EDITORIAL

INFERTILITY AND FAMILY PLANNING

Today there are increasing numbers of infertile couples, and the demand for treatment is growing. This situation is due to a variety of causes, including a higher prevalence of sexually transmitted diseases (STD) among men and women, with resultant pelvic inflammatory disease; postponement of childbearing to an age when fertility is reduced; and exposure by both men and women to occupational hazards which can affect fertility. On the other hand, new methods are now available to treat infertility, such as in vitro fertilization, microsurgery and hormonal therapy, and services for infertility management and counselling are increasingly being offered by hospitals and family planning clinics. The public is becoming more aware of these possibilities. Infertile couples tend now to look to medical science for a solution to this problem, which is also receiving greater attention in European countries with declining birth rates.
For this article we have sought the views of three specialists in this field: Dr. A. Balogh of the University Medical School, Debrecen, Hungary; Dr. T. Tamazevic of the University of Ljubljana, Yugoslavia and Dr. M.P. Molitor-Pfeffer of the Luxembourg Association for Family Planning and Sex Education. Their contributions give an overview of the present situation of infertility and its main causes, and look at such questions as the potential of recent advances in infertility management, the various public health and ethical issues involved, and the changes that have taken place in the attitude of family planning clinics to infertility management for couples.

INFERTILITY: CURRENT STATUS AND TRENDS

From sample surveys carried out by the United Nations Economic Commission for Europe, primary infertility rates have been estimated, showing that between 5% and 8% of ever married women in Europe are childless at the end of their reproductive life. In other regions the primary infertility rates are similar or lower, except for Africa where they are higher. For some countries they are as high as 20–30% (Farley, T.M.M. & Belsey, E.M., 1988).

A major WHO-sponsored study carried out from 1979 to 1984 has given new insight into the causes of infertility. For this investigation a standardized approach was used to examine over 8500 infertile couples, just under half of them from developed countries, at 33 medical centres in five regions of the world (Cates, W. et al.).

The role of infection

STD as well as postabortion and postpartum pelvic infection play a major role in the etiology of male and female infertility. Pelvic infectious abnormalities are especially important as a cause of female infertility in sub-Saharan Africa, where 85% of diagnoses showed this condition. In developed countries the figure was 36%. STD are a major contributing cause of infertility in both developing and developed regions. Abortion appears to play a larger role as a cause of infectious infertility in developed countries, while unhygienic midwifery practices with postpartum sepsis are an important factor in some developing countries.

The main infectious agents in STD are Neisseria gonorrhoeae and Chlamydia trachomatis. The precise role of Chlamydia is difficult to assess since chlamydial infections are often asymptomatic and therefore go unrecognized in women until they seek advice on their fertility.

Other causes of female infertility in different parts of the world are ovulatory disorders of endocrine origin (30–40%) and endometriosis (1–10%), while there is no demonstrable cause in 16–40% of cases. As far as male infertility is concerned, the main causes are insufficient sperm quality (6–12%), varicocele (10–12%) and primary disorders of the testicular function (7–25%), with no demonstrable cause in 25–58% of cases.

Despite considerable improvement in techniques for identifying the causes of infertility, much is still not known. In the WHO study, no demonstrable cause was found in 40% of women and 50% of men in developed countries.

Needs and realities

Infertility is a bigger problem than was previously thought, an estimated 60–80 million people being affected worldwide.

There have been spectacular advances in infertility management, although the progress in countries has been uneven. The investigation and successful treatment of infertility is expensive, and consequently this service is not accessible to third world patients and also to the poor in many developed countries. We need a new approach.

WHO's Special Programme of Research, Development and Research Training in Human Reproduction has done much to develop proposals for action, and every effort must be made to implement them in countries in the future.
Chief among the proposals are the following:

a) Governments should give priority to reproductive health in their national health policies and ensure the provision of appropriate services.

b) Governments should set up and/or strengthen educational programmes for young people on family life and sexual relationships, dealing with such questions as sexual hygiene, responsibility for partner and self, contraception and infertility.

c) Each country should launch an STD programme focusing on detection, treatment and prevention.

d) Governments should support research in reproductive health, and especially the epidemiology of infertility and the psychosocial aspects of the problem, as proposed by the WHO consultation on health and fertility research, held in Arusha, Tanzania, in March 1988.

e) Governments should introduce new, more patient-friendly and less costly services for examining and treating infertile couples.

Acting on these proposals will require international cooperation through bodies such as WHO and UNFPA.

[From: Dr A. Balogh, Consultant, Department of Obstetrics and Gynecology, University Medical School, 4012 Debrecen, Hungary]

**BIRTH CONTROL AND INFERTILITY: ALL PART OF FAMILY PLANNING**

Rapid population growth with its dramatic demographic and social consequences has seized the imagination of governments and the public. Worldwide resources have been mobilized to control this growth. In that light, it may be difficult to appreciate and support the great efforts that are needed to deal with infertility. Gynaecologists are concerned about these two apparently contradictory requirements: birth control and treatment of infertility. However, although they may seem contradictory at first sight, we find they have a common thread, namely, caring about the happiness of the individual or the health of the future generation.

Compared to birth control, infertility has been viewed by society as a matter for the individual, vested with lesser importance. In medicine, however, the prime concern is the patient's health and wellbeing, and infertility is therefore viewed as a serious problem. The physician is concerned with diagnosis and treatment, and the birth of a healthy child is the only criterion of success. From this point of view, infertility management should be seen simply as one of many, not contradictory but complementary, forms of family planning. Our constant concern is for the birth of a "wanted" but also a "healthy" child, whether through in vitro fertilization or through the termination of an unborn life, where genetic disease or malformation has been diagnosed.

**Infertility and behaviour**

Experts argue about the increase in infertility associated with a rise in STD, endometriosis and unexplained causes.

People tend to be careless in matters of sexual hygiene. They have several sexual partners and brief consensual unions. This favours the spread of STD and the subsequent risk of infertility. In some countries there is a trend to postpone marriage and childbirth. As a couple ages, their ability to conceive diminishes. So postponing parenthood may result in infertility. Also, a growing number of couples are deciding to stay childless.

**The limits to our knowledge and possibilities for help**

New knowledge and technologies have profoundly altered the treatment of infertility over the past 30 years. Advances in endocrinology have been especially important in this respect.
New new hormonal tests, for instance, have enabled the identification of ovulatory disorders, and other endocrine and metabolic disturbances, which are now successfully treated with newly isolated and synthetized hormones.

