for mood and pain. The VAS correlated well with several mood (Cella 1986) and pain scales (Miller 1993). It is important to take into account that the respondent's mood may vary during a study or between studies when VAS is used in measuring opinions. However, this problem is surely equally associated with other methods to measure opinions. The difficulty of measuring the impact of mood changes may well explain why there are no reliability and validity surveys of VAS concerning the measurement of mood.

The use of the mean values of a VAS scale is not without problems. The distribution of answers may vary differently. Sometimes it is surely useful to show the whole distribution.

Several questions involved difficulty in knowing exactly how respondents had perceived them. The majority were easy to analyze and the answers can be unambiguously interpreted. One problem was that as mentioned in the introduction, some questions may be lacking because the study was intended to be implemented in two different countries. For example physicians were asked the proportion of gynaecological patients in their work, but the proportion of patients attending their consultation on contraceptive matters was lacking. Moreover they were asked the share (hours/month) of family planning in their work. Hours per month seems somewhat difficult to measure; at least in Finland there might be respondents who had not taken into account family planning counselling patients during their normal consultation hours.

At the time of mailing the questionnaires the term continuous medical education (CME) was not very widely used, which may have caused misunderstanding among the respondents concerning the question dealing with physician's knowledge sources.

When population respondents were asked what kind of contraceptives they had ever used the names Norplant® and Depo Provera® might have been unfamiliar, likewise the term biological methods. This in turn might cause respondents to refrain from answering.

When population respondents were asked to name the three best contraceptive methods, the researcher had to accept that respondents might interpret the question in various ways; the matter is difficult to present unambiguously.

The postal survey is a widely used means of gathering data from a population. Face-to-face interview possibly involves greater opportunities for bias due to interviewer effect and reduced anonymity (Wellings et al. 1994) than the postal survey. It is possible that people answer more honestly and aptly when they can fill in a questionnaire alone. A postal survey is an easy and fairly cheap way to contact large numbers of people instead of personal interview. One disadvantage is that there are no opportunities for clarification or definition of terms as in the face-to-face technique (Wellings 1994). It is also easy to ignore or forget to answer and thus the response rates may remain rather low.

It might be that postal surveys are out of date and e.g. electronically conducted surveys via the internet will increasingly take the place in the future. According to a Consumer Survey made by Statistic's Finland in February 2003, 43% of the Finnish population have an internet connection in their home (http://www.stat.fi). However, there will always be people

who live without computers and internet connections and the reasonable means of reaching them is postal surveys.

5.2 Physicians´participation in family planning

Female physicians were according to this study more involved in FP work than their male colleagues. It has been shown that contraceptive counseling clients prefer to consult a female physician (Gottberg 1990, Hemminki and Koponen 1998), which accords with the present results. Of the women here 16% and of the men 20% did not answer this question. Possibly they in fact do FP work as part of their population-based work, but they are not working separately in FP units, and have thus omitted answering. One reason for this might be that most contraceptive methods are designed for women, and female physicians have their own experiences concerning family planning and hence are more interested to do FP work than male physicians.

There are few data on physicians´ involvement in FP work, but a Norwegian study from 1990 deals with the issue (Halvorsen et al. 1990). Results were similar in respect of the impact of gender on FP work. However, the amount of FP work reported in that study is not directly comparable to the present findings, as the results were presented as birth control consultations per week.

One way to evaluate physicians´ awareness of family planning is to ask figures on births and induced abortions. Those who did FP work were better apprised, but otherwise the results left something to be desired. It is possible that respondents think locally instead of nationally. If the number of births and induced abortions had been asked in the respondents´ own municipality, the knowledge might have been fuller.

It emerged that all respondents had recommended the most reliable contraceptive methods. However, a greater proportion of those who did FP work had recommended e.g. OCs, condoms, IUDs (hormonal and ordinary), female and male sterilization and Norplant than those not involved in this field, the differences being statistically significant. Post-coital emergency pills were also recommended more by those engaged in FP work than those not. These results are as one would expect.

Almost all responding physicians had recommended IUD contraception to their patients. According to a Finnish study from the 1980s, 53% of physicians had prescribed the IUD during the preceding year (Makkonen 1994). Our inquiry concerned recommendations of different contraceptive methods in general, which makes comparison of the two studies difficult.

5.3 Physicians´ and population´s sources of knowledge concerning contraceptive methods

5.3.1 Physicians

This study revealed that medical journals were the most important source of knowledge. One reason for this might be that all physicians who are members of the Finnish Medical Association regularly receive the Finnish Medical Journal, and other Physician Societies also send medical journals to their members, which facilitates reception of medical information. Electronic publications may likewise increase the popularity of medical journals.

Medical companies were also regarded as good information sources. One reason here might be that visiting sales representatives give information at work and in various educational sessions. The information and knowledge imparted are compact and easily available. Today one should not forget the economic situation in many health centres and the lack of training financed by the employer.

Vocational training proved not to be a particularly important source of knowledge. It is obvious that the amount of knowledge concerning family planning issues depends on place of work and mentor. It is also obvious that those who are involved in FP work are more interested to educate themselves on topics and issues concerning family planning and contraception than those who do not do FP work.

These kinds of studies are rare both nationally and internationally. However, that made by Visser and co-workers (Visser et al. 1993) was found to have reached conclusions similar to those in the present study.

5.3.2 The population

This study indicates that for both women and men literature was the most important knowledge source. The type of literature was not defined in the questionnaire, but it is obvious that by literature people usually understand books. Finland has a long tradition in reading skills (Laine 2002). The Church has stipulated already in ancient times that the prerequisite for a marriage is that both bride and fiancé´ be literate (Laine 2002)

One reason for the popularity of literature might be that books related to contraception and reproductive-health are easily available from libraries and bookstores. Public libraries have a tradition of over 200 years in Finland (Vaasan läänin yleisten kirjastojen 200-vuotis juhlavuoden työryhmä 1994). It is also a tradition to have medical books on one's bookshelves. For example, in September 1998 a new home doctor book topped the best-seller list of informational books.

For the women here physicians were an important source of knowledge. The result is logical, since women need to visit physicians to be checked and informed to obtain various contraceptives. For the men, the physician was less important as a source. Men in the youngest age group rated the physician more as an important source than men in the oldest

age groups. It is obvious that older men are not used to discussing contraception with a physician. The younger men have grown up in a more liberal atmosphere where sexual matters are openly discussed (Ritamies 1998).

For the men the spouse/partner was the second most important source of knowledge. There were few differences when male respondents were grouped by age. It is possible that the spouse/partner is seen as bearing the responsibility for contraception and thus as being the source of information. For most of the men it might be easier to discuss contraception with their spouse/partner than e.g. with a physician.

Among both women and men the two younger age groups had received more information from the school nurse and the teacher than the older group. This result is well in line with developments in the sex education curriculum in Finnish schools. Haavio-Mannila and Kontula reported that the school has a prominent role in sex counselling, especially among younger people (Haavio-Mannila and Kontula 2001), results which again fit well with those in the present study. It remains to be seen how the changes in school health care (Liinamo 1999) have an impact on the school as a knowledge source in sex education and counselling.

In all age groups among both women and men mother and father had a conspicuously low role as a source of knowledge. Although the sexual atmosphere has become more liberal, it seems that parents find it difficult to discuss sexual matters with their children.

This aspect has previously been studied mainly among women (Osler and Riphagen 1990, Riphagen and Ketting 1990, Makkonen et al. 1992, Oddens et al. 1994a, Oddens et al. 1994b, Oddens and Milsom 1994, Oddens 1996). In all of these studies the physician (gynaecologist or GP) proved to be the most important source. Part of the results was difficult to compare directly to the present findings due to the different form of questions. In some of the studies, for example, respondents were asked about the sources of information on contraception they considered important and the main sources of advice on contraceptive use (Riphagen and Ketting 1990).

In earlier Finnish studies (Sievers et al. 1974, Kontula and Haavio-Mannila 1993) both women and men were asked whether they had received any knowledge on sexual life at home. It is difficult to compare the results to those in the present study due to the different emphasis of the questions. In an Estonian survey women and men were approached with the same question (Kalda et al. 1998) as in the present work. The respective evaluations were very similar among both women and men; for the Estonian women the most important sources were literature, doctors and journals, while for the men the most important sources were literature, partners and TV.

It is obvious that the internet will become e a source of contraception knowledge in the future. It was not mentioned among the sources in the present study, because at the time of the study use of the internet was not so widespread as today.

5.4 Contraceptive methods used and preferred by Finnish men and women

The most reliable methods are used continuously and to obtain the desired mode one usually needs a visit to a physician. Less reliable methods can give quite good protection against pregnancy when used correctly. However, it is possible to forget to use the mode or buy it beforehand. In these cases it is not usually necessary to contact a physician.

In general the ever use of condom was quite high. Naturally the mode was scored first in men´s list. There are various reasons for this; it is almost the only method designed for men and there is no need to visit a physician to obtain it; side-effects are also very rare. Among the men here single respondents had used condom contraception to a lesser extent than men in other groups divided by marital status. Such a result might indicate that single men rely on their partner to take care of contraception. This is not a very reassuring observation. It is very important that people are adequately informed on the benefits of the condom in pregnancy and in STD prevention.

The majority of men's partners and female respondents here had used OCs and the mode was ranked best in womens´ and second in men´s list. This is no surprise, since the mode is known to be one of the most reliable contraceptive methods (Hatcher et al. 1997, Tyrer 1999). The use of oral contraceptives has remained fairly stable since the seventies. The "pill scare" in 1995 did not cause a decrease in OC use among teenagers in Finland (Kosunen et al. 1997). According to the statistics compiled by the Finnish National Agency for Medicines there was, however, a drop in OC sales figures among third-generation OCs subsequent to the scare (Finnish National Agency for Medicines 1997). This decrease in third-generation OC use in fact took place among older age groups (Kosunen et al. 1999).

