UNIVERSITY OF SOUTHAMPTON

FACULTY OF LAW, ARTS AND SOCIAL SCIENCES

School of Social Sciences

Reproductive Health in the Post-Soviet State: Abortion and Contraception in Estonia

By

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Thesis for the Degree of Doctor of Philosophy

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ABSTRACT

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Until 1991 Estonia was a republic of the Soviet Union and in common with other former Soviet and Eastern European States, Estonia has been experiencing a metamorphosis since independence. This has involved not just political and economic change, but also social change. Inevitably there have been both positive and negative consequences of this transformation, including impacts on reproductive health. It has been suggested that, throughout the Soviet period, family limitation in the USSR was predominantly achieved through induced abortion. Sex education and the promotion of family planning were limited, while abortion was legal and accessible, and attitudes to abortion were liberal. However, much of the literature has focussed on Russia and, despite the enormous diversity within the Soviet Union, less is known about other Soviet states including Estonia.

Official statistics show that, in Estonia, period fertility rates have declined dramatically over the period since independence. The use of modern contraceptive methods is thought to have increased, although there is a dearth of data to substantiate this. Abortion rates have declined, but rates remain high by European standards. However, little is known, at least outside Estonia, concerning the relevance of the Soviet model and 'abortion culture' today. Qualitative research methods are employed to investigate fertility control in Estonia. New analyses of survey data and evaluation of official statistics are used to illustrate the context within which the qualitative findings can be better understood.

Findings indicate that the use of modern contraceptive methods has increased and abortion rates, although high in the comparison with Western Europe, are falling despite the challenges of independence. However, abortion rates for non Estonian women are higher than for Estonian women and the differential is growing. The results of qualitative research suggest that the transformations associated with independence have been a painful experience for some inhabitants of Estonia. Young adults express wariness of having children when they feel insecure about the future, especially in terms of employment opportunities and living costs. Attitudes to contraception are positive, but fears concerning the safety of hormonal methods remain. The cost of modern and effective contraceptives may serve as a barrier to some potential users. Participants make a number of pertinent suggestions concerning how reproductive health in Estonia might be improved.

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Ian, for putting up with me for 33 years and always being my biggest supporter

Ali, Sophie and John, for all your jokes and hugs

…without your love, where would I be now?... (Cocker, J!)

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Chapter 1 – Introduction

The focus of this thesis is reproductive health, in particular abortion and contraception, in Estonia. In common with other former Soviet republics and Eastern bloc states, Estonia has a history of high abortion rates and low use of modern contraceptive methods. The promotion of family planning was limited but abortion was legal, at least from 1955, and accessible (Defosses, 1981).

Now it is the goal of Estonian policy makers to reduce abortion rates (Katus et al., 2000). This aim is in keeping with the statements made in the Programme of Action of the International Conference on Population and Development held in Cairo in 1994. In the chapter related to reproductive health and rights it is emphasised that countries where couples rely on abortion for fertility control must address this issue because "in no case should (abortion) be promoted as a method of family planning..." (United Nations, 1994 p 53). (see Appendix 1 for the verbatim text). Furthermore there is concern in Estonia about the cost (to the public purse) of abortion (Anderson et al., 1994).

However, after more than a decade of independence, abortion rates, though declining, remain significantly higher than those in the West (EOHS, 2000). Although there is a clear need for better access to reproductive health services for individuals there is no need for family planning for the purposes of fertility control at a national level. In fact fertility decline is a matter of considerable concern to policy makers and this may be creating a tension between the needs of the nation (in terms of the future population of Estonia and the size of the future workforce) and the rights and needs of the individual (WHO/UNFPA, 1995).

Much of the research concerning former Soviet states focuses on Russia but there is much less known about the smaller states. Estonia has been chosen as a 'case study' due to its unique characteristics which are the result of its history and its pathway into independence.

The aims of this investigation are:

1. To explore the context of fertility control in Estonia and investigate how the past influences the present.
2. To assess the levels and trends of fertility, contraception and abortion in Estonia.
3. To investigate people's knowledge of and attitudes surrounding fertility and fertility control and to ascertain how people believe members of their own 'social group' behave with respect to reproduction and reproductive health.

Research Questions

The research questions fall into three broad categories. The first category is concerned with the pathway taken to the present reproductive culture. The questions are:

- Over time, what factors have influenced the use of contraception and abortion in Estonia?
- Is there an 'abortion culture' in Estonia?

The second category relates to fertility rates, abortion rates and contraceptive prevalence. The questions are:

- How high are 'high' abortion rates?
- How do they compare to other states?
- To what extent have abortion rates, fertility rates and contraceptive prevalence rates changed over time?
- Do rates differ by ethnicity?

The third category is linked to the knowledge and perceptions of people living in Estonia regarding issues surrounding reproductive health. The questions are:

- What do people know about fertility control?
- What are people's attitudes to contraception and abortion?
- What do they see as barriers to informed choice in terms of fertility control?
- How do people perceive the behaviour of their own social group?

Aim	Research Questions	Investigative Approach
To investigate the context of fertility control	Over time, what factors have influenced the use of contraception and abortion in Estonia? Is there an 'abortion culture' in Estonia?	Historical and sociological investigation via literature review – Chapter 4
To determine levels and trends in fertility, abortion, and contraceptive prevalence	How high are 'high' abortion rates? How do Estonian rates compare to other states? Have rates differed by ethnicity? Have rates changed over time?	Analysis of official statistics Analysis of Estonian Health Interview Survey Report Analysis of Estonian Fertility and Family Survey data Chapter 3
To investigate people's knowledge and attitudes and how they perceive the behaviour of their own social group	What do people know about fertility control? What are people's attitudes to contraception and abortion? What do they see as barriers to informed choice in terms of fertility control? How do people perceive the behaviour of their own social group?	Focus Group Discussions and Key Informant Interviews Analysis of Findings Chapter 6

Chapter 2 presents the rationale for choosing Estonia as a case study for the purpose of investigating fertility control in the post Soviet context. There follows a description of the geo political location of Estonia and brief chronicle of Estonia's history and of the current demographic situation. Next, there is an account of some of the consequences for the people of Estonia of transition,

from membership of the Soviet Union to independence and beyond. The purpose of this information about the wider social and historical context is to provide a frame of reference against which the following chapters can be better understood. Furthermore, it is argued that these background factors play an important rôle in *shaping* norms, practices and behaviours.

Chapter 3 is devoted to the analysis of survey data and of official statistics. The aim of this chapter is to ascertain the levels of fertility and abortion in Estonia and to establish how fertility and abortion rates have changed over time. Furthermore, survey data are analysed to assess changes in contraceptive prevalence as well as contraceptive mix. A simulation exercise is then carried out to estimate what abortion rates might have been, had fertility rates remained stable from the time of independence.

Chapter 4 deals with a critical aspect of the context of fertility control in Estonia – that of 'abortion culture'. This phenomenon, thought to have been widespread in the Soviet Union and Eastern bloc states, is crucially important in explaining levels of, and attitudes to, abortion in the region. This chapter, therefore, consists of an account of how abortion came to play such an important rôle in family planning and how this rôle was sustained. Importantly however, it is argued that, contrary to conventional wisdom, an 'abortion culture' may not have been well established in Estonia during the Soviet period, at least not in all population groups.

Chapter 5 considers the methodology involved in conducting qualitative research in Estonia. A discussion of theoretical perspectives is followed by an account of how decisions were made to conduct both focus group discussions and key informant interviews. An account is then given of how preparatory work was carried out and how focus group discussions and key informant interviews were conducted. Finally, there is a discussion of the limitations of the qualitative research.

Chapter 6, which is seen as forming the heart of the thesis, is concerned with the findings of focus group discussions and key informant interviews. Focus

group participants are viewed as 'experts' with respect to the conditions of life in Estonia, whilst key informants bring knowledge, experience and awareness of various facets of life, health and family planning in Estonia, both past and present.

Chapter 7 brings together some of the main conclusions of the research and includes recommendations based on research findings and on the priorities identified by respondents.

This thesis is set against the backdrop of a story – one of domination and subjugation, war and terror, death and survival, and finally 'freedom'. It is also *part* of the story, for while the powerful were dreaming of new ways to dominate, subjugate and terrorise and were drawing up new borders and class hierarchies, ordinary women and men, whether serfs or proletarians, 'grey citizens' or new citizens of the European Union, were trying to live their lives as best they could. Even in the most difficult of circumstances people have sexual relationships, try to plan their futures, build and nurture families. In both the best and worst of circumstances some pregnancies are not welcome and women and couples seek to prevent pregnancies and avert births.

The chapters that follow will take the reader through a narrative aimed to explain the context of fertility control in Estonia, and especially in transition, to give an account of the levels and trends which are most significant in terms of fertility control, to examine the extent to which an abortion culture became embedded in Estonian life and, finally, to allow the people of Estonia, both focus group participants and key informants to be heard.

Chapter 2 – Estonia as a Case Study

Introduction

Estonia is an appropriate country in which to study the changes in fertility control in a post Soviet state. It has a history of being seen as one of the frontiers of Europe and having shared early fertility transition with its western and northern neighbours. From the Second World War, however, Estonia's path diverged from those of Scandinavia and Western Europe as Estonia became a part of the Soviet Union. One of the consequences of this diversion is that the ways in which fertility is controlled diverged too.

Much of the literature concerning the Soviet Union has focussed on Russia and, despite the enormous diversity within the Soviet Union less is known about other Soviet states including Estonia. As a consequence of mass immigration of (mainly) Russian labour, the ethnic composition of the population was transformed so that, by 1989, 39% of the population were of non Estonian ethnicity (Eesti Statistikaamet, 2002). Therefore Estonia represents a nearly unique opportunity to assess the similarities and dissimilarities in terms of fertility control by ethnicity, in a country where the ethnic groups share some of their history but not all. Furthermore, in the Estonian case, the host population were not dominant in a political sense. As a consequence of subordination, immigration led not just to the introduction of new residents with their own individual and community behaviours, but also the transplantation of Soviet laws, policies and practices.

These aspects of Estonia's history mean that fertility control can be investigated in terms of comparison with that of Europe, in terms of change over time, but also, and more importantly, in terms of diversity within Estonia.

The following sections will give some background information about Estonia – its geographical location, history and language. There follows a discussion about the population of Estonia, including a brief overview of mortality. The final section concerns socio economic and political transition, and issues such

as economic impacts, and the consequences of change for the people of Estonia.

Figure 2.1: Map of Estonia and the Baltic Region

Where is Estonia?

Geographically, Estonia is located in Balto-Scandia[1]. The eastern border is shared with Russia and to the south lies Latvia. Finland is located across the Gulf of Finland to the north, and to the west, across the Baltic Sea, lies Sweden. Estonia covers an area of 45 227 square kilometres (Estonia Ministry of Foreign Affairs, 2006).

Estonian history

The Estonian ethnic group has occupied roughly the same land for thousands of years, but the Estonians have had little experience of nationhood. Much of Estonia was dominated by the Danes in the 13th century, the Teutonic Knights from the 14th century and the Swedes from the 16th century. By the 18th century however the Estonian lands had been incorporated into the Russian Empire (Norgaard et al., 1999, Palli, 2004). Estonian belongs to the Finno-Ugric group of languages which sets it apart from all its neighbours except Finland. In terms of religion, Estonia has long been Lutheran, in common with the Finns and Swedes for example, but in contrast to the Lithuanians (mainly Roman Catholic) and the Russians (mainly Russian Orthodox) (Misiunas and Taagepera, 1993).

Despite a history of domination by foreign powers the Estonians retained their language and cultural identity and during the second half of the 19th century nationalist sentiment grew. Taking advantage of the vulnerability of their Russian rulers during 1917 and 1918, Estonia declared herself an independent sovereign republic. Estonia's independence was not recognised by the Russians until 1920, when they renounced their claims to Estonia 'for all time' (Lewis et al., 1976). However, independence was short-lived. During the 2nd World War, Estonia was occupied by the Russian army from 1940. Ten thousand ethnic Estonian 'anti Soviet' dissidents were deported to the Russian interior at this time. Estonia was then captured and occupied by German army from 1941 to 1944, when Estonia was 'liberated' again by the Red Army (Estonica, 2006). Although portrayed by the Soviet leaders as willing members of the USSR (Valt, 1980), Estonians consider the half century

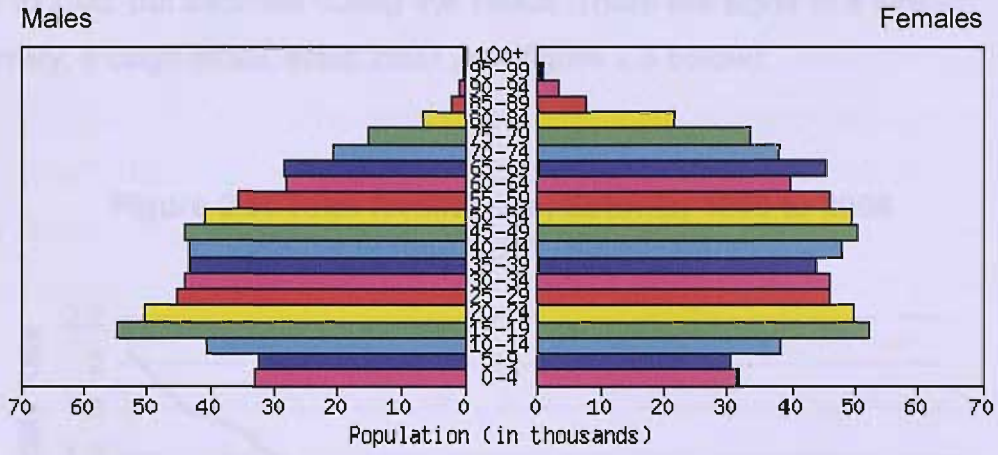
[1] See Figure 2.1

following WWII as a prolonged period of occupation. This is not surprising considering the size of the Red Army presence in Estonia throughout the Soviet period. Not until the end of the 1980s did Moscow admit to the Soviet rôle in the Molotov-Ribbentrop pact whereby, in 1939, the German and Soviet powers agreed to divide Eastern Europe among themselves (Rausing, 2004). More than 20,000 Estonians, including women and children, were deported to the Russian interior from 1949 to 1951 as part of Stalin's strategy to pave the way for collectivisation of agriculture (Estonica, 2006). There was little resistance following this wave of terror until the 'singing revolutions' of the late 1980s and early 1990s when Estonia, along with its Baltic neighbours Latvia and Lithuania, once again declared independence in 1991 (Blom et al., 1996). Estonia became a member of the European Union in April 2004 after approximately 67% of voters voted 'yes' to EU membership on the 14th of September 2003 (Estonia Ministry of Foreign Affairs, 2003).

The population of Estonia

In terms of population Estonia is a small country. The population at the first of January 2006 was 1,344,684, of which 619,299 were males and 725,385 females. Nearly 70% of the population is ethnically Estonian, and nearly 26% Russian. A small proportion of the ethnically Russian population is descended from the 'Old Believers' who settled in Estonia in the late 17th century in protest at changes being wrought in the Russian Orthodox Church at that time (Estonian Ministry of Foreign Affairs, 2004). However most of the Russian population are first or second generation immigrants, who were relocated to Estonia during the Soviet period. Most of these immigrants live in urban areas, especially in the North eastern region of Ida-Virumaa and in the capital city Tallinn (Tammaru, 2002). About 70% of the population of Estonia is urban and 30% rural (Eesti Statistikaamet, 2006). The population is 'ageing' due to both fertility decline and increasing life expectancy and the consequences of this can be seen in the population pyramid (figure 2.2) below:

Figure 2.2: Population Pyramid for Estonia, 2005



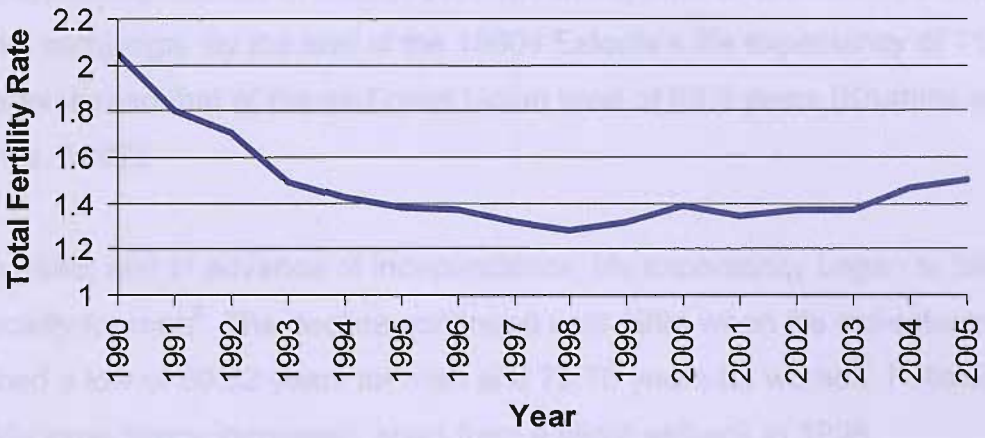
(United States Census Bureau, 2006)

As far as demographic transition is concerned, Estonia was more closely related to Western Europe than to its eastern neighbours. Katus (1994) states that while Estonia was politically part of the Russian Empire's western outpost, demographically Estonia was a western outpost in the East. Estonia lies to the north and west of the 'Hajnal line', stretching from St Petersburg to Trieste (Hajnal, 1965, Palli, 2004). As early as the late 18th century the western European marriage pattern was being established in Estonian lands (Coale et al., 1979). The western European marriage pattern, described by Hajnal (1965) as consisting of late and non-universal marriage, served to limit general fertility[2] by delaying exposure to pregnancy and by limiting the number of women so exposed. As might therefore be expected, birth rates declined in Estonia from the early 19th century (Katus, 1994). According to classical demographic transition theory, mortality rates tend to fall in advance of birth rates so that in the intervening period there is population growth (Notestein et al., 1944). In Estonia, however, Katus (1994) found that fertility and mortality declined nearly concurrently so that population growth was small.

[2] General fertility is defined as fertility without distinction concerning marital status (PRESSAT, R. (1985) *Dictionary of Demography,* Oxford, Blackwell.)

During the latter half of the Soviet period the total fertility rate[3] ranged from 2.01 to 2.06, but declined during the 1990s. There are signs of a fertility recovery, though small, since 2003 (see figure 2.3 below).

Figure 2.3: Total fertility rate, Estonia, 1990 to 2005
Source of data: Eesti Statistikaamet



Fertility and abortion rates will be discussed in more detail in chapter 3.

Mortality

In the interwar period, when Estonia was experiencing independence for the first time, life expectancy[4] exceeded that of the Soviet Union by approximately 10 years, but this advantage was virtually lost by the 1950s.

During the Soviet period, studies of mortality were scarce due to the 'top secret' nature of vital statistics in the Soviet Union. Data were collected within each republic but these were passed straight to Moscow. In the early days of the Soviet period in Estonia, mortality rates were high, largely due to Stalinist purges and forced collectivization. Population losses were further exacerbated by deportations to Siberia. Male deficits outweighed those of females.

[3] Total fertility rate (TFR) is the number of children a woman would have in her lifetime if she were to experience the fertility rates of the period (in this case a year) at each age. It is equal to the sum of the age specific fertility rates (Ibid.

[4] The term life expectancy used here is life expectancy at birth or the number of years a child born in year *x* at age zero could be expected to live, at prevailing age specific mortality rates.

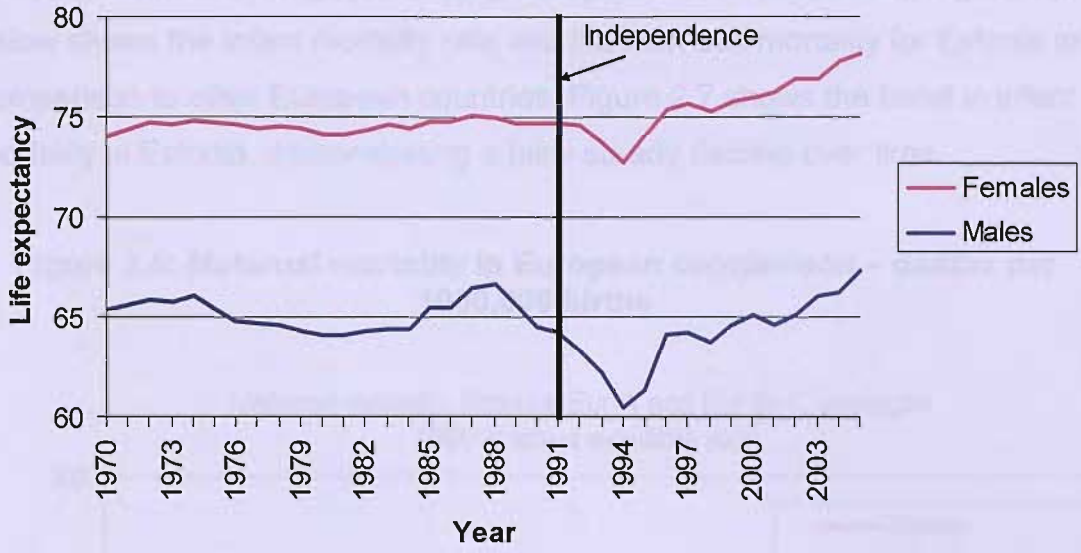
In the 1950s life expectancies in Estonia were broadly in line with most of Eastern Europe and exceeded the all-Soviet Union level, though they were less than those of Western Europe. The 1960s and 1970s were characterised by stagnation (and even reversals) and by the 1980s the gap between East (including Estonia) and West had widened considerably, even though life expectancy had rallied somewhat during the 1980s. This improvement, which was particularly marked in males, occurred at the time of Gorbachev's anti-alcohol campaign. By the end of the 1980s Estonia's life expectancy of 71 years exceeded that of the all-Soviet Union level of 69.5 years (Krumins and Zvidrins, 1992).

From 1988, and in advance of independence, life expectancy began to falter, especially for men[5]. The decline continued until 1994 when life expectancy reached a low of 60.52 years for men and 72.76 years for women. Following this life expectancy increased, apart from a slight setback in 1998, so that by 2005 it had reached 67.27 years for men and 78.14 years for women. In 1995 the difference in life expectancy between men and women reached a high of 12.8 years. Figure 2.4 shows life expectancy for females and males for the period 1970 to 2005[6].

[5] The excess mortality of men over women can be seen in the population pyramid for Estonia, figure 2.2

[6] It is important to note the that method used to calculate life expectancy changed in 1989 so a certain amount of caution must be exercised in comparing life expectancies before and after this point.

Figure 2.4: Life expectancy for females and males, Estonia 1970 – 2005
Source of data: Eesti Statistikaamet



Maternal and infant mortality

Maternal and infant mortality rates can be seen as indicators of development in general and health service provision in particular. In Estonia, maternal mortality rates are a matter of concern. Rates did not improve during the 1980s and actually rose during the 1990s. Of particular interest is the proportion of deaths occurring as a result of abortion; at 42% this is thought to be the highest proportion in the World Health Organisation European Region (World Health Organisation, 2005). Figure 2.5 shows the maternal mortality rate for Estonia in European comparison. [7]

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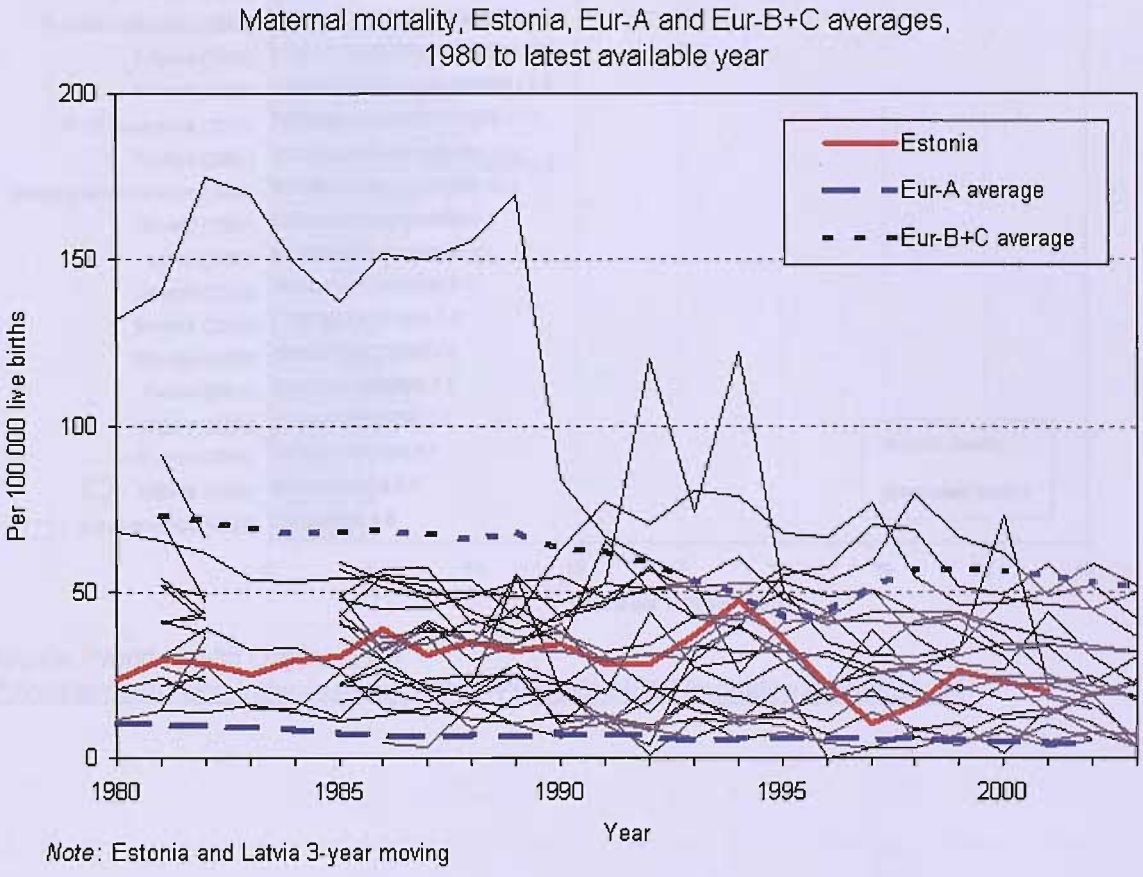
[7] The 27 countries with very low child mortality and very low adult mortality are designated Eur-A by WHO. Eur-A comprises Andorra, Austria, Belgium, Croatia, Cyprus, the Czech Republic, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Israel, Italy, Luxembourg, Malta, Monaco, the Netherlands, Norway, Portugal, San Marino, Slovenia, Spain, Sweden, Switzerland and the United Kingdom. However, data for most indicators are unavailable for two of the 27 countries: Andorra and Monaco. Therefore, unless otherwise indicated, Eur-A and averages for Eur-A refer to the 25 countries for which data are available.

The 25 countries with low child mortality and low or high adult mortality are designated Eur-B+C by WHO. Eur-B+C comprises Albania, Armenia, Azerbaijan, Belarus, Bosnia and Herzegovina, Bulgaria, Estonia, Georgia, Hungary, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Poland, Republic of Moldova, Romania, Russian Federation, Serbia and Montenegro, Slovakia, Tajikistan, The former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine, and Uzbekistan. Unless otherwise indicated, Eur-B+C and averages for Eur-B+C refer to these countries. WORLD HEALTH ORGANISATION (2005) Highlights on Health - Estonia. Copenhagen, World Health Organisation.

The picture for infant mortality is much brighter in that the infant mortality rate is close to that of the high performing European countries (Eur-A). Figure 2.6 below shows the infant mortality rate and the neonatal mortality for Estonia in comparison to other European countries. Figure 2.7 shows the trend in infant mortality in Estonia, demonstrating a fairly steady decline over time.

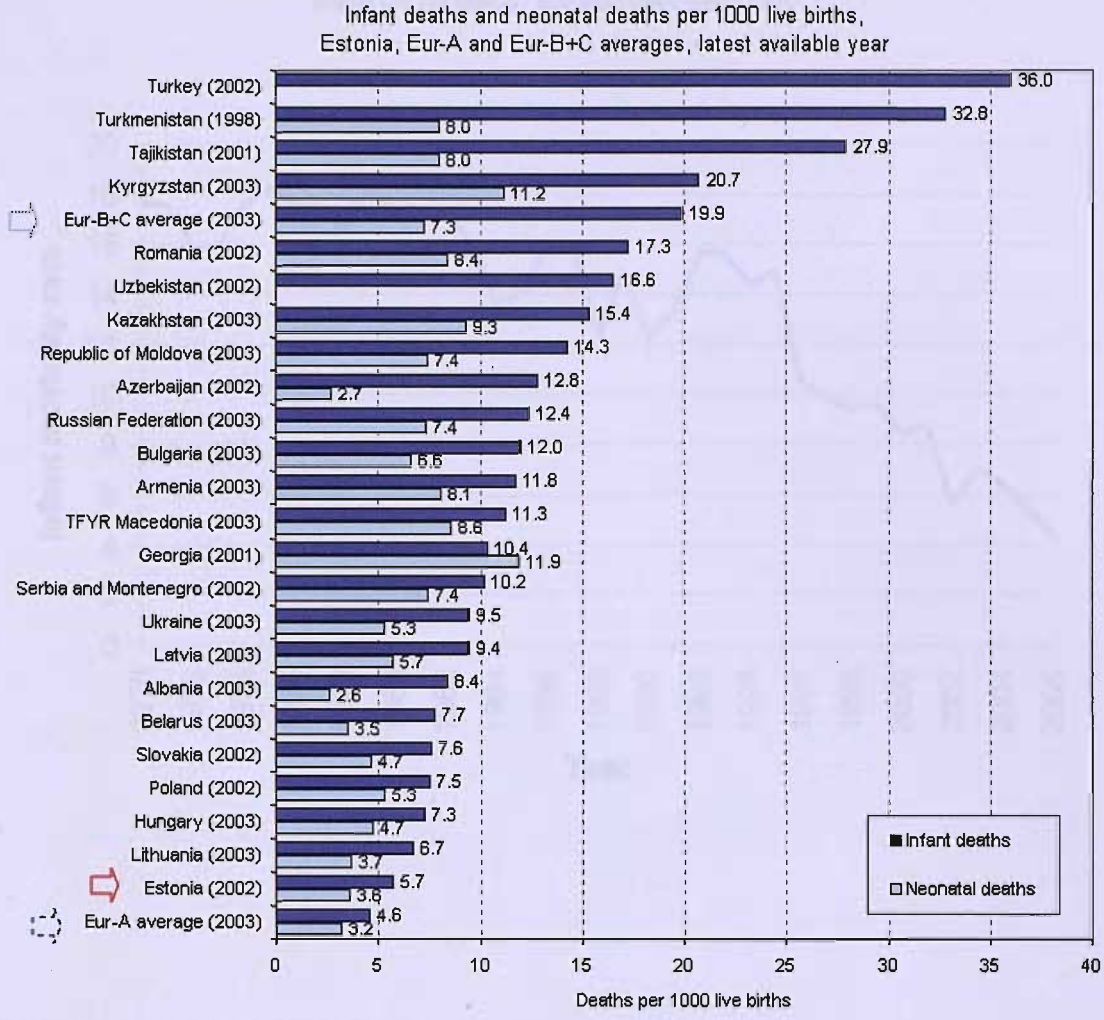
Figure 2.5: Maternal mortality in European comparison – deaths per 1000,000 births



Note: Estonia and Latvia 3-year moving

Source: World Health Organisation
http://www.euro.who.int/eprise/main/WHO/Progs/CHHEST/mortality/20050524_34

Figure 2.6: Infant mortality and neonatal mortality (deaths per 1000 live births) – Estonia in European comparison



Source: World Health Organisation
http://www.euro.who.int/eprise/main/WHO/Progs/CHHEST/mortality/20050524_34

Figure 2.7: Infant mortality (deaths per 1000 live births) 1940 to 2006
Source of data: Eestistatiskaamet

Estonia as a 'transitional' state

During the Soviet period socio economic conditions in Estonia were relatively good, with per capita income in the later years of the Soviet period ranking the highest of any of the Soviet republics (Krumins and Zvidrins, 1992). Despite perestroika, and possibly due to the inertia inherent in the Soviet system, the centrally planned economy still held sway in Estonian on the eve of independence. Now Estonia is said to be 'in transition'. This does not refer to any form of demographic transition. 'Transition' is a term used to encompass the profound political, economic and social changes experienced by nations which were formally members of the Soviet Union or were part of the Eastern bloc. Rausing (2004 p 2) has termed this "a fundamental transformation of material life and everyday culture".

Estonia has been transformed from single party state socialism directed from Moscow to multiparty democracy within the context of national sovereignty. State institutions have been remodelled or rebuilt. Systems of health and social care have been altered beyond recognition. The Estonian kroon was re-established as the national currency. There have been changes in terms of the means of production, from largely state ownership to private enterprise and the economy has moved from the Soviet model of a planned economy to a market economy. Gross domestic product per capita (GDP) declined from 1989, in advance of independence and only regained 1989 levels after eleven years (see 2.8 below). Economic inequality in Estonia has grown over the period of independence (UNICEF, 2001a).

The economic setback also had an impact on real wages[8]. In the Estonian case, real wages fell from before independence, reaching a low, in 1992, of 45% of 1989 levels. This is shown in 2.9 below, where 1989 is used as the base year.

Figure 2.8: Gross domestic product (GDP) per capita in constant year 2000 US dollars

Source of data: World Bank - World Development Indicators

[8] Real wages are defined as wages adjusted to take account of inflation.

Figure 2.9: Real wages (index, base year = 100) – Estonia, 1989 to 2004
(TransMONEE Database, 2006)

Figure 2.10: Real wages (index, base year = 100) – selected Eastern European States, 1989 to 2004
(TransMONEE Database, 2006)

To set this in context, figure 2.10 above shows real wages in other Eastern European States for the same period. Although all of these states experienced a decline in real wages over this period, it is clear that the situation was more acute for Estonia, and for Latvia, Lithuania and Russia.

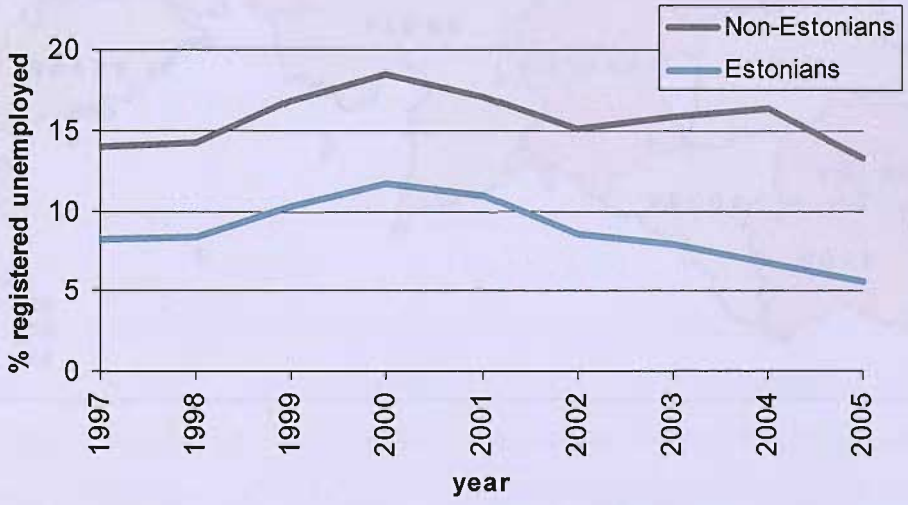
Economic liberalisation has been associated with to sweeping changes in employment and unemployment. Whilst not without its faults, the Soviet system virtually guaranteed job security but in the new independent state many workers became vulnerable. Firstly, there have been changes in the size of employment sectors. For example, whilst during the Soviet period the primary sector accounted for more than one fifth of employment, this sector was hard hit following independence so that by 1995 employment in the primary sector was halved (Puur, 1997a). Secondly, there has been considerable redeployment of labour from state owned enterprise to market enterprise. During the Soviet period full employment was ensured in part by the maintenance of unproductive labour. Hence, as part of the redeployment of labour to private enterprise, many workers have found themselves to be surplus to requirements as market competition and exposure to global markets has made the retention of unproductive labour untenable (Puur, 1997a, Puur, 1997b). Thirdly, Estonia had been very closely tied to the Soviet bloc economically, more so than countries of Eastern Europe, which meant the loss of the main market for Estonian goods and service. Furthermore, following the collapse of the Soviet Union, Estonia opted to remain outside of the Commonwealth of Independent States, resulting in economic isolation from members of that union (Lieven, 2005). Lastly, the government of the newly independent Estonia decided to pursue a fairly radical approach to economic adjustment so that social safety nets were limited and market reforms were made a priority (Puur, 1997a).

One result of these transformations has been an increase in unemployment and underemployment, for example those working part-time who would prefer full-time employment. Possibly due to a decline in the primary sector and heavy industry alongside an expansion of the service sector, men have been harder hit than women. The level of unemployment among youth has been a matter of concern. Puur (1997b) suggests that some delay in securing employment is to be expected due to "school-to-work transition" (p263). However he also suggests that there have been too few jobs for the young and that their skill levels may not have been adequate for the new economy. Amongst older people registered unemployment may not have been high but

this can in part be explained by the fact that only half of those without employment continued to seek work. Moreover, Rausing (2004) suggests that not all of the unemployed have registered as such as they are unsure of the consequences of doing so. In the Soviet era unemployment was not permitted.

In terms of educational level, unemployment has had an inverse relationship with education. Furthermore, unemployment for non Estonians has been twice that of Estonians (see Figure 2.11 below). Part of the explanation for this is that immigrants were more likely to have been employed in the industries that were culled early in the post Soviet period (Lieven, 2005). The higher rates of unemployment among the non Estonian population might also be seen by some observers as a sign of discrimination.

Figure 2.11: Percentage unemployed by ethnicity
Source of data: Eesti Statistikaamet



Closely tied to both issues of ethnicity and to sector of employment, levels of unemployment have varied by region. In particular, the north-eastern county of Ida-Virumaa, with high concentrations of non Estonians, has suffered significantly higher levels of unemployment than other regions or Estonia as a whole. Figure 2.12, below shows unemployment by county.

Unemployment levels rose until 1995 when the percentage unemployed approached ten per cent. Thereafter rates stabilised until 1998 when unemployment rose again. Rates peaked in the year 2000 at 13.6 per cent and have decreased since, so that the unemployment rate for 2005 was just under 8%. In comparison with other Eastern European states, Estonia has tended to remain in the middle in terms of unemployment (Eurostat, 2006) (see figure 2.13 below).

Figure 2.12: Unemployment rate by county – 2003
Source: Eesti Statistikaamet 2006

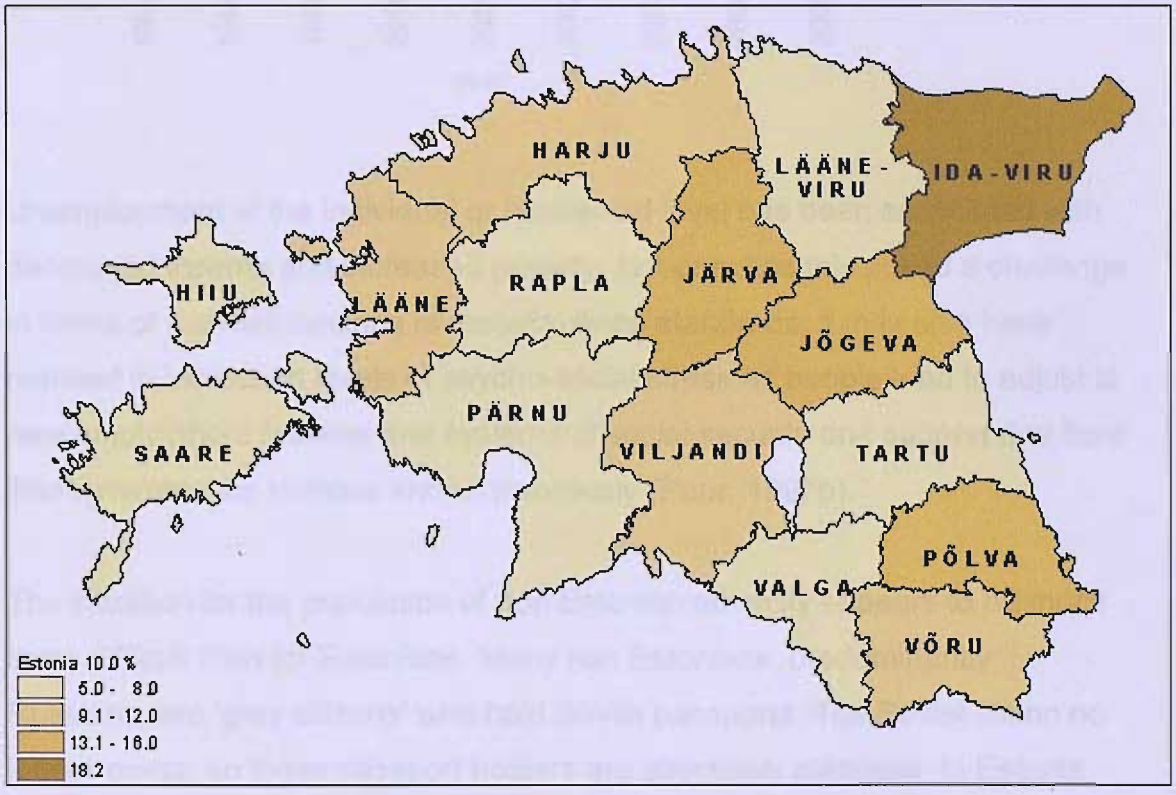
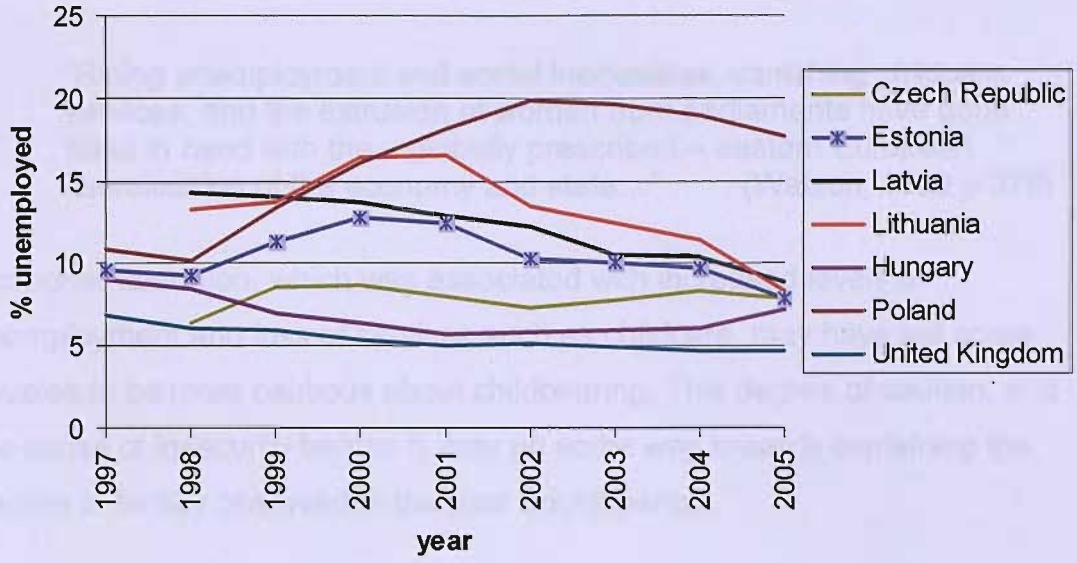


Figure 2.13: Unemployment in international comparison
Source of data: Eurostat 2006



Unemployment at the individual or household level has been associated with decreased income and increased poverty. Not only has this posed a challenge in terms of the maintenance of material living standards, it may also have resulted in increased levels of psycho-social stress as people tried to adjust to new employment realities and systems of social security and support that bore little resemblance to those known previously (Puur, 1997b).

The situation for the population of non Estonian ethnicity appears to be much more difficult than for Estonians. Many non Estonians, predominantly Russians, are 'grey citizens' who hold Soviet passports. The Soviet Union no longer exists, so these passport holders are effectively stateless. In Estonia they are seen as immigrants, but many were born in Estonia when it was a Soviet republic. Many cannot return 'home' as they have never lived in Russia. Those who were born in Russia fear returning as they no longer have ties or links to their homeland and are concerned that, although life is hard in Estonia, it may be harder still in Russia (Haas, 1996).

In what Watson has called 'state desertion' the safety nets of the Soviet system have been largely dismantled, creating a vacuum in the array of

support mechanisms, and the new experience of unemployment has been accompanied by increased inequalities.

> "Rising unemployment and social inequalities, vanishing childcare services, and the extrusion of women from parliaments have gone hand in hand with the – globally prescribed – eastern European liberalization of the economy and state..." (Watson, 2000 p 378)

Economic liberation, which was associated with increased levels of unemployment and loss of services such as childcare, may have led some couples to be more cautious about childbearing. This degree of caution, and the sense of insecurity behind it, may go some way towards explaining the decline in fertility observed in the post Soviet period.

Transformation of the health system

In addition to wide ranging political and economic change following independence, the health system and health services have been remodelled. During the time of the first independence, between the two World Wars, the health system in Estonia was similar to that in Western European countries (EOHS, 2000). Upon annexation by the Soviet Union towards the end of the Second World War, the organisation of healthcare in Estonia underwent a complete change. The system became highly centralised in order to conform to the 'Semashko model' which was imposed across the Union. Under this system mass public health interventions such as immunisation were effective. However too much emphasis was placed upon the training of specialists, too few nurses were enrolled and 'family practitioners' were virtually non existent. Instead, primary care occurred in 'polyclinics' (World Health Organisation/European Commission, 2001, EOHS, 2000). The Semashko system was very much hospital oriented so that the emphasis was on curative rather than preventive practice (Horga and Ludicke, 1999, Remennick, 1991). Furthermore, the state retained a monopoly on healthcare, forbidding the establishment of private clinics and ensuring that 'choice' was unknown (Popov, 1995).

In the 1940s 75% of Estonian doctors were forbidden to practice and many more took advantage of the opportunity to escape to the West, leading to a post war situation wherein there were few Estonian doctors remaining who maintained practices and values from the pre-war years. Further discontinuities resulted from the influx of doctors from other Soviet states[9].

During most of the Soviet period there existed 'the isolation of centralisation', where information was routed vertically, not horizontally. The result was that information was not shared between doctors, hospitals or republics – statistics went straight to Moscow and information came down from Moscow. The information doctors received from Moscow was of questionable quality – for example, they were told that contraceptive pills and intra-uterine devices were dangerous and doctors then disseminated this information to their patients[10]. Towards the end of the Soviet era the state began to loosen its grip on the healthcare monopoly and a few doctors began to practice outside the state system. Soon after independence the healthcare system underwent revolutionary change.

Funding of healthcare

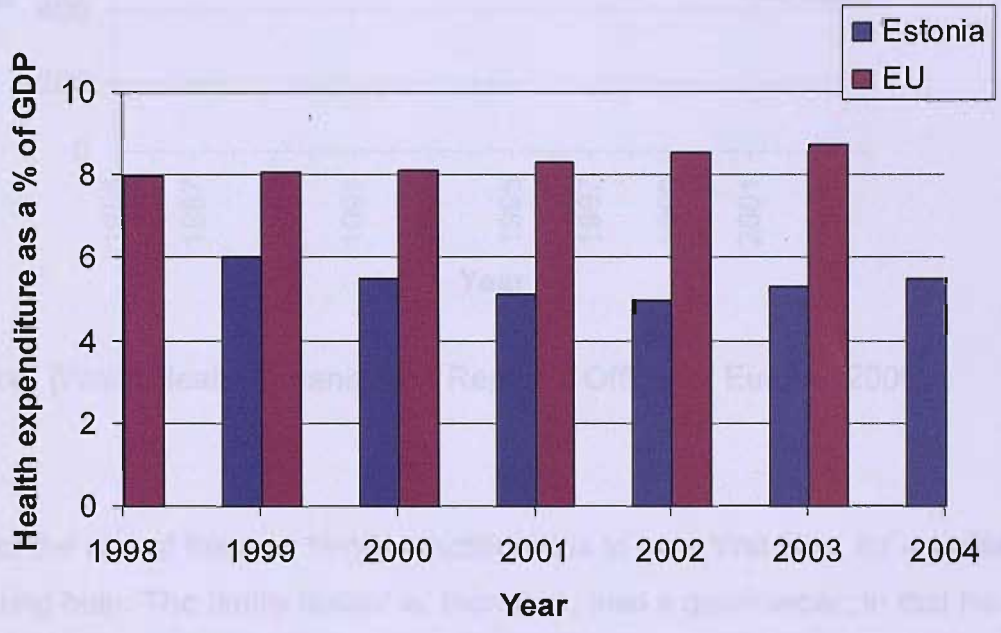
Firstly, the funding of healthcare, which had previously been through state revenues, became insurance-based, with residents paying into a health fund which then entitles them to healthcare. However, not all costs are covered, which means that many patients make part payments towards their treatment or prescribed medicines. This part payment also applies (with a few exceptions) to women who have been prescribed the contraceptive pill. Furthermore, up to 8% of the population are thought to be uninsured and therefore without entitlement (World Health Organisation/European Commission, 2001). The uninsured can only call upon state health services for emergency medical care. Those uninsured are most likely to be men, aged twenty to forty-four (EOHS, 2000). There are a number of reasons that residents may not be insured, for example those not working (but not registered unemployed), illegal immigrants, and those working in the informal

[9] Katus, K personal communication
[10] Katus, K personal communication

economy and evading taxation. Anyone resident in Estonia can 'buy in' to the healthcare system to secure access. In addition, private health insurance can now be purchased (EOHS, 2000).

Public expenditure on health care has changed little, at least in terms of the proportion of gross domestic product devoted to health (see Figure 2.14 below). Hence it would seem that any extra investment or spending has come from insurance contributions and user fees.

Figure 2.14: Total health expenditure as % of gross domestic product (GDP)



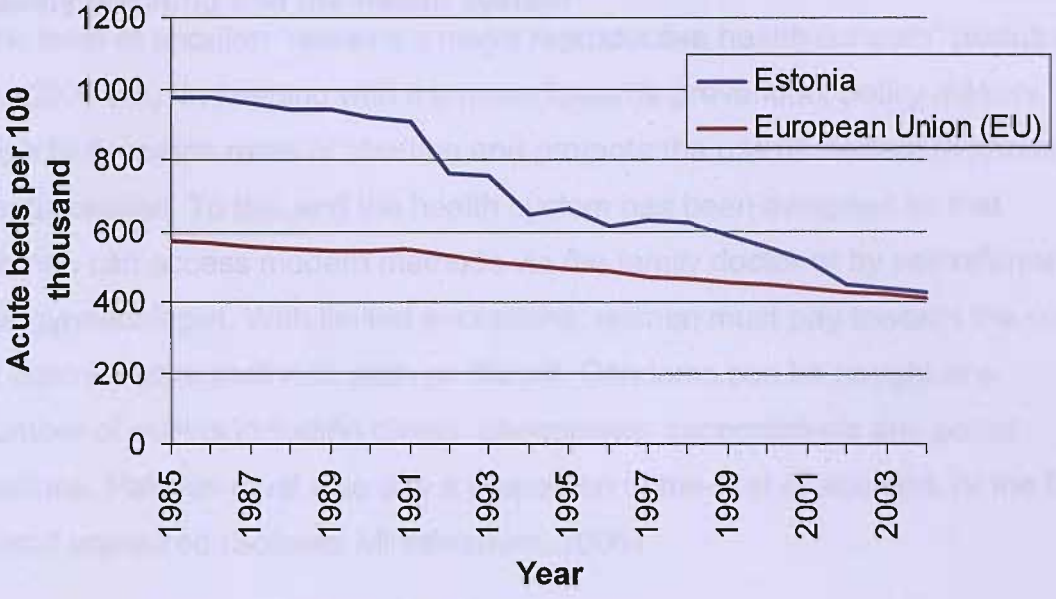
Source: (World Health Organisation/European Commission, 2001)

The new healthcare 'model'

Following independence the Semashko model was dismantled. One aim has been to promote the primary sector and create 'family practitioners', whilst another has been to prune the acute sector. At first there was resistance on the part of doctors to cooperate in this endeavour. The status of family doctors was perceived as low and the remuneration inadequate. In addition, doctors were expected to complete a re-training course to qualify to work in family practice. More doctors were persuaded to make this change when financial incentives were improved (World Health Organisation/European Commission,

2001). As more healthcare workers were encouraged to move to the primary sector, acute sector capacity was reduced, for example the ratio of acute care beds declined as can be seen in Figure 2.15 below.

