New directions
 ENTRE NOUS

Sexuality and Family Planning Unit
WHO Regional Office for Europe
Scherfigsvej 8
DK-2100 Copenhagen O
Denmark
Tel: 39 17 14 51 & 39 17 14 26
Fax: 31 29 44 13
Coordinator
Dr Daniel Pierotti
Editor
Diana Gibson
Administrator
Dominique Dalgaard
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In this issue

What do you expect to be doing and thinking – professionally – in 2001? Will you be using the same technology, training to meet the same needs, applying the same principles, or even working in the same type of organization? Most likely not, and in this issue of ENTRE NOUS we have tried to give you a foretaste of things to come in reproductive health between now and the 21st century.

Dr Malcolm Potts, guest editor for this issue, previews what he believes will be the two biggest issues of the next decade. To stabilise population growth, he feels, international donors must be prepared to give much more than .0001% of GNP to family planning, and in the AIDS field, the decision-makers who hold the purse-strings must stop discriminating against prostitutes and homosexuals. Strategies in both areas will need to be much more consumer-oriented, and costs strictly compared and controlled.

Is family planning really a demographic issue at all, asks Dr Doortje Braeken (page 7), or should it be taken out of this context now and treated as a contribution to sexual health and wellbeing instead? And what type of organization will be most effective in preventing unwanted pregnancy and sexual morbidity, and promoting sexual health? In a related article, Ms Maggi Ruth P. Boyer writes from Pennsylvania about new trends in training (page 8).

Men’s emancipation from women’s dominance in family planning is not far off – but is that what they want? Dr Karen Ringheim (page 5) explains how useful – but problematic – it is to do social-science research in this delicate area.

From Mexico City, Susan Pick de Weiss and Irving Perez (page 9) describe how – for the first time in Latin America – they have used descriptive and diagnostic research as a basis for sex education programmes adapted to the particular psychology and cognitive ability of adolescents.

Stirling Scruggs (page 11) tells how FAO and UNFPA have trained rural women and created employment for them in the harshest and poorest areas of China.

The growing popularity of IVF, write David Phillips and Sarah Blacksell of Exeter University (UK), is due to the fact that up to 1 in 6 couples are infertile and adoption is much harder than it was. However, the failure rate for IVF, worldwide, is 92%, which puts tremendous pressure on some clients. In the UK the law requires all services to provide counselling prior to treatment, but how good is it (page 13)?

By the time a trend is discernible it can perhaps hardly be described as new any more: almost by definition it will already be well established somewhere. Still, we hope that at least some of the ideas and developments included in this issue of ENTRE NOUS will be new and thought-provoking for many of our readers, including the steadily increasing number who live and work outside Europe.

Diana Gibson

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Diana Gibson
The future, and why the rich should pay

by Malcolm Potts

The 1990s are likely to be the most exciting and most challenging time in the history of international concern for reproductive health. They will be a "make or break" decade in the sense that unless certain problems are dealt with forcefully in the next ten years, huge numbers of people are going to suffer in the future.

In the case of family planning, we have a great deal of solid experience on how to set up culturally appropriate, cost-effective service programmes. The need is to expand what already exists, so that by the end of the decade people throughout the developing world can have universal access to family planning choices. In the case of AIDS, the full extent and threat of the disease daily becomes more apparent. We know enough to outline clinically plausible interventions, although experience of making programmes work has been limited and a great deal of evaluation remains to be done.

Last year, the UN recognized that it had underestimated recent population growth and brought forward the projected date by which global population will exceed 6 billion. If the international community fails to emphasize voluntary family planning services in the 1990s, then the world population could rise to as high as 14 billion before it finally stabilises. If, however, a vigorous and realistic attempt is made to meet individuals' desire for smaller families, then a stable population of under 10 billion could be achieved.

Family planning is a series of intimate, voluntary choices. The problem facing governments and international donors is quite simply that many of the technologies required to control family size are too expensive for the average Third-World citizen. If people are to be given informed voluntary choices and high-quality services then the industrialized nations will have to share some of the cost. As a result of yesterday's population explosion, in the year 2001 there will be almost 30% more women of fertile age than there are today. Taking into account this expanding target population and expected increases in contraceptive prevalence, then in order to meet the median UN population projection an additional 130 to 185 million couples would need to use family planning in the coming ten years. At present, less than 1% of the total flow of international development assistance goes into international family planning. Sweden, Norway and Holland — amongst other countries — give much above average. Germany gives below average and France, Spain and Italy contri-

but few or nothing to this important field. In the 1990s there needs to be a more equal sharing of the burden, as well as a commitment to increase the percentage of international aid going into family planning from less than 1% to 3-4%.

For Europe and the rest of the world the single most difficult challenge of the 21st century is likely to be the imperative of achieving a biologically sustainable economy. The cost of cleaning up environmental damage in Eastern Europe alone is astronomical. When developing countries are getting poorer, as in sub-Saharan Africa, they will be tempted to take short cuts in development. When they are getting richer, as in Thailand, Brazil or China, they will provide their own increasingly important challenge to the fragile planetary biosphere.

In times past, family planning was occasionally portrayed as almost the only problem in development. This was cruelly wrong and no-one denies the over powering need to increase incomes, improve the status of women and improve the education of children, girls particularly, in developing countries. Those people who are informed and realistic about family planning today are not zealots saying that it should be a major part of development spending — they are simply saying that it is more than one hundredth of the development equation.

We cannot deny the struggle of others to achieve the standard of living we enjoy as Europeans. We are committed to family planning as an informed choice and cannot tell others how many children to have. We can rejoice in the global trend to lower fertility and help those who want smaller families to achieve those goals.

Currently, less than 1% of Europe's wealth goes into foreign aid and, as noted, less than 1% of that goes into family planning. Will our grandchildren think we were prudent managers when we made available less than one part in 10,000 of our substance to help international family planning at this critical time?

Donors and aid agencies in general need to get away from the idea that family planning is some impossible task that will only be solved when infant mortality falls or everyone goes to school. Parents love their children and want to limit their fertility all over the world. Family planning assists education and enhances the status of women: it is cheap, it is wanted and we know how to make it available. We do not need more small-scale projects but huge social marketing programmes, realistic access to voluntary surgical contraception, and honesty in the face of the need for safe abortion.

A great deal has been written about the integration of family planning with other aspects of health care, but too often this has focused attention on the provider side. In family planning it is consumer perceptions that determine success. Integration means bringing choices to people's doorsteps, rather than setting up professional com-

Condom demonstration at a truck drivers' stop, Tanzania. If 75% of couples practised family planning, average family size would drop to the level needed to stabilize world population. 

Photo Family Health International
Low condom use leaves millions at risk

Condoms are used less than half as often as they should be, leaving millions of people at risk of unwanted pregnancy, AIDS and other sexually transmitted diseases, a new study estimates.

In roughly 13 billion acts of sexual intercourse in which condoms were needed in 1990, only about 6 billion were used, according to an estimate in a recent issue of Population Reports, published by the Johns Hopkins School of Public Health's Population Information Program (PIP). The estimate assumes that condoms should always be used by all unmarried sexual partners and by about 9% of married couples. The journal calls for broad action to increase condom use.

"The problem is critical. Many more condoms must be used to prevent AIDS and protect against pregnancy, especially among young people and in developing countries", says Phyllis T. Piotrow, Ph.D., director of the Center for Communication Programs.

"We need more promotion, more information, more education, more counselling and more outlets for condoms around the world. This study recommends 30 specific ways to increase condom use", she adds.

The report describes mass-media condom promotion combined with aggressive distribution and widespread use of retail outlets to distribute condoms in places as different as Zaire, Switzerland, Morocco and Pakistan. In Zaire, for example, sales of partially subsidized condoms jumped from 1 million in 1986 to more than 8 million in 1990 due to promotion efforts and an expanded distribution network.

"Condoms - Now More Than Ever", is available from PIP, Center for Communication Programs, The Johns Hopkins University, 527 St Paul Place, Baltimore MD 21202, USA.

Exploitation of the young is a growth industry

For about the last 20 years, in Europe, the exploitation of child labour has been increasing.

All around the Mediterranean, children can be found working full time in small, more or less clandestine workshops, especially in the textile and leather industries, in the farming sector, in construction, and of course in professions that service tourists.

In the North - mainly Great Britain, Germany, the Netherlands and Denmark - paid work occupies sizeable proportions of the child population, but only during the time not spent at school: morning, evenings, weekends and holidays. However, very many of these children do have job-related accidents.

The children of immigrants are often employed in workshops, small businesses or restaurants, but as employees of the "extended" family.

In all countries three child-labour sectors are expanding: begging, prostitution and drug trafficking. To these should be added another, although it is nearly always performed under parental control: publicity work. Begging - in highly organized networks - is done mainly by children of Slav origin.

New legislative and social practices in Europe, notably those connected with the coming of the Single Market, show a tendency to harmonize downwards. So it is to be feared that child labour may again spread in coming years.

Mr Michel Bonnet
Directeur
Centre d'Information sur le Travail des Enfants
304 rue de l'Ail
F-31810 Vernet
France

Continued from page 3

mites to "coordinate" activity. Different systems can be used to get condoms in the village store, to get pills to a community distributor, to encourage a family practitioner to offer an IUD, or to make voluntary surgical contraception available in the government hospital.

Finally, those pressing for increased funding have an obligation to make sure that the money available is well spent. At the moment, programmes providing family planning choices vary in cost from as low as $5 or $6 to almost $100 per couple-year of protection against pregnancy. The 1990s must see a more analytical approach to cost.

Options for slowing the spread of HIV are limited: educating people to have fewer sexual partners, promoting condoms and making them available, and treating other sexually transmissible diseases, which are important risk factors in the acquisition of HIV. European scientists have been at the forefront in understanding the natural history and epidemiology of the disease. In Third-World countries, from sub-Saharan Africa to India and Thailand, AIDS is primarily a sexually transmitted disease of the heterosexual community and it is spreading rapidly. By contrast, the spread amongst homosexuals in Europe and North America is relatively slow, and it seems that a reasonable use of condoms, fewer sexual partners and rapid, effective treatment of bacterial STDs can indeed control the spread of this fragile virus.

As HIV is a new sexually transmitted disease, it necessarily begins in those groups with most sexual partners (primarily prostitutes, their clients and the gay community), but none of these groups has been the focus of public health interventions in the past. Decision-makers have been slow to shift resources to improve the care of prostitutes or gay men, although AIDS is forcing them to a new realism and tolerance. People must be recognized for their intrinsic worth whatever their lifestyle or sexual orientation. Both family planning and AIDS prevention will only succeed so long as they are consumer-oriented.