It was noted in the present study that women of higher educational level were more likely to report use of OCs than women with lower education. Similar results are on record elsewhere (La Vecchia et al.1986, Riphagen and Lehert 1989, Jacobsen et al. 1992, Oddens and Lehert 1997). It is obvious that women with higher education like to control their lives, first during their studies and then during the phase of establishing a career. It might be that employers also control these women; pregnancy and birth may interrupt career formation or at least postpone it.

It was deemed easier here to use the term ordinary IUD, as the study was also carried out in Estonia, where it was difficult to specify types of IUDs. It might be that respondents at least in Finland see the ordinary IUD to be the copper device, which has long been available on the Finnish market. It seems that IUD contraception was more popular in the 1980s than now, but the technique has nevertheless maintained its position among popular methods. Internationally compared the IUD is more popular in Finland than in other parts of Europe (Ketting et al. 1993, Serbanescu 1993, Wellings et al. 1994, Oddens 1996).

In the present study 9% of female respondents reported having at some time used a hormonal IUD, but the ordinary IUD still predominates. This is not surprising, since the hormonal IUD had been a shorter time on the market. The device has its benefits; e.g. reduction of menstrual blood loss and menses duration, and of the risk of pelvic inflammatory disease (Luukkainen et al. 2001). It is clear that the use of hormonal IUDs will increase markedly due to these assets. The population's opinions regarding this mode of contraception in our study are clearly still mainly based on experiences of the ordinary IUD.

Married and delivered women had used more IUD contraception than single and cohabiting subjects. This is as one would expect and is in line with the guidelines concerning the use of IUD contraception (The National Board of Health 1972, WHO 1996). Other researchers have reported similar findings in terms of the impact of marital status and deliveries on IUD use (Makkonen et al.1994).

Female sterilization seemed to be more popular than male sterilization. Nationally the effect of the change in the sterilization law in 1985 is seen in female sterilization figures (Kosunen and Sihvo 1998). According to the present study older and married women reported use of sterilization more than other subgroups. It is obvious that women who have already had children may well choose sterilization as one possibility for contraception. Male sterilization is rare, possibly because men are somewhat reluctant to submit to an invasive operation. Moreover, some research findings suggest that male sterilization may harm men's health (McDonald 1997). Since sterilization is an invasive method and difficult to reverse, the motivations of both husband and wife, their mutual influence and communication, their present pattern of contraceptive use, and what they know about the satisfaction or dissatisfaction of other people who have undergone sterilization are all factors to be taken into account when the clinician helps a patient make the method choice decision (Miller MB et. al.1991).

The diaphragm is not currently popular in Finland, as was noted in the present study. Nowadays if a woman decides to use a diaphragm she has to order the mode through a pharmacy (Personal communication, pharmacist of University Drugstore Helsinki). It is obvious that people are not likely to choose a mode which is not easily available. Diaphragms are delivered from Sweden. This mode does not belong to the Finnish physicians´ family planning toolbox, one possible reason being that the insertion of the mode is not included either in the basic medical or in the specialist training curriculum. The diaphragm could in fact offer a good alternative for contraception, especially for those who do not need permanent contraception, or have problems with other contraceptive methods. In Great Britain for example (Wellings et al. 1994) the diaphragm is one choice and it would surely be an asset if also available in Finland.

Withdrawal and biological methods were quite widely used. One reason here might lie in the question formula "ever use". Probably many respondents had had a phase in their lives in which it would not have been a disaster if they or their partner had become pregnant. Sexually active men reported use of withdrawal more than men with low sexual activity. This is again not particularly reassuring considering the threat of unwanted pregnancy and STDs. The finding might indicate that women still have to take the responsibility for contraception.

Younger men and women reported use of post-coital emergency pills with their partners more than older men and women. This is to be expected, since younger people are more in danger of unwanted pregnancies due to higher fertility and the commonness of casual sex than older people. Moreover, pregnancy in the teenage period or early twenties might be a disaster. Single and cohabiting women had used the mode more than married women. In a Finnish study made in 1994 it also emerged that EC pills were used more among younger women and that non-delivered women had used more EC pills than women who had delivered (Kosunen et al. 1997a). It was reassuring that none of the respondents either among men or women named EC pills as their first choice. The present study is in line with

a study reported by Kosunen and associates where no women aged 18-44 reported using EC as their only contraceptive method (Kosunen et al. 1997a).

5.5 Physicians´ and population's opinions on family planning and sex education

5.5.1 Physicians

Among physicians it emerged that women's and men's opinions were fairly parallel, although statistically significant differences did emerge.

There has been a cut-down in school sex education since 1994, subsequent to the changes in the national guidance of planning curriculum in comprehensive schools (Liinamo et al. 1999). It is obvious that physicians will quickly see the consequences of this cut-down in their work with patients and can thus appreciate the impact of sex education.

In this study it emerged that female physicians are more involved in FP work and might thus be more familiar with the fact that adolescents need sex education, and that it is possible to provide them with it. Female physicians also agreed more than their male colleagues on the proposition that education on contraceptive methods reduces the number of induced abortions. Since female physicians are more involved in FP work than their male colleagues, they naturally also see in their counseling work the effect of rightly used contraception in preventing unwanted pregnancies.

Female physicians were more of the opinion than males that sex education is an essential part of a doctor's work. It is obvious that female physicians see more patients who need sex counselling. It has been proved in a study of London GP practice that 65% of women who had sex-related matters apart from pregnancy consulted a female doctor (Graffy 1990). Another study from the United Kingdom revealed that general practices with female physicians had lower teenage pregnancy rates than those without such doctors (Hippisley-Cox et al. 2000). One possible explanation is that female physicians have received their own sex education from mother, school nurse or female physician and thus see the necessity of sex education as gender-based.

5.5.2 The population

Also among the population women and men expressed fairly similar opinions, although again statistically significant differences were found.

The youngest age groups among the women were more strongly of the opinion than older women that information on contraceptive methods should be provided at school. There is evidence that the youngest age groups among both women (Ruusuvaara 1983) and men have received more information concerning contraceptive methods from school nurse and teacher than older age groups (Haavio-Mannila and Kontula 2001), which would confirm the present findings. Women with higher education were more inclined to agree that education

on contraceptive methods should be given at school. It is possible that those with advanced schooling believe more in the impact of education.

Women were less inclined to feel that education on contraceptive methods encourages young people to start sexual life too early. This would suggest that women might be more involved than men in dealing with children and teenagers in the context of sex education. According to data from the present study people receive more information about contraceptives from their mothers than their fathers, which would further support such a view. Women of high educational level do not believe that enlightenment on contraceptive methods will encourage young people to start sexual life too young. According to a study from 1992 subjects who had passed the matriculation examination had in fact started sexual intercourse later than those of lower educational levels (Kontula and Haavio-Mannila 1993).

Women were more ready than men to see sex education as an essential part of a doctor's work. In the present study physicians were the second most important source of knowledge for women in matters relating to contraception, which supports such a view.

5.5.3 Physicians and the population

It is of note that first-line physicians and the population at large share perceptions on many items concerning sex education regardless of gender. This would open up good prospects for properly timed and determined sex education and contraceptive counselling, which are prerequisites for good reproductive health and give the possibility to avoid unwanted pregnancies and induced abortions, especially among teenagers.

Female physicians and women did not agree as much as male physicians or men in general that education on contraceptive methods encourages young people to start sexual life too early. It is obvious that gender is a determining factor in this issue.

Both women and men among physicians and population agreed that the man should participate in matters relating to family planning. However, women and men in the population agreed more on this opinion than physicians. In an earlier Finnish study from 1994 it was noted that the majority of men aged 20-24 and a fair proportion of men 40-44 were of the opinion that the responsibility for contraception belongs equally to women and men (Sihvo and Viisainen 1998). Although the question was not comparable to the present formulation it brings out the notion of man's participation.

The question also arises whether physicians find it difficult to counsel a women and her spouse/partner simultaneously. However, it was not possible to answer this question via the present study.

6 CONCLUSIONS AND IMPLICATIONS FOR FURTHER STUDIES

Finnish health centre physicians are involved in FP work and have recommended reliable contraceptive methods, which the population are reported to have been used. A great deal more FP work is probably in fact done than our results reveal; this line of service seems at present to be in shadow. There are no detailed data concerning FP work in primary health care, and development of better methods of accruing information is clearly necessary. The impact of the population-based responsibility system on reproductive health services would constitute an interesting area of research in the future.

Concerning the most important sources of knowledge of contraceptive methods, medical journals, medical companies and medical literature proved to be most important to physicians. Among the population the most important sources for women were literature, physician and women's journals, and for men literature, spouse/partner and TV. Among both women and men in the youngest age group, the contribution of the school nurse as a knowledge source was conspicuous.

It is of the utmost importance to guarantee that physicians and population can obtain independent information concerning contraception and reproduction in the future. It is conceivable for example that owing to the economic cuts in health care, independent information sources are in danger.

Physicians´ and population's perceptions on contraception and family planning are realistic and in harmony. Nor should one forget the role of school health and school nurses in the future. By strengthening their role it is possible to safeguard the valuable tradition of e.g. contraceptive counselling and sex education given in the schools. The results of the present study certainly lend support to such a proposition.

7 SUMMARY

The aim here was to study Finnish health centre physicians´ and population's opinions and experiences concerning family planning, more specifically contraception.
More detailed aims were to study:
1. the proportion of family planning work in health centre physicians work and the kinds of contraceptives they have recommended to their patients.
2. physicians sources of knowledge concerning contraceptive methods.
3. the population's sources of knowledge concerning contraceptive methods.
4. the kind of contraceptive methods the population have used
5. physicians and population's opinions related to family planning and sex education.