Disorders of the male reproductive system have been studied more closely. The subspeciality of andrology has given us a better understanding of male infertility (caused by varicocele, failure of the testicular function, orchitis, obstructed vas deferens following STD infection, and other conditions) which has to be investigated in each case as a prerequisite for successful treatment. Both partners must always be examined in any treatment.

Operations such as artificial insemination have been developed. In vitro fertilization and related procedures are now in use. Immunological causes of infertility have been discovered, as have many forms of tuboperitoneal infertility and endometriosis through laparoscopy - a technique that is also useful in selecting patients for surgery.

Enormous progress has been made in microsurgery, although a number of unsuccessful operations and inoperable cases show that there are limits to this technique.

In vitro fertilization and embryo transfer may hold out the most promise for infertile couples. Multiple transfer of three embryos in the best equipped centres results in pregnancy in 30-40% of cases. Ultrasound has simplified this procedure and reduced its cost. New techniques of embryo freezing have had an even higher success rate. In some forms of unexplained female and male infertility, gamete intrafallopian transfer has been used successfully. In Singapore, a first clinical pregnancy has been achieved through embryo transfer by micro-injection of spermatozoa into the perivitelline space of the oocyte.

Although it is difficult to assess the prospects for in vitro fertilization and related procedures, there seems no doubt that this technique represents a real hope for many couples for whom adoption has been the only solution following lengthy treatment for infertility.

Nevertheless, we must ask ourselves whether these remarkable advances really offer hope to all infertile couples.

First, some methods will be unacceptable from a medical and ethical point of view. Not every biological development should be introduced in clinical practice.

Second, we should think about the extent to which medical assistance is available to the growing number of infertile couples who increasingly require such services. According to WHO, 50-80 million women and men have some kind of fertility problem and the incidence of infertility can be estimated at two million new infertile couples a year.

Infertility is a social problem and society should make infertility services available to all, not only to the rare individuals who are able to pay for them. This is a key issue of equity between rich and poor, and between developed and developing countries.

Finally, we should look at ways of preventing infertility. This means improving sex education and encouraging the use of harmless contraceptive methods. Carelessness in such matters has serious consequences. For the individual, infertility can be a tragedy. No material goods can compensate for frustration and loss of self-respect. For society, infertility means that expensive diagnostic and treatment services have to be provided.

[From: Dr Tomaz Tomazevic, Assistant Professor and Head of the Infertility Unit, Department of Obstetrics and Gynecology, University of Ljubljana, Yugoslavia]
ATTITUDES TOWARDS INFERTILITY MANAGEMENT

In Luxembourg, couples with infertility problems are mostly seen by private gynaecologists. No data are available on how many seek advice or treatment for infertility or on how gynaecologists deal with this problem. We do know that couples for whom artificial insemination or in vitro fertilization is indicated are referred to university clinics in Belgium, France or the Federal Republic of Germany, since Luxembourg does not have specialized services. Couples who attend our family planning centres are also referred to these clinics.

From our long experience of referring couples with infertility problems, we have learned to be more cautious in recommending artificial insemination or in vitro fertilization, having observed that many problems can arise both for the couple and for the child following the use of these techniques.

Originally, our attitude towards infertile couples was to help them at all costs, but we are now more cautious. We have come across a number of couples who have problems of their identity as man or woman or problems of sexual relationships or who wish to prove that they are "normal". In such cases, having a child is no answer. The underlying conflict should first be resolved before suggesting a procedure such as artificial insemination.

Our approach now is to consider the interests of the child. How well will it be accepted by its parents? What motivates the parents and what is the nature of their relationship? We do not automatically go along with a couple's wish for a biological solution to their problem of infertility. An assessment is made by the psychologists in our family planning centres and the couple's wish to have a child is carefully discussed. We have found that not all couples persist in seeking infertility management.

[From: Dr M.P. Molitor-Pfeffer, Présidente du Mouvement luxembourgeois pour le Planning familial et l'Éducation sexuelle, 18-20 rue Glesener, 1630 Luxembourg]

SELECTED REFERENCES


COUNTRY REPORTS

COURSES ON NATURAL FAMILY PLANNING: WHO ATTENDS?

The Austrian Institut für Ehe und Familie (Institute for Marriage and the Family) conducted a pilot study to assess the characteristics of attendees at courses on natural family planning methods (NFP). Interest in the attendees' profile stems from a growing interest in NFP and the fact that little was known about potential NFP users.

Some 173 participants in six NFP courses held over the period 1984-85 in Vienna were asked to answer a questionnaire anonymously. The four block diagrams show, in percentages, data on age (Figure 1), previously and last used family planning methods (Figures 2 & 3) and motivation for course attendance (Figure 4).
Contrary to common expectation, attenders at NFP courses turned out to be mainly young people under 30 years. Potential users of NFP are generally believed to be 30 and older, and this perception was confirmed in a recent study among Austrian gynaecologists, in which 149 out of 179 gynaecologists thought that only people over 30 would show interest in NFP. We assume that this age bias regarding NFP-users is related to the official information what medical students or doctors find in professional books and papers, but perhaps also to the earlier experience of doctors who used to explain the calendar method of NFP to older women who had completed their families. In either case, opinions about potential NFP-users need urgent updating in the literature.

Secondly, the study showed that religious motivation is not a dominant factor in the decision to attend NFP courses by interested persons. The main impetus to attend appears to come from the ecological movement. We assume that younger people have a different attitude towards their bodies and therefore are more interested and willing to learn about signs of fertility or infertility. Because of their age they are interested in family spacing, and at some later point in time may want to have children. Also they may be more inclined to share the responsibility for controlling their fertility with their partner.

The less dominant role of religious motivation in attendance at NFP courses was confirmed in a retrospective study of 127 attenders at courses on the sympto-thermal method taught in Vienna between 1979 and 1982. Motives for attendance were as follows:

<table>
<thead>
<tr>
<th>Women (N=74)</th>
<th>Men (N=53)</th>
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<tbody>
<tr>
<td>concern about one's health</td>
<td>58%</td>
</tr>
<tr>
<td>displeasure with previously used methods</td>
<td>49%</td>
</tr>
<tr>
<td>religious reasons</td>
<td>43%</td>
</tr>
<tr>
<td>Desire to find an alternative method</td>
<td>30%</td>
</tr>
<tr>
<td>other reasons</td>
<td>28%</td>
</tr>
</tbody>
</table>

These courses were advertised in Catholic circles only, yet no more than 43% of women and 34% of men cited religious reasons for attending. When courses are advertised both in and outside Catholic circles (as in the first study), the figure for women drops to 20%.

