IPPF EUROPE
Regional Information Bulletin

Vol 8 No 3 July 1979

Counselling in the German Democratic Republic

Over 200 marriage and sexual counselling (MSC) centres are integrated in the National Health Service. The majority of the staff in these centres (gynecologists, psychiatrists, social hygiene specialists, andrologists, general practitioners, psychologists, and sometimes family lawyers/pedagogues) are members of the family planning association *Ehe und Familie* and are trained in counselling.

These centres, which are open to all, provide counselling and medical treatment, free-of-charge. The field of activities covered by the MSCs include the following:

- sexual-ethical education of children and adolescents, in preparation for marriage and family life;
- planned parenthood (contraception and abortion, sterilisation and infertility counselling);
- counselling in and treatment of sexual difficulties;
- counselling in and treatment of partnership conflicts arising mainly from sexual incompatibility.

Unlike contraceptive services, which are available in urban and rural areas, the availability of sexological advice is limited to the larger towns, because of a lack of trained personnel. However, the proportion of people seeking advice on sexual problems is steadily increasing, and *Ehe und Familie* has endeavoured for years to increase staff training in this field, which is viewed as closely related to the whole complex of planned parenthood.

The condition of success in counselling is a good communication between counsellor and client, leading to the development of a working relationship in which both try to solve the problem, the final decision being left to the client.

Counselling in sexual and relationship problems is more time-consuming and more involved than counselling in contraception, and includes also information activities eg. where ignorance of the physiological reactions to sexual excitement has led to sexual incompatibility. If the treatment given appears insufficient, clients are then referred to psychotherapeutic institutions where further treatment is given (eg. in the case of primary impotence). In several larger centres, partner therapy is conducted by a qualified therapist dealing with both partners together. This method can be promising and is particularly suited for sexual difficulties such as frigidity, temporary impotence and relationship problems. In some towns, divorce courts may request couples to visit a counselling centre before making a decision, in cases where sexual problems have been identified as the main motivation for a divorce. The counselling centres also deal with sexual deviations and homosexuality which involve great emotional stresses when the need to talk is important.

Although this counselling activity requires improvements, the increasing number of people visiting the MSCs indicate that the basic concept of this activity meets certain needs which have been long neglected by traditional medicine.

Lykke Aresin
Leipzig

In this issue

Group Work in Austria

Although group work in various areas has been known in Austria since the 1950s, extensive experience could only be collected in the early 1970s. Since the counselling activities of the *Österreichische Gesellschaft für Familienplanung* (ÖGF) are restricted to individual counselling, the experience reported here refers solely to groups of social workers working within the framework of the Vienna Youth Office. Experience on group work undertaken elsewhere in Austria, eg. in adult care, adult education institutions, is not reported here.

The pioneers of group work brought the knowledge back to Austria after the Second World War, but it was some time before this method was accepted by public institutions and implemented in social work. The method was acceptable to the authorities because a greater number of clients could be treated by means of group rather than individual work, at a time of an acute shortage of trained social workers.

We are mainly concerned here with fringe groups directed towards a wide selection of people, from children to adults, and at different levels, depending on the group dynamics.

Some children groups, solely concerned with giving the children something to do, singly or together, do not attach great importance to the group dynamics concept of togetherness; this concept is emphasised when the objective is to establish contact with deprived young people.

In all these groups, no particular emphasis is placed on family planning and sex education and, if the subject arises during discussions, it may be dealt with fully or not at all, depending on the competence of the group leader. The basic training of social workers covers theoretical information on group work. Many social workers then obtain specific training by attending courses in group dynamics on their own initiative. They may also be supervised in the group by a more experienced colleague. The Vienna Youth Office intends to make such training compulsory.

There are altogether 6 groups for children aged 6–10 years, in Vienna, in which children, with school difficulties and family and leisure problems, can do school work and spend their free time under supervision. Usually group dynamics are not used – the primary effort is to encourage, to care for and to employ the free time of each child.