Dr Malcolm Potts
Secretary, International Family Health
First Floor, Margaret Pyke Centre
15 Bateman's Buildings
London W1V 5TW
United Kingdom
New methods could test male responsibility

Men will soon have new contraceptive methods to choose from. But will they – or women – accept them?

Picture family planning and fertility regulation in the 21st century. Men have as many options available to them as women, and are increasingly taking the responsibility for planning the size of their families and preventing unwanted births, using methods that are safe, effective, long-acting and reversible ...

A far-flung fantasy? Not if recent advances in male fertility regulation live up to their promise. A breakthrough in the fertility-regulation options available to men is likely to occur before the end of the decade, according to the manager of the Task Force on Methods for the Regulation of Male Fertility of the World Health Organization, Dr Geoffrey Waite. By that time, a reversible vas occlusion and a three-month hormonal injectable should be available in many parts of the world. Such an advance will place men on a more equal footing with women than ever before in terms of method choice. Given these improved options, will men take the responsibility for fertility control? Here social science and medicine join forces, to answer the questions: If the methods are available, will they be used? If not, what are the barriers to acceptance and how can they be altered?

Disadvantages of vasectomy

Although vasectomy, involving a surgical incision and partial dissection of the vas deferens, has been available for 20 years, it has the disadvantage of being basically an irreversible method. Vasectomy is appropriate for men who wish to stop having children permanently, but not for those who simply want to space births. Also, traditional vasectomy requires an incision, unacceptable in some cultures and to some men.

In contrast, the new vas occlusion is based on injection under local anaesthesia of liquid materials into the vas through a hypodermic needle. The liquid sets in 10 minutes to form a permanent plug. No incision is required. In China, 100,000 men have undergone vas occlusion, 98% becoming azoospermic (without sperm) within three to six months, similar to the time required with vasectomy. A sample of Chinese men who have had the plug removed up to two years after insertion (via a small incision), have been successful in impregnating their partners. Thus the vas occlusion appears to offer an effective method of family planning for men that would be more easily reversible should this be called for. Although several materials are being tested, WHO-sponsored clinical trials are using a high-quality liquid silicone.

Long-acting hormones

A second, so far less developed method, is a male hormonal method for fertility regulation. In a clinical trial conducted by WHO in 10 centres, it was demonstrated that a hormone, testosterone enanthate, had the potential to produce azoospermia in healthy fertile men within approximately six months. This hormone was injected intramuscularly every week for one year. After the injections were stopped, participants returned to normal sperm levels in less than six months. It is expected that the fertility-regulating effect of the hormone using a new testosterone ester may extend to three to four months from a single injection, putting male hormonal methods on a par with some of the long-acting female methods, and providing couples with a real choice of long-acting agents.

Although men already are significantly involved in family planning (60 million men worldwide have had vasectomies; 50 million men use condoms, and withdrawal is widely practised on an intermittent basis) the male methods currently available have proved unacceptable to many men. Throughout the world men still constitute the vast majority of contraceptors. In many developing countries, there exists a large potential clientele of couples in which neither partner contracepts. How will men be made aware of the availability of the new methods, and how willing will they be to adopt such methods?

New contraceptive methods undergo lengthy clinical trials to determine their safety and efficacy before they become available to the public. After the method has shown some promise from a medical standpoint, it becomes important to determine whether it will find social and cultural acceptance, not only among men and their partners, but among medical practitioners and policy-makers, health educators, and family planning clinic administrators and personnel – all of whom can facilitate or block the transmission of the new technology to users.

Male methods which are both very effective and long-acting, unlike the condom, and reversible, unlike vasectomy, are innovations whose study presents a great challenge to social science research. It would be ideal to determine whether couples in a "free choice" environment, in which they are presented with all the contraceptive options, will choose a male or a female method, and why. What are the dynamics of the decision-making process and do women have a real say in the selection? Would most women prefer that men take responsibility and vice versa, or do men and women feel more secure when controlling their own fertility?

Answering these important policy-relevant questions is made difficult by problems of sampling, ethical considerations, and availability of current and experimental methods in different parts of the world. Researchers would prefer to interview couples jointly as well as individually to determine what choices would be made by men and women separately and as a couple. Most of those who attend family planning clinics seeking a method or change of method are women, and ethically women cannot be asked to return with their husbands before they are allowed to select a method. A major educational/promotional campaign to make men and women aware of the new male methods is necessary, but it will be unlikely to attract the attention of men who are not motivated to regulate fertility or who are content with having their partners retain the responsibility for contraception.

User and supplier reaction

Social scientists are also interested in the socio-psychological and behavioural aspects of fertility regulation used by men. Because the spread of an innovation depends on the experience of early adopters, as well as on the promotion or dissuasion of medical and clinic personnel, how the male method is perceived by users is of critical importance. Are men who adopt the new contraceptives primarily those whose partners have had difficulty with one or more female methods? Does either partner attribute any change in libido to the methods? Does the method raise any concerns on the part of the spouse?

As part of WHO’s Human Reproduction Programme, the Task Force for Social Science Research on Reproductive Health and on Methods for the Regulation of Male Fertility will work closely together over the next several years to answer these and other questions as the new technologies move through clinical trials and become available to the public. In this way, policies can be implemented which increase the likelihood that men of the 21st century can and will adopt the new methods and share responsibility with women for controlling fertility.

Dr Karin Ringheim
Social Scientist, Task Force for Social Science Research on Reproductive Health
Human Reproduction Programme
World Health Organization
1211 Geneva 27
Switzerland

Entre Nous 19 December 1991
Muslims say yes to family planning

Religion is proving no obstacle to the many Muslims who are eager to plan their families. Imtiaz Kamal of Pathfinder International tells a story of innovation and success.

Attitudes to family planning in the Muslim world are changing fast. The largest Muslim country, Indonesia, has one of the finest family planning programmes in South Asia, with full community involvement. Bangladesh has moved very fast in the last two decades. Turkey has 70% CPR (contraceptive prevalence rate) for all methods. Pakistan, after an overcautious period of 10 years, is becoming frank and open about the population issue. North Yemen, with less than 1% CPR, is seeking international assistance for the training of all categories of health personnel to provide family planning advice and services. Men are also becoming interested and involved in promoting family planning. For example in Pakistan, Pathfinder International has two very exciting projects with an almost all-male "cast" who work as case-finders, motivators, referral agents and distributors of authorized contraceptives. Egypt's social marketing of contraceptives is unique in the region. Pakistan has made tremendous strides in the last five years, and is cited as a success story in international circles.

TBAs keen to cooperate
Some of the Muslim countries are experimenting with the participation of Traditional Birth Attendants (TBAs) in family planning programmes. They work as educators and promoters of contraception and also provide non-clinical contraceptives. Contrary to common belief they are interested and willing to work as family planning field workers. In the Middle East and North Africa Region of IPPF there are eight such examples. Pakistan has two projects which utilise only TBAs as field workers, and many other projects in which some of the field workers are TBAs. In many Muslim countries the teaching of family planning used not to be taken seriously by the medical colleges and the schools of nursing and midwifery. But this is now receiving a fair amount of attention. More than 80% of the Muslim countries have family planning associations, most of them affiliates of IPPF. In some countries the government may have no population policy or family planning programme, but nevertheless the NGOs are providing family planning services and the authorities neither support nor oppose their efforts (Lebanon and Sudan are two examples).

Motivation and supply
Many approaches are being tried. Among these are the doorstep delivery of contraceptives, male involvement, mobile clinics for temporary and permanent methods, the use of lane workers (housewives) and depot (stock) holders for motivation, supply and resupply, social marketing, family planning through family physicians, and the inclusion of TBAs and traditional healers in family planning programmes. Indonesia's boat or "floating" clinics are a unique addition to the many approaches being tried, tested and replicated in order to reach the community. The outlook is therefore not so bleak as some people present it. One fact stands out: there is no known example of a family planning field worker in any of the Muslim countries being sent to jail, or a clinic being raided, and so on. The resistance seems to be more verbal than actual, and the fear of a backlash from religious quarters more imaginary than real. It certainly does not come from the people. Most of them are waiting and waiting to be informed and served. With a clear understanding of the population issues involved, sincere cooperation and greater support from governments, provision of correct information to the public about contraception, and available and accessible services, every Muslim country by using culturally suitable approaches can achieve the successes that Turkey, Indonesia, Tunisia and Bangladesh continue to achieve.

Mrs Imtiaz Kamal
Country Representative, Pathfinder International
128-D, Block 5, F.B. Area
Karachi-75950
Pakistan

UNESCO believes that population education – every citizen's right – will be a vital step on the road to sustainable global development. B. Biyong sent this report from Paris

The right to well substantiated and easily understood information on population matters is a major challenge to politicians, because it reflects the relationship between governmental authorities and the individual citizen. It is in fact part of the broader issue of individual rights vis-à-vis the established powers such as the Church or State. This is why population education is not just a matter for educators: it also needs to reach officials and others who make the decisions which – through the intermediary of public institutions – influence not only family life but the views, and the future, of young people. Although population issues do form part of the school and university curricula in European countries, they have a very low "profile" and are poorly handled – not only in the formal and adult education systems but in public information too.

This was the conclusion reached at a UNESCO meeting held in Hamburg recently in preparation for the 1993 International Congress on Population Education and Development. (This Congress will be UNESCO's contribution to the International Conference on Population and Development in 1994). For the first time in Europe, the Hamburg meeting brought together educators who design and plan programmes and train trainers, and specialists in demography (in the broad sense of the term), from universities and research institutes in 11 European countries.

All agreed that Europeans need to become more aware not only of the problems caused by the global demographic situation, but the trends in Europe itself. They should also be involved in efforts to tackle these problems, by improving the general and individual quality of life, for example, or other initiatives that would contribute to a more sustainable form of world development.

For Europe specifically the most urgent population problems are:

- aging and the relationships between the generations

Continued on page 10
Metamorphosis of the FPA

The Nineties are giving FPAs everywhere a unique chance to transform themselves. Doortje Braekens reviews their options.

In the past, family planning has been associated with birth control and avoidance of pregnancy, although political and social pressure-groups in many Third-World countries have also linked it to demographic issues. During the last decade, however, there have been many discussions in western Europe about bypassing the birth control aspect of family planning, and relating it instead to sexual health and sexuality.

