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**SEX EDUCATION AND VALUES**

Although teachers are fully aware of the importance of young people's sex education, they rarely take the time to think about it as thoroughly as they should. Obliged to give an immediate response in certain situations, they stave off as well as they can the various social, psychological and moral problems related to an adolescent's increasingly precocious and public sexual life. Yet teachers, and especially Catholic teachers, could have a quite different role to play, one of integrating sex education into moral education and into a total Christian upbringing, since my point is that we should educate the whole person. The link between sex education and values is far from fortuitous: it is fundamental.

**A clarification of terms**

The concept of value is clearly a moral one: a discussion of values is a discussion of morality. A value entails a behaviour, an action regarded as 'good' or 'bad' depending on whether it respects the value that inspired it. In this sense, a value has the role of inciting people to act.
There is an ethical tendency in morality which sees a value solely in its prescriptive role: a value tells us what to do, and what not to do. In particular, this school of thought stresses the second aspect, that of listing taboos. It is quite plain to see that sexual morality has long been primarily negative, linked to an equally negative philosophy of sexuality. Sexual morality, in this view, therefore means strict compliance with a code of conduct.

On the other hand, a value also has the function of giving significance to a behaviour, in fact of legitimizing it. Seen in this light, morality is the elucidation of significance, or the search for meaning. Adolescents badly want to find a meaning to their lives, including their sex lives. One of the roles of sex education, in my view, is precisely to help young people in this search. A value is not merely an intellectual or moral concept: it is something (or somebody) you believe in and fight for. This affective component of a value explains why it is difficult to discuss values, and especially your own, in a dispassionate way. It also accounts for intolerance, crusades and ideological struggles, since a value always claims to be universal. The origin of this affective aspect of a value must be sought in childhood, when values are transmitted, learned and taken to heart, especially within the family. This is why many parents are afraid of sex education in schools, clearly feeling that it could threaten the values they have handed on, consciously or otherwise, to their children. This is also why sex education is linked to attitudes, behaviour patterns and experience; it is related to, but must be distinguished from, affective education.

Equally, a value is linked to action. Indeed, the gap between ideal and lived-out values is where action and education can take place. A value is also something sought, pursued, lived. A non-incarnate value is not a value. Living a value means far more than talking about values. Teachers have a responsibility to bear here: talking about values is not enough, they have to propose, discover, invent them.

The educational theorists of the New Education movement felt that moral values should be transmitted to pupils through the school's total moral life (as expressed in mutual help, shared work, intellectual honesty and respect for others) rather than through moral discourses. Similarly, sex education will be able to transmit values if it accepts the risk of a sexual life. By sexual life I mean the whole conscious life: a sexual human being, whatever form it takes, and not merely genital activity or sexual relations.

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[J'aime, Je m'informe, EN 11, p 16]
Some lines of thought for a sex education that is linked to values

It now seems that we must not only rediscover the positive side of a person's sexual dimension but also enlighten that dimension by relating it to educational values such as self-respect, respect for others, creativity, solidarity and interiority.

Self-respect includes respect for one's own body, a creation of God: this point is worth making again here, since there are many examples from history of the individual's sexual dimension being overlooked or disdained. A good sex education will help the child to discover, accept and integrate both his or her own body and those of others, while avoiding the twin excesses of narcissism and idolatry.

For teachers there are four aspects to respecting an individual's sexual dimension. Firstly, they must respect the child's sexual life, for instance by agreeing simply but wholeheartedly to answer his or her questions. They must also respect adolescence, seeing it not as the destruction of presumed childhood 'innocence', but rather as a difficult period of discovery and appropriation of the dimension of being a man or woman.

There is also the question of respecting adults as sexual beings: teachers must accept not only their own sexuality but also that dimension in the lives of their colleagues and the parents of their pupils. We cannot go on ignoring the marital and family difficulties experienced by adult educators, whether teachers or parents. Would it not be possible to give disinterested help to parents, alongside sex education for pupils? And since sexual life goes on until death, educators lastly have the difficult new task of respecting, and teaching respect for, the sexual life of the elderly. In sum, sex education could become the process of learning a new attitude of respect towards people, including their sexual component, whatever their age.

Creativity is also the search for, and imagining of, new Christian forms of sexual life. Rather than doing away with all past and present forms such as marriage or consecrated celibacy, this involves imagining or identifying ways in which people can live their sexuality that are more in tune with the present and future world. To do this, we must keep abreast of contemporary research on the family, male-female relationships, the communal lifestyles of young people, and women's and children's rights. Above all, we must open our eyes, seeking out and identifying those new values which young people are trying to live in their sexual experiences: spontaneity, sharing, freedom, respect for the group, independence, transparency, authenticity. It is easy to deplore the distaste young people currently have for making a commitment in marriage, and especially in a Christian marriage. But if sex education in Catholic schools persists in putting forward a fixed and reductionist model of marriage, one into which young people cannot integrate their own values, then they will be unable to see any meaning, value or possibility of fulfilment in such a marriage.