After finishing our survey we found two comparable studies in Canada and the Federal Republic of Germany undertaken at the same time which gave almost identical figures concerning the age distribution of NFP course-attenders and their motivations for attending the course.\(^a\)\(^b\) We also observe a growing interest in NFP in Austria, a finding supported by a detailed Austrian population analysis published in 1985 which showed that the use of NFP methods is increasing. The same trend holds true for the Federal Republic of Germany.\(^c\)

[Extract from a paper by Drs Romana Widhalm and Gerhard Wolfram on: Some characteristics of and background data on users of so-called natural family planning methods (NFP). Institut für Ehe und Familie, Spiegelgasse 3/8, 1010 Vienna, Austria]

\(^a\) Daly, K.J. & Herold, E.S. Who uses Natural Family Planning? Canadian journal of public health, 76 (May/June) (1985).


Current population policy and measures

The State so far has no official population policy. Provincial and local authorities practise population policy in terms of securing a sufficiently large workforce in the areas concerned. In addition, population developments have been discussed in various State committees and in programmes connected with family policy.

For example in 1966 the Committee on the Equalization of Family Expenditures proposed an annual population growth of at least 0.5% which it said could be achieved by improving the economic status of the family. Similarly in 1971 the Committee on Child Day Care proposed a day care as a way for society to help families with children, and a 1980 Government Family Policy Report stated that the aims of family policy are connected with the aims of the whole society. The Working Time Committee (1983) dealt with the effect of population developments on the supply of labour.

A Council on Population Policy

The Finnish Committee on the World Population Year 1974 proposed that a Council on Population Policy should be set up by the Government and that it should act as a coordinating body and prepare and follow up matters significant for population policy. The proposal was renewed by Väestöliitto, the Finish Population and Family Welfare Federation, in 1975, 1979 and 1987.

To date the Council has not been established. Nonetheless, the proposals of the various committees may have an indirect effect on practical decision-making, especially when they are part of the political programme of the government.

POPULATION AND POLICY IN FINLAND

Population concerns

In Finland the present and long-term influences of low fertility and aging population are being debated in the press and at public meetings. The Finns are especially concerned at the increase in the proportion of old people in the total population – particularly the increase in the number of elderly women – and the impact of this trend on both individual welfare and social activities.

Finland has a population of 4.9 million, of whom two thirds live in the southern and central parts of the country. Since 1968 fertility has been below replacement level, with a total fertility rate of under 2.1. At present the overall fertility rate for the country is 1.6, and for the Helsinki metropolitan area 1.4. Ordinary people, however, believe that fertility is high enough, since they see the population growing slowly. They do not know that this small population growth is due mainly to a decrease in mortality, a currently large reproductive age group, and the return migration of Finns from Sweden to Finland which started in the 1980s.

A second factor in the population debate is demographic aging. The proportion of old people in the Finnish population grew from 9% in 1970 to 13% in 1987. During the same period the mean expectation of life at birth for men increased from 66 to 71 years, and for women from 74 to almost 79 years. In Finland male excess mortality has existed for a long time. Although the mortality of middle-aged men has declined rapidly, male excess mortality is still high compared to other developed countries, while female mortality has continued to decline. Consequently, among 65-year-olds, 65% are women, and among the 75-year age group the percentage of women increases to 69.
- the job-security and social security of part-time workers will be improved;

- taxation reform and connected income transfers should ensure that the income of families with children, and of people with a low or middle income, will not be affected;

- the child allowance system will be developed in such a way that the support received by families with children will be improved and the age limit of the recipients will be raised;

- municipal day care facilities will be increased to guarantee day care by 1990 for every child under three that needs it. The child home care support system will be developed, thus giving freedom of choice to families with children;

In terms of regional policy, the Government wants a balanced development of the country's different regions.

In sparsely populated areas, for example, subsidiary industries of agriculture and forestry are being encouraged, to preserve present population levels. In June 1988, the Government presented to Parliament a bill designed to support to regional entrepreneurs. One of the aims of this bill to achieve a regional balance of population development.

Health policy also affects population growth and changes. Over the last 10 years, Finland has adopted a policy emphasizing the preventive and non-institutional aspects of health care, with targets of life expectancy at birth set at 82 years for women and 75 years for men by the year 2000.

Also the educational level of the population, which is high, will continue to rise in Finland, people will be better informed about health matters, and they will choose more self-care and healthier ways of life.

[From: Jouko Hulkko, Managing Director, Väestöliitto, Kalevankatu 16, 00100 Helsinki, Finland]
FOCUS ON THE RUTGERS STICHTING
(FOUNDATION) IN THE NETHERLANDS

The Rutgers Stichting is a Dutch national organization offering assistance to people with sexuality and relationship problems.

Established in 1970, the Stichting (Foundation) has its roots in the sexual reform movement, taking its name from one of the leaders of that movement. It first focused on access to contraceptives for everyone, including unmarried people, and on the right to choose whether or not to have children. Gradually the Foundation developed the basic principle of individual responsibility for one's sexual behaviour: this is apparent in the non-moralizing and non-discriminatory attitude of Rutgers' staff towards people with various sexual preferences, and in their acceptance of the sexuality of both men and women.

The Foundation has a central office in the Hague and 36 family planning centres throughout the country which provide four types of service: birth control services, psychosocial assistance, sex education and information.

The Rutgers Stichting is partly (70%) subsidized by the government (Ministry of Welfare, Public Health and Culture); the remaining 30% of its budget comes from client contributions. Consultations for birth control are charged at a fixed rate, but clients pay for psychosocial assistance according to their financial resources. For sex education courses, financial contribution is requested from participants. Thanks to a special grant from the Ministry of Welfare, Public Health and Culture, the Stichting is able to apply a lower contribution rate for adolescents up to 18 years of age. Some municipalities grant a supplement for young people up to 21.

Birth control services

The 36 family planning centres receive 60,000 clients a year, offer advice on contraceptives, and supply them. They refer clients with unwanted pregnancies to specialized services and help people with sexual problems. Easy access, anonymity and low cost have attracted young people: about 18% of clients are under 18 years old.