The World Congress of Sexology (Amsterdam, June 1991) included a symposium on this subject, one of the topics being the role of the family planning associations in changing societies. A panel of FPA experts discussed the question from three perspectives: those of the developing world, the developed world and eastern Europe.

Developing countries

In developing countries, family planning has spread rapidly: standing at only 9% in 1960-65, contraceptive prevalence had risen by 1990 to an estimated 50%. The number of governments providing direct support for family planning also rose from 97 in 1976 to 125 in 1988. Yet despite this relative success of family planning programmes during the last 20 years, the growing unmet needs and governments’ limited financial resources have remained a major problem. Many FPAs in developing countries find themselves today at a crossroads. Should they continue on the path of pregnancy avoidance, or adopt a different type of thinking and look at sexual issues from an overall perspective? Young people’s changing attitudes towards sexuality and the spread of HIV and other sexually transmitted diseases may have contributed to this quandary.

The current strategies of FPAs in developing countries mean that they have two choices: either they can continue doing the same thing — information, services, research and advocacy — or, recognizing their present weaknesses, they can head in a new direction and opt for new initiatives.

The new direction can be summarized as follows:

• the FPA can become a facilitator of community services, rather than a service provider
• it can become an innovator, adopting new service strategies, instead of merely consolidating, tried-and-tested existing services
• and it can act as an advocate, increasing the government’s awareness of sexual and reproductive health issues.

Developed countries

In most of Western Europe general practitioners play an important part in providing family planning. As a consequence FPAs in these countries are also moving in new directions. Many of them, now that the right to contraceptives is established and their availability is ensured by the GPs, have developed new areas of work. They are involved in education, STD/AIDS prevention, training in sexuality, psychosexual counselling, and assistance in cases of sexual abuse and violence. This has led them to realize that the term “family planning” is no longer an accurate reflection of their work. The British FPA, for instance, adopts in its new manifesto the term “sexual health”.

For many of these developed-country FPAs, the new strategies for action are:
• public information and education
• sex education for young people
• training of professionals
• networking with other organizations
• community education programmes
• raising the awareness of policy-makers and planners.

Another example comes from the Netherlands, where the FPA is in the middle of discussing the justification for its existence. In no other country in the world is the rate of unwanted pregnancies and abortions so low. Nevertheless, the Netherlands FPA still sees a role for itself in future. It will try to combine its traditional pregnancy-avoidance services with the new developments by becoming a new, well-adjusted organization based on integrated medical assistance, sexology, prevention, education and information.

Eastern Europe

The recent shifts towards democracy in eastern Europe are adding another dimension to the sexual debate. In the past, when safe contraception was not available, women in these countries resorted to abortion as a method of fertility regulation. Now, however, the right of access to abortion is in many places being curtailed, leading to a situation in which the sexual and human rights of women are under siege.

In a number of eastern European countries, institutionalized family planning needs to be de-governamentalized. This raises several important questions. What do we mean by nongovernmental? Has non-governmental family planning in western Europe proved so effective that it can be extended to the east? What role should the State and the NGO play in family planning and sexuality? In fact, how much of the State do we want in our bedrooms?

Democratic uprisings in eastern Europe have once again pinpointed the importance of the principles behind the FPAs’ work, which include decentralization, participation and democratic decision-making.

Where next?

In recent years — especially in western Europe — FPAs have moved increasingly towards a concept of promoting sexual well-being, thereby gradually demedicalizing their work. The organizational form taken by the FPA has become primarily the counseling centre. This contrasts with family planning provision in eastern Europe, which has mainly been integrated in the medical sector. The question now is, which organizational forms are the most effective in terms of prevention and the promotion of sexual well-being?

Another difference which has become clearer as a result of the changes concerns family planning as a woman’s issue. For the moment we seem to be faced with a plurality of women’s cultures (feminine, female, feminist) in the west, with in the east a socialist women’s culture whose dimensions we have only started to perceive.

To summarize, the present transformation phase — extremely difficult and yet so exciting — is a unique chance to rethink and rebuild the work of the FPAs.

[With thanks to Modouzidi (IPPF), Doreen Massey (FPA, United Kingdom) and Elke Thoss (Pro Familia, Germany)]

Dr Doortje Braeken
Head, Education Unit
Rutgers Stichting
Groot Hertoginnelaan 201
2517 ES ’s-Gravenhage
The Netherlands

FPAs in developing countries could facilitate, rather than provide, community services. Photo WHO/J. Abcede
Helping the client to reduce her risks

Family planning providers in the USA are asking themselves if they could – and should – do more for their clients. Maggie Ruth P. Boyer describes how training is changing in response to new ideas.

A woman arrives at a family planning clinic for her annual visit: she expects to speak to a counsellor, be examined by a clinician, have a Pap test and a breast exam, and get her next supply of birth control pills. During her interview with the counsellor, the counsellor notices some bruises on the patient’s arm and enquires about them. The patient says that sometimes, when she and her boyfriend have too much to drink, violence occurs – nothing major, but the bruise is from when she stumbled, backing away from him. During the physical examination, the clinician discovers that she has a sexually transmitted disease, although she says she has had no partner other than her boyfriend.

How can a family planning programme best serve the needs of this patient? How many layers of need have been identified in this one visit? How can the patient be successfully connected with the other health and social services that she may want? What is it reasonable to expect staff members to do with each client: how much time, money and efficiency can be devoted to needs other than family planning? What are the limits to our responsibilities? And what invitations are being issued to us by patients who are willing to confide in us to provide a better, more comprehensive service?

These are some of the questions about service provision that are being examined in family planning programmes in the United States. And of course, with the possibility of changes in service comes the need for new and different kinds of training for family planning personnel.

Exciting new developments are happening in four areas: self learning modules; integration of training, or “cross-training”; the creation of real and meaningful linkages between agencies; and service excellence, efficiency and hospitality.

With the downturn in US economy, budget constraints such as the high cost of travel and replacements are preventing some family planning programmes from sending their staff to centralized training courses at distant locations. As a substitute, some regional training centres, such as Training 3 of the Family Planning Council of South-eastern Pennsylvania, are developing self-learning modules. The modules, which are sent out by mail, consist of either instructional videos, accompanied by a post video knowledge test, or self-instructional workbooks. They enable even desperately under-funded centres to remain up to date on medical and social service issues.

Integration of services and “cross-training” refers to the growing recognition that family planning services have a natural connection with education, counselling, diagnosis, treatment and prevention of sexually transmitted diseases (STDs); education, counselling and testing for HIV; and the treatment of men – especially partners of patients – for STDs. Also, because family planning counsellors are so well trusted by patients they often hear of other needs – for shelter from domestic violence, day care, mental health counselling, and treatment for drug and alcohol abuse. In order to address all these needs, cross-training is now occurring in which family planning training is offered to the personnel of other health and social agencies and family planning staff are trained to deal with violence, substance abuse, and so on. Cross-training increases the likelihood that the family planning staff will be more comfortable talking to clients about other issues, more likely to bring the issues up directly, and more likely to make useful referrals to the right agency. Similarly the staff of drug and alcohol centres, women’s shelters, and so on become more comfortable talking to clients about sexuality and family planning.

This recognition of the natural connections between family planning and other services has also brought it home to us that the same client we see in family planning is being seen by other agencies as well, but as part of a disjointed and fragmented service delivery system. We have begun, therefore, to look at our patients in a more “holistic” way, and to hold conferences and seminars that help us to create inter-agency linkages, integrating the different services and making them more accessible to the client. In such seminars the discussion centres on the inconvenience for clients of keeping several appointments for different services in different locations at different times. For some of them, of course, it may be impossible.

How then can we create networks of services that are cost-efficient, convenient, and ethnically and culturally sensitive? Can we create a “supermarket” of services, all at one location? If not might we be able to take a “case-management” approach at family planning centres, helping to manage the total care of the patient, not just the reproductive and family planning side? For the moment, networking is still at a discussion stage and has not yet been translated into action.

Finally, training in clinic efficiency, service excellence and hospitality is helping family planning providers to analyse patient flow, assess staff time, and so on. Service excellence may mean re-designing our clinic’s schedule, or even its physical layout and decor, to make them more “client-friendly”. In hospitality training we learn how to put the needs of the client first, and to help the client feel welcome. We increase our reception skills, improve telephone etiquette, and learn how to help a client hear “bad news.” If we look back again at the patient we met at the beginning of this article, we see all the ways in which family planning training can be relevant for her: from giving the staff the courage to ask about her bruises, to teaching them how to help her assess the extent of her alcohol problem and realize that her sexually transmitted disease may raise questions about her partner’s fidelity (perhaps necessitating a referral to a therapist or counsellor), and helping to talk about their risk of HIV infection, and possibly to make additional decisions about antibody testing.

The four new trends in training aim to provide family planning staff with the skills, competence, sensitivity, and awareness to help clients assess the many different kinds of risks in their lives (risks which can often surface in the course of a family planning visit) and to give the clients the service, education, counselling or referral that they need to reduce those risks, whatever they may be.

Counsellors need to be perceptive and sensitive. Cartoon by Asun Balsola from Contraceptives and Sexuality (Instituto de la Mujer, Madrid)

Ms Maggi Ruth P. Boyer
Director of Education and Training
Planned Parenthood Association of Bucks County
721 New Rodgers Road
Bristol, Pennsylvania 19007
USA
Planning for life in Latin America

IMIFAP of Mexico City has introduced totally new approach to the prevention of adolescent pregnancy and STDs in Latin American countries. Our correspondents there are Susan Pick de Weiss and Irving Perez

Up to few years ago, sex education programmes for the general population of adolescents in Mexico and Latin America could be classified into one of three groups: inaccessible, ineffective, or both. Inaccessible because the vast majority of teenagers had not taken a course, and ineffective because in the case of the few who had, the course had been a traditional one, producing little if any effect in at least two key areas: pregnancy in adolescence, and the risk of sexually transmitted diseases, including AIDS.

There was an evident need to find out what was determining sexual and contraceptive behaviour among adolescents, and from this to create a programme and evaluate its impact in a representative population, keeping in mind that it would probably be used in other Spanish-speaking countries on the American continent.

At the Instituto Mexicano de Investigación de Familia y Población (IMIFAP), we started by carrying out a study to see what was the general level of knowledge about sexuality, and what were the current sexual and contraceptive practices of adolescents. At the same time, we decided to diagnose what were the psychosocial determinants of adolescent sexual and contraceptive behaviour and pregnancy.