Solidarity should extend to all those who are sexually exploited, attacked, disabled or harmed. Since sexuality concerns the whole person, sexual violence and exploitation affect the whole person, too. While avoiding sensationalism, sex education could draw young people's attention to both obvious and hidden forms of sexual violence and exploitation such as rape, sexual aggression, prostitution and pornography. The aim here is to make adolescents responsible for their behaviour and attitudes towards other people, in everyday life and especially at school. This is a stage they must pass through before making any kind of social commitment in a campaign against one of the many forms of sexual violence, a commitment which their natural generosity prompts them to make spontaneously.
Interiority, or internalization, includes acknowledging and valuing the fundamental sexual dimension of the individual. The human body, and in particular the sexual aspects of a human being, have long been regarded as an epiphenomenon external to the personality. Modern psychology, on the other hand, has shown that the individual's sexual dimension lies at the heart of his or her personality. Any sex education worthy of the name should enable young people to discover this fundamental dimension, holding up a true mirror to themselves: it should be where they are honest with themselves, discover themselves, become aware of themselves and work out their life plans. It should allow them to discover the true nature of their sexuality, presenting it not only as a store of riches which they may ignore, neglect or squander but also as a bounty that they can give and share.

Teacher training and the educational philosophy of values

We must now consider how values can be transmitted in sex education, and what role teachers can play as transmitters of values.

Values related to sexuality are transmitted in two ways, explicit and implicitly. Explicit sex education refers to sexuality by name and clearly states what it is. Implicit sex education runs through people's attitudes, behaviour, patterns, reactions and lifestyles; it is not always conscious, but it has a far greater impact than explicit sex education. What a teacher is comes across far clearer than what he or she says; the values a teacher lives with his or her pupils are stronger than those which are merely named or explained. In the family, a child is surrounded by implicit sexual values: the feelings which unite his or her parents, their acceptance or refusal of the child, their togetherness. There is no doubt that parents fear a conflict between the values they live and those that will be transmitted to their children at school.

School sex education, too, can be either explicit or implicit: the fact that there are no formal sex education classes does not mean that there is no sex education at all in a school. A certain implicit and total sex education is transmitted through young people's behaviour towards each other, through their relationships with their teachers, through the teachers' attitudes towards each other, the general atmosphere in the school, the tone of conversations and the type of humour. The least that one can ask of a teacher is that he or she is aware of this and tries to improve the atmosphere if it is detrimental to education.

In any case, teachers must take account of the implicit sex education dispensed by the school, the family and society if they want their action to have an effect: sex education classes will have meaning and impact only if they relate to real life within and outside the school.

Consequently, the educator's role may be seen as a threefold one. First of all, he or she is a transmitter of information about sexuality, sex education, sexual morals, and emotional and social life. Secondly, he or she should be an 'activator', a link between that information and the adolescents who will use it: a flexible educational approach based on stimulation, exchanges of views and discussion would seem to be better suited to the subject than conventional lectures. Stimulation may include using audiovisual techniques or inviting people from outside the school. Lastly, the teacher has a role as a model or significant adult who lives his or her values and helps young people to discover, adopt and live their own.

This threefold role, some of which is fresh ground for the educator, presupposes the possibility of teacher training or further training; one of the challenges facing an educational philosophy of values in the twenty-first century is to make this training or further training a reality.

[From a speech given by Madame Marie Paule Desaulniers, 815 des Fresnes, Trois Rivières, Québec G8Y 1E2, Canada]
COUNTRY REPORTS

LESSONS FROM A CONFIDENTIAL TELEPHONE SERVICE FOR ADOLESCENTS

The Irish Family Planning Association (IFPA) has been involved in sex education for a number of years now. The Association's involvement grew out of concern at the level of ignorance among young people and the problems they encounter in relationships and with their own sexuality. For example, in 1983, a doctor conducted a survey in the IFPA clinics and found that 20% of the first time attenders were between the ages of 17 and 20 years, and that 85% of them had been sexually active for an average of 1.8 years before seeking contraceptive advice. More than one third (35%) of these had already been pregnant.

Experience with young people led the IFPA to recognize the need to involve young people in their own education and to set up a youth group to run an Adolescent Confidential Telephone Service (ACTS) in 1985.

The ACTS aimed at:

- training a group of young people to run a confidential telephone service for other young people;

- providing factual information for young people on subjects related to sexuality and relationships, such as conception, pregnancy, sexually transmitted diseases, and the law relating to sexuality and contraception.

- offering informed peer group education to young people in areas related to sexuality and relationships, and also acting as an important referral service for young people to the health, medical and caring organizations they may need.

A group of interested young people from the Dublin area were asked to give their opinions on the needs of young people in this area, and how they might be assisted through the anonymity of the telephone.