Three groups for adolescents aged 10–15 years deal mainly with problems of truancy, neglect and aggression. Here again, individual care is preferred to group discussion. As far as we know, family planning and sex education do not significantly feature in these groups, which seek to soften the aggression of young people by means of discussion, to encourage their participation in school activities and to counteract the effects of neglect by establishing a firm and reliable contact with the social worker. The problem of unwanted pregnancy arises in these groups, and the ÖGF makes available to them leaflets on contraception and sex information. The problem does not depend solely on the youth of the girls and their obvious sexual confusion, but is made especially difficult because these girls come from the most depressed social group, which frequently does not use help which may be available.

There are at least three groups for young people aged between 15–20 years, using primarily group dynamics techniques. These young people usually suffer from lack of contact and are in search of a feeling of belonging – of group structure. These groups, which meet regularly, aim to create confidence among the participants, and do not apparently attach importance to sex education, family planning and contraception.

For parents expecting a child, there are 'parents' schools' which deal mainly with aspects of education, marriage and harmonious family life. These groups function in newly settled areas on the outskirts of the city, with problems of lack of infrastructure and of contact, which participants find easier to solve in the groups.

There are also groups for mothers (their children aged 3–14 years can take part in communal games) belonging mainly to the lower socioeconomic stratum, where they can discuss mutual problems of isolation, loneliness, lack of contact, difficulties with their partners and in bringing up their children. The women are informed on how to make use of different facilities which the City of Vienna and the Youth Office offer.

There are groups for foster parents also, (adoption is comparatively rare in Austria). When it becomes necessary to separate children from their parents, use is made of a municipal home or of foster parents who are financially compensated. An effort has been made to bring together the foster mothers in group meetings, regularly, and to draw attention in this way to the common problems of these women so that appropriate assistance may be given by the Youth Office.

There is also a group for parents, whose children have been taken into care, preparing them for the time when their children will leave the educational home and return to the family.

What advantages could or should these groups have compared to individual care? Experience shows that it is frequently only through groups that real help can be given to children or young people, because they would reject individual discussion until a genuine contact had been established with the social worker. The group also allows people to realise that their problems are not unique and, in newly settled areas, gives them an opportunity for mutual acquaintance and for overcoming isolation, as well as being a starting point for neighbourly help.

It should not be forgotten either that this type of group work can compensate for a shortage of qualified social workers. Individual care can only be given adequately to a few, and group work is one way of dealing with the large number of problem families and their various needs.

Any assistance from ÖGF to the group leaders or directly to the participants in the form of information and materials would be limited because of its small membership and their time limitations. In 1979, the ÖGF intends, experimentally, to try to use youth group leaders as mediators in the field of family planning and sex education by concentrating on this aspect in their training. They should then be able to discuss family planning and sexuality with young people and children, giving them not only information but also a good emotional background in these subjects. ÖGF hopes to report in 1980 on this experiment.

The foregoing clearly shows that family planning and sex education cannot be the *sole* subject for group discussion or group counselling. In any case, they are part of integrated work with different groups, and do not merely involve the provision of practical information, but also the changing of emotional attitudes which is a long and slow process. For this reason alone, an integrated approach to family planning and sex education is to be welcomed.

Elisabeth Jandl-Jager
Vienna

The CEMP Experience in Group Counselling

Six months ago, the *Centro Matrimoniale e Prematrimoniale* (CEMP) in Milan started providing group counselling on contraception. Previously, each woman or couple seeking contraception counselling at the clinic would first have had a meeting with a social worker. During this meeting, the social worker would provide information on all contraceptive methods and advise the woman or couple on the most suitable method. At this point, the physician's role was to ensure that the choice of contraceptive method was appropriate for the woman concerned. With this system the following constraints were found:

- it created organisational problems due to the increasing number of people visiting the clinic;
- sometimes the achievement of these meetings was low. The approach was not flexible enough to cater for those people who had information on contraception and knew which method they wanted to use; nor for those people who needed further information, but were too afraid to reveal their ignorance.

It was decided to adopt group counselling. Under this system, when a woman (or couple) telephones or asks for an appointment, we offer the individual or group approach. When group counselling is given, the group consists of 5–8 people. The social worker begins by introducing herself, and helps the girls to introduce each other to the rest of the group. The social worker continues by asking whether any of the girls have attended a family planning clinic in the past, and whether they have had a gynecological examination. Those who have had an examination are asked to give an account of the experience. The social worker then asks the group to exchange information on their use of contraceptive methods. During these discussions the social worker stimulates the exchange of information, corrects misconstrued ideas, and fills in any gaps. When discussions are uneven or prove difficult, the social worker explains all the contraceptive methods available, and stimulates questions and discussion on related topics.

