In 1974, a WHO meeting on education and treatment in human sexuality defined sexual health as: "The integration of the somatic, emotional, intellectual and social aspects of sexual beings, in ways that are positively enriching and that enhance personality, communication, and love" and stated that the right to sexual information and the right to pleasure are fundamental to this concept.¹

Is sexuality the same for everyone?

This definition does not imply in any way that sexual behaviour or sexual health must correspond to a norm, nor that specific sexual activities should be encouraged or condemned. It opens the door to individual expression and is independent of age, race, culture, religion, sex, or of physical or mental handicaps.

Such a flexible approach is a must when we are developing a programme on sexuality in an area as wide as the European Region of WHO, with its many historical, political, religious and cultural differences regarding sexual behaviour, the roles of men and women, the importance attributed to virginity, menstruation, exposing one's body, nackedness, the extent to which sex is considered as a source of joy, of satisfaction and of self-expression or solely as a means of reproduction. These differences must be taken into account.

It is not a question of everyone conforming to the opinion of an expert on what sound sexual behaviour is; everyone should, however, receive all the information that they feel they need about their body, their sexuality and contraception.

The objective of such a programme is for the individual to be able to choose a lifestyle that enables him to enjoy good physical and emotional health, for which he feels personally responsible.

If sexuality is a natural thing, why then are there sexual health problems?

There are several causes such as discrimination against the sexuality of the mentally or physically disabled, old people, homosexuals; deep-rooted, negative attitudes; discrimination between the sexes; the repression of children's sexuality; insufficient attention to groups exposed to specific situations, such as migrant workers, etc.

How to ensure sexual health?

Several steps should be taken. The first is education. Sexuality is a natural and normal component of the human being. Unfortunately, it is a cause of distress for many people. The need for sex education is obvious. People should know that sexuality is a positive and enriching element of life, not a source of anxiety and guilt.

To inform is not enough, however. In the past, sex education was seen as a means of avoiding the detrimental effects of sexuality: unwanted pregnancies and sexually-transmitted diseases. Consciousness of attitudes, communication skills and decision-making skills are therefore required. Such sex education must be adapted to the children's needs, and focus on boys as well as on girls.

An important prerequisite for the success of sex education is that it should not be brought up separately but presented in context and relate to all aspects of education. Sex education therefore involves the whole community. Specific training for those whose role will be to teach is indispensable. To avoid imposing on the public their own systems of values, teachers should take into account their own emotional reactions and attitudes to sexuality.

A second step involves the training of health professionals. At all levels, they share the opinions, myths and prejudices that are rampant in society; they may also have their own unresolved sexual problems. Patients should, however, be able to confide in their doctors and discuss their sexual problems. Doctors and other medical personnel should not feel shy about dealing with these questions.

As far as training objectives are concerned, a sex counsellor or therapist must fulfill two prerequisites: have sufficient knowledge and be able to exploit this knowledge without being handicapped by taboos, prejudices, ignorance and more or less subconscious emotional reactions.
Medical staff should also be knowledgeable about the physical causes of sexual problems and be aware of the conflict between the need to take rational steps in family planning and the desire to fully enjoy sexual relationships. They should be able to help people to find the method or methods that will enable them to cope with this conflict in the best possible way.

Furthermore, services should be improved. It is not necessary to set up complete networks of psychosexual guidance services. Health professionals, however, should acquire the understanding, information and skill to face individuals' sexual problems and worries.

Finally, legislation should be promoted to enable young people to benefit from sex education, as well as from family planning guidance and services. The equality of men and women must be guaranteed, so that both can achieve the lifestyle that will meet their needs. Legislation must not discriminate against certain population groups whose sexuality is not coined in the majority mould, such as homosexuals. Legislation should therefore be brought up to date, taking into account modern lifestyles (minimum age for heterosexual relationships, marriage) and liberalizing propaganda about the means of contraception as well as their sale.

What is the role of the WHO Regional Office for Europe?

For the period 1984-1991, the Regional Office's programme on family planning and sexuality will concentrate on the following areas of sexual health:

- the means of ensuring that adolescents have access to family planning services and sexual guidance;
- the promotion of male responsibility in family planning;
- a survey of definitions of a satisfactory sex life and of conditions that foster sexual health;
- an analysis of people's sexual experience, their satisfaction, and their negative experiences; and a study of programmes on sexual guidance;
- an analysis of the impact of an institutional environment on the sex life of old and of disabled people;
- an analysis of the influence of families and peer groups on sexual development during adolescence;
- an analysis of the extent and causes of sexual problems such as rape, sexual abuse, violence experienced by children, and of remedial action;
- the manner in which training programmes for health personnel prepare them to answer their clients' questions on sexuality.