Recruitment and training of volunteers

Training of volunteers was provided by the IFPA tutors, who provide sex education courses for teachers, social workers and youth leaders. The volunteers were given factual information and practice in telephone-answering techniques. They also took part in workshops that explored attitudes to various sexual subjects, and in exercises to promote confidence and enable the volunteers to feel more comfortable with their own and other people's sexuality.

It was agreed that training should be a continuing feature of the project. In response to feedback from volunteers on the calls received and their expressed needs, seminars on special areas such as pregnancy counselling, sexually transmitted diseases and homosexuality were held for them. Qualified professionals ran these seminars. The volunteer group also held sessions on the kind of calls received, and shared feedback on how best to deal with different types of call.

An information book in directory form was compiled to enable those answering the telephones to gain easy access to the information they required.

The service

The confidential telephone service was launched in January 1985 after a pilot testing period, and operated for 43 weeks of that year.

The service was provided from the Information and Education Office of the IFPA, and operated for four hours each Saturday between 1.00 p.m. and 5.00 p.m. The three telephone lines were answered by two females and one male, the volunteers working on a rota basis with each person on duty every third week.
Although the telephone service was advertised as operational only on Saturday afternoons, a large number of callers phoned the IPPA's information office during the week. It was not possible to record these calls. Had they been recorded, the total number of calls received for the first year of operation (N=653) would have been considerably higher. On the basis of the success achieved, the IPPA decided to continue this service the following year and expand its youth activities.

Evaluation of calls received

Little is known about the needs and problems that young people encounter in regard to sexuality, personal relationships and family planning in Ireland. Therefore, detailed information on the type of call and response given by the volunteers was also noted. A record of every call received was kept, showing, where possible, the sex, age and location of the caller. The records kept by the telephone service thus provide a valuable insight into a previously unexplored area.

Profile of callers

There were great similarities between the profiles of callers in 1985 and 1986, the first two years of operation.

In 1986, ACTS received 695 calls during its 44 weeks of operation. The highest percentage of calls (42%) came from the 16 - 20 year age group, followed by those aged 21 - 25 years (28%). Some 79% of the callers were males. The anonymity of the telephone greatly reduced the personal inhibitions of the caller in the sensitive area of sexuality. The response from males since the launch of the service has continued to expose the myth that all young men are "macho", and have no worries or interest in learning about sexuality and relationships.

The telephone service was designed to serve the information needs of any young person living anywhere in Ireland. However, scarce financial resources made it difficult to advertise the service among those living in rural areas, and thus only 28% of callers were from rural areas.

The most common request (20%) was for information on contraception. As in 1985, the volunteers were surprised at the level of risk taking among young people. Most had been using the withdrawal or safe period methods or had just "hoped for the best". Many had recently had a pregnancy scare and this was the main reason for contacting the service. They had little or no understanding of how conception occurred, and often believed myths about pregnancy and sex such as "you don't get pregnant the first time if you have sex in the bath". Many callers had experienced peer pressure to have sex, and were relieved to know that not everybody was having sex, and that it was all right to refuse.

Some 13% of all calls concerned enquiries about sexually transmitted diseases. Information was requested on such diseases and how they could be avoided. There was a general lack of factual information among callers, and many were totally unaware of the free treatment clinics available.

As in the previous year, the telephone service confirmed the belief that many young people are worried about pubertal changes and lacked general information on such things as basic physiology, wet dreams, masturbation and conception. These calls accounted for 22.2% of the total number of calls.

Funding difficulties

The major problem encountered is finding funds to continue the project. The telephone service is run on a voluntary basis using existing IPPA resources. However, there are expenses incurred in employing one person full time to run the project, in publicizing and promoting the service, and in printing and postage. National grant aid has been sought in the belief that the project deserves to be supported in this way, but to date this has been unsuccessful. The main reason for this is probably that sexuality is still such a sensitive subject in Ireland. For this reason the future of the project remains precarious. By mid-1986 the telephone service was in serious danger of closing. A much-needed grant from the Family Planning International Assistance (FPFA) organization prevented closure, at least for the time being.
Conclusions

This project has demonstrated the value of peer-group education in reaching young people who might not otherwise have received the information they required. It also put into practice the concept that young people have the ability to educate themselves if given proper instruction and opportunity.

The volunteers developed into a cohesive and dynamic group, which has contributed greatly to the IPPA as a whole. The active involvement of young people in a family planning organisation is a valuable asset that should be fostered.

The urgent need for a comprehensive sex education programme in schools and youth clubs has become more evident. Many of those who telephoned lacked even basic information on how their bodies worked. It is interesting to note that the same level of ignorance exists among older people. Worries that manifest themselves in puberty seem to remain, leading to feelings of abnormality or guilt in later years. It is disturbing to note that many of those in their late teens/early twenties who did not receive sex education still have problems and, generally, do not have easy and open access to information and services to help them.