Prior to leading these group discussions, the social worker holds trial discussions with a physician and two other social workers. It was seen that whenever a physician was present discussions tended to be of a medical nature and had the physician as the focal point. Also, whenever two social workers were present, there tended to be some confusion in the group, even when their roles had been properly identified. Some further problems were identified concerning the composition of the group. The group functioned best when it was composed only of women of a similar age; whenever men were present, discussion was not free. Whether they took an active or passive part in the discussions, it was felt that their presence intimidated women. A further problem encountered was that women tended to discuss problems which are socially accepted and with which they are not too emotionally concerned. Women would bring up deeper sexual problems after the group discussions and seek the advice of the social worker or physician in private.

Antonietta Corradini
Milan

Sex Education Training : a Pro Familia Pilot Project

Background
In out-of school activities, young people can fulfil needs which are condoned but not actively encouraged in other social circumstances, eg. needs for contacts and sexuality. But their experience with relationships and sexuality is not entirely positive: it may lead to problems of misunderstandings with the partner about expectations and fears, conflicts with parents, pressure from the peer group, etc.

Those responsible for youth activities are often unable to deal with such problems because of their lack of training in sex education training; and evidence of this lack arises from the experience of counselling centres. Traditionally, these centres have had the function of 'treating' problems which have become major issues eg. partnership problems and emotional problems associated with pregnancy. It has now been realised that the centres must offer 'preventive' counselling to young people. As Pro Familia has not enough personnel available to undertake such preventive counselling, it seemed sensible to train youth leaders for this work.

Project and aims
Pro Familia (Saarbrucken) has established a pilot sex education project aimed at providing youth leaders with the skills which will help them: to teach young people to develop happy sexual relationships, without exploiting their partners and without irresponsibly risking the conception of an unwanted child; to show them how relationships are influenced by social environment, family origins, peer groups and public opinion. The training project aims to develop this ability through biological, psychological and social information on sexuality, discussions on different living patterns and the provision of contraceptive information; it seeks to enable the youth leaders to recognise and analyse young people's problems, to help them find their own solution,

and to show them that conflicts can be used as a learning experience.

The people for whom this training is intended can be divided into two groups, requiring two different types of training:

Personnel involved in out-of-school activities will be given training in 5–10 sessions of 2–3 hours each. This basic course will highlight the participants' own attitudes towards sexuality, teach them the content and methods of sex education, familiarize them with conflicts arising in youth work and enable them to establish a discussion group on 'sexuality and partnership' with young people. This is followed by a practical phase whereby the experience and knowledge gathered during the course is put into practice. Six months later a further course follows which has the purpose of exchanging practical experiences.

Training in the field is also provided for personnel of youth clubs, youth centres, etc. During the first stage, personal attitudes are discussed, content and methods for working are proposed and a discussion group with young people is formed. During the second stage, the discussion group meets with Pro Familia workers who initially take the lead and gradually assume a more passive role by only offering advice.

Future workers in out-of-school activities need to consider further forms of training. At present the following are under discussion: a two term course at the Technical High School for social workers; and extra courses for psychology, sociology, and teacher training students. The experience gained by those participating in the project will be assured by the scientific basis of the project's contents. The project can be seen as an example of sex education training portrayed and disseminated in general terms to those responsible for young people.

Leaflet for Migrants

The *Pro Familia* leaflet ('Family Planning – why and how?') intended to provide information on family planning and fertility regulation to Turks, Yugoslavs, Spaniards, Italians, Greeks and Portuguese, emphasises the mother and child aspect in the context of the socio-cultural backgrounds of the different nationalities. The groups concerned helped to prepare the text and layout of the leaflets.

The basic concept of the leaflet was elaborated in consultation with the Information and Publications Committee and the International Committee of *Pro Familia*, and with migrant families and foreign PPAs who checked the completed texts in six languages, and advised on printing and distribution.