While the number of birth control consultations has been falling each year – mainly because of the lower birth rate and the drop in six-monthly check-up consultations for women using oral contraceptives, which were encouraged in the past but are no longer needed in view of the new generation of oral contraceptives, requests are now being made concerning more time-consuming and complicated problems: contraceptive assistance to migrant workers, questions from women in the menopause, pregnancy testing, examination for sexually transmitted diseases (including AIDS), and problems of sexual abuse.

This has prompted the Foundation to reconsider the work of the family planning centres. Tasks will be shifted from doctors to nurses, more referrals will be made to other specialized services, and general practitioners will be trained in sexual counselling.

Psychosexual assistance

The Rutgers Stichting is the only organization in Holland offering specific and systematic psychosexual assistance. This service is part of the country's ambulatory mental health care system, and is available at 14 of the Stichting's 36 centres. In the large centres, assistance is given by a team made up of a doctor, a psychiatrist, or a psychologist and a social worker. Smaller centres have one therapist.

* This may explain why the Netherlands has a lower rate of unwanted pregnancies among adolescents compared to Sweden and the United States. However, Rutgers staff are currently seeing an increase in requests for pregnancy-testing and for the "morning-after" pill. Youngsters still do not think seriously about contraception until after they have some sexual experience.
Some 15 000 clients come for help every year (30% men, 40% women, 30% couples, 50% on their own initiative) with complaints such as lack of orgasm, impotence, vaginismus, or early ejaculation. Few complaints have an organic cause. The treatment is usually short, taking not more than 10 sessions in 75% of cases.

As with the birth control service, the demand for psychosexual assistance is changing. More problems of sexual abuse (both victims and offenders) are being seen, as well as people with tendencies towards exhibitionism or paedophilia, and clients with doubts about their sexual identity.

It is becoming increasingly difficult to maintain short treatment schedules, and the help given is tending to become more specialized. In future the traditional short-term treatment will be maintained, but the Rutgers Stichting is looking for ways and means to deal with victims of sexual abuse and incest, to consult with and refer problems to agencies specializing in crisis management, and to provide in-service training for staff in these new problems areas.

Sex education

Teams in 6 of the 36 family planning centres provide sex education counselling and courses to groups of young people, reaching 1 300 groups or about 20 000 youngsters a year. Sex education courses are also offered to teachers and health workers.

Currently, there is a decrease in the number of sex education courses being offered to secondary schools, but an increase in demand from teachers and health workers. In addition, sex education for drug addicts, mentally disabled people and adolescents with a penal record requires a more specialized approach towards client and community, and this calls for a wider "prevention role" for the teams. The scope and feasibility of this approach are currently being explored.

Receptionists at the Foundation's centres play a key role as "visiting cards" of the organization. They have to answer questions from clients, anticipate needs for information, detect more serious problems, receive telephone calls for appointments, and answer questions about birth control and sexual or relational difficulties. The centres receive some 15 000 enquiries (mostly by telephone) each year.

The centres' information function will be further developed by extending telephone consulting hours, engaging nurses to answer technical questions, showing groups of visitors round the centres, and offering a "once-only" sex education course.

Written information (e.g. on sexually transmitted diseases or natural methods of contraception) is regularly expanded and updated. Some 750 000 brochures have been distributed and are used by other organizations. Publicity is mainly aimed at adolescents and is distributed through various channels (youth groups, pop concerts, etc.). A video film on sexual violence has been produced, and materials on sexuality are being developed for boys.

Conclusion

The Rutgers Stichting with its 36 centres is easily and genuinely accessible to clients. Its staff have an open attitude towards sexuality and are committed to their work.

This may explain why the centres often function as the first step in providing help and information for people who mistrust other health and social services. But how far should and can the Foundation develop its services? What links should be fostered with other agencies? How much additional training is required so that staff can cope with new demands? These are some of the questions and challenges currently being faced.

[From: B. Lam, Rutgers Stichting, P.O. Box 17430, 2502 CK The Hague, Netherlands]
"SEXOLOG" – A COMPUTERIZED INFORMATION SERVICE ON SEXUALITY

"Telematics" is a term coined in France at the end of the 1970s to describe the combination of technologies used in telecommunications and computerized information processing. Small, easy-to-use terminals (Minitels)*, provided free of charge by the French postal service, enable millions of homes, businesses and offices to make use of the telematics services available (more than 4000 different services were on-line by the end of 1987).

In September 1987 the Institute of Sexology in Paris set up "Sexolog", a computerized service offering information and advice on problems related to sexuality. This service, for which a charge is made, is more "neutral" than a consultation with a doctor or a direct telephone enquiry, since the system is accessed by means of a Minitel keyboard. The service is available round the clock and is designed for use by the general public.

Users of "Sexolog" currently have access to five programmes:

1. A glossary giving definitions of the most common terms in the field of sexuality. Eighty–three terms, ranging from "andropause" (male menopause) to "vaginisme" (vaginal spasms), have so far been defined. Not only does this list of definitions enable the "reader" to check his or her knowledge, it is also the source to which he or she is referred, if necessary, for clarification of terms used in other "Sexolog" programmes.

2. A self-assessment programme: in addition to promoting the "serious" side of the process of self-discovery, this programme is also seen as meeting the public's expectation of finding, as in many open-access services, tests which are very close to being games. Here the user can get to know himself or herself better and assess his or her preconceptions more accurately, by means of multiple-choice questions which deal with sexual life, of course, but in a way that may be described as educational.

This programme also contains full details of the latest developments in publishing and the production of audiovisual material on sexuality.

* As with other telematics services, the subscriber pays a charge of 98 centimes per minute of connection to the system, and the total sum due is added to his or her telephone bill at the end of the month.
3. The file meets the user's need for more information on a given subject, offering up to 10 screen-loads of text. Emphasis is placed on the clinical aspects of such topics of sexology as premature ejaculation, vaginal spasms, difficulties with ejaculation, non-consummation of marriage. However, it must be realized that the small television screen used in the Minitel system can only display some twenty lines of text at one time, and that users may get bored with messages that are too long... except when the information is presented (as here) under well-defined headings which run over several screens.

4. Tell us about yourself is naturally the most important programme in the system. First of all, a user can be given a confidential personal code number under which he or she can ask sexologists from the Institute questions at any hour of the day or night (these are answered within 12 hours). Secondly, users can make direct contact with Institute staff on Wednesday mornings and have a genuine written dialogue on their Minitels, thus offering an effective substitute for a telephone conversation.