[For further information, contact: Jon O'Brien, Information/Youth Officer, Irish Family Planning Association, 15 Mountjoy Square, Dublin 1, Ireland]

FAMILY HEALTH COUNSELLING AT THE NATIONAL RESEARCH INSTITUTE OF MOTHER AND CHILD (NRIMC)

In Poland, as in many other European countries, traditional health services do not provide family health counselling for young people and young families, despite a growing demand. Adolescents especially find it difficult to get competent and confidential help for psychosocial problems.

Against this background, the National Research Institute of Mother and Child in Warsaw set up an Anonymous Clinic for Children and Adolescents eight years ago. Young people could call, phone or write to the Clinic without having to provide personal details.

The Clinic staff included a paediatrician, a psychologist, an educational counsellor and a social worker under the leadership of a child psychiatrist. The Clinic is very informal and is set in the non-clinical part of the Institute as part of the Family Health Department; this avoids it being labelled a "hospital service". Nevertheless, young people coming to the Clinic can, when needed, benefit from the Institute's wide range of specialist services, e.g. in genetics, endocrinology, surgery, oncology and neurology.

Since the opening of the Clinic the consultations have had a family planning component. Gradually, a Family Planning Counselling Unit was developed under the responsibility of an experienced gynaecologist who had worked in family health for many years.

Experience showed first that young people expressed less need for anonymity than expected. If during the first visit contact is established and the family or the young person feels accepted, full cooperation is obtained.
Secondly, what was intended as a service for adolescents has become a counselling unit for the family. Parents of adolescents come for help more frequently than the adolescents themselves. More often problems concern the family as a whole rather than just the person referred for counselling.

Predominant family problems at present include:

- adolescent children having emotional problems or difficulties at school;
- small children presenting difficult behaviour;
- marital crises;
- a handicapped child in the family;
- adolescent pregnancy; and
- relationships between the child and its foster parent or its adoptive family.

For each type of problem, family therapy is provided by the multidisciplinary team under the supervision of a specialist.

Work with families focuses on non-directive counselling, which means searching together with the family for feasible solutions. The goal of the counselling is to mobilize coping mechanisms in the family, and this requires the active involvement of all members of the family.

An analysis of the cases seen at the Clinic shows that this type of counselling meets existing social needs and provides a service not found in other forms of family health care arrangement.

[From: Dr Aldona Sito and Dr Irene Kornatowska, Department of Family Health, National Research Institute of Mother and Child, ul. Kakprzaka 17, 01-211 Warsaw, Poland]
communities (11 clinics). Also, there are several private marriage counselling institutes, mainly located in big cities.

Most family therapists in marriage counselling clinics are members of the Israeli Association for Marital and family Therapy.

Voluntary organizations

Voluntary organizations offering a "willing ear" to people in distress or other difficulties include: walk-in "Open Door" counselling centres for young people (Tel Aviv, Haifa, Netanya) operated by the Israel Family Planning Association, which provide an opportunity for the young to discuss sexual relationships and obtain contraceptive services; Eran, a personal mental health telephone service; the Rape Victim Aid Centres which are open 24 hours a day in Tel Aviv, Jerusalem and Haifa; the Association for Rights of the Individual (homosexuals) with a telephone service in Tel Aviv called "White Line"; and the Israel Association for Family Life Guidance.

Family and sex education in the schools

The Ministry of Education has established a special unit for developing education programmes in family planning and sexuality. These activities are presented in schools by counsellors, specially trained teachers or nurses. 7000 teachers have been trained throughout the country. There are also joint projects with parents, community groups and nurses.

A survey conducted in 1987 found that 80% of classes grades 10-12, 75% grades 7-9 and 50% grades 1-6 participated in the programme for education on family life and sex education. This is an increase of 30% over 1982. The programme is carried out by educational counsellors (50%), homeroom teachers (30%) and nurses or teachers (20%).

From 1988 onwards, the Ministry of Education has made the programme compulsory for nursery, primary, junior and high schools. The minimum time suggested for the programme is 6 meetings of 2 hours each.

Family and sex education in the army

A well known project of the Israel Defence Forces (IDF) is the completion of the high school education of young recruits and their preparation for civilian life. In this context, a special programme on family life and sex education for soldiers (female and male) has been developed by the IDF and the Israeli Family Planning Association, the latter being in charge of its implementation.

Communications and publications

There is no national professional journal specifically on sexual functioning, but the subject is covered in the medical literature (i.e. articles in the medical journals Harefuah and the Israel Journal of medical science). In addition, the Israel Family Planning Association publishes a bulletin covering family planning, contraception and sexual relations. Also the Israel Association for Marital and Family Therapy and Family Life Education publishes the quarterly magazine Ba'mishpacha (In the family).

Almost all the daily newspapers and in particular women's journals carry regular columns on popular subjects of sexual functioning, interpersonal relations, contraception. This also includes weekly magazines such as Ma'ariv for youth, with its regular column on guidance and current information for youth.