Figure 2.15: Acute care hospital beds per 100000 people



Source: (World Health Organization Regional Office for Europe, 2006)

Part of the rôle of the new family practitioner is to be a 'first stop' for a patient requiring help. The family doctor is, therefore, also a gatekeeper, in that he or she decides whether the patient's problem can be managed at the primary level or if a referral to a specialist is required. Patients can still self-refer for specialist services in some instances, for example to a gynaecologist (Sotsiaal Ministeerium, 2006).

Part of the rationale for changing the system of healthcare finance was to make the cost of healthcare transparent for both patients and providers. Under the centralised Soviet system neither health care works nor the public had to consider costs. In addition, there was a wish to encourage members of the public to take responsibility for their own *health* as well as the subsequent medical costs (EOHS, 2000). In exchange, the patient has been given the

right to take part in decision making concerning his or her own treatment. Doctors are no longer permitted to dictate how a patient will be treated but instead must discuss treatment options and obtain informed consent (Sotsiaal Ministeerium, 2006).

Family planning and the health system

The level of abortion "remains a major reproductive health concern" (Katus et al., 2000 p x). In keeping with the move towards prevention, policy makers wish to decrease rates of abortion and promote the use of modern methods of contraception. To this end the health system has been designed so that women can access modern methods via the family doctor or by self referral to the gynaecologist. With limited exceptions, women must pay towards the cost of contraceptive methods such as the pill. Condoms can be bought at a number of outlets including clinics, pharmacies, supermarkets and petrol stations. Patients must also pay a proportion of the cost of abortion, or the full cost if uninsured (Sotsiaal Ministeerium, 2006).

There are a small number of 'youth clinics' designed specifically for the use of young people up to the age of twenty-five (or older if still a student) where consultation is free. However, these youth clinics are still considered experimental and permanent funding is not guaranteed[11].

An improved health system?

Upon independence in 1991 policy makers faced a substantial task in bringing about change, one for which they and providers were ill-equipped (EOHS, 2000). Although health system reform is taking place there is the inevitable inertia involved in performing a U-turn in an institution that is not just large but also pervasive in the way in which it reaches into the lives of the people. Moreover there has been resistance to change, both on the part of healthcare workers and users of services. Reform has brought about a more efficient service, but one to which many users must now make out-of-pocket contributions. In view of the difficulty that this presents for some people,

[11] Karro, H, personal communication

further improvements may only be brought about when a larger proportion of Estonia's budget is devoted to health.

Conclusion

The Estonian ethnic group has a long and chequered history, most of which has been spent under the thumb of one foreign power or another. Despite this the Estonian language and culture have survived. After a brief period of nationhood between the two World Wars, Estonia fell under the control of the Soviet Union until independence was gained once again in 1991.

Estonia experienced demographic transition early and alongside Western Europe rather than its neighbours in Eastern Europe and Russia. In common with much of the Eastern bloc and the Soviet Union, life expectancy in Estonia stagnated in the 1960s and 1970s and mortality reversals were seen in the 1990s.

Although much of the population welcomed independence in 1991, the resultant period of adjustment has been a harrowing experience for many as sweeping changes have been made in the economic, political and social life of the country (Lieven, 2005). As well as new freedoms and new opportunities there have been both new challenges and new risks associated with independence. The loss of social safety nets, high inflation rates and the new experience of unemployment have all played a part in shaping the setting in which decision making processes occur. How has this changed setting affected the population? It would be difficult to establish a causal relationship between mortality or fertility and social, political and economic change. However declines in fertility rates have been observed throughout the former Soviet states and also in former Eastern bloc countries[12]. That this decline

[12] See also:
EBERSTADT, N. (1994) Demographic Shocks After Communism: Eastern Germany, 1989-93. *Population and Development Review,* 20, 137-152.
KOHLER, H.-P. & KOHLER, I. (2002) Fertility Decline in Russia in the Early and Mid 1990s: The Role of Economic Uncertainty and Labour Market Crises. *European Journal of Population,* 18, 233-262.

has occurred in such contrasting settings and yet where populations have faced similar social and structural transformations suggests that these transformations have indeed affected fertility rates, although the impact of change may be experienced differently according to, for example, ethnic group (Agadjanian, 1999). Similarly, increases in mortality have been observed in the states experiencing the shift from state socialism to a capitalist system (Cornia and Paniccia, 1999). Once again these increases have been sharper for some groups; for example in Estonia Leinsalu and colleagues (2004) found, not only differences in mortality by ethnicity, but also a *widening* gap between ethnic Estonians and Russians.

This chapter has given an account of the context of life in Estonia, in terms of history, geography, politics, demography, and socio economic and political transformation. The following chapter, through quantitative analyses, will look at the ways in which contraception and abortion have evolved over time and will aim to cast light on the status of fertility control in Estonia. Finally, it will be argued that the climate or 'imperative' of low fertility associated with the disruption of post Soviet adjustment plays a rôle in sustaining abortion rates.

SOBOTKA, T. (2002) Ten years of rapid fertility changes in the European post-communist countries - evidence and interpretation. Groningen, Population Research Centre, University of Groningen.
WITTE, J. & WAGNER, G. (1995) Declining Fertility in East Germany After Unification: A Demographic Response to Socioeconomic Change. *Population and Development Review,* 21, 387-397.

Key Points

- Due to its socio-political history and ethnic mix Estonia presents a nearly unique opportunity to study fertility control in a former Soviet state
- Estonia is going through a period of socio economic and political evolution which has created new freedoms and opportunities but has had negative consequences for some population groups
- Mortality rates are high in comparison to Western Europe, particularly for men. Maternal mortality rates remain high, though infant mortality rates are now comparable to much of Europe
- The health system has been undergoing significant change which has been slowed by the inertia of the previous system and by some resistance on the part of providers and users

Chapter 3 – Levels and Trends in Abortion and Contraception

Introduction

The aim of this chapter is to set the scene in terms of fertility control in Estonia. This is considered to be very important as the context of fertility control forms a part of the environment within which women and couples conduct their lives. The quantitative analyses to follow draw upon both published statistics as well as new analyses, carried out by the author, of the Estonian Fertility and Family Survey (EFFS). Before these analyses are presented, there is a brief evaluation of the EFFS and of the Estonian Health Interview Survey (EHIS). Following this evaluation, levels and trends in fertility over time are examined. Official statistics from Eesti Statistikaamet (Statistics Estonia) are used alongside statistics from the Council of Europe.

Next, age at sexual debut[13] is explored. The timing of this event is important as it determines how early in her (physiologically defined) reproductive life a woman is exposed to the risk of pregnancy. Data from the EFFS are analysed to assess changes in age at sexual debut by birth cohort. Additional information from the Estonian Health Interview Survey is used so that age at sexual debut for males can be compared to that for females. Contraception is then analysed, using data from the EFFS, to explore contraceptive use at sexual debut, types of contraceptive methods ever used and contraceptive use in the four weeks prior to interview. These analyses are supplemented by information from the EHIS, which includes data for *men* and shows data broken down by *ethnicity*. EFFS data and statistics from Eesti Statistikaamet are then used to assess levels and trends in abortion. Lastly, simulations are carried out to estimate the relationship between fertility and abortion[14] trends.

[13] Sexual debut is defined as the first act of sexual intercourse

[14] Abortion, unless otherwise stated, is defined as the legally induced termination of pregnancy excluding therapeutic termination

Secondary Analysis of the Estonian Fertility and Family Survey (EFFS)

During the 1990s, under the auspices of the Population Activities Unit of the United Nations Economic Commission for Europe (UNECE), a series of Fertility and Family Surveys were conducted in a number of European countries (and some non European countries), including Estonia. This project was intended to provide nationally representative and internationally comparable data for policy makers. These surveys were of particular significance in former Soviet states as they were the first of such surveys to be carried out following independence (Festy and Prioux, 2002).

The female survey in Estonia covered women born from 1924 to 1973 and, as data were collected during 1994, the ages covered were from 20 to 69 years. As a result, the age range in the Estonian FFS exceeded that laid down by UNECE, in defining women born as early as 1924 as part of the target population. The women interviewed therefore included those beginning their adult lives just as Estonia was being annexed to the Soviet Union, those born and living their entire reproductive lives within the Soviet period, and those moving into young adulthood in an independent Estonia (Katus et al., 2000). This extension of the target age range enables the researcher to fully investigate trends over time and to view those trends in terms of the regime in power at that time.

The survey instrument consisted of the UN/ECE core questionnaire, with the addition of an expanded module concerning reproductive health and a more extensive module concerning migration. Of the 5932 sampled potential respondents 5021 were interviewed resulting in a response rate of 84.6%. Respondents were interviewed in Estonian or Russian by trained interviewers (Katus et al., 2000).

The approach to data collection was that of retrospective recording of event history in chronological order. This means that a respondent was asked to identify the first of a series of events, such as births, and asked a number of questions about that event. The interviewer would then proceed to the next such event, for example the first birth followed by the second birth. This

method builds up data for each individual, recording significant life events in biographical order, rather than generating cross-sectional data (Katus et al., 2000).

Although the resulting dataset contained 5021 cases, it was not possible to obtain a useable copy of this dataset. The dataset used for the analyses to follow was derived from the original EFFS dataset, but contained only 3307 cases. Of these 3307 nearly 95% are of Estonian ethnicity, which compares to a population proportion of approximately 68%. The result is that this subset of data is not representative in an ethnic sense. Much of the non Estonian population is deemed to be an immigrant population and as such did not fall within the remit of the FFS. In order to supplement the survey data, official statistics relating to abortion are analysed. However there are no such statistics relating to age at sexual debut or contraceptive use, although the Estonian Health Interview Survey (EHIS), discussed below, included questions on sexual debut and contraceptive use.

When attempting to generalise and draw conclusions from the analysis of survey data it is important to reflect on how the data were generated and how accurately they might reflect the reality of respondents' lives. In particular, when survey questions are 'sensitive' and are invading respondents' private, and indeed intimate, lives consideration should be given to the chance that reporting of events might be less than perfect. This is an important consideration as poor quality data may lead to biased results.

Although a respondent may be willing to recall and event he or she may have forgotten the event entirely or may find it difficult to place accurately in time. The event history approach, where respondents are asked to recount a series of events in order (or reverse order) has been shown to improve the quality of recall (Cleland, 1996). However, the dates of some events are easier for respondents to remember than others. For example, the date of a child's birth, at least in the developed world, is likely to be recalled accurately. Firstly, there is likely to be a birth certificate and also a child's birthday will almost certainly be celebrated on an annual basis. Equally, in the developed world, familiarity

with family birthdates is essential for medical and school registration and many other 'everyday' occurrences.

The exact date of either a spontaneous or induced abortion may however be more difficult to recall. Firstly, this type of date may not have been imprinted on the respondent's memory by constant repetition. Secondly, this may have been a painful or traumatic experience and one the respondent would prefer not to recall. Furthermore, the respondent may fail to reveal that the event occurred at all. Again, this could be because of the emotion surrounding the event or it could be because the practice (for example induced abortion) is seen as immoral or socially unacceptable, resulting in 'social desirability bias'(Tourangeau et al., 2005).

Anderson and colleagues conducted a 'validation' survey of 360 women in Tallinn (the capital city of Estonia) in 1992 to assess how accurately abortions would be reported. The women had all had an abortion in 1991 but they were unaware that they had been selected for this reason. The interviewers who administered the survey were also unaware of its true purpose and forty extra controls were interviewed in order to conceal the nature of the survey from the interviewers. Half of the respondents selected were Estonian, the other half were non-Estonian (Russian speaking). The research team found that 80% of the women reported their recent abortion, with Russian speakers more likely to do so than Estonians. Furthermore, women over forty years of age, women who had three or more children and women who had had later term abortions were less likely to report the abortion. In some cases induced abortions were reported as spontaneous abortions (Anderson et al., 1994). These results suggest that, although the level of reporting of abortions in Estonia is higher than in the United States (as indicated by the authors), respondents in surveys such as the EFFS might also misreport or underreport. It is possible therefore that the levels of abortion found in the analysis of EFFS data are approximately 20% lower than actual levels.

The reporting of, for example, age at sexual debut may have been subject to recall error, especially for the oldest respondents (born as early as 1924).

However, it is worthwhile noting the there is no evidence of age heaping in responses. Other details that respondents were asked to recall were the use of contraceptives at sexual debut, including the type of contraceptive method (if used). According to the data, all those who had experienced sexual debut were able to answer 'yes' or 'no' to the question asking if they had used a contraceptive method at sexual debut. No respondent replied 'don't know'. Furthermore, none of those reporting use of contraception at sexual debut had forgotten which method had been used. This may have been the result of diligence on the part of interviewers.

The Estonian Health Interview Survey (EHIS)

Where evaluation of the health of the population had previously been based on mortality rates, the stated purpose of the EHIS was to explore health issues in a way that had not previously been done, by collecting data concerning morbidity. The survey was designed to be consistent with earlier surveys, such as the EFFS, particularly in terms of the definitions employed. The target population was defined as all those persons, male or female, born 1916 to 1980 (aged 15 to 79) on January 12 1996. 4,711 men and women were interviewed (response rate 84%) in late 1996 and early 1997. The EHIS was more representative of the population than the abridged data set for the EFFS in that 66% of those surveyed for the EHIS were Estonian, and 29% were Russian (Leinsalu et al., 1999). This compares with the population proportions of 68% Estonian ethnicity and 26% Russian (Eesti Statistikaamet, 2006). No dataset, and therefore no individual level data, has been obtained for the EHIS, therefore analyses are based on the aggregate data contained in the survey report.

Fertility in Estonia

Estonia was early to experience fertility transition in relation to most of its Eastern European neighbours and Russia (Coale et al., 1979). Estonia is found to the north and west of the Hajnal line, indicating that historical marriage patterns were Western European in nature, with delayed and non universal marriage (Hajnal, 1965). This marriage pattern had the effect of reducing general fertility.

Fertility declined further when *marital* fertility was reduced. This was well established by the end of the 19th century in Estonia, whilst at this time there was little evidence of a reduction in marital fertility in any of the other provinces of European Russia, with the exception of Latvia (Coale et al., 1979). The fall in marital fertility suggests the use of family planning practices, at this time, in the absence of modern methods, probably 'traditional' methods such as coitus interruptus or the rhythm method (Coale et al., 1979).

In the interwar period, the years of Estonia's first period of independence, fertility rates fell further so that replacement levels were reached in the 1920s and by 1938 the net reproduction rate[15] was 0.8 (Kirk, 1946). This experience is one which Estonia had in common with many European states when at a time of global recession in the 1930s fertility rates fell or stagnated over a broad swathe of the region.

During the early years of the Second World War crude birth rates rose slightly in Estonia but soon began to fall. It was at this time that Estonia was 'liberated' from German occupation and soon after became a Soviet republic. A further decrease in fertility was seen from 1955 when abortion was legalised (Katus, 1994). While total fertility rates remained at or close to replacement levels throughout the 1970s and 1980s, rates fell from 1990, just in advance of independence (CoE, 2002). However, there has been a slight recovery in total fertility rate over the last few years (see figure 3.1 below).

Why is fertility important when studying contraception and abortion?

It is generally accepted that abortion can play a part in reducing fertility rates, but it might also be the case that the imperative to prevent or limit births helps to perpetuate the practice of abortion (Anderson, 1998). Women, and their partners, are social actors and abortion is not just an individual act, but a

[15] Net reproduction rate is the number of daughters each woman has on average, adjusted for the mortality risk for those daughters. It can be interpreted as the size of the next generation relative to the current generation. A net reproduction rate of 0.8, as in the case of Estonia in the 1930s, indicates, ceteris paribus, a shrinking population HINDE, A. (1998) *Demographic Methods,* London, Arnold..

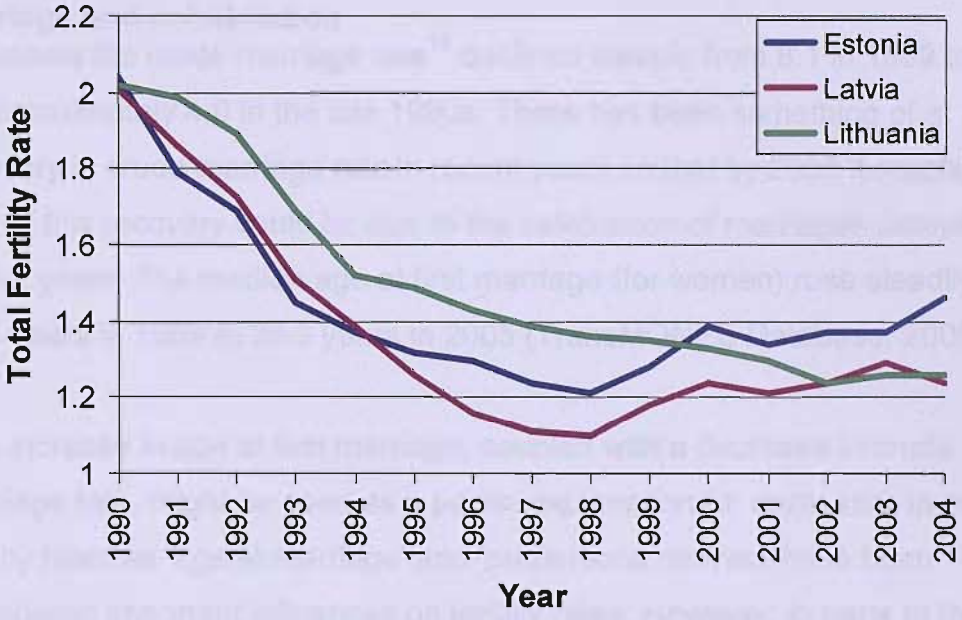
social act as well (Stloukal, 1999). Just as cultural, religious or ideological climates can affect fertility rates (Friedman et al., 1994), the social and economic situation may influence also fertility. In societies challenged by drastic change there may be an 'imperative of low fertility' as women (or couples) seek ways of what Friedman and colleagues (1994 p 381) call "uncertainty reduction". At the same time as contraceptive use may be increasing, the imperative of low fertility may be applying pressure in the opposite direction. Indeed abortion rates can increase at the same time that contraceptive prevalence increases, especially when fertility rates are in steep decline (Frejka, 1985).

Figure 3.1 Total Fertility Rate – Estonia (1970 – 2005)
Source of data: Eesti Statistikaamet (2006)

The reason for fertility decline in the former state socialist nations is the subject of debate. One explanation is that this decline is simply an indication that these states are moving toward a 'western' European pattern, and that fertility will catch up when women who are currently delaying childbearing have their babies later in life. This theory explains the decline in fertility as a tempo effect. Another is that the traumas (or joys) of socio economic transformations have led to a reduction in fertility quantum as women or couples elect to have smaller families under the new conditions of life

(Sobotka, 2002). Whatever the reason, fertility has fallen in all former Soviet states and the post-socialist states of Central and Eastern Europe and, more than a decade into independence, there have been only a few signs of recovery. For a comparison between the three Baltic States, see figure 3.2 below.

Figure 3.2 Total fertility rates – Baltic States (1990-2004)
Source of data: Council of Europe (2005)



While in the early days of the new Estonian state it might have been hoped that abortion could be simply replaced by contraception to produce the 'perfectly' contracepting society (Bongaarts and Westoff, 2000), it must now be clear that this was a vain hope. At the same time as contraceptive methods were being introduced, there was a marked and persistent decline in fertility so that more of the theoretically possible conceptions were being prevented but more conceptions were also deemed unwanted (or at least inconveniently timed). As Bongaarts and Westoff state, "abortion rates are highest in societies where small families are desired, because of the increase in the risk of unintended pregnancy" (Bongaarts and Westoff, 2000). The wish to limit or space births drives both contraception and abortion so that in the situation of falling fertility a rise in contraceptive prevalence and abortion rates can

coincide (Frejka, 1985, Marston and Cleland, 2003). In addition, the smaller the required family size, the greater the period that a woman will be at risk of unwanted pregnancy (Cohen, 1998). Although there are indications that age at first birth is *rising* (Eesti Statistikaamet, 2006), it is also clear that age at sexual debut[16] is *falling* (see discussion on sexual debut below), so that the 'at-risk' period is extending at the beginning of reproductive life. Nor have couples had access to permanent methods[17], so the risk period following the final desired birth has been lengthy too.

Marriage and cohabitation

In Estonia the crude marriage rate[18] declined steeply from 8.1 in 1989 to a low of approximately 4.0 in the late 1990s. There has been something of a recovery in crude marriage rate in recent years so that by 2005 it reached 4.5. Part of this recovery could be due to the celebration of marriages delayed in earlier years. The median age at first marriage (for women) rose steadily from 22.5 years in 1989 to 26.3 years in 2005 (TransMONEE Database, 2006).

This increase in age at first marriage, coupled with a decrease in crude marriage rate, might be seen as a partial explanation for decreases in period fertility rates as 'age at marriage' and 'proportions married' have been considered important influences on fertility rates. However, in parts of the developed world a significant number of births occur outside marriage. This has become the case in Estonia, where the proportion of births outside marriage has increased over time – from 25% in 1989 to 59% in 2005. Extra marital births now exceed births within marriage and have done so since the year 1997 (TransMONEE Database, 2006). This suggests that in Estonia formal marriage can no longer be seen as a precondition or precursor to childbearing.

[16] Sexual debut is defined as the first act of sexual intercourse

[17] During the Soviet era vasectomy was not carried out and female sterilisation was done only for medical reasons. However, this policy may be changing. In Estonia for example, recent legislation has made it possible for a woman or man to be sterilised, but only if she/he is over the age of 35 or already has at least 3 children (LTammemae 2003, personal communication), although this legislation is currently under review (Social Ministry of Estonia, 2003 personal communication).

[18] Crude marriage rate is defined here as marriages per 1000 population

Sexual debut

Why is age at sexual debut important? Following puberty, and once sexually active life begins, females are at risk of pregnancy. Those wishing to avoid pregnancy can take preventive measures, or, should pregnancy occur, birth can be averted by induced abortion. The earlier sexual debut occurs the greater the proportion of the reproductive life where women are exposed to the risk of pregnancy, ceteris paribus. Furthermore, if early sexual debut is not accompanied by early (and effective) use of contraception then there is a risk of increased levels of pregnancy and induced abortion, or births, to very young women.

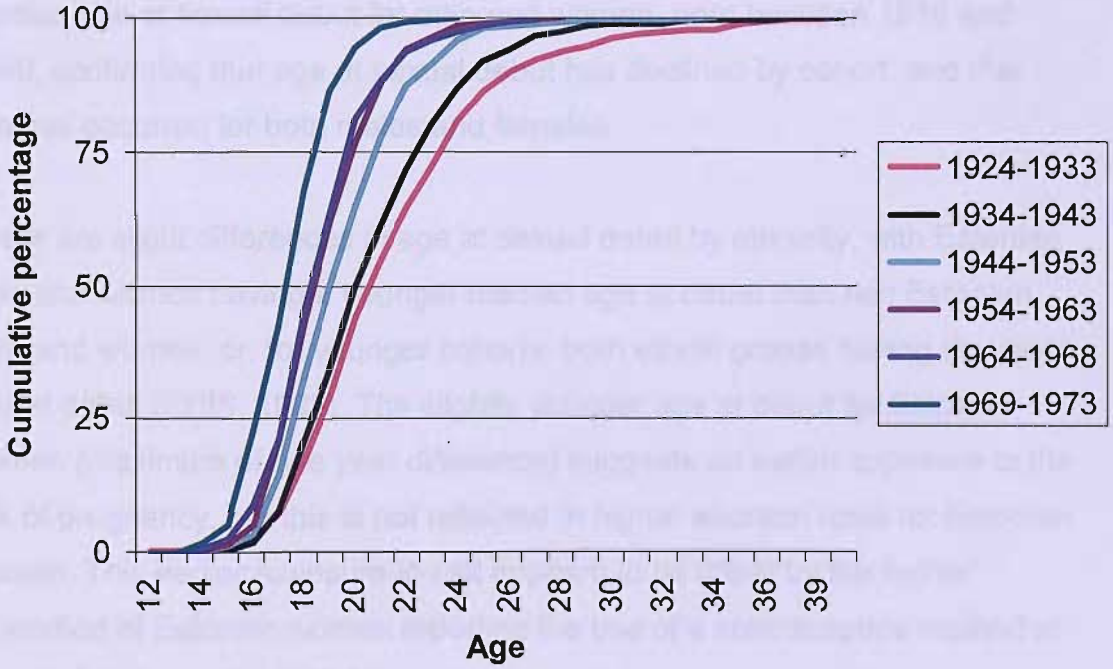
It is therefore important to note that, despite the lower ages at sexual debut for subsequent cohorts shown below, abortion rates have been falling (see discussion below concerning abortion rates). This would suggest that contraceptive practices have been changing, with more young women (or couples) employing modern effective methods than in the past and/or young women (or couples) becoming more effective users.

Figures 3.3 and 3.4 below show age at sexual debut for women born between 1924 and 1973. It was initially decided to create 5-year cohorts. However, the resultant graphs, with ten groups, were indecipherable; therefore 10-year cohorts were constructed. However, in assessing whether combining the five year age groups was appropriate, it was found that within the youngest cohort (1964-1973) there was considerable heterogeneity. Thus the oldest four groups are ten-year birth cohorts (1924 -1933, 1934 -1943, 1944 -1953, 1954 -1963) while the final two groups remain five-year cohorts[19]. The four older (10-year) cohorts show a clear decline in the age at sexual debut for each subsequent birth cohort. The youngest respondents were divided into two five-year cohorts to show that while the older five-year cohort, born 1964 -1968, had a similar age at sexual debut to those born in the next oldest group (1954-1963), sexual debut occurred at a much earlier age for the youngest respondents, born 1969-1973.

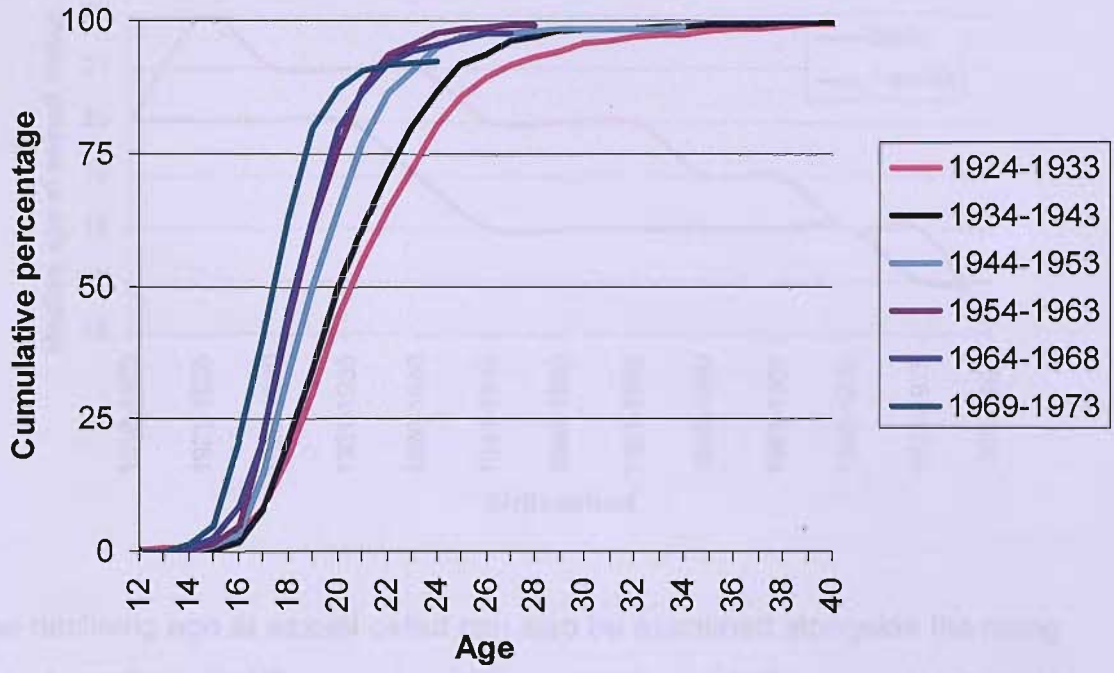
[19] See Appendix 2 for table of birth cohort sizes

Figure 3.3 shows age at sexual debut for all those respondents who answered 'yes' to the question asking if they had ever experienced sexual intercourse (n = 3252). It is important to note that, as data were collected in 1994, not all respondents would have commenced their sexual lives, especially the youngest, who would have been as young as 21 years old at the time of survey (55 respondents reported that they had not experience sexual debut). Therefore, in Figure 3.4, which takes into account all women, cumulations fall short of 100%. It is equally important to take into consideration the possibility that women may have had difficulty in accurately recalling age at sexual debut or may have reported an age at sexual debut which they considered more appropriate or more socially acceptable than the 'real' age. These errors could produce biased results.

Figure 3.3 Age at sexual debut by birth cohort (only respondents who had experienced sexual debut)
(n= 3252)
(author's own analysis based on EFFS data)



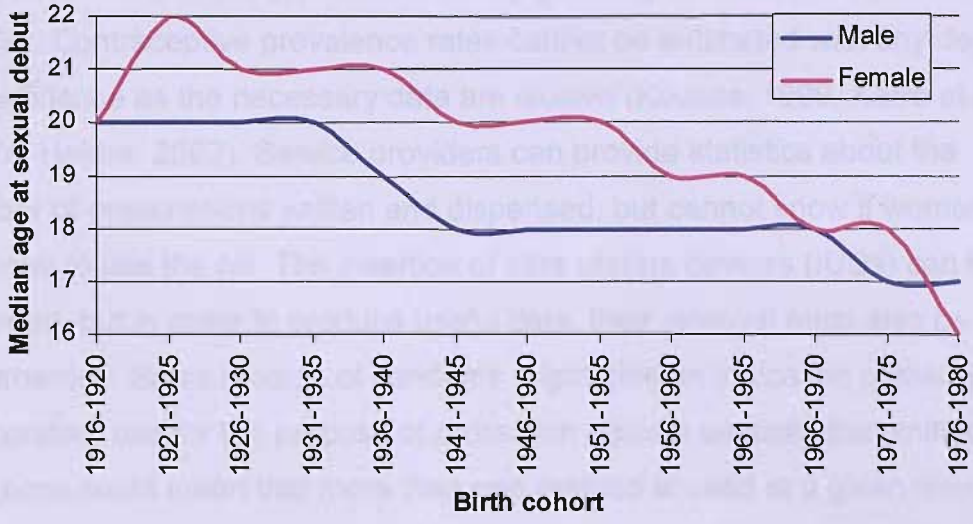
3.4 Age at sexual debut by birth cohort (all women)
(n = 3307)
(author's own analysis based on EFFS data)



Data concerning at a sexual debut were also collected for the Estonian Health Interview Survey (EHIS Leinsalu et al., 1999). Figure 3.5 below shows the median age at sexual debut for men and women, born between 1916 and 1980, confirming that age at sexual debut has declined by cohort, and that this has occurred for both males and females.

There are slight differences in age at sexual debut by ethnicity, with Estonian men and women having a younger median age at debut than non Estonian men and women, or, for younger cohorts, both ethnic groups having the same age at debut (EHIS, 1999). The slightly younger age at debut for Estonian women (maximum of one year difference) suggests an earlier exposure to the risk of pregnancy, but this is not reflected in higher abortion rates for Estonian women. This earlier exposure to risk appears to be offset by the higher proportion of Estonian women reporting the use of a contraceptive method at sexual debut (see figure 3.8 below).

Figure 3.5: Median age at sexual debut, males and females, born 1916 to 1980
Source of data: EHIS



The declining age at sexual debut can also be examined alongside the rising age at marriage and the increase in the proportion of births occurring outside marriage[20]. This paints a picture of social change, where earlier sex has become permissible and both sex and childbearing outside marriage are (generally) accepted.

What is known about contraception in Estonia?

In societies where fertility is controlled, contraception may play an important part. Whilst early decline in general fertility in Estonia was brought about by social controls (such as delayed marriage), there is evidence that, by the dawn of the twentieth century, marital fertility was being controlled in Estonia, probably by traditional methods of contraception (Coale et al., 1979). Fertility continued to decline, probably as a result of the use of traditional methods of contraception, possibly by the use of condoms and possibly by recourse to abortion, at least to some extent[21] even though abortion was illegal in the interwar period (Anderson et al., 1993). When Estonia became a Soviet republic abortion was, at first, illegal. The Soviet law of 1936 banning abortion was repealed in 1955 meaning that abortion was legalised in Estonia.

[20] See page 50 for details concerning extra marital births
[21] Katus, K personal communication

Data concerning contraceptive use and prevalence appear to be non existent until the 1990s. However, during the Soviet period contraceptive use is said to have been low and the provision of family planning services poor (Karro, 1997a). Contraceptive prevalence rates cannot be estimated with any degree of confidence as the necessary data are elusive (Kovacs, 1999, Karro et al., 1997c, Haldre, 2002). Service providers can provide statistics about the number of prescriptions written and dispensed, but cannot know if women continue to use the pill. The insertion of intra uterine devices (IUDs) can be recorded, but in order to produce useful data, their removal must also be documented. Sales records of condoms might give an indication of their use but condom use for the purpose of protection against sexually transmitted infections could mean that more than one method is used at a given time, so that contraceptive prevalence could be overestimated. Estimates derived from nationally representative survey samples are generally used to calculate contraceptive prevalence rates, but there have only been two such surveys in Estonia.

There are also issues of comparability and consistency between data sources. For example the age groups differ (for example18-49 as opposed to 20-49), classifications of women vary ('all women', 'all married women', 'all sexually active women') and definitions of contraception are confusing ('all methods', 'modern methods', 'supply' and 'non-supply' methods). In addition, contraceptive prevalence rates are often quoted without any indication of ages, classifications of women and types of contraception, nor are data collection dates specified. Table 3.1 (below) illustrates these issues.

Table 3.1 Sources of information relating to contraceptive prevalence in Estonia

Date stated?	Source of data or report	Contraceptive prevalence	Ages of women
1990	All Union Survey (Popov et al 1993)	26.4%	Not indicated
1992/3	WHO/UNFPA	26%	Not indicated
1994/5	UN	70% "all methods – supply + non-supply"	20-49
1994	Family and Fertility Survey	52% any method no indication of 'status unknown' (native born sample)	20-49
1996	Estonian Health Interview Survey	60% (all types) (of that 70% is traditional and 30% modern)	15-49
Not indicated	unfpa.org	56.4% (modern) 70.3% (any)	Not indicated
Not indicated	IPPF	36%	15-49

For the purposes of research into family planning and reproductive health, the paucity of high quality data concerning contraceptive prevalence means that when observed abortion rates fall at the same time as fertility rates fall it must be assumed that contraceptive prevalence rates are rising. Other explanations, such as increases in ages at sexual debut, decreases in numbers of women sexually active, decreases in rates of sexual activity or mysterious increases in sterility, are less likely to be credible.

As part of the Fertility and Family Survey, respondents were asked about contraceptive use. The first such question related to use of contraception at sexual debut and simply asked whether contraception was used. This question was posed only to those who had answered 'yes' to the question asking if the respondent had ever had sexual intercourse. Of the 3252 respondents eligible for this question, 719 (22%) replied 'yes' and 2533 (78%) answered 'no'. Figure 3.6 below shows how this is broken down by birth cohort. The graph shows that the proportions of women reporting contraceptive use at sexual debut increased over the birth cohorts, although it is important to note that even in the youngest cohort only 34% report use of contraception at sexual debut. However, if the final cohort is broken into two five-year groups a significant change in contraceptive use emerges, as can be seen in figure 3.7. While only 30% of respondents in the earlier of these five-year cohorts answered that contraception had been used at first intercourse, 40% of the youngest group reported having done so.

As the younger of these cohorts would have left school by the time of independence and changes in the teaching of sex education it is unlikely that this type of 'formal' education would have brought about behaviour change. It is possible that increased access to the media may have had an impact on the tendency to use contraceptives but it may also be the case that, even pre-independence, modern methods were becoming available and the ability to obtain contraceptive supplies drove behaviour change. When examining the types of methods used (see Figure 3.11) this explanation seems plausible. Whilst the increase in use of hormonal methods is small, there is a significant increase in condom use.

Figure 3.6: Use of contraception at sexual debut - proportions answering 'yes' and 'no'
(n = 3252)
(author's own analysis based on EFFS data)

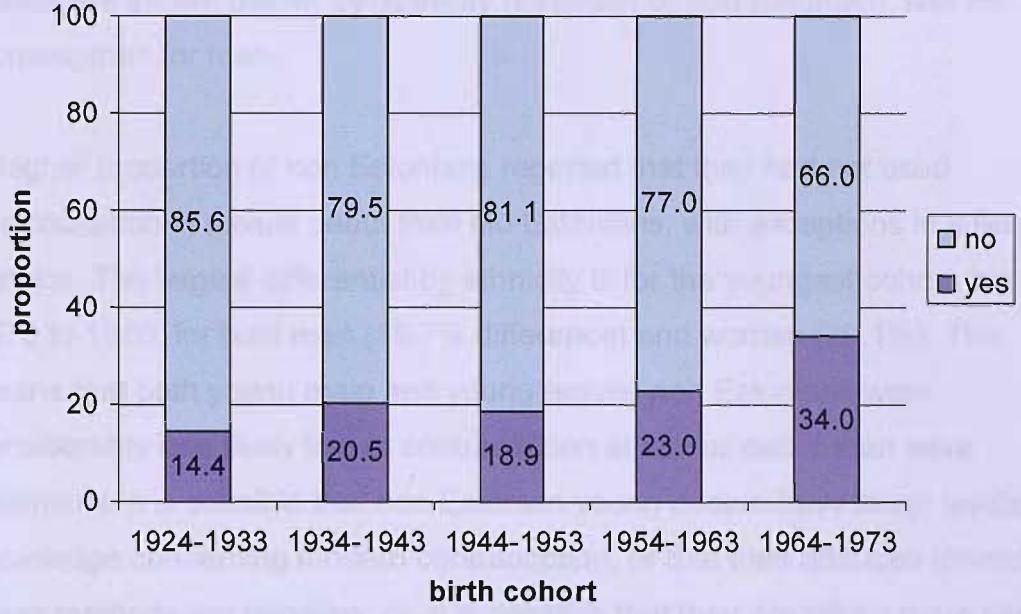
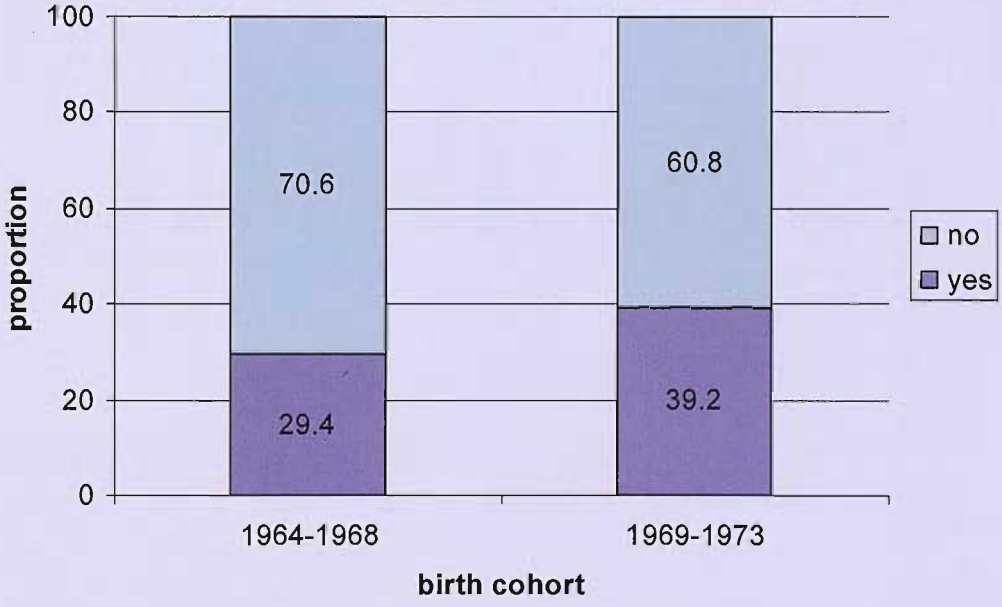


Figure 3.7: Use of contraception at sexual debut - proportions answering 'yes' and 'no' – youngest two five-year cohorts only
(1964-1968 cohort n = 332, 1969-1973 cohort n = 310)
(author's own analysis based on EFFS data)



The EHIS also included a question about use of contraception at sexual debut. This question was posed to both men and women. It should be noted that men who were asked this question may have been unaware of their partner's use of a method, for example the pill or contraceptive injection. The results are shown below, by ethnicity (Estonian or non Estonian), first for women, then for men.

A higher proportion of non Estonians reported that they had not used contraception at sexual debut than did Estonians, with exceptions in a few cohorts. The largest differential by ethnicity is for the youngest cohort, born 1976 to 1980, for both men (19.7% difference) and women (20.1%). This means that both young male and young female non Estonians were considerably less likely to use contraception at sexual debut than were Estonians. It is possible that non Estonian young people have lower levels of knowledge concerning modern contraception, or that their attitudes towards these methods are negative, or, it is possible that they are taking more risks, in spite of knowledge. This should be a matter for concern for policy makers and suggests that attention should be paid to the particular needs and concerns of non Estonian youth.

Figure 3.8: Women who reported using *no* contraceptive method at sexual debut

Source of data: EHIS

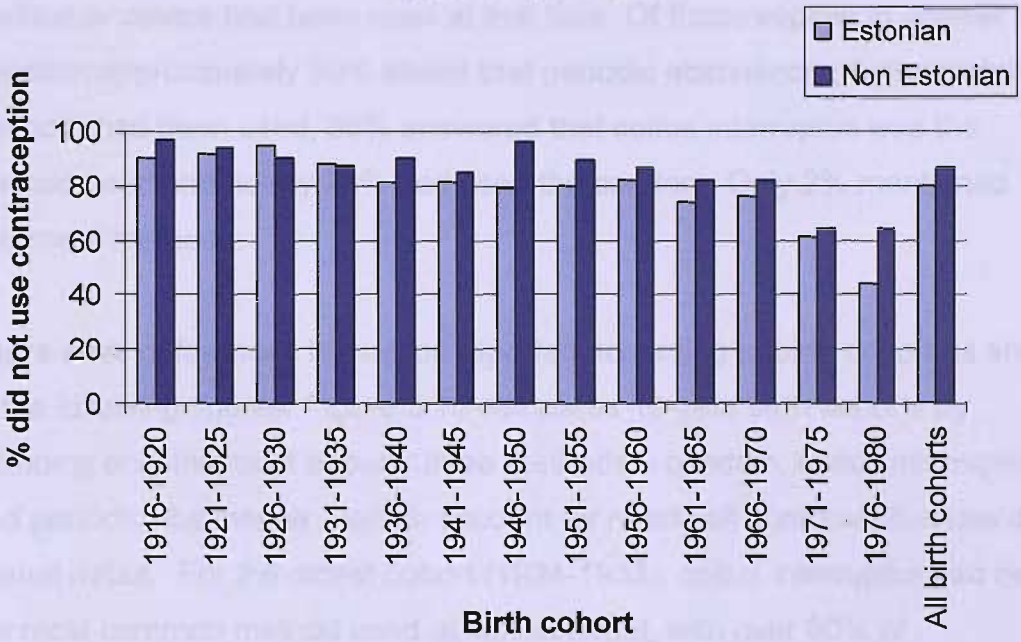
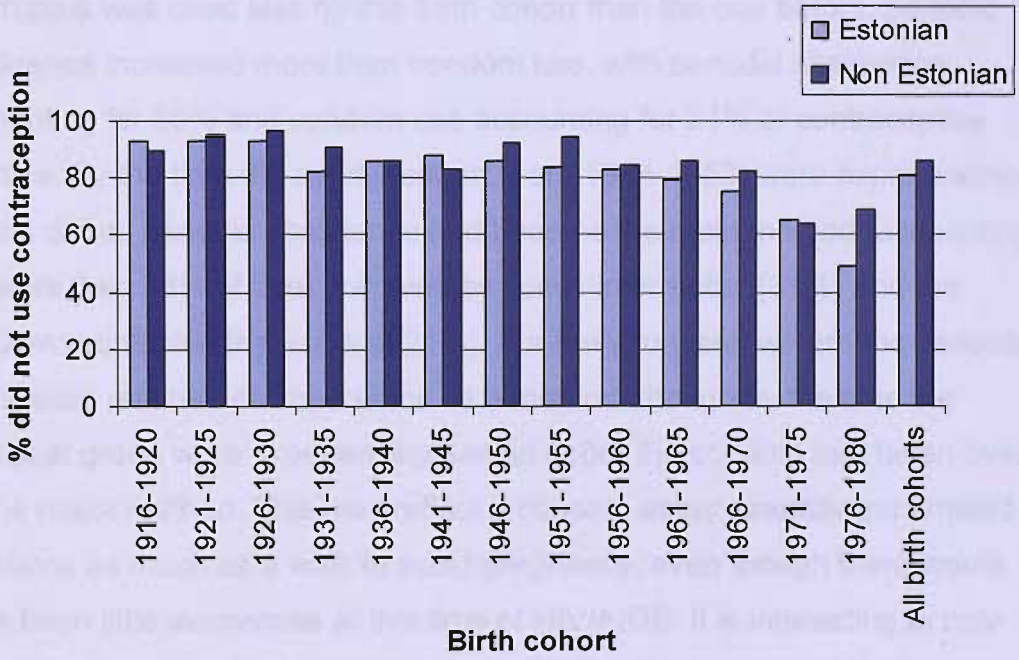


Figure 3.9: Men who reported using *no* contraceptive method at sexual debut

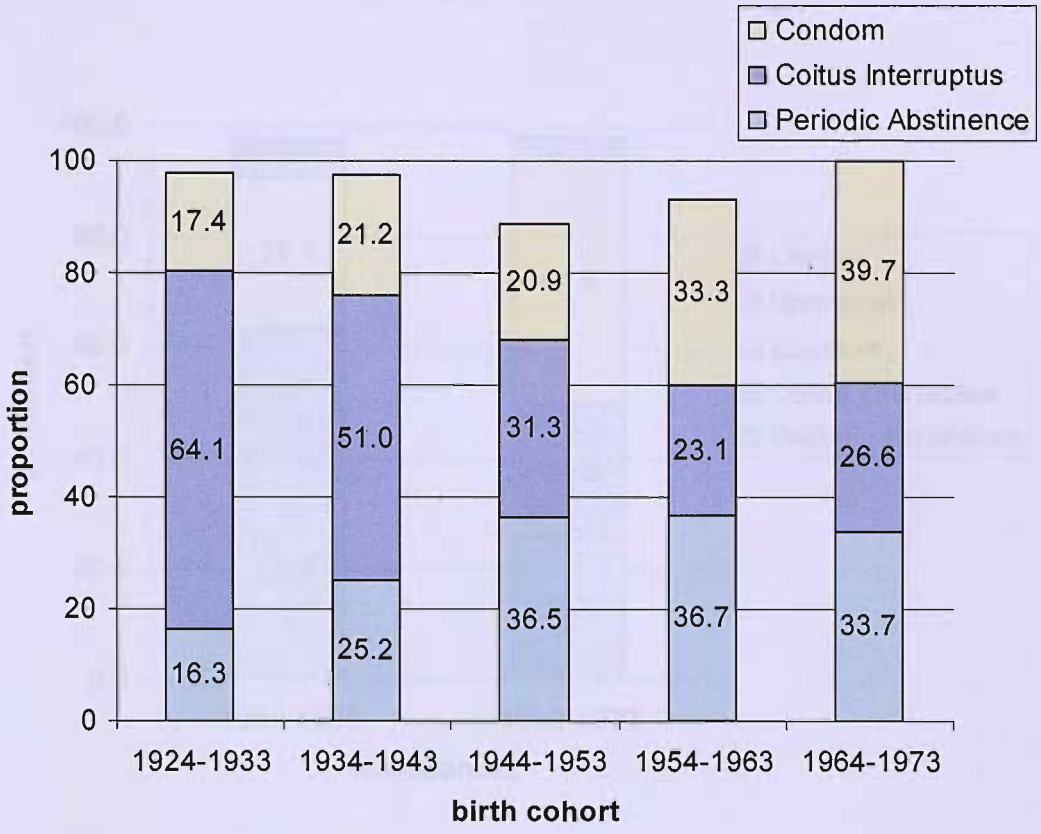
Source of data: EHIS



Respondents who had answered 'yes' to the question on the EFFS concerning use of contraception at sexual debut, were then asked which method or device had been used at that time. Of those eligible to answer this question approximately 30% stated that periodic abstinence (rhythm/calendar method) had been used, 36% answered that coitus interruptus was the method used and nearly 28% had used the condom. Only 2% mentioned hormonal methods.