A random sample of Finnish health centre physicians (n=351) received a postal questionnaire in 1996. The sample was derived from the Finnish Medical Association's file. The response rate was 69% after two reminder letters.
A random sample of Finnish women (n=393) and men (=395) received a postal questionnaire on contraception and family planning. The sample was derived from the National Population Register. The response rate was 56% for women and 45% for men.

The main results were:

1. Of the female physicians 76% and of their male colleagues 52% stated that they did FP work. The mean burden of family planning work was 5 hours/month among those respondents who answered this question, the mean among females being 7 hours and 2 hours among males. The majority of respondents had recommended OCs, condom and IUDs to their patients.
2. Among physicians the most important sources of knowledge concerning contraceptives were medical journals, medical companies and medical literature.
3. Among the population the most important sources of knowledge concerning contraceptives were: for women literature, physician and women's journals, for men literature, spouse/partner and TV. Among the youngest age group among both women and men, the contribution of the school nurse was prominent.
4. Among the women condom, OCs and IUDs were the most widely used contraceptives. OCs, condoms and IUDs were the most commonly used methods among men and their partners.
5. Both among women and men physicians and population agreed that education on contraceptive methods should be given at school and that education on contraceptive methods reduces the rate of induced abortions. Both physicians and population disagreed on the opinion that education on contraceptive methods encourages young people to start sexual life too early. Women and men in both groups were of the opinion that man shall participate in matters related to family planning.

8 FINNISH SUMMARY

Tämän työn tarkoituksena oli tutkia.suomalaisten terveyskeskuslääkärien ja väestön mielipiteitä ja kokemuksia perhesuunnittelusta ja siihen liittyvistä asioista, erityisesti raskaudenehkäisy menetelmistä.

Yksityiskohtaisina tavoitteina oli tutkia:
1. perhesuunnittelun osuutta terveyskeskuslääkärien työssä sekä mitä raskaudenehkäisy menetelmiä lääkärit ovat suositelleet potilailleen.
2. mitkä ovat lääkärien tietolähteet raskaudenehkäisyyn liittyvissä asioissa.
3. mitkä ovat väestön tietolähteet raskaudenehkäisyyn liittyvissä asioissa
4. mitä raskaudenehkäisy menetelmiä väestö on käyttänyt
5. lääkärien ja väestön mielipiteitä perhesuunnitteluun ja seksuaalikasvatukseen liittyvissä asioissa.

Lääkäriliiton rekisteristä satunnaisotannalla valituille 351 terveyskeskuslääkärille lähetettiin postikysely ehkäisymenetelmiin ja perhesuunnitteluun liittyvistä asioista keväällä 1996. Vastausprosenttti oli 69 kahden muistutuskirjeen jälkeen.

Väestörekisteristä satunnaisotannalla valituille 18-50 vuotiaille naisille (n=393) ja miehille (n=395) lähetettiinn postikysely kesällä 1997. Kahden muistutuskirjeen jälkeen vastausprosentti oli: naisilla 56 ja miehillä 45.

Tutkimuksen päätulokset olivat:
1. Naislääkäreistä 76% ja mieslääkäreistä 52% ilmoitti tekevänsä perhesuunnittelutyötä. Perhesuunnittelutyön osuus tähän kysymykseen vastanneilla oli 5 tuntia kuukaudessa, naisilla 7 tuntia ja miehillä 2 tuntia. Vastaajat olivat useimmin suositelleet asiakkailleen ehkäisypillereitä, kondomia, kierukoita ja naisen sterilisaatiota.
2. Lääkärien merkittävimmät tietolähteet raskaudenehkäisyyn liittyvissä asioissa olivat lääketieteelliset lehdet, lääkeyhtiöt ja lääketieteellinen kirjallisuus.
3. Väestön merkittävimmät tietolähteet raskaudenehkäisyyn liittyvissä asioissa olivat naisilla kirjallisuus, lääkäri ja naistenlehdet;. miehillä kirjallisuus, puoliso/partneri ja TV. Kouluterveydenhoitajan osuus oli merkittävä nais- ja miesvastaajien nuorimmassa ikäluokassa.
4. Naiset olivat käyttäneet kumppaniensa kanssa kondomiehkäisyä, E-pillereitä ja kierukkaehkäisyä. Miehillä kumppaneineen käytetyimmät menetelmät olivat E-pillerit, kondomi ja kierukka.
5. Sekä naiset että miehet niin lääkäreistä kuin väestöstäkin olivat sitä mieltä, että ehkäisymenetelmien opetusta tulee antaa koulussa. Lääkärit ja väestö olivat sitä mieltä, että ehkäisymenetelmien opetus ei rohkaise nuoria liian varhaiseen seksuaalielämään. Naiset ja miehet niin lääkäreistä kuin väestöstäkin olivat sitä mieltä, että miehen tulee osallistua perhesuunnittelua koskeviin asioihin.

Keywords: contraception, family planning, physician, population, primary health care, information sources

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APPENDICES

Appendix 1

- reproductive and sexual rights

Appendix 2

- Cairo declaration

Appendix 3

- Physicians´ survey questionnaire

Appendix 4

- Reminder with reasons for not answering

Appendix 5

- Women´s survey questionnaire

Appendix 6

- Men´s survey questionnaire

Appendix 7

- Reminder with reasons for not answering

Appendix 1

1. The right to life
2. The right to liberty and security of the person
3. The right to equality, and to be free from all forms of discrimination
4. The right to privacy
5. The right to freedom of though
6. The right to information and education
7. The right to choose whether or not to marry and to found and plan a family
8. The right to decide whether or when to have children
9. The right to health care and health protection
10. The right to the benefits of scientific progress
11. The right to freedom of assembly and political participation
12. The right to be free from torture and ill treatment

Appendix 2

1 - Universal Education

"Beyond the achievement of the goal of universal primary education in all countries before the year 2015, all countries are urged to ensure the widest and earliest possible access by girls and women to secondary and higher levels of education, as well as to vocational education and technical training, bearing in mind the need to improve the quality and relevance of that education." [para. 4.18]

2 - Reduction of Infant and Child Mortality

"... Countries should strive to reduce their infant and under-five mortality rates by one third, or to 50 and 70 per 1,000 live births, respectively, whichever is less, by the year 2000, with appropriate adaptation to the particular situation of each country. By 2005, countries with intermediate mortality levels should aim to achieve an infant mortality rate below 50 deaths per 1,000 live births and an under-five mortality rate below 60 deaths per 1,000 live births. By 2015, all countries should aim to achieve an infant mortality rate below 35 per 1,000 live births and an under-five mortality rate below 45 per 1,000. Countries that achieve these levels earlier should strive to lower them further." [para. 8.16]

3 - Reduction of Maternal Mortality

"Countries should strive to effect significant reductions in maternal mortality by the year 2015: a reduction in maternal mortality by one half of the 1990 levels by the year 2000 and a further one half by 2015. The realization of these goals will have different implications for countries with different 1990 levels of maternal mortality. Countries with intermediate levels of mortality should aim to achieve by the year 2005 a maternal mortality rate below 100 per 100,000 live births and by the year 2015 a maternal mortality rate below 60 per 100,000 live births. Countries with the highest levels of maternal mortality should aim to achieve by 2005 a maternal mortality rate below 125 per 100,000 live births and by 2015 a maternal mortality rate below 75 per 100,000 live births. However, all countries should reduce maternal morbidity and mortality to levels where they no longer constitute a public health problem. Disparities in maternal mortality within countries and between geographical regions, socio-economic and ethnic groups should be narrowed." [para. 8.21]

4 - Access to Reproductive and Sexual Health Services Including Family Planning.

"All countries should strive to make accessible through the primary health-care system, reproductive health to all individuals of appropriate ages as soon as possible and no later than the year 2015. Reproductive health care in the context of primary health care should, inter alia, include: family-planning counselling, information, education, communication and services; education and services for pre-natal care, safe delivery and post-natal care; prevention and appropriate treatment of infertility; abortion as specified in paragraph 8.25, including prevention of abortion and the management of the consequences of abortion; treatment of reproductive tract infections; sexually transmitted diseases and other reproductive health conditions; and information, education and counselling, as appropriate, on human sexuality, reproductive health and responsible parenthood. Referral for family-planning services and further diagnosis and treatment for complications of pregnancy, delivery and abortion, infertility, reproductive tract infections, breast cancer and cancers of the reproductive system, sexually transmitted diseases, including HIV/AIDS should always be available, as required. Active discouragement of harmful practices, such as female genital mutilation, should also be an integral component of primary health care, including reproductive health-care programmes." [para. 7.6]

Appendix 3

KYSELYLOMAKE SUOMALAISILLE PERUSTERVEYDENHUOLLON LÄÄKÄREILLE

QUESTIONNAIRE TO FINNISH PRIMARY HEALTH CARE DOCTORS

Vastausohje: Ympäröi Sinua kuvaavan vaihtoehdon numero ja/tai kirjoita vastaus annettuun tilaan.
***Instruction:** Answer by circling the number of the alternative which best describes you and/or by writing the answer in the space provided.*

Sukupuoli 1. nainen 2. mies Syntymävuosi: _____
Sex female male Year of birth

Seuraavaksi haluaisimme tietää päivittäisestä työstäsi jotakin
Next we would like to know something about your daily work are you

Oletko
Are you

1. Peruskoulutettu lääkäri
   Doctor with basic training
2. Yleislääketieteeseen erikoistuva lääkäri
   Vocational trainee of general practice
3. Yleislääketieteen erikoislääkäri
   General practitioner
4. Muulle erikoisalalle erikoistuva, erikoistumisala _____
   Vocational trainee of other speciality, what speciality
5. Muu erikoislääkäri, erikoistumisala _____
   Other specialist, what speciality