5. A news programme, giving our "invisible clients" book and film reviews, information about exhibitions, surveys, lectures, etc., in other words promoting the world of sexology in its broadest sense.

With the one-year evaluation phase (October 1988) at an end, "Sexolog" is now aiming at an increasingly wide audience.

Despite the fact that the service has not been systematically promoted since its launch in September 1987, the number of users has grown steadily and more than 1000 connections are currently being made each month. However, this level of use belies the system's real potential, since large sections of the public have barely been reached by the limited advertising undertaken.

The aim of the evaluation during the past year was not to do a market survey in commercial terms, but to assess how accurately the public were "targeting" their requests.

It should be explained that the Minitel is a media tool that has been rapidly taken over by "porn barons" and the like, clearly with the aim of publicizing "encounters" and "exhibitions", especially since the system guarantees absolute anonymity. "Sexolog" has won out, however, precisely because all the messages sent in were either requests for general information or admissions (often expressed in dramatic terms) of a major mental and/or physical problem in the user's private life.

So why are people using this service? Why aren't these potential "patients" consulting their doctor? That's what's strange (and what's good) about the service.

It is clear that the users can be classified into certain categories: people who are hesitant, reticent, isolated or "too" young (5% of calls are from children under 15 years old). Or too old? No, apparently there is an age limit for familiarity with a discursive technology that is so far removed from the spoken word (3% of calls come from clients over 60 years old). Sixty-seven per cent of all calls are directly related to questions about genuine sexual dysfunctions and ways of dealing with them. However, it is apparent - although we can't prove it - that our recommendations to clients to consult their doctor are not complied with.

Calls can be made to the service from any point in the country, provided one has a telephone and a Minitel screen. Obviously, we try (if necessary) to direct the caller to the sexology centre nearest to his or her stated place of residence, but it is not easy to find out whether such advice has been followed. So far as Paris is concerned, there is every reason to believe that people do not follow through their
initiative to the end – because they are distrustful, unprepared, or immature? Here, too, it is difficult to say.

Ultimately, a service like this must act as a mediator between isolated or simply worried members of the public and professional counsellors. Such a role apparently covers an as yet unexplored field in which information and assistance are being requested by many people in France, and especially by young people. Of those 40% state that their fathers are in middle or senior management. Freedom of speech is clearly not keeping pace with the moral freedom our society claims to enjoy!

[By Dr J. Waynberg, Director, Institute of Sexology, 30 rue Saint-Dominique, 75007 Paris, France]

In the meantime, preventing abuse from happening in the first place has itself become a topic for discussion. "Won't talking to children about strategies for keeping them safe from abuse by persons known to them make all children frightened of everyday, loving affection? By all means talk to children about strangers, but don't mention anyone else!" But in cases of child sexual abuse reported to the police in the United Kingdom, 75% of the abusers were known to the child. So abuse by strangers is much less of a problem for children than abuse by someone they know. At the same time, the media present misleading statistics, which should not, however, lead us to switch the emphasis from "stranger danger" to "daddy danger".

There is a way of teaching positive strategies for safety without frightening children. In fact, the "stranger danger" messages which many societies have used with their children have primarily relied on frightening them. But fear often leads to panic and paralysis, rather than action and getting away to safety.

A two-year project

Kidscape is a national campaign based on the belief that children can be taught effective, practical strategies for keeping safe from a variety of potential dangers, but that it is essential to have the help of their parents, teachers and other responsible adults.

During a two-year pilot project, started in 1984, 4,000 children were taught to trust their own feelings; to differentiate between forms of touching which felt safe or unsafe (or "good" or "bad") to them; not to keep hugs or kisses from an older person secret; to break rules when necessary in order to protect themselves; and always to try to seek adult help.

The project was successful not only in terms of helping children to deal with problems of bullying, but also in the sense that it led to hundreds of disclosures of sexually abusive
experiences from children and adults, and dozens of reports of children keeping themselves safe after the workshops. Although it is not possible to know whether these children would have been safe without the lessons, the children themselves credited the workshops with having taught them what to do.

**Developing a kit and other activities to meet the demand**

The major problem at the end of the two years was a waiting list of nearly 1 000 schools wanting a programme, and thousands of enquiries from parents, teachers, police and others about child sexual abuse prevention.

Subsequently it was decided to make the Kidscape programme accessible to any school by providing a kit. It was essential that the kit could be used by teachers without special training, otherwise it would take years for the messages to reach the children.

Around this time, three short items on the work of Kidscape were included in the Thames Television Help! programme, shown in London. Kidscape also wrote a booklet for parents and designed a poster for children, which the Help! programme funded. As a result of the broadcasts, 5 000 booklets and posters were requested in the first two weeks. The broadcasts were later re-made into a 20-minute programme and twice shown nationwide. Some 50 000 free parents' packs have now gone out.

The kit became available in the summer of 1986. Since then, about 250 000 children, and their parents and teachers, have been involved in the Kidscape programme for 5- to 11-year-olds. The programme has been adopted by whole counties, such as East Sussex where 40 000 children were reached.

In addition, training courses on the problem of child sexual abuse and on ways of coping with interprofessional and personal responses to it have been devised by Kidscape, and made available to authorities throughout the United Kingdom, the Metropolitan Police (Scotland Yard) and youth leaders.

The Church of England has sent information on the programme to its 15 000 dioceses, and Kidscape is working with the Catholic Children's Society, the Scripture Union and numerous other organizations.

Currently the programme is being tried out in one Australian state and in Ireland.

A new publication for children, Willow Street kids: its your right to be safe (Michele Elliott), is now available, and a previous book by the same author, Preventing child sexual assault, has entered its third edition under a new title, Keeping safe: a practical guide for talking with children.

**To conclude**

As a campaign, Kidscape has made an impact not only on children's ability to ask for and receive help, but also on the way children are treated and perceived in society. It is not the answer to all the problems of child sexual abuse, nor should we expect that all children will be safe because of a prevention programme. Nevertheless, it is one practical, positive way of starting to combat the problem instead of merely debating the issue.

[From: Michele Elliott, Child Psychologist and Co-Director, Kidscape, 82 Brook Street, London W1Y 1YG, United Kingdom]
WORLD CONTRACEPTIVE USE IN 1987

World contraceptive use, a UN Population Division wallchart, shows levels and trends in contraceptive use by method in 1987, for the world as a whole and for 92 individual countries and areas.