Pro Familia encountered special problems in producing the leaflet, such as the amount of time it took to: find representative families willing to be 'studied'; receive replies from PPAs in other countries, select the appropriate terminology for translation.

Child Welfare Seminar in Yugoslavia

Following the meeting of the IPPF Europe Regional Council in Cavtat/ Dubrovnik (which will be reported in the October issue of the *RIB*), the *Family Planning Council of Yugoslavia* (FPCY) held a seminar on 17/18 May on *Child Care in the Yugoslav Socialist Self-Management Society*.

Opening the seminar, Nevenka Petrić, FPCY President, welcomed participants and emphasised the importance of working towards providing children all over the world with better conditions for a brighter childhood and happier future, recalling the words of President Tito on the occasion of the International Year of the Child: 'The attitude towards today's children is the attitude towards the future of mankind'.

In a paper: *The Interest of the Child is the Centre of Attention in Fulfilling the Constitutional Right to Free Choice on Childbirth*, Nevenka Petrić spoke of the need for parents to be assisted in fostering the necessary conditions for the psycho-physical development of their children. A basic contribution to such assistance was assurance of the information and means enabling the individual to regulate his/her fertility. Society at large could not replace individual parental love and care. The achievement of freely desired and responsible parenthood is an integral part of the socialisation of childcare, which does not, however, mean the alienation of childcare by its transference to the state. In Yugoslavia planned parenthood is not prescriptive in the sense of indicating the desirability of couples having more or fewer children – there is no ideal family size.

The child's interests are considered as the central interest of both the parents and the social community: 'The stimulation of parents, as well as citizens who are not parents, to organise themselves, using their democratic rights in the basic units where they work, in order to establish necessary forms of childcare and to improve the care of children, is in fact the realisation of parental duty and responsible

parenthood. Such unique socialisation of citizens in discharging parental duty is realised in the local community, and the basic associated labour organisation, in an attempt to avoid differentiating between personal and general interests, and in accordance with the general intentions of our self-managing socialist society for the welfare of all children. In this way the interest of the child is central to the realisation of the human right to freely decide on family planning'.

In order to assure the interests of the child before birth it is essential that the conditions exist for workers to decide on the conditions and results of their labour (self-management). Equally, it is essential that all, particularly younger people, are fully informed on their constitutional rights to free decision-making in parenthood. For this purpose more premarital counselling centres are required, and greater efforts are needed to involve men in decision making in this field in the context of 'humanisation of relations between the sexes'.

Other papers presented at the seminar were: by Šefćet Jašari, Secretary of the Trade Union Council of Yugoslavia on *Activity of the Trade Unions on Furthering Social Childcare*; by Zoge Gruevski, President of the Committee of Local Communities of the S.R. of Macedonia on *The Local Community and Social Childcare*; by Jelka Ilić, of the Coordination Committee of the Childcare Communities of the Republics and Provinces on *The Self-Managing Organisations of Common Interest in Meeting the Needs of Children*; by Ljubica Prodanović, Vice President of the Union of Pedagogical Societies of Yugoslavia, on *The Coordination of Activity of all Social Factors in the Development of Children*; and by Zora Šerbedžija of the Union of Societies for Education and Care of Children in Yugoslavia on *The Role of Voluntary Social Labour in the Upbringing and Care of Children in Yugoslavia.*

North African Migrants in France

At the Middle East and North Africa (MENA) Regional Council Seminar held on June 9, a presentation was made on *The MFPF and North-African Immigrants in France*, which is here summarised.

The needs of migrants have not been treated specially by the *Mouvement Français pour le Planning Familial* (MFPF) which views these in the global context of the basic right of women and couples to maintain their own attitudes towards sexuality and fertility.

Migrant Population in France
In 1977 there were over 4 million foreign workers in France (8% of the total population) of whom 31.5% were from the Maghreb countries.