There are regular radio programmes in which listeners are able to address questions to a guest panel composed of sexologists, psychologists, doctors and social workers. Occasionally there are special information programmes.
Television presents from time to time programmes on fertility, birth, contraception, abortion and its complications, and family problems. Such programmes are still comparatively rare, but further use of this medium is expected in the future.

Courses for professionals

There are training courses at university and other levels of schooling. The programmes range from courses on human sexuality to supplementary information within the framework of a degree programme, for example in medicine, psychology or social work. Several medical schools are involved, as well as the Tel Aviv University School of Social Work. The Israel Family Planning Association offers an bi-annual course on human sexuality and the family, geared towards training family life educators.

[From: Dr Yoram Lotan, National Coordinator for Sexuality and Family Planning, Hospital Services Division, Ministry of Health, 2 Ben Tabei Street, Jerusalem 91010, Israel]

IMPROVING THE CARE OF THE YOUNG ABORTION PATIENT IN FINLAND

In the early 1980s the National Board of Health sponsored a campaign under the theme “People in Health Care Systems”. Its objective was to improve the quality of care for people using different types of health care and to encourage health professionals to adopt a sympathetic attitude towards patients and clients.

Within this context, the Central Hospital District of Middle Finland started a project to improve the quality of care given to young patients (under 20 years of age) who enter the hospital for an elective abortion.

Elective abortions are free in Finland. They are performed in district or regional hospitals by recognized specialists. In 1984, there were 185 abortions per 1000 births and there has been a continuous downward trend in the number of abortions, both in absolute figures and in relation to the number of women of fertile age and to the number of births.

At the Central Hospital District, 23 young abortion patients were interviewed at their first clinic visit; 12 of them were re-interviewed after the abortion. A number of problems in hospital care were identified through these interviews.

- Health professionals do not take enough time with abortion patients. Possibly because of this, the girls have very little information about alternative solutions to their problem other than an abortion. As a rule they have not been able to work through their decision to have an abortion. It was also found that the patients had defective knowledge of abortion as a medical operation which caused them unnecessary fears.

- During the short hospital stay the young abortion patient meets a large number of health professionals. Continual encounters with new people make it difficult to build a trustworthy relationship with any one of the hospital staff.

- Hospital care easily becomes a routine and individual care is forgotten.

- Hospital staff find it difficult to meet a youngster going through a personal crisis.

- The hospital has not been able to guarantee the patient “a personal nurse”, a nurse specifically assigned to see the patient through her hospital stay.

The findings of the interviews led to the following recommendations.

1. Youngsters need more information about contraceptives. Most girls know about effective contraceptive methods, but somehow do not accept the fact that they themselves should use them. They feel they are too young to become pregnant, or that taking the Pill will lead to sexual intercourse. In previous studies in Finland we have found that the school nurse is in a key position to help youngsters to face the reality of contraceptive use.
2. As soon as an unwanted pregnancy has been diagnosed, a discussion in a primary health care centre should be arranged. All alternatives should be discussed with the girl. The doctor, nurse, social worker or psychologist should have proper training for this task and the discussion should not depend on the initiative of the patient. Many girls said that after the first shock of discovering the unwanted pregnancy, all they were able to think about was how to get out of the situation as quickly as possible.

3. Hospital personnel need to be better prepared to meet the psychological and emotional needs of young abortion patients and a system by which these patients can have their "personal nurse" should be developed immediately.

4. Among young abortion patients there are vulnerable groups who require special attention. They are:

- the very young (13-16 years of age),
- those who have had several elective abortions,
- those who before the beginning of their pregnancy have had psychological and social problems.

From the limited number of replies of young abortion patients to questions about hospital care, it seems that the health care organization so far has not met the psychological needs of the young abortion patient. Clearly, high quality technical know-how and easily available abortions are not enough. Improving the quality of care for the abortion patient does not necessarily require expensive investments.

[From: Marja-Leena Kärkkäinen, Senior Nursing Officer, Pirjo Viinikainen, Social worker, and Mikko Viinonen, Senior Medical Officer, Middle Finland Central Hospital, 40620 Jyväskylä, Finland]

POINTERS ON PROGRESS IN FAMILY PLANNING IN PORTUGAL

Officially family planning activities began in 1976, two years after the democratization of the political system. The objectives were: to improve the wellbeing of families, to improve indicators of maternal and child health, to allow couples to regulate their fertility as they wished and to reduce the number of unwanted pregnancies, to reduce the number of complications of abortion, and to promote the appropriate use of contraceptive methods. No demographic policy stands behind family planning in Portugal. Its focus is on the health and wellbeing of mothers, children and couples.

The Directorate-General for Primary Health Care of the Ministry of Health gives a high priority to the training of health professionals in family planning so that high-quality services can be delivered. Such training has been an important element in the family planning programme. For example, from 1977 until the end of 1986, 158 courses were held in Directorate-General and 2650 health professionals (1318 nurses, 1319 physicians and 13 social workers) are now prepared to work in family planning in various health centres.