COUNTRY REPORTS

TRENDS IN FAMILY PLANNING AND GOVERNMENT ACTION IN HUNGARY

Over the past 40 years drastic economic and political changes have taken place in Hungary. Knowledge of these events makes it easier to understand the changing approaches of society towards population problems, including family planning.

After the Second World War, the nation had to rebuild its devastated homeland. After an enthusiastic beginning, however, the restoration process slowed down, with social and political results, particularly in the population field. The country needed manpower, so families were encouraged to have more children and were discouraged from seeking abortions, which were illegal at that time. Consequently there was a steady increase in the population.

a The population in 1983 was 10.74 million, distributed over 93 000 square km. The birth rate was 11.9 and the death rate 13.9 per thousand. Population growth was -0.2%.
In the mid-1950s, demands for better social conditions and civil rights were made, including the right to limit the size of one's family. This last demand could be met only by making induced abortion available, as it was the only existing and efficient method of birth control. Thus, induced abortion became widely used and was quite rapidly accepted by the public and the medical profession. Initially there were a few reservations, primarily of an ethical nature, but later concern about the method grew, related to possible impairment of subsequent fertility.

Birth rates decreased steeply from the late 1950s onwards, reaching a low point in 1964. The Government decided at that time on to take action to encourage couples to have more children. The measures included paid nursing leave for the mother until her child was 3 years old. Birth rates went up again.

In the mid- and late 1960s, oral contraceptives began to appear and spread rapidly. However, the abortion rate remained high. But about the same time, part of the lay public and the medical profession began to see abortion as an evil, the sole cause of low fertility and of a high level of prematurity in babies. Recent controlled international studies have shown, however, that induced abortion alone cannot explain these changes.

A second generation birth control pill, containing 50 micrograms of ethinyl-estradiol, was introduced in the early 1970s, simultaneously with the IUD. Both measures were subject to widespread public discussion.

In 1973, recognizing the need for improved sociomedical services, the Government passed the Population Act which emphasized the right of couples to determine the size of their family and made new provisions for improved family planning services. This Act heralded the spread of a nationwide network of regional family planning centres. At the same time, young couples were encouraged to have 2-3 children to maintain a balance between different age groups in society and they were given free choice of and access to a variety of effective and modern birth control methods and services (new pills, safe IUD insertion, improved obstetrical care, measures against premature births, perinatal intensive therapy centres, prenatal genetic care). Non-medical actions included more nursery schools and improved housing conditions for young couples. As a result, the prematurity rate has decreased significantly over the last 5 years.

Looking to the future

Due to Government action and the efforts of social organizations, the decrease in the birth rate has slowed down. However, further medical and social efforts are needed to prevent a decrease in the population which would result in an undesirable restructuration of age groups in society. These include:

- motivate the young to have more children, on economic and moral grounds;
- decrease the rate on teenage pregnancies and abortions;
- place more emphasis on the protection of the first pregnancy of married women;
- introduce new methods in the diagnosis and treatment of infertility;
- decrease age-specific mortality;
- provide harmless birth control methods on a wide scale throughout women's fertile lifetime

[From: Professor L.G. Lampé, Director, Department of Obstetrics and Gynaecology, University Medical School of Debrecen, 4012 Debrecen, Hungary]

[a The use of modern birth control methods compared with traditional methods rose from nil in 1966 to as much as 65% in 1977. The use of traditional methods over the same period declined from about 66% to about 25% of all users.]
FAMILY PLANNING AND SEX EDUCATION
IN CANTON TESSIN, SWITZERLAND

The first initiatives in the field of family planning can be traced back to 1975, in a regional hospital in Locarno and to the work of a feminist group in Lugano in 1976. At that time Canton Tessin had no legislation on family planning.

In 1978, as a result of the problems raised by the vote on abortion, the Department of Social Affairs set up a family planning centre in the Canton. Numerous difficulties were experienced.

At first, the centre did not enjoy the popularity nor the medical support that it required. It only has an advisory function and its location outside town has prevented further development. Its reorganization is now under way and it is foreseen that an office may open in the local hospital; consultation and prescriptions of contraceptives will be available.