Työpaikka:
Working place

1. Terveyskeskus
   Health center
2. Sairaala
   Hospital
3. Yksityisvastaanotto
   Private practice
4. Joku muu, mikä _____
   Some other place, what

Työkokemus lääkärinä (vuosina): _____
Working experience as a doctor (in years)

Gynekologisten potilaiden osuus työssäsi: _____ %
The percentage of gynaecological patients in your work

Perhesuunnittelun osuus työssäsi: _____ tuntia/kuukausi
The share of family planning in your work, hours/month

Seuraavaksi haluaisimme tietää tupakointitavoistasi. Mikä seuraavista parhaiten kuvaa tupakointiasi:
We would like to know about your smoking habits. Which of the following best describes your smoking situation:

1. Poltan päivittäin noin _____ savuketta
   I smoke daily about... cigarettes
2. Poltan kerran viikossa tai useammin, mutta en päivittäin
   I smoke once a week or more often, but not daily
3. Poltan harvemmin kuin kerran viikossa
   I smoke less than once a week
4. Olen lopettanut tupakoinnin
   I have given up smoking
5. En ole koskaan tupakoinut
   I have never smoked

Suomen väkiluku on n. 5 000 000
The population of Finland is ca. 5 000 000

Mikä on arviosi seuraavista asioista:
What is your estimation of the following facts:

synnytysten kokonaismäärä vuodessa Suomessa? _____
the total number of births per year in Finland?

raskauden keskeytysten kokonaismäärä vuodessa Suomessa? _____
the total number of abortions per year in Finland?

Seuraavaksi haluaisimme tietää, onko sinulla henkilökohtaisessa käytössäsi
Next we would like to know if you have following instruments at your personal disposal

Gynekologinen tutkimuspöytä 1. Kyllä 2. Ei
Couch for gynaecological examination

Gynekologiset tutkimusvälineet 1. Kyllä 2. Ei
Gynaecological instruments

Miten tarpeellisia seuraavat kalusteet, instrumentit, lääkkeet ja laboratoriotutkimukset ovat sinulle päivittäisessä työssäsi. Arvioi asteikolla "Täysin tarpeeton"–"Erittäin tarpeellinen". Aseta pystysuora viiva asteikolle siihen kohtaan, joka vastaa mielipidettäsi.

How necessary the following pieces of furniture, instruments, drugs and examinations are for you in your daily work. Evaluate on the scale "Totally unnecessary" – "Very necessary". Put a mark on the line at the point, which corresponds to your opinion.

Esimerkki: Jos olet sitä mieltä, että otoskooppi on melko tärkeä, se tulisi merkitä asteikolle näin:
Example: Here is an example: If you think that auriscope is quite necessary the mark should be like this:

	Täysin tarpeeton Totally unnecessary	Erittäin tarpeellinen Very necessary
Otoskooppi *Auriscope*	———————————	———————————

	Täysin tarpeeton Totally unnecessary	Erittäin tarpeellinen Very necessary
Gynekologinen tutkimuspöytä *Couch for gynaecological examination*	———————————	———————————
Gynekologiset tutkimusvälineet *Gynaecological instruments*	———————————	———————————
Raskaustesti *Pregnancy test*	———————————	———————————
Ehkäisypilleri *Oral contraceptives*	———————————	———————————
Estrogeeni lääkkeenä *Oestrogen as drug*	———————————	———————————
PAPA-koe *Papanicolau smear test*	———————————	———————————

Mitä seuraavista ehkäisymenetelmistä olet suositellut potilaillesi? *Which of the following contraceptive methods have you recommended for your patients?*	1 = kyllä *yes*	2 = ei *no*
Biologiset menetelmät *Biological methods*	1	2
Keskeytetty yhdyntä *Withdrawal*	1	2
Kondomi *Condom*	1	2
Pessaari *Diaphragm*	1	2
Ehkäisyvaahto *Spermicidal foam*	1	2
Ehkäisypilleri *Oral contraceptives*	1	2

Hormonikierukka *Hormonal IUD (intra uterine device)*	1	2
Muu kierukka *Other IUD*	1	2
Depo-Provera	1	2
Norplant (ihonalainen ehkäisykapseli) *Norplant (subcutaneous contraceptive capsule)*	1	2
Katumuspillerit *Postcoital emergency pills*	1	2
Yhdynnän jälkeinen kierukka *Postcoital IUD*	1	2
Miehen sterilisaatio *Sterilization of man*	1	2
Naisen sterilisaatio *Sterilization of woman*	1	2

Arvioi seuraavien ehkäisymenetelmien tarpeellisuutta työssäsi alla olevalla asteikolla. Aseta pystysuora poikkiviiva asteikolle siihen kohtaan, joka vastaa mielipidettäsi.
Please evaluate the necessity of the following contraceptive methods in your work on the scale below. Put a mark on the line at the point which corresponds to your opinion.

	Täysin tarpeeton *Totally unnecessary*	Erittäin tarpeellinen *Very necessary*
Biologiset menetelmät *Biological methods*	_____	
Keskeytetty yhdyntä *Withdrawal*	_____	
Kondomi *Condom*	_____	
Pessaari *Diaphragm*	_____	
Ehkäisyvaahto *Spermicidal foam*	_____	
Ehkäisypillerit *Oral contraceptives*	_____	
Hormonikierukka *Hormonal IUD*	_____	
Muu kierukka *Other IUD*	_____	
Depo-Provera	_____	
Norplant (ihonalainen ehkäisykapseli) *Norplant (subcutaneous contraceptive capsule)*	_____	

	Täysin tarpeeton *Totally unnecessary*	Erittäin tarpeellinen *Very necessary*
Katumuspillerit *Postcoital emergency pills*		
Yhdynnän jälkeinen IUD *Postcoital IUD*		
Miehen sterilisaatio *Sterilization of man*		
Naisen sterilisaatio *Sterilization of woman*		

Oletko asentanut kierukoita 1. Kyllä 2. Ei
Have you inserted IUD? *Yes* *No*

Jos olet, niin koska ensimmäisen kerran? _____ (vuosi)
If yes, when was the first time? (year)

... ja missä vaiheessa lääkärin ammattiasi
... and at what point in your life as a doctor

1. Lääketieteellisten perusopintojen aikana
   During basic medical education
2. Orientoivan vaiheen aikana
   During orientating phase
3. Peruskoulutettuna lääkärinä
   As doctor with basic training
4. Yleislääketieteeseen erikoistuessa
   During specialization in general practice
5. Jossakin muussa vaiheessa, missä _____
   During some other phase, what

Kuinka monta kierukkaa olet asentanut? _____
How many IUDs have you inserted?

Seuraavaksi pyydämme sinua arvioimaan kuinka paljon ehkäisymenetelmiin liittyvää tietoa olet saanut seuraavista lähteistä. Aseta pystysuora poikkiviiva asteikolle kohtaan, joka vastaa mielipidettäsi.
Next we ask you to evaluate, how much knowledge connected with contraceptive methods you have got from the following sources. Put a mark on the line at the point which corresponds to your opinion.

	Ei lainkaan *Not at all*	Hyvin paljon *Very much*
Lääketieteelliset perusopinnot *Basic medical education*		
Erikoistumiskoulutus *Vocational training*		
Lääketieteellinen jatkokoulutus *Continuous medical education CME courses*		
Kolleegat *Colleagues*		

	Ei lainkaan *Not at all*	Hyvin paljon *Very much*
Omat potilaat Own patients		
Lääketieteelliset kirjat *Medical textbooks*		
Lääketieteelliset lehdet *Medical journals*		
Muut lehdet *Other journals*		
Televisio *Television*		
Radio		
Lääketehtaat *Pharmaceutical companies*		
Sanomalehdet *Newspapers*		

Seuraavassa on mielipiteitä ehkäisymenetelmistä. Arvioi oma mielipiteesi alla olevalla asteikolla. Aseta pystysuora poikkiviiva asteikolle siihen kohtaan, joka vastaa mielipidettäsi.

Here are some opinions about contraceptive methods. Evaluate your opinion on the scale below. Put a mark on the line at the point, which corresponds to your opinion.

	Täysin eri mieltä *Strongly disagree*	Täysin samaa mieltä *Strongly agree*
Ehkäisypillerit sopivat kaikille naisille *Oral contraceptives suit to all women*		
Ehkäisypillerit ovat kalliita *Oral contraceptives are expensive*		
Ehkäisypillerit ovat riskittömiä *Oral contraceptives are without risks*		
Ehkäisypillerit lihottavat *Oral contraceptives increase weight*		
Ehkäisypillerit aiheuttavat ylimääräisiä vuotoja *Oral contraceptives cause extra bleeding*		
On vaarallista tupakoida, jos käyttää ehkäisypillereitä *It is dangerous to smoke while using oral contraceptives*		

	Täysin eri mieltä *Strongly disagree*	Täysin samaa mieltä *Strongly agree*
Ehkäisypillerit lisäävät laskimotukosten vaaraa *Oral contraceptives increase risk of thrombosis*		
Kondomi suojaa sukupuolitaudeilta *Condom prevents venereal diseases*		
Kondomi on hyvä ehkäisymenetelmä teini-ikäisille *Condom is a good contraceptive method for teenagers*		
Ehkäisyvaahtoa täytyy käyttää kondomin kanssa *Spermicidal foam has to be used with condom*		
Pessaaria on helppo käyttää *Diaphragm is easy to use*		
Pessaari ei sovi teini-ikäisille *Diaphragm is not suitable for teenagers*		
Ihmisten ei tulisi luottaa biologisiin menetelmiin *People should not trust biological methods*		
Raskauden keskeytys on suositeltava ehkäisymenetelmä *Induced abortion is a recommendable contraceptive method*		
Kierukka on varma *IUD is safe*		
Kierukka on halpa *IUD is cheap*		
Kierukassa ei ole riskejä *IUD is without risks*		
Kierukka on helposti saatavissa *IUD is easily available*		
Kierukka lisää gynekologisia infektioita *IUD increases gynaecological infections*		
Kierukka lisää anemiaa *IUD increases anemia*		
Kierukka aiheuttaa vatsakipuja *IUD causes pain in abdomen*		
Kierukka ei ole varma raskauden ehkäisyssä *IUD is not sure in preventing pregnancies*		