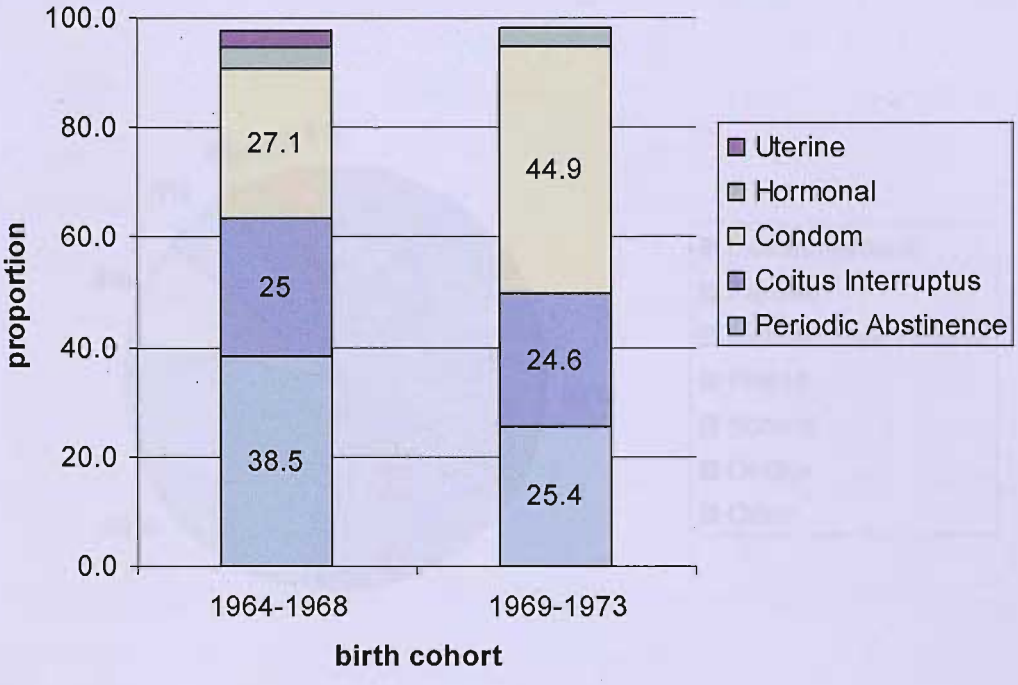
There were differences in method reported according to birth cohort as shown in the following figures. Figure 3.10 compares 10-year birth cohorts by including only the most popular three methods – condom, coitus interruptus and periodic abstinence - which account for nearly all contraceptive use at sexual debut. For the oldest cohort (1924-1933), coitus interruptus had been the most common method used at sexual debut, with over 60% of respondents having used this method, and condom and periodic abstinence being roughly equal at approximately 15%. For the next cohort (1934-1943) coitus interruptus remained the key method, still accounting for more than 50% of contraception at sexual debut. It is interesting to note that while coitus interruptus was used less by this birth cohort than the one before, periodic abstinence increased more than condom use, with periodic abstinence accounting for 25% and condom use accounting for 21% of contraceptive practice. By the time the middle cohort (born 1944-1953) were experiencing sexual debut, periodic abstinence had become the main method (accounting for more than 36% of use), followed by coitus interruptus (31%) and the condom (remaining the same at 21%). For the youngest two groups periodic abstinence retained its importance as a method, though by the time the youngest group were experiencing sexual debut the condom had taken over as the major method. This may reflect a concern about sexually transmitted infections as much as a wish to avoid pregnancy, even though there would have been little awareness at this time of HIV/AIDS. It is interesting to note that while the use of coitus interruptus tended to decrease over the birth cohorts, there was an increase in its reported use between the last two ten-year cohorts.

Figure 3.10: Use of contraceptive method at sexual debut by 10 year birth cohort
(n = 719)
(author's own analysis based on EFFS data)



As before, if the final birth cohort (1964-1973) is divided into two five year cohorts differences can be seen between these groups; see 3.11 below. Caution must be used in interpreting these results however as some cell counts are small. Nevertheless, it would appear that the biggest change between the youngest two five-year birth cohorts is the increase in condom use at sexual debut, from 27% for the 1964-1968 birth cohort to 45% for the 1969-1973 cohort. It is interesting to note that even for the youngest women, the use of hormonal contraception at sexual debut is uncommon, with less than 5% of women reporting these methods in each of the youngest five-year cohorts.

Figure 3.11: Use of contraceptive method at sexual debut by 5 year birth cohort, women born 1964 to 1973 only
(1964-1968 n = 96, 1969-1973 n = 118)
(author's own analysis based on EFFS data)



Following the question about method of contraception used at sexual debut, respondents who had reported the use of a method were asked about the source of their knowledge about the method used at sexual debut. The most common source of knowledge was in the form of literature (53%), followed by information from the partner at 25%. Mothers (or close relatives) and friends accounted for 8% and 6% respectively.

However, if the analysis is carried out by 10-year birth cohort some changes can be observed over the groups. In particular, the influence of the partner declined from 53% to 16 % from the oldest 10-year cohort to the youngest. School did not play role until the second oldest cohort (born 1934-1943) and did not account for more than 5% in any cohort. The category 'mother or close relative' never accounted for more than 10% of responses. Due to the limitations of the questionnaire approach it is not clear whether the use of

literature or books as sources of information was an independent activity or one instigated by, for example, parents or teachers.

Figure 3.12: Source of knowledge about method used at sexual debut
(n = 720)
(author's own analysis based on EFFS data)

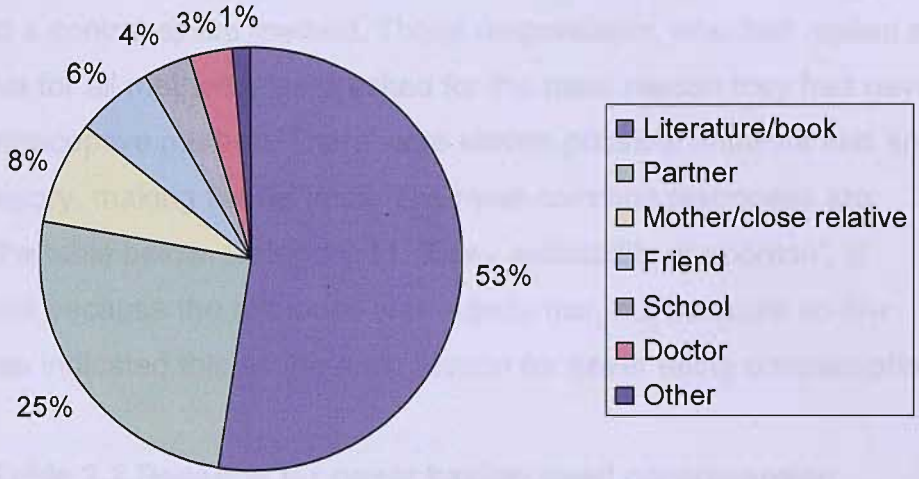
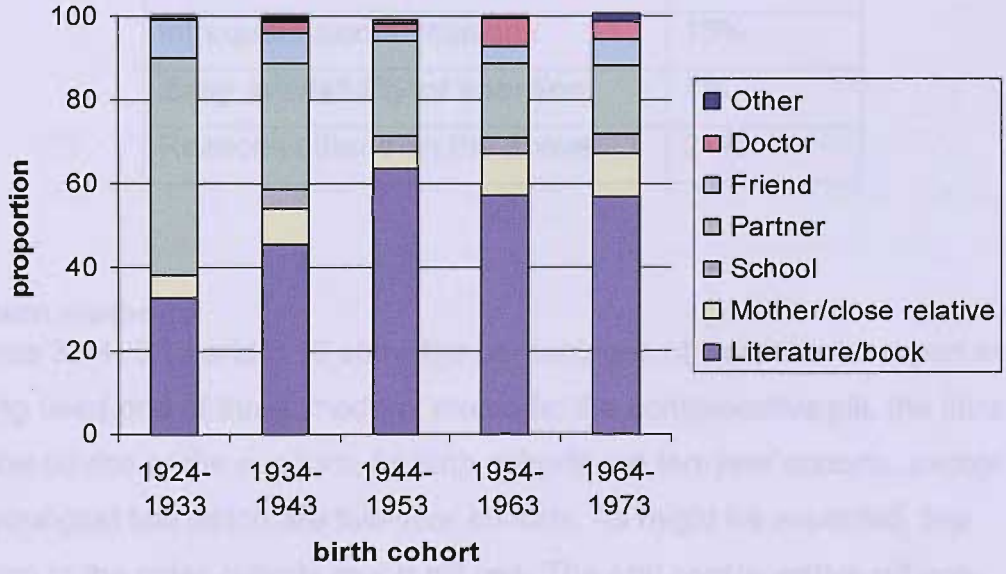


Figure 3.13: Source of knowledge of contraceptive method used at sexual debut by 10-year birth cohort
(n = 720)
(author's own analysis based on EFFS data)



Contraceptive methods ever used

Respondents were asked whether they had ever used the following contraceptive methods: the oral contraceptive, the intra-uterine device, the condom, the diaphragm, contraceptive foam, douching or vaginal cleansing, coitus interruptus, the rhythm method (periodic abstinence). These questions were posed only to women who had experienced sexual intercourse (3252 respondents). Of women who had experienced sexual intercourse, 14% had never used a contraceptive method. These respondents, who had replied in the negative for all methods, were asked for the main reason they had never used a contraceptive method. There were eleven possible answers and an 'other' category, making twelve in all. The most common responses are shown in the table below. Category 11, 'Easy availability of abortion', is included, not because the response was substantial, but because so *few* respondents indicated this as the main reason for never using contraception.

Table 3.2 Reasons for never having used contraception
(n = 452)
(analysis based on EFFS data)

Reason	Percent
Do not easily get pregnant	29%
Lack of knowledge	20%
Own infertility due to disease	13%
Infrequent sexual relations	13%
Easy availability of abortion	***1%***
Reasons other than the above	24%

Modern methods

Figures 3.14, 3.15 and 3.16 show the percentages of women who report ever having used one of three 'modern' methods: the contraceptive pill, the intra uterine device or the condom. All birth cohorts are ten-year cohorts, except the youngest two which are five-year cohorts. As might be expected, few women in the older cohorts report pill use. The oral contraceptive pill only

became available in the 1960s in the West and was not readily available in Estonian until the early 1990s. Pill use increases by birth cohort, with the maximum proportion of use being 31% in the cohort born 1964 to 1968. In the youngest group, born 1969 to 1973, a lower proportion of women report having used the pill. This could be due to their young age – some would not have experienced sexual debut by the time of the survey. Another possibility is that the pill may be perceived as a method to be used when in a committed long-term relationship and the relative youth of this group might mean this type of relationship has not yet been established.

The intra uterine device (IUD) was used very little by the two oldest cohorts, but high proportions of women born between 1944 and 1968 report its use, with the maximum proportion being in the cohort 1954 to 1963 at 64%. Just over a quarter of women in the youngest cohort, born 1969 to 1973 report ever having used the IUD, but this could be because this method is not usually prescribed for nulliparous women.

'Ever use' of the condom rose from 22% in the oldest cohort to 75% in the cohort born 1969 to 1973. The increase in use may be partly explained by the increased availability of condoms of acceptable quality and also by concerns about the risk of contracting sexually transmitted infections, not just the risk of becoming pregnant.

Traditional methods

Figures 3.17, 3.18 and 3.19 below, show the percentages of women who report ever having used one of three 'traditional' methods. Proportions of women reporting the practice of coitus interruptus ranged from 51% to 65%. For periodic abstinence the proportions are similar, ranging from 55% to 64%, except for the cohort born 1924 to 1933, of whom only a third report having used this method. The proportions of women reporting the use of the douching method ranged from 10% in the youngest cohort to 16% in the cohort born from 1934 to 1943. No information was collected at interview regarding the douching solution used.

Given the proportions of women reporting 'ever use' of traditional methods, especially amongst the older cohorts, unplanned pregnancies must have been common. Although traditional methods can be effective if used 'perfectly', in 'typical' use the risk of pregnancy is much higher for traditional methods than for the most effective modern methods as can be seen in table 3.3 below.

Table 3.3 Contraceptive effectiveness
Pregnancies per 100 women per year, expressed as a percentage
Source: (Planned Parenthood, 2004)

Method	Typical Use	Perfect Use
Pill	8%	0.3%
Condom	15%	2%
Withdrawal	25%	9%
Rhythm	27%	4%

Figure 3.14: Proportions of women who have ever used the contraceptive pill by birth cohort
(n = 3252)
(author's own analysis based on EFFS data)

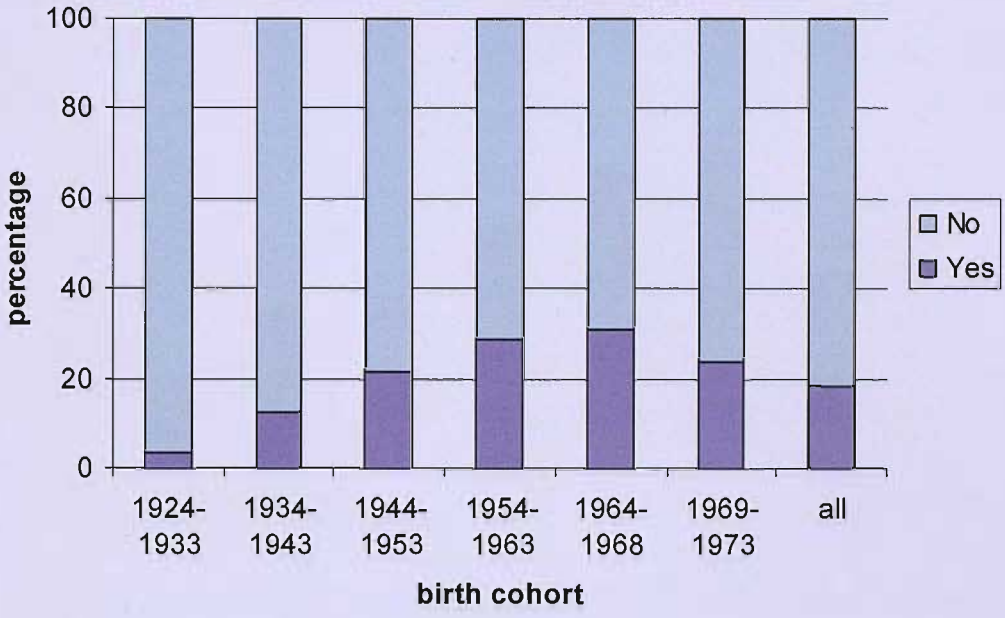


Figure 3.15: Proportions of women who have ever used the intra uterine device (IUD) by birth cohort
(n=3252)
(author's own analysis based on EFFS data)

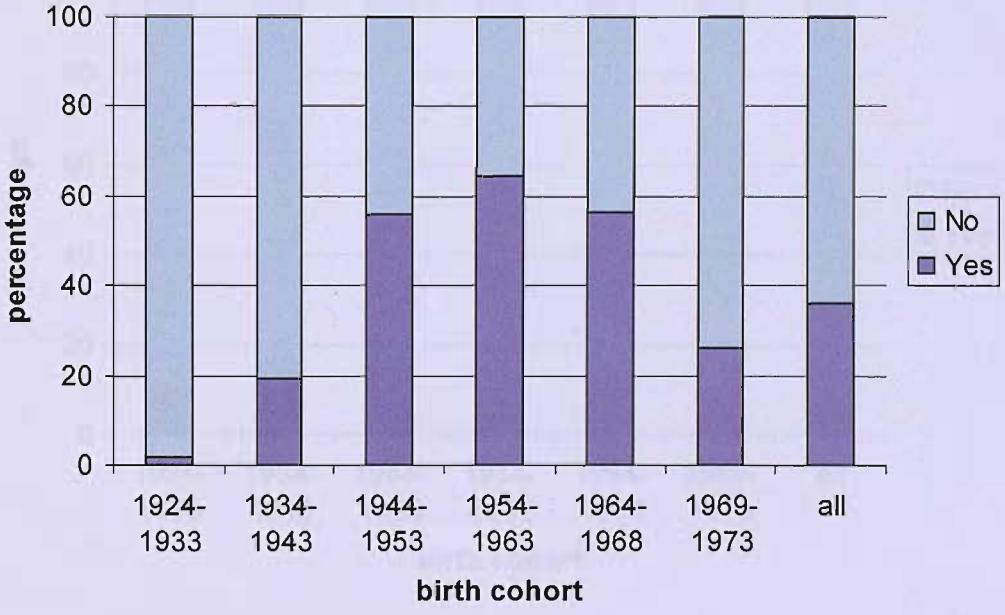


Figure 3.16: Proportions of women who have ever used the condom by birth cohort
(n=3252)
(author's own analysis based on EFFS data)

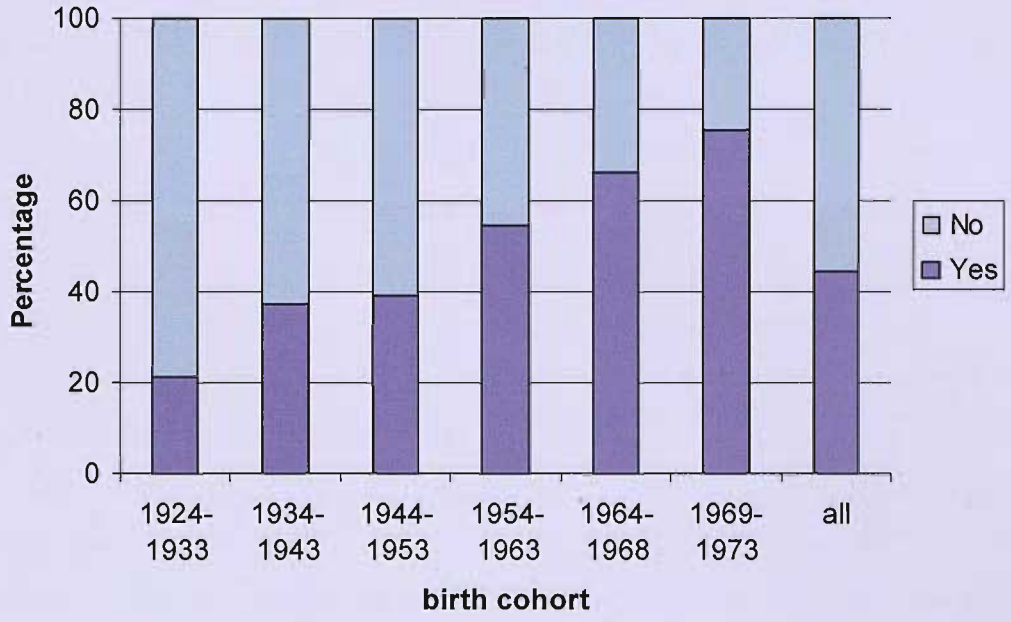


Figure 3.17: Proportions of women who have ever used the douche method by birth cohort
(n=3252)
(author's own analysis based on EFFS data)

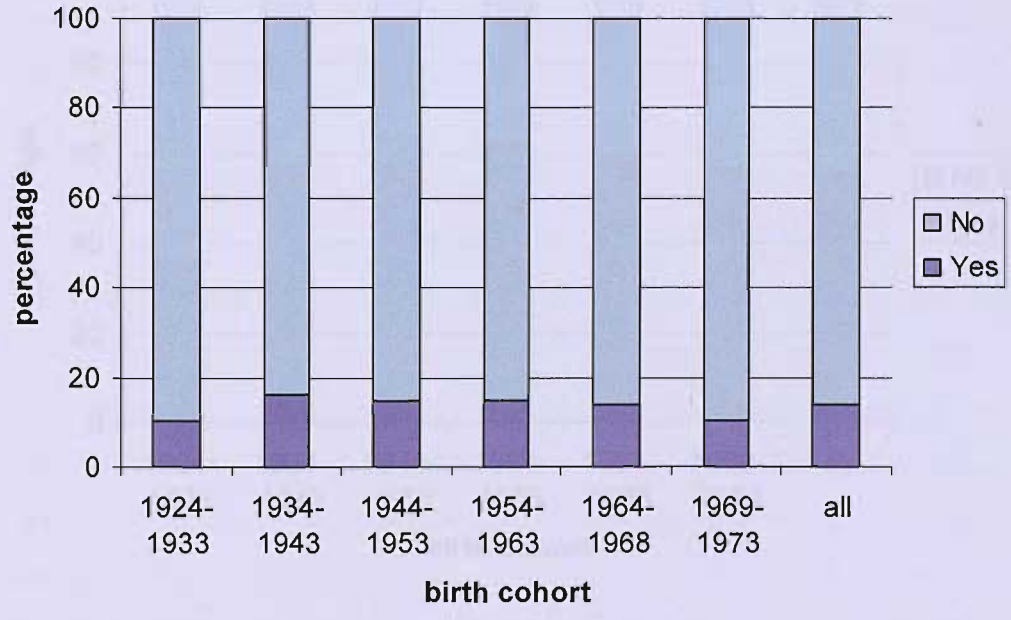


Figure 3.18: Proportions of women who have ever practiced coitus interruptus by birth cohort
(n=3252)
(author's own analysis based on EFFS data)

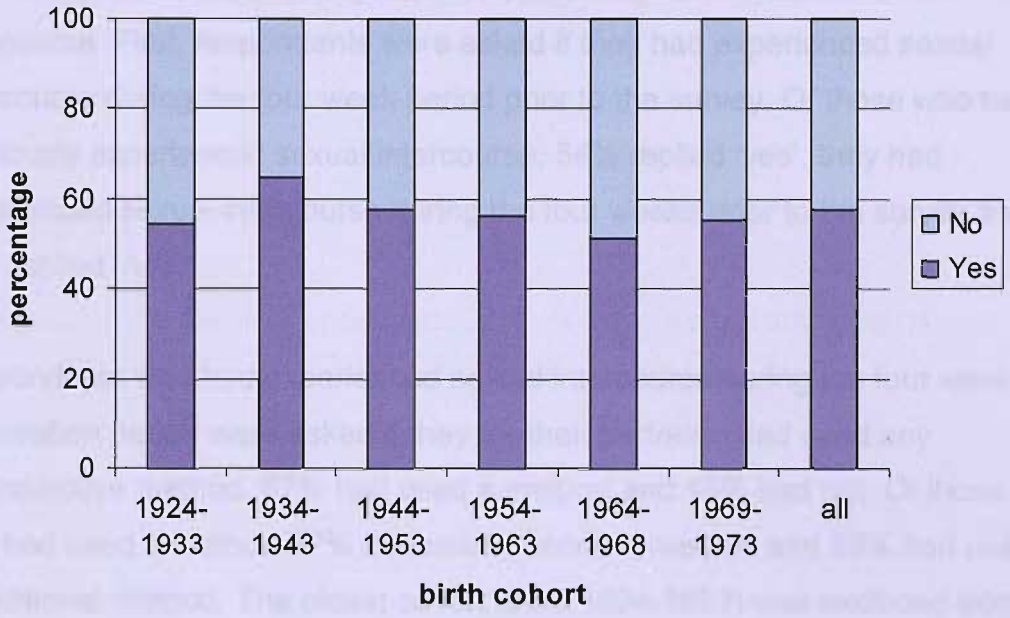
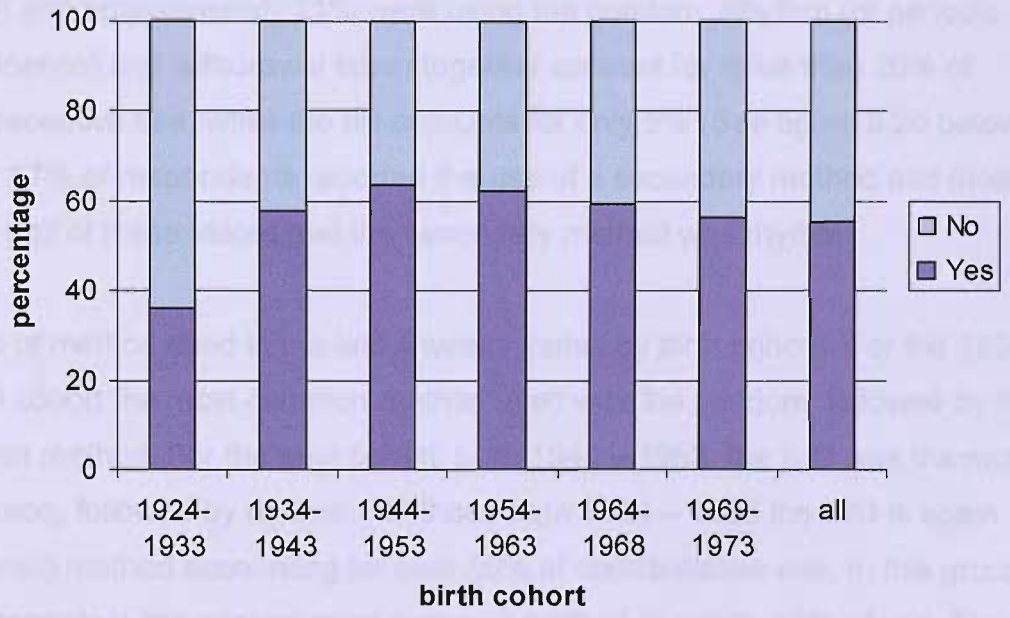


Figure 3.19: Proportions of women who have ever practiced periodic abstinence by birth cohort
(n=3252)
(author's own analysis based on EFFS data)



Recent use of contraceptive methods

In the EFFS, a question concerning the use of contraception in the four weeks prior to the survey was put to respondents. A small proportion of respondents were excluded from analysis (1.7%) because they had never had sexual intercourse. First, respondents were asked if they had experienced sexual intercourse during the four week period prior to the survey. Of those who had previously experienced sexual intercourse, 54% replied 'yes', they had experienced sexual intercourse during the four weeks prior to the survey and 46% replied 'no'.

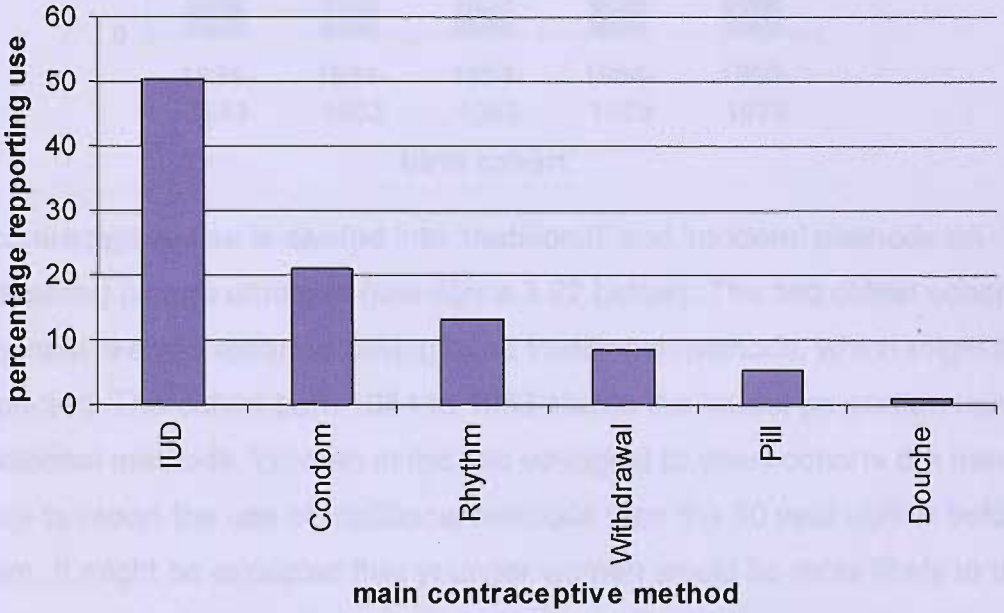
Respondents who had experienced sexual intercourse during the four week observation period were asked if they (or their partners) had used any contraceptive method. 57% had used a method and 43% had not. Of those who had used a method 77% had used a modern method and 23% had used a traditional method. The oldest cohort (born 1924-1933) was excluded from the following analyses as no respondent in this group reported contraceptive use.

Just over half of those using a method were using the intra uterine device (IUD) and approximately 21% were using the condom. Rhythm (or periodic abstinence) and withdrawal taken together account for more than 20% of contraceptive use, while the pill accounts for only 5% (See figure 3.20 below). Only 17% of respondents reported the use of a secondary method and more than half of these stated that the secondary method was rhythm.

Type of method used in the last 4 weeks varies by birth cohort. For the 1934 - 1943 cohort the most common method used was the condom, followed by the rhythm method. For the next cohort, born 1944 – 1953, the IUD was the most common, followed by rhythm. For those born 1954 – 1963 the IUD is again the main method accounting for over 60% of contraceptive use. In this group the condom is the second most common method at nearly 18% of use. The last two birth cohorts are five year cohorts. For the older of these cohorts,

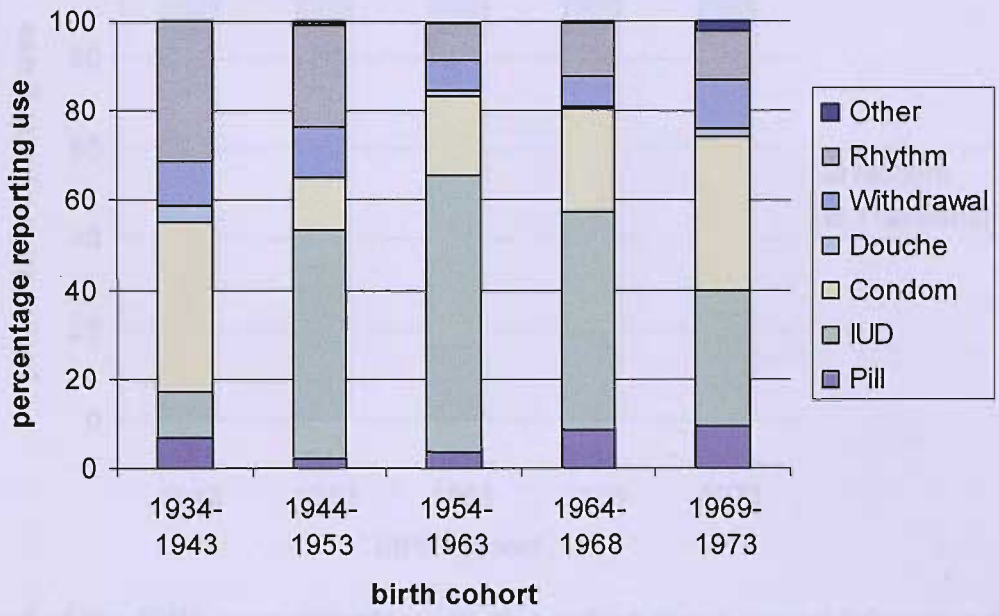
women born 1964 – 1968, the IUD is again the most common method accounting for nearly half of contraceptive use. Nearly a quarter of contraceptive use for this cohort is accounted for by the condom. In the youngest five year cohort, women born 1969 -1973, the condom is the most common method cited (34%) with the IUD very close behind at 31% (see figure 3.21 below).

Figure 3.20: Contraceptive use in 4 weeks prior to interview – main method
(n=1763)
(author's own analysis based on EFFS data)



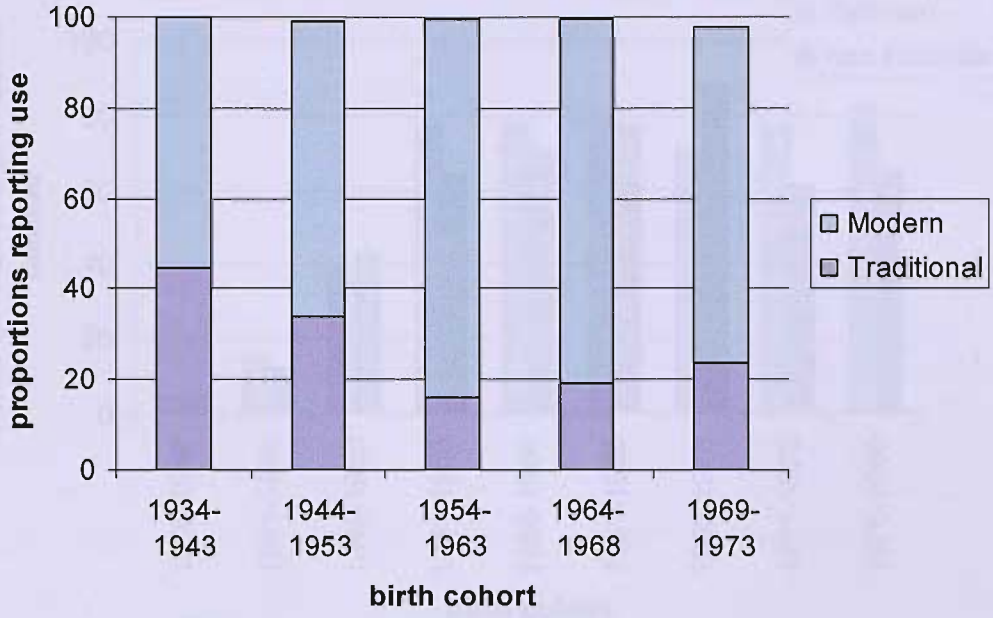
Some of these observed differences could be due to different norms concerning contraceptive methods at different times. Equally, the differences in practices could be due to the different stages in the life course, and in the *reproductive* life course, being experienced by respondents at the time of the survey. For example the IUD is not often offered to women until they have had a full term pregnancy. Part of the lower reported use of the IUD in the 1969-1973 cohort might be accounted for by fewer women in this youngest group having given birth.

Figure 3.21: Contraceptive use in 4 weeks prior to interview – main method, by birth cohort
(n=1008)
(author's own analysis based on EFFS data)



If contraceptive use is divided into 'traditional' and 'modern' methods an interesting picture emerges (see figure 3.22 below). The two oldest cohorts are most likely to reported having used traditional methods, which might be expected. The cohort born 1954 to 1963 shows the lowest proportion using traditional methods. Women in the two youngest (5 year) cohorts are more likely to report the use of traditional methods than the 10 year cohort before them. It might be expected that younger women would be more likely to use modern methods than older women. However, the higher use of traditional methods reported by the younger women could be a reflection of their relative youth and position in the life course. They may be less concerned than older women about the risk of pregnancy, they could be less well informed about the efficacy of traditional methods in comparison to modern methods or they could be eager to begin childbearing.

Figure 3.22: Contraceptive use in 4 weeks prior to interview – main method, traditional or modern, by birth cohort
(n=1008)
(author's own analysis based on EFFS data)



As part of the EHIS respondents were also asked about sexual intercourse and contraceptive use in the four weeks prior to interview. The question was somewhat different in that it asked if any method had been used to prevent pregnancy *and/or* a sexually transmitted infection, whereas the EFFS asked only about any method to prevent pregnancy. The results, by gender, ethnicity and birth cohort are shown below in figures 3.23 and 3.24. The proportions of Estonians reporting use of a preventive method exceed those for non Estonians in all age cohorts and for both sexes except for females born 1946 to 1950 and females born 1966 to 1970. The reasons behind the lower levels of preventive methods for non Estonians as compared to Estonians cannot be ascertained as no questions were asked about the decision making behind the behaviour. It is possible that there are different levels of knowledge between the two groups, different perceptions of risk, different attitudes to risk taking or different attitudes towards contraceptive methods and their use.

Figure 3.23: Proportion of females who report having used a preventive method in the 4 weeks prior to interview, by ethnicity
(EHIS)

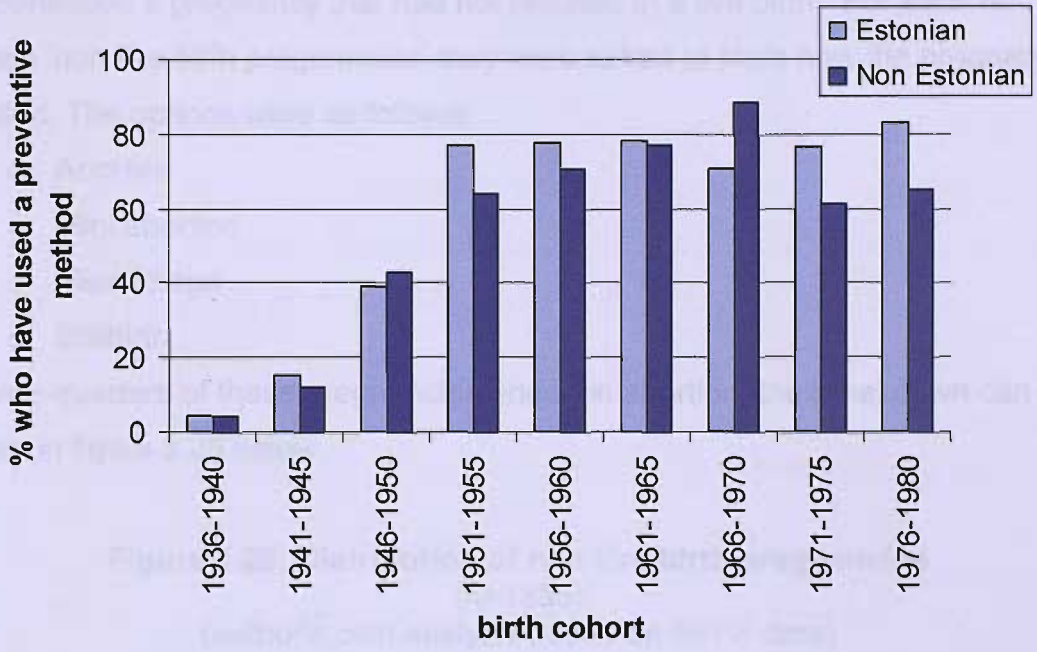
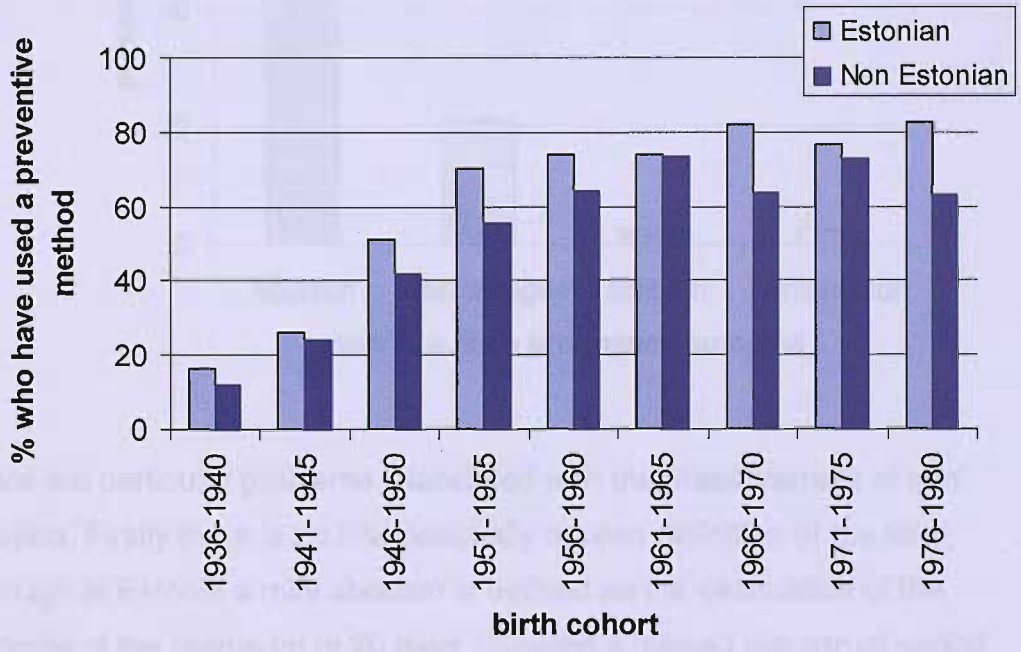


Figure 3.24: Proportion of males who report having used a preventive method in the 4 weeks prior to interview, by ethnicity
(EHIS)



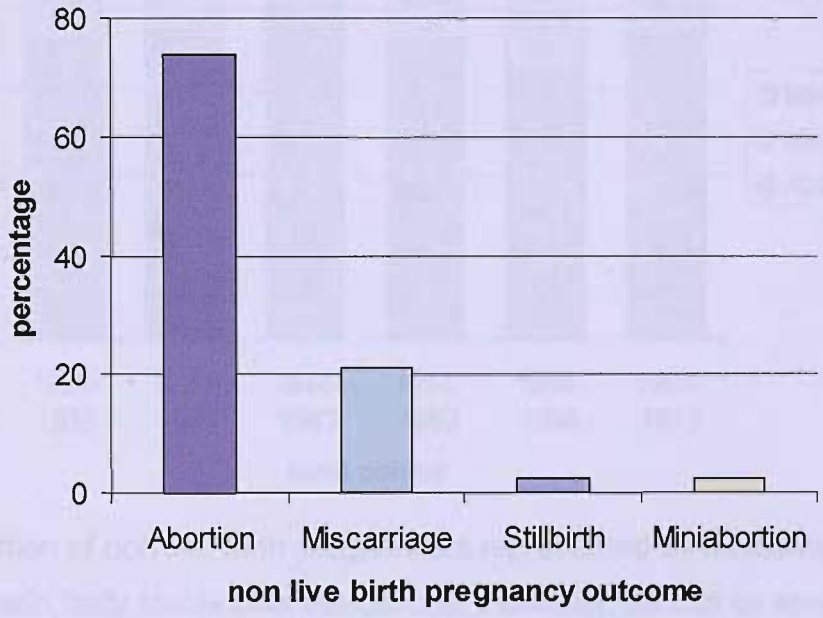
Abortion

Of 3307 women in the EFFS data set, 3253 had had sexual intercourse at some time. 62% of these women reported in the EFFS that they had experienced a pregnancy that had not resulted in a live birth. For each of these 'non live birth pregnancies' they were asked to state how the pregnancy ended. The options were as follows:

- Abortion
- Mini abortion
- Miscarriage
- Stillbirth

Three-quarters of these pregnancies ended in abortion; the breakdown can be seen in figure 3.25 below.

Figure 3.25: Distribution of non live birth pregnancies
(n=1355)
(author's own analysis based on EFFS data)

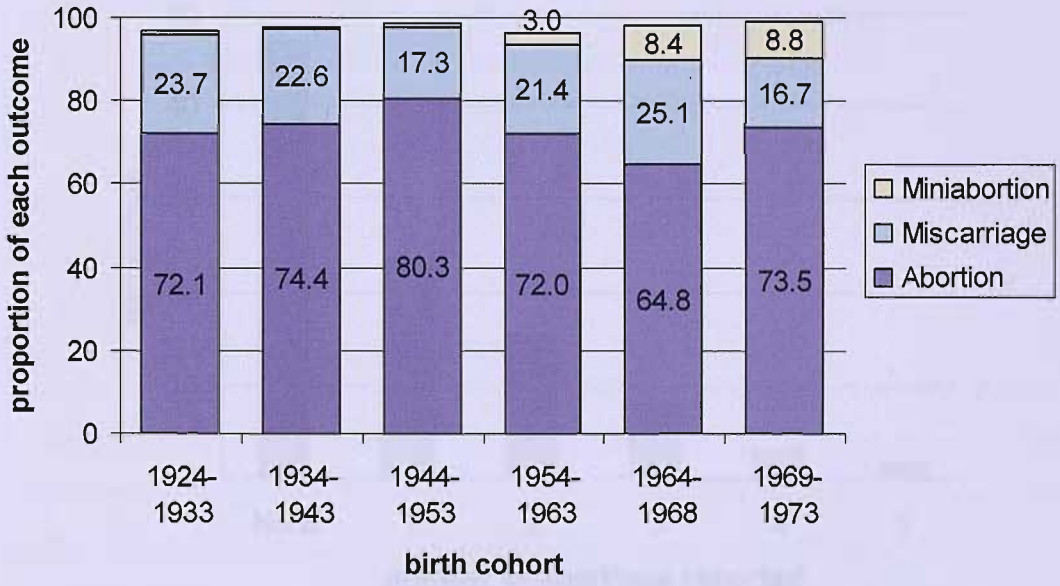


There are particular problems associated with the measurement of mini abortion. Firstly there is no internationally agreed definition of the term although in Estonia a mini abortion is defined as the evacuation of the contents of the uterus up to 20 days following a missed menstrual period (Karro, 1997a). Secondly, some of these abortions may not be abortions at all but delayed menstrual periods without fertilisation having taken place.

Furthermore, a mini abortion takes place so early that some of these pregnancies would have resulted in spontaneous abortions at a later date. The result is that counts of mini abortions may overestimate the number of pregnancies terminated which would otherwise have gone to term.

If non live birth pregnancies are analysed by birth cohort, small differences in distribution can be seen. Stillbirths have been excluded from the following analysis as the proportion of stillbirths is so small, with the highest proportion reported being 3.6%, from the 1954-1963 birth cohort.

Figure 3.26: Distribution of non live birth pregnancies by birth cohort
(n=1355)
(author's own analysis based on EFFS data)

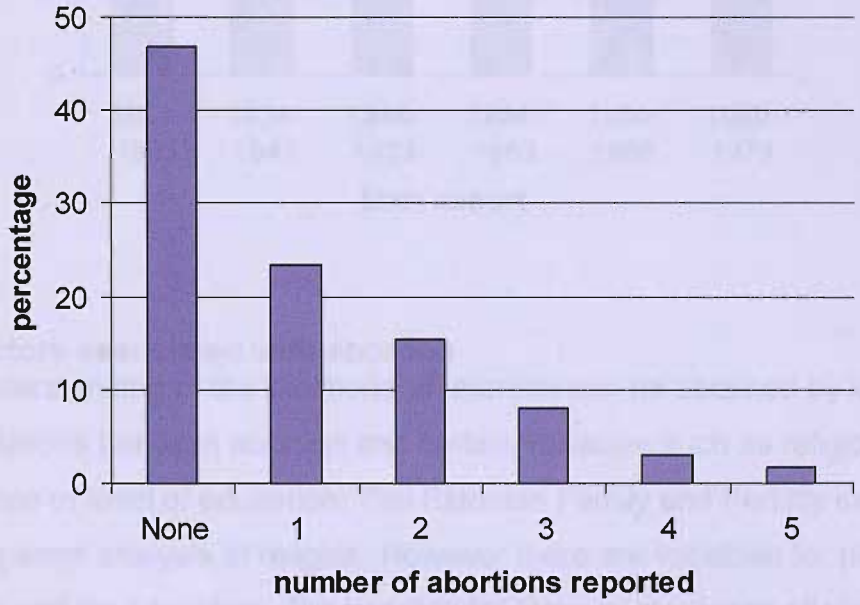


The proportion of non live birth pregnancies represented by miscarriage should remain fairly stable over the cohorts. However, as can be seen in figure 3.26 above, the proportion reported by the 1944 to1953 cohort is somewhat lower than that for all other cohorts and the proportion of non live births ending in abortion is larger. This suggests that there may have been a tendency to report a small proportion of abortions as miscarriages in some birth cohorts. It is important to note that women in the 1944 to 1953 cohort reporting a higher proportion of abortions within non live birth outcomes and this is also the group where women are least likely to report having had no

abortions (see below). More of these women report one abortion, two abortions or three abortions than any other age group. It may therefore be the case that abortion was more common for this cohort or that they felt able to report their abortions or a combination of these two factors.

Of 3307 women in the data set, 3253 had had sexual intercourse at some time. Of these women, nearly half reported never having had an abortion, nearly 25% had had one abortion and 15% had had two abortions. Less than 15% of women reported having had three or more abortions (see figure 3.27 below).

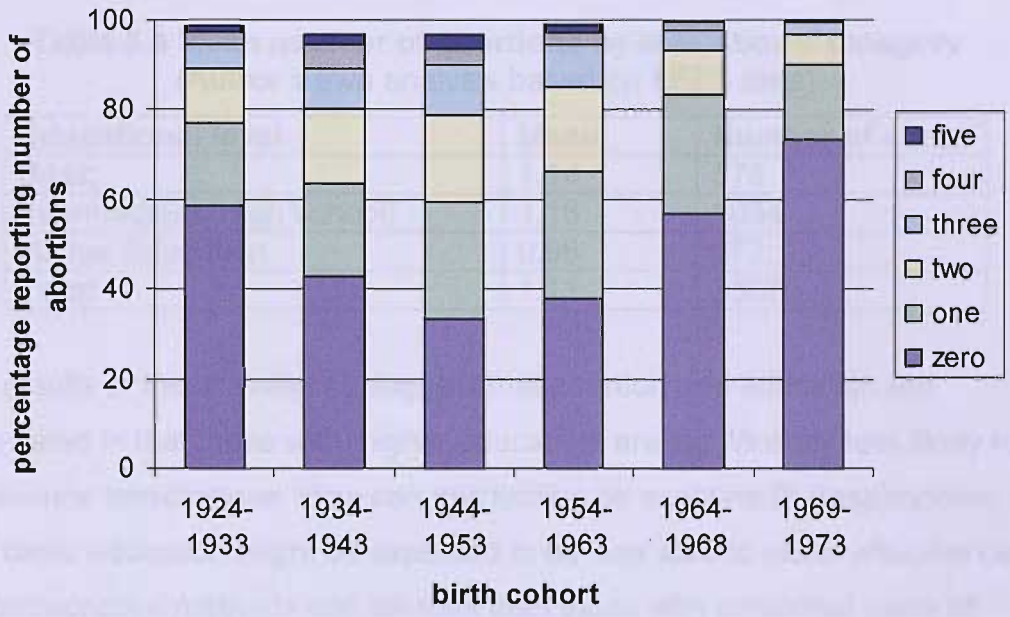
Figure 3.27: Total abortions reported
(n=3307)
(author's own analysis based on EFFS data)



As can be see in figure 3.28 below, the number of abortions reported varies by birth cohort. Fewer abortions are reported for those born 1964 to 1973, but these women have not yet completed their reproductive lives. Women in the birth cohorts 1934 to 1943, 1944 to 1953, and 1954 to 1963 are less likely to report no abortions and more likely to report two, three, four or five abortions. Some respondents may have failed to report abortions. However, based on the relatively small number of abortions reported by most women (mean =

1.11), it appears unlikely that abortion was the primary method of fertility control employed by the majority of these respondents.

Figure 3.28: Total abortions reported by birth cohort
(n=3307)
(author's own analysis based on EFFS data)



Other factors associated with abortion

Better understanding of the likelihood of abortion can be obtained by looking for associations between abortion and certain variables such as religion, place of residence or level of education. The Estonian Family and Fertility data used does not permit analysis of religion. However there are variables for place of residence and for education. The variable for place of residence allows for only two possibilities: urban or rural. The education variable is divided into 3 categories: basic, intermediate (approximately high school) and higher education (college, university etc).

Education

Cases were recoded into three groups: 'no abortions', 'one or two abortions', 'three or more abortions' and a cross tabulation was performed including all three educational levels. The results demonstrated a statistically significant association (p-value = 0.022).

To confirm this result a comparison of means (number of abortions) was performed based on the three educational categories. This demonstrated a significant difference in mean number of abortions according to educational level. The mean number of abortions for each educational category can be seen in table 3.3 below.

Table 3.4 Mean number of abortions by educational category
(Author's own analysis based on EFFS data)

Educational level	Mean	Number of cases
Basic	1.14	876
Intermediate (High school)	1.15	1854
Higher Education	0.96	577
Total	1.11	3307

The results of these analyses suggest that abortion and education are associated in that those with 'higher education' are significantly less likely to experience terminations. How can this finding be explained? Respondents with basic education might be expected to be less able to make effective use of contraceptive methods and devices than those with additional years of education. For those with intermediate education, some will have left school at the age of sixteen, while others would have stayed on in order to gain access to higher education even though they did not obtain a place. In view of the paucity of school based sex education (see Chapter 4 and Chapter 6), it is perhaps understandable that these two groups of respondents might have had more abortions due to lack of knowledge. Those with higher education might have been better informed, not necessarily as a result of sex education per se, but as a bi-product of the teaching and learning involved in participating in higher education. It is interesting to note that focus group respondents (see Chapter 6) speak of learning about sex whilst at university, which suggests that those attending university might be better able to take preventive measures and less likely to need abortions.

Place of residence
To assess whether there was any association between abortion and place of residence cross-tabulations were carried out between urban or rural location

and abortion in three categories: 'no abortions', 'one or two abortions', and 'three or more abortions'. The result demonstrated a significant association at the 1% level (p-value = 0.001).

When means (of total number of abortions) were compared for 'urban' and 'rural' residence the results indicated that the mean number of abortions for 'urban' residence was 1.172, whilst that for 'rural' residence was lower at 1.017. This difference was significant at the 1% level (p-value = 0.005).