Occupation by nationality

	Unskilled workers (1)	Skilled workers	Total of workers	Office workers	Others (2)	Total
Italian	39.9	45.9	85.8	7.0	7.2	100.0
Other EEC	30.8	27.5	58.3	14.7	27.0	100.0
Spanish	48.6	40.5	89.1	8.1	2.8	100.0
Portuguese	60.5	36.2	96.7	2.7	0.6	100.0
Moroccan	76.2	20.8	97.0	2.5	0.5	100.0
Algerian	73.6	22.7	96.3	3.4	0.3	100.0
Tunisian	63.6	26.6	90.2	8.0	1.8	100.0
Other African	75.5	12.2	87.7	10.3	2.0	100.0
Other nationality	57.0	26.0	83.0	8.4	8.6	100.0
Total of foreigners	61.4	30.5	91.9	5.1	3.0	100.0

(1) Labourers + specialised workers
(2) Supervisors, technicians and executives

Source: Ministry of Employment

The MFPF sent me to represent the association at the meeting of the Regional Council of IPPF MENA Region because I live and work in a department around Paris, (Seine Saint-Denis) where numerous migrants live and work. They are my neighbours, and my friends.

The needs of the migrants and the answers of the MFPF
Over ten years ago, the need for migrants to limit births was expressed eg. on the occasion of visits to PMI (MCH) centres. The MFPF has an agreement with the PMI services whereby it conducts activities in the centres visited by French and migrant women. (The MFPF has refused to work in centres which required our services for migrants alone).

At the time, it seemed to us that the subject was viewed in terms of segregation rather than as the right of each woman (married or not, adult or minor, French or foreign) to self-determination, and to exist other than as a reproductive being – a view which seemed much more important to us.

In all the centres where the MFPF works, the waiting time before the medical consultation is used to provide information either by individual contact or in small groups, and to facilitate exchange of experiences between women and understanding of other cultures. 'These things' which are not to be spoken of are no longer a solitary experience but are shared and put into a global context.

Meetings of women belonging to the same ethnic group, with or without an interpreter (one of the women may

assume this task) have led women to realise that their sisters, their compatriots, were suffering similar difficulties and sharing the same aspirations.

As a rule we always start from the women's concerns. Among the discussion themes are:

- female and male sterility;
- why do people want a boy so much?;
- young people's development;
- fear when girls go out of the house or go to work;
- should a husband be chosen for a daughter? Will she accept him?;
- the French 'pattern', its limitations;
- the difficulty of being a migrant;
- racism;
- changing relations between men and women.

Whenever possible, we use audio-visual materials to illustrate the information.

We are aware that our material is not well adapted, that it is too abstract and that we have neglected the importance of contacts with the countries of origin.

What do these women ask for in the MFPF centres?

Not to have as many children, so close together; to have no children at all (requests for sterilisation); infertility services.

These requests are answered by means of information, contraception, sterilisation (in some cases) and abortion.

Sexual information, contraception, sterilisation and abortion do not have the same significance for the MFPF workers (for whom such services relate to women's emancipation), as for migrant women (for whom they relate to birth limitation and spacing).

Problems facing the Migrants

When migrants visit our centres, they may express their sorrow at having left their country (a rural environment for the majority), left the family group and arrived in a new country with a different civilisation, finding themselves in cramped accommodation, without space and with a restricted family. The woman is isolated, her possibilities of communication being even more limited because of the language problem. All these factors have an effect on them and weaken them because so many things have changed in so short a time.

In their country, children are such a source of riches, of happiness not only for the father, the mother but also for the group, while here they become a source of worries, burdensome and costly.

The family size, the sex of the children, the women's ages, their living conditions, working conditions, their length of stay in France – are all primary motivations which force them to review their fertility patterns.

But to question this pattern is to go against the education which they have received and assimilated. It is to go against the only feminine fulfilment which tradition allows them: to be the mother of numerous children and to be praised for that alone.

Young people – isolated people

Among migrants, young people concern us particularly. They are torn between two civilisations, that passed on by their parents, which tends to fade, and that received in France, inculcated by the school, the street, the mass media. Sometimes they appear to be completely torn between two contradictory cultures and they find it hard to relate to one or the other.

Girls, especially, experience difficulty in finding their identities: if they lead a sexual life outside marriage, it is without their families' knowledge. They increasingly refuse to accept the husband chosen for them by their parents; they claim the right to work, to have more freedom.