The global level of contraceptive use among married or cohabiting couples with the wife of reproductive age is estimated at 51%, reflecting the rapid growth of contraception in "developing countries".

In those countries, less than 10% of couples were using contraception before the mid-1960s. But the latest figure (May 1987) is 45% (74% in East Asia, 54% in Latin America, 33% in South Asia and 14% in Africa).

Contraceptive prevalence has been rising at a rate of over 20% of couples per decade in one third of developing countries, and by 10-20% in half of them.

Contraceptive use in "developed countries", estimated at an average of 70%, has risen slightly in recent years, although the types of contraceptive used have changed.

Prevalence by country and region

Developing-country contraceptive prevalence ranges from as little as 1% of couples in Mauritania and Yemen to 70-75% in China, Hong Kong, Mauritius, Puerto Rico, the Republic of Korea and Singapore. In the developed countries the range is narrower, with a prevalence of at least 50% in all countries and in the majority 70% or more, the maximum being 83% in the United Kingdom.

In most of Africa south of the Sahara and in parts of Asia contraceptive use is still very low, with no sign of substantial change. However, in some countries where levels had been both low and stagnant there is evidence of an increase, as in Bangladesh, Nepal and Pakistan. Moderate levels (25-50% of couples) have already been reached in Botswana, South Africa and Zimbabwe. There are signs of some increase in Kenya and Senegal, although prevalence remains below 20%.

Use of major contraceptive methods

Couples in the developed countries are more likely to be using most methods of contraception, with two exceptions: sterilization and the IUD.

Female sterilization (two to three times more women than men have been sterilized for contraceptive reasons) has increased rapidly since the early 1970s, a trend due at least in part to simpler, less painful and less costly techniques. Nonetheless, male sterilization (vasectomy) remains a surgically simpler and therefore cheaper procedure. The Netherlands is the only country (of those with data available) where male sterilization is more common than female. Vasectomy is, however, an important method in many countries, including several of the most populous: Bangladesh, China, India and the United States. It is uncommon in Latin America (where female sterilization is high), and in Africa, Western Asia and Eastern and Southern Europe.

IUDs are used by an estimated 6% of couples in developed and 10% in developing regions. The latter figure is strongly influenced by the high level of IUD use in China - 30% of couples, or roughly two thirds of the world's IUD users. For developing countries other than China, the average IUD prevalence is 2-3%.

The pill is used by roughly 13% of couples in developed and 6% in developing countries, including 17% of those in Latin America, but only 4 to 5% in Africa and Asia. The relatively low prevalence of the pill in Asia reflects
<table>
<thead>
<tr>
<th>Country or Area</th>
<th>Women aged 15-49 (millions)</th>
<th>Total fertility rate</th>
<th>Year</th>
<th>Age range</th>
<th>Percentage using:</th>
<th>Other supply methods</th>
<th>Non-supply methods</th>
<th>Time period</th>
<th>Annual increase in percentage using a method</th>
</tr>
</thead>
<tbody>
<tr>
<td>WORLD TOTAL</td>
<td>1188.5</td>
<td>3.8</td>
<td>1980</td>
<td>1 1980</td>
<td>51</td>
<td>5</td>
<td>1</td>
<td>8</td>
<td>1975-1983: 0.3</td>
</tr>
<tr>
<td>AFRICA</td>
<td>125.3</td>
<td>6.4</td>
<td>1980</td>
<td>1980</td>
<td>14</td>
<td>1</td>
<td>0.5</td>
<td>2</td>
<td>1975-1983: 0.3</td>
</tr>
<tr>
<td>ASIA AND THE PACIFIC</td>
<td>667.6</td>
<td>4.1</td>
<td>1980</td>
<td>1980</td>
<td>50</td>
<td>7</td>
<td>3</td>
<td>1</td>
<td>1975-1983: 0.3</td>
</tr>
<tr>
<td>EURASIA</td>
<td>294.1</td>
<td>2.6</td>
<td>1980</td>
<td>1980</td>
<td>74</td>
<td>9</td>
<td>3</td>
<td>1</td>
<td>1975-1983: 0.3</td>
</tr>
<tr>
<td>SOUTH AMERICA AND THE PACIFIC</td>
<td>372.5</td>
<td>5.1</td>
<td>1980</td>
<td>1980</td>
<td>33</td>
<td>10</td>
<td>4</td>
<td>1</td>
<td>1975-1983: 0.3</td>
</tr>
<tr>
<td>LATIN AMERICA</td>
<td>97.6</td>
<td>4.1</td>
<td>1980</td>
<td>1980</td>
<td>54</td>
<td>19</td>
<td>0.5</td>
<td>2</td>
<td>1975-1983: 0.3</td>
</tr>
<tr>
<td>MORE DEVELOPED REGIONS</td>
<td>294.1</td>
<td>2.6</td>
<td>1980</td>
<td>1980</td>
<td>70</td>
<td>7</td>
<td>4</td>
<td>1</td>
<td>1975-1983: 0.3</td>
</tr>
</tbody>
</table>

**Use patterns in the two largest countries, China and India, where it is a minor method.**

The condom is the current method for an estimated 13% of couples in developed countries and 3% in developing, including 2-3% of those in developing countries in Latin America and Asia but only 0.5% in Africa. Japan has by far the highest condom use at 45% of couples.

Couples in developed countries are much more likely to rely on methods that do not require medical services or contraceptive supplies, such as withdrawal and the rhythm method. "Non-supply" methods are used by an estimated 25% of couples in developed but only 5% in developing countries.

In fact, the higher overall level of contraceptive practice in developed countries is due entirely to higher use of these non-supply methods, and of the condom all of which were widely used in developed countries before modern IUDs, the pill and better sterilization techniques were developed.

The regional averages mentioned above conceal much variation within each region, as for example in the case of developed countries. Even neighbouring countries and those with similar cultural backgrounds show different patterns of contraceptive practice, both with respect to levels of use and the types of method used (see table).

[Extract from: Population Newsletter, June 1988, pp. 1-5]
MEETINGS REVIEWED

SEMINAR ON "SEXUALITY AND FAMILY PLANNING: PERSPECTIVES FOR THE MENTALLY ILL AND HANDICAPPED".