The results of analyses based on place of residence suggest that urban dwellers have more abortions and rural inhabitants fewer. It is possible that this difference is based on differential access to services, both for contraception and abortion. During the Soviet period access to contraception was limited throughout the country (and the Union) and so it seems unlikely that this factor would drive the difference in abortion levels. It is however possible that access to *abortion* services may have been more problematic in rural areas, especially given that there was an imperative to terminate within the first three months of gestation. Delay in reaching an abortion clinic could lead to the procedure being denied.

It is possible that attitudes to abortion differed according to place of residence. Furthermore, given that the Russian-speaking ethnic groups had higher abortion levels than those of the Estonians and that non-Estonians immigrants were concentrated in the urban areas, the higher rates of abortion in urban areas could, in part, be a reflection of the different ethnic mix between urban and rural locations.

Lastly, the difference in abortion levels between urban and rural locations could be linked with desired family size, so that more of the pregnancies occurring were deemed 'unwanted' in the urban setting, whilst in rural areas larger families were more desirable and could be accommodated.

Official statistics on abortion

Abortions are recorded by service providers and the data collected are transferred to the Estonian Medical Birth and Abortion Register. This register was set up in 1994 in order to ensure systematic collection of data concerning the termination of pregnancy (Haldre, 2002). It is only from 1994 that age specific abortion data have been collected enabling the calculation of age specific abortion rates.

Abortion rates have been calculated based on the number of abortions recorded for each year and the base population of women, by age group, for the corresponding year. Data on the number of abortions is available for 'all women' and for 'Estonian women'. Numbers of abortions for non Estonian women have been derived from these. Of the non Estonian female population, 87% is ethnically Russian, and a further 11% is Ukraine or Belarussian (Eesti Statistikaamet, 2006).

The abortion rate is defined as the number of (legally induced) abortions per thousand women in the relevant age group. Abortions to females under 15 years of age, over 49 years and where age is unknown have been excluded. All data are from the Statistical Office of Estonia (Eesti Statistikaamet, 2006).

Figure 3.29 below shows age specific abortion rates for 'all' women aged 15 to 49. Rates decline until 2001, at which point there is a flattening or even a small increase, for example in the ages from 20 to 39. During the period from 1994 to 2001, the steepest declines can be seen in the age groups 20 to 24 and 25 to 29. Despite some setbacks, no age group has a markedly higher abortion rate in 2005 than it had in 1994[22]. Another feature of the overall decline is the convergence of rates over the period, so that the range of rates in 2005 is somewhat narrower than it had been in 1994.

[22] Only the oldest age group showed an increase in rate – from 1.67 to 1.77

Figure 3.29: Age-specific abortion rates 1994-2005 - women aged 15-49
(analysis based on Eesti Statistikaamet data, 2006)

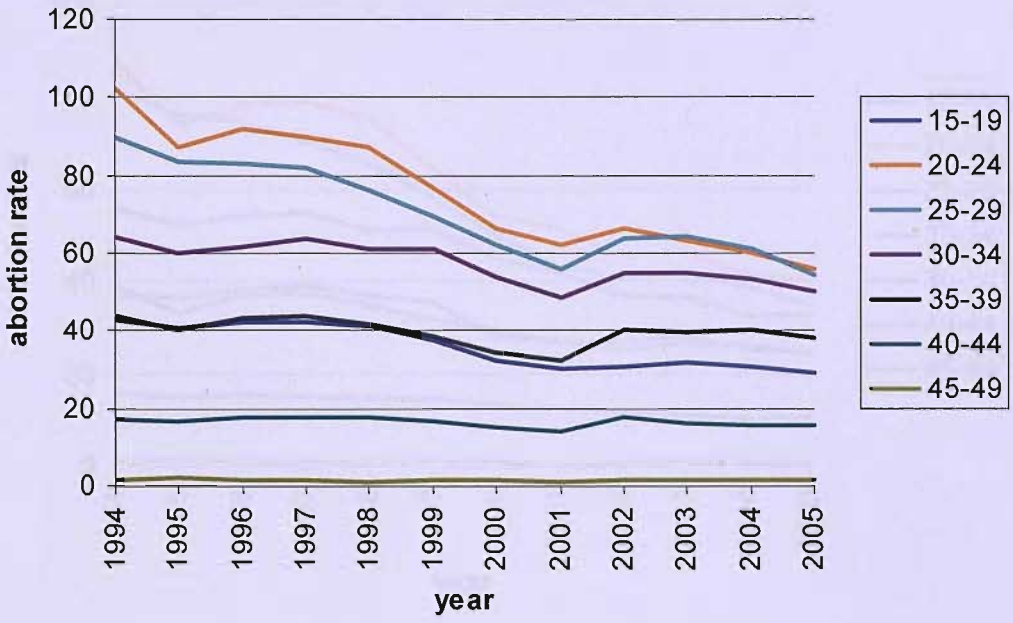


Figure 3.30 demonstrates age specific abortion rates for 'Estonian' women. Rates decline overall and the steepest declines are again registered in the 20 to 24 and 25 to 29 age groups. However, flattening does not occur until 2002, and is followed by further decline from 2003. Rates converge over the period. Rates for 'Estonian' women are markedly lower than those for 'all' women. The highest rate for 'Estonian' women for 1994, in the age group 20 to 24, is 88 per 1000. This compares to the highest rate for 'all' women which is 102 per 1000, also for the age group 20 to 24 for 1994.

Figure 3.30: Age-specific abortion rates 1994-2005 - Estonian women aged 15-49
(analysis based on Eesti Statistikaamet data, 2006)

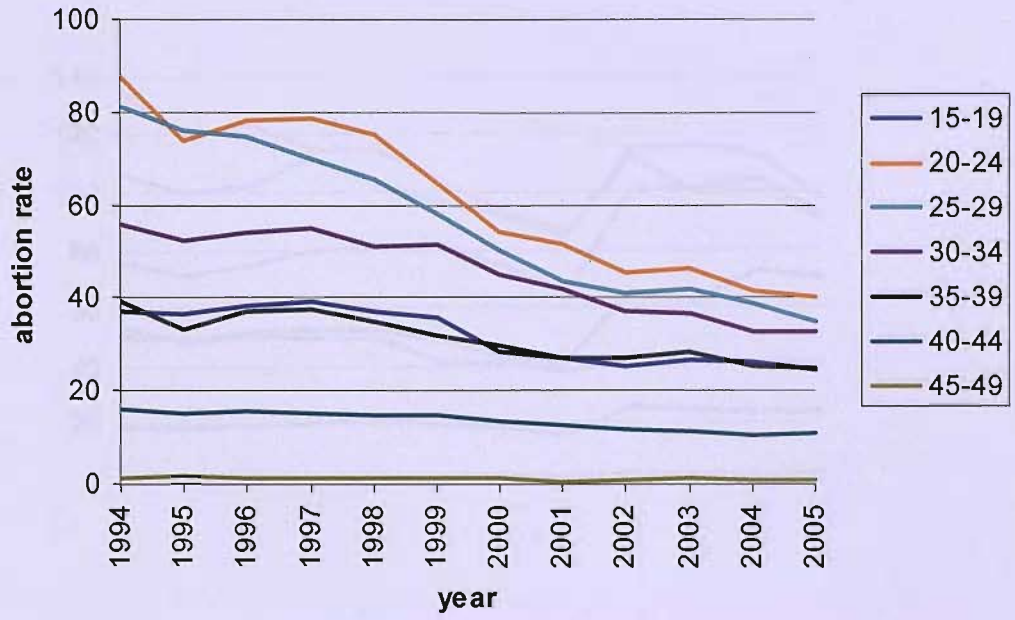


Figure 3.31 below confirms that rates for 'non Estonian' women differ substantially to those for 'Estonian' women. Firstly, there is a difference in magnitude, as the highest rate for 'non Estonian' women is 135 per 1000, the rate corresponding to1994 for the age group 20 to 24 (and for Estonian women this is 88 per 1000). Secondly, the shape of the trend over time is different for 'Estonian' women and 'non Estonian women'. There is a decline for both groups until 2001 and the decline is steepest in the age groups 20 to 24 and 25 to 29. In the 'non Estonian' group however the trend for the age cohort 30 to 34 departs from the general trend of decline as rates for this group rise from 1995 to 1999. Most remarkable however are the sharp increases from the 2001, which are in marked contrast to the 'Estonian' rates for the same period.

Figure 3.31: Age specific abortion rates 1994-2005 – non Estonian women aged 15-49
(analysis based on Eesti Statistikaamet data, 2006)

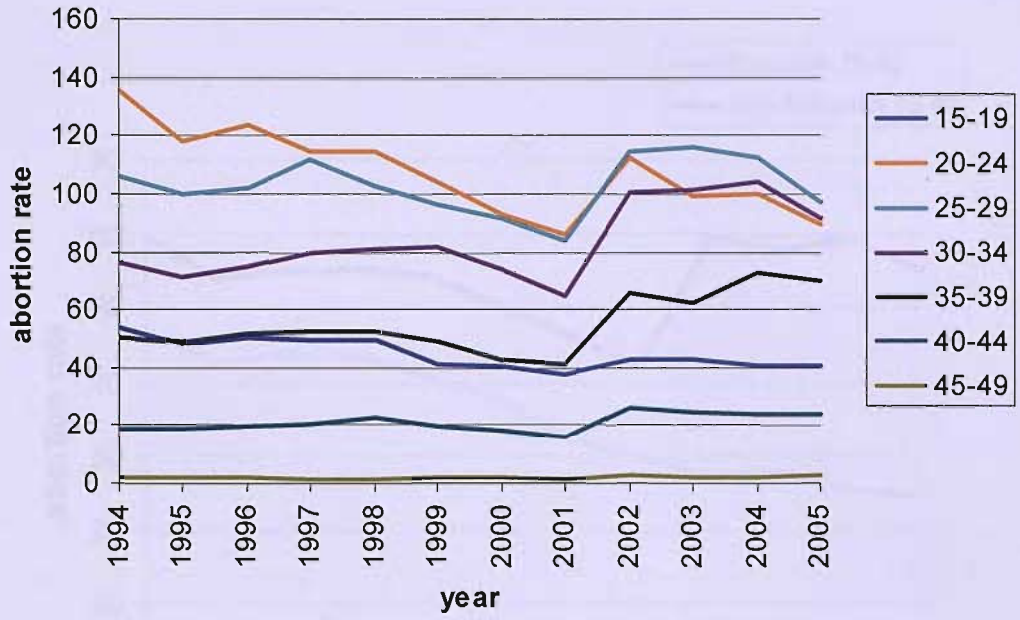
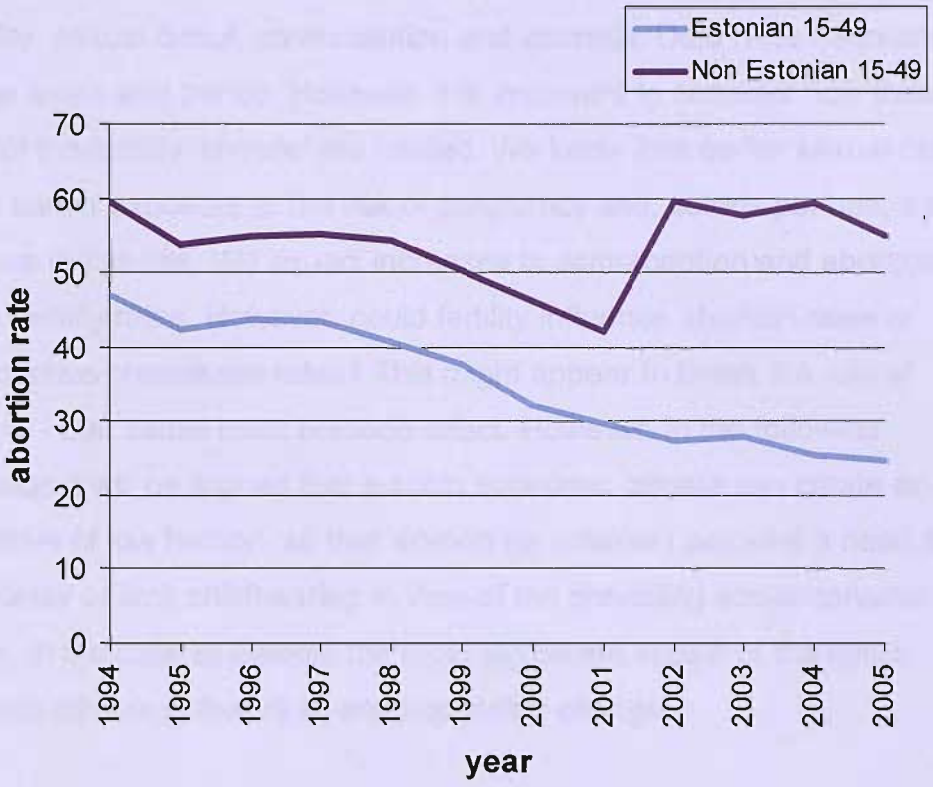


Figure 3.32, which shows abortion rates for women in the whole reproductive age group (15 to 49), compares rates for Estonian and non Estonian women. This throws into stark relief the differing levels and trends for these two ethnic groups. Rates for non Estonian women aged 15 to 49 increased from 42 per thousand in 2001 to 60 per thousand in 2002, whereas those for Estonian women continued to fall. The *difference* in rates which is observed throughout the period suggests different contraceptive and abortion practices between the two groups. The *divergence* of trends from 2001 suggests that there were factors specific to the non Estonian population which were associated with increases in the abortion rate at that point in time. It might be hypothesised that public discourse at this time concerning the negotiations for Estonia to join the European Union might have increased the sense of insecurity for some non Estonian people resulting in higher recourse to abortion.

Figure 3.32: Abortion rate all women age 15-49 by ethnic group
(analysis based on Eesti Statistikaamet data, 2006)



Abortion Rates in the Context of Socio Economic and Political Change

In the earlier parts of this chapter, the Estonian 'scene' has been set in terms of fertility, sexual debut, contraception and abortion. Data have been analysed to show levels and trends. However, it is important to consider how these facets of the fertility 'climate' are related. We know that earlier sexual debut means earlier exposure to the risk of pregnancy and, ceteris paribus, a longer exposure to this risk. We expect increases in contraception and abortion to reduce fertility rates. However, could fertility influence abortion rates or contraceptive prevalence rates? This might appear to break the rule of causality - that cause must precede effect. However. in the following discussion it will be argued that a socio economic climate can create an 'imperative of low fertility', so that women (or couples) perceive a need to either delay or limit childbearing in view of the prevailing socioeconomic climate. In the case of Estonia the most significant aspect of the socio economic climate is that of all-encompassing change.

Until 1991 Estonia was one of the constituent states of the Soviet Union. Soviet abortion levels were notoriously high in international comparison, although rates had fallen in Estonia from 1970 (Mogilevkina et al., 1996). Abortion rates have declined further in Estonia over the years since independence, but rates remain higher than those in Western Europe (IPPF, 2003) (see also Fig 2. below). This can be interpreted in two ways: as a sluggish decline or a success story. The first would assume 'failure' of policy makers and service providers to replace abortion with contraception as the primary method of fertility control over the last decade, while the second would acknowledge abortion decline as a success, given the context of economic, political and social transformation and the perceived need to control births.

Aggregate population, abortion and birth statistics from the Council of Europe publications *Recent Demographic Developments in Europe*, derived from data from the national statistical offices of member countries, are used to

demonstrate, using a simple simulation model, how prevailing fertility levels might influence abortion rates. It is argued that success in reducing the role of abortion has been remarkable, in the context of rapid political and socioeconomic change and given that fertility decline has been so pronounced over the 1990s. If we can imagine a hypothetical situation where fertility had remained at 1991 levels, the number of abortions might have been considerably lower. While it is commonly accepted that there is an important association between abortion rates and contraceptive use (and use-effectiveness), it might also be the case that the 'imperative of low fertility' helps to maintain high abortion rates. The lower the fertility norms in a society the greater is the risk of unwanted pregnancy (Bongaarts and Westoff, 2000). Hence, trends in abortion rates cannot be judged without reference to fertility levels.

Abortion decline

Abortion has declined in Estonia since independence. This phenomenon can be seen in other former Soviet states. Figure 3.34 below shows the trend in abortion rates for Estonia with the other Baltic states, Latvia and Lithuania for comparison. Figure 3.35 then shows Estonia against the United Kingdom (UK) and Finland, both countries where modern contraception has been available for decades.

Figure 3.33: Abortion rates, Baltic States 1991 to 2000
(data source: Council of Europe 2002)

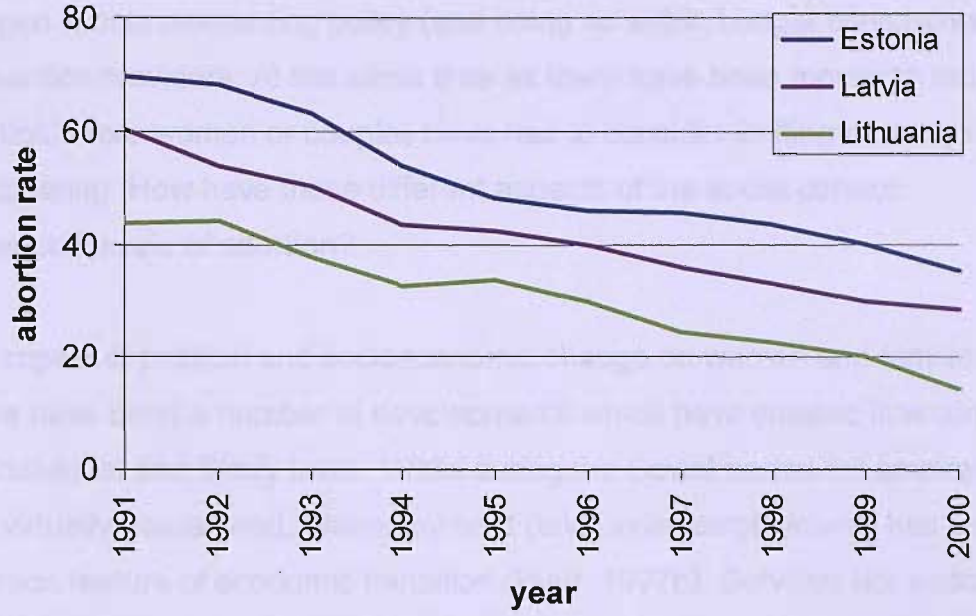
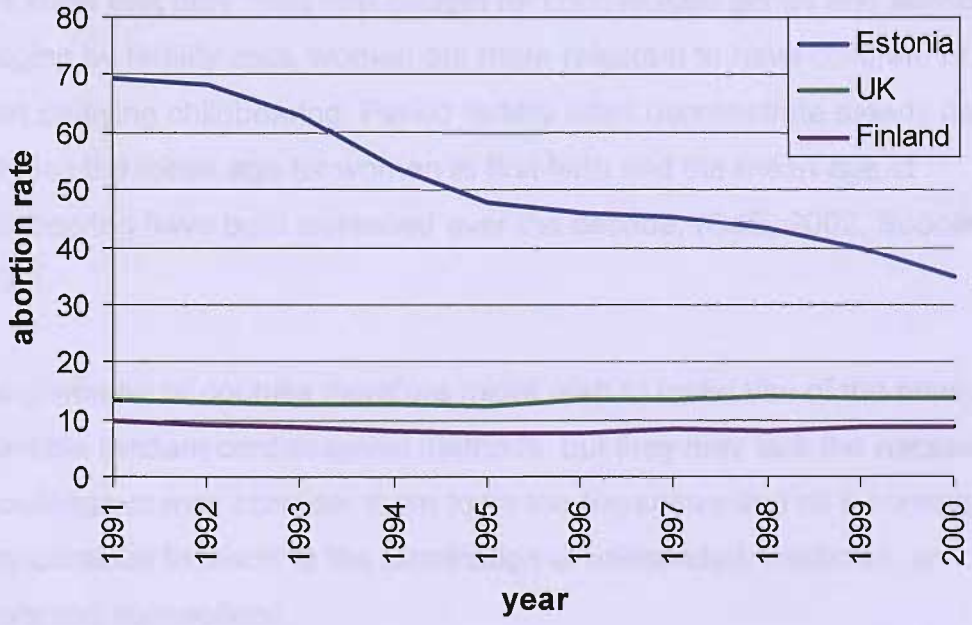


Figure 3.34: Abortion rates, Estonia compared to United Kingdom and Finland 1991 to 2000
(data source: Council of Europe 2002)



Evaluating success within the social context

It is important to examine the social context when evaluating success in reducing abortion. More than a decade of change has left its mark on Estonia,

at the level of the individual (or family) and at the state level. Stresses at the state level have been passed down to policy makers and to those who are charged with implementing policy (and doing so within budget constraints) – the service providers. At the same time as there have been moves to reduce abortion, more women or couples have had to consider limiting or delaying childbearing. How have these different aspects of the social context influenced levels of abortion?

The impact of political and socioeconomic change on women and families
There have been a number of developments which have created insecurity at the individual and family level. While during the Soviet period full employment was virtually guaranteed, unemployment (and under employment) has been a common feature of economic transition (Puur, 1997b). Services (for example health, childcare), which were once provided free of charge or at low cost, now carry fees. People in Estonia, like those in other post Soviet economies, have suffered "the most acute poverty and welfare reversals in the world" (UNDP, 1998 p 5). Women or couples may feel less able to afford to have children (or to add to those they have) as they lack job security (Puur, 1997a) and know that they must now budget for child-related goods and services. Judging by fertility data, women are more reluctant to have children, or are at least delaying childbearing. Period fertility rates demonstrate steady declines, but also the mean age for women at first birth and the mean age of childbearing have both increased over the decade. (CoE, 2002, Sobotka, 2002).

Many women or couples therefore might wish to make use of the newly available modern contraceptive methods, but they may lack the necessary knowledge or may consider them to be too expensive and as a consequence may continue to resort to the termination of unintended, mistimed, or unwanted conceptions.

Competing calls on social support from the state
At the state level too there is a squeeze on funds. Estonia may be amongst the 'winners' of political and economic transition, compared for example to

Russia, the Caucasian states and the Asian republics (UNICEF, 2001b), but even so the government must balance competing demands on resources. Social and health policy makers may wish to reduce the numbers of abortions performed (Anderson et al., 1993), but the funding of family planning services and contraceptive supplies may not be seen as a high priority (Karro, 1997a), especially when politicians and the public are alarmed by falling birth rates (BalticTimes, 2003b, UNDP, 2002)

Simulating Abortion Rates

What might have occurred if fertility levels had been maintained at those of 1991? How might abortion rates have evolved without the 'imperative of low fertility' experienced in the post Soviet period?

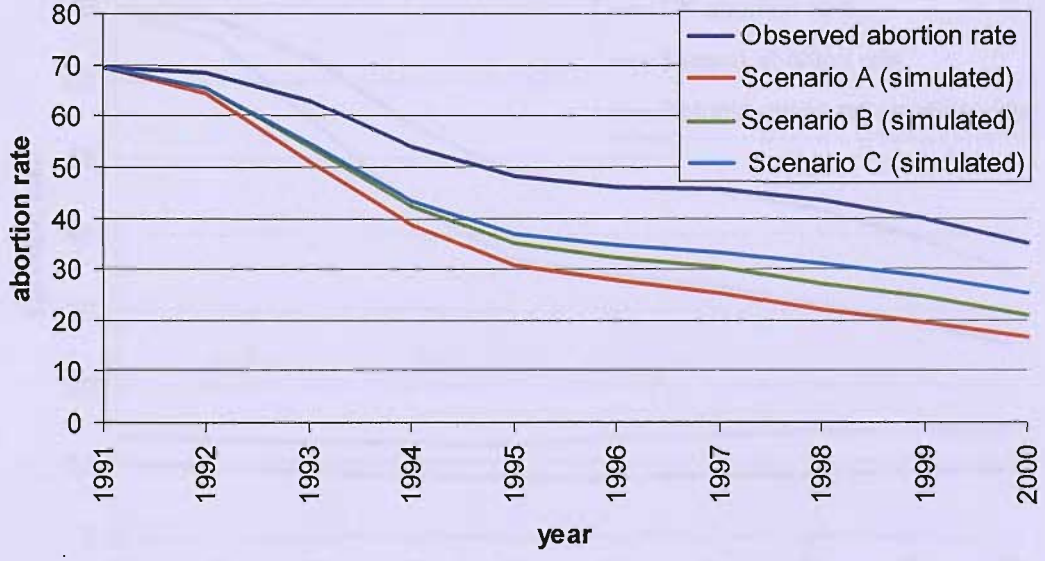
Ideally, calculations to estimate abortion rates, had fertility rates not declined, would be carried out using the Bongaarts formula (1978). This formula however requires information, such as proportions of women exposed to pregnancy, contraceptive prevalence rates and the extent and duration of lactation, which is not available for Estonia, or for the other Baltic states. Instead simple simulations are carried out and the results shown in graphs below. Simulated abortion rates are calculated by holding general fertility rates at 1991 levels. General fertility rates, that is the number of births per thousand women aged 15-49 in a given year (Pressat, 1985), are used in order to ensure consistency with abortion rates, calculated as the number of abortions per thousand women aged 15-49 in a given year. Preferably, simulations would be performed based on accurate information concerning contraceptive use. However, a complete series of contraceptive prevalence rates is not available for the period so, for the purposes of the simulations to follow, assumptions have been made which are, as far as possible, consistent with the data available.

Under scenario A, fertility rates are maintained by simply transferring abortions to births but adjusting for the fact that an abortion averts less than one birth (Bongaarts, 1978). However, this is a crude simulation, not taking into account the proportion of potential conceptions being prevented through

the use of contraception; hence scenarios B and C take contraception into account. Assumptions about the fertility-inhibiting effect of contraception, based on 'best guesses' using available data, have been made for scenarios B and C. It has been assumed that contraception accounts for 25% of potential births averted in scenario B. However, over the last ten years the prevalence of contraception has increased. It is necessary therefore to take account of this and also the likelihood of increased average effectiveness, so in scenario C, 25% contraceptive prevalence has been set as the starting point (1991) but then contraception is allowed to increase in a linear fashion at the rate of 2.5% per annum to reach 47.5% in the year 2000. It is argued that scenario C is the most realistic representation of 'what might have been' if fertility rates had been stable through the post Soviet period.

In Figure 3.36 below, observed abortion rates are compared with simulated rates (scenarios A, B, and C) calculated by holding fertility rates at 1991 levels. It can be seen that, had fertility rates remained at 1991 levels, abortion rates might have been much lower, ceteris paribus.

Figure 3.35: Abortion rates – observed compared with simulated rates
(author's own analysis of data from Council of Europe 2002)



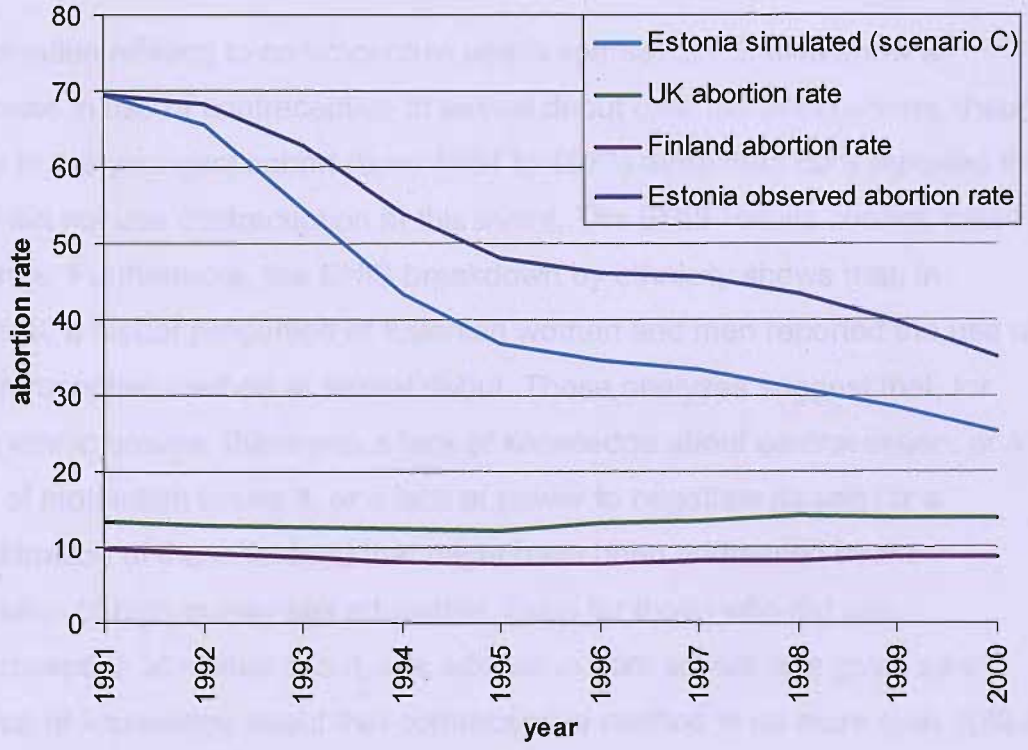
Furthermore, Figure 3.37 below shows Estonian abortion rates, observed and simulated, in comparison to abortion rates for the UK and Finland. This graph

shows that, not only are the simulated rates much lower than the observed rates for Estonia, they are also considerably closer to the observed rates for the UK and Finland. Table 3.5 shows the relevant rates for the year 2000, showing that the simulated rate for Estonia is about twice that for the UK (and about three times that of Finland), whereas the observed rates are two and a half times greater than those of the UK and nearly four times those for Finland.

Table 3.5: Abortion Rates (abortions per 1000 women aged 15-49)
(author's own analysis of data from Council of Europe 2002)

Year	*Estonia Observed*	*Estonia Simulated [C]*	*UK Observed*	**Finland Observed**
2000	35	25	14	9

Figure 3.36: Abortion rates for Estonia, observed and simulated (scenario C) compared with UK and Finland
(author's own analysis of data from Council of Europe 2002)



Conclusion

Total fertility rates in Estonia began to fall before independence. This decline in period fertility rates has occurred not only in Estonia, but in other former Soviet or Eastern bloc states. Whether this is a tempo or quantum effect remains to be seen. In Estonia total fertility rates have risen slightly in the last few years. It is possible that this is a sign that births delayed in previous years are now occurring.

Analysis of EFFS data, confirmed by the results of the EHIS, shows that age at sexual debut has fallen, resulting in an increase in the 'at risk of pregnancy' period early in reproductive life. This might be expected to result in an increase in the abortion rate, especially given the greater vulnerability and lesser experience of young adults. However, age specific abortion rates, derived from official statistics, show no such increase in rates even for the youngest age category (15 to 19). For some cohorts age at sexual debut is lower for Estonians than for non Estonians, though this does not translate into a higher abortion rate for Estonians.

Information relating to contraceptive use is sparse. EFFS data show an increase in use of contraceptive at sexual debut over the birth cohorts, though even in the youngest cohort (born 1964 to 1973) more than 60% reported that they did not use contraception at this event. The EHIS results confirm these findings. Furthermore, the EHIS breakdown by ethnicity shows that, in general, a higher proportion of Estonian women and men reported the use of a contraceptive method at sexual debut. These analyses suggest that, for both ethnic groups, there was a lack of knowledge about contraception, or a lack of motivation to use it, or a lack of power to negotiate its use (or a combination of these factors) that might have been addressed by the provision of high quality sex education. Even for those who did use contraception at sexual debut, sex education from school was given as a source of knowledge about that contraceptive method in no more than 10% of cases according to analysis of EFFS data.

Responses related to 'ever use' of contraceptive methods and use over the four week observation period leading up to the survey indicate that only a small proportion of women have never used contraception (15%), many have used the intra uterine device or the condom, but many have made use of traditional, less effective, methods.

Questions were included in both the EFFS and the EHIS concerning use of contraceptive methods in the four weeks prior to the interview. EFFS analysis shows that the use of traditional methods declined by birth cohort, but these methods continued to play an important part in family planning as even for the youngest respondents (born 1964 to 1973) traditional methods accounted for approximately 20% of use. The EHIS data show that a higher proportion of Estonians reported the use of a preventive method during the observation period than did non Estonians, with the exception of the female cohort born 1966 to 1970.

According to the EFFS data, of all women who had been sexually active at some time, half had never had an abortion and less than 15% reported three or more abortions. Official statistics show that abortion rates have been in decline since independence. However, when abortion statistics are analysed by ethnicity, it is apparent that rates for Estonian women are lower than those for non Estonian women and that trends for these two groups diverged from 2001, when rates for Estonian women continued to decline, but those for non Estonian women rose sharply.

When Estonia became independent in 1991 one of the goals of policy makers was to reduce the levels of induced abortion. As has been found elsewhere, recourse to abortion may decrease over time as contraceptive prevalence rises. However, where fertility rates are declining rapidly, abortion rates may fall slowly, may show no change, or may even increase (Marston and Cleland, 2003). Simulations of fertility and abortion rates show that, had fertility rates remained stable during the post Soviet period, abortion rates may have fallen more steeply. Given the context of socio economic and political transfiguration

and significant reductions in fertility, it can be argued that the decline in abortion in Estonia, however measured, has been considerable.

A crucially important aspect of the context of fertility control in Estonia, which so far has only been touched upon, is the question of 'abortion culture'. Many commentators have suggested that conditions in the Soviet Union led to the creation of an 'abortion culture', whereby abortion was legal, easy to access and acceptable to policy makers, service providers and the population. This, it is argued, led to reliance on abortion as a method of fertility control. Furthermore, it is also suggested that this dependence on abortion may be a hard habit to break (Stloukal, 1999, David and Skilogianis, 1999, Haldre, 2000, Popov and David, 1999). The next chapter will look at the history of abortion culture and evaluate the extent to which abortion culture became established in Estonia.

Key Points

- Abortion rates have fallen and modern contraceptive use has increased
- Differences in abortion rates are apparent, by ethnicity, by level of education and by place of residence
- It can be argued that policy makers have been successful in reducing abortion rates, given the context of rapid and wide ranging socio economic and political change and fertility decline, in addition to the fall in age at sexual debut

Chapter 4 – Abortion Culture

What is 'abortion culture'? Whenever family planning in former Soviet states is discussed it is almost inevitable that the phrase 'abortion culture' will be used to describe the context within which fertility was, and to an extent still is, controlled in this region (Stloukal, 1999, David and Skilogianis, 1999, Sabatello, 1992, Agadjanian, 2002). Abortion rates in the former Soviet states remain the highest in the developed world (Henshaw et al., 1999). High abortion rates are said to be a result of abortion culture and, in a kind of circular argument, abortion culture the result of high abortion rates. Mention is often made of limited access to modern and effective contraception (David and Skilogianis, 1999, Agadjanian, 2002, Horga and Ludicke, 1999), but otherwise little attempt is made to unpick the elements that might together constitute abortion culture.

Abortion rates in the Baltic region of the former Soviet Union have neither been stable over time, nor uniform within or between states; whilst a high abortion rate is seen as a characteristic feature of the former Soviet states, there is considerable diversity (Potts, 1967, Agadjanian, 2002).This suggests that the impact of abortion culture was not homogeneous but varied over the decades and was felt differentially by place and ethnicity. This in turn suggests that the constituents of abortion culture, or at least the degree to which they affected behaviour, may have varied too.

The aim of this section is to look at the background to abortion in the former Soviet bloc in general and in Estonia in particular, to see how an abortion culture might have been created and maintained, and to discuss how such a culture might be breaking down now that Estonia has been established as an independent state.

Estonia provides an interesting case as, historically, Estonia was 'western' in terms of fertility transition, had achieved below replacement fertility by the 1920s (Katus, 1994) and had done so without the benefit of modern methods

of contraception (Anderson et al., 1993). In addition, abortion rates in Estonia have varied with time and rates have differed by ethnicity (Katus et al., 2000).

In this chapter it is argued that abortion is not just an individual matter but is also a social phenomenon and as such, involves many actors. Furthermore, abortion must be investigated with reference to its historical, socio-cultural, political-ideological and ethno-medical contexts (Rylko-Bauer, 1996). An account is given of the emergence of abortion as an important method of fertility control in Russia, and then the Soviet Union. In the creation and maintenance of abortion culture, the rôles of the state, service providers, society, and the individual are considered. Finally, abortion in the context of the post-Soviet period is discussed and some thoughts about the future of abortion in Estonia are put forward.

History and the 'Woman Question'

Soviet state socialism was born of mass unrest in Russia in the late nineteenth and early twentieth centuries. Female revolutionaries such as Alexandra Kollontai played an important part in the mobilisation of women to the cause (Kollontai, 1977a). Kollontai envisioned a future socialist society where women would be equal to men, 'free' to work (freed from domestic slavery) but able to have many children (Kollontai, 1977c) In the new world the state would ensure that all children were fed, clothed, educated, housed and cared for (Bebel, 1988, Kollontai, 1977c).

There was however a divided women's movement. The bourgeois feminists wanted to be free to work (in the professions, which was difficult for the educated woman at that time), but the proletarian woman might have preferred to be freed from work. The Russian working class woman did not need revolution to be freed to work, she already worked and worked hard, whether in the rural (peasant) situation or in the burgeoning urban centres. Kollontai, a socialist feminist, recognised the oppression of the proletarian woman on the basis of sex and class and argued that "the future of the family question is no less important than the achievement of political and economic independence" (Kollontai, 1977b). However the Bolshevik leadership gave

more credence to the Marxist view that class was the basis of oppression in capitalist society and once class issues were made obsolete in the new socialist society, the 'woman question' would be answered.

Hence the post-revolutionary reality was quite different from that envisaged by Kollontai and Bebel. The' woman question' was not a major preoccupation for the leadership. They paid lip service to 'equality' without developing policies that might have helped to make it a reality (Holt, 1977). Key revolutionary women found themselves demoted and the women's departments, set up to support women's issues, were closed by 1930 (Holt, 1977).

Not only was there little will on the part of the leadership to change women's lives, there was also little opportunity to do so. From the start, life was hard in Soviet Russia – before they could recover from the aftermath of revolutionary uprising and civil war, the people were subjected to forced collectivisation and industrialisation, and famine (Koutaissoff, 1971). Women were not just free to work, they were expected to work alongside their male comrades in all spheres of labour:

> "the equal duty of all to labour, *without distinction of sex*, will become the first fundamental law of the Socialistic community" (Bebel, 1988 p 180) (italics added)

Indeed, women's labour was vital. It is estimated that the losses to the Russian population during the period 1914 – 1920 totalled 25 million, which would have resulted in a much depleted work force (Pirozhkov and Safarova, 1994). However, women had a dual role - they were also expected to produce children even though the promised childcare facilities were slow to materialise (Lapidus, 1978, Heitlinger, 1979). Modern methods of birth control were not available and the practice of traditional methods was not widespread (Stloukal, 1999, Sabatello, 1992). Finding themselves pregnant, unable to feed their families, many women turned to abortion to terminate pregnancies they could not face. The only other alternative would have been to add to the already considerable number of abandoned children roaming the streets of post-revolutionary Russia (Koutaissoff, 1971).

Concerns over the level of illegal abortion and concomitant maternal morbidity and mortality, as well as recognition that repression of abortion had been a failure, led Soviet leaders to legalise abortion in 1920 (Avdeev et al., 1995). Legal abortion was seen not as a woman's right but as a temporary measure which would no longer be required when the socialist state was well established (Holt, 1977, Avdeev et al., 1995). The need for abortion was, after all, the result of capitalism and would not be a feature of socialist society (Lenin, 1973). Moreover, no mention was made of a role for family planning, during hard times or in the future and even Kollontai began to emphasise that motherhood would be a "social obligation" (Holt, 1977p 119). This hegemonic ideology promoted the role of woman as mother-heroine, placed the needs of the nation above those of the individual and eliminated discussion of family planning (Avdeev, 1994, Avdeev et al., 1995).

The result was that abortion became established as a key element of fertility control (Horga and Ludicke, 1999, Popov, 1991). This deviates from the Western route to lower fertility, where birth rates were reduced first by traditional methods such as the calendar method and/or coitus interruptus on the part of individual couples and by societal level controls such as delayed and/or non-universal marriage (Hajnal, 1965). With the advent and accessibility of modern methods in the West, traditional methods were increasingly replaced by modern methods, though by the 1960s it was recognised by policy makers in many Western states that safe, legal abortion should be available too.

The first era of legal abortion in Russia was short-lived. By the early 1920s the crude birth rate was 35 per1000 though by the late 1920s it had risen to 44 per 1000. However by the early 1930s the crude birth rate had fallen to approximately 37 per 1000 (Mitchell, 1981). Alarmed by the falling birth-rate, and concerned at the level of population losses sustained, not just from 1914 - 1920, but throughout the 1920s and beyond, Stalin made abortion illegal once more in 1936. He made clear his belief that it was the duty of the Soviet woman to procreate (Remennick, 1991, Attwood, 1987). Ironically, the law

was allegedly passed out of concern for the health and welfare of mother and child, while virtually the same wording was used in 1920 to legalise abortion (Avdeev et al., 1995). Only after Stalin's death in 1955 was the law again changed permitting abortion on social, not just medical grounds.

What did all this have to do with Estonia? Estonia had been part of the Russian Empire since the early sixteenth century, but took the opportunity to gain independence while the Russians were otherwise engaged during the turmoil of revolution, the first World War, and then civil war. Russia finally recognised the sovereignty of Estonia on the 2nd of February 1920. However, the First Republic was short-lived. Estonia was occupied during the Second World War, first by the Russians (1939-1940), next by the Germans (1941-1944) and finally by the Russians again. Estonia, like its Baltic neighbours Latvia and Lithuania, was annexed and soon after became the Estonian Soviet Socialist Republic (Norgaard et al., 1999). Up to a point Estonia 'inherited' a new history and the legacy of the early Soviet days as there followed nearly half a century of 'occupation' and 'Sovietization', the process by which the 'Soviet model' was imposed in member republics. In addition, vast numbers of workers, soldiers and administrators from other Soviet republics (chiefly Russia) were directed to work and live in Estonia, so that over time those of titular nationality represented only about two-thirds of the population in the republic, only half the population in the capital city Tallinn, and were a minority in the north eastern region (Eesti Statistikaamet, 2006).

Abortion had been illegal in Estonia during the brief period of the First Republic between the two world wars (Anderson et al., 1993). In the early days of the Soviet period, as elsewhere in the USSR, abortion remained illegal, except on medical grounds (Tietze and Henshaw, 1986), but from the mid-fifties abortion was legalised. As in other Soviet republics, Estonian women were expected to be full-time members of the labour force as well as mothers. The population had been depleted by the out-migration of Baltic Germans to the fatherland in 1939, war deaths, the flight of refugees, executions and deportations. All ages and both sexes were represented (even in deportations to Siberia), but men disproportionately so (Winter, 1992).

Hence the labour of women was crucial in the post-war period. However, childcare facilities were inadequate, the housing situation was dire (Misiunas and Taagepera, 1993) and even food supplies were erratic. Most women opted for small families. The crude birth rate was just over 18 per 1000 in 1950, falling to 16.5 by 1960, with fertility rates of non native (mainly Russian) women in Estonia being even lower than native Estonians by the 1960s (Taagepera, 1981). Wishing to limit the size of their families and in the absence of (effective) contraception women had little alternative but to terminate unwanted pregnancies.

The rôle of the Soviet state

The Soviet state has been described as 'totalitarian' which is defined as 'a system of government that is centralized and dictatorial and requires complete subservience to the state' (Pearsall, 2001). However, in spite of this apparent omnipotence, women continued to procure abortions, even during the period when this was illegal[23].

It is known that criminalising abortion does not eliminate the practice; abortions are still performed, but often under unsafe conditions (Tietze and Henshaw, 1986). However, law and policy are important – not just in making something legal, but 'legitimising' it in a wider sense. What rôle then did the Soviet state play in creating and sustaining abortion culture?

Firstly, the state was responsible for abortion law, legalising abortion in 1920, revoking this in 1936 and once again liberalising abortion in 1955. It could never be said that the state approved of abortion, however the 1955 legislation may well have been signalling what the state would accept without approval. Certainly, in the early 1950s, just before liberalisation, data suggest that legal sanctions were not being implemented (Avdeev et al., 1995). The state was also responsible for the law concerning sterilization. Throughout the Soviet period sterilization was only permitted for strictly defined medical

[23] Katus, K, personal communication

reasons, for example following a third delivery by Caesarean section[24]. Couples were therefore denied the possibility of sexual intercourse free of the risk of pregnancy when they might have been prepared to adopt a permanent method.

Secondly, the state was, at least theoretically, responsible for mandating and funding health-related services. Abortions were carried out in hospitals and polyclinics (which are multipurpose health centres), but the establishment of family planning clinics was neglected. Popov describes the 'abortion paradigm' of the Soviet Union, involving the "presence of an abortion industry and the technological adaptation of the whole public health system to abortion production" (Popov, 1992 p9). Family planning belonged within the private realm, unlike abortion and pregnancy which were matters of medical, and therefore state interest (Vikat, 1994). Only in the 1980s was the need for family planning recognised and then the attitude was dictatorial: "From the early 1980s the Ministry of Health enforced family planning measures to reduce abortions" (Avdeev, 1994). A further disincentive to the use of preventive methods was that the state charged for contraceptives whilst abortion was free (Karro, 1997a).

Thirdly, in a planned economy the state was responsible for the production (or import) and distribution of all consumer goods and held a complete monopoly in this regard (Popov et al., 1993). The Soviet record in terms of the production and distribution of consumer products was poor (UNDP, 2002). The production of birth control supplies was not a priority (Heitlinger, 1979), and their distribution was sporadic. This was not only the case for contraceptives – other essentials, such as toilet paper and soap were often unobtainable[25]. It was, after all, a command not demand, economy and the state prioritised industry and the military with scant attention to the wishes or even needs of the consumer.

[24] Higher order Caesarean sections can be associated with raised operative and post-operative complications (NHS DIRECT (2006) Common Health Questions.)
[25] In one focus group (older Estonian women) members spoke of the joy of buying toilet paper, soap and tampons in the late 1980s when they became available on a regular basis – see Chapter 6

Lastly, the state should have provided up-to-date and accurate education and information, or at least facilitate its provision. However, sex education was virtually absent from the curriculum until the late 1980s (Attwood, 1987). The result was a low level of knowledge about sexual matters so that behaviour was based on incomplete or inaccurate information (Papp et al., 1997). Kon argues that the state, in an Orwellian way, feared sexuality as it was something outside of party control. Hence, sex education was taboo and the population was both "sexually ignorant and mute" (Kon, 1992 p 2).

Not only did the public have little access to accurate information concerning contraception, the medical profession fared little better (Bruyniks, 1994). The oral contraceptive was effectively banned in 1974 and doctors were informed that it could only be prescribed for medical reasons (Hutter, 2003). The hegemonic view was that the pill was dangerous and the ban ensured that no independent thinkers could prescribe it. Popov and collegues cite the following excerpt from an official edict of 1983: "The long-term use of pills can have as a result a serious destruction of the main internal organs..." (1993 p 232) Furthermore, the state ensured that no alternative views were promulgated. This was not what Bebel envisaged when he stated that the socialist press would contain "the conflict of opinions of those who seek the best" (Bebel 1988 p222). The media were organs of the state, there were no non-governmental organisations (which might have campaigned for contraception) and the churches, whose members might have protested at abortion levels, were silenced. Willekens and Scherbov state that "Contraception was not an issue to be discussed before perestroika", suggesting that not only was information scant but also that debates surrounding family planning were suppressed (1994 p208).

Paradoxically, the lack of investment in contraceptive methods and family planning clinics led to an excessive consumption of scarce resources by abortion services (Remennick, 1991). Indeed, the Soviet socialist system meant that the actual costs of any particular aspect of healthcare were not calculated (EOHS, 2000). This raises the question of whether the state had a

policy concerning family planning, or whether what has been observed was the consequence of the absence of a coherent policy. On the other hand, the result was that the state effectively retained control over women's fertility (Heitlinger, 1979). As late as 1959 Khrushchev was still associating birth control with bourgeois ideology and asserting the need for births, not just for the labour force but also "for the future of our nation" (quoted in Avdeev et al., 1995). The development and distribution of modern methods of birth control risked leaving "choice in the hands of the individual, and that might have unforeseen demographic and moral consequences" (Heitlinger, 1979).

Service providers

Like other professionals, doctors and healthcare workers were 'blanketed' by the totalitarian state and isolated from their peers in the West. The state had control over information and communication as well as the education and careers of medical professionals (Stloukal, 1999) and was willing and able to deal harshly with dissent.

> (People) "were paralysed as citizens because they were convinced that everything was controlled ... the relentless application of a quiet coercion leading to compliance... children were taught that any adolescent rebellion could deny them a university place. Cooperation, on the other hand, was the route to a better life. So you had the twin methods of bribery and blackmail..." (McDermid, 2002).

Not surprisingly, healthcare providers accepted and promoted the 'party line'.

Doctors and their colleagues in healthcare were deprived of access to their own service statistics – these were sent vertically to Moscow, there was no horizontal dissemination of data. From 1929 until 1988 abortion statistics were classified 'secret' and only available to the USSR Ministry of Health in Moscow (Popov, 1991). Hence, service providers were unable to compare, for example, their abortion rates with colleagues in other locations. Needless to say, they were not able to make international comparisons, especially with the West. This was treason. Nor were providers able to decide upon and implement changes as healthcare decisions were made in Moscow (EOHS,

2000). Indeed, taking responsibility or showing initiative were considered risky practices (Stloukal, 1999).

The focus of medical advance was on methods of abortion, not the development of home-grown preventive measures. Not only were doctors unable to make statistical comparisons with colleagues abroad, but they were also isolated from debates surrounding 'best practice' which might have challenged their assumptions regarding contraception (Stloukal, 1999, Brandrup-Lukanow, 1999).

Modern contraceptives were distrusted. The contraceptive pill was considered dangerous and indeed it may have been – the Soviet variety was an early version containing high hormone doses and would therefore be more likely to produce adverse side effects (Westoff et al., 1998). There was a ban on the (legal) import of the Western product as the Soviets wished to be self-sufficient in all things. The state had a monopoly on import and distribution of Eastern bloc products (Popov et al., 1993). In common with many other consumer products, the supply of the pill was erratic. Intra-uterine devices were old-fashioned - for example no copper intra-uterine devices were available (Popov et al., 1993). Condoms were of poor quality with a high failure rate (Defosses, 1981). The production of better quality contraceptives was not considered an industrial priority (Heitlinger, 1979).

Abortion was promoted as a safer alternative, although this was not always so – the incidence of adverse sequelae was a matter of concern in the Soviet Union (Remennick, 1991). On the other hand, for many years abortion was illegal in the West (and being performed clandestinely in less-than-ideal conditions) when it was being performed legally in hospitals in the Eastern bloc. In addition the use of the vacuum aspiration technique, though pioneered by Simpson in Scotland in 1860 and used by Bykov in Russia as early as 1927, was already in common usage in Russia by 1967 (Potts, 1967), though it was not adopted in the UK and USA until 1977 (Tietze and Henshaw, 1986). This method is still regarded as the safest for terminations in the first trimester.

An 'abortion industry' was created with many doctors working full-time in performing abortions (Stloukal, 1999) – what incentive would there have been for a doctor to discourage abortion when that was how he or she earned a living?