	Täysin eri mieltä *Strongly disagree*	Täysin samaa mieltä *Strongly agree*
Opetusta ehkäisymenetelmistä tulisi antaa koulussa *Education about contraceptive methods should be given at school*		
Ehkäisymenetelmien opettaminen rohkaisee nuoria aloittamaan seksuaalielämän liian nuorena *Education about contraceptive methods encourages young people to start sexual life too early*		
Ehkäisymenetelmien opetus laskee raskauden keskeytysten määrää *Education about contraceptive methods will decrease abortions*		
Tehokkaat ehkäisymenetelmät uhkaavat pienen kansan olemassaoloa *Effective contraceptive methods threaten the existence of a small nation*		
Perhesuunnittelun tulisi olla oleellinen osa työtäni lääkärinä *Family planning should be an essential part of my work as a doctor*		
Seksuaalikasvatus on olennainen osa lääkärin työtä *Sexual education is an essential part of doctors work*		
Hyvä raskauden ehkäisy antaa naiselle enemmän itsenäisyyttä *Good contraception gives more independence for woman*		
Miehen tulee osallistua perhesuunnittelua koskevaan päätöksentekoon *Man shall participate in decicion making concerning family planning*		
Yleislääkäri kykenee huolehtimaan perhesuunnittelusta *General practitioner is able to take care of family planning*		
Potilaiden on helpompi käydä perhesuunnitteluun liittyvissä asioissa yleislääkärillä kuin gynekologilla *It is easier for patients to visit a general practitioner than a gynaecologist concerning family planning*		

Tartossa 10. elokuuta 1996

Appendix 4

Hyvä Kollega,

Viron perhelääkärit ovat huolissaan maansa korkeista aborttiluvuista. Siksi virolaiset perhelääkärit ovat kehittämässä perheneuvontaa yleislääkäritoimintana. Hankkeeseen liittyy tutkimusprojekti, jonka taustatukena ovat kollegat Tarton, Tampereen ja Turun yliopistoista*. Hankkeen arvioinnin kannalta on tärkeää tietää, miten suomalaiset yleislääkärit toimivat ja ajattelevat perhesuunnitteluun liittyvissä kysymyksissä.

Kuulut Suomen Lääkäriliiton jäsenrekisteristä tehtyyn terveyskeskuslääkärien satunnaisotantaan (N=351). Tähän mennessä olemme saaneet vastauksen noin 200 suomalaiselta kollegalta. Epäilemme, että kyseinen vastausprosentti ei vielä anna täysin oikeata kuvaa suomalaisten perusterveydenhuollossa toimivien lääkärien perhesuunnitteluun liittyvistä kokemuksista ja mielipiteistä. Koska kysely on ajoittunut kesälomakauteen, lähetämme kyselyn vielä kerran niille, joiden vastausta emme ole saaneet. Mielipiteesi on meille tärkeä, vaikka perhesuunnittelu ei mitenkään liittyisi nykyisiin työtehtäviisi.

Mikäli et halua vastata täydelliseen kyselyyn, toivomme, että siinä tapauksessa kuitenkin täyttäisit ja palauttaisit mukana seuraavan lyhyen tiedonannon. Se on tärkeä kyselyn luotettavuutta arvioitaessa.

Vastaukset käsitellään täysin luottamuksellisesti ja tulokset julkaistaan taulukkomuodossa ja tilastollisina suureina. Tähän asti lomakkeissa on ollut tunnusnumero postituksen seuraamiseksi. Nyt lomakkeissa ei enää ole tunnusnumeroa, joten voit olla varma siitä, että vastauksia ei voida yhdistää henkilöösi. Kirjekuori tulee numeroituna, mutta palautuskuoressa ja lomakkeessa ei ole numerointia.

Toivon, että saamme Sinulta postia 10. syyskuuta 1996 mennessä. Postimaksu on maksettu puolestasi. Tarvittaessa kollega Anna-Leena Kirkkola Suomesta antaa mielellään lisätietoja (puh. 931-2156111 tai 937-5422555).

Kiitos avustasi

Margus Lember
Eesti Pereartide Seltsin puheenjohtaja, Tarton yliopiston dosentti

*Tutkimusryhmä: Heili Sarapuu, Margus Lember, Aili Pikk, Anna-Leena Kirkkola, Mauri Isokoski, Irma Virjo, Kari Mattila

Hyvä Kollega,

Vastaa tähän tiedonantoon vain, mikäli et halua vastata varsinaiseen kyselylomakkeeseen. Nämä tiedot ovat meille tärkeitä arvioidessamme kyselyn katoa. Palauta tämä tiedonanto tutkijoille mukana seuraavassa kirjekuoressa. Postimaksu on maksettu puolestasi. Tätä ilmoitusta ei voida mitenkään yhdistää henkilöösi.

Rengasta oikean vaihtoehdon numero tai kirjoita vastaus sille varattuun tyhjään tilaan.

Oletko?

1. Nainen,
2. Mies

Minkä ikäinen olet? _____ vuotta

Mikä on työpaikkasi tällä hetkellä?

1. Terveyskeskus
2. Sairaala
3. Yksityisvastaanotto
4. Muu

Miksi et halua vastata kyselyyn?
Valitse asiaan vaikuttaneet syyt oheisista tai kerro ne omin sanoin.

1. Tutkimus on lähtökohdiltaan asenteellinen.
2. En näe tutkimuksesta olevan mitään hyötyä, kyse on "nollatutkimuksesta".
3. En usko tutkijoiden vakuutuksiin vastausten luottamuksellisuudesta.
4. Tämän tutkimuksen kyselylomake on työläs vastattavaksi.
5. Lomaketta on vaikea täyttää, koska äidinkieleni ei ole suomi.
6. Kysymykset ovat tutkimustavoitteen kannalta huonoja.
7. En yleensä vastaa kyselyihin.
8. Perhesuunnittelu ei kiinnosta minua.
9. Perhesuunnittelu ei kuulu päivittäiseen työhöni.
10. Perhesuunnittelu on vastoin vakaumustani.
11. Vastaamisesta ei ole minulle mitään hyötyä.
12. En halua tukea "meriitti"tutkimusta.
13. Minulla ei ole aikaa paneutua vastaamiseen.
14. Jokin muu syy, mikä?

_____

_____

Appendix 5

KYSELYLOMAKE SUOMALAISILLE NAISILLE

Ensiksi hieman taustatietoja. Ympyröi oikean vaihtoehdon numero ja/tai kirjoita vastaus annettuun tilaan.

Ikä: _____

Peruskoulutus:
1. kansakoulu (tai vähemmän)
2. keski- tai peruskoulu
3. ylioppilastutkinto

Siviilisääty:
1. Naimaton
2. Naimisissa
3. Avoliitossa
4. Eronnut
5. Leski

Ammattikoulutus:
1. ei ammattikoulutusta
2. ammattikurssi tai -kursseja
3. koulutason ammatillinen tutkinto
4. opistotason ammatillinen tutkinto
5. korkeakoulututkinto

Uskonto:
1. Luterilainen
2. Ortodoksi
3. Roomalaiskatolinen
4. Ateisti
5. Jotakin muuta: _____
6. En osaa sanoa
7. Minulla ei ole uskontoa

Kotikunta: _____

Mikä seuraavista parhaiten kuvaa tupakointiasi:
1. Poltan päivittäin noin _____ savuketta
2. Poltan kerran viikossa tai useammin, mutta en päivittäin
3. Poltan harvemmin kuin kerran viikossa
4. Olen lopettanut tupakoinnin
5. En ole koskaan tupakoinut

Seuraavat kaksi kysymystä koskevat ehkäisyvälineisiin liittyvää tietoutta.

Jos kondomi menee rikki yhdynnässä ja haluatte välttyä ei-toivotulta raskaudelta, niin naisen tulee ottaa jälkiehkäisypillerit:
1. 2 tunnin kuluessa
2. 24 tunnin kuluessa
3. 48 tunnin kuluessa
4. 72 tunnin kuluessa
5. viikon kuluessa

Kierukka on ehkäisyväline, joka asetetaan:
1. emättimen pohjaan
2. kohdun sisälle
3. munasarjaan
4. vatsaonteloon
5. ihon alle

Kuinka usein olet sukupuolisessa kanssakäymisessä?
1. useita kertoja viikossa
2. noin kerran viikossa
3. 2–3 kertaa kuukaudessa
4. noin kerran kuukaudessa
5. 3–10 kertaa vuodessa
6. 1–2 kertaa vuodessa
7. harvemmin
8. ei lainkaan

Seuraavaksi haluaisimme tietää kuinka paljon ehkäisyyn liittyvää tietoutta olet saanut eri tahoilta. Vedä pystysuora viiva asteikolle siihen kohtaan, joka vastaa mielipidettäsi.

Esimerkki: Jos olet sitä mieltä, että olet saanut työkaveriltasi melko paljon ehkäisyyn liittyvää tietoutta, se tulisi merkitä asteikolle näin:

	Ei lainkaan	Hyvin paljon
Työkaveri	——————————+——	

Miten paljon raskauden ehkäisyyn liittyvää tietoa olet saanut seuraavilta?