The Danish Family Planning Association (FPA) and the World Federation for Mental Health Committee jointly organized a two-day seminar in May 1987 on how to deal with the family planning and sexual needs of mentally disabled people. The 50 participants came from Denmark, other European countries and the United States. The proceedings of the seminar have been published in a 59-page report available from the Danish FPA.

Several issues were discussed – the right of the mentally disabled to express and gratify their sexuality, but also the specific problems that may arise, such as possible genetic risks to their offspring, and problems with child-rearing (competence of the mother and the father) and parent-child relationships (the child may become a parent to the mentally weaker father and mother). The balance is indeed fragile between on the one hand protection of the human right of mentally disabled people to express their sexuality and to procreate, and on the other the care and educational rights and requirements of the future children.

The report contains two interesting discussions of situations where mentally disabled parents live with normal children. Many problems arise for parents and children alike, and among the practical approaches proposed and tried out with success has been the establishment of a permanent meeting-place for families with similar problems.

Other studies and case histories presented at the seminar cite some of the practical problems faced by staff. For example: how can one obtain informed consent for particular family planning methods from patients who are mentally impaired? How can one help male and female patients to satisfy their sexual needs (for example by making appointments with prostitutes, purchasing sex aids or teaching either men or women to masturbate), and this against the backdrop of restrictive legislation?

Finally, the participants discussed the relationships between the incidences of pregnancy, childbirth, abortion and psychiatric admissions, and also studies of the onset of menarche, length and cycle of menstrual bleeding, sexual experience, and use of family planning methods of women with Down's Syndrome, compared with healthy women of the same age group.
The report covers a lot of ground but excels in its frank, specific and practical treatment of the issues at hand. It is useful reading for all health and social workers who are or will be responsible for mentally disabled people.

[Copies of the report available from: Danish Family Planning Association, Aurehojvej 2, 2900 Hellerup, Denmark, free of charge till stock lasts]

EDUCATIONAL AIDS

CHARACTERISTICS OF WALLCHARTS ON CONTRACEPTIVE METHODS

Wallcharts on contraception use visually striking pictures, but in contrast to posters they provide more information and are better used inside the clinic. A typical contraceptive-method wallchart, for example for Turkey, is the "methods-choice" wallchart, where different methods are listed with their advantages and disadvantages.

According to the Population Communication Service (PCS) of Johns Hopkins University, planning a wallchart is not terribly difficult but requires a systematic approach and answers to the following questions: What is the goal in producing a wallchart? What is the message to be conveyed? Who are the target audience? Where will the wallchart be used and which contraceptive methods should be displayed?

Interested persons will find useful tips in information Packet No. 7, prepared by PCS and dealing with designing and printing a wallchart prior to its large-scale distribution. Illustrations are shown from different countries. For example, a wallchart from Tanzania is visually striking, and clear in its symbolic message form (a couple with two children considering contraceptive methods). It has warm and contrasting colours, is not overcrowded and can be easily followed by the eye. These are features which make the wallchart more effective in communicating its messages. Another example of a visually striking wallchart, designed to be read from right to left, is from Egypt.

[From: Population Communication Service, Johns Hopkins University, 624 North Broadway, Baltimore, MD 21205, USA. Packet No. 7 is available in English, French and Spanish and is free of charge for developing countries]
Contraception after the age of 35 years

Vie Féminine, a Christian movement for cultural and social work in French-speaking Belgium, has produced a 32-page brochure covering some of the issues that are of concern for women in their late thirties and early forties. These include the type of contraception to use and the changes to be expected in one's sex life, given that some women are discovering a new language of sexuality now that they can control their fertility.

As a movement for continuing education, Vie Féminine wants women and couples to be able to enjoy a satisfactory and fulfilling sex life and therefore has brought together information on the premenopause, the menopause, gynaecological examinations and effective contraceptive methods.


Le stérilet

JE NE VEUX RIEN AVOIR DANS MON CORPS!

BOOKLETS FROM YUGOSLAVIA

The Family Planning Council of Yugoslavia (FPCY) announces a series of booklets on AIDS and on Family Planning/MCH. The Council does not produce its own materials, but works closely with the Primary Health Care and Maternal and Child Health Government services and has links with the Yugoslav Red Cross for the publication of information materials.

The booklets on AIDS and on Family Planning have been produced by the Belgrade Bureau for Primary Health Care and the Red Cross Chapter of the Autonomous Province of Voivodina.

The AIDS booklets cover different aspects such as: What is AIDS? What women should know about AIDS; and How to protect yourself. The Family Planning booklets deal with: Regular and irregular menstruation; How to prevent unwanted pregnancies; and Nutrition and care of pregnant women and breastfeeding mothers.

Since Yugoslavia has six republics and two autonomous provinces with different population groups, the materials are published in different languages.

[Source: Danica Sasic, Secretary, Family Planning Council of Yugoslavia, Bul. Lenjina 6, 11070 N. Beograd, Yugoslavia]
CURRICULUM ON AIDS FOR FAMILY-PLANNING NURSES AND NURSE-MIDWIVES

Ann Wilson, clinical nurse specialist, has prepared a 50-page AIDS curriculum on HIV infection and AIDS, for nurses and nurse-midwives working in family planning. The aim of the curriculum is to give essential and correct information, and to provide nurses with guidelines for the care of patients, including HIV-infected children, and for handling potentially infectious materials and situations. The curriculum also stresses how to counsel individuals prior to HIV-testing.

The curriculum sections are well presented and the material should be used in the context of training sessions. More discussion on the attitudes of health personnel towards HIV-infected clients, and how these attitudes may affect the care of patients, would have been welcome.

[For a copy of the AIDS curriculum write: Development Associates, Inc., Division of Population Programs, 2924 Columbia Pike, Arlington, VA 22204-4399, USA: Available in English and Spanish]

EXPLAINING AIDS TO YOUNGSTERS

Children and teenagers read newspapers, watch television and listen to the radio, and may hear about AIDS in a frightening or misleading way. How then to explain AIDS to young people?

Inon Schenker of the School of Public Health and Community Medicine, Hebrew University, Israel, has developed two health education programmes for schools: one for 11- to 15-year-olds and one for 15- to 18-year-olds.

Each teaching programme comprises a set of slides, a teacher's guide, work sheets and a bibliography, and aims to increase students' knowledge about the human immune system, to alleviate fears of routine immunization, to increase knowledge but decrease fear about AIDS, and to show ways of coping with a child suffering from AIDS at school. The 15- to 18-year-old programme has a section on safe sex.