The number of health centres offering family planning consultations rose from 155 in 1982 to 470 in 1986. The consultations include: information on sexual matters and on all contraceptive methods (which are provided free of charge); medical examination, including gynaecological and breast examination and cervical smear tests; counselling and referrals for infertile couples; and health education.
A study in 1985 of 6 districts (one third of all districts in the country) revealed that 41.5% of the women questioned practised some form of contraception and 31.8% obtained services from health centres. The contraceptive methods used, in order of frequency, were: the Pill (45%); the IUD (7.6%); fertility awareness methods (3.9%); chemical methods (3.9%); combined chemical and barrier methods (1.6%); and hormonal injections (1.9%). Coitus interruptus is still practised by 32.2%, probably owing to tradition.

The Portuguese family planning programme, assisted technically and financially by WHO and UNFPA, has contributed to improving the health of mother and child, as shown by:

- a decrease in unwanted pregnancies, from 40.5% of all pregnancies in 1980 to 26.7% in 1983;
- a reduction in maternal mortality from 30.5 per 100000 live births in 1979 to 10.7 in 1985;
- a decline in perinatal mortality from 25.8 per 1000 live birth in 1979 to 19.8 in 1985.

[From: Maternal Health and Family Planning Department, Directorate-General for Primary Health Care, Alameda D. Afonso Henriques No. 45, 1056 Lisbon Codex, Portugal]

**INTERCOUNTRY NEWS**

**THE IMPACT OF HEALTH PROFESSIONALS ON FAMILY PLANNING**

To assess the effect of the behaviour of health professionals on family planning counselling and on family planning practices by clients, the Sexuality and Family Planning Unit of the WHO Regional Office for Europe commissioned a literature review. Some salient points are reported here.

Many factors intervene in the selection of health workers in family planning and in the definition of their activities. There are legal requirements concerning, for example, the insertion of IUDs, the performance of sterilization and abortion, the prescription of the pill. The legal requirements vary from country to country and in some the laws are ambiguous. One position is that only a physician is permitted to perform sterilization, insert IUD, even prescribe oral contraceptives. In other countries, trained midwives insert IUDs with the same or even better effects on continuation rates. Still the legal situation needs to be clarified to provide proper legal protection for non-medical health personnel.

In all Western European health service systems, the physician tends to have a key role in dealing with health needs, including those related to family planning. The doctor/patient relationship influences the choice of contraceptive method made and the physician usually has definite ideas about each method. However, he or she is not the guardian of the client's choice.

In the literature, we find reports of prejudice against male doctors working in family planning. Some of the prejudice is related to culture and religion, but women in general prefer to see a female doctor.
Should health professionals in family planning practice always be physicians? There are many suggestions and some evidence that nurses and midwives can and should provide most family planning services, a recommendation that has practical utility in countries with unfavourable physician/population ratios. However, the involvement of allied health personnel in family planning should not be considered a stop-gap measure to compensate for a shortage of medical manpower.

In fact, nurses and midwives are extensively engaged in various family planning activities. Their responsibility and tasks vary from country to country. Much can be said for the promotion of a nurse specialist in family planning as has been done successfully in the United States for more than 20 years. She offers to the client a comprehensive selection of family planning methods, and advises on fertility, pregnancy testing, premenstrual tension, the menopause, unplanned pregnancies and sexuality. She may also carry out health screening such as cervical smear tests and breast examination.

Technical skills can also be mastered successfully by the nurse or midwife if proper training and supervision are provided. With training and experience nurses become skillful in counselling in family planning, in creating a proper climate for clients to make their own decisions and in listening to their concerns. Studies stress the fact that the attitude of the family planning provider and the support given to the client is more important than the particular position of the provider within the health team.

When family planning providers operate as a team, the medical and nursing personnel have complementary, not dependent, roles. Lately, the role of pharmacists as adviser/counsellor on contraceptive and sexual problems has been recognized. They too complement the primary health care team and are often in the right place to answer young people's questions, as they purchase their contraceptive supplies.

To conclude, in the earlier years family planning relied almost exclusively on medical personnel. Non-medical personnel became involved, originally because of the short supply of physicians, and are now members of the family planning team. There is, however, little research on the specific impact of the attitudes, feelings and practices of various health professionals on the practice of family planning and this is an obstacle to developing recommendations for realistic professional training in family planning, especially in conducting grassroots family planning consultations.