These psychosocial variables had been shown by several independent researchers to be related to the behaviour of adolescents. We looked specifically for factors associated with abstaining from sexual intercourse, practising contraception and avoiding pregnancy. A representative household and clinic sample of 12-19 year-old girls of lower-middle and lower socioeconomic levels in Mexico City showed: 1) a need to do away with their erroneous beliefs, but at the same time provide them with detailed and practical knowledge about the types of sexual behaviour studied; and 2) a need for a broader definition of sex education which would emphasize family, partner and peer communication, the clarification of values, assertiveness, decision-making and support networks among peers.

We then developed a programme called Planeando Tu Vida (Planning Your Life), which was innovative in several ways, mainly in that unlike the traditional sex programmes, it was based on this descriptive and diagnostic research. When designing the programme, we also kept in mind the following goals:

- the programme should be able to provide up to date information about sexuality, while making the adolescent aware of myths and erroneous beliefs and replacing them with facts
- it should be adapted to the adolescent's psychology and should make the best use of his/her cognitive abilities

- and parents, teachers and the community should participate actively in the educational process, to reinforce the newly learned attitudes and behaviour.

The teaching techniques used for Planeando Tu Vida also differed from those used in traditional courses. The students took part in group and individual exercises where they were meant to translate the new concepts into action; they were also given "active homework" so that they could to practise their newly acquired skills and abilities.

After the first three versions of Planeando Tu Vida, in which improvements were made in the contents, exercises and duration of the course, we evaluated its effect on knowledge and contraceptive behaviour. Two groups were formed from public high schools: 1) a control group which had not attended a formal course, and 2) a group which had attended a Planeando Tu Vida course.

As expected, there was a significant increase in the level of knowledge of the group that had attended the course. We also found a higher probability that adolescents, especially boys, who attended the course before beginning sexual relations would use contraceptive methods. There were no differences in contraceptive behaviour in those adolescents who had already had at least one sexual relationship before taking the course. The results indicated that sex education should start before the sexual debut.

Concurrently, we performed another set of analyses to determine the relationship between the behaviour preceding the sexual act, risk behaviour, personality traits, characteristics of the adolescents' interpersonal relationships, and sexual and contraceptive behaviour. The fourth and fifth versions of Planeando Tu Vida incorporated changes that dealt specifically with the attitudes and behaviour associated with a higher risk of becoming pregnant, and with the prevention of psychoactive substance abuse, which in one of the evaluations had been found to have similar determinants to those for early sexual intercourse and non-use of contraceptives.

For early sex education to be effective, it should provide youngsters with certain "tools". For example, it should enable them to:
- relate to others in healthy and constructive ways
- make decisions which agree with their knowledge
- be aware of the sexual roles and values common in their societies
- make additional efforts to pursue a higher level of education
- strengthen family ties. Communicate with others
- plan for the future while, in the case of girls, perceiving motherhood as an inappropriate alternative
- and be aware of the likely effect of their present behaviour.

We are now developing a series of books to educate young children in the areas mentioned. Each book is age-appropriate and content-specific, and gives hints and guidelines for parents. All the material is fully tested for its effectiveness in conveying messages to adolescents and children. Programmes for parents are also on the way, and teachers and health workers are being trained all over the country to implement the course in their respective institutions.

The course and the books are also being tested in Colombia, which will give us new experience with the programme. Our aim is not only to educate about sexuality, but to integrate sex education with education for life and health.

Dr Susan Pick de Weiss and
Dr Irving Perez
Instituto Mexicano de Investigacion de Familia y Poblacion (IMIFAP)
Apartado Postal 41-595
Mexico, D.F.
11001 Mexico

ENTRE NOUS 19, December 1991
Effective family planning in Rwanda

Gaudence Habimana Nyuirasafari reveals the secrets that have made Rwanda more successful at family planning than many of its neighbours.

Rwanda’s family planning programme began in 1981, the year in which the Government set up the National Population Office (ONAP0) to study ways of tackling the country’s sociodemographic problems. Today, 10 years after ONAP0 was founded, one of its main programmes – the promotion of family planning services – is showing encouraging results. These results have been achieved by using approaches and strategies that are relevant to Rwanda. Three of these strategies are the subject of this article.

Decentralization
In order to approach the population more effectively and to explain to people the benefits of family planning, ONAP0 quickly set up regional offices with a permanent staff in each of Rwanda’s 10 districts or préfectures. Each regional team, with the support of the central office, was able to bring the family planning message directly to even the most isolated populations. This was the first and best strategy adopted for Rwanda: it ensured acceptance of the family planning programme in a country where the population is renowned for its pro-birth outlook. Today, an estimated 85% of all Rwandans have been reached by this decentralized information work.

Volunteer extension workers
Once the programme had been decentralized and explained by the permanent regional teams, the next step was to secure the support of volunteer extension workers. Chosen from the community by the population, these extension workers (17,536 in all), each responsible for a cell of at least 50 households, have the job of motivating couples to adopt family planning and referring them to health units, where they receive the methods chosen. The extension workers carry out their work free of charge, arranging community meetings, making home visits, and so on. The statistics now show that 60% of birth control users in the country were recruited by these volunteers.

Integration
The integration of family planning with the other services normally offered by health facilities in Rwanda has been just as effective as the other two strategies mentioned. As ONAP0 is not a medical institution, it has been careful to cooperate closely with its sponsor, the Health Ministry, to make sure that the medical staff who answer to the Ministry include family planning in their daily work at all the health units. ONAP0 itself provided the equipment needed, built and/or renovated premises to provide a better setting, and trained health personnel in family planning. A figure of 80% integration has so far been achieved.

Thanks to these strategies, work by other departments and the support of the national authorities, the family planning programme in Rwanda has made considerable progress, especially when compared with other countries in the region, and notably those of sub-Saharan French-speaking Africa.

The contraceptive prevalence rate, which was 0.9% in 1983, rose to 2.93% in 1987, 4.5% in 1988, 6.2% in 1989 and 10% in 1990. The aim is to achieve 15% by the end of this year; the action plan adopted in June 1990 sets a target of 48.4% by the year 2000.

Mrs Gaudence Habimana Nyuirasafari
Director, National Population Office
(ONAP0)
P.O. Box 914
Kigali
Republic of Rwanda

Demographic literacy for Europe

Continued from page 6

- fertility, sexual health and responsible parenthood
- morbidity and mortality, including sexually transmitted diseases and AIDS
- migration and intercultural cohabitation
- mobility and family change and
- the status of women.

Other issues include the importance of the world demographic situation, and its repercussions on economic growth, poverty, urbanization, health, the environment, resource availability, and so on. The world’s population forms a whole; this is why a global solidarity matured by education is essential.

The Hamburg meeting clarified a number of basic concepts and laid the foundation for a new, interdisciplinary approach to population education that will make use of interactive teaching techniques.

The participants thought that educators and population specialists should aim to increase the "demographic literacy" of Europeans. Generally speaking, neither the results of past population teaching nor the more recent innovations in the field are widely known. There is a real need to exchange information on techniques, materials, training and ways of making the findings of research known to a wider public.

Special mention was made of the universities’ role in promoting research, and in training demographers and other professionals. Demographers themselves need a more multi-disciplinary training, and the universities, it was suggested, should play a far more active role in teaching population subjects.

A proposal was endorsed to set up a European monitoring facility or "observatory" for population education and information.

After an experimental phase concentrating on Europe, the observatory would be gradually expanded to take in other countries or regions. UNESCO is working out the details of the proposal and will assess its feasibility with other interested parties.

Population education could become a real catalyst for dialogue on a number of issues that affect people’s everyday lives. It could also make a significant contribution to developing that civic conscience and solidarity that the growing interdependence of human groups requires.

Mr B. Biyeng
Chief, Population Education Section
UNESCO
7, place de Fontenoy
F-75700 Paris
France
Women lift their families out of poverty

A scheme to train and employ mainly women has improved living standards in poverty-stricken rural China. Stirling Scruggs writes from Beijing

Mao Zedong once said, "Funue Nengding banbian tian" - women hold up half the sky. His point was that in new China, the People's Republic, which came into being in 1949 after the successful communist revolution, women would be equal to men. For thousands of years, Chinese had lived under a feudal system where women had lower status and less power than even their own male children.

Vestiges of those feudal values still exist today in China, especially in poor, remote areas where the women are often illiterate, subservient to men and badly off economically. These areas are typically dry, inhospitable and home to many of China's minorities. The standard of living lags far behind that of the cities and prosperous coastal regions, where the bulk of earlier socio-economic development efforts have been directed. China's Eighth Five-Year Plan, however, which roughly coincides with the United Nations Population Fund's Third Country Programme (1990-94), devotes greatly increased attention and resources to these under-served, poor, remote areas.

Realizing that women's status, and particularly their educational level, has a marked impact on child care and fertility, and also out of concern for the equality of women and the elimination of poverty, China and UNFPA have agreed that about 20% of the resources UNFPA has made available for its Country Programme will go to projects to improve the situation of women in poor areas.

These projects are being implemented in 30 poor counties in nine provinces, mainly in the northern and western parts of the country. A pilot phase began in three provinces in 1989; the other six provinces joined in in 1990 and 1991.

Millions of rural unemployed

According to the 1990 census, 900 million people live in China's rural areas and their numbers are swelling by 13 million per year. Over-population, environmental degradation and water shortages have caused a decline in the amount of land suitable for land-based employment. As a consequence, the Government estimates that there is a surplus of over 100 million rural labourers who need to be trained and moved into other economic activities.

The purpose of the projects is to provide training and create rural employment – usually supported by agriculture – primarily for women. The ultimate objective is to help families and communities to improve their standard of living through gender-based income-generating activities.

About 80% of the funds are set aside in each province as a revolving loan that is used by enterprises to strengthen, convert or refine their operations in order to increase employment. The remaining 20% is used for female literacy classes, small enterprise and household income-management training, maternal and child health and family planning information and services, day care and care of the elderly.

The loans are guaranteed by the local county government and must be repaid in three years. A 4% surcharge is assessed to pay for general community development activities, while the original amount is re-loaned to other enterprises or to women's group or families for village- or household-based economic activities.

Boost for local producers

A major feature of the projects is that the enterprises selected must use local raw materials. This ensures that the projects also help many other people engaged in "upstream" or "downstream" activities. For example, starch noodle production benefits upstream households that raise the peas and potatoes used to process the noodles, while waste material from the factory can be used downstream to feed livestock.