	Ei lainkaan	Hyvin paljon
Isä		
Äiti		
Veli		
Sisko		
Ystävä (poika/mies)		
Ystävä (tyttö/nainen)		
Puoliso/partneri		
Lääkäri		
Koulun terveydenhoitaja		
Opettaja		
Kirjallisuus		
Miestenlehdet		
Naistenlehdet		
Televisio		
Radio		

Mitä seuraavista ehkäisymenetelmistä olet käyttänyt yhdessä kumppanisi tai kumppaniesi kanssa? Ympyröi oikean vaihtoehdon numero.

	1=kyllä	2=ei	3=en tiedä
Biologiset menetelmät eli "varmat päivät"	1	2	3
Keskeytetty yhdyntä	1	2	3
Kondomi	1	2	3
Pessaari	1	2	3
Ehkäisyvaahto	1	2	3
Ehkäisypilleri	1	2	3
Hormonikierukka	1	2	3
Muu kierukka	1	2	3
Depo provera (hormoniruiske)	1	2	3
Norplant (ihonalainen ehkäisykapseli)	1	2	3

	1=kyllä	2=ei	3=en tiedä
Jälkiehkäisy eli katumuspillerit	1	2	3
Yhdynnän jälkeinen kierukka	1	2	3
Miehen sterilisaatio	1	2	3
Naisen sterilisaatio	1	2	3

Mitkä ovat mielestäsi kolme parasta ehkäisymenetelmää? 1. _____

2. _____

3. _____

Vaikuttaako uskonto raskauden ehkäisyä koskeviin päätöksiisi? 1. Kyllä 2. Ei

Seuraavat kysymykset koskevat raskauksia ja synnytyksiä:

Oletko ollut raskaana? 1. Kyllä 2. En

Jos vastauksesi on "En", siirry suoraan seuraavaan kysymysryhmään.

Synnytysten lukumäärä _____

Ikä ensimmäisen raskauden alkaessa _____

Kohdunulkoisten raskauksien lukumäärä _____

Itsestään tapahtuneiden keskenmenojen lukumäärä _____

Raskauden keskeytysten lukumäärä _____

Seuraava osa sisältää mielipiteitä perhesuunnittelusta. Arvioi omat mielipiteesi alla olevalla asteikolla. Vedä pystysuora poikkiviiva asteikolle siihen kohtaan, joka vastaa mielipidettäsi.

	Täysin eri mieltä	Täysin samaa mieltä
Ehkäisypillerit sopivat kaikille naisille	_____	
Ehkäisypillerit ovat kalliita	_____	
Ehkäisypillerit ovat riskittömiä	_____	
Ehkäisypillerit lihottavat	_____	
Ehkäisypillerit aiheuttavat ylimääräisiä vuotoja	_____	
On vaarallista tupakoida, jos käyttää ehkäisypillereitä	_____	
Ehkäisypillerit lisäävät laskimotukoksen vaaraa	_____	
Ehkäisypillereiden päivittäinen käyttö on epämukavaa	_____	
Kondomi suojaa sukupuolitaudeilta	_____	
Kondomi on halpa	_____	
Kondomi on helposti saatavilla	_____	

	Täysin eri mieltä	Täysin samaa mieltä
Kondomi on hyvä ehkäisymenetelmä teini-ikäisille		
Ehkäisyvaahtoa täytyy käyttää kondomin kanssa		
Pessaaria on helppo käyttää		
Pessaari ei sovi teini-ikäisille		
Ihmisten ei tulisi luottaa biologisiin menetelmiin eli "varmoihin päiviin"		
Raskauden keskeytys on suositeltava ehkäisymenetelmä		
Kierukka on turvallinen		
Kierukka on halpa		
Kierukassa ei ole riskejä		
Kierukka on helposti saatavissa		
Kierukka lisää synnytinelinten tulehduksia		
Kierukka lisää anemiaa		
Kierukka aiheuttaa vatsakipuja		
Kierukka ei ole varma raskauden ehkäisyssä		
Opetusta ehkäisymenetelmistä tulisi antaa koulussa		
Ehkäisymenetelmien opettaminen rohkaisee nuoria aloittamaan seksuaalielämän liian nuorena		
Ehkäisymenetelmien opetus laskee raskaudenkeskeytysten määrää		
Tehokkaat ehkäisymenetelmät uhkaavat pienen kansan olemassaoloa		
Seksuaalikasvatus on olennainen osa lääkärin työtä		
Hyvä raskauden ehkäisy antaa naiselle enemmän itsenäisyyttä		
Miehen tulee osallistua perhe-suunnittelua koskevaan päätöksentekoon		
Terveyskeskuslääkäri kykenee huolehtimaan perhesuunnittelusta		
On helpompi käydä perhesuunnitteluun liittyvissä asioissa terveyskeskuslääkärillä kuin gynekologilla		

Appendix 6

KYSELYLOMAKE SUOMALAISILLE MIEHILLE

Ensiksi hieman taustatietoja. Ympyröi oikean vaihtoehdon numero ja/tai kirjoita vastaus annettuun tilaan.

Ikä: _____

Peruskoulutus:
1. kansakoulu (tai vähemmän)
2. keski- tai peruskoulu
3. ylioppilastutkinto

Siviilisääty:
1. Naimaton
2. Naimisissa
3. Avoliitossa
4. Eronnut
5. Leski

Ammattikoulutus:
1. ei ammattikoulutusta
2. ammattikurssi tai -kursseja
3. koulutason ammatillinen tutkinto
4. opistotason ammatillinen tutkinto
5. korkeakoulututkinto

Uskonto:
1. Luterilainen
2. Ortodoksi
3. Roomalaiskatolinen
4. Ateisti
5. Jotakin muuta: _____
6. En osaa sanoa
7. Minulla ei ole uskontoa

Kotikunta: _____

Mikä seuraavista parhaiten kuvaa tupakointiasi:
1. Poltan päivittäin noin _____ savuketta
2. Poltan kerran viikossa tai useammin, mutta en päivittäin
3. Poltan harvemmin kuin kerran viikossa
4. Olen lopettanut tupakoinnin
5. En ole koskaan tupakoinut

Lasten lukumäärä: _____

Onko partnerillesi koskaan tehty aborttia? 1. Kyllä 2. Ei

Seuraavat kaksi kysymystä koskevat ehkäisyvälineisiin liittyvää tietoutta.

Jos kondomi menee rikki yhdynnässä ja haluatte välttyä ei-toivotulta raskaudelta, niin naisen tulee ottaa jälkiehkäisypillerit:
1. 2 tunnin kuluessa
2. 24 tunnin kuluessa
3. 48 tunnin kuluessa
4. 72 tunnin kuluessa
5. viikon kuluessa

Kierukka on ehkäisyväline, joka asetetaan:
1. emättimen pohjaan
2. kohdun sisälle
3. munasarjaan
4. vatsaonteloon
5. ihon alle

Kuinka usein olet sukupuolisessa kanssakäymisessä?

1. useita kertoja viikossa
2. noin kerran viikossa
3. 2–3 kertaa kuukaudessa
4. noin kerran kuukaudessa
5. 3–10 kertaa vuodessa
6. 1–2 kertaa vuodessa
7. harvemmin
8. ei lainkaan

Seuraavaksi haluaisimme tietää kuinka paljon ehkäisyyn liittyvää tietoutta olet saanut eri tahoilta. Vedä pystysuora viiva asteikolle siihen kohtaan, joka vastaa mielipidettäsi.

Esimerkki: Jos olet sitä mieltä, että olet saanut työkaveriltasi melko paljon ehkäisyyn liittyvää tietoutta, se tulisi merkitä asteikolle näin:

	Ei lainkaan	Hyvin paljon
Työkaveri	———————————	

Miten paljon raskauden ehkäisyyn liittyvää tietoa olet saanut seuraavilta?

	Ei lainkaan	Hyvin paljon
Isä		
Äiti		
Veli		
Sisko		
Ystävä (poika/mies)		
Ystävä (tyttö/nainen)		
Puoliso/partneri		
Lääkäri		
Koulun terveydenhoitaja		
Opettaja		
Kirjallisuus		
Miestenlehdet		
Naistenlehdet		
Televisio		
Radio		

Mitä seuraavista ehkäisymenetelmistä olet käyttänyt yhdessä kumppanisi tai kumppaniesi kanssa? Ympyröi oikean vaihtoehdon numero.

	1=kyllä	2=ei	3=en tiedä
Biologiset menetelmät eli "varmat päivät"	1	2	3
Keskeytetty yhdyntä	1	2	3
Kondomi	1	2	3
Pessaari	1	2	3

	1=kyllä	2=ei	3=en tiedä
Ehkäisyvaahto	1	2	3
Ehkäisypilleri	1	2	3
Hormonikierukka	1	2	3
Muu kierukka	1	2	3
Depo provera (hormoniruiske)	1	2	3
Norplant (ihonalainen ehkäisykapseli)	1	2	3
Jälkiehkäisy eli katumuspillerit	1	2	3
Yhdynnän jälkeinen kierukka	1	2	3
Miehen sterilisaatio	1	2	3
Naisen sterilisaatio	1	2	3

Mitkä ovat mielestäsi kolme parasta ehkäisymenetelmää? 1. _____

2. _____

3. _____

Vaikuttaako uskonto raskauden ehkäisyä koskeviin päätöksiisi? 1. Kyllä 2. Ei

Seuraava osa sisältää mielipiteitä perhesuunnittelusta. Arvioi omat mielipiteesi alla olevalla asteikolla. Vedä pystysuora poikkiviiva asteikolle siihen kohtaan, joka vastaa mielipidettäsi.