The two teacher's guides contain sound methodological suggestions. A capable and interested teacher should have little problem handling lectures and discussions on AIDS. There could have been more diversity between the 11- to 15- and 15- to 18-year-old programmes, as students levels of comprehension and experience differ considerably.

The author suggests that the total AIDS programme should first be introduced to the school staff. Also schools should consider orientation sessions on AIDS for parents after the youngsters have been taught.

As information on AIDS changes rapidly, bi-monthly updates are provided free of charge for those interested in purchasing the teaching package.

[Write to: AIDS Project, School of Public Health and Community Medicine, P.O. Box 7956, Jerusalem, Israel 91077. (Purchase price not indicated)]
WHAT TO WRITE FOR

AN ASSESSMENT AND CASE MANAGEMENT MANUAL ON CHILD SEXUAL ABUSE

More and more incidents of sexual abuse are being recognized and require intervention from many quarters. Physicians are being asked whether they can make a medical diagnosis. Law enforcement officers are obliged to investigate sexual abuse as a crime. Child-protection case-workers are receiving growing numbers of referrals in cases where children are at risk from continuing abuse. Social workers have to identify, diagnose and treat current incidents, while mental health professionals are seeing adults who were victims of sexual abuse as children and now are finally seeking treatment. Lawyers are being required to use the juvenile courts to protect victims, and to prosecute sexual offenders in the criminal court.

Yet these professionals receive little training in sexual abuse. For them, this book provides information beyond what is found in most professional training programmes. Its contents are organized in the form of a manual covering comprehensive assessment, case-management and treatment methods for sexually abused children.

The author succeeds in conveying in great detail much-needed information on child sexual abuse, and illustrates many points through case histories drawn from her years of practice with abused children and their relatives.

An excellent resource on child sexual abuse.


AIDS PATIENT CARE JOURNAL

A practical and well written bimonthly magazine for health care professionals who work with AIDS patients and their relatives. Articles include for example in the April 1988 issue: how to teach self care to patients; bereavement counselling; how adolescents face up to AIDS; why women who have unprotected vaginal intercourse with an HIV-infected man can be infected.

Subscription inquiries should be addressed to Mary Ann Liebert, Inc. publishers, 1651 Third Avenue, New York, NY 10128. Rates are $140 for 9 issues (overseas/air) with three issues in 1987 and 6 issues in 1988.

INFERTILITY: TREATMENT AND CHOICES

Planned Parenthood of Newfoundland province, Canada, launched a survey among 2000 couples and found that 17% considered themselves infertile. The association therefore produced a set of booklets for the public on: What is infertility? What infertility services are available in the province? What are the specific treatments and choices for the infertile couple, such as artificial insemination, adoption, non-parenthood, or in vitro fertilization?

The booklets have been distributed to physicians and public health nurses in the province, in the hope that they will pass them on to people in rural communities.

Currently, six booklets are available. They are written in a very accessible language, have a nice large-letter type, and cover basic facts about infertility and methods in a warm, emotional but realistic way. An exemplary initiative for helping couples concerned about fertility to make the best choice.

[Copies available from Ms Debie Redfern, Planned Parenthood Newfoundland, 203 Merrymeeting Road, St John's, Newfoundland A1C 2W5, Canada]
DOCUMENTS AVAILABLE FROM WHO’S REGIONAL OFFICE FOR EUROPE

GUIDELINES ON CERTAIN ASPECTS OF HOMOSEXUALITY. Aspects of sexuality and family planning. Module 5 (Dr L.N. Schönnesson). WHO Regional Office for Europe, Copenhagen and BLITHE Centre for Health and Medical Education, London. 82 pages, 1988 (English only).

Homosexuality, which is one aspect of human sexuality, has aroused and still arouses considerable controversy among many professional groups as well as among lay people. Religious leaders have attempted to eliminate homosexuality by viewing it as sinful and punishable by the State, and psychiatrists by labelling it a mental illness and trying to "cure" it. None of these strategies, however, has worked. Too often, health personnel display ignorance about homosexuality: what it means to the individual to be a homosexual, and what it means to be part of a minority group. Too often also they show a lack of awareness of both their own attitudes to homosexual men and women and their society’s attitudes towards homosexuality in general. The result is that many health workers have difficulty in counselling homosexuals, or even in relating to homosexual patients in a natural way.

This manual on certain aspects of homosexuality aims to improve the skills of health personnel so that they can more easily identify a given society’s attitudes towards homosexuality, increase their knowledge about various aspects of homosexuality (the book provides a diversified picture of homosexual men and women), increase their awareness of their own attitudes,
values and fears with regard to homosexuality, and thereby offer better services to homosexual patients.

The guidelines are divided into five modules, each designed to deal in depth with a specific area: what is homosexuality; conceptual and anthropological aspects; origins of homosexuality; homosexuality and psychopathology; and homosexual identity. Each module contains self-evaluation tests, exercises, trigger-pictures and instructional texts.

Like the other training materials published earlier (ENTRE NOUS No. 12, October 1988, p. 10), the guidelines are best used in small groups made up of health personnel and/or social workers, under the guidance of a trainer/supervisor.


This study by Denis Couet and Alain Jourdain of the National School of Public Health in Rennes (France) complements other studies, symposia and books on the role of men, with particular reference to fatherhood. What does it mean to be a father? Statements are made in their name, but who are they? How do they see their role in the contemporary family setting, especially with regard to their children and the reproductive function of the couple?

The study, carried out at the request of the Sexuality and Family Planning unit at WHO’s Regional Office for Europe, consists of a semi-structured survey of 40 male subjects, covering their views on domestic work, jobs, birth, the education of children, divorce, contraception, sterilization, sperm donorship, fatherhood and the falling birth rate.

ENTRE NOUS may be freely translated into your national language and reprinted in national journals, magazines and newspapers, provided that acknowledgement is given to ENTRE NOUS and the WHO Regional Office for Europe.

Inquiries should be addressed to the authors of signed articles. For information on WHO-supported activities and WHO documents, contact the Unit of Sexuality and Family Planning, WHO Regional Office for Europe, Scherfigsvej 8, 2100 Copenhagen O, Denmark.

WHO publications should be ordered direct from the WHO sales agent in your country or from WHO, Distribution and Sales Service, 1211 Geneva 27, Switzerland.

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