Society and community

Those living under Soviet rule became immured, accepted the inevitable and lost the will to resist. A sense of powerlessness was pervasive. Those born after the Second World War had never experienced any other life and lacked comparative information - "How to explain to people who have never been out in the fresh air or had a window open, that the room they live in is stuffy almost to the point of suffocation?" (Van der Post, 1965 p 42)

The system bred a culture of dependency on the state – it was expected that the state would provide and in healthcare this meant cure rather than prevention. In addition, public opinion was "physician-dictated" (Popov et al., 1993) and physicians themselves had been 'informed' of the dangers of the oral contraceptive.

There was probably some stigma attached to abortion, at least there is evidence of reluctance on the part of some women to report abortions (Anderson et al., 1994). Some abortions were also carried out 'privately' in order to avoid the statutory sickness absence note, which revealed details of the operation and involved a three-day hospital stay (Remennick, 1991). On the other hand, it must have been difficult to stigmatise something that was so common – stigma is usually reserved for 'outsiders' and applied by 'insiders'. In the Soviet situation, who could cast the first stone?

Generally the population can expect the media to extract information from the state and disseminate it to the public. However, under the Soviet system the media were part of the state machinery, therefore they did not subject the state or providers to scrutiny (Stloukal, 1999), did not call them to account, nor raise issues such as the abortion rate (other than to blame this for low birth

rate). 'Civil society' was empty – there were no pressure groups, no non-governmental organisations or at least no non-party organisations. The church had little power or influence as the Soviet state had "abolished God" (Van der Post, 1965 p 40).

Was there an acceptance of abortion? Up to a point, there must have been, though abortion was seen not as desirable but inevitable. In addition the abortion issue had "been deliberately denied its ethical and humanitarian dimensions" (Remennick, 1991 p841). The embryo was seen as biological material and the abortion as removal of that material as opposed to the termination of a potential human life. According to Popov, "the most essential element (of the abortion paradigm) was the mental adaptation by ... most of the population to induced abortion as a regular means of family planning" (Popov, 1992 p9).

The individual

In the West, abortion is often referred to as a 'choice', but what choice was there in Estonia during the Soviet era?

Throughout the Soviet period sex education in schools was at worst non-existent or at best inadequate (Remennick, 1991, Bruyniks, 1994). Classes were based on hygiene and biology (and the discouragement of male masturbation) and otherwise concentrated on instilling fear and myths (Rivkin-Fish, 1999). In the 1980s fears of depopulation prompted a number of pronatalist measures. One of these was the implementation of 'sex role socialisation' classes in schools, which aimed mainly to modify the behaviour of females. Rivkin-Fish states that "sex education discourses held women responsible or blameworthy in practically every account of social and familial problems" (Rivkin-Fish, 1999 p805). This is an important point as the placing of such responsibility on women's shoulders alone may have set the stage for later difficulties in involving men in reproductive health.

Other possible sources of information, such as the media, were state-controlled and the airing of sexual issues was taboo. Few parents felt

comfortable discussing sexual issues with their children, so young people discovered by trial and error. Family planning advice was received from the gynaecologist after the first birth or abortion[26]. There were no competing sources of information, such as family planning associations or pro-life or pro-choice pressure groups.

Information is very important in the way that it prefigures, if not determines, the choices that people make. Hutter (2003 p 185) states that "...abortion and contraceptive behavior are seen as being shaped by individual perceptions and motivations that in turn are based on the information that individuals derive from the context in which they live.' During the Soviet era individuals would have had a narrow range of sources from which to assemble information. People should have been able to rely on medical professionals for accurate factual information, but these professionals were themselves deprived of high quality information from a variety of sources. The result was that people's behaviour in terms of contraception and abortion, which might appear irrational to outsiders, was rooted in the Soviet context and based upon the only information that was available at the time.

The state controlled supplies of contraceptives (such as they were) and both legitimate and black market supplies were often interrupted, which would have been a problem for those using the pill or the condom (Vikat, 1994). It was generally cheaper for the individual to resort to abortion than to use contraception. Many women were advised against the use of oral contraceptives and the intra-uterine device was only prescribed for women who had previously had a full term pregnancy (Remennick, 1991, Karro, 1997a). Women would not have been encouraged to challenge medical advice – birth control was seen as being the business of doctors, whose expertise enabled them to make family planning decisions for women (Rivkin-Fish, 1999).

[26] Karro, H, personal communication

Child bearing was early in the reproductive span and pregnancy often preceded marriage. Marriage and childbearing moved a couple up the housing list and this was an important incentive due to the shortage of suitable housing. Early marriage was followed closely by childbearing (Katus et al., 2000). Total fertility rates for the years from 1970 to 1989 varied from 2 to 2.2, suggesting that many women or couples, having completed their families, were controlling their fertility for twenty to twenty-five years. Vasectomy and sterilisation were not permitted. So many years 'at risk' meant a high probability that abortion would be necessary (Marston and Cleland, 2003). This led to a different abortion 'profile' to that of the West, where abortion tends to be more common amongst the young (Anderson, 1998, Anderson et al., 1993, Bankole et al., 1999).

In view of the absence of choice, and system-generated ignorance, there must have been an element of internalisation. D'Andrade explains the process of internalisation as follows:

> "Through secondary appraisals and the cultural shaping of emotion, the beliefs and values of a culture may be internalized...(internalisation is) the process by which cultural representations become a part of the individual; that is, become what is right and true." (1995 p 227)

Remennick states that there was a "psychological tolerance to abortion on both individual and social levels" and that the procedure was viewed as a "routine, although certainly unpleasant, medical procedure, comparable , say, to a removal of a decayed tooth" (1991 p 844). However, as the procedure was usually carried out without the benefit of anaesthetic and on an assembly-line basis, women must have dreaded abortion (Remennick, 1991).

Why did couples terminate pregnancies rather than having children? People's lives were often difficult during the Soviet era and not conducive to having large families. Relationships between men and women remained traditional with the notable exception that women were expected to participate in the labour force. Soviet-style equality was "masculine-oriented" so that women could be engineers or astronauts, but still had to go home to do the

housework (Heitlinger, 1979, Karro, 1997a). Housing, particularly in urban areas, was in short supply and apartments were very small (Koutaissoff, 1971). Estonia was the most highly urbanised of the Soviet republics (Parming, 1972), but even rural lives were 'urbanised' as people on collective farms lived in blocks of flats (Rausing, 2004).

Abortion culture in Estonia

Estonia had a history of being more advanced than Russia in development terms. For example, whereas literacy approached one hundred per cent as early as the 19th century in Estonia (Coale et al., 1979), only twenty five per cent of Russians were literate by the time of the revolution (Van der Post, 1965). Estonia was also 'ahead' of Russia in terms of demographic transition. Indeed Estonia fell west of the Hajnal line (Katus, 1994). Replacement fertility levels were achieved early and without the benefit of modern contraception. During the 1920's and 1930's, in common with many western European states, fertility fell to below replacement level (Titmuss and Titmuss, 1942).

In a society where fertility had been controlled with little recourse to abortion, it is less easy to understand why abortion later became so much more prevalent, especially amongst cohorts born in the early 1950s (Katus, 2000). This may however be partly explained by the following. Firstly, part of Estonian fertility decline earlier in the twentieth century could be attributed to late and far from universal marriage (Katus, 1994). By the 1950s, more women were exposed to the risk of pregnancy because age at marriage fell and a higher proportion of women married (Katus, 2000). Consequently the length of time exposed to the risk of pregnancy was extended and, ceteris paribus, the number of pregnancies deemed unwanted would tend to rise (Tietze and Bongaarts, 1975).

Secondly, considerable numbers of migrants, chiefly from Russia, were directed to work and live in Estonia (and elsewhere in the Soviet Union). In Russia, abortion had become established as a key method of fertility control long before contraception had been known. Migrants brought with them their own reproductive culture, including higher abortion rates (Katus, 2000). It is

interesting to note that Sabatello found that Soviet women who emigrated to Israel took their own abortion practices there too (1992). In addition, Russian doctors and specialists were moved, along with industrial workers and the military, and they too brought with them their own beliefs and working practices.

Thirdly, the local population may have adopted some of the habits of the incomers, especially if these were seen to be beneficial. Some who might otherwise have been content with, for example, calendar methods and coitus interruptus, and accepted the risk of method failure, might have perceived advantages in abortion.

Lastly, abortion was legalised in the Soviet Union in 1955. This may have led to a 'real' rise in abortion (more abortions were performed) or equally it could have led to an increase in the number of abortions performed legally and *recorded* (Avdeev et al., 1995).

Abortion culture may have become established in Estonia. Evidence of this is that abortion rates were, and still are, considerably higher than in the West, but on the other hand they were not as high as, for example, Russia. In 1989 it is estimated that the total abortion rate[27] for Russia was 3.45, for the USSR as a whole, 3.08 and for Estonia, 2.17 (Avdeev et al., 1995). In addition, as low fertility rates were achieved early and without the use of modern contraception, natural/traditional methods must have been used and it is difficult to accept that these could have, or would have, been forgotten. Indeed Anderson and colleagues state that, for Estonian women, abortion was not the primary method of fertility control, but a resort when other methods failed, whereas for Russian women in Estonia abortion was more likely to be the primary method of fertility control (Anderson et al., 1993). This is important as what is now being observed (increased uptake of contraception and falling abortion rates) may be a change from one type of contraception (traditional and not highly effective) to another (modern and effective), as much as a

[27] The total abortion rate equals the sum of age specific abortion rates

change from abortion to contraception, at least for some sub groups of the population.

The Post Soviet Era

The new state

Soviet successor states, despite their diversity, are all experiencing a decline in abortion rates and this in spite of marked fertility decline (CoE, 2002, EOHS, 2000) (see also Chapter 4). To what can this be attributed?

Clearly, the role of the state has undergone rapid and far-reaching change. Generally, the move has been towards democratic free-market nationhood, so that the role of the state has been diminished. Successor states have had to devise their own abortion legislation, but this has tended to remain liberal, although in Russia for example recent legislation reduced the number of 'valid' reasons for an abortion after the first trimester from thirteen to four (Paton-Walsh, 2003). Estonian legislation allows abortion on demand in the first trimester and up to 21 weeks on medical grounds or if the mother is under fifteen years of age or over forty five years (Karro, 1997). Therefore, little of the recorded abortion decline cannot be attributed to restrictive legislation, in Estonia or elsewhere in the former Soviet bloc.

Legislation passed in 2004 in Estonia allows sterilization (male or female) for the purposes of fertility control, but only for those over 35 years of age, or those who already have three children. This could allow those who have completed their families to have many years free of the need for contraception and free too of the fear of unwanted pregnancy. There may however be little uptake. Qualitative research reveals abhorrence for the idea of permanent methods and some suggestion that sterilization is associated with Nazism (see Chapter 6).

Although there has arisen a plethora of private health providers, including those offering abortion services, the vast majority of people still rely on state (or municipal) services. These are no longer free (except for emergencies),

but operate under the cost-sharing principle, whereby users pay a fee, and the remainder is covered by the social insurance scheme[28]. Perhaps due to what Agadjanian, (2002), describes as the "inertia of the soviet tradition" the organisation of healthcare has proved to be remarkably resistant to change. The system remains top-heavy, with a sizeable number of specialists and hospital doctors and a relatively undeveloped primary sector, in spite of attempts to create a family doctor service. Doctors are now being trained (or re-trained) to fulfil the role of family doctor, where it is intended that they will be the first port of call for family planning advice (EOHS, 2000). However, as patients still have direct access to some specialists including gynaecologists (and venereologists) this attempt to change the patient's pathway to reproductive health services may not succeed (EOHS, 2000). Family planning advice still tends to be delivered by gynaecologists and for too many young women this is rather late.

In recognition of the new challenges faced by the population, especially with respect to HIV/AIDS, the Estonian government adopted a new national reproductive health programme in 2001, but its implementation has been hampered as it was not allocated a share of the state budget (UNFPA, 2003).

The state is no longer responsible for the production and distribution of supplies; there is now a market in contraceptives. However, the state health budget struggles to cope with the financial burden of internationally priced pharmaceuticals, as do individuals when they pay a part of the cost (for example for the oral contraceptive) or buy their own (for example condoms). In spite of this there is good evidence that the use of modern methods of contraception has increased (Katus et al., 2000). In Estonia the increase in supply facilitated by the state has improved access to contraception.

In terms of information and education, great strides have been made. Doctors and scientists were given some freedom to travel to international conferences

[28] The uninsured must bear the full cost. Uninsured people are those who do not pay tax, for example illegal residents. EOHS (2000) Health Care Systems in Transition - Estonia. Copenhagen, European Observatory on Healthcare Systems.

during the 1980s. However, it was not until the 1990s that high abortion rates were discussed by doctors and policy makers (Papp et al., 1997). An encouraging aspect of independence is that doctors now have full access to data and to peer-reviewed international journals.

In Latvia conservative attitudes have hampered attempts to introduce sex education into the curriculum (Cengel, 1999) whereas in Estonia 'human education', which includes sex education, has been revolutionised. Teaching is earlier, broader and deeper. However, some teachers have found the material, and the rôle, too challenging, so that the standard of sex education in schools remains variable (see Chapter 6).

The media and the end of censorship

Those raised during the Soviet period were deprived of sex education within the school system and had little reliable information from other sources. Adults have been 'catching up' in terms of sex education, via the media. Some of this is factual and of high quality. However, the market for pornography was quicker to establish itself than public television and radio were able to adapt to the new freedom, so that in Estonia, as elsewhere, a good deal of misinformation was made available before high quality information could reach the public (Peetso et al., 1999). In reference to the Ukraine, Vornik and Govorun, (1996), state that oppression has been replaced by exploitation and that society has become permissive, but without proper sex education. In addition, not all branches of the media employ responsible journalism – the 'yellow press', with a taste for reporting 'moral panics', has become established in Estonia in recent years[29].

A new society

Pressure groups and non-governmental organisations are now being created, for example Eesti Pereplaneerismise Liit , (The Estonian Family Planning Association) linked to the International Planned Parenthood Federation (IPPF, 2003), and their impact is growing (Karro et al., 1997c). In addition, the

[29] Ilvi Joe-Cannon – personal communication

influence of the churches has grown, though the impact of this may be negative in terms of reproductive health (Karro et al., 1997c).

Improvements in the expertise of providers, the education of young people (and some of their parents), and the development of non-governmental organisations have all served to increase the demand for contraception, without which access to modern methods would be wasted. However, economic transfiguration has imposed some constraints. At the same time as the state has instituted fees for healthcare or reduced subsidies, many people are experiencing unemployment or a lack of job security which makes healthcare expensive for many people. In addition, fertility rates have fallen substantially over the decade since independence, so that even with increased contraceptive prevalence abortion may still play a key rôle. There is a level of anxiety about the new political and economic system, and the possible costs as well as benefits of membership of the European Union. Furthermore, there is a continuing fear in Estonia of Russian aggression: "It is like living next to a volcano" (Eve Variksoo, personal communication 2003). The increase in age at birth may be a sign of people adopting what Stloukal calls "wait-and-see forms of behavior (sic)" as a response to feelings of insecurity (1999 p37).

A threat to choice?

A new development is the emergence of an anti-abortion movement in states of the former Soviet bloc (Walder, 2000, Stloukal, 1999). This has three elements: firstly the revival of religion (especially relevant is the recovery of the Catholic[30] and Russian Orthodox churches); secondly there is a reawakening of conservatism as a reaction to years of socialism and all its ills (and in this context the ills are women's 'liberation' in general and abortion on request in particular); and thirdly, with reference to low fertility rates, there is a fear of "ethnic extinction" (Haas, 1996 p 72), especially in the Baltic states where titular population sizes are so small (WHO/UNFPA, 1995). Some go as far as blaming the 'demographic crisis' on non-governmental organizations

[30] Not only does the Catholic Church in Lithuania oppose abortion, but also contraception and sterilization. (Karro, Klimas and Lazdane 1997)

promoting contraception and the right to abortion (Johansson, 2001). However, it is likely that recent steep fertility declines throughout the region are the result of economic change and associated social upheaval, indeed there is a near linear relationship between the economic situation and fertility in Estonia (and Lithuania) (UNECE, 1999). After all, abortion is only a proximate determinant of fertility (Horga and Ludicke, 1999). This situation demonstrates perfectly what Freedman and Isaacs call "the tension between demographic priorities and reproductive choice" (1993p18). It is to be hoped that governments are not persuaded to pass restrictive abortion legislation, which may serve only to transfer abortions from legal to illegal status. Restrictions have been considered in several former Soviet states (Rahman et al., 1998). So far abortion and the birth rate have not been explicitly linked by policy makers in Estonia, even though a population affairs Minister has been appointed to explore ways to increase fertility (Gunter, 2003). In Latvia, the Minister for Child and Family Affairs Ainars Bastiks, who has also been charged with increasing fertility levels, has been quoted as stating "It is tragic that so many babies that could have been born were killed" (BalticTimes, 2003a p2).

Conclusion

Abortion culture was just one of the consequences of an ideological stance which prioritised the productive over the private sphere, industry over the health and service sectors. Abortion culture was created by a "complex combination of perceptions, beliefs, attitudes and practices" and the process of change may be protracted (Horga and Ludicke, 1999 p 109). However in sections of the population where abortion culture was not so firmly entrenched we hypothesise that abortion rates will fall faster than in those groups where abortion culture was well established. This might be because some women or couples had a previously unmet aspiration for contraception whilst others see no reason to replace abortion with contraception. In addition, abortion culture may fade as those raised in its atmosphere become older and move out of the reproductive ages, to be replaced by those with better knowledge and different attitudes and practices, as Agadjanian found in Kazakhstan (2002).

Clearly, access to a range of modern affordable contraceptive methods will an important factor in hastening further decline in abortion. However, in the new market economies healthcare is no longer free-at-point-of-delivery. Cost recovery policies mean that most people have to pay for contraception and the level of payment is perceived as expensive for some (Brandrup-Lukanow, 1999). In Estonia a social insurance system has been established, however there are some people who are not insured and who are not therefore entitled to subsidies (EOHS, 2000, Karro, 1997a). Indeed affordability is especially important in the post-Soviet context where unemployment and underemployment are new concerns (Puur, 1997a, Puur, 1997b).

Sex education that is light years away from that provided during the Soviet period should begin to leave its mark, especially if and when parents themselves are well informed and no longer reluctant to talk to their own children about sexual issues[31].

It is easy to blame former Soviet bloc peoples for high abortion rates and yet most of those involved would have been powerless to act differently. As Haldre (2000 p 3) states:

> "I'm sure that if people in the Netherlands had lived in isolation under Soviet occupation for 50 years, they would have similar abortion rates. For a better understanding of why people in this region have behaved in certain ways under the given circumstances I'd like to recommend reading George Orwell's classics 1984 and Animal Farm".

This chapter has discussed the relevance of the concept of abortion culture in Estonia. The literature reviewed suggests that an abortion culture might have had a significant impact on attitudes, practices and behaviours in Estonia. However, it was considered important to discover, first hand and face-to-face, how people in Estonia view the past, the present and the future, in terms of fertility control. In order to conduct this type of face-to-face enquiry qualitative approaches were deemed apposite.

[31] see Chapter 6

The following chapter will discuss the way in which qualitative methods were used to explore the views of people in Estonia. It begins with a brief discussion of theoretical perspectives, which is followed by an account of how qualitative theories were put into practice in the Estonian context.

Key Points

- An abortion culture emerged in Estonia during the Soviet era
- As a consequence of the Soviet system and command economy:
  - Modern contraceptive methods were rare and abortion was free (or inexpensive)
  - Sex education was limited
  - Doctors and other health service providers existed in an information 'blackspot'
- Abortion culture was experienced differentially by population subgroups and as such may fade at different rates according to group

Chapter 5 – Selecting Methods to Investigate Fertility Control in Estonia

We have seen in previous chapters that, although abortion rates remain high in comparison to Western Europe, abortion plays a much smaller rôle in fertility limitation in Estonia today than in the past. Throughout the period since independence Estonia has been emerging from the yoke of the Soviet system. However, little is known, at least outside Estonia, concerning the relevance of the Soviet model and 'abortion culture' today. Many questions remain unanswered. Has sex education in schools improved? What do people know about fertility control? If modern methods of contraception are available, have attitudes changed and can people access these methods? If people were comfortable with the use of abortion for fertility control, why have abortion rates fallen? What do people see as barriers to informed choice? What do people say about the behaviour of their own social group? Are people in Estonia content with the situation regarding reproductive health or could they suggest ways in which further improvements could be made?

This chapter concerns the strategy and methods chosen to investigate these questions about fertility control in Estonia. It begins with a brief discussion of the main theoretical approaches to social research and the reasons that a mixed method approach was adopted. Next, there is a discussion on the subject of qualitative research and the ideas that underpin both theories and practice of qualitative approaches in general. This is followed by an account of how focus group discussions were conducted in Estonia and how data collected were analysed. Subsequently, the rationale for key informant interviews is discussed, including a brief description of the type of people approached to act as key informants and how these interviews were conducted.

Theories of social research

Social research methods are broadly divided into two camps – positivist (or empiricist) and interpretivist (or constructivist). Different researchers, or

disciplines, within social science have different views of the social world and about the very nature of reality, which give rise to different ideas about how social phenomena should be investigated and how knowledge should be assembled. The positivist paradigm occupies a dominant position but there have been a number of philosophical debates about, and critiques of, this model as applied to human beings and the social world. Indeed Robson (1993) has referred to the relationship between the two factions as "sporadic warfare".

Positivism is generally associated with the 'natural science' model. Its proponents would argue that it represents a scientific approach to research, that an objective reality exists and gives rise to facts which are measurable. The approaches used to investigate phenomena are quantitative.

Interpretivism is associated with anthropological and ethnographic modes of research. The basic tenet is to conduct in depth investigation of social phenomena. Interpretivists would argue that there is no objective reality, that 'reality' is context and perspective-dependent and that even 'truth' is a normative concept (Ulin et al., 2002, Tashakkori and Teddie, 1998). The research methods used are qualitative.

However, many researchers, whom Tashakorri and Teddie refer to as the 'pacificts', have sought to bring an end to the "paradigm wars" (1998 p 4, p 3). The pacificists have advocated a pragmatic approach to the selection of methods, arguing that the method used should be one dictated by the research question and the one that works best. Furthermore, although many purists might argue that it is neither advisable nor even possible to combine approaches, researchers, and indeed funding bodies, are increasingly favouring 'mixed method' approaches (Tashakkori and Teddie, 1998).

Analysis of quantitative data is necessary when looking for associations between variables and describing trends and patterns. Hence, for this investigation, not just survey data but also official statistics are used to

describe patterns of abortion and contraception and trends over time[32]. However, in order conduct an in depth investigation and to view the relevant issues from the perspective of the people involved, it was also deemed necessary to conduct qualitative research.

What is qualitative research?

Qualitative research involves the collection of data, by means such as in-depth interviews, focus group discussions, observation or discourse analysis for example. These methods of data collection enable the investigator to make sense of human behaviour within the context of that behaviour (Bryman, 2001). Qualitative research moves the investigator closer to that context through interaction with respondents within their own environment or 'natural setting'. Not only can the researcher see the socio-cultural situation, but the material environment too. In addition, respondents can talk about their own experiences using their own vocabulary (Ulin et al., 2002). Large scale survey data may fail to uncover the often complex process of decision making, so that we may find out what people do, but be none the wiser concerning why or how. Qualitative approaches allow the researcher to coax the respondent to recount and explain aspects of decision making. Moreover, the use of qualitative methods enables the researcher to pose open ended questions which are problematic for quantitative survey instruments.

Where quantitative research is generally associated with the positivist perspective and empiricist approaches to finding 'the truth' and identifying 'facts', researchers employing qualitative methods are acknowledging that there may not be one objective truth which is measurable by natural science methods, but that instead there may be a number of versions of what is 'fact' and that truth, like beauty, may be in the eye of the beholder (Ulin et al., 2002). Equally, the interpretivist subscribes to the view that the respondent's interpretation of his or her own world is valid and valuable and that this world can be better understood by adopting an emic approach, where the research lens is directed from the point of view of the respondent, rather than an etic approach where the researcher stands outside and looks in (Barfield, 2004).

[32] See Chapters 2 and 3

Unlike the process of quantitative data collection, qualitative research is iterative - the researcher can and should reflect on emerging concepts and modify the research instrument(s) accordingly (Arthur and Nazroo, 2003). In addition, data collection should be flexible. The agenda is set, up to a point, by the researcher and moderator but a certain (controlled) amount of "rambling" can occur. Respondents are able to introduce topics they think are relevant (Bryman, 1988). However, the loosely structured approach does not imply that there is no plan and no preparation (Arthur and Nazroo, 2003). The wording of questions is of crucial importance and question order can make a big difference to response. Questions must be clear and must employ culturally appropriate terms and should flow from general to specific and from least to most sensitive.

Feminist researchers have often opted to use qualitative methods due to what they perceive as some of the limitations of quantitative social research. For example, Devault states that "traditional research paradigms have been shaped by the concerns and relevances of a relatively small group of powerful men" (Devault, 1990). Feminists argue that methods such as large scale surveys exploit respondents (Oakley, 1981). Information is extracted from respondents according to researcher-defined questions and organised into researcher-defined categories with the implicit assumption that this process is rational and will reveal the reality of peoples' lives. Peacock however suggests that: "The positivist model is rational, but it is rationality as defined by the observer rather than by the actor." (Peacock, 1986)

Qualitative research however aims to place respondents at the centre and to give credence to their accounts and interpretations. Ordinary people are positioned as 'expert' informants about issues related to their own lives and their communities. As Ulin and colleagues have said "If you want to know, [what people do and why] ask them" (2002 p2-3).

On the other hand, 'common sense' respondent accounts may not be faultless either (O'Connell Davidson and Layder, 1994). What the individual perceives

for example may be constrained by the limitations of his or her experience as illustrated by the following excerpt from the novel Cold Mountain:

> ...Swimmer had looked out at the landforms and said he believed Cold Mountain to be the chief mountain of the world. Inman asked how he knew that to be true, and Swimmer had swept his hand across the horizon to where Cold Mountain stood and said, do you see a bigger'n?" (Frazier, 1998 p 19)

It is therefore the task of the social researcher to evaluate alternative versions of the phenomena of interest (O'Connell Davidson and Layder, 1994), to hear the accounts of respondents within the context of their own lives and experience, and then to set this within a broader social science framework.

Using a qualitative approach to investigate abortion and contraception in Estonia

It is possible, through literature review and access to policy documents, to discover a great deal about Estonia, its population, and policies which have consequences for reproductive health. However, the bases on which people assess their choices, make decisions, and carry out actions are predicated, not on what is 'real' and 'true', but on what those people *perceive* as being 'real' and 'true'. For example, health promotion literature may say that the contraceptive pill is safe, but men and women may base their own opinions on anecdotes from friends or on newspaper headlines. Their decision, in this case to use or not to use the pill, may be founded on the informal sources of information rather than the 'scientific' sources that policy makers have promulgated. Actions are taken as a consequence of information received, not information delivered. There is a need therefore to uncover the perceptions of respondents to understand what drives behaviour. How can these perceptions be exposed?

Although there are (limited) survey data concerning abortion and contraception in Estonia, this type of data is collected by the use of survey instruments which are based on closed questions. These questions are designed to uncover what people do (or at least what they say they do) and include some attitude-measuring questions employing researcher designed

categories or scales. However, they do not allow respondents to use their own words, to define their own categories or to challenge the researchers' assumptions. The 'agenda' is very much set by the institution commissioning and/or conducting the survey. Furthermore survey responses do not allow us to hear the voices of respondents, unmediated by institutions, in their own environments, and in the context of their lives.

This is important because reproductive decisions (and non-decisions) are made within the context of the lives of respondents, moderated by socio cultural norms and expectations, prevailing gender relations, and existing social and health service provision. In order to understand behaviour we need to go to the site of that behaviour, not just the physical location, but also the psycho social location. The quantitative approach fails to penetrate this last location, tending instead to focus on the individual 'case' and aggregating up to the population level, but missing the intermediate social level. Whilst many theories of behaviour concentrate on individual decisions based on individual calculations of risk and benefit, it is also argued that

> ...reproductive "choices" are far more than individual, or psychological. Broad demographic, sexual, reproductive (and nonreproductive) patterns are ultimately social patterns, contextualised by the rationalities of class, race ethnicity, sex, religious background, family and reproductive history, and not simply by individual "risks and benefits" (Rapp, 1991 p385)

Furthermore, to the researcher making observations from the outside, using an etic approach, the perceptions, decision-making and behaviour of those inside the group may seem irrational. However, Goffman (1968 p ix) states that:

> "...any group of persons – prisoners, primitives, pilots or patients – develop a life of their own that becomes meaningful, reasonable and normal once you get close to it..."

In order to 'get close' a qualitative type of approach was considered to be appropriate.

Focus group discussions

Why choose focus group discussions?

Focus group discussions resemble group interviews in that a group of people are assembled with the aim of obtaining answers to a number of questions. The difference however is that in the focus group discussion the role of interviewer becomes that of moderator and the aim is to stimulate interaction between participants, not just between moderator and participants. The aim is to make use of a mode of communication that people often use to share information and one which they should therefore find comfortable, but also to hear and observe how individuals negotiate meanings within a group. In addition, the focus group is used, not where the objective is to extract individual level information (which might be better gained through in depth interview), but where the researcher is looking for social meaning and exploring social or community norms (Ulin et al., 2002).

Focus group discussions were selected as the appropriate method of qualitative data collection for this research. Although in-depth interviews might have elicited information about individual knowledge, attitudes and behaviour, a key premise of this research is that individuals make 'choices' about contraception and abortion within the constraints of the socio-cultural context. It was felt that 'natural' discussion in a group would be more likely to generate information about societal norms and shared beliefs.

Ethical considerations

Although individual participants would not be placed in physical danger (as may be possible in medical research for example) ethical considerations were seen as important. Anonymity was promised to participants and to this end no names appeared on transcripts and location details were kept deliberately vague. Confidentiality was seen as more problematic. Although the researcher could promise confidentiality no such promises could be made on behalf of other group members, although participants were asked to keep other members' comments confidential.

The voluntary nature of participation was emphasised at the beginning of each focus group discussion. Participants were informed that they were not compelled to answer any question and could leave at any time. Permission to proceed with the discussion was actively sought as was agreement to recording participants' comments.

Social research may trigger painful memories and worry and while the researcher should not take on the role of counsellor, there is a responsibility to provide advice about appropriate sources of help should these be required (Lewis, 2003). As sensitive issues were being raised, at the end of the discussion participants were offered exit materials containing information about where they could access appropriate sources of help if they wished to do so.

Ethical approval for the project was sought and obtained. This involved the submission of drafts of research instruments which were then edited following the advice of the ethics committee.

Selection of participants and composition of focus groups[33]

Although qualitative data are not intended to be statistically representative, they should be symbolically representative as far as practicable, in that coverage of different elements of the target population is important (Ritchie et al., 2003 p 107). This means that the target population should be divided according to relevant criteria (age, sex, ethnicity for example) and groups should be organised accordingly so that participants are divided by age, and may be further divided by, for example, ethnicity. The aim is to obtain a wide range of respondents, but to organise groups which are internally homogenous. This internal homogeneity is designed to make participants feel at ease and ready to take part in the discussion.

Selection of focus group participants in Estonia was purposive. Local contacts were given the criteria and asked to recruit suitable participants. Russian contacts were asked to find Russian respondents, Estonian contacts to find Estonian respondents. The target population was 'adults living in Estonia'. The criteria for selection were based on age, gender, ethnicity and geographic location and the aim was to obtain a wide variety of groups.

While diversity of groups is desirable the internal homogeneity of each group is an important consideration. Firstly, it is generally accepted that participants are likely to feel more comfortable discussing sensitive issues with those they perceive as sharing their own characteristics, so the focus groups were split for by gender and age. Secondly, key informants indicated that there could be discomfort in discussing these sensitive topics with persons of the 'other' main ethnic group, so it was decided to separate groups by ethnicity. In addition, survey data (Katus et al., 2000), official statistics and anecdotal evidence from key informants indicated that levels of abortion and contraceptive use differed at the aggregate level by ethnicity. It was also anticipated that Estonians and Russians would have differing perceptions of the previous regime and the independence of Estonia. Lastly, there was the practical consideration of location. Groups were recruited within defined geographical areas so that

[33] See Appendix 7, Focus Group Table, for more detail concerning group composition

participants could easily travel to the venue but this also meant that they shared, to some degree, a common environment.

Both women and men were recruited as it was considered that men as well as women have a rôle to play in terms of both contraception and abortion, but more women's groups were convened as it was thought that childbearing and family planning have a bigger impact on women's lives than on men's. Recruiting men proved difficult, for instance no Russian men willing to participate were found and only one focus group with older Estonian men was conducted. This was due to the difficulty of finding the right contacts and then reluctance on the part of prospective participants to agree to take part or to attend. The absence of any type of sampling frame resulted in difficulty in identifying respondents with the necessary characteristics.

Adults of all ages were considered to be able to make valuable contributions, the young possibly better able to report on the current situation of young people, the older adults able to reflect on the past and how provisions of services and norms of behaviour might have changed. Participants were grouped by age into the young, 18 to 25 years, and 'mature' adults, 25 and over. For the groups of mature adults, recruiters were asked to keep the age range to 10 to 15 years (for example, women aged 30 to 45), although this was not always possible.

There is some debate about whether focus group discussions should consist of participants who know each other or should be strangers (Ulin et al., 2002). As the aim of the discussions was to find out about social attitudes rather than individual behaviour and while the subject was sensitive but not about deviance, it was decided to proceed with groups where people were acquainted with each other when this occurred. In the some of the small communities in Estonia, this was almost inevitable. Discussion by these groups appeared to be more relaxed and yielded more contributions, suggesting that 'friendship' groups should be used more often in the focus group context.

Groups tended to be small, but discussions did not appear to be hampered by this. In fact, the small, friendly atmosphere appeared to encourage interaction and facilitated moderation, recording and transcription.

How many groups?

In order to elicit a wide range of views and ideas, a number of focus groups were required. There is no simple formula to calculate this number. Glaser and Strauss (1967) suggest that 'theoretical sampling' should be carried out (cited in Arber, 2004). This means that the researcher should continue to conduct focus groups until the level of 'theoretical saturation' is reached whereby no new ideas are being added by subsequent groups. For the research in Estonia, focus groups were convened first, for convenience, in Tallinn, amongst groups with whom contact could easily be made. Following this, groups were added and the geographical area expanded as more contacts were established and the theoretical gaps in the programme of focus groups were identified. In total fourteen focus groups were conducted.

Locations[34]

Focus group discussions took place in Tallinn (the capital city), Narva (a small town on the Russian Estonian border, suffering from economic decline, with a largely Russian population), Viljandi (a provincial town with a largely Estonian population), and Haapsalu (a small town on the west coast). Focus group discussions should be held in places that are convenient, familiar and safe for participants in order to ensure that all or most participants attend. In Estonia focus group discussions were conducted in 'comfortable' environments such as University meeting rooms, a social club, a town hall meeting room, and the home of a participant. Appropriate refreshments were provided.

Incentives

It is common practice to offer incentives or gifts to encourage participation in focus group discussions. However, offering incentives presents the risk that people may agree to attend in order to receive the gift or payment. Although it may seem unreasonable to ask people to give up time without compensation,

[34] See Appendix 8 for map showing focus group locations

it was thought that discussions would be more productive when participants were taking part because they were interested in the subject matter and felt it was important than if participants were enticed with offers of cash or gifts. This issue was discussed with local experts, who did not believe incentives would be expected. Travel expenses were made available at the end of each discussion session, although these were not always collected. It may of course have been easier to recruit participants if incentives had been offered or travel money had been provided in advance.

The discussion guide

A generic discussion guide was developed and it was then modified according to the composition of the group; for example for older groups questions about the past were asked, whereas for younger groups this was omitted. The question order was from the general to the particular and the most sensitive questions were left towards the end[35].

The wording of questions was developed in advance, rather than made up on the spot. This was to ensure that no leading questions were asked and the wording was not confusing. The wording of some questions was modified when it was found that these questions were difficult for respondents to grasp. It was considered important to keep to the finalised wording as far as possible, as suitable words and terms had been agreed with the interpreter. Prompts and probes were prepared in advance (and agreed with the interpreter) in case of silence or ambiguity. However, flexibility was considered important too, if appropriate. If a respondent introduced a topic before it appeared on the guide the discussion was allowed to continue. Then later, if further information or clarification was required a question such as the following was asked: "you have already mentioned *x* which is my next topic – can I just ask you to talk about that in more detail?" Equally, participants' responses were 'analysed', in a sense, during the discussion in order to exploit the opportunity to probe for more information or to ask additional questions.

[35] See Appendix 5 for example focus group discussion guide

Questions were added or modified in the light of early focus group discussions. A good example of this was the topic of illegal abortions, termed 'round the corner abortions' in Estonia. This was not originally included on the discussion guide but when raised spontaneously by a participant during the second focus group, the topic was added to subsequent discussions.

Although the discussion guide was thought to be comprehensive, previous experience suggested that a 'sweeping up' question would help to ensure that no information was missed and so this question was placed at the end. This was designed to elicit any thoughts or concerns participants may have had, that had not been aired in earlier discussion (Krueger, 1998).

What to ask?[36]

An important consideration when preparing to conduct focus groups is not just how to ask questions but also what to ask. The questions were linked to the research questions:

- What do people know about fertility control?
- What are people's attitudes to contraception and abortion?
- What do they see as barriers to informed choice?
- Howe do people perceive the behaviour of their own social group?

The questions were loosely based upon the 'knowledge' 'attitude' 'practice/behaviour' (KAP) framework used in the evaluation of family planning programmes as early as the 1960s[37]. This framework is based on the premise that what people do (practice or behaviour) is based on what they know and their attitudes. For example, women may *know* about modern methods of contraception but may have negative attitudes towards them, preferring traditional methods and/or abortion. Hence their behaviour is influenced by their attitudes. This is a simplistic version of people's 'real life' situations however. Knowledge may be imperfect, women may not be free to make decisions, couples may wish to use modern methods but there may be

[36] See Appendix 5 for an example discussion guide

[37] See for example MAULDIN (1967) Measurement and Evaluation of National Family Planning Programs. *Demography,* Vol. 4, pp. 71-80.

barriers, constraints or costs. Hence, a number of questions supplemented those arising from the KAP framework in order to uncover what other factors played a part in influencing behaviour.

The first question on the discussion guide was intended to be an 'icebreaker' – a question that would be relevant for all participants. Furthermore this question was designed to elicit contextual and background information, which might help to make sense of later responses.
The next topic concerned 'having a family'. This question was thought important as the control of fertility is, generally, associated with the attempt to delay, space, or end childbearing, that is, to plan a family.

It is argued that people have the *right* to knowledge about sex and sexuality so that they can make informed choices (International Planned Parenthood Federation, 2006, Reiss, 2001). Therefore the third topic dealt with the acquisition of knowledge – how would people report finding out about sex and how would they, with hindsight, evaluate the way in which they learned? This issue was considered to be inextricably linked with contraception and abortion as lack of knowledge could be a factor in behaviour.

Next, questions about contraception and abortion were included on the guide as these were seen as the 'key issues'. Not only were questions on knowledge, attitude and practice included, but also probes concerning barriers and constraints. Questions concerning sexually transmitted infections followed. This was considered important as not only are these infections of concern in their own right but also the acquisition of such an infection is an indication that 'unprotected' sex has taken place. Clearly if the female partner is using methods such as the pill or the intra uterine device she is protected against pregnancy. However, in the absence of such protection pregnancy could occur and this pregnancy could end in abortion.

The final questions were included on the discussion guide in order to allow participants to introduce subjects that had been omitted, add to discussions

that had already occurred, reiterate points about which they felt particularly strongly and suggest ways in which improvements could be made in Estonia.

The moderator

The task of the moderator involves making people feel at ease, keeping the discussion going (mitigating the effects of the dominant, encouraging the passive members) and knowing when to probe or wait. The moderator also needs to know when to allow diversions and when to bring participants back to task. In addition the moderator must find ways to facilitate open expression of views and 'real' feelings as participants may feel pressured to be socially acceptable, both to the moderator and to the group.

The personal characteristics, behaviour and skills of the moderator are considered to be important. It is recommended that the moderator be 'matched' in terms of, for example, gender, ethnicity and age with the members of the focus group. He or she must be able to quickly build rapport with the group and make them feel at ease. All focus group discussions in Estonia were moderated by the researcher. Although an experienced moderator, as a researcher from England I was a foreigner. However, I was well-received and a number of participants remarked that it was easier talking to a 'stranger', and were pleasantly surprised to find that people from abroad were interested enough to listen to them and care about their problems. This meant that the rules, in terms of matching, were broken. However, it was considered that the benefit of the previous moderating experience of the researcher, and knowledge of the research aims and discussion guide, outweighed the risk that personal characteristics would adversely affect the discussions.

The possibility that discussion was hampered by the presence of a stranger cannot be discounted. Those who did not feel comfortable with this situation would be less likely to reveal this than those who were at ease. Being female might also have had an inhibiting effect when focus group discussions were with males. However, in spite of possible inhibition all the focus groups yielded

plenty of rich data, though it is possible that data quality might have been superior with moderators matched to participants.

Language, interpretation and translation

Where interpretation is required the personal qualities of the interpreter are important. The interpreter takes an active part in the running of the focus group and must therefore have some of the qualities and skills of a moderator, for example, making the participants feel welcome and comfortable, allowing them time to respond, avoiding leading questions and knowing when to remain silent, or to probe or ask for clarification. In addition the interpreter must be able to work as a team with the moderator. The interpreter must also possess the necessary level of language skill and knowledge and must also be able to interpret quickly during the focus group discussion.

Interpreters, both Estonian speaking and Russian speaking, were recruited to assist with focus group discussions where interpretation was required. Rehearsals were carried out and agreement reached about what parts the interpreter and moderator would play. The questions were discussed and appropriate, locally meaningful terms agreed. During focus group discussions the interpreter was asked to feed back some answers and comments immediately so the moderator could stay in touch with the discussion and suggest probes when appropriate. All questions were posed by the moderator in English then translated into Estonian or Russian. Many of the respondents had a good understanding of English even if they felt more comfortable responding in their own language. A proportion of the focus group discussions were carried out without the aid of an interpreter, where participants had indicated that they were happy to carry out the discussion in English.

Preserving data

With the consent of participants, focus group discussions should be recorded However, respondents may feel self conscious in the presence of recording equipment in a way they might not in natural conversation. Although note taking may therefore feel less obtrusive for the respondents it places a heavy burden on the moderator or note-taker. Unless notes are taken verbatim

information can be lost between the stages of discussion and transcription. It was therefore decided to record discussions using a high quality minidisc recording device and external stereo microphone, with a cassette recorder as backup. Although cassette recorders have been used successfully for many years, the minidisc recording quality is far superior. In addition there is far less background hiss and crackle which makes transcription easier, faster and more accurate (Stockdale, 2003). There is a possibility that the use of recording equipment could inhibit some respondents, even if they have agreed to the use of such equipment. However, the minidisc and microphone were small and completely silent in operation, so it is believed that recording was unobtrusive. It is advised that notes should also be taken as a back up procedure in case the recording equipment fails and in order to record impressions that will not be picked up by recording equipment (Arthur and Nazroo, 2003). Notes were therefore taken during each session, just in case of recording failure, and to register impressions, body language and points to clarify later with interpreter.

Technical hitches are worth mentioning. On two occasions transcripts could not be produced due to failure of the recording device and in these cases only notes taken during the discussion could be used. In some group discussions comments were missed at the transcription stage due to background noise or lack of volume or clarity on the part of the speaker. The minidisc was, as expected, far superior in terms of recording quality to the cassette recorder.

Translation and transcription were carried out as soon as practicable after each focus group. This was done alongside the translator (who had also acted as interpreter during the discussion), allowing clarification of meaning, not just the direct translation of words. Although this process was time consuming it was seen as worthwhile in terms of producing valid, high quality transcripts. The recordings were transcribed in English into WORD. Simple identifiers for place and group characteristics were used to preserve anonymity.

Limitations of the focus group discussions

An important limitation of this type of study is that participants are volunteers. Firstly this can result in bias, in that those who respond may share characteristics such as an interest in the topic or a willingness to help. Secondly, no one can be compelled to take part and no one should be induced to do so.

Discussion groups can only be assembled if, firstly, potential participants can be identified and secondly, if they can be persuaded to take part. Unfortunately no Russian male focus groups were conducted. Participants were contacted and some declined to take part. Others agreed but did not arrive at the appointed time and place. This 'failure to attend' occurred in Estonian male groups also, to the extent that in two cases the discussion had to be abandoned. In all groups fewer people attended than had agreed to participate, but this was anticipated and the discussion went ahead if there were more than three participants and all were happy to carry on. It is important to note that no female groups had to be abandoned due to non-attendance. This suggests that women may feel more comfortable participating in this mode of research or that women found the discussion topics less threatening than did men.

Another important issue is the social and educational status of participants. The majority of men and women taking part had a minimum of completed secondary education. Many had tertiary education and all the young people were university students. This had the advantage that many participants spoke, or at least understood, English and all were literate and articulate and discussions were rich and wide-ranging. However, these participants could not be considered representative of the general population. Issues such as lack of knowledge or inability to pay for or access services for example could be expected to be much more acute amongst members of the lower socio-economic strata.

A key consideration in the evaluation of the focus group approach is that of group dynamics. In any group it is likely that there will be individuals who are

reluctant to speak and some who are reluctant to stop. Equally, participants may not avoid participating but may instead model their responses on those being professed by the others in the group introducing what is termed social acceptability bias. In most of the focus groups conducted as part of this research there were participants who contributed more and some who contributed less. On occasion it was necessary to steer the discussion away from the more confident participants in order to provide opportunities for others to contribute. The moderator noted those who appeared to remain silent and encouraged them to voice their thoughts. However, participants can only be coaxed to take part and cannot be compelled to do so. In one focus group a participant made no comment at all. The significance of these silences is that information is being missed. Moreover, the type of information being omitted from the data is not known.

An important task for the moderator is to establish rapport with the group and to do so early. If the moderator is unable to do this answers may not be forthcoming or may be monosyllabic. Building rapport did not pose difficulties with most groups. Participants were invited to partake of refreshments, time was taken to thoroughly explain the research and the aims of the focus group, and participants were given the opportunity to ask questions. However, at the beginning of one male focus group, participants, concerned about the nature and purpose of the research (and the researcher), asked a number of probing questions. After a thirty minute deliberation about whether the discussion should go ahead, the participants agreed to proceed, on the condition that the discussion would stop if they did not wish to continue. The time taken at the beginning proved to be time well spent as this focus group discussion generated a good deal of rich data.

There may be topics which participants are reluctant to discuss, for example those issues which are considered taboo, issues that are thought of as private, or subjects that involve deviance, such as drug use. The focus groups conducted in Estonia involved a number of issues that might be seen as sensitive, such as contraception, abortion and sexually transmitted infections. However, all participants had been informed in advance what the subjects

would be and all were told that they did not have to answer any question they deemed unacceptable. Once rapport had been established, participants appeared relaxed in discussing these issues, possibly because questions were posed in the third person rather than asking about personal behaviour.

Data analysis

Data were collected and then analysed on the premise that respondents perspectives were likely to differ from those of the researcher (Ulin et al., 2002). Firstly, the lives of respondents are conducted within settings to an extent alien to the researcher (and vice versa). Secondly, the researcher adopts the stance of a social scientist so that the framework of ideas is likely to be somewhat different to the framework of the respondent. For example, to investigate the use (or non-use) of family planning, the researcher might adopt the framework of:

- Knowledge – what people know about family planning
- Attitude – what they think about it; do they have positive or negative attitudes?
- Practice (or Behaviour) – do they use contraception?

The respondent in a focus group situation might start from the opposite end, talking about people who do not plan their families and only on probing raising issues of knowledge or attitude. Both questioning during the focus group and analysis later must be flexible enough to allow for this.

A second premise was that the topics of interest, chiefly abortion and contraception, are social phenomena and could not therefore be investigated without regard to the context within which they arise. Nor could these phenomena be studied without consulting the social actors who play important parts in their construction (Ulin et al., 2002).

A third premise was that the process of data collection would be responsive to participants, so that although plans had been made concerning the composition of focus groups and a focus group discussion guide had been

developed, these would be modified in light of the information arising from participants themselves.

Lastly, the process of data collection and analysis would be iterative. Although a framework had been postulated in advance of data collection, this framework changed during the data collection period and, for the purposes of analysis and reporting, was further modified in view of the information arising from preliminary analysis of the focus group discussions.

What theories were applied in the conduct of this analysis?

Much of qualitative research is based upon 'Grounded Theory' as proposed by Glaser and Strauss (1967), who developed their approach based on the idea that theory arises from and is grounded in the data and that data collection and analysis should be iterative processes. This means that data drives the emergence of theory and then this emerging theory is tested against existing data or more data are collected in order to test the theory. Grounded Theory arose from the idea that social phenomena, and people's reports of phenomena, should not be forced to fit researchers' pre existing categories. Furthermore, Grounded Theory stipulates that samples are selected according to emerging theory, both in terms of the characteristics of the sample elements selected and their number. The result of this is that data collection only stops when theoretical saturation point is reached, that is no 'new' information is being collected.

However, it would seem difficult to ensure such a truly inductive approach, uncontaminated by previous knowledge or existing research paradigms. Questions posed to focus group participants were based upon the framework of 'knowledge, attitude, practice (or behaviour)' (KAP). A pragmatic approach was therefore adopted, loosely based on the 'constructivist grounded theory' described by Charmaz (2000). Based on information gleaned from key informants and from background reading, a scheme was developed with regards to recruitment of respondents, discussion guides and early analysis. However data collection and analysis plans were modified in light of the

results of focus group discussions, so that analysis was based on participant *responses* not on the researcher's questions.

Establishing themes

The first step in analysis involved reading, and re-reading, all of the transcripts. The purpose of this exercise was to become intimately familiar with the data, with the characteristics of the different focus groups, and with the particular contexts of those groups. At this stage themes began to emerge. For example, the first topic on the discussion guide concerned the lives and problems of the people (ie 'people in your community' or 'students today'). Responses to this question differed according to group but certain key themes could be identified, for example, insecurity in employment, money worries, the cost of education.

Moving to codes

The next step was to move from themes to codes. Coding refers to the process whereby markers or labels are attached to segments of text. A coding framework was adopted whereby a 'parent' code was established to represent each individual topic on the discussion guide. Under each of these parent codes, 'child' codes were created. These child codes corresponded to themes which became apparent during data collection or transcript interrogation. For example, the following list indicates the child codes, derived from respondents' discussions, under the parent code 'abortion' (5):

5 abortion access
5 abortion barriers
5 abortion now and then
5 abortion source of info
5 avoid telling
5 disapproval
5 men's support
5 men feel about abortion
5 public opinion
5 reasons to abort
5 round the corner abortions
5 stigma
5 talk to

However, coding was far from a linear process. Firstly a code had to be developed, next a definition needed to be recorded. After coding a few transcripts, code definitions were re-visited. When definitions were modified in the light of later transcripts, earlier transcripts had to be checked and re-coded in order to ensure coding consistency across the groups.