	Täysin eri mieltä	Täysin samaa mieltä
Ehkäisypillerit sopivat kaikille naisille	_____	
Ehkäisypillerit ovat kalliita	_____	
Ehkäisypillerit ovat riskittömiä	_____	
Ehkäisypillerit lihottavat	_____	
Ehkäisypillerit aiheuttavat ylimääräisiä vuotoja	_____	
On vaarallista tupakoida, jos käyttää ehkäisypillereitä	_____	
Ehkäisypillerit lisäävät laskimotukoksen vaaraa	_____	
Ehkäisypillereiden päivittäinen käyttö on epämukavaa	_____	
Kondomi suojaa sukupuolitaudeilta	_____	
Kondomi on halpa	_____	
Kondomi on helposti saatavilla	_____	

	Täysin eri mieltä	Täysin samaa mieltä
Kondomi on hyvä ehkäisymenetelmä teini-ikäisille		
Ehkäisyvaahtoa täytyy käyttää kondomin kanssa		
Pessaaria on helppo käyttää		
Pessaari ei sovi teini-ikäisille		
Ihmisten ei tulisi luottaa biologisiin menetelmiin eli "varmoihin päiviin"		
Raskauden keskeytys on suositeltava ehkäisymenetelmä		
Kierukka on turvallinen		
Kierukka on halpa		
Kierukassa ei ole riskejä		
Kierukka on helposti saatavissa		
Kierukka lisää synnytinelinten tulehduksia		
Kierukka lisää anemiaa		
Kierukka aiheuttaa vatsakipuja		
Kierukka ei ole varma raskauden ehkäisyssä		
Opetusta ehkäisymenetelmistä tulisi antaa koulussa		
Ehkäisymenetelmien opettaminen rohkaisee nuoria aloittamaan seksuaalielämän liian nuorena		
Ehkäisymenetelmien opetus laskee raskaudenkeskeytysten määrää		
Tehokkaat ehkäisymenetelmät uhkaavat pienen kansan olemassaoloa		
Seksuaalikasvatus on olennainen osa lääkärin työtä		
Hyvä raskauden ehkäisy antaa naiselle enemmän itsenäisyyttä		
Miehen tulee osallistua perhesuunnittelua koskevaan päätöksentekoon		
Terveyskeskuslääkäri kykenee huolehtimaan perhesuunnittelusta		
On helpompi käydä perhesuunnitteluun liittyvissä asioissa terveyskeskuslääkärillä kuin gynekologilla		

Tampere 11.8.1997

Appendix 7

Arvoisa vastaanottaja,

Tampereen, Tarton ja Turun yliopistoissa on meneillään tutkimus- ja kehitysohjelma, jonka tavoitteena on kehittää perhesuunnittelupalveluja Virossa ja Suomessa.

Kuulutte väestörekisterikeskuksen arpomaan otokseen. Edustatte oman ikäluokkanne suomalaisia. Teille on lähetetty kyselylomake alkukesästä. Emme ole vielä saaneet vastaustanne. Vastauksenne on tärkeä, jotta voidaan muodostaa mahdollisimman todenmukainen kuva suomalaisten naisten ja miesten mielipiteistä ja kokemuksista. Aikaisemmissa lomakkeissa on ollut numerointi postituksen seurantaa varten. Tähän postitukseen kuuluvissa lomakkeissa ei ole numeroa, joten voitte olla täysin varma siitä, että vastauksia ei voida yhdistää henkilöön.

Toivon, että palautatte vastauslomakkeenne mukaan liitetyssä kirjekuoressa 31.8. 1997 mennessä. Postimaksu on maksettu puolestanne. Mikäli ette halua täyttää kyselylomaketta, toivon, että siitä huolimatta vastaisitte värillisellä paperilla oleviin kysymyksiin.

Tarvittaessa lisätietoja antaa tutkija Anna-Leena Kirkkola p. 03-2662464

Kari Mattila
Professori
Tampereen yliopisto

Osoitelähde: Väestötietojärjestelmä
Väestörekisterikeskus
PL 7
00521 HELSINKI

Mikäli ette halua täyttää varsinaista kyselylomaketta, pyydän, että vastaisitte tämän sivun kysymyksiin. Ympyröikää mielipidettänne vastaavan vaihtoehdon numero, voitte vastata useampaankin vaihtoehtoon. Voitte myös kirjoittaa mielipiteenne sivun alaosaan.

Olen jättänyt vastaamatta perhesuunnittelua koskevaan kyselylomakkeeseen, koska

1. en yleensä vastaa kyselyihin

2. kyselylomake on liian pitkä

3. kyselylomake on vaikea täyttää

4. en ymmärrä kysymyksiä

5. en ole koskaan joutunut tekemisiin perhesuunnittelun kanssa

6. kyselylomakkeessa on liian intiimejä kysymyksiä

7. perhesuunnittelu ei kuulu miehille

8. en usko voivani vaikuttaa vastaamalla

9. erilaisia kyselylomakkeita tulee liikaa

10. en halua olla tutkimushenkilönä

11. pelkään henkilöllisyyteni paljastuvan

12. en jaksa vastata

13. en vastaa uskonnollisista syistä

14. jokin muu syy, mikä:

APPENDIX TABLES

Table1. "Evaluate the necessity of the following contraceptive methods in your work" Evaluations of Finnish health centre physicians on VAS scale from totally unnecessary (0) to very necessary (100) by gender: mean VAS value and statistical significance of difference .N=number of respondents in various modes.

Contraceptive method	Woen N=108-130 mean VAS	Men N=93-103 mean VAS	p-value
Oral contraceptives	89	81	0.005
Ordinary IUD	86	76	0.001
Hormonal IUD	85	70	<0.001
Condom	77	73	n.s.
Female sterilization	71	611	0.003
Postcoital emergency pills	68	64	n.s.
Male sterilization	62	54	0.02
Norplant®	48	41	0.05
Postcoital IUD	40	34	n.s.
Spermicidal foam	31	30	n.s.
Diaphragm	25	2	n.s.
Depo Provera®	24	27	n.s.
Biological methods	17	18	n.s.
Withdrawal	12	14	n.s.

Table 2. "Evaluate the necessity of the following contraceptive methods in your work" Evaluations of Finnish health centre physicians by family planning work on VAS scale from totally unnecessary (0) to very necessary (100): mean VAS value and statistical significance of difference. N=number of respondents in various modes.

Contraceptive method	Physician´s family planning work		p-value
	Yes	No	
	N=134-158	N=32-35	
Oral contraceptives	89	71	<0.001
Ordinary IUD	86	66	<0.001
Hormonal IUD	83	64	<0.001
Condom	77	70	n.s.
Female sterilization	71	47	<0.001
Postcoital emergency pills	68	56	0.019
Male sterilization	61	45	0.02
Norplant®	48	35	0.019
Postcoital IUD	39	30	n.s.
Spermicidal foam	32	25	n.s.
Diaphragm	27	26	n.s.
Depo Provera®	26	22	n.s.
Biological methods	17	15	n.s.
Withdrawal	13	13	n.s.

Table 3. "Where is the IUD inserted?" Answers (%) of Finnish population by gender and age groups.

	Women			Men		
	Age group			Age group		
	18-29	30-40	>=41	18-29	30-40	>=41
	N=59	N=58	N=55	N=68	N=71	N=66
	%	%	%	%	%	%
Intrauterinely	50	59	67	36	41	55
Bottom of vagina	46	37	32	48	47	44
In ovary	3	4	0	17	12	2
Subcutaneously	2	0	2	0	0	0.

Table 4. "Where is the IUD inserted?" Answers (%) of Finnish population by gender and marital status.

	Women				Men			
	single	married	cohabiting	divorced/ widowed	single	married	cohabiting	divorced/ widowed
	N=49	N=104	N=36	N=16	N=42	N=86	N=30	N=11
	%	%	%	%	%	%	%	%
Intrauterinely	51	68	44	58	31	52	23	73
Bottom of vagina	43	31	50	31	55	40	60	27
In ovary	4	0	6	6	14	8	17	0
Subcutaneously	2	0	0	6	0	0	0	0

Table 5. "Where is the IUD inserted?" Answers (%) of Finnish population by gender and educational level.

	Women Education			Men Education		
	low	medium	high	low	medium	high
	N=59	N=67	N=77	N=36	N=73	N=63
	%	%	%	%	%	%
Intrauterinely	54	58	64	47	51	40
Bottom of vagina	46	36	34	50	40	44
In ovary	0	5	3	3	10	16
Subcutaneously	0	2	0	0	0	0

Table 6. "Where is the IUD inserted?" Answers (%) of Finnish population by gender and sexual activity.

	Women Sexual activity		Men Sexual activity	
	high	low	high	low
	N=129	N=75	N=103	N=66
	%	%	%	%
Intrauterine	57	63	38	52
Bottom of vagina	40	33	50	41
In ovariy	2	3	13	8
Subcutaneously	1	1	0	0

Table 7. The proportion of Finnish men and women who have ever used together with their partner(s) contraceptive methods by age group, and statistical significance of difference. N = number of respondents in various modes.

	Men					Women				
Contraceptive method	single	married	cohabiting	divorced/ widowed	p-value	single	married	cohabiting	divorced/ widowed	p-value
	N=39-40	N=74-83	N=26-30	N=9-11		N=44-49	N=92-107	N=29-34	N=9-13	
	%	%	%	%		%	%	%	%	
Oral contraceptives	80	86	97	100	0.04	76	83	79	100	n.s.
Hormonal IUD	8	20	15	22	n.s.	0	17	3	27	0.001
Ordinary IUD	3	48	7	78	<0.001	9	40	25	77	<0.001
Female sterilization	3	20	4	0	<0.006	11	20	13	33	n.s.
Male sterilization	0	5	0	0	n.s.	0	4	3	0	n.s.