In the mean time, on the initiative of two regional hospitals, a private medical practice and a group of women, other family planning centres have been created, in addition to the one mentioned above. These centres have different structures and activities, however, which may have led to different interpretations of the concept of family planning. The people in charge of the centres therefore met in 1982 to coordinate their activities and to define a unified family planning policy for all the centres.

As far as the centres' staff is concerned, three of them have been trained as family planning counsellors and work in the family planning centres in Cordererio/Mendrisio (the Canton centre), in La Carità hospital in Locarno, and in the communal hospital in Lugano.

Family planning legislation is very recent. According to the new federal law now being enforced, cantons are responsible for setting up counselling centres to deal with problems of pregnancy and its prevention through family planning.

Sex education

The concept that sex education is required at school was developed at the end of the 1960s by a group of teachers from primary and secondary schools. Later, several groups and committees were set up and many proposals were put forward. The best one involved motivated, available teachers receiving on-the-job training in children's and adolescents' sex education. Several obstacles have, however, made it impossible to introduce sex education in schools.

Sex education and contraceptive advice in higher education and professional training is based on ad hoc initiatives in which staff of family planning centres are active. The staff is also involved in surveying draft laws on family planning and sex education.

[From: Bruna Parini and Marina Armi, family planning counsellors, Dipartimento delle Opere Sociali, Centro di Pianificazione Familiare, 6877 Cordererio, Switzerland]
RAPE INFO-SERVICE PART OF FAMILY PLANNING CENTRES IN LUXEMBOURG

Women victims of rape consulted our services for the first time in 1982. They came to family planning centres for postcoital contraception but also to receive psychological help, to be listened to and to have someone to talk to. This year, we have seen 26 raped women, only four of whom lodged a formal complaint. In 1983, 23 women were raped and none complained, and in 1984, we met 30 such women, nine of whom lodged a complaint. For the first time, this year raped children have come to our service. Five out of 11 cases were also incestuous (father or brother); two children were mentally disabled.

Our Rape Info-Service acts in three ways.

- Medical services carry out gynaecological examinations to determine bodily harm, look for sperm, carry out bacteriological tests for sexually transmitted diseases, and, if required, offer postcoital contraception. All the findings are given to the woman in writing and she can use them should she decide to lodge a complaint even at a later stage.

- Listening and guidance service. Some women feel compelled to discuss in detail what they went through and, in particular the fear of death they experienced. Others are unable to speak as they remain overwhelmed by the shock of a totally unforeseen event. We respect their silence but invite them to return later, with or without their partner, who frequently reacts in a very ambivalent fashion (at first, anger against the aggressor; later, disbelief: did she really not consent? ...).

- Companionship service. A network of female volunteers has been set up throughout the country to help raped women and offer them companionship during the ensuing days and weeks.

The Rape Info-Service is open from 8 to 11.30 and from 13.30 to 18.00 hours during the whole week. A telephone number is printed every day in various newspapers, so that women can call us immediately. Midwives in the Maternité d'Etat who are sensitive towards and able to deal with rape victims, take care of them during week-ends and at night.

Children are referred to the Clinique pédiatique de l'Etat, where an association has been created to prevent and treat violence towards children. It is staffed by pediatricians, psychologists, social workers and representatives of the "juge des mineurs" (magistrate responsible for cases involving children). Mentally disabled children, who are unable to express clearly what happened, are the most difficult cases. Furthermore, many people in society tend to doubt what children say, on account of their imagination, but psychologists very often succeed in determining facts and in assessing the damage suffered through drawings.

Legally, rape is defined as forced vaginal penetration. However, sexual abuse can also take on other forms, such as indecent assault, that can cause severe trauma.

We feel that pornographic literature and prostitution, which present women as sex objects available to anyone, encourage aggression against women and children. This hypothesis must be verified in the years to come.

[From: Dr (Mrs) M.P. Molitor-Peff, Présidente du Mouvement luxembourgeois pour le Planning familial et l'Education sexuelle, 18-20 rue Glesener, L-1630 Luxembourg]
FAMILY PLANNING, SEX EDUCATION
AND HEALTH PROMOTION IN ICELAND

Family planning services in Iceland are part of the activities of health centres: 48 health centres are located throughout the country. Their staff includes a physician, nurse, midwife, physiotherapist and secretary (Health Act 1974). There is no age limit to the provision of family planning services which include various contraceptive methods as well as counselling on sexual or couple's problems by the nurse.

The use of contraceptive methods has changed over the last 10 years. In 1971, 32% of clients at the health centres used the Pill and 12% the IUD. By 1981, the use of the IUD has gone up to 37% and Pill use declined to 29%. The decline in the use of the Pill in favour of the IUD is observed in all age groups.