Although the parent codes corresponded to discussion topics, if a respondent raised an issue or made a comment that was tangential, or not related to the topic being discussed at that time, the comment was coded according to where it 'fit' within the coding framework not artificially forced into the topic being discussed at that point in time. In addition, each text segment could have more than one code applied as neither text segments or codes need to be mutually exclusive. For example, if a respondent mentioned the stigma of abortion in response to the *first* question in the discussion, it would be coded as:

1 abortion *and*
5 stigma

(See appendix 3 to view a coded segment)

Codes were applied to sizeable text segments. This was done in order to ensure that partial quotes were not taken out of context. This is important when the 'search' stage is reached, where text segments are retrieved according to code, but are no longer therefore seen in the context of the rest of the discussion.

Searching

During the coding process and when coding had been finalised, a series of searches were carried out. This involved searching based on individual codes (eg all 5 stigma coded segments) in the first instance. The next step was to test theories arising from the data. For example, "are Russian women more likely to mention traditional methods of family planning?" In order to answer this type of query transcripts were organised into families. The families were not mutually exclusive so that, for example, a transcript relating to Russian women could belong to the 'female', 'Russian' and 'older' families. Searches were then conducted by family and code until the data had been thoroughly interrogated. (See Appendix 4 to view transcript families)

Interpreting the results

The final part of analysis involved interpreting the results of coding and searching. The framework adopted was based on the focus group topics, but within each topic the responses of participants formed the basis of interpretation and reporting. The findings follow in chapter 6.

Key informant interviews

The rationale for conducting key informant interviews

It was seen as important to meet and interview local experts, not just to gather factual information about abortion and contraception in Estonia but also to see these issues through the eyes of those people most closely involved with reproductive health in a professional or academic sense. This striving to see through another's eyes is deemed vital to understanding meaning in another culture (Peacock, 1986). A further aim was to discover whether social and health policies were implemented in practice or whether there were areas in which implementation was failing.

Theoretical underpinnings

It is important to establish what is meant by 'key informants'. Bryman defines them as informants who "become particularly important to the research" and explains that they help to identify possible areas of interest to the researcher (Bryman, 2001 p 297). Key informants can be those with relevant expertise or knowledge (USAID, 1996). They may also be stakeholders and therefore important sources of information in that they may have influence over the design of policy, may be involved in policy implementation and service provision, or may be affected by policy in their professional lives. Equally, key informants may be involved in policy design or implementation and be well placed to suggest recommendations, but may be relatively powerless to bring these about[38].

[38] An example of this might be a civil servant who has a suggestion for the improvement of a service but cannot implement it as it is inconsistent with government policy, such as the provision of free contraceptives to adolescents when government policy states that users must pay part of the costs

Key informants might be selected from a list in a similar way to the selection of survey participants, however in the absence of such a list informants may be identified by asking existing informants to recommend others who may have relevant information and who may be willing to be interviewed (USAID, 1996). It is important to identify the appropriate groups in any given context. These groups might be differentiated in terms of professional capacity (doctor, civil servant, teacher), gender, ethnic group, or age for example. Informants can then be drawn from these groups. In summary, informants are selected purposively, with consideration of their areas of knowledge, expertise or other salient characteristics, and 'snowball' techniques may be used to build the sample.

Other than considerations of time and cost, how is the 'right' number of key informant interviews decided? In common with in-depth interviews and focus group discussions, the aim should be to obtain a range of views and to cease conducting interviews when no new information appears to be arising. Kumar suggests that, typically, between fifteen and thirty-five interviews should be conducted, but he does not state how this number is computed (Kumar, 1989).

Key informant interviews and this study

Why were key informant interviews conducted for this study? Key informants were interviewed in order to gain as much knowledge as possible about the issues being investigated, but to do so in the context of Estonia. Information collected from key informants was not considered to be in any way superior or more important to that gleaned from focus group respondents. On the contrary, focus group respondents were seen as 'experts' in their own way. Key informants however were seen as essential in providing a different perspective, being not just members of the public (and therefore possibly users of services), but also having gained particular, and relevant, insights through their professional rôles. Furthermore, key informants were selected on the basis that they were critical 'players' in the arena of reproductive health. Each key informant was involved in policy making, or influencing policy makers, or was charged with the task of implementing policy or providing

services. (see Fig 5.1) By combining key informant interviews with focus group discussions, the aim was to ensure that information had been sought from all manner of stakeholders.

The key informants interviewed were academics, gynaecologists, doctors (family doctors and those working in polyclinics or sexual health clinics), civil servants (in Population Affairs, the Education Department, the Social Ministry, the National HIV Prevention Programme), teachers, social workers and the director of the Estonian Family Planning Association.

Key informant interviews were commenced during the 'scoping' visit in advance of the focus group discussions, although further key informants were interviewed throughout the data collection period. Key informants were identified by starting with academics involved in the field of population research and then asking these informants to suggest others who might be of help. In addition, direct contact was made with other informants by emailing relevant institutions and government departments and asking for the names of suitable contacts. In this way it was possible to recruit key informants from differing social and professional networks thereby avoiding one of the pitfalls of the snowball approach.

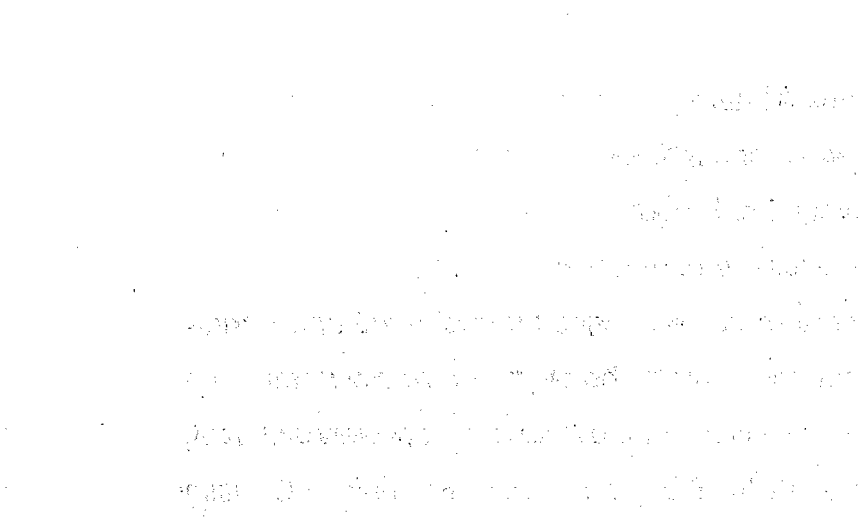
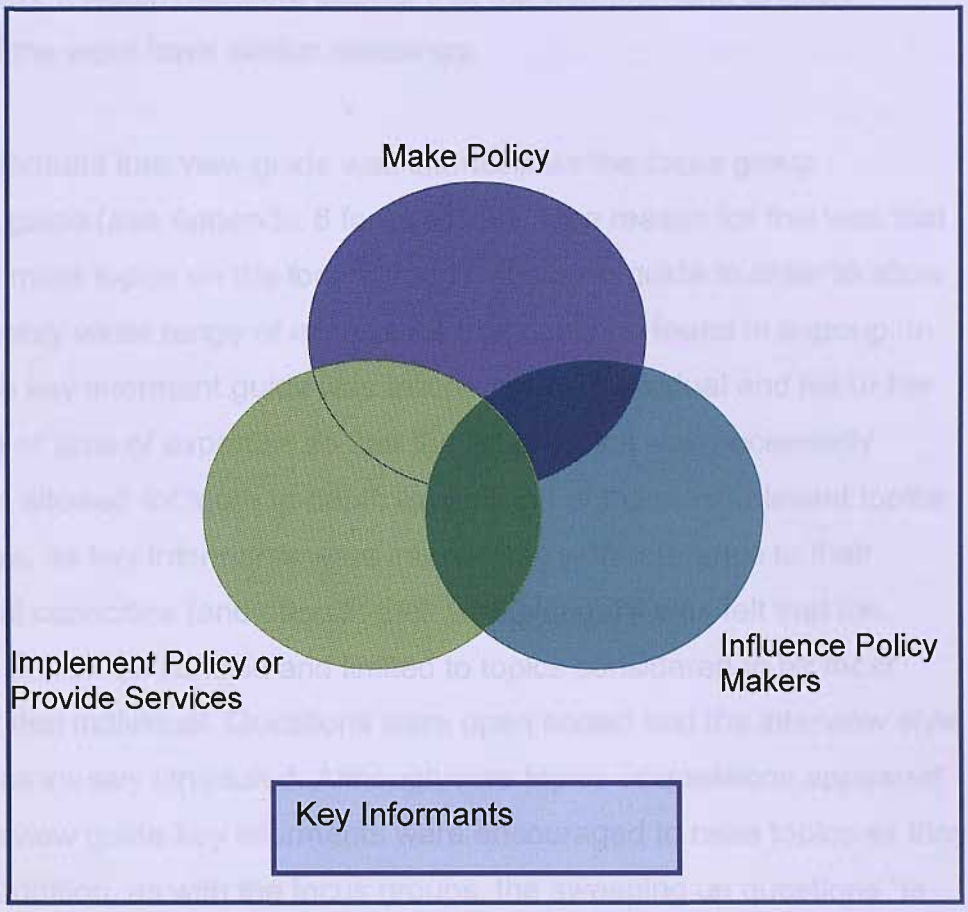


Figure 5.1: The concept of key informants



A total of sixteen key informant interviews were conducted, all by the researcher. In two instances, for the convenience of the interviewees, two informants were interviewed at the same time. No potential key informant refused to be interviewed, however it is possible that names were selected and suggested by others in their networks with regard to their willingness to help out in this way. Only one interview was deemed a failure – it proved very difficult to build rapport with the informant concerned, answers were monosyllabic and the interview was completed within fifteen minutes. In contrast, the longest interview lasted over two hours. All interviews were conducted in English. Only one word caused any difficulty and required recourse to an Estonian-English dictionary and that was the word 'stigma'. In English the word 'stigma' is defined as "a mark of disgrace" (Pearsall, 2001 p

1826). In Estonian the word is 'häbiplekk' which is made up of the word 'plekk' meaning 'mark' (or 'stain') and 'häbi' which means shame (Kiik et al., 2002 pp 521 and 626). It would therefore appear that the Estonian and English versions of the word have similar meanings.

The key informant interview guide was shorter than the focus group discussion guide (see Appendix 6 for example). One reason for this was that there were more topics on the focus group discussion guide in order to allow for the possibly wider range of experience that could be found in a group. In contrast the key informant guide was tailored to the individual and his or her experience or area of expertise so that the list of topics was necessarily shorter, but allowed for more in-depth exploration of the most relevant topics. Furthermore, as key informants were interviewed with reference to their professional capacities (and often in their workplaces) it was felt that the discussion should be concise and limited to topics considered to be most relevant to that individual. Questions were open ended and the interview style adopted was loosely structured. Although core topics or questions appeared on the interview guide key informants were encouraged to raise topics as they saw fit. In addition, as with the focus groups, the sweeping up questions "Is there anything else you think I should have asked about? Anything else you would like to add?" was posed at the end of the interview in order to allow the informant to fill any gaps that he or she felt remained by that point. In common with the focus group discussions this question proved to be fruitful in a number of instances.

Interviews were not recorded. Instead answers were noted on a copy of the interview guide, with the exact words of the informant noted wherever possible. The decision not to record was made with the view that informants would be more relaxed in the absence of recording equipment, especially since many informants were state employees. Only one informant asked to see the transcription of notes after the interview to ascertain that it was a fair record of the discussion.

Interviewees were informed in advance of the types of topics and questions that would be involved. This information was reiterated at the beginning of the interview. Each interviewee was also informed that transcripts would be anonymised, although profession or rôle would be indicated where relevant if permission to do so was granted. The interviewees were reminded that they could abstain from answering any question and that they could terminate the interview at any time, and for any, or no, stated reason.

Analysis of key informant interview data

Notes taken in the field were transcribed immediately. The short time-to-transcription was considered important as there were no recordings to back up notes. Transcripts were then loaded into Atlas ti. Text segments were coded according to a coding scheme which arose from respondents' words as well as from a framework based on the questions on the interview guides. All transcripts were read thoroughly and read again. Key themes which emerged from the transcripts were:

- Sex Education and Information
- Family Planning Services and Contraception
- Abortion
- Sexually Transmitted Infections
- The Importance of Ethnicity
- Pronatalism and 'the Nation'
- Independence and Change Issues
- Key Informants' Views on What Should Be Done

As with focus group transcripts, the interview transcripts were coded and searches performed. The results of these searches form the basis of the findings discussed in chapter 6.

Strengths and limitations of key informant interviews

One of the main limitations of the key informant interview approach is that these interviews are susceptible to informant bias (Kumar, 1989). Informants are essentially volunteers. This could mean that those who choose to take

part are systematically different to those who do not, with the risk that responses to questions could be biased. In addition, the characteristics of the first informants contacted, those from whom the snowball originated, can result in a group of 'snowballed' informants who share characteristics or, as Arber (2004 p63) suggests, the sample "only includes those within a connected network of individuals."

Informants in Estonia volunteered their knowledge and gave generously of their time and this may mean that they were a select and altruistic group and not representative of all local experts. The result of this could be that responses were biased, and biased in an unknown, unanticipated way. In addition, the characteristics of the first informants might be shared by those whose names they put forward for the next round of interviews. For this reason, snowballing was commenced from a number of original sources, rather than just one, in order to generate a more diverse group of informants from more than one network. Furthermore, some contacts were approached independently, via the internet for example.

Furthermore, the characteristics (gender, age etc) and behaviour of the interviewer could influence the responses of the informants. In addition, respondents may feel obliged to answer in a politely worded rather than strictly truthful way resulting in what is often called 'courtesy bias' (Williams et al., 2000)

The characteristics of the interviewer (female, foreign) could have influenced the responses of the informants. In a bid to prevent this, full information was given at the outset before each interview and local references were offered to establish legitimacy. Although courtesy bias was a possibility, the equal or higher status of the respondents in relation to that of the interviewer should have reduced the likelihood of this.

Just as important is the fact that the researcher/interviewer, whilst striving to remain neutral and objective, can never truly be so (Peacock, 1986). The influence of the researcher can be manifest in the 'agenda setting' activity of

designing the interview guide and that of the interviewer can occur through the way in which questions are posed, the vocabulary used, body language or through the way in which probes and prompts are used or answers from respondents drawn out or cut short.

The researcher/interviewer strived to remain neutral and non-judgmental throughout the interview process and respondents were encouraged to make full and frank comments. In order to allow them to escape from the confines of the interview guide, respondents were urged to comment on the questions and put forward their own ideas. Each interview ended with a question designed to give respondents the opportunity to fill in any gaps they could identify or to suggest questions that should have been asked or topics that should have been covered.

Language and, more importantly, understanding were important issues. Although all key informants agreed to be interviewed in English and appeared happy to do this, there may have been misunderstandings that were not noted and therefore not clarified. However, respondents were encouraged to ask for further explanation at any time and respondents were asked to clarify and confirm responses wherever there was doubt about meaning. The fact that there were sometimes lengthy and involved discussions (with most respondents) concerning the meaning and application of the term 'stigma' seems to suggest that respondents were happy to seek clarification.

In terms of strengths, the key informants interviewed came from a wide range of backgrounds and had the requisite knowledge and experience to make valuable contributions to the pool of data. An example of this is the way in which informants explained the organisation and functions of state institutions and healthcare provision. Key informants appeared to be honest enough to explain 'what should be' compared to what is often found in reality. Key informant interviews also allowed the researcher to make contacts and links for the future. This was to prove invaluable later in validating the findings of focus group discussions.

There was a certain disadvantage to the timing of the qualitative data collection. These data were collected approximately ten years after the EFFS, so that the two sets of results could not be seen as two sides of the same coin as might have been the case had the two approaches been designed to complement each other and implemented simultaneously. The qualitative findings cannot therefore be seen as explaining the findings of the quantitative analysis of EFFS data. Rather, the quantitative findings are seen as providing an essential background, historical and contextual basis for understanding the qualitative findings.

Evaluating qualitative research

Having conducted an investigation it is considered important to reflect upon the quality of the process and the findings, and how useful the research might be to others. Below, the issues of validity, reliability and generalisability are discussed, followed by a brief consideration of the rôle of the researcher in the pursuit of qualitative data.

Validity, reliability and generalisability in relation to qualitative research

Validity is concerned with the question "Are we investigating what we think we are?" (Lewis and Ritchie, 2003). In terms of qualitative data collection, this would include issues such as the wording of questions and the appropriate use of probing to confirm shared understanding of responses. In order to ensure validity a number of steps were taken. The first is what Lincoln and Guba (1985 p 301) call "prolonged engagement." This involved living in Estonia for over four months in total (with an Estonian family), becoming familiar with the material circumstances of the lives of the people and with the cultures represented in that society. The second strategy was to spend time building trust with local assistants, key informants and focus group participants to establish legitimacy. The purpose of this was to encourage candid responses and to engender patience in the face of constant questioning and checking on the part of the researcher. A third strategy was to discuss the process and progress of the research with colleagues, in England,

Estonia and Finland in order to ensure that both process and progress were generally consistent with others' experiences (Erlandson et al., 1993).

The concept of reliability is not entirely compatible with qualitative research. In quantitative data collection reliability is equated with replicability – the same results should be obtained if the same methods and instruments are used. When adopting a qualitative approach, the very flexibility of the approach is one of its strengths. As long as the 'pathway' through the research process is made clear, Lincoln and Guba (1985) suggest that being flexible is a sign of *dependable*, if not replicable, research. As discussed above, the research instruments used in Estonia for both focus groups and key informant interviews were modified to accommodate the ideas and priorities of respondents to ensure that the data collected were dependable and relevant.

The generalisation of qualitative data is a contested issue. Purists would argue that only data generated by statistically sound sampling procedures and the consistent use of research instruments can yield generalisable results. Others argue that qualitative results can be generalised, if not in the statistical sense to provide conclusions, but in the process of developing hypotheses (Lewis, 2003). No claims of generalisability are made for the results of focus groups and key informant interviews in Estonia. However, the results may be 'transferable' to other settings. The objective has been to provide detailed information about the context in Estonia and about the way in which data were collected so that the reader can assess the degree to which results may be transferred to other settings (Lincoln and Guba, 1985).

Reflexivity

It is the responsibility of the researcher to investigate thoroughly the subject of research and the setting. However, there is then a danger of thinking that one has become an 'expert' without truly comprehending. To help to minimise this risk advice and information were gathered from a wide variety of sources in every possible setting and throughout (and after) the data collection period. The rôle of the researcher was seen as being someone close enough, and knowledgeable enough, to grasp what was relevant and to be able to identify

the questions worth asking, but someone far enough outside the context to challenge the assumptions that an intimate might not recognise.

One of the primary aims of scientific research is objectivity. It is argued, however, that no researcher can be truly objective (Bryman, 1988). In *quantitative* research the investigator sets the research agenda and designs the research instruments and in this way influences how data are collected and what data are collected. This can mean that the results are biased towards what the researcher thinks are the priorities. Conducting *qualitative* research tests the investigator's objectivity further, especially when, as in this case, the investigator is also the moderator and interviewer. The face-to-face interaction obliterates distance and exposes the researcher in a way that is less likely to happen during the administration of a survey. Every attempt was made by the researcher to remain objective, but sympathetic. There were occasions when this became difficult. An example was when, during a focus group discussion, a male informant stated that abortions were not important and that he had told his partner that there would be no babies in the house or she would have to leave. Following this comment the moderator and interpreter remained impassive as had previously been agreed. However, the contrast between this impassivity and the encouraging responses made to other participants must have been stark.

It is important to reflect on the emotions engendered by qualitative methods and especially the intensity of focus group discussions. Participants can find the experience emotionally taxing but the moderator does not remain untouched. Feelings of anger arose on a number of occasions – anger with the previous regime for example, as people recounted the circumstances in which they lived. There was also a sense of guilt, that we, in the West, had experienced a higher standard of living. There was guilt too for not being able to reciprocate, being in Estonia as a researcher, but one who could not promise to make a difference to people's lives. Related to this was a sense of powerlessness in bringing about real change in a situation where there is so much to be done.

Conclusions

Although much social research takes place within either the positivist or the interpretivist camp, it is possible to take a pragmatic stance and apply either or both approaches to ensure that the research questions are answered in the best possible ways. Whilst survey data and official statistics provide valuable information concerning trends and patterns of contraception and abortion, qualitative research was conducted to generate rich data and to allow respondents to play the roles of actors rather than just the subjects, or objects, of research.

The focus group approach was adopted in order to gather information at the social rather than individual level and to discover what meanings participants attach to choices, decisions and actions in the realm of reproduction and how these meanings are negotiated in a group situation.

Participants of both genders, the two main ethnic groups, and a variety of ages were recruited in key locations throughout Estonia. There were difficulties in recruiting males, especially Russian males. Focus group discussions were conducted, sometimes with the assistance of interpreters. In spite of the reluctance of males the discussions that did take place generated a considerable amount of rich data, which was then transcribed and analysed.

The focus of this chapter has been qualitative methodology, both theoretical an applied. The focus group approach was deemed to be the most appropriate way of hearing the views of people in Estonia. Question guides were developed and focus groups convened. What did people say? The following chapter will be devoted to the findings which were the result of the focus group discussions and key informant interviews conducted in Estonia.

Key Points

- The best way to conduct social research has been a contested issue, with proponents of the two main camps, positivism and interpretivism, engaged in "sporadic warfare"
- However, pragmatic approaches can be adopted, by choosing the best method for the job or combining methods
- Qualitative methods were felt to be the best method for obtaining the rich data required to answer the research questions, set against analyses of survey data and official statistics to provide the context of patterns and trends of abortion and contraception
- Focus Group Discussions were selected as the best way in which to obtain information about social norms pertaining to fertility control
- Discussions included women and men, Estonians and Russians, and different age groups in a variety of locations within Estonia
- Key Informant Interviews were also conducted with respondents from a variety of professional backgrounds
- Key Informants were found to be crucially important sources

Chapter 6 – Findings from qualitative research

We have seen in chapter 3 that, although abortion rates remain high in comparison to Western Europe, abortion plays a much smaller rôle in fertility limitation in Estonia today than in the past. Throughout the 'transition' period Estonia has been emerging from the yoke of the Soviet system. However, little is known, at least outside Estonia, concerning the relevance of the Soviet model and 'abortion culture' today. Has sex education in schools improved? Is information available to the general public? If modern methods of contraception are available, have attitudes changed and can people access these methods? If people were comfortable with the use of abortion for fertility control, why have abortion rates fallen? Are people in Estonia content with the situation regarding reproductive health or could they suggest ways in which further improvements could be made?

In view of the paucity of this type of information key informant interviews and focus group discussions were conducted in various locations in Estonia during 2003. Estonians and Russians (who make up 26% of the population), both men and women, were invited to participate in focus group discussions. Key informant interviews were conducted in advance of focus group discussions and continued during the time period during which focus groups were being convened. Key informants were approached in order to gain a different perspective on reproductive health issues in Estonia, different that is to the researcher perspective and different to the perspective of focus group participants. They were also consulted in order to illuminate the particular issues that might concern policy makers and those charged with implementing policy or providing services.

Results suggest that the move to independence has been a painful experience for some inhabitants of Estonia. Young adults express wariness of having children when they feel insecure about the future, especially in terms of employment opportunities and living costs. Although the provision of sex education has improved drastically, some young people have missed out,

sometimes because of non-attendance at school. Attitudes to contraception are positive, but fears concerning the safety of hormonal methods remain. The cost of modern and effective contraceptives may serve as a barrier to some potential users. Views concerning abortion remain liberal, but abortion is not treated lightly. Respondents speak not of choosing abortion, but *resorting* to it. Respondents are aware of the situation pertaining to sexually transmitted infections, especially the issue of HIV, and are well-informed about risk factors and methods of prevention.

Having first hand knowledge of life in Estonia, respondents, both focus group participants and key informants, make a number of pertinent suggestions concerning how reproductive health in Estonia might be improved. These range from 'micro' issues such as enabling parents to teach their children about sex and risky behaviour, to structural matters such as reducing unemployment.

Findings

Where parts of transcripts are used for illustration please note that 'R' represents a respondent, 'G' represents the moderator and 'I' represents any comment by the interpreter.

Context of respondents' lives

The first question put to focus group participants, concerning people's main concerns and difficulties, was intended to be a 'warming up' question – something that respondents from a wide variety of backgrounds would be able to comment on. It was also intended to be brief and general but actually led to some lengthy and involved discussions. These discussions illuminated the contexts of people's lives, the context within which people live, relate to each other and make important decisions. This context is also relevant in terms of reproductive health and therefore formed an important part of focus group discussions.

Perhaps not surprisingly given Estonia's status as a newly independent state, many respondents raised issues concerned with recent and on-going change and made comparisons between the present and the Soviet era. Although feelings of insecurity, worries about economic stability and concerns about the future were raised in all groups, it was clear that these anxieties were more acute in the Russian groups, especially those in the economically depressed north-east town of Narva[39].

Worries about money abounded as did those concerning jobs, careers and unemployment[40]. Closely linked to the issue of money was the perceived cost of having children. Respondents were not so much concerned about the immediate costs associated with having a baby, but with the long-term financial implications. One respondent linked these issues to abortion.

> R: ...it isn't a problem to give birth to a child, the problem is to raise them. Financial problem, job .... The cost of education - a good education is the most important thing for a child.
> (Russian Women 25-35 Narva)

> R: And it is closely related to the issue of abortion I think when just....women feel that they can't secure their children, their future, their education, well it comes to just this drastical solution then....you can't account on your man and.....it's the natural way and I think in the animal world the same ...
> (Estonian Women age 45-60 Tallinn)

A number of respondents also stated that childbearing has a considerable opportunity cost for women and that employers actively discourage motherhood.

> R Something that .... I remembered, when we said we don't have enough money and we won't get hired later if we have small children

[39] See map of unemployment rates on p 33 – Narva is located in the northeast county of Ida-Viruma, which has the highest unemployment rate in the country
[40] Fears of unemployment are well founded – see discussion in chapter 2 and figures 2.4, 2.5 and 2.6

G Yes…
R Then the thing is that a young woman like aged 18-30 if you go for a job interview many of the employers ask 'are you planning children in your future?'
G Do they?
R They do
R There are some
R They do, but it's completely unprofessional but they do.
G Are they allowed to ask that question?
R No, actually, it's not allowed but they still do
R They still do, there is no control - how can you prove, where are you going to go, to say they asked me these questions
R If you say no, I'm not going to answer this question they say OK there's the door and they will call the next person
R I know a company, that one of my friends worked there, that they have this contract that the women who work there are not allowed to have children in five years….I don't know what will happen if some of them have children, I don't know, I didn't ask her ….probably get fired, but they have a contract - you are not allowed to have children in the first five years you work in this company. I think this is absurd
(Estonian Female Students age 18-25 Tallinn)

In view of the problems raised by focus group respondents concerning questions asked of women (about intentions to have children) at interview by prospective employers, a question about this topic was posed to both informants from the Ministry for Population Affairs. One stated that prospective employers were not supposed to ask such questions about the personal life of the interviewee, but indicated that it was not a major problem stating that "It may happen, but it is not common". The other informant explained that her department was endeavouring to convince the Chamber of Commerce and Industry (employers' organisation) that there were benefits to employing 'family people' and that contented employees were better workers, bringing benefits to businesses. She added that the advice to employers was that such questions (for example, "When are you planning to start a family?") should not be asked. However, she explained that there is no explicit legislation relevant to this aspect of equal opportunities, at least none backed up by recourse to an ombudsman, so that it was difficult to impose sanctions on employers who discriminate against young women.

Students expressed concerns about the pressure to go to University. Once there, most students have to take on paid work in addition to academic study, especially those whose families do not live close by. Students explained that paid work often impinged upon study time and academic work suffered in consequence. Older students with children effectively had three 'jobs' – paid work, academic work and work in the home.

Students were also anxious about the future and the 'next step' after finishing University – finding a job that pays enough to establish a home and family. Older respondents also spoke of concerns about jobs and money, explaining that a family could not manage on a single salary and that it was very difficult for young people to afford a home. Again, Russian respondents expressed concerns about unemployment, low wages, and the vulnerability of working in the private sector rather than for the state[41].

> R Now you need 2 salaries, this is necessary for the normal life. If one is unemployed you can't manage. The average salary in Estonia is 6000/6500 EEK, in Narva it is 2000 EEK. And there is very little employment in the public sector, only in the private sector. Apartments are so expensive. Employers don't pay us what we should get because of our educational level, but if we ask for more, they just say OK, I'll take someone else. Why am I worth so little?
> R Many people in Narva have a high level of education (but there are) not enough job opportunities in Narva. If in Narva if you have small salary, well you took the job at that salary even if it is low. High levels of unemployment forces wages down. This is the situation in the private sector.
> (Russian Women age 25-35 Narva)

A number of respondents were clearly apprehensive about the future and some specifically mentioned concerns about the impact of European Union membership[42].

[41] See Chapter 2 – state enterprises were dismantled following the collapse of the Soviet Union
[42] Estonia's referendum (with a majority 'yes' vote) had occurred within a few weeks before the focus group discussions were conducted

Russian respondents had particular concerns about language, nationality and citizenship. Since independence Estonian has become the official language, yet many residents of the country do not speak Estonian, nor do they have citizenship[43]. Yet command of the Estonian language has become increasingly important in securing employment. In addition, there are some tensions between the Estonian and Russian-speaking communities.

> Normal people, Estonian and Russian, get on fine, but politicians make nationality an issue, especially if they are trying to be elected....(they) use this issue as a vehicle. In Narva it is difficult in a Russian speaking family to teach the children the Estonian language - the parents don't use the language. If their children want to get on they must learn to speak Estonian. Some families where the children go to Estonian schools then have problems when they are teenagers - the Russian children don't want the Estonian children to know that they are from Russian families. My son went to an Estonian kindergarten and the result was that he didn't know Estonian and he didn't know Russian well. That is the point. There isn't a common language any more. Estonians and Russians understand things differently. In the south Estonian people are more polite with Russians, but in the north, Russian people feel that there is more distance.
> (Russian Women age 25-35 Narva)

A number of key informants also mentioned issues associated with ethnicity, nationality and language. A gynaecologist described the social disadvantages of many immigrants, for example the loss of social connections and separation from friends and family. A doctor explained that many immigrants are suffering from an 'identity crisis' because they are, for example, no longer Russian but they are not Estonians either.

A civil servant (Population Affairs) explained that part of the remit of the Minister for Population Affairs was to promote the integration of non-Estonians in the population. The 'problem' areas for integration were identified as the capital, Tallinn, and the northeast (Ida Virumaa). This respondent stated that Russians resident in Estonia now wanted Estonian citizenship because it

[43] For example in the North East our Russian interpreter estimated that less than 5% of the population would be proficient in the Estonian language. Many 'Russians' were born in Estonia, but in order to obtain *citizenship* they must pass a language and citizenship examination.

would give them access to the European Union (EU). However non Estonians are required to pass language and citizenship tests to gain citizenship. Russian 'immigrants' do not think they should have to take these tests believing that citizenship should be an entitlement, especially for those born in Estonia.

A medical social worker talked of the contrasts in experience since independence between those with and those without social capital. She stated that the bulk of her work involved Russian speaking clients. She went on to explain that many of these people have no passports, no citizenship, no housing. Many of the fourteen and fifteen year olds do not attend school and those who do attend are disaffected and feel excluded as they do not have the right clothes or CDs and furthermore they have no money to buy these things. In their homes little value is placed on education and many suffer from drug addiction.

Another key informant (prison service) also spoke of disaffected youth from 'problem' families where parental support is lacking. She echoed the concern about addiction and the crime problems created when poor young people turn to crime to fund their drug needs. This has led to the imprisonment of young people. It is worth noting that Russian speaking people are over represented in the prison population.

Having a family and saving the nation

Human reproduction can be seen in a number of ways. Individuals have children thereby creating new families or adding to existing families (intentionally or not). Relatives and elders or community members may see childbearing as a duty for married adults. This duty may be extended to 'the nation' or the state, especially where the existence of that institution is fragile or threatened. This fragility may be the result of population losses through war or out migration, or through low fertility rates. It might also be linked to the perception of being a small nation within a vast group of nations. This has been the experience of the Estonian national group as part of the Russian Empire, the Soviet Union, and now the European Union.

Focus group respondents were asked questions about family formation, but not about fertility rates or pronatalism. Even so, they demonstrated awareness of the issue of low fertility. Some key informants were asked about efforts to increase fertility rates and explained the need for pronatalist policies and attitudes in terms of saving the nation.

The importance of having a family

In response to the question 'Is it important to have children?' focus group participants (both Russian and Estonian) indicated that having children was considered very important in their society. Some respondents also interpreted the question at an individual level and these responses were virtually all positive.

> G: Is it important to have children?
> R: Yes, definitely – what else is the point of life?
> (Estonian Women age 30-45 Happsalu)
>
> G: Is it important to have children?
> R: ...for women it is the most important thing. It is your biological programme to reproduce.
> (Russian Women age 25-35 Narva)
>
> R:..it is so obvious you don't even think about it.
> R: People value their careers and education but at a certain age you think "what is the purpose of living if you don't have children?"
> (Estonian Women age 30-45 Viljandi)

One respondent remarked that it was important to have a family, but one child is often seen as enough to satisfy this need. Only two respondents, one male and one female, declared the wish to remain childless.

Family size

In discussing average family size, respondents commented that nowadays it was one or two children, but that families had been bigger in the recent past and still tended to be bigger in rural communities. Showing an awareness of current preoccupations with fertility in the public sphere, many respondents

referred to the average family size in terms of the total fertility rate (1.7 or similar, which is quite close to the official statistic for that year of 1.5 – see page 23). With respect to ethnic fertility differentials, some respondents thought that Estonian families were smaller than Russian families, some thought they were bigger but most indicated that family sizes were similar in the two main ethnic groups. One respondent (male 30-45) stated that Russian families were smaller, but that this was related to place of residence (that the majority of Russians lived in urban areas) rather than ethnicity.

The stated 'ideal' size for a family was consistently bigger than actual family size, with respondents discussing the difficulties in securing employment and affording a home suitable for a family as factors influencing the difference between 'ideal' and achieved family size.

Best time to have a family

In response to the question concerning the 'best time' to have a family, participants talked about age but also about 'being ready' and having a home and partner. It was interesting to note that respondents discussed the fact that young people were delaying childbearing but that delaying sometimes meant waiting until the age of 25 for example, rather than the 'delayed' age of 30-35 that might be mentioned in many Western European countries. Another respondent thought that women were either delaying *or* having babies while they were still at school, the latter being 'very stupid'. (Russian Women age 30-45 Narva)

Fertility rates

A number of focus group participants spontaneously raised the issue of low fertility rates and the population of the Estonian nation, population decrease, and population ageing. Key informants raised these points in reply to the question: "When fertility rates are so low how much commitment is there on the part of government to support contraceptive services?" or "Is there a tension between promoting the birth rate whilst also supporting family planning?" No key informant stated a personally held belief that there was a

tension between these two goals, all thought that the birth rate and family planning must be seen as separate issues.

> "They (government) support (family planning) even though low fertility is acknowledged. The individual woman has to decide. Times are hard, in a way harder, before at least there was stability. Women want education, jobs. Men don't stay around for too long. Two wages are still essential in a family."

Others questioned the commitment of the government on the grounds that policy had recently changed so that the subsidy on the contraceptive pill was reduced, making it more expensive for pupils and students. One key informant stated that the Social Minister at the time had suggested that young people buy condoms and have less sex if the charges for the pill were too high.

A gynaecologist stated that reproductive health services should be supported as they can promote better general health and ensure that 'better babies' are born to healthier parents at a time when they are ready for children. She remarked that some people argued that funding should go towards in vitro fertilisation instead of family planning and there had also been a discussion in government about how to encourage women under the age of twenty four to have children. However, she added "it is not the solution".

Two informants remarked that although the government funded family planning services (one cited the funding for five years of youth clinics run by the Family Planning Association), some members of the government linked family planning with low fertility rates. One informant stated that the Family Planning Association was considered "the enemy of the nation". Another said:

> "There is always someone in government who will complain – "you people (family planning providers) are to blame for the low birth rate in Estonia""

Asked about the rôle of the Population Affairs Department an informant (Population Affairs) indicated that one of the rôles was to identify population problems – "for example to increase the population and reduce abortions".

This was the only occasion on which *any* informant mentioned these two issues in the same sentence.

An informant (Population Affairs) explained that as there are now less than one million Estonians there was a need to take steps to maintain the ethnic group, the language and Estonian culture. This informant stated that biggest problem identified by the new government was that of population decline and that this decline put into question the viability of the nation.

Informants (Population Affairs) detailed recent government initiatives such as increased parental benefit and financial assistance for student mothers, which are both designed to increase the birth rate. Another proposal had been to fund in vitro fertilisation (IVF) for infertile couples because children born to these couples would be "100% wanted", whereas those born as a result of parental benefit might not be valued.

Sex education

In view of the generally accepted premise that sex education will have a positive impact on reproductive health it was considered important to ask respondents about how and when they received this type of information and whether they felt that they had received enough information. Key informants also raised the matter of education and information in relation to reproductive health issues.

Sources of information

The most common sources of information mentioned by older participants were books. One book in particular, called 'Openly About Marriage'[44], was mentioned spontaneously by four out of five older Estonian female groups and both groups of Estonian female student groups. In some cases women had been given a book by their mothers or the book had been 'left out' for them to find. In many cases books had been kept hidden by parents, but unearthed by their curious children.

[44] This book had been translated into Estonian from Finnish in the 1970s

R: My mother left the same book openly on the shelf, before that it was somewhere, I don't know, behind the other books…
Laughter
R…but then she put it openly on the shelf, but we never talked about sex and until now I have never talked about sex with my mother
(Estonian Women 45-60 Tallinn)

G OK then and did you get these books at school or at home?
R At home
R At home
R Our parents hid them away from us and so we were trying to find them - we knew they were somewhere!
R Oh, on the top shelf behind all the other books
(Estonian Women 30-45 Tallinn)

Amongst older Estonian women school based sex education was rarely a source of information; when it had been provided the topics concentrated on hygiene and biomedical information. The younger the women, the more likely were classes at school, so that students most frequently gave this as a source of information. Even then, many young people were disparaging about school sex education, citing reasons such as the focus on biomedical facts and hygiene, though there were also examples of good practice.

R No, I had really good teachers both at basic school and at the high school. The teacher at high school also wrote a book about the same subject and this is now taught about - this book. … …..teachers use this book now, nowadays.
G So, a teachers' handbook?
R Yes
(Estonian Female Students 18-25 Tallinn)

A number of students explained that their schools had not delivered sex education, but had organised a visit to the women's clinic or the youth clinic, where medical staff made presentations, answered questions and gave students a tour of the clinic.

R We were 10th or 11th grade and our class teacher she said we were visiting … I don't know…this women's advice centre? We went there and we didn't talk about anything we haven't already heard. Only they had the fake penis - we hadn't seen that before.
G You got to put the condom on?
R The woman showed us, the only good thing about that was you know the place exists, you know the people there so next time if you had questions you could go there - I think that was the point of that
G That's good
R But it was only in the 10th or 11th grade - then you already get the information from your friends …
G So by the time you went to this women's clinic you were already about 15, 16?
R Yes, 16,17
(Estonian Female Students 18-25 Tallinn)

Others had visits from a gynaecologist. One student raised the issue of a visit from a company representative promoting sanitary towels whilst making a presentation. More worryingly, an older respondent stated that representatives of drug companies who manufacture oral contraceptives had visited her daughter's school.

Key informants indicated that sex education now takes place in schools (as part of 'human education'), but that quality, extent and content may vary. A gynaecologist stated that sex education is "better and sooner" (than it used to be), but added that not all teachers are comfortable teaching this topic. One respondent pointed out that in the past sex education was two lessons – hygiene and biology, with some teaching concerning sexually transmitted infections, whereas today there are more lessons and teachers are being trained to teach the subject. Training of teachers and of trainers is taking place with the assistance of the Swedish Association for Sexual Education (Ministry of Education informant). However, one respondent (sexual health clinic) stated that the time allotted to sex education was very much at the discretion of the head teacher. Another informant (Ministry of Education) explained that sex education in schools was not mandatory and "we don't have the power to pressure".

A teacher explained that Human Education is taught from Grade 1 to Grade 7 (approximately 7 to 14 years of age), and at the gymnasium (high school) from grades 10 to 12 (approximately 17 to 19 years of age). When asked about the missing years from 14 to 17 she explained that these years were devoted to citizenship education as pupils must pass an important citizenship exam at the end of 1st school. She went on to explain that although the trend was for most pupils to go on to the gymnasium, not all do. In consequence, some young people leave school having had their last sex education lessons at the age of fourteen.

In discussion about sex education lessons in prisons, an informant explained that many young prisoners had no sex education at school because they failed to attend school. She added that "no one knows how many children (fail to attend)" now, whereas during the Soviet period it was thought to be a small number as punishments for non-attendance were draconian. This informant spoke of the importance of seizing the opportunity while young people were in prison to inform them. They are interested and ask questions about HIV as well as other topics such as family planning and sexuality.

Younger respondents were more likely than older respondents to mention parents as sources of information, although many stated that the topic was taboo at home. The mother (or in two cases the grandmother, and in one case the aunt) was the 'parent' who discussed sexual issues. In no case was a father mentioned in this role[45]. In two cases someone else's mother had been the source of information, one of these was a gynaecologist.

Key informants did not see parents in a particularly positive light in terms of sources of information. Informants suggested that parents themselves lacked knowledge and either did not wish to discuss issues concerning sex with their children or did not know how to approach such a topic. It was also pointed out that young people may be no more comfortable discussing sex with their parents than parents were in discussing sex with their children. One informant

[45] Fathers were not mentioned by male respondents either although some had received information from mothers.

(sexual health clinic) explained that parents had not yet 'mobilised' in terms of sex education and that it was not necessary to seek parental permission to teach sex education in schools. However, she also pointed out that parents' lack of experience may mean that they will be "open to suggestion" and may be more receptive to the abstinence lobby rather than one promoting education and information.

Key informants suggested youth clinics, gynaecologists and doctors as reliable sources of information. One key informant mentioned two peer education programmes, one supported by the Family Planning Association and UNESCO, the other run by the Junior Red Cross.

Whilst younger respondents spoke of access to media (such as television, video, internet, magazines and newspapers) as sources of information, older respondents either had no access or, during the Soviet period, topics concerning sex were omitted or heavily censored. A number of older respondents recounted an occasion in the late 1970s when it was discovered that the film Emmanuelle would be screened on Finnish television, whose signal could be received in Northern Estonia:

> Finnish TV in northern Estonia showed Emmanuelle in late 70s and the whole of the north stayed home to watch, Tallinn was like a ghost town and everyone in the south went north to see it too!
> (Estonian Women 30-45 Haapsalu)

A key informant explained that The Family Planning Association run an email and website question and answer service where young people email questions in and the questions and appropriate answers are posted on the website.

There were differences in the reported sources for Russians in comparison to Estonians. In the two Russian groups of older women a book was mentioned in the younger of the two groups and by only one woman. Only novels, not

reference books, were mentioned by Russian female students.[46] For all three Russian female groups informal sources were much more prevalent, for example 'on the street', 'from friends', 'overhearing adults'. Parents were rarely referred to as sources of information. School was a source of information for the Russian students, although the subject matter focused on the biomedical. One Russian-speaking student, who had been educated in Israel, described a comprehensive sex education programme in her Israeli school, contrasting her experience with that of her peers in Estonia. In the Russian women's groups school was mentioned by one respondent and the first year of University by another. The older Russian women, who like their Estonian counterparts had grown up in Soviet times, recalled that they had had no access to videos, magazines or television for information.

> R (We) learned by trying.
> R We lived like forest people - know nothing, see nothing - isolated, no magazines, no TV programmes, no information.
> (Russian Women 30-45 Narva)

One respondent remarked that she was informing her own children as she thought the neglect of sex education in earlier times was wrong.

> R My children - I give them information - I bought some books, gave them to the children and later when they asked some questions I explained them, because I had this information in the 1st class from my girlfriend, not the right way and didn't want this for my children - not the right information at all.
> (Russian Women 25-35 Narva)

Another expressed concerns that the new access to media may not be entirely positive, mentioning children's access to pornographic information at the present time.

[46] 'Openly About Marriage' may not have been accessible - it is quite possible that it was not translated into Russian.

R In Soviet time no magazines, no pornography, now you can see this everywhere and can buy in kiosks. Children listen to information prepared by adults and it is vulgar and tasteless - crude.
(Russian Women 25-35 Narva)

There were also differences in response by gender. In the group of older Estonian men 'family education' at school was brought up by the youngest respondent although he stated that it was vague. This group had received most of their information from friends. Only the youngest respondent had had access to magazines or videos, although he explained that these were pornographic rather than educational.

In the two groups of male Estonian student respondents recounted some information via school, including one who mentioned regular visits to the school by a 'psychiatrist' who offered help with a variety of problems. Sex was discussed amongst friends, but this tended to be jokes rather than information. More of the young stated that they had accessed information from television and magazines, but not videos. The internet was not mentioned by any male respondent and none had used books, with the exception of one respondent who cited novels as a source of information.

Attitudes of those providing sex education

The attitudes of those providing sex education were generally described in negative terms. Parents tended to treat the topic of sex as a taboo and avoided becoming involved. Teachers were often embarrassed and got through the lesson as quickly as possible, without providing opportunities for pupils to ask questions. However, respondents acknowledged on many occasions that parents and teachers lacked knowledge themselves and did not know how to approach the subject with their children or pupils. Even some health professionals were reported as being uncomfortable with the topic of sex.

R: For me it is sort of a different case, my mother was....midwife and she had friends also the same profession. I remember that I was like 4

or 5 and they were drinking coffee and discussing about giving birth and breaking the waters and all the things that happen during childbearing and giving birth so I was at a very young age, I was very informed
G So you heard all these stories
R: Yeah and I informed other girls and boys in the school. laughing..... But it was only this one side I was very familiar with - babies and giving birth, but other topics my mother wasn't really so eager to talk about. She was embarrassed and I felt that.
(Estonian Women 25-35 Tallinn)

R: In Soviet times it was not common to talk about sex in families, not the proper thing - it was a taboo. Just for discussion between a man and a woman ... even doctors didn't like talking about sexual issues in Soviet times.
(Russian Women 25-35 Narva)

R it wasn't that there was any shame attached to it but they (parents) didn't know ... how to or what to say about it
(Estonian Women 45-60 Tallinn)

R The other thing is that maybe teachers think that they are not competent because they haven't had this education themselves and they don't know how to tell this
R Do you mean what or how?
R How to tell this. They probably think that we know everything already and it would be embarrassing and they wouldn't be comfortable
(Estonian Female Students 18-25 Tallinn)

A number of Estonian student participants, both male and female, recounted examples of teachers who had open attitudes and had made a good job of delivering sex education classes.

Quality and quantity of sex education

The vast majority of respondents felt that quality, quantity or both were lacking. This was especially true of older respondents. Explanations were often missing or were vague.

G: Was it good quality..... correct information?

R: Well....an example is explanation of onset of menses: "Your underwear is getting dirty"
(Estonian Women age 30-45 Happsalu)

R: we know only the biological cycle, but if we had known about other things maybe we would have different lives. Every year there is more and more information now
(Russian Women age 25-35 Narva)

An Estonian woman commented that it is only in retrospect that she had thought about the extent of information she received.

No, no we didn't. But then we didn't know to want more information. We didn't have much but didn't know to have more. But now I realise that I should have had more. But somehow we managed anyway! (laughing)
(Estonian Women age 30-45 Viljandi)

Others spoke of being misinformed by friends, pornographic videos or 'Hollywood films'. Many respondents felt that they had been given accurate information but that too much emphasis was placed on biomedical aspects and not enough on sexuality. Moreover there was little opportunity for discussion or questions. A number of respondents remarked that they had enough information eventually, having constructed their knowledge from a number of sources such as school, mother and the media.

G: So the information you did get, do you think it was good quality information?
R: No
R: It wasn't kind of a whole....
R: Yes
R: you got one piece here and one piece there...
R: you had to put the picture together yourself ...
R: ....so some things you heard were completely wrong.
(Estonian Male Students 18-25 Tallinn)

Two respondents, one Russian woman and one Estonian woman, expressed the opinion that school sex education now is too much, too explicit and too soon.

R: now the children are taught everything openly, but it is too much detail - "habi" (shame). They are too young to take in this information. They learn about condoms in the 5th class. Children use them on absolutely strange things - play with them - children put condoms on a cactus! You can tell them about all things, but you must use the right words and the right way and this is not done in these books for 5th class children. For 5th class children you should explain things, not give them book. It is important to understand what is right for the age group. Estonian people, when the girl is 12 years old they think she has an adult life - a sex life.
(Russian Women 25-35 Narva)

R Sometimes I think that the trouble nowadays is that they talk too much about it, they show too much about it and the consequences are that ah...
R There really isn't much to it
R ...yes, not much to it
G OK, so there are no mysteries left?
R Yes
Laughter
(Estonian Women 45-60 Tallinn)

A Russian woman and an Estonian woman remarked on the risk of misinformation due to young people's access to pornographic media since independence.

A young Estonian woman (23) was concerned that although sex education had been introduced into schools there was a chance that it was now being displaced by drugs awareness, indicating the competition between health promotion topics.

Although male respondents, both student and older, reported receiving less information[47] than did women, males were no less likely to report being satisfied with the amount and quality of their sex education. However, like the women, most men felt they should have had more information, while some younger men felt they had had sufficient.

[47] Sex education used to be segregated so that boys missed lessons on menstruation, hygiene, pregnancy and birth.There is now a tendency towards mixed lessons. No men reported reading 'Open About Marriage'.

Timing of sex education

Where the question was answered, respondents almost universally said that they should have received information earlier. A number of Estonian women gave the example of starting menstruation without having had any preparation. Although students tended to report better and earlier sex education programmes, some did not experience this until the age of 16 to 18.

> R On the eighth grade, the whole knowledge about it... not practical obviously..
> Laughter.... We were at school then...laughter
> G How old were you? 14 or 15 by then?
> R Yes
> R I got some theoretical opinion in my secondary school time... there were some classes on family education or something like that
> G Yes....how old would you have been then?
> R 17....18 about
> (Estonian Men 30-45 Viljandi)

Two women, one Estonian and one Russian, remarked that the best sex education they received was at university[48].

Then and now

Two focus groups explicitly discussed how times had changed, with respondents remarking upon the speed of change and erosion of the taboo around discussing sexual issues.

> R: It is good that we are different ages, (I learned) when I was 20, it was a taboo before! No one talked about it, no literature. 'Talking About Marriage' was hidden in the closet, behind all the other books.
> R: We had it too and I just discovered it.
> G So when you said you were about 20, that nobody talked about it, did you say it was taboo?
> R: Yeah, yeah
> (Estonian Women 25-35 Tallinn)

[48] This is an interesting comment in view of the findings from quantitative analysis (see p79), indicating that abortion rates are lower amongst those with tertiary education. If sex education was standard practice at University, but not at school, this could help to explain the survey findings, if it is the case that sex education helps individuals to avoid abortion.

R: I think we can see that time changed so quickly - only a few years and the age and the situation is completely different.
(Estonian Women 25-35 Tallinn)

R: The people before us, I mean, older generations, that time they didn't tell them ... this kind of things at school at all, I mean sexual behaviour...this thing was...you .... just didn't talk about that. But in our generation people are understanding ... understood that it is an important thing but still it was... ...it wasn't really I think err, I mean people...., I mean teachers they felt a little uncomfortable...