Few men accompany their wives to the centres, fewer still come by themselves; they too suffer from the sexual repression which their situation imposes on them.

Conclusions

It is out of the question for us to impose our patterns on migrants. Each woman, each couple will find what suits them, temporarily, by trial and error. Modern rapidly changing society affects French women also.

Laws on contraception and abortion are recent, and some regions do not yet have the necessary structures to satisfy all peoples' needs. The MFPF continues to draw attention to these deficiencies. It is also concerned at the consequences of unemployment among migrants and at government measures intended to control the employment and residence of foreigners in France. Insecurity of work, of accommodation, can only damage our attempts through information on family planning and contraception services to improve the status of women, of all French and migrant women, and to improve family and child welfare.

Justice for all implies that governments evolve social and economic policies and programmes aimed at satisfying the basic needs of the more deprived communities and to reduce inequalities in the quality of life.

Family planning and population activities can only be invoked in the context of large scale campaigns by all to eradicate the gap between rich and poor countries, by a better use of technological progress and energy resources in order to guarantee equality of rights and freedom for their implementation for all people.

Jacqueline Revert
Paris

Computerised Record System for Irish Contraception Clinics

Since January 1979, the two *Irish Family Planning Association* (IFPA) clinics in Dublin have administered a new record system to new clients. This consists essentially of a chart designed for computerisation. Information from the client at interview and medical examination, and details of the treatment prescribed, are entered in appropriate boxes on the chart. The coded data are punched on to computer cards.

This computerised system was considered suitable for the IFPA because of the relatively large number of clients attending the clinics: about 6000 new clients every year, excluding those seeking condoms or spermicides. Because only two clinics are involved, the limited number of staff using the charts minimises faulty completion.

At the client's first visit, a three-page chart is completed, each page with a copy which is subsequently removed. The top copy remains in the clinic, and the carbon copy is used to transfer the information to the computer. To ensure confidentiality, the client's name and address do not appear on the computer copy, only appearing on the top copy kept in the clinic.

The layworker enters the client's age, marital status, occupation (and partner's occupation), and the advice requested. The sections completed by the nurse and physician were planned to minimise the work. Most boxes are left blank, requiring completion only if a positive answer is indicated. In this way, the client's medical and reproductive history and initial examination are recorded. Past contraception, complications and any referrals to specialist clinics or hospital outpatient clinics may be completed simply. Space is allowed for additional notes.

A condensed 'followup' page, again with a carbon copy, is used for subsequent visits. The identification number of the patient remains the same. Information on this followup page includes the contraceptive used, information on its continuation, or reasons for discontinuation, any side effects, urine and smear test results, and any referrals.

The vast amount of information in these charts, and the large number of clients attending the clinics, required computerisation for complete statistical evaluation. Possibly significant correlations of side-effects with specific contraceptives may emerge, which might otherwise be overlooked. Computerised information is also more accessible to IFPA personnel interested in specific research projects.

In Ireland, contraception and planned parenthood are political issues. Individuals and organisations on both sides of the debate have definite opinions, and their altercations may become heated. It is increasingly important for the IFPA to have data accessible as quickly as possible, in order to refute or confirm any claims.

G. Coffey and
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Dublin

Postcoital estrogen or IUD?

Introduction
The fertilised human egg takes about three days to reach the uterus, and about another three days to implant.[1] This report summarises a controlled trial of postcoital ethinylestradiol (EE) versus the Copper-T 200 IUD (Cu-T).

Method
In 1977 and 1978, 120 women aged 15–35 years, attending the CEMP Centre in Milan in search of postcoital fertility regulation, were assigned randomly (60 each) to the following procedures: five tablets EE (1 mg) daily for five days (total dose, 25 mg EE); or insertion of Cu-T. All women were followed up for at least 40 days since last menstrual period.

The mean age of the women was 22 years (90% under 25 years). Of the 120 women, 88% were nulliparous (78% nulligravid). Relative to ovulation estimated as 14 days before the mean length of the six previous cycles, 40% had had unprotected coitus within two days of ovulation; 30% had had coitus 3–4 days before, or 3–5 days after ovulation; and 30% had had coitus 5–6 days before, or 6–7 days after ovulation. The interval between unprotected coitus and treatment was less than 24 hours in 76%, and 24–48 hours in 24%.