[Excerpts from: A literature review on the impact of health professionals on family planning counselling and practice among clients by Gillian Randa, Royal College of Nursing, Society of Primary Health Care, 20 Cavendish Square, London W1M 0AB, United Kingdom]

AIDS AND FAMILY PLANNING: SELECTED NOTES ON WHO MEETINGS AND DOCUMENTS

By informing and educating clients about safe sexual practices, family planning workers are in the forefront of preventing the spread of AIDS in the heterosexual population (EN 9, pp. 12-13, December 1986). The content of such education to different groups of the population is detailed in the document on Safer Sex prepared by Wadad Haddad of the sexuality and family planning unit at the WHO Regional Office in Copenhagen and available from that unit.
Also available from the unit in the near future is a training manual for health professionals who are or will be dealing with AIDS in clinical or educational settings (Aspects of sexuality and family planning. Module 6: AIDS: Counselling skills for health professions, by John Sketchley, WHO Regional Office for Europe, Copenhagen, and BLAT Centre for Health and Medical Education, London, 1987, 91 pages). The manual aims to overcome the reluctance of the helping professions to talk about sexuality, and provides them with skills to counsel potential and actual AIDS victims and their family or partner.

Three meetings in 1987 sponsored by the WHO Regional Office for Europe dealt with various aspects of AIDS. Several points in the reports of the meetings have practical implications for family planning workers. The first meeting, held in Munich on 16-20 March, reviews the current situation of AIDS in Europe, predicts the future of the epidemic and identifies needs for further research (Aids diagnosis and control: current situation: report on a WHO meeting, Copenhagen, WHO Regional Office for Europe, 1987, 36 pages).a

The following points covered in the report may be of interest to family planning workers.

- Routine screening of all family planning clients is not recommended but testing on a voluntary and anonymous basis, with data kept confidential, should be offered to clients who are at high risk or who are living in high prevalence areas. Voluntary testing should be used to motivate people to change risky behaviour.

- If testing is done, counselling should be mandatory both for HIV positive and negative clients and for partners and families when appropriate. Family planning workers should be trained to counsel people about HIV infection.

a Copies may be ordered from WHO sales agents or from Distribution and Sales, World Health Organization, 20 Avenue Appia, CH-1211 Geneva 27, Switzerland. Sale price: Sw.fr. 5.

- Education of family planning clients about safe sexual practices remains the cornerstone of AIDS prevention. Encouraging the use of condoms falls readily within the range of services offered by family planning clinics and should be done with frankness and persistence for clients at risk. Clients, however, should not abandon safer methods of contraception (e.g. the pill) when using condoms.
A second meeting sponsored by WHO was a Consultation on AIDS and the Newborn held in Copenhagen on 9-10 April. Since countries are likely to see an increase in the number of infected babies over the next 3-4 years, the problem of maternal-fetal transmission of the AIDS virus was reviewed, as well as the consequent problems to mother and child (AIDS and the Newborn: preliminary report on a WHO Consultation, Copenhagen, WHO Regional Office for Europe, 1987 (document ICP/CDS 017/ UNFPA/RMI/79/P05, English only) available from the sexuality and family planning unit.)

Participants in the Consultation recommended, for example, voluntary testing of women in the antenatal period. Women found positive should be counselled about the risk of fetal infection and offered termination of the pregnancy. Although maternal-fetal transmission occurs (an estimated 20% to 50% of infants from HIV-positive mothers develop HIV-related disease) the exact route(s) of transmission from mother to child should be better studied.

Children born to HIV-positive mothers require regular paediatric follow up for 3 years with social support and counselling for the families. They should be managed in the same way as any other child, except that breastfeeding is contraindicated. Exclusion of infected children from day care or school should be prevented by health professionals informing concerned parents and members of education boards about the absence of risk of infection for other children and adults.

Participants at a third meeting, in Bremen on 26-28 August 1987, discussed the issue of training personnel in drug treatment centres to deal with the existing AIDS crisis among drug users (Training on AIDS for personnel in drug treatment centres: report on a WHO Meeting, Copenhagen, WHO Regional Office for Europe, 1987. Available from the mental health unit).

The main emphasis of the meeting was on the development of training guidelines and programmes for drug treatment staff, but linkages were discussed with community agencies and health facilities including family planning clinics. It was recommended that drug treatment staff act as training consultants to health professionals of other agencies, particularly informing them about the psychosocial issues of chemical dependency among intravenous drug users or their partners.

Enquiries for information on AIDS from the WHO Regional Office for Europe should be addressed to Dr Bytchenko, Regional Officer for Communicable Diseases, and focal point on AIDS for the Office, Scherfigsvej 8, DK-2100 Copenhagen.

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AIDS
Information for Travellers

If you plan to travel, or are already on your way, here are some basic facts about AIDS.

Concern about AIDS should not prevent travel to any part of the world.

Whether at home or travelling, avoiding AIDS is mainly up to you.

World Health Organization
Special Programme on AIDS

[Order leaflet from: Special Programme on AIDS, World Health Organization, 1211 Geneva 27, Switzerland]
NEW LEAFLET FOR YOUNG PEOPLE

A new information leaflet for young people is being launched by the Irish Family Planning Association (IFPA). "Tender, loving, careful" gives straight facts about sex and contraception and encourages responsible sexual behaviour among young people.