R: But I think that thing is changing, that now a new generation is coming they're absolutely ..... with different thinking than we are....
R: more informed than we are .....of diseases and stuff
G: So, they are getting lots more information, now, the younger ones?
R: I believe so....
R: It seems to me they are 10 times more open-minded than we were, I can be wrong of course...but for me it seems like
(Estonian Male Students age 18-25 Tallinn)

Although some respondents had positive reports about sex education, many, even amongst younger respondents, indicated that they received too little information, too late. Amongst parents the tendency was to avoid the subject. Although some teachers had positive attitudes, many were embarrassed to be teaching these topics.

Contraception

In view of the history of low use of modern contraceptives and high resort to abortion, it was thought important to ask focus group participants what they knew about contraceptives and contraceptive practices. Key informants were asked to comment on family planning services and contraception, both during the Soviet period, if they had knowledge of that time, and in the post-Soviet era. Informants discussed matters pertaining to access to family planning services and modern methods as well as the use of traditional methods. In addition informants were asked if they thought potential clients might experience any barriers to use of services or particular methods.

Contraceptive methods and most common methods

In answer to the question 'What types of contraceptive methods or contraceptive practices have you ever heard about?' focus group participants created comprehensive lists of both modern and traditional methods making it clear that lack of awareness is not an issue, at least for these adults. However it was interesting to note how much emphasis was placed on methods such as douching with lemon juice or aspirin solution or the use of pessaries and creams by women, especially older women. When asked about the most common methods used now pills and condoms were most often cited. There were exceptions, such as older women who stated that the most common method for their own age group was the intra-uterine device (IUD) or 'spiraal', at least for women who had borne children. In addition, a group of Russian women (age 25-35) stated that they preferred 'biological' methods.

> But it is important to know about the natural method - we use this - it is not a problem and that is how we avoid pregnancy. We only knew about the biological method when we were young. We were once shown some contraceptive, but not condom. Do you remember the cap? Didn't know what it was for. We still don't know (laughter).
> (Russian Women 25-35 Narva)

Asked about traditional methods, key informants indicated that these were still used, in particular the calendar method and withdrawal. However these methods were thought to be ineffective – "that's why we have so many abortions". One gynaecologist made an important point about the definition of contraception. She explained that when she asked a patient if she was using contraception she might say no, but on probing would answer that she used withdrawal, the calendar method or condoms, not defining these as contraception in the same way as the pill.

Access to contraception

All focus groups were provided information about how to access family planning services and different types of contraception. A key informant stated

that it would be unusual in urban areas for a woman to approach the family doctor for family planning purposes. Instead she would self-refer to the gynaecologist (and this is permitted in Estonia). Other key informants and focus group participants explained that for young people, up to the age of twenty-five, there are youth clinics, though only in certain urban areas. These clinics were always spoken of favourably, with respondents praising the staff for being 'youth-friendly' and non-judgemental. In rural areas family planning advice could be accessed by visiting the family doctor. The pill is only available on prescription and the intra uterine device from a gynaecologist. Emergency contraception (Postinor) is available at chemists. The condom was said to be available 'everywhere' - supermarkets, chemists, licensed kiosks - and has been distributed free-of-charge during health promotion campaigns.

Barriers

Cost

Problems in accessing contraception were not because methods were not available per se, rather that the costs, relative to resources, could be prohibitive. Female respondents complained about the cost of the pill and explained that it had become more expensive due to a recent reduction in government subsidies for the pill. Key informants too saw cost as a possible barrier. One respondent was of the opinion that costs were high in the context of Estonian earnings, particularly in rural areas where wages are lower than they are in the capital city, Tallinn. The cost of contraceptive pills is subsidised for pupils and students, but the subsidy has been reduced from the original 90% subsidy to a 50% subsidy, except for those women up to one year post partum or three months post abortion, who benefit from a 75% subsidy. One respondent pointed out that the price of the pill varied according to the brand or type prescribed so that the cost could be higher for one individual than for another.

An important point was made by one respondent concerning the relative costs of abortion and contraception – one year of pill use costs about the same as an abortion so she felt that some people would take the risk. The pill would

require a high level of commitment (remembering to take it each day) and would be a particularly expensive method for someone who is not in a relationship.

Asked whether the government would consider making contraception free, a civil servant (Social Ministry) replied that there was no proposal to do this and that it would be too costly to do so. Another key informant stated that the patient contribution helped to guarantee supplies, whereas elsewhere (citing Russia and the Asian republics), where the pill was free, supplies were erratic.

Young people

A number of respondents mentioned the particular difficulties of young people, not just in terms of cost but due to lack of confidence. Respondents indicated that although contraceptive pills were subsidised for students many young people were just too embarrassed to request the pill or buy condoms. This problem was thought to be particularly acute in rural areas:

> "In rural areas the youth clinic and even pharmacy may be far away. It may be difficult in a small village situation where you may be known...for example a small town where there is only one shop, a youth asking for condoms. His mother's friend is at the till!"

One respondent stated that there were not enough youth clinics, even in the capital, and that young people living in rural areas might have to travel some distance to access a youth facility. One of the male student groups raised the issue of access for the young in rural areas, recounting the story of young teenagers being denied access to the condom.

> G Where can you get these methods?
> R Well, I read from newspaper some time ago that there was case that there was in smaller parts of Estonia where there was not this kind of opportunity to get condoms from supermarkets, there was only one ...not hospital, but this ..... one pharmacy.
> There was a case that some ten years old couldn't get condoms there ... maybe twelve or thirteen years...but they couldn't buy it...
> G: They weren't being allowed to get condoms?
> R: It's quite strange...

R: it's strange they were not sold them but it is also strange why did they need it
(Estonian Male Students 18-25 Tallinn)

In terms of possible interventions, one key informant mentioned the problem of public attitudes to young people and their sexual lives. There had been an initiative to locate condom machines in high schools, but this had been ridiculed by a local Head Teacher who asked "When will they have time for sex in school – in Maths?" The same respondent spoke of the power needed to negotiate the purchase and use of contraceptives and the difficulties this presents for young people.

Quality of care

Quality of care was thought to be good and unlikely to be linked to barriers to contraception. One provider (polyclinic) stated that the opening times were from 8.00 to 19.00. One key informant indicated that, although emergencies would be seen on the same day, there could be a long wait for non-urgent appointments at clinics.

A number of focus group respondents reported that women might have to wait a long time to see a doctor or a gynaecologist. Students praised the youth clinic as they were able to get immediate access there to a doctor.

At youth clinic - it is fast and easy there. (You) can also go to family doctor or gynaecologist, but you have a long wait for appointment.
(Estonian Female Students 18-25 Tallinn)

R So if you know, if you want something emergency for example...ah and one more thing from Estonia that is not typical from other countries, if you want to go to the doctor, it's not like you are coming to the hospital or polyclinic and saying 'I want to go to the doctor', and you are going, no, we have to wait. It can be 2 weeks, it can be 3 weeks, it depends what kind of doctor. If it's very popular doctor - you can wait for 2 weeks to go to the gynaecolog(ist). If you have something emergency, maybe if you are going in the morning and saying 'I'm dying' ... (laughter)
(Russian Female Students 18-25 Tallinn)

Key informants reported that there was a range of modern methods available, the most common mentioned by informants were the contraceptive pill, the intra uterine device and the contraceptive injection. Whilst condoms used to be available in pharmacies only, this is no longer the case and condoms can be purchased in a variety of locations.

Respondents stated that emergency contraception was available on prescription from any doctor. Youth clinics can provide this free for young people, others must pay to fill the prescription at a pharmacy. One key informant mentioned that there have been discussions concerning the possibility of buying emergency contraception over the counter (without a prescription). However, concerns have been expressed that women will come to rely on this method instead of using preventive methods such as the pill.

Male needs

On the topic of male needs, respondents stated that men could access the same facilities as women, although men would visit an andrologist or urologist rather than a gynaecologist. It is important to note that no male focus group participant mentioned youth clinics although key informants stated that young men were as welcome as young women at youth clinics.

One (female) key informant was pessimistic about men and family planning:

> "Men – yes, but ….! They don't like vasectomy, they can use condoms but they don't like those either."

Permanent methods

Focus group participants and key informants were unanimous that sterilisation was not popular and that "both patients and doctors have big reservations" due to the finality of the procedure. A number of informants stated that sterilisation had, until recently, been illegal unless done for medical therapeutic reasons. It was explained that the law had been changed in 1998

to allow sterilisation but only for those with three children or those over 35 years of age. One month waiting time (to reconsider) is obligatory. Women for whom pregnancy would be a health risk are still permitted to have a sterilisation procedure. One respondent pointed out that men are particularly reluctant to consider vasectomy stating that "they might not feel so responsible for contraception because they don't get pregnant".

Doctors and patients/clients

An interesting point was made by two key informants. They expressed the opinion that there was a top down push for contraception; patients, especially in the early days of independence, were not clamouring for modern methods, rather gynaecologists and doctors were trying to convince them and the increase in uptake during the 1990s was supply rather than demand driven.

Another respondent remarked that not all doctors promoted contraception. In some areas such as Narva, where the population is mainly Russian, most of the doctors are also Russian. As they were trained in Moscow they might retain Soviet attitudes to the pill and the intrauterine device and might refrain from actively motivating patients to use modern methods.

Sources of information about contraception

The most common source of information especially for older people had been friends. It is interesting to note that two of the three male groups stated that men were informed by their partners. The student groups were more likely to report learning at school, although this was not the case for the Russian students, and was not unanimous amongst the male students. Parents were rarely a source of information. Doctors or gynaecologists were common sources, although one respondent remarked that during the Soviet period doctors would not give family planning advice until after the first birth and another reported that advice was not forthcoming until a woman had a baby or an abortion.

Media sources tended to be mentioned more by the students. Older respondents remarked that there were no such sources during the Soviet

period, but that now information was available in this way. Television, radio, newspapers, magazines, advertisements and brochures were listed. Surprisingly, given the high level of Internet access in Estonia, only one respondent (Russian female student) referred to the Internet as a source of information about contraception. A number of respondents of both sexes and all ages remarked that information is now 'everywhere'. One student mentioned health promotion campaigns but pointed out that the message concerned the prevention of infection not pregnancy.

A key informant explained that information and counselling could also be accessed at the Estonian Family Planning Association, which also has a website.

Attitudes to contraception

Attitudes to contraception were universally positive though respondents mentioned that some religious believers were not in favour. Respondents explained that the method used would depend on age, type of relationship, parity, and opinions or experience about side effects. The efficacy of methods was also thought to be important.

Disadvantages of methods

In discussions concerning advantages and disadvantages of different types of contraception older women expressed concerns about the safety of the pill for women's health or for that of their future children. Respondents in both of the male student groups also raised the issue of pill safety, as did Russian female students. A key informant remarked that not all doctors promoted modern contraception and therefore some women would not use it. In areas such as Narva, where the population is mainly Russian, most of the doctors are also Russian. As they were trained in Moscow some retain Soviet attitudes to the pill and the intrauterine device and might refrain from actively motivating patients to use these modern methods.

Although the condom as a possible method was put forward by all groups except one (Russian women 25-35), and condoms were considered to be one

of the most common methods used, attitudes to condom use were not always positive. Male respondents tended to report disliking condoms and women stated that men did not wish to use condoms. Objections centred on diminished male pleasure, though the need to purchase condoms in preparation and the risk of breaking were also seen as problematic. Other explanations were that clients thought that condoms were "harmful to the relationship", "spoil the moment" or indicated that one partner did not trust the other. In one group of Russian women the dislike of the condom, romance and a cavalier attitude to risk were combined in one quote:

> (Concerning condoms) Men hate them and the women don't like them either. Condoms are a bad method for Russian women - "If you love, you love, don't be afraid."
> (Russian Women 25-35 Narva)

The IUD too was thought to have disadvantages. Older women cited method failure, bleeding and having to visit the gynaecologist to have the IUD inserted. This method was seen by all as a method suitable only for women who have had a child.

Estonian women stated that the traditional methods (calendar, coitus interruptus, douching with lemon juice for example) were unreliable, however one group of Russian women favoured 'natural' methods above modern methods, which they felt were dangerous and expensive and this was the same group cited above with regard to 'biological' methods.

> G what do you see as the advantages and disadvantages of different types of contraceptives or practices?
> R Spiraal is not good for every woman
> R (Pills) - health concerns about hormonal imbalance and it is easy to forget to take them every day. (We) don't like pills as they are dangerous and expensive.
> R Best methods are natural....(it is) important to shower or douche afterwards.
> R But we don't avoid (pills and condoms) because of the cost but because we don't like them.
> (Russian Women 25-35 Narva)

Non-use and barriers to contraception

Many of the barriers to contraception are linked to access (eg cost of the pill) and to advantages and disadvantages (eg fear of side-effects), both discussed above. However focus group participants and key informants raised a number of other pertinent points, discussed below.

Lack of knowledge

Some key informants did not think lack of knowledge could be a barrier to the use of services and contraceptive methods, arguing that sex education now took place in schools. However, others pointed out that some 'knowledge' was superficial and that what was known was not necessarily practiced:

> "They know, but they don't use. The young say they didn't think they could get pregnant the first time.... Depth of knowledge is lacking."

Another informant said:

> "We think they know but – reality check – they don't know, even though the information is there."

One respondent stated that age was an important factor in terms of knowledge and contraceptive use and that young people were actually less of a concern than older people. People in their 30s or 40s had entered reproductive life before independence and so lacked knowledge. Young people "are not the big problem".

Another issue raised was the problem of 'myths' - the things people think they know but misunderstand. Myths were thought to be a problem by three respondents. One gynaecologist mentioned a 'pill scare' ("pill causes cancer") the previous summer which she thought to be an example of irresponsible journalism. She explained that boyfriends and husbands believed these myths and discouraged women from taking the pill. She added that women's fear of hormonal methods and dislike of the idea of the intra-uterine device contributed to the continued use of traditional methods.

Fears and side effects

Focus group respondents spoke of concerns about side effects such as weight gain. They also reported that doctors recommended 'pill breaks' for health reasons. A gynaecologist confirmed that this happens, resulting in unplanned pregnancies and abortions.

> R: But there are several side effects for example gaining weight ....unclear.... some problems with the skin
> R: There are some articles in the media which said it is connected with cancer, breast cancer...
> G: You've heard these pill scares?
> R: And with me when I got those pills my doctor said use them for 3 or 4 years and then don't use them for a while
> R: Quite many people talk about the disadvantages still.
> (Estonian Women 25-35 Tallinn)

Key informants deemed ethnicity very important with regard to contraception and abortion, pointing out that both Russian patients and Russian doctors were less likely to be comfortable with the use of modern contraceptives and more likely to favour traditional methods.

Comments concerning sterilisation, male or female, were almost universally negative, suggesting that prevailing attitudes would be a barrier to this approach to contraception. Concerns were expressed about the permanent nature of the procedure. It was also explained by the oldest group of Estonian women that abhorrence for this procedure may be rooted in its associations with Nazi and Stalinist methods of social control. Furthermore, sterilisation is clearly associated with issues of masculinity and femininity in this society.

> G Can I ask you what you think about sterilisation? Because this is not common in Estonia but it is common in other countries
> R... it's not even discussed here and the gynaecologists don't even suggest it
> R ...It has a Nazi time association with ...Where they sterilised the mentally retarded
> R And homosexuals
> R Yes, and homosexuals, though I don't know why they need to sterilise homosexuals!
> R during the Soviet period, ... there were instances of sterilisation of those that were deemed mentally ill, but the risk was that in the Soviet

Union also they considered political dissidents as mentally ill...it would have been abused
R This information became available after, you know with independence, it never was disclosed at the time of the Soviet period, that this was going on
(Estonian Women 45-60 Tallinn)

G what about male sterilisation?
R It's such a disapproval against all of those things you know, not even the gynaecologist could have courage to suggest such things in this country
R It's probably something like your masculinity is lost
R Oh, probably in this society it's unthinkable, that any man
R the understanding of femininity and masculinity would be lost with this sterilisation
R and not a woman could confess for instance that she is operated on ... well let us say that it is cancer and it has been taken out, well just a wise Estonian woman never tells those things to husband because then she is considered automatically not worthwhile any more
R not a woman any more
(Estonian Women 45-60 Tallinn)

Barriers for young people

In student groups some of the discussion concerning barriers centred on cost, though in one group being drunk was given as a reason for non-use. In addition it was suggested that young people may lack the confidence to discuss contraception with their partners, lack the confidence to buy condoms and lack awareness of the risks involved in non-use.

G So what do you think stops young people from using contraceptives? Because we know that they sometimes don't use them....what do you think it is?
R I think that maybe they're afraid or maybe too shy to buy condoms, for example if they are very young
R How do you go to a shop and ask can I have a packet of condoms, maybe the woman there knows me and will tell my father or something
R Also that they think they are too young to have children so .... It won't happen, this time it won't happen...
(Estonia Female Students 18-25 Tallinn)

The issue of non-use was summed up succinctly in one group:

> R: They think they won't get pregnant....
> R: Kids
> R: Religious
> R: But there are not so many in Estonia
> R: I know a woman who is Catholic, so no contraceptions at all.....
> R: Some are just lazy.... Irresponsible
> R: There is this idea you know ... God is giving me babies, this is supposed to happen ....but I think this is the minority...
> R: The exception
> R: It might be that something does not suit you, you don't .... You can't have a spiraal ...or pills or something...
> G: You just can't find something that suits you?
> R: No
> (Estonian Women 25-35 Tallinn)

Contraception then and now

There were some interesting comments concerning the issue of contraception during the Soviet period. Older respondents in particular remarked on the dearth of contraceptive supplies under the previous regime. According to key informants, in the later days of the Soviet era, the importing of contraceptive pills and intra-uterine devices from Russia and other Eastern bloc countries began. However, these pills contained higher hormone levels than those produced in the West. According to a gynaecologist, many doctors continued to recommend traditional methods as they considered the IUD suitable only for women who had already had a full term pregnancy and they considered the pill to be too dangerous. Women who did take the pill were recommended to have 'pill breaks', sometimes when they had only been on the pill for six months or a year, "so there were a lot of pregnancies as a result" (of this advice).

When modern methods were imported pills were not made available to all, and condoms were of poor quality.

> (You) could only get coil if you already had a child. During Soviet times the pill became available, but you had to have a 'contact' – it was not openly available. It meant for young women - 18-25 lets say, there was

> nothing, they were officially not supposed to have sex before marriage and this led to a pattern - the first baby just happened to come and after (it) was possible to get some education and contraceptions.
> (Estonian Women 30-40 Tallinn)

> Well you know they had no spiraal to speak of, and then, you know, the condoms were unknown. When they did get them from Ukraine...well they had them, but you know what they called them? They called them galoshes[49]....I remember it so well ...Laughter
> (Estonian Women 45-60 Tallinn)

In addition to highlighting the issue of later sexual debut during Soviet times, Russian female respondents contrasted methods promoted during the Soviet time and methods young people were informed about now.

> R: Girls are now women at 14 - they have first sex at 14. In our time it was 18. We were taught how to use the biological cycle but now children only have knowledge about contraception, but not natural methods.
> R: The first time I heard about contraception was when I was 19, but that was a bit late. But it is important to know about the natural method - we use this - it is not a problem and that is how we avoid pregnancy. We only knew about the biological method when we were young.
> (Russian Women 25-35 Narva)

Abortion

A number of questions were asked about induced abortion, to enquire about how abortions could be obtained, if there were any barriers to surmount, attitudes to abortion, and why respondents thought women had abortions. Key informants were asked about abortion with reference to their particular professional rôles.

Hearing about abortion

All focus groups participants were fully aware of the practice of abortion. Respondents spoke of finding out about abortion from books, from friends, and when hearing about a peer experiencing abortion. Very few had heard from parents. Some respondents said they 'just knew' before information was

[49] Galoshes are rain boots that are worn over shoes

imparted formally. Younger respondents were more likely than older respondents to mention school lessons as a source of information. Teachers warned that abortion could have negative health consequences including infertility. In two groups (Estonian female students 18-25 and Russian women 25-35) the use of "horror" pictures in a school lesson was mentioned, with a Russian respondent stating that this was done to discourage abortion in view of concerns about low fertility rates. The ages at which respondents first heard about abortion ranged from six to sixteen years.

Public opinion, stigma and disapproval

Five questions were posed in order to uncover different aspects of negative attitudes to abortion. The first concerned public opinions and this was followed by a question about stigma. The third question probed for groups or types of people who might disapprove of abortion. The last two questions asked to whom a woman would talk about an abortion and with whom she would avoid discussing an abortion.

It is worth noting that the seemingly innocuous question 'What is public opinion about abortion?' elicited longer silences and shorter responses than any other question. The most frequent responses were 'it's private', 'it's personal', 'there is no public opinion/discussion' or 'people don't talk about it'.

> G what is 'public opinion' about abortion?
> R There isn't really public opinion, it is a matter of choice.
> (Estonian Male students 18-25 Tallinn)

> G what is 'public opinion' about abortion?
> R This is not a topic to be discussed. Not that we don't want, but it is usually not discussed. .... People don't want to talk about it, it's a painful subject.
> (Estonian Women 30-45 Viljandi)

In all three Russian groups (female students, women 25-35, women 30-45) respondents spoke of negative attitudes to abortion, with one saying public opinion was 'against' abortion, another that doctors admonished women who were requesting abortions. In the oldest group of Estonian women (45-60) a respondent also stated that doctors have protested at the number of abortions carried out.

Key informants were asked about the nature of the 'abortion debate' in Estonia and were as bemused as focus group participants were when asked about public opinion. No key informant thought that an abortion debate existed in Estonia. They indicated that some individuals and groups, such as religious followers, objected to the practice of abortion but these were 'small minorities'. In addition, mention was made of doctors and gynaecologists who have a 'pro-life' stance. One informant stated that some 'pro-life' doctors show films and photographs of abortion during educational visits to schools.

The question concerning stigma also proved to be problematic. In focus groups where the discussion took place in English, and during key informant interviews, this was the one word which had to be translated. The consensus of opinion was that since abortion was not discussed (other than with close friends and family) a woman was not stigmatised. Many respondents stated that there was empathy, sympathy and understanding for women who have had abortions. There were comments concerning the difficulty of stigmatising something so common. On the other hand, one respondent (Estonian woman 25-35) expressed the opinion that the very fact that abortion was never discussed must mean that it is stigmatised.

In one group the dilemma faced by women with an unwanted pregnancy was poignantly described:

> R If you're in trouble you have to do it
> R I think that it's like..... because society thinks if you do abortion you are black sheep, but the other side, if you are single mother and then give your child adopted...

R You are even blacker
R If you have one adopted child, for men it is awful, much awfuller than (if) you did abortion - you had no choice, you did this, it's OK, but a child somewhere - who are you then?
R This is where I think the American practice is really cool, they don't abort their children, but they give them away for adoption - if they're really, really in trouble they can give their children away to somebody
R We don't have this here if you abandon a child you are really dark - pitch black
(Estonian Women 30-45 Tallinn)

It is interesting to note that while some respondents felt that abortion carried more stigma in the past (in spite of its regularity during the Soviet period), others felt that women were more likely to be blamed now because unwanted pregnancies could be prevented by the use of contraceptives.

G OK, what is public opinion about abortion?
R it's normal
(otherwise silence)
R No particular outcry, it's not an issue I guess
R It is an issue
R It is an issue now you think?
R Yes, I think so
R What do you think it is, what is public opinion?
R It is as the....maybe it's because now contraceptives are available, so abortion is really that you are not umm.... You are not behaving.....
R Responsibly
R Not behaving responsible if you are having abortions - it doesn't count for Soviet period, but now when everything else is available it's very .....unresponsible. Maybe one time it can happen, but then you.....
G So maybe it's changing?
R I think it's changing
(Estonian Women 45-60 Tallinn)

None of the male groups reported stigma or negative public opinions towards abortion.

In answer to the question about disapproval of abortion ('Is there any particular type of person or group that disapproves of abortion?') the most common response was to refer to 'religious groups' (12 out of 14 groups). After probing for type of faith, Roman Catholics, Baptists, Jehovah's

Witnesses, and 'Old Believers'[50] were mentioned. However, it was emphasised firstly, that these were small groups, secondly, that Lutherans (the largest church in Estonia) had more liberal attitudes and thirdly, that religion had in any case a very small impact on society in Estonia.[51]

> G What type of person or group disapproves of abortion?
> R Church, but that has little influence here in Estonia.
> (Estonian Male students 18-25 Tallinn)

In two focus groups the issue of doctors' disapproval was raised. Health promotion campaigns were mentioned in two groups, but it was explained that this was not disapproval of abortion per se, but rather that the use of preventive measures was being promoted as a better alternative.

When asked in whom a woman would confide about abortion the most common responses were 'best friend' (14) and 'husband/partner/boyfriend' (14). In twelve cases 'mother' was suggested as a confidant. When asked about whom would be avoided, mother was most often cited (8), indicating that some women confide in their mothers and for some that might be more problematic. One young male respondent stated: 'the mother would be the first or the last!' (Estonian male student 18-25).

Respondents, both male and female, indicated that a woman would not talk to her husband, partner or boyfriend if the baby was not his, or if she was adamant about the abortion and expected him to object. Respondents explained that, although women would talk to friends, these would be chosen carefully, with one respondent stating that one would not talk to 'the village telephone' (Estonian female 30-45).

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[50] This is a group formed by a schism with the Russian Orthodox Church in the 17th century.
[51] In one of the Russian groups (women 30-45) religion was not mentioned at all. When asked why this was the case, the interpreter explained that during Soviet times those who went to church had a 'black mark', so religious practice was not for those who wanted a career for example. She added that during under the Soviet regime the embryo or foetus was designated a 'biological mass', thereby silencing ethical or moral debates and added that this had now changed and 'horror films' were used to discourage young people from having abortions.

Of some concern is a comment made during one discussion, in answer to the question concerning avoiding discussion, where a respondent indicated that a woman would not tell her boss because she would be 'directed' to have an abortion:

> G: Do you think there is anyone a woman would really avoid telling?
> R: Maybe at work, the other people and especially the boss
> (Laughter)
> R: If you are discussing about whether to have this child or not, if you tell the boss, of course his or her attitude to you will change - he will direct you to have this abortion.
> G: Really?
> R: Yes
> G: Why?
> R: Because they need you at work
> G: OK so they are not very keen on women going to have a baby?
> R: Yeah
> R: We have this situation at work where we have 4 people, 4 women who are on this childcare leave and I think like 3 that are going there and you always have to employ new people and educate them .....our bosses make these really fun jokes about these women.....It's like .... really uncomfortable
> (Estonian Women 25-35 Tallinn)

Reasons to abort

Respondents were asked what they thought the reasons were for recourse to abortion. The most common response was 'financial reasons' (12 out of 14 groups cited this). In eight groups being too young was suggested, in six groups relationship or partner issues were raised. Other reasons put forward were: not being ready/too soon to have a baby (5) contraceptive failure (4), health reasons (4), having enough/too many children (4), career (3), concerns about being a single mother (3), child spacing (3) and the cost of raising children (3). Other suggestions were: a pregnancy being the result of a one-night stand or rape, mother's advanced age, concerns about environmental health and therefore the health of the foetus, and awareness of the number of street children.

Access and barriers

Respondents were all clear that abortion was accessible and all focus group participants knew how to do this – via the youth clinic (Estonian female

students), by going to the doctor or gynaecologist or attending a state or private clinic. Key informants stated that a woman could self-refer to a gynaecologist for abortion services.

As poor quality of care can sometimes create a barrier to the use of services a number of questions were posed concerning quality of care issues, for example opening times, waiting time, privacy and confidentiality, technical (medical) expertise and performance, and client handling skills[52]. The consensus amongst key informants was that quality of services was good and that these issues were unlikely to pose a barrier to the use of services. In particular, key informants pointed out that regulations concerning the recording and reporting of abortions had changed since independence so that the woman's personal identification number was no longer recorded and the reason for absence from work was no longer revealed on the sick note submitted to her employer. The result of this change was that employers were no longer privy to their female employees' medical histories. In terms of waiting time for a termination, a gynaecologist stated that women in need of an abortion could not be kept waiting as abortions (unless therapeutic) must be carried out within the first trimester.

In response to a question about abortion methods and anaesthesia gynaecologists stated that both dilatation and curettage (D&C) and vacuum aspiration abortions were carried out. One pointed out that while during the Soviet period there was little anaesthesia used, by 2001 over 93% of abortions were carried out with the aid of general or local anaesthesia. A gynaecologist explained that post operative care was provided, with follow-up at two weeks. She also pointed out that contraception was subsidised for three months following an abortion (and for 12 months following a birth).

While in three focus groups respondents said that private clinics were preferable for reasons of privacy, staff attitudes or cleanliness, in one group it

[52] Based on BRUCE, J. (1990) Fundamental Elements of the Quality of Care: A Simple Framework. *Studies in Family Planning,* 21, 61-91.

was suggested that private clinics did not necessarily have enough equipment to deal with abortion complications.

> G: Is it easy to arrange an abortion?
> R: I think so
> R: Yes
> G: You don't think there are any problems to arrange an abortion?
> R: If you can get an appointment!
> R: I have heard there are state clinics and there are private clinics and some people actually try to avoid the public medical system and go to the private ones because you can get there more quickly and it is more ..... private is not so open and your Mum does not go to this clinic ....and ah.... What I've also heard is that sometimes these clinics are set up not so well as public ones, they don't have enough equipment or whatever, so if there are some complications they have to take you to the public clinic anyway
> R: So you wake up (and) you're in a different place!
> R: I read an article about such a case
> (Estonian Women 25-35 Tallinn)

The issue of waiting for an appointment was raised on a number of occasions (for example see above), but some respondents stated that early appointments could be accessed at the youth clinic or at a local polyclinic.

The question about barriers to abortion elicited a wide range of responses. Firstly there were issues of cost, which are high in local terms especially for those who do not have social insurance. This reason was put forward in half of the groups. In contrast, in one group (Estonian men 30-45) respondents stated that cost was not an issue. In two student groups (Estonian male students 18-25 and Russian female students 18-25) respondents thought that cost was not an issue because if the abortion was imperative the money could be found. Key informants indicated that the patient was required to pay 30% of the cost of an abortion, with the remaining costs being borne by the social insurance fund. The cost to the patient was therefore 300 EEK (approximately £15 or $25 at the time of fieldwork). However, respondents pointed out that this meant the *uninsured* would be liable for the full charge. One respondent estimated that approximately 10% of the population was uninsured and explained that the unemployed and housewives fell into this category. Another

respondent suggested "the young, the poor, the homeless" would find cost a problem. It was suggested that the local authority might step in to pay the charge for someone 'poor' but that this was not a right. Private abortions were estimated to cost approximately three times the cost of an abortion carried out in a state clinic.

Other barriers suggested were: husbands/men (3), health risks/fear of infertility (4), guilt (3) and pregnancy beyond 12 weeks[53]. In a male student group it was suggested that girls want to have their babies and do not want to have pregnancies terminated, and in two other groups it was mentioned that some women reconsider motherhood and decide not to abort. In an Estonian male student group the issue of age was raised with respondents stating that girls under 16 need their parents' consent. In the same group doctors' attitudes were discussed:

> G Do you know how an abortion can be arranged?
> R Doctors
> R Doctors approval or something
> R I think if doctors approve but of course if it's too late then you can't do it, it's illegal but also if you are 16 then you need your parents' approval
> R Doctors they want you to be absolutely certain...they ask you this a hundred times
> R: I heard about it exactly like this
> G: So the girl just goes to the doctor
> R: Yes to the doctor but he tries to persuade her not to have it and it comes out that maybe she doesn't....
> (Estonian Male Students 18-25 Tallinn)

Two key informants raised the issue of a proposal to change the law concerning induced abortion. Both stated that the change would require doctors to provide pre abortion counselling. One of the informants indicated that the aim was to "avoid the next abortion, not just this one" and added that doctors would be expected to give contraceptive advice as part of the counselling session. The other informant explained that the purpose was not to force women to have children, but to encourage them to "fully consider" the

[53] 12 weeks of gestation is the limit for abortion, other than for therapeutic termination

abortion. This new policy may be perceived to be a barrier by some women seeking an abortion.

Emotional attitudes to abortion

In no instances were respondents asked about their own emotions concerning their own abortion or that of a partner. However, the issue was introduced by respondents in a number of discussions. Rarely were 'matter-of-fact' attitudes to abortion expressed. A male respondent (Estonian 30-45) was adamant that he did not want a child and if an abortion was necessary to achieve this it would have no emotional impact on him. A younger male (Estonian student 18-25) expressed the opinion that an abortion would not have a psychological effect unless he had wanted the child. A female respondent (Estonian 45-60) explained that she had had a number of abortions due to contraceptive failure and had had no other option. Otherwise however, respondents spoke of sadness, frustration and regret.

> G How do men feel if their partner has an abortion?
> R (My) close friend experienced this. He was shocked and became depressed.... felt a great deal of sorrow, (he) said "I was almost a father". But he was too young.
> (Estonian Male students 18-25 Tallinn)

Another respondent spoke of her mother's experiences:

> R It's so awful because my mother told me 2 years ago maybe, the first time..... that she ..... she has been carrying this pain and guilt feeling. But it was so normal, and my father told, 'oh all my girlfriends go and what is wrong with you - just go! I don't want any more children'. It was so awful...because it was ....no anaesthetic, plus psychological
> G Yes, so she found this psychologically upsetting?
> R Yes
> G It upset her?
> R Yes, uhuh
> (Estonian Women 30-45 Tallinn)

A gynaecologist remarked that "abortion is not an easy choice and never has been".

Abortion then and now

Comments concerning abortion in the Soviet era were made spontaneously and also as responses to a question on this topic. The consensus of opinion was that other than the issue of cost, abortion is 'easier' now. A number of negative comments were made about experiences of, or anecdotes about, abortion during the Soviet period. These concerned the attitudes of providers, the absence of anaesthesia, the risk of infection and lack of respect for confidentiality.

> The attitude of doctors was terrible in Soviet times, they treated you like a dog. They inflicted pain to discourage you from coming back. But they were badly paid and stressed, there were long queues of women waiting for abortions. It improved towards the end of the 1980's. (Estonian Women 30-40 Tallinn)

> With no anaesthesia with all your abortions.... my last one was with anaesthesia, but with my first one I had it was so painful, with the second and third ones, successive ones, I already knew it was like going into the slaughterhouse...)

A particularly interesting statement was made in the oldest group (Estonian women 45-60) about abortion being 'official policy' in the Soviet era, at least from the mid 50s, but that illicit abortions took place in earlier years:

> G Can I ask you now about abortion - how did you first hear about abortion?
> R ... information moved - it was official policy - it was the state's form of birth control in the Soviet Union
> R But in the 50s I remember when I was a school girl, I remember for the first time I learned it from my aunt who talked to one of her friends about you know this legal abortion, because in the 50s it was not legally um....
> R it was not legal
> R It was not legal, yes it wasn't just allowed and women had all those 'morka'
> R back alley ones, back alley abortions

G Around the corner or back street?
R yes, yes
R Yes and then just all those tragic cases happened....all sorts of things, there were rumours you know those things happened and then again just I remember there was a case that was told when a woman just herself made all those things...using awful things
G Yes, self-induced?
R Yes, yes
(Estonian Women 45-60 Tallinn)

Issues surrounding the provision of abortion under the Soviet regime, even when it had been legalised, led some women to seek illicit abortions.

G Have you ever heard of women 'going round the corner' for an abortion?
R Yes, we have heard, but don't know anyone. (We) have read about it. There is a possibility but today there is no point. During the Soviet times it might have been a problem because it was not easy to have an abortion.
G Why was it more likely in Soviet times?
R The communist party, your work, (there was) no confidentiality. Now there is not this problem. If you want to do it secretly you can go to Tallinn.
(Estonian Women 30-45 Viljandi)

The topic of 'round the corner' abortions (the Estonian version of 'back street' abortions) was introduced spontaneously in two female groups, the oldest group (45-60) and in a group of female Estonian students (see FGD 12 below). However, in instances where the topic was not introduced by respondents the question 'Have you ever heard of women going 'round the corner' for an abortion?' was posed. In the Russian female group (25-35) one respondent explained that during the Soviet period these took place when girls did not want to reveal their pregnancies.

G: How can you arrange an abortion?
R: Clinic only.
G: Are there any back street abortions?
R: Not now, but in Soviet period it was common because young women were afraid their parents or school would find out.
(Russian Women 25-35 Narva)

One respondent (female Estonian 25-35) recounted that her mother had told her that 'round the corner' abortions had also occurred during the period of the First Republic (between WWI and WWII).

Focus group participants commented on the high risk nature of these abortions, for which there was 'no need' any longer. Reasons suggested for women resorting to a 'round the corner' procedure in the post-Soviet period were the cost of abortion, especially for those not covered by health insurance, and the need for anonymity.

> G What about school – did they explain about abortion to you when you were at school?
> R They just say that it's bad – don't do it, it might be bad for your health and you might not get children later.....and if you really really want to do it, just do it in a good hospital, not just around the corner places.....
> G OK ..... and you said they told you to have it done in the right place, the hospital or clinic not in a 'round the corner place'. Do you think there are places where people have these 'unsafe abortions'?
> R Yes
> R Yes, I do
> R But I think it's not so expensive in Estonia
> R I think it's like if you are secure maybe....
> R Social security
> R And then, if you are unsecure it means that you don't have a job, because if you have a job you are secured
> R It means you don't have a job, then you don't have this money to pay, over 1000 kroons you pay them, so you find other possibilities somewhere - around the corner or something
> G So these could take place?
> R Yes, because it's so expensive
> (Estonia Female Students 18-25 Tallinn)

> G Have you ever of anybody 'going round the corner' for an abortion. In Britain we call it 'back street abortion, meaning some illegal type of situation. Have you ever heard of that?
> R Yes, I heard it and it is.....as I know it's a little bit expensive, it's like a private clinic
> G OK, it's a private clinic?
> R But you're not ....writing your names, it's like anonymous
> G Sort of unofficial?
> R Yes
> (Russian Female Students 18-25 Tallinn)

The key informants who discussed illegal abortions were unanimous that these occur but rarely. A gynaecologist stated however, that doctors only heard about illegal abortions when 'something goes wrong', for example the onset of sepsis. She added that, in her opinion, illegal abortions were more frequent in the past than now. Another gynaecologist explained that there would be little incentive for a gynaecologist to perform an illegal abortion and added that private clinics were, like state facilities, regulated by law.

In response to a question about quality of care in Estonia in comparison to the rest of the Soviet Union during the Soviet period, a gynaecologist explained that it would be difficult to draw any conclusions as data were not made available, even to gynaecologists. She explained that there was no media scrutiny in pre independence times and no internet resulting in a kind of "news blackout".

Other key informants expressed the opinion that quality of care would have been good in Estonia compared to other Soviet states. One pointed out that there was considerable diversity within the Soviet Union, despite abortion regulations which applied across the Soviet Union, and that whilst the standard of provision was high in Estonia, Moscow and Leningrad, this would not have been the case in the Asian republics. A gynaecologist indicated that septic abortion was a rare occurrence even pre independence. A further point was made concerning women's evaluations of clinics, with one gynaecologist recalling that there was one clinic that women avoided, that 'no one wanted to go there'.

In discussion about whether doctors were aware in the Soviet period that abortion rates in Estonia were high in comparison to those in Western Europe, one key informant pointed out the problem of access to data, but another suggested that doctors did know and that there was talk of 'too many abortions'.

Answering a question about whether in the past doctors were more likely to encourage the use of contraception or abortion, a gynaecologist indicated that

those in her profession were overworked during the Soviet period and that there were no family doctors to share the family planning workload, so that many would have felt that it made no difference to them whether someone used contraception or attended for an abortion.

Sexually transmitted infections

Although the issue of sexually transmitted infections (STIs) may at first appear to be unrelated to those of contraception and abortion, these issues are closely linked. If sexually active people rely on abortion (or for that matter non barrier methods of contraception, whether traditional or modern) to avert births, then they may discount the importance of barrier methods, which in turn results in vulnerability to sexually transmitted infections.

Sexually transmitted infections known

Focus group respondents listed a wide range of sexually transmitted infections including HIV/AIDS, gonorrhoea, syphilis, chlamydia, trichomoniasis, herpes, 'crabs' (Phthirus pubis), fungal infections, vaginosis, and hepatitis. The number of infections named ranged from three to seven, with most groups naming five or six. There were no diseases incorrectly referred to as 'sexually transmitted'. In one group (Russian women 30-45) one respondent declared twice that she knew nothing about these infections[54] and in the same group one respondent was not aware that HIV could be transmitted sexually. Human papilloma virus was not mentioned in any group.

Sources of information about STIs

The most common source of information was school, with thirteen out of fourteen groups mentioning this. However, amongst older respondents school tended to be referred to as a source of information for young people *now* as opposed to their own generation. Moreover, even when school was cited as a source, respondents often stated that the information was incomplete or inadequate. In many of the groups, even young student groups, when some respondents talked of learning at school, others asserted that they had not

[54] Her intention may have been to establish that she had no *experience* of sexually transmitted infections, even though it was emphasised that the question concerned STIs *ever heard of.*

learned about STIs at school. The media[55] were the next most common sources (12/14). Half of the groups mentioned hearing about sexually transmitted infections, or more specifically about HIV/AIDS, via health promotion campaigns. Five out of fourteen groups indicated that information was available in leaflets, in clinics, doctors' surgeries and other public places. Books, the internet, parents and friends were each mentioned in two groups, while doctors were referred to in three groups. Two respondents stated that they found out about STIs by contracting an infection. On two occasions respondents reported instances of misinformation - that STIs could be caught from toilet seats or in the sauna.

> R: Not parents because this subject would have been taboo and also they had no knowledge themselves.... (there was)...discussion of using a towel to sit on in the sauna.
> (Estonian Women 30-45 Viljandi)

One respondent explained that information is not accessed until the individual has a problem (although there is time to read!).

> R: Media yes
> R: But you usually don't read it when it's not your problem
> R: There are also leaflets when you have to go to gynaecologist, you'll have waiting time...
> (laughter)
> (Estonian Women 25-35Tallinn)

In the oldest group of women (Estonian 45-60) the problem of reaching the target audience was introduced:

> R... despite all the information that is available a recent study of teenagers showed that half of them didn't know how one gets HIV and so much of the information that has been distributed has not reached the target
> (Estonian Women 45-60 Tallinn)

[55] Media here include: television, radio, newspapers and magazines

Prevention of STIs

Respondents were generally familiar with methods of preventing the transmission of STIs. Suggestions were: abstinence, condom use, avoiding casual sex/multiple partners and preventing transmission by the intravenous route in drug users. In one group (Russian women 25-35) respondents thought that it might be possible to take 'some pills' prophylactically, although they were not sure. In two groups, both female, respondents remarked that being faithful was only effective if one's partner was also faithful. The issue of toilet seat transmission and the media was raised again with respondents in both cases stating that they were aware that this was a myth.

Treatment of STIs

Respondents in all groups were able to explain how to access treatment for sexually transmitted infections. Possible sources of help were: family doctor, gynaecologist, youth clinic, hospital, andrologist, special clinic and HIV/AIDS centre. A number of respondents remarked that they would wish to go to a doctor they knew and trusted as opposed to just any available facility. Others suggested that anonymity was important and therefore treatment might be obtained at a private clinic or in a nearby city, rather than in the home town. In one group (Estonian women 25-35) there was a discussion of the advantages and disadvantages of different facilities. Getting an appointment to see a specialist would mean waiting for an appointment and would involve a fee, whereas there is no waiting involved at the youth clinic and clients are seen the same day. One student (Russian 18-25) remarked that a person would dread going to the doctor with this type of infection and would delay going, although eventually there would be no choice. In another group there was a comparison with the Soviet period:

> R.... (there is) no fear of being locked up now as there was in Soviet times. If you had a sexually transmitted infection diagnosed you were admitted and kept in until infection resolved. But....that system helped to prevent transmission.
> (Estonian Women 30-40 Tallinn)

A key informant expressed the opinion that there was still some stigma attached to sexually transmitted infections and that this resulted in delay in seeking treatment. He pointed out an interesting anomaly – the personal identification number is no longer attached to the treatment form for an abortion, but it is for a sexually transmitted infection, so that it is possible for such a patient to be traced.

One key informant (demographer) explained that during the Soviet period a patient's medical history was not considered confidential (for example, even the diagnosis of a sexually transmitted infection could be disclosed to an employer via a sick note). For this reason, some people who could afford to pay 'under the table', and who had the necessary contacts, obtained treatment without their condition being recorded. This informant suggested therefore that some of the increases in the levels of sexually transmitted infections recorded post independence could be the result of more complete recording of cases.

During one discussion (Estonian male students 18-25) respondents were probed to see if they would consider going to a youth clinic if they were concerned about sexually transmitted infections but answered 'We don't have youth clinics", which suggests that although those who know about the clinics use them and have very positive experiences, some young people are unaware of their existence.

Who is at risk?

Generally speaking, respondents reported that STIs were of concern in Estonia, especially since independence. In answer to this question HIV/AIDS was by far the most frequently mentioned STI. When asked to state who was at risk the most common response was 'narcoman' or intravenous drug users (ten out of fourteen groups). One group (Estonian female 30-45 Haapsalu) felt that it was not a concern in their own small town. In half of the groups the higher rate of HIV in the North East was discussed. In one of the groups from this area (Russian female 30-45 Narva) a respondent stated that she had never heard of a social or public organisation dedicated to HIV/AIDS and did

not think the government were concerned about the issue, which suggests that the coverage of health promotion campaigns has not been complete. A key informant (Social Ministry) explained that the HIV problem was most acute in the north eastern region around Narva, where the population is predominantly Russian, there were high levels of unemployment, and significant number of intra venous (IV) drug users. She went on to explain that although HIV had initially been concentrated amongst the IV drug using population, it had moved into the general population through the partners of drug users. Levels were growing in Tallinn possibly due to the migration of people from the Narva area looking for work in the capital.

In five groups 'young people' were thought to be at risk, and in four groups those who have casual sex/multiple partners were mentioned. In only three groups was commercial sex referred to and in only three groups was homosexual transmission raised. In two groups the problem of HIV/AIDS moving into the general population was touched upon. In one group (Estonian female 25-35) respondents commented that although the common perception was that injecting drug users and homosexuals are most at risk, this could be a media created stereotype.

An expert on HIV prevention in Estonia detailed the interventions being carried out: youth projects, targeting vulnerable groups, voluntary counselling and testing and blood donor services. An informant for the prison service stated that there were concerns about the possibility of the spread of HIV throughout Estonia, including the prisons. She added that funding from the United States Embassy had been used to initiate a programme in the female prison, using trainers from non-governmental organisations such as the FPA. This programme had been deemed so successful that it had been rolled out to all prisons.

Respondents could list a wide range of sexually transmitted infections, could explain how to get treatment and how the transmission of infections could be prevented. Health promotion campaigns however appear to be missing some

members of the community and some young people were unaware of the existence of youth clinics as a place to access treatment.

Improving Reproductive Health

'To improve reproductive health in Estonia, what could or should be done?'

The aim of this question was to allow focus group respondents and key informants to make their own suggestions about how reproductive health might be improved in Estonia. The wide range and pertinence of the suggestions from focus groups demonstrates just why 'ordinary' respondents should themselves be viewed as 'key informants'. Suggestions ranged from micro level such as condom vending machines through to macro level structural issues such as economic stability.

Information and education

Improvements to sex education were suggested by eleven out of fourteen focus groups. Respondents noted a need, not just for better sex education, but for earlier provision. Rural children were highlighted as being particularly likely to be in need, due to the paucity of other sources of information and the quality of teaching in rural schools. School drop-outs were also seen as a group of young people who may be missing out on school-based sex education. Respondents indicated that teachers themselves needed to have a higher level of knowledge and that they needed appropriate attitudes as well as personal and social skills. Furthermore, teachers needed training in order to adapt their teaching methods – respondents were aware of a shortage of teachers able and willing to tackle this subject. In two groups there were discussions of teachers' pay and status and their relationship to motivation, with respondents commenting that the pay and social status of teachers was low and high motivation could not therefore be expected of them. Another respondent raised the issue of teachers 'editing' the syllabus according to their own judgements:

R ... it's not relevant for my students! It's not normal!
(Estonian Women 45-60 Tallinn)

One respondent advocated the use of peer education methods as she thought that many young people did not trust their elders and would not therefore trust the information being imparted.

R as children don't always trust the teachers they don't trust the information they get from teachers they more trust the people of their own age, so it's very important to have these kind of approaches where young people talk to young people, that you get this information from somebody who is like you
R You can trust, yeah
R Who you trust and also who can ask and who you can talk to and who you can ask the questions
(Estonian Women 45-60 Tallinn)

It was also suggested that the provision of a range of up-to-date and appropriate teaching aids would have a positive impact. Respondents commented that information should be appropriate for the age of pupils, incremental in nature and should be delivered in such a way that young people gain understanding not just 'facts' learned by rote. In two groups there was discussion of the difficulty of reaching young people and of achieving behaviour change in informed youth.

The responses of key informants echoed many of the suggestions that arose in focus group discussions. Key informants recommended that the focus of interventions should be on the young. Sex education was still seen as one of the key areas for improvement. One pointed out that this is now done well in some schools but not in others. The same respondent suggested that young people need to think about life planning and they need to know where to go for help and for contraceptive supplies. A gynaecologist echoed this, saying that young people do not just need to know the 'what' but also the 'how'. She

suggested that sex education could be integrated in the curriculum with drugs and alcohol awareness.

A respondent (sexual health clinic) asserted that sex education of the young was important, but equally so was education of the educators and of doctors too. Teachers needed training to better enable them to deliver sex education and doctors needed training in how to deal with issues of sex and sexuality with their patients. An informant (Family Planning Association) also urged training of those working in the field, to include social workers, gynaecologists, school nurses and the police.

Focus group respondents stated that school based sex education was not enough, especially considering how many people had not experienced this at school or at home. Respondents suggested that information should be made available through more sources and that existing sources of information and services should be better publicised.

In six out of fourteen groups there were references to the issue of parents informing children. Respondents of all ages felt this was important and it was suggested that parents are in need advice and information about how to approach the subjects of sex and reproductive health with their offspring. The need is especially acute for those who never received information themselves as youngsters and are not sure what to tell their children or how to broach the subject.

> R Parents have to speak with children
> R But first of all special people have to speak with parents and then parents have to speak with children, because it can be like father can say to boy 'go and be with woman' and so on and so on for example and won't say in the right way what will happen
> G So, parents have to learn and then they can talk to their children?
> R Yes absolutely
> (Russian Female Students 18-25 Tallinn)

Respondents in one male group were aware that this might be challenging, but felt that it was very important:

G What about at home - do you think that those of you who are parents, could you teach your children about sex? About safe sex?
R I think I would, for my children
G Do you think you will do better than your parents?
(Laughter)
G Couldn't be much worse?
(Laughter)
R... it would be a difficult subject
G You think it would be difficult?
R Youth nowadays they start it earlier than we did and that is why it would be difficult
R The whole understanding is that we would that yes...we would like to be better
R We have to be!
R Yes, we have to for sure
R Because I don't want that a lady from England comes again ...
(Laughter)
(Estonian Men 30-45 Viljandi)

Society, attitudes and responsibility

Respondents discussed aspects of society which have consequences for reproductive health. One respondent felt that employers' negative attitudes to childbearing was an issue and that more could be done to encourage women to have more children and to do so earlier.