Result
None of the 120 women became pregnant: all reported subsequent menstruation on the due date. Of the 60 women taking EE, 80% experienced side-effects: 51% nausea, 18% vomiting, 30% breast pain and/or tenderness, 25% headache, 22% bleeding and 7% leg cramps; and one woman had superficial venous thrombophlebitis. Of the 60 women bearing Cu-T, 38%

experienced side-effects: 8% vagal reflex during insertion; 11% serious uterine cramps within four days of insertion; 33% bleeding; and one woman expelled the IUD five days after insertion.

Conclusion

Both EE and Cu-T seem effective in preventing pregnancy.

The effectiveness of EE confirms previous studies;[2] one study of postcoital IUD insertion found no pregnancy in 100 women.[3]

Postcoital Cu-T is clearly much better tolerated than EE; and IUD use continues subsequently. Moreover, in case of failure, steroids may be teratogenic in early pregnancy.[4]

IUDs may be effective even if inserted 3–4 days after unprotected coitus,[3] and are recommended as the first choice under such conditions. Postcoital steroids should only be considered if both IUDs and early abortion are unacceptable. (Further details of the trial are available from the authors at the UICEMP address below.)

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Regional concern for Portuguese journalist

The Europe Regional Council at its 8th meeting held in Yugoslavia in May, became aware of the trial of Maria Antonia Palla charged with 'outrage to public morals' and 'incitement to crime' for her journalistic work in presenting a television programme in 1976. The film, for which Maria Antonia Palla only provided the text, was called 'Abortion is not a Crime' and was attacked by conservatives and Catholic bishops. The Regional Council's concern was expressed in the following resolution which it unanimously agreed to send to the Ministry of Justice. The RC states that it:

- is aware of the hazards to women of illegal abortions, aware of the need for the public to be informed of these, and points to the need to provide safe and legal abortions where these hazards exist,
- protests against the infringement of the right to free speech apparent in this case, and asserts the right of the media to discuss matters of public concern, wherever in the world,
- deplores the indictment of Maria Antonia Palla and expresses its solidarity with her,
- urges the responsible Portuguese Authorities to withdraw the charge against her, and
- asks national member associations of the IPPF to make such protests or representations as they see fit to the Portuguese Authorities.

Following strong local and international support, in June Maria Antonia Palla was acquitted of all charges. In his judgment, the judge expressed the opinion that the law on abortion (which dates back to the last century) was not in accordance with the Constitution which refers to family planning as a human right. At present, infringement of the law on abortion carries a penalty of 2–8 years imprisonment. The case of Maria Antonia Palla has created a favourable climate which hopefully will encourage a review of the present law on abortion.

Conrad van Emde Boas 75th birthday

Born on 17 June 1904 in Rotterdam, Professor van Emde Boas, registered as a psychiatrist in 1932, was in contact with the well-known pre-war Middle-European sexologists, Hirschfeld, Fetscher and Hodann. From 1932–35 he was a leading figure in the World League for Sexual Reform.

From 1932 to 1954 he was first interim medical director and then full Director of the Aletta Jacobs Huis, the first Dutch Institute for sexological consultations, whose role in sexological therapy, the training of sexologists and research in sexology he greatly advanced. In 1947 he initiated the first psychoanalytical group psychotherapies in Holland and, ten years later, he began with the treatment of couples in such groups.

Apart from his membership of several international and national institutions, Professor van Emde Boas was a leading figure in the IPPF as a Dutch representative from NVSH (Dutch Association for Sexual Reform) and President of the Europe Region 1957–64.

Professor van Emde Boas lectured at many universities in the Netherlands and in Europe and has written numerous books, the best known of which in Holland were *De periodieke onvruchtbaarheid der vrouw* (periodical infertility in women), *Abortus Provocatus*, and a psychoanalytical and sexological study entitled *Shakespeare's sonnets and their relationship to the Travesti Double Plays.* In 1975 he published *Verspriede opstellen over geboorteregeling en abortus* (Essays on abortion and contraception).

ISSN–0306–9303

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Printed in England by Stephen Austin/Hertford