In 1977, a prevention campaign in primary and secondary schools on sexually transmitted diseases and contraception was launched by the Chief Medical Officer. Since then there has been a 30-40% decrease in gonococcal infections among 15-17 year-olds (1980 data) and fewer pregnancies were observed among 14-16 year-olds.

In 1984, an experimental programme of health teaching with evaluation was started in two schools on behalf of the Ministry of Health and Social Security and the Nordic Council. Other schools serve as controls. The programme focuses on communicating facts about health to youngsters through their teachers, who themselves have been trained to talk about health topics such as smoking, alcohol, sexually transmitted diseases, drugs, accidents and sexuality. These health facts are integrated under different subjects in the curriculum. The results of the programme of health teaching will be evaluated after 2 and 4 years.

[Source: Dr Olafur Olafsson, Chief Medical Officer, Landlaeknir, Laugavegur 116, 105 Reykjavik, Iceland]

PEOPLE

DR JO E. ASVALL APPOINTED REGIONAL DIRECTOR FOR EUROPE

At its seventy-fifth session, the WHO Executive Board appointed Dr Jo E. Asvall as Regional Director for Europe. He succeeds Dr Leo A. Kaprio who is retiring after 18 years of service and to whom we extend our warm thanks and deep gratitude for his unswerving support and encouragement to the family planning programme of the WHO Regional Office for Europe.

Dr Asvall, born in Drammen, Norway in 1931, is one of the key architects of the regional strategy of health for all by the year 2000 adopted by the WHO Regional Committee for Europe in September 1980.

He is keenly interested in enlarging the approach to family planning to include more emphasis on people's lifestyles and basic decisions concerning sexuality, human relationships and procreation. Family planning in his view is intimately related to an overall pattern of sexual feelings, attitudes and relationships in which both female and male play a role. He is also concerned about the impact new techniques of reproduction may have on society from the medical, ethical, psychosocial, legislative and economic point of view.

Having served as Director, Programme Management, prior to his appointment as Regional Director, Dr Asvall's extensive knowledge of the Region and its health problems will be a very valuable asset in guiding the various programmes of the Regional Office in the best interests of the Member States.

ENTRE NOUS wishes him success
DR JEAN-PAUL JARDEL, NEW DIRECTOR,
PROGRAMME MANAGEMENT

Dr J.-P. Jardel has been appointed Director, Programme Management of the WHO Regional Office for Europe and assumed his new post on 1 April 1985. With his background in medicine, biostatistics and epidemiology, Dr Jardel has been instrumental in advising countries on how to collect and use health information effectively.

Coming from the French National School of Public Health in Rennes, he joined the permanent staff of WHO in 1971 and first worked in the Regional Office for Africa in Brazzaville. In 1980 he became Regional Officer for Epidemiology and Information Support at the Regional Office for Europe.

In this capacity, Dr Jardel has been a great help to the programme of family planning through his continuous advice on how to collect basic family planning and demographic indicators of importance to the development of family planning programmes. He was instrumental in the preparation and organization of the Berne meeting in March 1982, at which data were presented from studies on demographic trends in the European Region related to fertility, family formation and mortality and the effects of these trends on young people, adults and elderly, with particular reference to health and social policy. The data from this meeting form the backbone of the important WHO Regional Publication, European Series No. 17, Demographic trends in the European Region, 1984.

Among his many qualities we would like to single out his willingness to share his expertise, his humour and his warmth in human relations. We wish him all the best in the new task he has been assigned.

INTERCOUNTRY NEWS

DEMOGRAPHIC CHANGE AND ITS IMPLICATIONS FOR THE YOUNG

The WHO Regional Office for Europe has published a book on demographic trends in the Region to anticipate changing health needs for different age groups and thereby to advise Member States better on the implementation of the regional strategy of health for all.

In one section of the book, Teper and Backett deal with the implications of demographic change for the young population. Of the 31 countries studied in the European Region, 16 will experience a decline in the number of young people (defined as the 0–19 age group), 9 countries will experience little change and 6 will show a substantial to large increase in this age group. The trend is not new. The authors indicate that since 1960 every country in the Region has shown a continuing reduction in the proportion of people under 20. This trend will continue until 2000.