The pilot phase included seven enterprises in three provinces. The seven are engaged in carpet making, clothes manufacture (two), dairy farming, starch noodle production, felt cloth processing and flax processing. The estimated reach of these initial seven activities is about 80,000 people.

In Longxi County, Gansu Province, 8,472 households are producing raw material (potatoes) for the starch noodle factory. Household income has increased by 40%. The factory, which is now employing women who formerly men were given priority, has seen an increase in individual income of 49%.

Before the loan was made available, this dilapidated enterprise was on its last legs. Now, with the new equipment purchased using the loan and the additional county development funds which it attracted, business is booming. Raw material-producing households have a guaranteed market, and the factory is planning to expand.

In the same community, 7,000 women are enrolled in functional literacy classes. Groups have been organized for maternal and child health/family planning programmes, and village women have formed group savings clubs. The savings clubs receive household income; their members are trained in small-enterprise management and may qualify for second-generation loans.

Results in other enterprises have been equally encouraging. The Food and Agriculture Organization of the United Nations (FAO), responsible for executing the projects, decided to focus on training, organization and general community development, rather than trying to introduce new products. That is, it chose to support what local people know how to do using local products, rather than inventing new industries.

Carpet-weaving: women have been willing and able to benefit from the scheme. Photo UNFPA

Although specifically designed to improve women's status, these projects benefit women, men and their families, reduce rural under- and unemployment, and improve community services.

The key elements in the success of the pilot efforts have been the political will and commitment of the local governments, the tireless efforts of FAO's Women's Specialist, Ms Fely Villarea, and the desire and ability of women to take advantage of the opportunities offered by the projects to improve their lives and the lives of their families.

These projects were designed specifically to respond to Chinese needs in the framework of China's politico-economic system. However, some elements could surely be adapted for use in other countries. The early results have been far beyond expectations and plans are in hand to extend the projects to other counties and provinces in China's vast rural hinterland.

Mr Stirling D. Scruggs
UNFPA Country Director
United Nations Building
2 Sanlitun Dongqijie
Beijing 100600
People's Republic of China
Life, sex, aging and death

Denmark has added several fresh concepts to its new health and sex education curriculum for schoolchildren. Karen Akhojem, psychologist, was closely involved.

With the start of the new school year (August 1991), the Danish Government has introduced entirely new guidelines for the teaching of health education and sex education in Danish schools.

It was time to make changes for several reasons, not least the number of abortions (20,000 a year: abortion is freely available in Denmark), AIDS, and sterility problems.

After much heart-searching, a committee of nine appointed by the Education Minister decided to combine sexuality and health in one programme, despite the risk – which they freely acknowledge – that sex could “drown in a sea of health education” (Kirsten Kjoebly, Entre Nous 17, April 1991, page 4).

According to Health and sexual education: guidelines for schools, a booklet intended for parents, pupils and teachers, the new curriculum should:
- develop the children’s ability to promote their own and other people’s health
- contribute to their awareness of the physical, psychological and social aspects of health, living conditions, lifestyles, the links between sexuality and health, and sexual and health ethics
- develop their understanding of the different types of relationships, and help them develop their own identity
- contribute to their ability to assess ethical questions, and develop their self-respect and courage.

Relationships and sexuality can have extremely negative effects on physical health, the most serious being AIDS; other sexually transmitted diseases can lead to sterility and other problems. Early pregnancies and abortions – especially in the very young age group – also have a bad effect on everyone involved. Teachers need to explain the possibility for avoiding such problems, the first prerequisite being to understand bodily functions and development.

Environmental influences

On the other hand living conditions – the quality of housing, for instance, or the psychological cost of one’s work life – can influence personal relationships and sexuality.

We might see inequality between the sexes as a phenomenon deliberately maintained by many parts of the educational system, work and everyday life. Prostitution often grows out of dreadful living conditions. In such areas, ethics and values are not just matters of equality and discrimination, but of the conditions and opportunities that society offers us for setting these problems to rights.

The way in which we allow our sexuality to express itself affects both ourselves and others. Rape and incest are extreme examples of how to violate other people’s health and integrity. There are also lesser forms of pressure; to deal with them we need to be able to say yes and no. In this instance our values and ethics are connected with responsibility towards other people. We can actively develop our sexuality and relationships but still consider others and ourselves. Other subjects in the new curriculum are:
- growth and development (social intercourse, self-confidence, group pressure, stress, sex life, nature, culture, etc.)
- different forms of relationships (family, parenthood, infatuation and love, STDs, etc.)
- the body, exercise and movement (maintenance of health, puberty, sexual differences, relaxation, sports heroes, mass and elite sports, and so on).

"Health throughout life" is an important new section that examines not only pregnancy, childhood, adolescence and partnership but – for the first time in Denmark – "normal aging", from a psychological point of view. Too many Danish children know no old person; they and the elderly often live far apart. "Death" is another new, and very necessary, subject.

Teachers should always have in mind that they are cooperating with the parents. The parents in turn need to be informed about the curriculum and have the opportunity to ask questions, discuss, see the teaching material and approve it.

Dr Karen Akhojem
Consultant Psychologist
Hoejby Rosenvæj 10
4573 Hoejby Sj.
Denmark

Spotlight
Rostock’s pioneer

Professor Karl-Heinz Mehan of Rostock, Germany, was a courageous pioneer at a critical time in the history of family planning. He brought clinical leadership skills and personal enthusiasm to the practice of fertility regulation in the 1960s. His influence as a senior gynaecologist encouraged others to enter the field and encouraged policy-makers to take family planning seriously.

To have done these things alone would have been a considerable achievement, but Professor Mehan added a particular courage and a much needed realism, not only by assisting the development of contraception, but by being a leading commentator on induced abortion. The careful documentation of the experience of Eastern Europe, at a time when abortion was illegal in most of the rest of the world, was highly influential in changing policies in the United Kingdom, the British Commonwealth, the United States of America and eventually the rest of Western Europe.

As a young medical student in Hitler’s Germany, Karl-Heinz Mehan risked his career to help women in need. In 1956 he founded the Institute for Hygiene at the University of Rostock Medical School, serving as its long-time Director. In 1960 he organized in Rostock perhaps the first ever international conference on reducing abortion and promoting contraception, from which emerged the successful annual Rostock workshops.

With his colleagues, in 1963 Professor Mehan founded the Society for Marriage and the Family, later to become the IPPF affiliate in the GDR and now merged with Pro Familia. Known affectionately in East Germany as the Pillenwasser (Father of the Pill), he was largely responsible for introducing a 30-hour course in family planning into the medical schools there. Now retired, Karl-Heinz Mehan continues to inspire others with his enthusiasm, spirit and humour.

Professor Karl-Heinz Mehan in conversation with Dr Nafs Sadik, Executive Director of UNFPA, at the Tbilisi Conference. Photo WHO/Jørgen Schyte
IVF: counselling for success and (probable) failure

Counselling is essential prior to IVF treatment, not least because most attempts end in failure. But the quality of such counselling is very variable, as David Phillips and Sarah Blacksell found out.

During the last decade, spectacular advances in human reproduction research have permitted the birth all over the world of several thousand children following fertilization achieved outside the human body by in-vitro fertilization (IVF). IVF's popularity is evidence of the great demand for children; infertility can affect up to one in six couples and adoption is increasingly difficult to arrange, particularly in the USA and Europe, where the majority of IVF centres are located.

In the United Kingdom, the number of licensed IVF centres has grown to 34 at the beginning of 1990 and 59 by mid-1991. But while there is excitement about the new reproductive procedures, there is also caution. Concern in the UK has focused on IVF in particular because of questions relating to the status of the embryo and its use in research. In 1990, the Human Fertilization and Embryology Act (HFE Act) established the Human Fertilization and Embryology Authority (HFEA). The HFEA has wide-ranging powers to regulate not only IVF and other services that use donated gametes or embryos, but also the related research.

Counselling has also been recognised as an essential element of treatment, because of the medical, ethical, social and legal questions associated with these new reproductive procedures, particularly IVF. It is now officially considered extremely important to protect the welfare and rights of children conceived in this way. Where donated sperm, eggs or embryos are used, the nature of the family is affected and careful and informed decisions are required from both donors and recipients.

Stressful experience

The protection of couples seeking treatment is also a major concern, since treatment fails, worldwide, in about 92% of attempts. The UK has live birth rate per treatment cycle of 9% and a 91% failure rate. It has also been claimed that psychological problems may accompany infertility, and that feelings of isolation, guilt and reduced self-worth may be exacerbated by the often lengthy and sometimes unpleasant process of treatment. IVF often comes at the end of the process and this, combined with the high risk of failure, can place considerable pressure on some clients.

In recognition of these factors, counselling has come to be seen as a crucial issue. A 1987 Government White Paper stated that "counselling is a key element in the provision of any infertility service. It is distinct from discussion with a doctor of treatment proposed and should be carried out by someone different". The HFE Act of 1990 requires that people considering using of the new reproductive technologies should be given "a suitable opportunity to receive proper counselling". However, while counselling is now offered more widely at IVF centres, not much was known about what it entailed. Accordingly a survey was conducted in 1990 to establish the extent and nature of the counselling offered at the 46 IVF centres in the UK which had either been licensed or were waiting for approval. Only two of the centres were fully funded by the National Health Service. The survey was paid for by the Department of Health, and carried out by the Institute of Population Studies at Exeter University.

Different interpretations

The diversity of the interpretation and practice of counselling found by the survey was very wide indeed. What kind of service existed depended on the type of centre, the senior medical staff and hospital managers' commitment to counselling, and the type of support and counselling expected from individual members of the team. While it may seem impressive that 41 of the 46 centres claimed to offer counselling of some sort, the ambiguity surrounding what was meant by "counselling" may reduce its significance. For survey purposes, it was interpreted in its broadest sense. Four types of activity were accepted as relevant: obtaining informed consent; providing information about the medical procedures involved; providing personal support before, during and after treatment; and making psychotherapy available if needed.

Only 11 of the 46 centres employed a counsellor as a regular member of the team and offered appointments and accommodation specifically for counselling. Such a service tends to ensure that counselling takes place in a neutral time and space, and independently of treatment. With one exception the 11 centres did not charge the cost of counselling directly to clients.