R Another thing is that it is not popular to have children, when you are, I don't know from 17 to 25 or something, because you are supposed to study and make career at that time.
R It has changed in this regard
R And so the attitude is quite, it's ....it's not like "Oh welcome, you have a baby", it's
"Oh you have a baby" (different tone of voice). Like "how did it happen?"
(Laughter)
G Negative?
R Exactly
(Laughter)
R Working accident!
R And this attitude should change to have more babies born and to have younger women to have more babies.
(Estonian Women 25-35 Tallinn)

The issues of discussion and shared responsibility were raised. One respondent remarked that girls were socialised to take responsibility but boys were not.

R It seems to me, maybe you will tell differently, but it seems like all this cautiousness, it seems to me, maybe it is because I am a woman…it's really consciously made a woman's choice…I don't think, I haven't heard my mother talking to my brother about these things, maybe they talk in secret, I don't know but it seems that boys are not given this responsibility, that you should be careful or anything like that whereas a woman, you are told and you accept that but it seems to me that boys, it is not targeted at them
G so the business of sex education, preventing pregnancies and safe sex, not getting an infection, that's more aimed at…
R I think maybe the disease, but considering pregnancy I don't really see them targeting boys, it seems to me anyway…..In society, it is the woman
(Estonian Female Students 18-25 Tallinn)

It was also suggested that men know less than women do about the physiology of reproduction, although it was also pointed out that women have access to more specialists as a source of information (for example gynaecologists) than men do. Female respondents also remarked that men are not inclined to discuss sexual issues with each other or with their partners.

Services

A number of focus group respondents made suggestions relating to service provision. The most common suggestion related to affordability, with respondents advocating free or cheaper pills and condoms. Some pointed out that although the cost was not significant for those with resources, the cost might be prohibitive for the very poor. One respondent expressed the opinion that free contraception would lead to a reduction in abortion rates (FGD4 Russian Women 30-45 Narva). Another suggested approaching from the other end – increasing salaries so that people could afford medical services (FGD1 Estonian Women 30-40 Tallinn). One respondent (FGD3 Estonian Women 30-45 Haapsalu) suggested that there should be condom vending machines 'like cashpoints'. There were few 'quality of care' issues, however, the attitudes of service providers were discussed in two groups and one respondent suggested that the organisation of healthcare provision was inadequate as it was possible to wait three or four months for an appointment with a gynaecologist. (FGD1 Estonian Women 30-40 Tallinn)

A gynaecologist also spoke of the needs of the young, suggesting that costs for young people and students should be reduced. She also recommended that condom vending machines should be installed in toilets, including those in gymnasium level schools. She explained that young people could be too embarrassed to purchase condoms in the supermarket or the pharmacy, especially in small towns where everyone knows everyone else.

Integration of services was advocated by a key informant (sexual health clinic). She cited the example of a substantial UN funded campaign to promote the awareness of safe sex and prevention of HIV/AIDS, where the Education department was not involved. She revealed that a number of agencies were working in this area but there was no integration of activities. This problem was confirmed by another informant (Family Planning Association), who expressed frustration at the lack of integration, communication, and links between agencies. It had taken her a year to convince the Ministry of Health that the FPA could be a partner in HIV prevention.

Other recommendations included a particular focus on rural areas, Information, Education and Communication programmes to dispel myths and the promotion of the preventive approach to health.

Structural issues

In a number of groups structural issues and solutions were discussed. Some respondents felt that economic stability was paramount and that problems such as unemployment had negative health consequences for communities and families. This opinion was expressed particularly strongly in the two discussion groups in the north east of the country.

> R We have lost motivation.
> R ... the situation of Russian people in Estonia.... The government have destroyed the towns of the northeast - Narve, Kohtla-Jarve and Sillamae. All the investment goes to Tallinn, Tartu and Parnu. It is not possible to start own business here.

R (there are) lower salaries for Russians - half of that paid to Estonians.
R Many long-term unemployed. Social insurance for family of 4 is 1700 EEK, nearly as high as a salary 2000 EEK, but not because social payment is high, but because salary is low.
(Russian Women 25-35 Narva)

The increase in the level of parental benefit was discussed, with one respondent believing that it would make a difference but others suggesting that it would not address the longer term problems of affording children.

R: Parental benefit will not solve the problem - the money may be enough to feed the child, but not to educate. I have a daughter and I don't have to worry about feeding her, but next year she wants to go to University.
(Russian Women 30-45 Narva)

Conclusions

In view of the comments of both focus group respondents and key informants it is clear that reproductive health in Estonia must be set against a landscape of change. For many people change has brought new opportunities and aspirations, for others change has presented new challenges and insecurities.

Whether change is viewed positively or negatively, it has resulted in an attitude of caution for many people in Estonia, particularly with regard to having children. This is reflected in the respondents' comments concerning the monetary and opportunity costs of having children and the difficulty of combining work (or study) and family responsibilities in the new socioeconomic and political climate, bereft of Soviet safety nets (however inadequate). Responses were entirely consistent with issues discussed in Chapter 2, such as structural change and unemployment. Furthermore, Russian respondents demonstrated a higher level of insecurity which is unsurprising given the statistics concerning, for example, employment and mortality. Focus group respondents and key informants alike demonstrated a keen awareness of the issue of low fertility but none expressed the opinion that individuals had a responsibility to procreate and 'save the nation'.

In terms of sex education, key informants and focus groups respondents spoke of considerable advances over the period of independence, although some respondents were wary of the change in timing and content of 'human education'. These comments confirm the conclusions of Chapter 4, concerning the poor quality of sex education during the Soviet period and the new improved curriculum. However, respondents revealed that some young people do not receive adequate sex education (or general education) due to non-attendance or leaving school at the statutory leaving age of sixteen.

Respondents discussed a wide range of issues related to the improvement of reproductive health. Improvements in school-based sex education programmes, the provision of up-to-date teaching aids and the training of teachers was suggested. However, in order to reach those past school age or those failing to attend school it was felt that information must be made available to the general population, possibly via the mass media. In addition, existing sources of information need to be more widely promoted.

In contrast to the Soviet period, information can also be accessed via the media, although not all the information made available in this way is of acceptable quality or content. In particular, a number of respondents spoke of concern that young people could now access pornography. Information is available on the web via the Family Planning Association (and thousands of other organisations) but this is only of use to those who have access to the necessary hardware and the knowledge to use it.

Parents have not been seen as particularly instrumental in giving their children information, advice and support. However, this may be changing. Younger adults spoke of the wish to do things differently and to take an active part in the education of their own children. Many of these young adults have themselves had a better experience of sex education and may not feel that they lack the knowledge and ability to speak to their children about issues former seen as 'taboo'.

Focus group respondents were familiar with a number of contraceptive methods, with men being as well informed as women. Both respondents and key informants remarked on the change in the availability of modern methods over recent years. Young people tended to view the pill and the condom favourably, whilst older people were more likely to speak of, and express a preference for, traditional methods. This was particularly true of Russian women. While knowledge of a wide range of contraceptive methods was shown, it is clear that there are still concerns about modern methods, especially amongst older respondents and among Russian women. Although a wide range of methods were said to be available, access might be constrained for some people due to cost, distance to the provider or simply embarrassment. As permanent methods are viewed with so much distaste in Estonia it is unlikely that the new more liberal laws permitting sterilisation will be exploited.

Abortion was seen very much as 'common knowledge' by all. Although the practice of abortion has been common for decades respondents did not speak of abortion as being a *chosen* method of fertility control, but as a resort when other methods failed, or when unwanted pregnancies occurred as the result of ignorance or carelessness. Although abortion may not be stigmatised and there may be little overt disapproval in the public sphere, it was clear that respondents were not comfortable with the subject of abortion, seeing it very much as a private matter. Although quality of care was thought to have improved since the Soviet period, there were concerns that costs now were prohibitive for some people. Although focus group respondents and key informants had heard of illegal abortions these were said to be few in number. It would appear that 'round the corner' abortions occurred in the past, both during the Soviet era and before. It should be a matter for concern that these may still occur, especially for those who have no financial resources and who do not have health insurance.

Respondents could list a wide range of sexually transmitted infections, could explain how to access treatment, and could give accounts of how the transmission of such infections could be prevented. Health promotion

campaigns however appear to be missing some members of the community. In view of the high esteem in which young *women* hold youth clinics it is unfortunate that some young *men* were unaware of the existence of youth clinics as a place to access treatment.

Cultural attitudes regarding the roles of men and women are problematic, with women being socialised to be the ones to 'take care'[56]. The dual responsibility of both sexes should be part of sex education programmes and information campaigns. In addition, female respondents gave examples of discrimination against women with children or women of child bearing age. Although legislation to protect women exists, there are clearly issues of implementation and enforcement that could be addressed.

Finally, respondents spoke of a need for political, economic and social stability, security in employment, and an improved safety net, all of which might serve to help people to stay healthy.

[56] Kalda and colleagues state that the three main reasons for unplanned pregnancies in Estonia are: "women's failure to use a contraceptive method correctly, their poor knowledge of contraceptive methods and ineffective teaching of women." ***No mention is made of the rôle men play in pregnancy***. KALDA, R., SARAPUU, H., PIKK, A. & LEMBER, M. (1998) Sex education and contraceptive methods: knowledge and sources of information among the Estonian population. *Advances in Contraception,* 14, 121-130. p 122

Key Points

- The ways in which fertility is controlled in Estonia are changing in spite of the constraints of transition
- Sex education, which was limited during the Soviet period, is improving, in terms of quality, quantity and timing
- Respondents suggested that parents should be enabled to contribute to the sex education of their children
- Knowledge of contraceptive methods, both traditional and modern, was high but some respondents spoke of concerns surrounding hormonal methods and preference for traditional 'biological' methods
- Abortion was seen as 'common knowledge'. Respondents, both male and female, expressed distaste for the practice of abortion and a preference for preventive methods
- A wide range of suggestions regarding the improvement of reproductive health, including family planning services, was offered. These ranged from micro level interventions such as teaching packs for parents, through to macro level issues such as reducing unemployment and eliminating discrimination

Chapter 7 – Discussion

After centuries of domination by neighbouring powers, Estonia became an independent republic in 1918. This period, of the first republic, lasted just over two decades, ending when Soviet troops 'liberated' Estonia from the Germans during the Second World War. Estonia remained a part of the Soviet Union for the next half century, until independence was again declared in 1991. Following this declaration Estonia became an independent state, a former Soviet state developing its own institutions, a democratic political state, and a market economy.

The process of transfiguration since independence has made available opportunities which were unknown during the Soviet period. However, change has also had its costs and for some people it has proven to be a challenging experience. Older people, for example, have been more likely to have negative perceptions of the changes in Estonia than the young. Similarly, residents of non Estonian ethnicity have reported fewer positive expectations than Estonians (Leinsalu et al., 1999). Soviet institutions, systems and safety nets have been replaced by Estonian models but this transformation has not always been seamless.

Upon independence revolutionary changes were commenced in health policy and provision of services. The family doctor system has been reinstated and health services restructured to boost the primary sector and slim down the acute (tertiary) sector. There is a nascent private sector, something which had been banned until the last few years of the Soviet period. The new health system is insurance based, but it is estimated that up to 8% of people in Estonia are not covered[57]. Furthermore, policy makers have instituted out-of-pocket payments for prescriptions and abortion services (World Health Organisation/European Commission, 2001).

[57] Those people who are not paying tax or who are classed as illegal residents are not insured

Analysis of survey data and official statistics show that age at sexual debut has fallen and that contraceptive practices have been transformed. Results also demonstrate that abortion rates have decreased and this has been achieved in spite of the challenges of the reconfiguration of state institutions and social welfare, and in spite of the concurrent decline in fertility.

However, survey data were collected in the 1990s (EFFS in 1994 and EHIS in 1996-1997) meaning that these data are already, to an extent, out-of-date. Whilst the data for the older cohorts, where the reproductive ages had already passed, might still be reliable, younger respondents will have moved on and a new 'youngest' cohort entered the target population. While data concerning abortion are collected and made available through the Estonian Medical Birth and Abortion Registry (but not at individual level), there is no up-to-date information concerning contraceptive prevalence or types of contraceptives employed. It is not possible therefore to assess more recent levels and trends concerning contraception.

Ideally, qualitative and quantitative data would be collected at similar times and the topics and questions integrated so that findings could be interwoven. However, qualitative data were collected nearly a decade after the EFFS and seven years after the EHIS so that quantitative and qualitative data have been 'patched' together rather than interwoven.

How has the population of Estonia arrived at its current position in terms of fertility control? Estonia was, at the dawn of the 20th century, well advanced in terms of demographic transition and particularly in terms of fertility transition. This was in marked contrast to Russia, where birth rates and death rates were considerably higher than those in Estonia (Coale et al., 1979). When Estonia became a part of the Soviet Union, Soviet laws and policies were put in place. Under the Soviet regime, access to modern methods of contraception was limited. In 1955 induced abortion was legalised. With little in the way of contraception on which to rely, many women turned to abortion to limit family size. The term 'abortion culture' has been used to describe this situation,

where abortion is a prominent proximate determinant of fertility while modern contraception has little impact.

There is some evidence to suggest that an abortion culture did become established in Estonia. Firstly, use of modern methods of contraception was low, provision of modern methods was poor, and doctors were instructed not to promote the oral contraceptive pill. Secondly, abortion rates were high, in comparison to Western Europe and Scandinavia, although low compared to many other Soviet states such as Russia. Thirdly, abortion rivalled contraception in terms of fertility inhibiting impact on total fertility. It is however important to emphasise that the many claims that abortion was the primary method of fertility control must be challenged. Avdeev (1994) estimates that the fertility inhibiting effect of abortion (47%) was nearly equal to that of contraception (53%) in Estonia, at least in the late 1980s when these data were collected. Tietze and Henshaw (1986) also found that:

> "Even in the countries with the highest abortion rates, abortion is only one of several factors that reduce fertility below its theoretical "natural" level of about fifteen lifetime births per woman. ..... Even in the Socialist European countries with high abortion rates, abortion has had less influence on fertility than has contraception." p133

Furthermore the practice of abortion varied, not just between member states of the Soviet Union, but also within states, suggesting that different abortion cultures existed or that people reacted to or were influenced by the existing culture in different ways. In Estonia, *non* Estonian women have tended to rely more on abortion than have Estonian women[58] (Anderson et al., 1993).

In a state where abortion has been a legal and accepted practice for decades, why are policy makers intent on reducing abortion rates? The 'default' position appears to be that abortion should not be used for family planning and should be replaced by contraception. But why is this so? The assumption, explicit or implicit in literature concerning this subject is that abortion levels *should* be reduced and that the practice of abortion should be discouraged because abortion is not safe or not acceptable. This aspect of the context in which

[58] See Chapter 3 Figure 3.33 for abortion rates by ethnicity

fertility control is embedded is crucially important. If there were no disadvantages to abortion then why should policy makers in Estonia try to replace abortion with contraception? Furthermore, why would individuals wish to cooperate in this endeavour?

Some are concerned that abortion is to blame for the decline in fertility seen in Estonia since the late 1980s (Karro, 1997a). This group might like to see abortions replaced by births. However, abortion is only a *proximate* determinant of fertility and women turn to this method when they perceive a need to avert a birth. This need is determined, not by access to abortion (or denial of such access), but by the circumstances of peoples' lives.

Concerns are often expressed in the literature about the health risks of abortion (Remennick, 1991, Anderson et al., 1993, Muscato and Kidd, 2003, Kon, 1992, Brandrup-Lukanow, 1999). However, an abortion done *professionally*, *legally*, and *early in gestation*, is safe (AGI, 2002, Paintin, 2004, Royal College of Obstetricians and Gynaecologists, 2004). In Estonia, abortions are carried out in hospitals and clinics within the first trimester and although 'round the corner' abortions do occur these are rare.

There are, however, sound reasons to pursue policies to replace abortion with contraception. An important aspect of reliance on abortion is that it places both men and women at risk of contracting sexually transmitted infections. Converting couples to condom use would have a beneficial impact on the transmission of STIs as well as reducing the incidence of unplanned pregnancy.

A second justification is that abortion tends to be more expensive than contraception and that contraception is, generally, a more efficient use of resources for providers (Forrest and Singh, 1990). However, the situation may be different for the individual, depending on the relative costs of contraception and abortion.

Thirdly, the use of abortion for family planning places the responsibility for the consequences of unprotected sex firmly on the shoulders of women (Bird Francke, 1979). This can not only make women *responsible*, it can make men *irresponsible* as they are led to believe that the consequences of their sex lives are not their own concerns.

In addition, the Programme for Action resulting from the International Conference for Population and Development in 1994 states categorically that abortion should not be promoted as a family planning method and that governments have a responsibility to help women avoid abortion (United Nations, 1994).

However, the most critical consideration is the way in which women express their feelings about abortion. This study has revealed that, in Estonia, women themselves[59] demonstrate an aversion to abortion. Women, generally, express a preference for safe methods of contraception, which are effective and acceptable to use. Therefore regardless of its utility, abortion should be regarded as a back up to contraceptive methods in case of failure rather than a primary method.

It should be the aim of policy makers to facilitate this balance between prevention and termination. How can this be achieved? The discussion to follow brings together the findings of the research with the suggestions of focus group participants and key informants to make recommendations for policy.

Recommendations

The special case of young people

Young people have particular needs in terms of reproductive health. Youth is a time of great change and one where young people are moving out of childhood and into adulthood. During this period young people may be vulnerable as they have left behind the (relative) safety of childhood and yet

[59] Not only do women reveal these feelings, men express similar sentiments - See chapter 6

are not yet fully independent and empowered adults. For some policy makers, and some members of the public, the very idea that young people have reproductive health needs is anathema. However, information concerning sexual debut, adolescent pregnancy and the prevalence of sexually transmitted infections is evidence that young people *do* have sexual intercourse. The particular needs, and rights, of the young were recognised and highlighted in the Programme of Action following the International Conference on Population and Development in Cairo and concern expressed that:

> "The reproductive health needs of adolescents as a group have been largely ignored to date by existing reproductive health services." (United Nations, 1994 7.41)

The first task then of policy makers is to focus on the needs of young people and to advocate for support in the public arena.

Sex education is an important element of any programme designed to meet the needs of the young. It is clear that sex education in schools in Estonia has improved enormously in the years since independence and this should be seen as evidence that government and policy makers take the needs of young people seriously. However, there are a number of issues to be addressed in terms of sex education provision. The teaching of sex education is not seen as consistent across the education system. This may be because, in some schools, the head teacher does not consider this topic to be a priority. Furthermore, not all teachers charged with teaching sex education are comfortable in doing so. This may be because they find it difficult to talk about sex to young people or they may feel that they lack the knowledge and expertise to do a good job. The policy implication here is that teachers must receive training, not just in terms of the content of the curriculum but also in terms of how to deliver it. Teachers who feel too embarrassed to discuss sex should not be compelled to do so. Head teachers need to be informed about the importance of including sex education in the curriculum, especially as this is now government policy.

Sex education does not need to be confined to the classroom – young focus group respondents spoke in very positive terms about a school trip to visit the youth clinic, which made them feel much more confident about returning when they felt they need to do so. Young respondents suggested the use of peer educators, so that young people could talk to others their own age as some young people do not trust adults.

Respondents suggest that, although the content of the sex education curriculum had been enhanced and extended, there remained a need to ensure that young people had the necessary depth of knowledge and understanding at an age-appropriate level. Furthermore, young people also need to be empowered by educators so that they know how to negotiate relationships and how to look after themselves.

It is not just the content of sex education teaching and the attitudes of teachers, but also the timing that is important. Focus group participants and key informants stated that sex education is starting much earlier. However, there should be concern about the competition between sex education and citizenship education in the critical ages of fourteen to seventeen, especially as survey data suggest that the median age at sexual debut, for females, may now be as low as sixteen. Haldre and colleagues have found that approximately one quarter of deliveries and about one third of teenage (15 to 19) abortions occur in the under seventeens, which suggests that *young* teenagers need information (Haldre et al., 2005).

A number of respondents raised the issue of gender and sex education. These respondents were concerned that girls were 'targeted' in sex education as well as being seen as the responsible partner in public discourse. As both girls and boys should now receive sex education at school, this issue may be resolved in time. However, this may not be an issue only for sex education, it may be a much wider phenomenon related to gender socialisation and 'approved' sex rôles.

Russian respondents generally expressed support for sex education but some had concerns about the content and timing of this part of the curriculum. It may therefore be the case that there is a greater need for consultation and communication between Russian communities and educators.

Information, education and communication for the wider community

Although sex education has now been implemented in most schools, many adults will not have benefited from this provision and need the opportunity to catch up. Not only do these adults need information for themselves, they may also want to inform and support their own children. Focus group respondents stated that many parents would like to talk to their children about sexual issues, but felt that they lacked the factual knowledge and the language needed to communicate with their children. Policy makers could address this need by making provision for parents to enable them to contribute to their children's sex education.

There is a need for high quality information to be delivered to the wider community in order to challenge the messages and norms being disseminated through pornographic media (Peetso et al., 1999). Although people in Estonia may be reluctant to return to the days of censorship, many expressed concern at the impact, especially on the young, of pornography which is now freely available. Policy makers need to ensure that there is no information vacuum waiting to be filled by pornography. Information should be delivered in a way that is accessible and attractive to a wide audience.

Members of the public need to know how to access family planning services and support and they need accurate and up-to-date information concerning contraceptive methods. In particular, policy makers should provide information about the relative risks and benefits of different contraceptive methods so that potential users could make informed choices. Particular efforts need to be made to dispel myths and misconceptions that were promulgated during the Soviet period. Information should be provided, not only in clinics, but independently of service provider sites so that non users can access the same information as service users.

Family planning services

A metamorphosis has taken place in Estonia in terms of family planning services. Much effort has gone into moving the focus away from abortion and towards contraception. However, barriers to the use of contraception remain. Respondents reported that some doctors were still reluctant to prescribe the contraceptive pill or advised women to take 'pill holidays' in order to allow their bodies a respite from contraceptive hormones[60]. Policy makers therefore need to ensure that service providers, as well as their clients, are up-to-date and well informed.

A particular concern amongst respondents was the affordability of contraception. Although contraceptive supplies such as the pill are subsidised the subsequent cost to the user may still be high in some contexts. Respondents spoke of the difficulties for the young, for students, for the poor, for the uninsured, and for those living on rural wages. Cost was considered to be a significant barrier to use. Although risking abortion by not using contraception may be seen by others as irrational, for the woman concerned this may not be so. For women who are not in permanent long-term relationships taking the pill, 'just in case', might mean a very expensive sex life. This 'save now and risk paying later' attitude may be considered irresponsible – but that is exactly what a very well-informed government is doing when deciding not to fund free contraception, as is the case in Estonia. One respondent pointed out that the cost of an abortion was roughly equivalent to a year's supply of the pill and therefore some women (and couples) were willing to take that risk. On the other hand, the cost of abortion was seen as problematic in some situations. Respondents stated that, although very few 'round the corner' abortions were thought to occur, one reason for their occurrence could be the cost of an abortion in a clinic.

[60] Whilst the contraceptive pill should not be taken by some women, for most women the pill is safe and effective. NHS DIRECT (2006) Common Health Questions.

There were many positive aspects to family planning services. Quality of care was thought to be high, service providers were seen as knowledgeable and skilled and most modern methods of contraception were available. In addition, abortion services were considered to be far superior to those in Soviet times, particularly with regard to the use of anaesthesia and the attitudes of service providers.

Throughout the research period no adverse comment was voiced with respect to youth clinics. These were praised by young female focus group respondents and key informants alike and comments suggest that these clinics present an ideal "point of entry" for young people into reproductive health services. However, young male respondents did not mention youth clinics and when questioned professed ignorance of their existence. The young men in question may have 'forgotten' something that they considered irrelevant to their needs. However, there could be a need to make sure that boys and young men are as well informed of youth services as are girls and young women.

The creation of the Estonian Family Planning Association was seen as a progressive step and this non governmental organisation plays a key rôle in providing services and disseminating information, including the management of a website and on-line discussion forum for young people.

Women, work and reproduction

Both male and female respondents, in general, thought that having children was important. A number of respondents however spoke of the particular issues faced by women in the workforce. The burden of working as well as caring for a family was seen as a problem. Women also spoke of sexism in the workplace, particularly when applying for jobs. Respondents stated that, at interview, women would be asked about their plans to have a family. Women already in post are discouraged by employers from having children as this is seen as an inconvenience in the workplace. Legislation exists to protect women from this type of abuse. However, policy makers should consider ways

of making this legislation stick by taking steps to censure employers who break the rules.

The vulnerability of the non Estonian population

Many respondents, male and female and of all ages, raised the issue of insecurity, especially financial insecurity. However, these concerns were more acute in the Russian focus groups. Many Russian speaking people do not speak Estonian and are therefore not able to secure jobs where there is a language barrier (Haas, 1996). During the Soviet period, the language of administration was Russian. Understandably, since independence, the required language is Estonian. In addition, many of the industries in which the Russian workers were employed have been closed, so that whole communities have been made redundant[61]. Russian respondents also reported that the salaries for Russians were lower than for Estonians.

A further source of insecurity is the issue of citizenship. Many Russians (and other non Estonian residents) hold Soviet passports and in order to be granted Estonian citizenship they must pass a language test and a citizenship exam. Many Russian speakers resent this hurdle and many would find it insurmountable (Lieven, 2005).

Russian women are more likely than Estonian women to have an abortion. It should be of some concern to policy makers that, although abortion rates in Estonia have tended to decline, the differential in abortion rates, between Estonian women and non Estonian women, has not narrowed but widened[62].

However, not only are there differences in rates of abortion. Russians are also disproportionately represented in the prison population and are more likely to be intravenous drug users, and therefore more likely to be HIV positive (Hamers and Downs, 2003). These issues illustrate the significant (and widening) gap between Estonians and non Estonians. This difference is a reflection of *inequities* within society which must be addressed by policy

[61] See for example the example of Narva: STEPANOV, S. (2004) Krenholm plans more layoffs. *Baltic Times.* Tallinn.
[62] See Figure 3.32

makers if the overall situation in terms of reproductive health is to improve in Estonia.

It would appear that Russian people in Estonia are more inclined to adopt risky behaviours than are Estonians. Could this be a case of 'nec spe, nec metu'[63]? Respondents spoke of the identity crises being experienced by some members of the Russian community and the sense of isolation that came from the loss of family connections following the breakdown of the Soviet Union. One Russian informant spoke of this experience as feeling like being on the losing side, but there had not even been a war. Estonia's entry into the European Union was perceived as threatening by some members of the Russian community, being seen as further evidence of the move to face the West, rather than the East.

Estonia has a Minister for Population Affairs whose remit is to increase the fertility rate and promote the integration of ethnic minority populations. However, these two aims could be diametrically opposed. The reason given for increasing the fertility rate, in addition to the need to slow down population ageing, is to ensure the survival of the Estonian ethnic and linguistic nation. As the Estonian population, in Estonia, is now less than one million this objective is understandable. However, unless equal emphasis is placed on increasing the fertility rate of the non Estonian (largely Russian) population, the Minister will be attempting to promote integration at the same time as demoting the problem of low fertility in the non Estonian population. There is no explicit policy to discourage fertility in the non Estonian population, but Russians may see this as being the *implicit* aim of policy makers (Haas, 1996). There is a real danger that, if Russian people are seen as the "ethnically different Others"[64] further social polarisation will occur along with a hardening of attitudes on both sides of the ethnic divide.

What are the future prospects for fertility control in Estonia?

[63] Meaning 'without hope, without fear'
[64] Phrase coined by EINHORN, B. (1993) *Cinderella Goes to Market - Citizenship, Gender and Women's Movements in East Central Europe,* London, Verso. p 260

The prospects for fertility control in Estonia are good. Policy makers have demonstrated a commitment to replacing abortion with contraception. Sex education has been improved and services revamped so that users can make informed choices concerning family planning. Further changes, in terms of contraceptive use and recourse to abortion, should be observed as people who came to maturity during the Soviet period, and adopted prevailing norms, leave the reproductive ages, to be replaced by younger people who bring with them different norms. This 'replacement' will not just apply to users of services but to providers too.

An indicator of the commitment on behalf of policy makers to transform fertility control in Estonia, but to do so with regard to equity, will be the way in which the particular needs of the most vulnerable members of society are addressed. Whether these vulnerable members are young, poor, female, or members of an ethnic minority, they will play a part in the future of Estonia and are therefore deserving of the support of those in positions of power.

Independence has presented Estonia with considerable challenges but also abundant opportunities. Great strides have been made in undermining abortion culture and abortion rates have fallen. If the impetus is maintained in training providers and teachers, involving non-governmental organisations, supporting high quality public broadcasting and health promotion campaigns, much will be accomplished. It is however vital that policy makers ensure that a wide range of affordable services and contraceptive methods are available so that use and effectiveness are maximised and only a "residual demand" for abortion remains (Marston and Cleland, 2003, Cohen, 1998). It would be ironic if newly acquired freedoms lead to loss of reproductive rights, so perhaps the most important task for those in power is to resist the pressure to pass restrictive abortion legislation, which could have dire and predictable consequences for women in Estonia and in other states which share the Soviet past.

Future Research?

In view of the transformation of Estonia since independence future research could focus on the developments in terms of contraception and abortion in more recent years. Both quantitative and qualitative approaches could be employed. More recent data concerning contraceptive use are not yet available (EFFS data were collected over a decade ago), so research could be hampered by the lack of survey data. Ideally, if a mixed method approach were to be used again, the collection of survey data and qualitative research could be integrated. This would mean not only that data would be collected over the same time period, but also that topics and questions could be harmonised so that the results could be truly integrated. Qualitative research could again be conducted and creative methods used to recruit a wider range of participants, especially those from less advantaged backgrounds, minority ethnic groups and those with lower levels of education. Particular attention could be paid to the topics discussed under the heading *Recommendations* above to find out how much progress has been made by policy makers and how much commitment they have shown to issues surrounding reproductive health in Estonia.

Appendices

Appendix 1

Programme of Action of the United Nations International Conference on Population and Development

Chapter VII: Reproductive Rights and Reproductive Health

7.10. Without jeopardizing international support for programmes in developing countries, the international community should, upon request, give consideration to the training, technical assistance, short-term contraceptive supply needs and the needs of the countries in transition from centrally managed to market economies, where reproductive health is poor and in some cases deteriorating. **Those countries, at the same time, must themselves give higher priority to reproductive health services, including a comprehensive range of contraceptive means, and must address their current reliance on abortion for fertility regulation by meeting the need of women in those countries for better information and more choices on an urgent basis.**

7.24. **Governments should take appropriate steps to help women avoid abortion, which in no case should be promoted as a method of family planning,** and in all cases provide for the humane treatment and counselling of women who have had recourse to abortion.

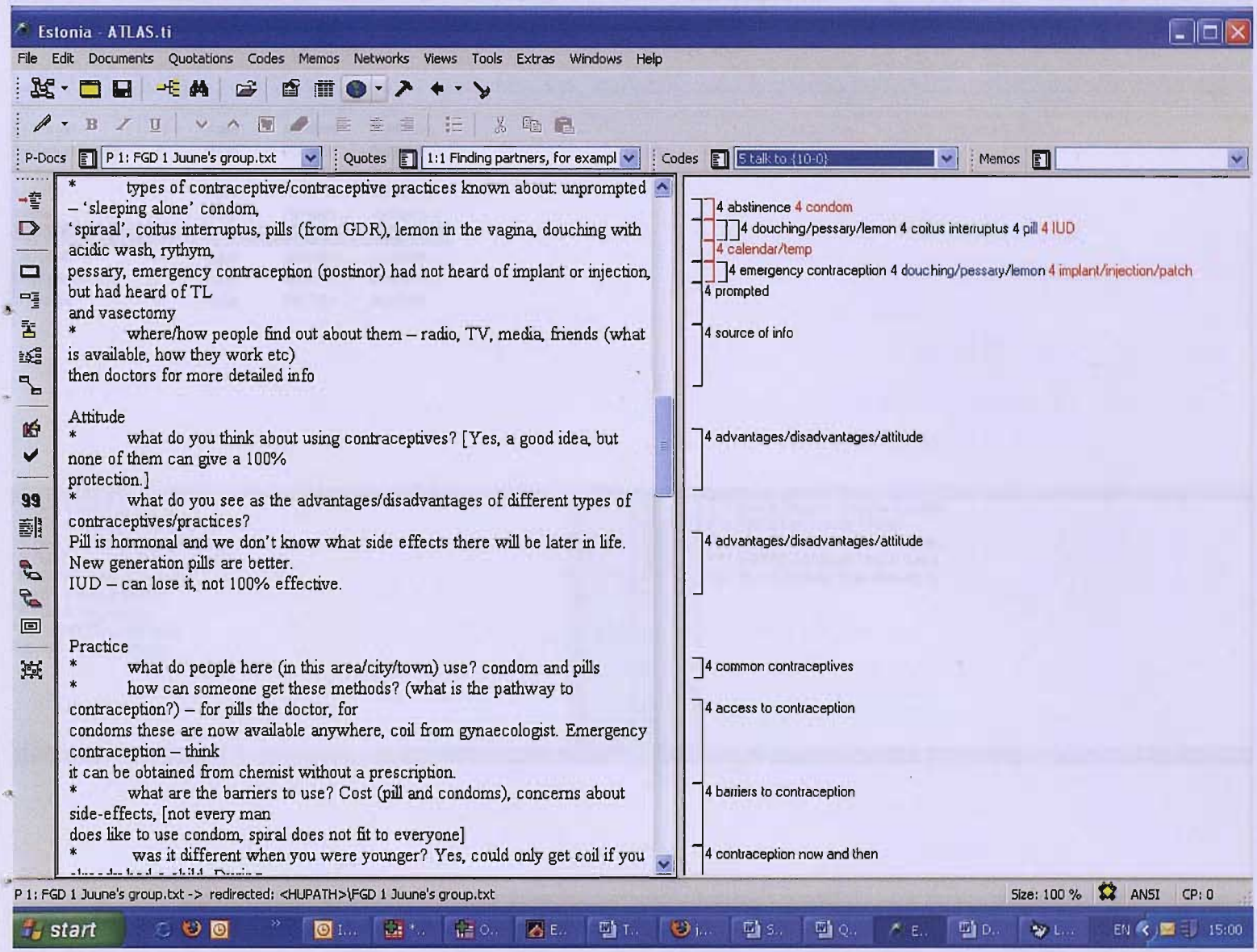
(United Nations, 1994)

(emphasis added)

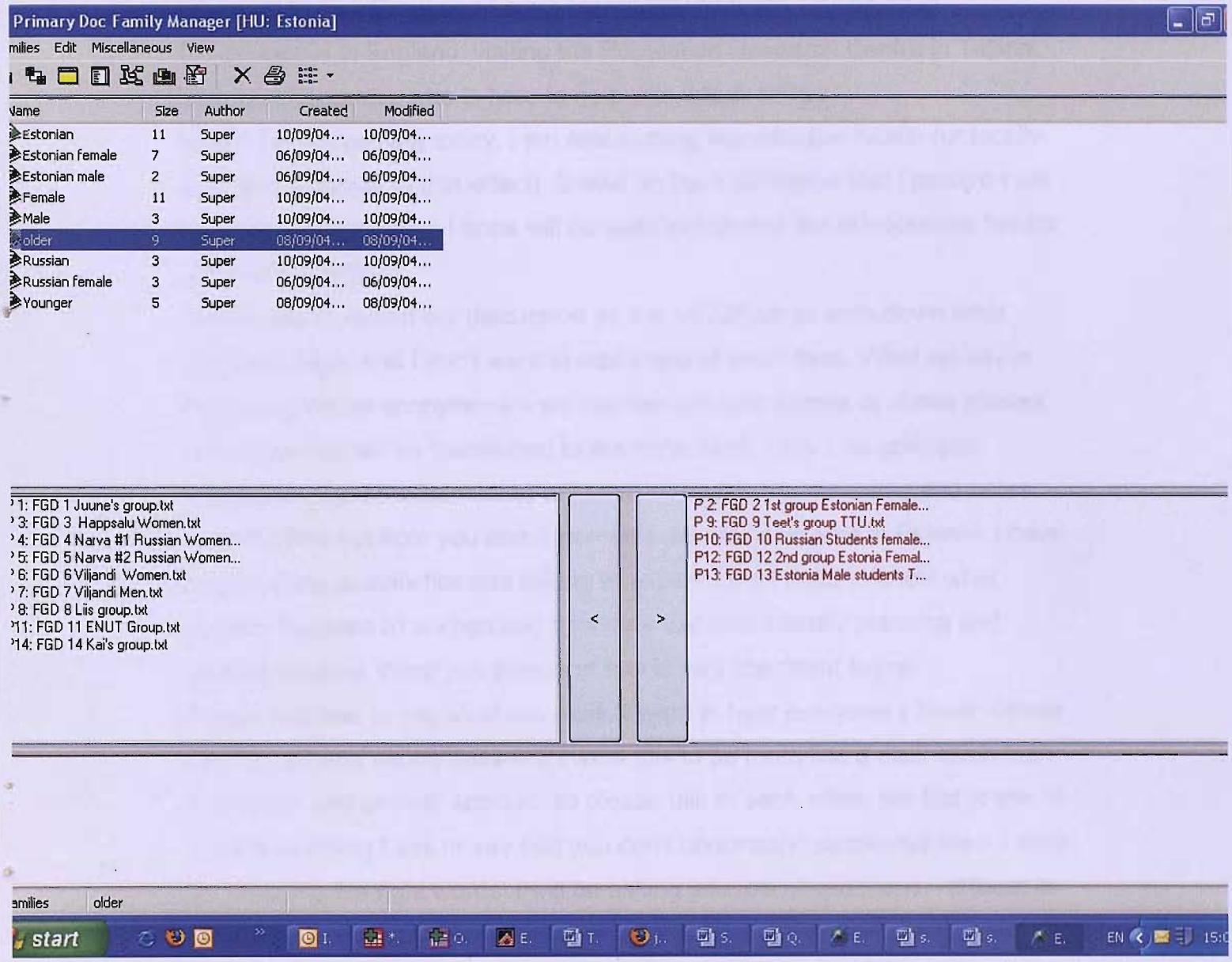
Appendix 2 – Birth cohort table

Birth cohort	Size of cohort	Proportion of respondents (%)
Ten year cohorts		
1924 – 1933 (10 yr)	648	19.6
1934 – 1943 (10 yr)	741	22.4
1944 – 1953 (10 yr)	617	18.6
1954 – 1963 (10 yr)	642	19.4
1964 – 1973 (10 yr)	659	20
Five year cohorts		
1964 – 1968 (5 yr)	333	10.1
1969 – 1973 (5 yr)	326	9.9

Appendix 3: Screen shot showing part of a transcript, illustrating coded segments and demonstrating that one segment can bear a number of codes.



Appendix 4: A screen shot of transcript ('primary document') families and the members of one family



Appendix 5: Focus Group Discussion Guide – Women

Introductory Statement

My name is Gail Grant and I am a researcher from the University of Southampton in England, visiting the Population Research Centre in Tallinn. This is (interpreter), who is here to help with interpreting.

Thank you for coming today. I am researching reproductive health (or locally appropriate words to that effect). Based on the information that I receive I will produce a report which I hope will be used to improve the reproductive health of people in Estonia.

I would like to record our discussion as it is so difficult to write down what everyone says, and I don't want to waste any of your ideas. What we say in this group will be anonymous – we can use our own names or chose aliases, but names will not be transferred to the transcripts. Only I, as principle researcher, (and the translator) will have access to the recording and notes.

I want to find out from you about women's experiences here in Estonia. I have been looking at statistics and talking to experts, but I need to know what actually happens to women and how they feel about family planning and keeping healthy. What you think and feel is very important to me.

Please feel free to say what you think. I want to hear everyone's ideas – there are no right and wrong answers! I want this to be more like a discussion than a question and answer session, so please talk to each other, not just to me. If there is anything I ask or say that you don't understand please tell me – I may not be using the right words! I will be asking you lots of questions – if there is anything you want to ask me you can do that too. [If they ask questions that anticipate later discussions, ask if it's OK to leave it until later]

Do I have your permission to proceed?

[Record some thoughts about participants, body language etc]

Discussion Guide

1 Life in Estonia today for you
What are the main concerns/difficulties for people of your age group?

Are they different now compared to during the Soviet period?

Are they different because you are older or because the situation has changed?

2 Fertility Preferences
is it important to have children?

How many children in the 'average' family [probe: then and now, them and us]

ideal number of children

the best time (life course) to have children [probe: is it changing?]

3 Sex Education
Where (source) and when (what age) did you receive information about relationships, sex, contraception etc
[Allow offers then probe: school, home, friends, other sources such as magazines, videos etc]
Was what you were told

Good quality/correct info?

Enough?

Soon enough to prepare you?

Delivered with open attitude?

4 Regulating Fertility

Knowledge

types of contraceptive/contraceptive practices known about

where/how people get their knowledge about them

Attitude

what do you think about using contraceptives?

Are there advantages/disadvantages of different types of contraceptives/practices?

Pills?

Condoms?

Practice

what do people of this age use?

how can someone get these methods?

Some people don't use contraception, what stops people from using contraception?

5 Abortion

Knowledge

How did you first hear about abortion? Can you remember how old you were?

(Probes: From school? Parents?)

Attitude

what is 'public opinion' about abortion?

is there any stigma (habimark, habiplekk) attached to it?

Who disapproves of abortion? What type of person or group?

who would a woman talk to about her abortion?

who would she *avoid* telling?

Practice
what might lead a woman to have an abortion?

How can you arrange an abortion?

Have you ever heard of women 'going round the corner' for an abortion (illegal, not at clinic)?

Some people don't have abortions, what might be the reason?

Was it easier or more difficult in the past? Why?

6 Sexual Health
STIs known about – can give examples of?,

perceive the issue as something to worry about in Estonia?

In Tallinn?

What type of person is most likely to be HIV+?

how do people get knowledge about STIs? (probe: school, media etc)

know about prevention of STIs

how to obtain treatment for STIs

7 Communication, Responsibility and Cooperation Between Women and Men
do men and women discuss contraception?

whose responsibility is it to use a method?

do men and women discuss having children?

discuss abortion?

Can a woman insist her partner uses a condom?

8 Improving Reproductive Health in Estonia
what could/should be done?

9 Sweeping up question
Is there anything you can think of that I haven't asked about that I should have?

Thanks

You may be interested in the results of the work I am doing here in Estonia. If there is anyone who would like to have a summary of the report, please leave me your contact details and I will post or email a copy to you in due course.

Thank you for coming today, I'm very grateful for your help.

Appendix 6 Example of Key Informant Discussion Guide
(this example used with gynaecologists)

Interview with key informant: Name, Location

Time, Data

Background Information

Title:

Responsibilities: Since?

The Soviet Period

The use of abortion as opposed to modern contraception
What did doctors know/think?

Unofficial payments for abortion?

What did patients ask? (for contraception, TL?)

Unofficial payments for quality contraceptives?

Abortion Morbidity/Secondary Infertility

Quality of services/Estonia in comparison to the rest of the Soviet Union?

Methods used

Anaesthesia

Reproductive health in Estonia Today

Sex education

Contraception

Emergency contraception

TL or vasectomy

Abortion (any private clinics? any illegal abortions?)

STIs

Men

Young people

Ethnicity

Barriers to use of contraception

Knowledge

Cost

Choice

quality of care

client handling issues (access, opening times, appointments, waiting)

privacy/confidentiality

other

Barriers to abortion

knowledge

stigma

cost

quality of care

client handling issues

privacy/confidentiality

Other

Society and Policy

Is there an 'abortion debate' in Estonia or women's groups campaigning for change? For example for free contraceptives?

When fertility rates are so low, how much commitment is there on the part of government to support contraceptive services?

If the Estonian government decided to improve reproductive health, what would you suggest are the priorities?

Anything I didn't ask about but should have?

Appendix 7: Focus Group Distribution

Group/No/ /type of group	Sex	Ethnicity	Age	Location	Recruiter
1 6 respondents, 2 friendship groups	Female	Estonian	30-40	Tallinn Capital city	J
2 4 respondents, some knew each other	Female	Estonian	18-25 (students)	Tallinn Capital city	KT
3 9 respondents, friendship group	Female	Estonian	30-45 (plus one of 23)	Haapsalu Small town	J
4 6 respondents, friendship group	Female	Russian	30-45	Narva Large town	JR
5 5 respondents, friendship group	Female	Russian	25-35	Narva Large town	JR
6 7 respondents, friendship group	Female	Estonian	30-45	Viljandi Medium town	IT
7 6 respondents, some knew each other	Male	Estonian	30-45	Viljandi Medium town	IT
8 5 respondents, some knew each other	Female	Estonian	25-35 (grad students)	Tallinn Capital city	L
9 4 respondents, friendship group	Male	Estonian	18-25 (students)	Tallinn Capital city	T
10 3 respondents, friendship group	Female	Russian	18-25 (students)	Tallinn Capital city	JR
11 6 respondents, 'Women's Group'	Female	Estonian	45-60 (and one of 30)	Tallinn Capital city	IJC
12 4 respondents, friendship group	Female	Estonian	18-25 (students)	Tallinn Capital city	KT
13 3 respondents, friendship group	Male	Estonian	18-25 (students)	Tallinn Capital city	KT
14 4 respondents, friendship group	Female	Estonian	30-45	Tallinn Capital city	K

Distributions:

By ethnicity →	Estonian x 11
	Russian x 3
By sex →	Female x 11
	Male x 3
By size of town* →	Capital city x 9
Large town x 2	
	Medium town x 2
	Small town x 1
By age →	18-25 years (students) x 5
	25-35 years x 2
	30-40 years x 1
	30-45 years x 5
	45-60 years x 1

*** Locations and ethnic mix**

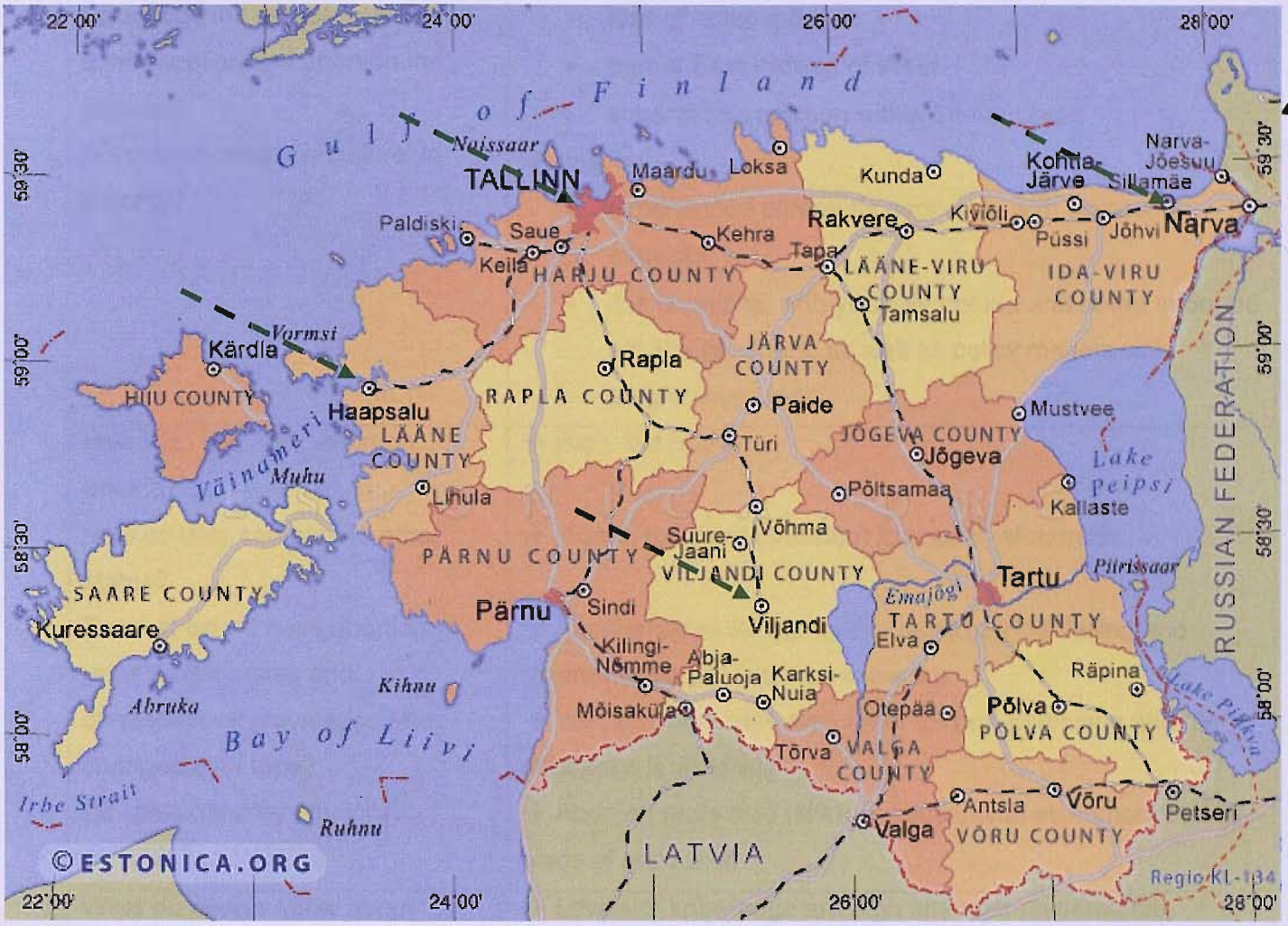
Capital city is located on north coast and is half Estonian, half non-Estonian (mainly Russian/Russian speaking)

Large town is located in north east on Russian border and is over 90% Russian/Russian speaking

Medium town is located in south central region and is predominantly Estonian

Small town is located on west coast and is predominantly Estonian

Appendix 8: Focus group locations



Focus group locations are identified by green arrows

Appendix 9: Research Questions Revisited

Research Question	Answer
Over time, what factors have influenced the use of contraception and abortion in Estonia? Is there an 'abortion culture' in Estonia?	→ Historical and political experience • loss of independence • part of East instead of West • subordinate position within Soviet Union → Yes, but • experienced differently especially with respect to ethnicity • it is changing, with younger people and better informed service providers, as well as policy makers with progressive ideas
How high are 'high' abortion rates? How do they compare to other states? To what extent have abortion rates, fertility rates and contraceptive prevalence rates changed over time? Do rates differ by ethnicity?	→ High, but falling → High in relation to Western European standards → Abortion rates falling, fertility rates (period) falling and contraceptive prevalence increasing → Yes, abortion rates are higher for non Estonians and the difference is widening → Abortion rates also differ by educational attainment and by place of residence
What do people know about fertility control? What are people's attitudes to contraception and abortion? What do they see as barriers to informed choice in terms of fertility control? How do people perceive the behaviour of their own social group?	→ Levels of knowledge are high amongst respondents → Attitudes to contraception are positive and abortion is perceived as something to be avoided →Respondents see these choices as being embedded in their social lives and affected by the experience of the transformation of Estonia since independence. They acknowledge individual choice and responsibility but are aware of the ways in which structural issues and government policies shape choice → They see behaviour as being influenced by knowledge and empowerment and 'choices' as being limited for some people, due, for example, to cost constraints or lack of access

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