Table 8. The proportion of Finnish men and women who have ever used together with their partner(s) contraceptive methods by marital status and statistical significance of difference. N = number of respondents in various modes.

Contraceptive method	Men				Women			
	Age group				Age group			
	18-29	30-40	≥14	p-value	18-29	30-40	≥14	p-value
	N=56-59	N=52-59	N=43-55		N=64-71	N=62-71	N=54-66	
	%	%	%		%	%	%	
Oral contraceptives	93	84	85	n.s.	79	86	81	n.s.
Ordinary IUD	2	36	63	<0.001	8	25	65	<0.001
Hormonal IUD	0	22	28	<0.001	0	17	18	<0.001
Female sterilization	0	8	31	<0.001	0	17	37	<0.001
Male sterilization	0	2	7	n.s.	0	0	9	0.002

Table 9. The proportion of Finnish men and women who have ever used together with their partner(s) contraceptive methods by educational level, and statistical significance of difference. N = number of respondents in various modes.

Contraceptive method	Men				Women			
	Education				Education			
	low	medium	high	p-value	low	medium	high	p-value
	N=31-35	N=63-71	N=57-61		N=47-59	N=59-66	N=69-77	
	%	%	%		%	%	%	
Oral contraceptives	80	86	93	n.s.	78	72	92	0.005
Ordinary IUD	41	30	29	n.s.	37	32	27	n.s.
Female sterilization	16	11	10	n.s.	25	14	15	n.s.
Hormonal IUD	27	15	11	n.s.	17	11	6	n.s.
Male sterilization	3	3	2	n.s	4	0	4	n.s.

Table 10. The proportion of Finnish men who have ever used together with their partner(s) contraceptive methods by children and partner´s induced abortions. N = number of respondents in various modes.

	Children			Partner(s) induced abortions		
Contraceptive method	yes	no	p-value	yes	no	p-value
	N=81-93	N=70-74		N=27	N=120-136	
	%	%		%	%	
Oral contraceptives	88	87	n.s.	96	86	n.s.
Ordinary IUD	56	4	<0.001	44	29	n.s.
Female sterilization	20	3	0.001	19	9	n.s.
Hormonal IUD	27	3	<0.001	19	16	n.s.
Male sterilization	5	0	0.024	0	3	n.s.

Table 11. The proportion of Finnish women who have ever used together with their partner(s) contraceptive methods by deliveries and induced abortions, and statistical significance of difference. N=number of repondents in various modes.

	Deliveries			Induced abortions		
Contraceptive method	yes	no	p-value	yes	no	p-value
	N=109-130	N=66-74		N=33-39	N=142-165	
	%	%		%	%	
Oral contraceptives	82	81	n.s.	77	83	n.s.
Ordinary IUD	48	3	<0.001	43	30	n.s.
Female sterilization	25	4	<0.001	41	12	<0.001
Hormonal IUD	18	0	<0.001	12	11	n.s.
Male sterilization	4	2	n.s.	3	3	n.s.

Table 12. The proportion of Finnish men and women who have ever used together with their partner(s) contraceptive methods by sexual activity, and statistical significance of difference. N = number of respondents in various modes.

	Men			Women		
Contraceptive method	Sexual activity			Sexual activity		
	high	low	p-value	high	low	p-value
	N=93-104	N=55-60		N=118-130	N=56-73	
	%	%		%	%	
Oral contraceptives	93	78	0.006	86	74	0.034
Ordinary IUD	35	26	n.s.	29	39	n.s.
Female sterilization	12	11	n.s.	15	22	n.s.
Hormonal IUD	14	19	n.s.	14	5	n.s.
Male sterilization	3	2	n.s.	2	5	n.s.

Table 13. The proportion of Finnish men and women who have ever used together with their partner(s) contraceptive methods by religion, and statistical significance of difference. N = number of repondents in various modes.

Contraceptive method	Men				Women			
	Religion				Religion			
	Lutheran	atheist/ no religion	other	p-value	Lutheran	atheist/ no religion	other	p-value
	N=125-140	N=17-18	N=8-9		N=149-174	N=16-19	N=10-11	
	%	%	%		%	%	%	
Oral contraceptives	87	94	75	n.s.	84	84	46	0.019
Ordinary IUD	28	59	38	0.047	32	41	18	n.s.
Female sterilization	12	12	13	n.s.	17	19	20	n.s.
Hormonal IUD	17	6	22	n.s.	12	6	0	n.s.
Male sterilization	3	0	0	n.s.	3	6	0	n.s.

Table 14. The proportion of Finnish men and women who have ever used together with their partner(s) contraceptive methods by age group, and statistical significance of difference. N = number of respondents in various modes.

Contraceptive method	Men				Women			
	Age group				Age group			
	18-29	30-40	>=41	p-value	18-29	30-40	>=41	p-value
	N=64-71	N=62-71	N=54-66		N=56-59	N=52-59	N=43-55	
	%	%	%		%	%	%	
Condom	90	93	89	n.s.	97	94	96	n.s.
Withdrawal	54	42	51	n.s.	53	34	60	0.013.
Postcoital emergency pills	26	0	13	<0.001	34	5	0	<0.001
Biological methods	27	27	42	n.s.	28	28	39	n.s.
Spermicidal foam	4	8	18	0.043	6	13	22	0.046

Table 15. The proportion of Finnish men and women who have ever used together with their partner(s) contraceptive methods by marital status, and statistical significance of difference. N = number of respondents in various modes.

	Men					Women				
Contraceptive method	single	married	cohabiting	divorced/ widowed	p-value	single	married	cohabiting	divorced/ widowed	p-value
	N=39-42	N=73-86	N=25-31	N=9-11		N=44-48	N=92-109	N=29-36	N=9-15	
	%	%	%	%		%	%	%	%	
Condom	79	94	97	91	0.03	96	94	100	100	n.s.
Withdrawal	51	42	61	67	n.s.	45	51	34	92	0.002
Postcoital emergency pills	20	8	18	22	n.s.	30	3	29	0	<0.001
Biological methods	23	35	32	44	n.s.	21	33	26	69	0.012
Spermicidal foam	3	12	4	30	0.046	4	16	7	30	n.s.

Table 16. The proportion of Finnish men and women who have ever used together with their partner(s) contraceptive methods by educational level, and statistical significance of difference. N = number of respondents in various modes.

Contraceptive method	Men				Women			
	Education				Education			
	low	medium	high	p-value	low	medium	high	p-value
	N=30-37	N=62-73	N=56-63		N=47-61	N=59-69	N=69-79	
	%	%	%		%	%	%	
Condom	87	92	92	n.s.	95	94	98	n.s.
Spermicidal foam	13	5	12	0.05	15	12	13	n.s.
Withdrawal	47	55	44	n.s.	58	45	47	n.s.
Biological methods	27	38	27	n.s.	28	28	35	n.s.
Postcoital emergency pills	15	14	12	n.s.	14	16	13	n.s.

Table 17. The proportion of Finnish men who have ever used together with their partner(s) contraceptive methods by children and partner´s induced abortions, and statistical significance of difference. N = number of respondents in various modes.

	Children			Partner(s) induced abortions		
Contraceptive method	yes	no	p-value	yes	no	p-value
	N=79-95	N=69-78		N=26-27	N=117-142	
	%	%		%	%	
Condom	94	87	n.s.	100	89	0.021
Withdrawal	49	49	n.s.	65	46	n.s.
Biological methods	38	24	n.s.	44	29	n.s.
Spermicidal foam	11	7	n.s.	4	11	n.s.
Postcoital emergency pills	7	21	0.012	7	15	n.s.

Table 18. The proportion of Finnish women who have ever used together with their partner(s) contraceptive methods by deliveries and induced abortions, and statistical significance of difference. N = number of respondents in various modes.

	Deliveries			Induced abortions		
Contraceptive method	yes	no	p-value	yes	no	p-value
	N=109-134	N=66-75		N=33-36	N=142-171	
	%	%		%	%	
Condom	95	97	n.s.	95	96	n.s.
Withdrawal	55	40	n.s.	65	46	0.034
Biological methods	36	22	0.05	43	28	n.s.
Spermicidal foam	17	6	0.028	23	11	n.s.
Postcoital emergency pills	7	26	<0.001	21	13	n.s.

Table 19. The proportion of Finnish men and women who have ever used together with their partner(s) contraceptive methods by sexual activity, and statistical significance of difference. N = number of respondents in various modes.

Contraceptive method	Men			Women		
	Sexual activity			Sexual activity		
	high	low	p-value	high	low	p-value
	N=90-105	N=55-65		N=118-134	N=56-74	
	%	%		%	%	
Condom	94	86	n.s.	96	95	n.s.
Withdrawal	57	35	0.006	48	52	n.s.
Biological methods	34	28	n.s.	27	38	n.s.
Postcoital emergency pills	19	5	0.013	15	12	n.s.
Spermicidal foam	1	1	n.s.	11	16	n.s.

Table 20. The proportion of Finnish men and women who have ever used together with their partner(s) contraceptive methods by religion, aand statistical significance of difference. N = number of respondents in various modes.

Contraceptive method	Men				Women			
	Religion				Religion			
	Lutheran	atheist/ no religion	other	p-value	Lutheran	atheist/ no religion	other	p-value
	N=125-144	N=15-18	N=7-10		N=149-180	N=16-18	N=10-11	
	%	%	%		%	%	%	
Condom	90	94	100	n.s.	96	100	82	n.s.
Withdrawal	48	50	56	n.s.	48	58	50	n.s.
Biological methods	32	29	33	n.s.	30	32	50	n.s.
Postcoital emergency pills	14	12	13	n.s.	14	19	10	n.s.
Spermicidal foam	8	1	13	n.s.	13	12	20	n.s.

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