Five centres did not admit having any formal responsibility for counselling, and at another three there was only very limited use of an external counsellor. In effect there was no counselling, or only a minimum, at 19% of the centres.

Counsellors too far away

Eighteen centres referred clients to an external counsellor. At the majority however (13 centres) referral was rare, with counsellors seeing at most no more than 10% of clients and in many cases far fewer. Independent counselling for people receiving donated gametes was recommended as a basic minimum in the voluntary guidelines in operation at the time of the survey. Nevertheless, at some of the centres counsellors were so remote that they could provide no more than compliance with the guidelines for only a minority of this "target" group.

For nurses and doctors at the centres, involvement in counselling could be most rewarding. However, it is debatable whether those responsible for treatment can also provide completely independent and objective counselling. Twelve centres relied for counselling only on doctors and nurses working at the centre.

Given the wide range of counselling issues, the reality of what senior medical staff can provide must be very much limited by the time available. Many nurses were concerned that the little time and space at their disposal did not permit them to offer adequate support and counselling to clients. There was almost no supervision of nurses who did provide counselling, although several of the team counsellors offered support and supervision to their colleagues.

Nurses feel unprepared

Nurses were often aware that they needed more training in counselling, but only a few had been successful in getting any support for such training. Some of those with a formal responsibility for counselling had paid for their own training, including some quite lengthy courses. In some localities it was difficult for them to find courses that were suitable. As a result, many nurses felt that they were not properly prepared for the rigours and the often distressing aspects of counselling.

The requirement of the newly formed HFEA that counselling must be given prior to treatment, and the continuing increase in the number of centres offering IVF have created a growing demand for adequately trained counsellors. However, professional boundaries, particularly between medicine and social work, make it difficult to provide counselling from existing resources. Training specifically for counselling on infertility treatment is as yet poorly developed. For the immediate future, therefore, the way forward is likely to consist of attempts to reduce such barriers and to facilitate cooperation between counsellors from different professions and backgrounds.

Dr David R. Phillips and Ms Sanah Blacksell
Institute of Population Studies
University of Exeter
101 Pennsylvania Road
Exeter EX4 6DT
United Kingdom
English youth exposed to AIDS

Young people in the South West of England are nearly all sexually experienced by their early twenties, but they do little to protect themselves against AIDS and are astonishingly ignorant about other sexually transmitted diseases.

These are some of the conclusions drawn by researchers from the University of Exeter (UK), who have just completed a two-year survey of young people's AIDS awareness and sexual lifestyles on behalf of the South West Regional Health Authority. The findings indicate a reasonable knowledge of HIV/AIDS, but abysmal levels of knowledge about other sexually transmitted diseases (STDs). Very few young people, for instance, had heard of chlamydia, even though it has reached epidemic proportions in the South West in recent years.

The overall sexual culture turned out to be one in which pre-marital sexual intercourse is virtually universally condemned and practised, with a fairly early age of first intercourse. Two fifths of non-virgins claimed to have had intercourse before the age of 16. Half of the 16 year-olds were non-virgins, the proportion rising to practically 100% of those in their early twenties. While the majority had either not engaged in intercourse in the last year (26%) or had done so with only one partner (43%), a substantial number had done so with four or more partners (9%). However, only one third had used a condom during their last intercourse.

The general pattern is that although most young adults intend to use a condom with a "new" partner they do not always do so and tend to dispense with this precaution once they have established a "steady relationship". Given the transience of young people's "steady relationships", this behaviour pattern can afford them little protection against HIV and other STDs, where the person can remain infectious but asymptomatic for long periods. Moreover, the group who had had four or more partners in the last year and had the most "casual-recreational" sexual lifestyle multiplied their likelihood of becoming infected by a particularly low level of condom use.

The aims of the surveys were to collect representative and reliable information about young people's AIDS awareness and sexual lifestyles, and secondly to identify the implications of that information for the health authorities' HIV/AIDS risk-reduction strategies.

In all, nine surveys were undertaken, covering a total sample of 4,163 young people aged 16-24. All the surveys contained core questions on sexual behaviour and attitudes. Individual surveys also investigated - for instance - psycho-active drug use (including alcohol) and tourism, to assess their impact on the practice of "safe(r) sex". Young people were interviewed personally in their homes for the socio-demographic and attitudinal questions, but for the more sensitive questions on sexual and drug-use behaviour they were asked to fill in their replies in a booklet.

One of the most striking features of the research programme was the similarity between the results from the different districts. The young people's sexual lifestyles were heterogeneous (regarding for instance numbers of sexual partners, sexual attitudes and psycho-active drug use), but the actual pattern of this heterogeneity was replicated throughout the different Districts and across the entire region.

The study report also identifies the links between sexual lifestyles and a whole range of variables, including the importance accorded to sexual activity, leisure activities, and use of psycho-active drugs (principally alcohol). It should be stressed that the association between alcohol consumption and sexual lifestyle needs to be interpreted in terms of the young person's socially determined expectations of the effects of alcohol, rather than in terms of a simple pharmacological effect, leading to a loss of inhibitions. Health promotion concerning AIDS and alcohol needs to therefore break down the prevailing expectations, which at the moment are being used as an "excuse" for unsafe sexual behaviour.

HIV/AIDS prevention programmes need to be integrated with a wider strategy for general sexual health. In 1975 the World Health Organization defined this as "the integration of the somatic, emotional, intellectual and social aspects of sexual being in ways that are enriching and enhance personality, communication and love". Public Health Departments and other bodies need to translate this general definition of sexual health into specific and attainable, objectives, as part of a carefully organized, multi-sectoral strategy with clearly specified responsibilities and adequate funding. Comprehensive sex education in schools needs to start early and respond to young people's needs as they mature. According to Bandura's social cognitive theory, the best way of influencing people to adopt "safe(r) sex" is to work with them in small groups where they can observe and participate in models of communication between one person and another. The more closely young people themselves are involved in the design and implementation of "safe(r) sex" strategies, the more likely they are to be effective.

[The author would like to acknowledge the assistance of Elspeth Mathie, Ruth Priest and Elaine Davies in this researh. The report: Ford, N.J. (1991) The Socio-Sexual Lifestyles of Young People in the South West of England, 170 pages, is available from the South Western Regional Health Authority, c/o Ms Rosanne Skillen, Services Planning, King Square House, 26/27 King Square, Bristol BS2 8EF, UK (Price £10).]

Dr Nicholas Ford Lecturer, Institute of Population Studies University of Exeter 101 Pennsylvania Road Exeter EX4 6DT United Kingdom

Aware of AIDS, but abysmally ignorant of other STDs. Photo The Family Planning Information Service
Unwantedness in early pregnancy

Some effects on adolescent development of unwantedness in early pregnancy and compulsory childbearing are apparent from a continuing study in Prague, Czechoslovakia, reported here by Zdenek Dytrych.

The unwanted pregnancy study group consisted of 220 children (110 boys and 110 girls) born in 1961-63 to Prague women twice denied abortion for the same pregnancy, and 220 pair-matched controls born to women who accepted their pregnancies. Matching was for age, sex, birth order, number of siblings, and school class. Mothers were matched for socioeconomic status and the presence of a partner at home. All the children were born into intact families.

After the initial follow-up at age nine, additional follow-ups were conducted when the children were between 14 and 16 years of age. It was possible to locate 216 unwanted-pregnancy (UP) children and 215 accepted-pregnancy (AP) children, achieving a 98% follow-up rate. A mail questionnaire was dispatched two years later when the adolescents were between 16 and 18 years of age.

The findings accumulated through adolescence suggest that differences in the psychosocial development of children born to women twice denied abortion for the same pregnancy, and pair-matched controls, persisted and widened into the adolescent years. The school performance of the UP study group continued to deteriorate. The difference was not so much in UP children failing more often than AP children, but rather in their being substantially under-represented among students graded above average, very good, or outstanding. In comparison to AP controls, a significantly larger number of UP children did not continue their education to secondary school, but instead became apprentices or began working without prior vocational training.

Compared to the AP controls, the UP children were rated by their teachers as significantly less obedient, less sociable, and more hyperactive. The UP subjects perceived their parents as being less interested in them and felt either neglected or oppressed by parental demands. There was considerable disagreement between UP and AP respondents in their perceptions of the mother's or father's parental warmth. UP parents were more often viewed discordantly, one as warm and the other as cold.

Although differences were not always easy to detect at the individual level, they were apparent in the aggregate, having attained increasing statistical significance over time. The pressures of the stresses and frustrations of this particular developmental period (early to mid-adolescence) seem to act as aggravating factors, causing even mild psychosocial deviations to become noticeable.

Socially handicapping characteristics noted in the UP subjects appear to have an accelerating momentum, with even wider differences between the UP and AP subjects noted at ages 21-23. A further follow-up at age 30 is currently in progress.


Dr Zdenek Dytrych
Associate Professor and Deputy Director
Prague Psychiatric Centre
CZ-1 03 Prague 8
Czechoslovakia

Once-a-month estrogen/-
progestogen injectables

Among the various contraceptive methods, injectables have particular advantages in that they are simple to administer, long-acting, and can be used independently of sexual activity. The two most widely used preparations are depot-medroxy-progesterone acetate (DMPA) and norethisterone enanthe (NET-EN); an estimated 8 million women currently use them. However, like all long-acting and progestogen-only preparations, they induce considerable disturbances in menstrual bleeding and high rates of amenorrhea, which have a marked effect on their acceptability.

As estrogens are used to treat menstrual irregularities, the idea was conceived of adding an estrogen to DMPA and NET-EN. To avoid exposing the endometrium continuously to estrogens, however, it was necessary to select esters with a limited action, which in turn called for monthly administration. This had the added advantage of causing endometrial bleeding at regular one-month intervals, i.e., close to the normal menstrual cycle.

To date, two main types of once-a-month injectables have been used, one containing 150 mg of dihydroxyprogesterone acetophenide and 10 mg of estradiol enantate, and the other containing 250 mg of 17-alpha-hydroxyprogesterone caproate plus 5 mg of estradiol valerate. The latter is used in the People's Republic of China under the name "Injectable No.1." Studies there have shown that it has acceptable efficacy and few side-effects; however, these findings have not been reproduced in Europe. Other preparations containing NET-EN or medroxyprogesterone acetate have also been evaluated in China.