As a consequence, changes in groups other than the 0–19 age group will affect societal policies towards and resources for the young. Only 12 countries in the Region are likely to have fairly stable age groups and societal priorities by age groups are likely to be decided not by demography but by broad social preferences. The other countries will be faced with massive groups of people aged 20 years and over which are likely to compete with the young for society's attention to their needs.

a Teper, S. & Backett, M. Implications of demographic change for the young population (0–19 years). In: Demographic trends in the European Region. Copenhagen, WHO Regional Publications, European Series No. 17, 1984, pp. 133–147.

b Algeria, Morocco, Turkey and the USSR are not included.
What are some of the needs of the young?

The under 20-year-olds have never been so healthy physically. According to the authors, however, they are psychosocially vulnerable because of unemployment, the breakdown of the family, migration and loneliness. Healthwise they may experience unwanted teenage pregnancy, sexually transmitted diseases and abuse drugs and alcohol. Therefore, the under 20 age group will need psychosocial support especially from the family, as the integrity of emotional ties and the assurance of parental love have been shown to be important to the mental and social health of the young. Such health includes sexual health, successful parenthood, and family building.

In terms of future priorities, Teper and Backett suggest: (a) a shift in emphasis from physical health to mental and social health of the young; (b) an emphasis on the family and its educational and preventive medical role; (c) more attention to employment opportunities for the young; and (d) the promotion of an earlier adult role for the young, such as caring for the elderly, for those without parents or for the disabled.

[Photo: Nuno Silva Miguel, Os Juvenis Sexualidade, Comissao da Condição Feminina, Av. da Republica, 32-1, 1093 Lisboa Codex, Portugal]

MEETINGS REVIEWED

COUNTRY OF ORIGIN - MIGRANT WORKERS - HOST COUNTRY. A TRIANGULAR RELATIONSHIP

The Family Planning Unit of the WHO Regional Office for Europe and the International Children's Centre convened a meeting in Paris, on 11-14 December 1984, with participants from three countries of immigration (France, the Federal Republic of Germany and Sweden) and from four countries of emigration (Algeria, Morocco, Portugal and Tunisia), and a representative of the European Office of the International Planned Parenthood Federation (IPPF).

The purpose of the meeting was to determine the needs of migrants in family planning, to study family planning services in host countries and to propose steps necessary to improve these services.
The participants mentioned that family planning needs of migrant families in host countries are numerous and inadequately covered. Spacing of births is practised, however, by most migrant families and decrease in the birth rate among foreigners is associated with an increased length of stay in the host country. This may be related to new aspirations, new behaviour, the acquisition of new roles for women, but also to a decrease in infant mortality. Last and certainly not least, it also reflects simultaneous changes in family models in the countries of origin and the setting-up of family planning programmes in these countries.

Migration in itself has an impact on the wish to have children, but another influence may be the availability in receiving countries of information on contraceptive methods, on how to treat sterility and, generally speaking on sexuality and health. The need for this information has emerged from surveys carried out among women, men and adolescents of different origins, who have migrated to different countries (women from North-West Africa in France; women from Yugoslavia in France, in the Federal Republic of Germany and in Sweden; Turkish women in the Federal Republic of Germany; a Moroccan women in Belgium; a Kampuchean women in France).

Family planning services in the various host countries in Europe vary widely depending on the health and social structure of each country and the position of foreigners in the population. In some countries, family planning services are inadequate or staff is not trained in family planning. Furthermore, proper use is not made of various anthropological parameters for interpreting needs of migrants and for defining family planning messages.

As far as countries of origin are concerned, family planning needs in Algeria, Morocco, Portugal and Tunisia were discussed. The very concept of fertility control and family planning also exists in more traditional environments, and family planning policies established by governments for some time have enabled populations to receive information on modern family planning methods.

On the other hand, the participants indicated that actual usage rates are still low. They vary with age and the socioeconomic status of the woman. The method selected as well as the duration of use also vary.

Lastly, the participants proposed various solutions to improve family planning services for migrant populations: the selection and training of "cultural interpreters" to facilitate the dialogue between staff and migrants, and the promotion of a permanent "triangular" exchange and consultation between representatives of the family planning programmes of the countries of origin, migrant populations and representatives of the family planning programmes of the host countries.

[Source: Summary report of the WHO/ICC working group on improving family planning services for migrant populations. WHO/EURO document (ICP/MCH 504/m01(s), UNFPA/RMI/79/P05), 1985]

Educational AIDS

Dr J.L. Garcia, from the Public Health Institute of Navarra, in Spain, informs us about a vast programme to develop educational tools for sex education at school. Part of the programme is intended for educators and parents, and is prepared in the form of monographs, to make them aware of how important sex education is, both at school and in the home.
This material, focusing on the various levels of childhood and adolescence includes booklets, posters, colouring books, as well as films intended to foster discussions about sex.