This new leaflet is written in simple language and explores the responsibilities involved in a sexual relationship and the role of peer pressure, and gives information on family planning centres. This is the first in a series of leaflets for young people to be produced by the IFPA. Leaflets are available free of charge from the IFPA to youth clubs, schools and other youth organisations.

[Contact: Jon O'Brien, Information/Youth Officer, Irish Family Planning Association, 15 Mountjoy Square, Dublin 1, Ireland]

J'AI ME, JE M'INFORME

The National Secretariat for Youth and Sports in France, in cooperation with several other French associations including the French Health Education Committee, has produced an innovative document on contraception for young people. Nearly one and a half million copies of the 24-page booklet, entitled 'J'aime, je m'infore', have so far been distributed. We were very impressed with the way it has been put together; the simple and direct style is likely to appeal to young people.

LA CONTRACEPTION

Si on a décidé d'avoir une relation sexuelle dans la confiance réciproque...

C'est choisir le moment ou l'on veut avoir un enfant.

Il n'y a pas une seule contraception mais des contraceptions.

[Copies available from: Comité français d'Education pour la Santé, 22 rue Lecourbe, 75015 Paris, France]
WHAT TO WRITE FOR

WHO DOCUMENTS ON SEXUALITY AND FAMILY PLANNING RECENTLY AVAILABLE


Why do disabled people often encounter barriers to the development and expression of their sexuality? Is the reason the actual disability, lack of information or lack of understanding and support from relatives, professional staff or the community at large?

These issues were explored in a study sponsored by the Sexuality and Family Planning Unit of the WHO Regional Office for Europe and conducted by Mary Porter, short term consultant.

The report has two main sections. The first is a description of the background and approaches used in the project. The report itself follows. The basic material for the report was the concrete experience, conclusions and recommendations of 29 people with disabilities. They attended three workshops and their ideas were written up and collated into a unified text.

This approach is an example of the WHO health for all policy of encouraging people actively to control and improve their health, to take responsibility for themselves and to make changes where necessary in their environment.


This literature study was conducted by Lena Nilsson Schönnesson, short term consultant, at the request of the Sexuality and Family Planning Unit of the WHO Regional Office for Europe, to explore the relationship between psychological dysfunction and sexuality within marriage. Although the original intention was to review research studies conducted within the Member States of the WHO European Region, a computer search of the MEDLINE data base showed that the majority of relevant research came from the United States.

The study makes no claim to have completely covered the extensive research area or cultural or historical aspects of the question. Further, the word relationship does not permit causal inferences to be drawn. From an etiological perspective several alternatives are possible. Psychological dysfunction may be the result of difficulties in sexuality (in its broadest sense), but the opposite may also be possible. Psychological dysfunction may affect sexuality, which then in its turn may affect psychological status.

- Sexuality, family planning and migrant populations. Annotated bibliography. Copenhagen, WHO Regional Office for Europe, 1987 (unpublished document ICP/MCH 535, UNFPA/RMI/79/P05), 177 pages. The bibliography has been available in French since 1984 under the title Sexualité, planification et population migrante. Revue annotée d'ouvrages and was reviewed in ENTRE NOUS, No. 4, July 1984. The current English version has been updated.

- Two reports, one on Child sexual abuse (reviewed in ENTRE NOUS No.9, December 1986) and the other entitled Sex and family planning: how we teach the young (see ENTRE NOUS No.6, July 1985), are now available in French.
Positive Health

A newsletter published with WHO support to provide information and practical ideas on health promotion in Europe. It is circulated by the Institute for Health Promotion, University of Wales College of Medicine, 24 Park Place, Cardiff CF1 3BA, Wales, UK. You receive it free with a subscription to the International Journal "Health Promotion", published by Oxford University Press. Inquiries to above address

SELF-HELP FOR PREMENSTRUAL SYNDROME

Dr Michelle Harrison was one of the first doctors in the United States to specialize in the premenstrual syndrome (PMS). Her wide experience with the problem led her to write a useful guide Self-help for premenstrual syndrome for women so they understand better the physical and emotional signs of PMS ("my body swells up, I just want to be alone and hide, getting my period is a bother but being premenstrual is a nightmare") and are better equipped to cope with their own feelings and society's predominantly negative attitude towards PMS.

A chapter in the book deals with sexuality and PMS by using, as in other chapters, short case studies to bring the problem closer to real life. The author discusses the influence of PMS on the sex drive of women (it may be higher or lower) and the difficulties created in an intimate partner relationship. For example, a woman may want to be held, not to have sex, which is confusing both to the woman and to her partner.

How can women help themselves? Dr Harrison proposes first that women think about a list of questions so they understand PMS and sexual changes better. Second, hormonal treatment is of limited applicability. In most cases the real solution lies in the ability of women and their partners to talk about sexual changes and how to respond to them with mutual understanding.