In response to requests from a number of countries for once-a-month injectables that are effective, safe and thoroughly studied, and which cause a minimum of menstrual disorders, the Special Programme of Research in Human Reproduction has drawn up a two-part strategy comprising:

- first, maximum improvement of two preparations, HPR102 (50 mg NET-EN plus 5 mg estradiol valerate) and Cyclofen (25 mg DMPA and 5 mg estradiol cypionate), with the aim of reducing the dose of one or both of the two components; and
- second, a study of the efficacy and side-effects of these two preparations, with a view to introducing them into national family planning programmes.

This study has shown that these once-a-month injectables (a) are efficacious, (b) cause fewer irregularities in the menstrual cycle than progestogen-only preparations, and (c) are well accepted, despite the need to attend a clinic once a month at a specific date, between the 27th and 33rd day after the previous injection. Studies are currently being done to assess the effects of the two preparations on lipid and glucose metabolism and on coagulation and fibriolysis, as well as to evaluate the time required for a return to fertility once the treatment has been ended. A study already carried out on 15 women has shown that two of them ovulated during the menstrual cycle following the end of the period of protection. In 11 other ovulation recommended during the next (second) menstrual cycle, and in the last two ovulated during the third cycle.

Phase IV (introductory) trials are now under way in Indonesia, Jamaica, Mexico, Thailand and Tunisia to assess the efficacy and acceptability of Cyclofen when distributed outside research centres, in national family planning programmes.

[It is not yet known when these contraceptives will become generally available.]

Dr C. d'Arcangues
Special Programme of Research, Development and Research Training in Human Reproduction
World Health Organization
20, Avenue Appia
CH-1211 Geneva 27
Switzerland
Adults not equipped to help adolescents

Montreux in Switzerland was the site of the Fifth International Congress on Adolescent Health (3-6 July 1991), the first meeting of its kind organized under the auspices of the International Association for Adolescent Health (IAAH). This young association, founded in Sydney in 1987, derives its philosophy and objectives from several principles dear to WHO. In particular, it aims to promote an active dialogue between representatives of developed and developing countries, it is open to all the professions involved in one way or another with adolescent health, and it strives to encourage young people themselves to participate in designing and implementing strategies for health care and disease prevention.

The main challenge of this Congress, which was actively supported by WHO, the International Children's Centre in Paris and the Swiss Office of Public Health, was to give practical expression, for the first time, to IAAH's ambitious objectives. Some 350 participants from around 50 countries met therefore to exchange experience and compare research findings and action strategies. Among them were professionals from various disciplines: teachers, social workers, physicians, nurses, psychologists, sociologists, ethnologists, etc. The audience was also much wider than the conventional representation from North America and Western Europe: many participants came from the African countries, South America, Eastern Europe, Asia and Australia. Above all, more than 25 youth leaders from various continents took an active part in the discussions and acted as co-facilitators at a special session, sponsored by WHO, devoted to adolescents' perception of health. These young people also provided the conclusion to the Congress, in the form of a short show, half-comedy, half-tragedy, illustrating the pitfalls of health promotion at the present time.

Multiple risks

Sexuality, diet, drugs, violence, suicide, accidents, sport, disabilities and social problems were the main subjects tackled during the eight half-day sessions. It became clear that, even though the majority of adolescents are in good health and manage to adapt to the society in which they live, a growing minority take multiple risks and adopt multiple risk behaviour, engaging in drunken driving, drug abuse, unprotected sexual relations, and so on.

Moreover, while adolescents are going through this particularly sensitive period in their development, physically, psychologically and socially, adults — and above all the professionals — who come in contact with the young are not knowledgeable enough to play their role to the full.

Frequently, the "health coverage" of adolescents is less good than the coverage of children and adults. All too often, adolescents do not benefit from the overall approach that needs to be adopted if health is seen as not merely the absence of disease but, as WHO suggests, the physical, emotional, relational and social wellbeing to which every person has a right. Helping young people to win their independence, therefore, means training people to listen closely to their statements, plans, rejections and suffering...

Behaviour as a symptom

Over and above the individual responses that health and social professionals can make, it is essential to think about the "upstream" prevention of these difficulties. Thinking about prevention must be directed, in particular, at "experimental and risk behaviour": attempted suicide, consumption of dangerous substances, and so on. Such behaviour should be seen as a symptom of suffering, rather than as the sign of a specific attraction to danger. Several speakers pointed out that, although an education beginning in childhood which provides a framework, security and the ability to manage one's feelings acts as an effective form of prevention against risk behaviour, adolescence is still a fruitful period of life during which well-structured preventive interventions can if necessary bring positive and lasting changes in lifestyle.

From the 200 or so statements made during the Congress, it was clear that many experiments in prevention are now based on involving young people themselves, both as sources of information and as "outreach workers" who can connect with their peers. Preventive techniques no longer rely on fear: they incorporate the values reflected in young people's speech, such as game-playing and idealism.

In a newsletter which they produced at the end of the meeting, the young participants emphasized that there was no simple answer to many of their problems, which are also the problems of society as a whole. We must think, they wrote, about making room in our structures for young people and their ideas and projects. After all, the young represent the future.

The main speeches and discussions from the Congress will be published in the next few months in the Journal of Adolescent Health, the official publication of the American Society of Adolescent Medicine. In addition, a few copies of the set of abstracts are still available from J. Ferguson, Programme of Adolescent Health, WHO, 1211 Geneva 27.

[In our April 1991 issue we erroneously described Dr Michaela as a sex educator and psychiatrist. He is in fact a general practitioner and public health physician. We apologize to him and are glad to set the record straight.]

Dr Pierre-André Michaud
Permanent Secretariat
IAAH, Fifth Congress
Office du Tourisme
Case postale 97
CH-1820 Montreux
Switzerland

Society needs to make room for young people and their ideas and projects. Photo WHO/Jørgen Schytte
Call for central contraceptive procurement and funding

The following extracts are from UNFPA’s recent report on Contraceptive Needs and Demands in Developing Countries in the 1990s.

The 1990 total fertility rate (TFR) in developing countries was approximately 3.8 births per woman, and the estimated contraceptive prevalence – the proportion of married women of reproductive age (MWRA) practising contraception – was 51%. According to the latest UN medium-variant population projection, the fertility rate will fall to 3.3 births per woman by 2000. Reaching this modest but challenging goal entails substantial implications for family planning programmes in the developing countries.

If the TFR in the developing countries is to decline to 3.3 births per woman by the year 2000, and if population growth is not to exceed 900 million persons, contraceptive prevalence must rise to 59%. This modest increase, combined with the large growth in the number of MWRA, requires that the number of contraceptive users increase by 186 million, to 567 million in 2000. By far the largest absolute increase will be in Asia and the Pacific (140 million); considerably smaller increases will occur in Latin America and the Caribbean (18 million); Africa (14 million) and the Arab States region, covering North Africa and the Middle East (12 million). Proportionately, the greatest increase will be in Africa (158%); large increases will also be required in the Arab States region (84%), Latin America and the Caribbean (45%) and Asia and the Pacific (44%).

Meeting the UN high population projection (where the fertility rate will decline to 3.7 in the year 2000) requires that contraceptive prevalence increase to 57% by the decade’s end. The number of contraceptive users must grow by 170 million to 551 million. Similarly, to reach the UN low population projection (TFR of 2.9) contraceptive prevalence will have to increase to 65% in 2000. Achieving this goal will require a substantially greater effort than will reaching the other goals. The number of users will have to increase to 599 million by the end of the period, i.e., by 218 million, as compared with the medium-projection goal of 186 million additional contraceptive users. Attaining replacement fertility for each country in the world, an objective consistent with a TFR decline to 2.1 births per woman in 2000, requires a contraceptive prevalence level of 75% in that year. This rate implies a near doubling in the number of users, from 381 million in 1990 to 720 million.

Contraceptives for the developing countries could cost almost 60% more by the end of the decade than they do today. Photo WHO/ J. Littlewood

These two goals will be extremely difficult, if not impossible, to reach, as the data suggest that as much as 89% of the increase must come from countries where contraceptive prevalence was less than 60% in 1990.

To reach the UN medium population projection goals, the number of sterilization users will have to increase from 171 million to 254 million in 2000 (i.e. by 49%). The number of IUD users will have to increase from 93 million to 125 million (34%); the number of pill users from 46 million to 75 million (64%); the number of condom users from 23 million to 35 million (54%); and the number of injectable users from 12 million to 21 million (71%).

By decade’s end, 151 million surgical procedures for female and male sterilizations, 8.76 billion cycles of oral pills, 663 million doses of injectable contraceptives, 310 million IUDs and 44 billion condoms will be required. The numbers appear less formidable if expressed in terms of yearly averages: 15 million sterilization procedures, 876 million cycles of pills, 66 million doses of injectables, 31 million IUDs and 4.4 billion condoms.

A 1989 survey by the Family Planning Services Division of the USAID Office of Population reveals that if the projected contraceptives and commodities required by the developing countries are purchased in the international market at current prices, the costs will be about $627 million in the year 2000, 57% more than the 1990 total. The total cost will be about $5 billion.

Among the conclusions and recommendations of the report are the following:
- The volume and cost of contraceptive requirements within the next decade call for a co-ordinated international system for procurement, storage, distribution and logistical support. Centralized purchasing and production in bulk can effect economies of scale and lower costs, and help avoid duplication and waste. It can also respond much more quickly and effectively to contraceptive demand worldwide.
- There is a clear need for a central funding mechanism devoted to supplying the contraceptive needs of developing countries. Donor countries and institutions might pool their resources and provide resources in addition to their regular contributions to multilateral assistance. Contributions to this fund may take the form of monetary contributions or donations of contraceptives. The exact nature of country and agency participation in this fund’s operations will depend on the mandate and operating procedures of such countries and agencies.
- To the fullest extent possible, the responsibility for meeting the requirements for contraceptives should rest at the country level. Local production capabilities, where appropriate, should be fully encouraged. Until countries can meet their contraceptive requirements, however, there is an urgent need for a co-ordinated global system.

- Populi, Vol. 18 No. 1, 1991
India’s poor tribes stick to their traditions

Vinod Sharma suggests that time-honoured family planning methods used in isolated tribal communities deserve closer investigation.

India was the first country in the world to launch a National Family Planning Programme as early as 1952. Despite an all-out effort by the Government, however, the gains of the family planning programme (now rechristened the National Family Welfare Programme) have only been modest in terms of its acceptance by the general population. Only 35% of all eligible couples in India currently practise some form of family planning to limit their family size. Among the primitive tribal communities which constitute more than 7.5% of India’s total population, the figure is even lower.