For example, a booklet intended for 6-7 year-olds, tells the story of "Bolita linda" (the pretty little ball) i.e. the ovule, and a spermatozoa called "Colita larga" (little long tail) who meet during fertilization with a hormone "Botones-N" (errand boy).

Similar booklets have been prepared for the other age groups. According to Dr Garcia, the sex education programme intends to be "global" in the sense that it involves parents, schoolchildren and teachers, "progressive" (adapted to the needs and the maturity of the child) and "practical" (i.e. can be applied without difficulty).

[For further information write: Dr J.L. Garcia, Associate, Public Health Institute of the Diputacion Foral of Navarra, COFES, c/Eza 4, Tudela, Spain]

**WHAT TO WRITE FOR**

**SEX AND FAMILY PLANNING: HOW WE TEACH THE YOUNG**

The programme of sexuality and family planning of the WHO Regional Office for Europe initiated a study to assess sex education programmes and family planning services for young people in the European Region. First, a short questionnaire was sent to the governments of every Member State to obtain their views on sex education and family planning for young people. Nine countries were specially selected for detailed study (Belgium, the Federal Republic of Germany, Italy, Morocco, the Netherlands, Poland, Portugal, Sweden and Yugoslavia). Their replies were followed up with field visits by a WHO temporary advisor from the Department of Sociology, University of Uppsala, Sweden.

**A few highlights of the study**

Legally, sex education for the young varies from compulsory to voluntary but no countries have direct legal obstacles. Adolescents are identified as the most important target group and secondary schools are considered the main vehicle for sex education. The general view of the governments was that they should primarily be taught four themes (sexual anatomy, reproductive biology, contraception, and parenthood) the emphasis being on the biological basis of procreation and parenthood. Several countries have ambiguous views about including homosexuality and pornography in sex education.

The availability of contraceptives for the young varies from one country to another. Hormone-based contraceptives and IUDs are available mostly on medical prescription. Diaphragms are available on prescription in eight countries and over the counter in seven countries. Condoms are easily available. Most countries have no legal obstacles to free information for young people about contraception, although the sale and
distribution of contraceptives is subject to regulations. There are in most cases no real legal obstacles to the young using family planning services. Practical obstacles, however, may be the attitude of the service provider towards young people requesting contraceptives and the fact that existing special programmes/clinics for the young are not available nationwide in any country. Finally in most countries family planning services for young people are free of charge.

Dr Leo A. Kaprio, former WHO Regional Director for Europe, states in the preface to the report on the study:

"The study clearly demonstrates how small a proportion of young people receive instruction in a subject that will profoundly affect their future life and that of the community. It reveals the need for a more systematic approach to sex education and, more broadly, to education on family life and its problems.

The findings of the study are obviously applicable not only to the WHO European Region but also to many other parts of the world. It is to be hoped that governments will study the findings with care if only because, as the study points out, it is cheaper to provide the young with adequate education on family planning and sex than to cope with the abortions, ruined educational opportunities, and other unwelcome side effects of today's sexual freedom."


COOPERATION BETWEEN COUNTRIES TO IMPROVE FAMILY PLANNING PROGRAMMES

In its medium term programme in 1980, the Family Planning Unit of the WHO Regional Office for Europe included the need for countries to consolidate their knowledge and experience in order to introduce innovative ideas and methods into various aspects of family planning. In collaboration with five countries of the Mediterranean Region and southern Europe (Algeria, Morocco, Portugal, Tunisia and Turkey) and with the assistance of the coordinators of the United Nations Fund for Population Activities, the Unit launched a country case study project.

Each of the participating countries drew up the profile of its family planning programme, based on survey guidelines, national reports, official documents and field visits undertaken by a study group, comprising two participants from every country. Through comparisons with the experiences of other countries, participating countries were able to assess the strengths and weaknesses of their own programmes.

This "intercountry cooperation" resulted in a lucid and frank publication on the similarities and differences among the five countries in the field of family planning. This publication will be of interest to national officers in family planning programmes in other countries, as it is not merely a survey of family planning activities in five countries, but a reference document to foster research on alternative approaches and to stimulate the development of national family planning programmes.

[L'amélioration des programmes de planification familiale: report on a country case study. Copenhagen, WHO Regional Office for Europe, 1984 (EURO Reports and Studies, No. 82). English text in preparation]