According to the 1981 census, there are more than 425 tribes in India, most of which still lead an existence far removed from the modern way of life. They are often abjectly poor, malnourished and illiterate, and all hold to practices such as child marriage, polygamy, preference for the male child, and male dominance. A large number of these communities still observe their time-tested and traditional customs of sexual and reproductive behaviour and child-rearing, and have yet to accept the modern methods of family-size limitation and birth spacing. The only modern contraceptive methods they know or accept are the permanent or irreversible methods, which attract them because of the monetary incentives generally attached to them.

Tribal communities in India use a number of traditional or indigenous methods of limiting their families. The most common consists of using half of a partly scraped-out and used up lemon which is introduced high up in the vagina by the woman just before coitus. The acidic juice of the lemon probably acts as a spermicide, while the peel is like a primitive version of the diaphragm and cervical cap combined. Tribal men prefer this method because a woman with a disease of the genitals will not be able to tolerate a lemon inside her vagina. This contraceptive method therefore protects the men from contracting venereal diseases and also – they believe – helps “to keep the woman faithful to her partner.”

Tribal women also use vaginal douches or, more precisely, vaginal washes post-coitally for contraception. The solutions most often used vary from diluted vinegar, alum solution or diluted lime-juice to herbal solutions or medicines given them by the folk or witch doctor or village quack. This method is essentially a thorough wash of the woman’s private parts with the solution immediately after unprotected sexual intercourse or, alternatively, a wiping clean of the parts with the help of cloths also dipped in one of the solutions. Tribal couples in certain parts of India also regularly drink herbal concoctions which are believed to be potent abortificients and/or contraceptives.

Tribal women also use a type of vaginal sponge made of old pieces of cloth soaked in various solutions. This is inserted in the vagina pre-coitally as a barrier.

Certain of the tribes’ socio-cultural practices also play a vital role in family-size limitation, although the tribal people themselves are not aware of their contraceptive effects. The practice of extended breastfeeding of children (even up to the ages of three or four in some tribes) is universal. Similarly, they practice total abstinence for certain days of the month and for a period of two to three months following the birth of a child.

Although the Government is making sincere efforts to make its National Family Welfare Programme a people’s programme, yet it has failed to make a significant impact on the tribal psyche. Promotion of some of the beneficial practices of the tribal people, like extended and exclusive breastfeeding, would no doubt increase the programme’s popularity and acceptance among the tribal population. Scientific research into the efficacy and acceptability of traditional or indigenous methods should also be encouraged, as it might provide more acceptable answers to the difficult problem of population explosion.

Dr Vinod Sharma
Assistant Professor
Department of Community Medicine
Medical College and Hospital
Karamsad 388 325
Gujarat
India

Safe abortion care
Almost every country’s legal code includes some indications for induced abortion, and all health systems provide emergency treatment for abortion complications. But, write K. E. McLaurin, C. E. Hord and M. Wolf in Health Systems’ Role in Abortion Care: the Need for a Pro-Active Approach (1991), most health systems neither acknowledge the extent of the need for abortion-related care nor make effective plans to provide the services legally required of them. The authors recommend that appropriate abortion care should be integrated conceptually and practically in reproductive health care throughout the world, and that whenever possible electrical or vacuum extraction should replace the more dangerous and now outdated D&C procedure. They also point out that it is the responsibility of all countries, NGOs and the international family planning community to reduce this enormous problem and affirm the value of women. Obtainable from: IPAS, 303 East Main Street, PO Box 100, Carboro NC 27510, USA. Fax (919) 929-0258.
Provision and use of technology
Improving Family Planning: A Decade of FHI's Programmatic Research (1991), by K. Hardee-Cleaveland and B. Janowitz, is a new report from Family Health International. It covers the types of programme studies FHI has carried out, method-specific studies, policy and programme issues, institutionalization of programme research, and new directions. From: FHI, PO Box 13950, Research Triangle Park NC 27709, USA. Tel (919) 544-7040. Fax (919) 544-7261. ISBN 0 939704 08 0.

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Books
Sex education in a democracy
Since the return of democracy to Chile in 1990, the NGO PAESMI has scored a notable success in persuading teachers, parents and community to bring a taboo subject of long-standing out into the open for public discussion. Educación Sexual: Experiencias y Desafíos (Sex Education: Experiences and Challenges) (1991) tells the story of the work behind a national seminar which has persuaded the education authorities to integrate sex education into the national curriculum, beginning in 1992. This decision will reduce patriarchalism and sex discrimination in the education sector and increase the status of both teachers and their profession, as well as having a profound effect on Chilean society as a whole. Available from: PAESMI, Miraflores 113 Of. 73, Casilla 121A, Correo 29, Santiago, Chile. Fax (562) 6321571.

Population increase in the Third World
Conséquences de la croissance démographique dans les pays en développement (Consequences of population growth in developing countries) (1991), edited by G. Tapino et al. and published by INED/UN Population Division, presents the state of current research on demographic-economic problems in the Third World. It reemphasizes that growth is not an obstacle to economic revival, and questions the legitimacy of state intervention in this field. From: PUF, Département des Revues, 14 avenue du Bois de l’Epine, BP 90, F-91003 Evry Cedex, France. Price: 150 French francs.

Tragic details
In Maternal Mortality – A Global Factbook (1991), C. Abou Zahr and E. Royston have compiled the first (developing) country profiles combining socioeconomic and other background data with facts and figures on many aspects of maternal health and maternal care. "Anyone who wants to understand the forces at work behind one of the greatest avoidable tragedies of modern times, and prevent the deaths of women giving life, will find this book an invaluable resource," say the publishers. For policymakers, health professionals, communicators and others. From: Distribution and Sales, WHO, CH-1211 Geneva 27, Switzerland. Price: 50 Swiss francs. ISBN 92 4 159001 7.

My life and RU486

Mujeres (Women) is the attractively presented magazine of the Instituto de la Mujer in Madrid. As the Institute draws up its Second Equal Opportunity Plan for Women, Ms Purificación Gutiérrez, Director-General of IMM, writes that "full integration in the labour market is still the biggest challenge". From: Instituto de la Mujer, Ministerio de Asuntos Sociales, Almagro 36, S-28010 Madrid, Spain.

IPPF Medical Bulletin appears every two months in English, French and Spanish. It covers advances in contraception and allied matters and carries reviews of articles on aspects of these subjects. Free from: IPPF, POB 759, Inner Circle, Regent’s Park, London NW 1 41Q, UK. Tel (71) 486 0741. (Note: Publication of IPPF’s Research in Reproduction has been discontinued, but wallcharts (see Entre Nous 18) are still available from the above address.)

General
In Turkish and Arabic
The Rutgers Stichting produces inexpensive illustrated booklets and cassettes on birth control in Turkish and in Moroccan Arabic. Write to: Rutgers Stichting, Postbus 1734430, NL-2502 CK 's-Gravenhage, Netherlands.
Sexology handbook in Greek
The Sexuality and Family Planning Unit's handbook on Sexology for Health Professionals is also available in Greek from the Ministry of Health, Welfare and Social Services, Athens, Greece.

AIDS hygiene
"Follow the infection control rules every hour, every day, with every client", says IPPF's practical plastic wallsheet Protect Yourself and Your Clients. In plain words and pictures, it describes how to take care of hands, disinfect surfaces, dispose safely of waste, and sterilize instruments and syringes. From: IPPF (address as above under Magazines). Price: £1. In English, French and Arabic.

Health education resource packs
A wide range of resources that can be photocopied free of charge by secondary schools and health authorities is available from: Daniels Publishing, Barton, Cambridge CB3 7BB, UK. Fax (0233) 264888. Subjects include AIDS and HIV for Health Care Professionals, Sex, Child Protection, Counselling Skills, Dealing with the Media and many more. All packs cost £24.95 for an average of 35-40 sheets.

Training opportunities
Family health workshops, USA
For 1992, International Health Programs offer the following continuing education programmes for professionals of all levels working in health and family planning organizations:
- Family Planning Programme Management and Supervision (Spanish 6 July to 14 August, English 14 September to 23 October, Arabic 2 November to 11 December); IEC for AIDS Prevention (French 11 May to 12 June, English 22 June to 24 July, Spanish date to be announced);
- Advanced Training for Family Planning Trainers (French 27 July to 21 August, English 28 September to 23 October); IEC programme management (Arabic 27 April to 22 May, French 16 November to 11 December). For prospectus and prices, write to: International Health Programs, Western Consortium for Public Health, 22210 High Street, Santa Cruz 95060-3173, USA. Fax (408) 458-3659.

Methods of Regulating Human Reproduction (Delphi, 6-10 October 1992)
International Delphi Seminar organized by the International Association of French-Speaking Demographers, in conjunction with the Greek National Centre for Social Research. Main themes will be: the socio-cultural and political environments and their effect on fertility; policies and fertility; techniques for regulating reproduction, and the effects of the choice of technique on fertility; problems of data collection and measurement; and several others. Details from: Alain Parant, INED, 27 rue du Commandeur, F-75675 Paris Cedex 14, France. Tel (1) 43.20.13.45. Fax (1) 43.27.72.40.

2nd International Conference on Psychosocial Medicine (Cambridge, 29 July to 1 August 1992)
The main theme of this conference is psychosocial medicine in the 90s. Details from: Dr F. D. Hutchinson, IPM Conference Secretariat, 65 West Drive, Cheam, Sutton, Surrey SM2 7NB, UK.

Congenital disorders
Infant mortality is now so low in Europe that congenital disorders have become a leading cause of infant death. Affected babies which survive infancy also live longer than before; at the same time the general aging of the population is leading to more late-onset genetic diseases.

Community Genetics Services in Europe contains the results of a WHO survey of European screening services for Down's syndrome and inherited haemoglobin disorders. It shows that good screening programmes should have three parts: laboratory services, clinical services, and community services staffed by lay people. The latter are the rarest, despite the great need for them.

The survey also highlights ethical issues, such as whose choice it should be to screen, which disorders should be screened for, and equity, a sensitive question which can arise when a genetic disease affects only certain areas or certain cultural or ethnic groups.

This well-timed study draws clear and cogent conclusions about the type of community genetics services Europe should be aiming for.

Available in English (French and German versions will be published later) from:
- Distribution and Sales
  World Health Organization
  CH-1211 Geneva 27
  Switzerland

Price: 24 Swiss francs
ISBN 92 890 1301 X
Order No: 131 0038

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